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Employing Empowerment: Developing the Discourse for Women's Empowerment in Uttarakhand, India

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Employing Empowerment:

Developing the Discourse for Women's Empowerment in Uttarakhand, India

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India: Health & Human Rights
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Abbreviations

NRHM – National Rural Health Mission
ASHA – Accredited Social Health Activist
ANM – Accredited Nurse Midwife
CMO – Chief Medical Officer
VHW – Village Health Worker
BHP – Basic Health Promoter
GRC – Gender Resource Coordinator
NGO – Non-Governmental Organization
PHC – Primary Health Center
CHC – Community Health Center
DARC – District ASHA Resource Center
RLEK – Rural Litigation & Entitlement Kendra
CFHI – Child Family Health International
IGHEF – Indian Global Health and Education Forum
PRAGATI – Panchayati Rule and Gender Awareness Training Institute
WHO – World Health Organization
CRHP – Comprehensive Rural Health Project
DHFWS – District Health and Family Welfare Society
HIMS – Himalayan Institute of Medical Sciences
SBMA – Shri Bhuvneshwari Mahila Ashram
NCIH – National Council of International Health
MDGs – Millennium Development Goals

Introduction

The following research study was conducted between the dates of 12 April, 2011 and 6 May, 2011 in the district of Dehradun, Uttarakhand, and in surrounding rural villages. The investigation focuses on the empowerment of marginalized women through NGO and government programs, particularly through their employment in the field of public health within the role of Accredited Social Health Activist (ASHA) and related Community Health Worker models developed by NGOs. The study will consider how empowerment through employment in the health sector works to decrease gender inequities by improving the status of the woman, increase the woman's confidence, training her to be an advocate of health matters (both her own and those of her community) through educating her on her rights, while simultaneously tackling the social development and poor health indicators of marginalized populations. Other evolutionary methods of women's empowerment, spearheaded by active NGOs in different parts of India, will be discussed and used to identify the limitations of the government ASHA program. The training, implementation, monitoring, and financial affairs which are specific to a grassroots-based scheme, require careful consideration and continued support; in locally-implemented schemes, where the context is one of historic structural violence, a proper translation of policy into practice is essential. NGO additions to government empowerment programs will be used to detect specifically where written policy fails to become actual practice. The rhetoric of globalization and the accepted universal human rights discourse, as well as the impressive arguments and evidence provided by research subjects, make it mandatory that no one is neglected services by India's public health sector regardless of the beneficiary's apparent inaccessibility to the provider and vice versa.

Research Questions & Hypotheses

The Accredited Social Health Activist (ASHA) Program of the National Rural Health Mission (NRHM) has the potential to accomplish the following goals essential to successful development and poverty eradication: it can improve health indicators through utilizing local human resources, can better connect marginalized, rural populations with available (but possibly hard to reach) government health services, and can empower women by offering them a position which can improve their status in the village, through both economic and social measures. However, if implemented in a cursory manner, the ASHA program can further exacerbate gender discrimination, financial insecurity, and can exploit the health worker merely as a means to improve health indicators, rather than a means to ensure a society based on gender and social equity.

Having the federally recognized position of ASHA is a perfect opportunity to consider development and empowerment of the female population within the marginalized population. Although there is a looming gap between policy and practice, legal and political support *is* essential in ensuring the legitimacy of a program: an element essential in successfully reframing the detrimental structure of society. Furthermore, the ASHA can act as an intermediary between the beneficiaries and the providers. Such a liaison is crucial when a nation's public sector finds they are still failing to reach the most marginalized, especially when it is greatly due to gender and inherent but unintended structural violence.

Women have shown the need for an intermediary who both understands local culture and rhetoric but also understands the need to connect women to the gamut of public health services in order to instigate development and the maintaining of a healthy lifestyle. In order for her to be

successful, this intermediary must understand and employ her economic and social freedoms as outlined in the Indian Constitution. It is concluded that the shortcomings of the government's empowerment programs stem from improper or hasty implementation: the improper translation of policy into practice. Successful women's empowerment programs, executed by active NGOs can be used to highlight the government's inadequacies.

Methodology

The majority of the research findings are derived from formal and informal interviews with a varying range of research subjects: hospital staff (interns, nurses, and doctors) in the Doon District Hospital, and the Doon Women's and Children's Hospital, multiple Primary Health Centers (PHCs), Community Health Centers (CHCs), and the Mazra Ayurvedic Primary Health Center, all existing in the district of Dehradun or in its outskirts, approximately thirty ASHAs (at various health centers, at home, at a training at the Mehuwala Panchayat Center, and at the Pratipur health *mela* or health camp organized by the NGO Mamta), ANMs (at Doiwala Community Health Center), Anganwadis (at the Pratipur health *mela* and in a village of Doiwala), and Basic Health Promoters (BHPs) in the village, Patti, through the NGO Child Family Health International (CFHI) and Indian Global Health and Education Forum (IGHEF).

Small focus groups (consisting of an average of six subjects, with one large focus group at an ASHA training session) were conducted in order to spark discussion and debate on one topic between a group of equals. These focus groups were informal and conversational, and, from them, a great deal of useful information was gained.

A survey of approximately 12 subjects was conducted in Kehrigaon, Prem Nagar: the area surrounding the Mamta office. Adolescent girls and young, newly married women were questioned about a range of topics: the ways in which they perceive their own self-confidence, support within their family, and available resources to women in their community. In some cases, there was conversation with multiple generations at once, which was quite beneficial to the research as it offered a picture of how gender issues have progressed over the past fifty to sixty years in one, specific area. No men were present during these interviews.

The NGOs which were primarily utilized in the following research were: Mamta Samajik Sanstha (Mamta), Rural Litigation & Entitlement Kendra (RLEK), PRAGATI (Panchayat Rule and Gender Awareness Training Institute), Astitva, Child Family Health International (CFHI) and the Indian Global Health and Education Forum (IGHEF). The State Women's Department and the District Help Line were both consulted for information regarding government programs for women's protection.

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*Development for women
is not planned within a framework of equality. There
is no system or framework with a clear mandate or the
requisite authority
to ensure that policies and recommendations are acted upon.
Development programmes often separate women from men,
homogenizing women rather than recognizing diversity within women,
instead of evolving mechanisms to ensure that the most dis-privileged benefit from every
intervention.
Where there are efforts, these are largely islands of innovation and commitment, and
little is being done to integrate their strong points into all
development programs.¹*

~ ~ ~ ~ ~

¹ Desai, Armaity S. "Higher Education and Human Rights."

I. The Continued Plight of Women in the 21st Century

At the foundation of every program, whether it be a community health program, an education agenda, a good governance initiative, lies the crucial but potentially wholly theoretical entity: policy. In examining the shortcomings of any program, one must first consider where policy meets barriers that prevent it from translating from theory into reality. By considering the context in which a theoretical strategy is applied, and then determining where and how, specifically, the context inhibits the program from reaching its full potential, the social, political, or economic obstacle can be identified. “In India,” one woman who requested anonymity stated, “what is shown on paper is totally different than the practicalities.” In order to comprehend the faults of the women’s empowerment programs, directed and implemented by the Indian government, one must first begin with an evaluation of modern gender policy. An analysis of gender policy will outline the rights and freedoms which a woman has theoretically been granted by her federal and state governments. After fully understanding the veracity of gender relations in India, one can credibly argue how specifically gender equity must be promoted through carefully and sensitively *enforced* legislation, based at the grassroots level, rather than through mere legislation.

The characterization of traditional Indian social structure as one in which the male is dominant discourages, among other things, the vocalization of mental and physical health concerns and the care-seeking behavior of the female. Beena Walia, a Senior Project Officer and founding member of Mamta Samajik Sanstha, a Dehradun-based non-profit voluntary organization dedicated to women’s empowerment, with a unique focus on adolescent girls, stated that the conditions of public and private society are such that, “women don’t have any protection,

any security.”² For the female, a patriarchal society translates into limited power to make decisions, decreased ability to control her access to outside resources, and the struggle to safely and confidently direct her own mobility within the public realm. As Mr. Tej Ram Jat of the United Nations Population Fund expressed during an interview on 15 March, 2011, women, regardless of their socioeconomic status, find themselves suppressed by traditional societal constructs that have maintained their strength (even if only in mindset) albeit recent social, economic, and educational developments of the nation. Even when comparable or even identical authority is held by male and female in the workplace, Mr. Jat explained, women find that their gender alone stands in the way of complete equality.³

Legal documents attempted to combat such gender inequality years ago, but still, themselves, possess tangible contradictions. Within Article I of Part I of the *International Covenant on Economic, Social and Cultural Rights*, drafted in January of 1976, it is stated that:

All people have the right of self-determination. By virtue of that right they freely determine their political status and freely pursue their economic, social, and cultural development.⁴

And yet, it is stated in Article II of Part II, that,

Developing countries, with due regard to human rights and their national economy, may determine to what extent they would guarantee the economic rights set forth in the present Covenant.⁵

This second statement reduces pressure on developing nations to recognize the economic freedom of marginalized populations (in the case of this study, women) despite the fact that within Article III it is further stated that State Parties must guarantee the equal rights of both genders. Although attempting merely to apply to all countries regardless of their stage of development, such an article ultimately deems economic and social rights as flexible to the

² Walia, Beena. NGO, Mamta Samajik Sanstha. Personal Interview. 20 April, 2011.

³ Jat, Mr. Tej Ram. Interview. 15 March, 2011.

⁴ Talwar, Rajesh. “The Third Sex and Human Rights.” 133.

⁵ Talwar, Rajesh. 134.

cultural environment in which they are being applied, reducing the likelihood of women in a conservative society to experience equal rights which are written but left to the local government to ensure. Within “Women & Law in India,” Flavia Agnes offers a compelling theory on the consistent inadequacy of India’s written legal code to properly address gender issues, a fault which one could argue stems from a lack of transparency:

Unfortunately, the anomalies and anti-women bias within the Hindu code were not discussed widely in public forum. They remained hidden in statute books and legal manuals. There seemed to be almost a conspiracy of silence beneath which these inadequacies were crouched. This led to a fiction that the Hindu Code is sufficiently modernized and hence it is the perfect family code, which ought to be extended to other religious denominations in order to liberate women. The Acts were neither Hindu in character nor based on modern principles of equality but reflected the worst tendencies of both.⁶

In her paper for The Essex Human Rights Review, Kathleen Ho considers such inequities that result directly from social or legal structure, but hold compelling cultural explanations: explanations which actually divert attention from drafted or published faults. She questions whether accepting culture as a shared standard of life can actually permit the suppression of women and other minority groups, reducing the control of policy in *amending* culture, and instead allowing culture to *amend* law.⁷ Molding law to cultural norms makes for an easier transition of policy into practice, as policy is inevitably better suited to the current societal framework. Effortless law reforms take this form. If the impediments and inequities in written law are not addressed, it will be impossible to transform potentially beneficial law into actual principle, thus defeating the purpose of circulating any set of ethics in the first place.

It is, however, not an easy task to ensure the proper balance between acknowledging culture as a driving force while still ensuring that a written law has the power to confront inequities that stem from cultural or societal implications. In her writing on post-independence

⁶ Angnes, Flavia. “Women & Law in India.” 81.

⁷ Ho, Kathleen.

gender developments, Flavia Agnes discusses the consistent failure of drafted equality laws to both properly represent and address a culture's present gender relations: "Crucial provisions empowering women [have] had to be constantly watered down to reach the level of minimum consensus."⁸ Diluting or concealing the ultimate demands of a law will never lead to an acceptance or even a full understanding of the law. Rights must be enforced such that they are as actual as they are conceptual, if any transformation within a discriminatory society is desired. Although many argue that India's blooming democratic edict has significantly reduced former gender inequalities, the current state of affairs suggests quite the opposite.

On Wednesday, April 20th, 2011, in Haridwar, Uttarakhand, after a scandal in which a young woman eloped with an employee, several local panchayats jointly issued a law banning women from working outside the home. The panchayat leaders held that the risks associated with allowing women to have jobs were too great, and could bring "disgrace to their religion and families."⁹ If any woman was found attending work, she would be fined 5,100 rupees, and would be subject to a public beating. The title of one article in *Times of India* addressing the affair read: "Working Women of Haridwar Village Face Panchayat's Wrath." Five days later, on the 25th of March, it was publically confirmed that the ban had been lifted, and women of Haridwar's Godawali and Sarai villages had begun to return to work, after much agitation from the Uttarakhand Women's Commission and other legal women's rights supporters. Regardless of the hasty legal counteraction, the mere fact that such a diktat was able to pass in a forum in which,

⁸ Agnes, Flavia. 81.

⁹ *Dehradun Times*. "Ban on women from taking up jobs withdrawn in Uttarakhand." Accessed 25 April, 2011. Available from IndianExpress.

according to the Uttarakhand Panchayat Bill of 2008, there is legally required to be a fifty percent reservation for women¹⁰, proves that women are still far from equal in today's society.

PRAGATI, a women's empowerment NGO working throughout Uttarakhand, focuses specifically on ensuring gender equity within local governance, which is, in the Indian context, through the village Panchayats. Shefali Rawat, who works at the Dehradun Pragati office, explained the challenges associated with women's leadership in local governance. "Women," she explained, "are proxies of their husbands. Pradhan patti, we call it. Even after they are elected to their village panchayat, they are still unaware of their rights. [The women] should use their elected positions to take initiative, to do something beneficial to her society, but in male-dominated Uttarakhand, they do not take initiative. They still feel they are limited to household chores."¹¹ Thus even with a written fifty-percent reservation in the system of local governance, women in Uttarakhand still find themselves "under the wrath" of those with whom they are legally and theoretically equal.

How, therefore, does one address challenges of the twenty-first century, which represent the inevitable collision of modern policy and its actual practice within the developing nation of India, which is so often torn, when it comes to gender expectations, between tradition and the notion of liberalism? The most difficult task is not writing or passing the law, but ensuring that society as a whole first understands and accepts the law, and then allows for the target of such a decree (in this case, women) to benefit from the law's intended fruition. In translating this into the Indian context, one can reference, among others, the following amendments or additionalities that have been introduced to "safeguard Constitutional rights to women"¹² and to "secure equal

¹⁰ This is an increase from the one-third reservation in local Panchayats and Municipalities found in the 73rd and 74th Amendments of the Constitution of India, of 2003.

¹¹ Shefali Rawat. NGO, Pragati. Personal Interview. 5 May, 2011.

¹² Dash, Siddhartha. "Women Empowerment in India." *Orissa Review*. December 2004.

rights”: fifty-percent reservation for women in the local panchayat, the National Women’s Commission, the Accredited Nurse Midwife (ANM), Accredited Social Health Activist (ASHA), and Anganwadi initiatives through the NRHM, the Right To Education Act, passed in 2009, the Domestic Violence Bill of 2005, and the endorsement of the 1993 Convention of Elimination of All Forms of Discrimination Against Women (CEDAW), which has driven much of the policy in subsequent emancipation efforts. Yet, as Flavia Agnes argues in “Hindu Law Reforms- Stilted Efforts at Gender Justice,” reforms themselves, although presented as capable of so, cannot be the sole “vehicle for ushering in [the positive aspects] of western modernity”¹³ when the social and traditional composition of a nation is so resistant to universal liberal reform.

II. Education & Capability

The notion of empowerment is projected; it is an agenda that prescribes immediate policy amendments to gradually but steadily revolutionize societal structure. Because successful empowerment requires an evolution of the mindset, efforts must efficiently target the youngest generations. Under S.15 of the *Hindu Succession Act* of 1956, it is stated that sons and daughters legally hold equal rights, yet, still, as Dr. Savita Kotiyal of the Mazra Ayurvedic Hospital explained, “the health of girls is more deteriorated than that of her brothers because of her treatment in her household.”¹⁴ The larger the family size¹⁵, Dr. Savita continued, the less concerned the mother and father become with the health of their girl child. She is subsequently fed less than male siblings, denied an education, and in some families with whom Dr. Akanksha

¹³ Agnes, Flavia. 80.

¹⁴ Kotiyal, Dr. Savita. Interview. 25 April, 2011.

¹⁵ Large families are not uncommon in the area surrounding the Mazra Hospital, with quite a few reaching between eight and twelve children. It is within a family of this size that Dr. Savita Kotiyal has noticed deteriorating sanitation, nutrition, and general well being of the girl child.

Joshi, an intern of three years at Mazra Hospital, has worked, the daughter's name, too, is forgotten. In response to the daunting sex ratio, legislation has positioned itself to target both public and private society, providing incentives for having a girl-child, banning sex-determination of an unborn child, and even creating a National Girl Child Day in 2009 to, "[target] the scourges of female foeticide, domestic violence, and malnutrition,"¹⁶ an act that was paralleled by televised awareness campaigns.

Despite this focused legislation of the past decade on improving the status of the "girl child," the problem still remains: society does not offer women equal participation; it does not allow women to safely practice the liberal values and freedoms they are theoretically offered. "The Study of Gender in India: A Partial Review" emphasizes that as tradition holds, the female is transitioned out of her birth family and into her husband's family after marriage. When a woman leaves her household following marriage, entering into an entirely new family network, she "faces multiple subordinate status as a wife, daughter-in-law, sister-in-law, and mother. Patrilocal residence and patriarchal family structures place the wife at the bottom."¹⁷ As will be further discussed, being situated at the bottom of a hierarchy translates directly into a reduction in one's freedom of agency and autonomy within the public and private realms, regardless of society's claimed opportunities. In Development as Freedom, Amartya Sen considers the distinction (which is crucial to apply when considering the implications of gender discrimination) between what is theoretically available to a person, and what a person is actually capable of accessing: "A person's capability refers to the alternative combinations of functionings that are *feasible* for her to achieve. Capability is thus a kind of freedom."¹⁸

¹⁶ "Govt to declare National Girl Child day on January 24," *The Economic Times*. 6 January, 2009.

¹⁷ Bandana Purkayastha, Mangala Subramaniam, Manisha Desai and Sunita Bose. "The Study of Gender in India: A Partial Review," 2005. 517.

¹⁸ Sen, Amartya. 75.

In the third round of the National Family Health Survey, conducted in the fiscal year 2005-2006, it was concluded that: “Access [of women] to spaces outside the home increases with both education and wealth; however, the variation is quite limited. Less than half of women have the freedom to go alone to these places in every education and wealth category.”¹⁹ See the below data table from which this conclusion stems:

	Women allowed to go alone:			
	To the market	To the health center	Outside the community	To all three places
Age				
15-19	29.7	23.1	16.8	12.8
20-29	46.2	42.7	32.3	28.0
30-39	62.9	60.3	48.1	43.6
40-49	68.2	65.2	55.6	51.2
Marital Status				
Never Married	40.7	32.3	25.0	20.3
Currently Married	52.8	50.2	39.3	35.0
Divorced/separated/ deserted/widowed	76.1	73.5	68.6	65.6
Education				
None	49.0	45.9	36.3	32.0
0-4 years	47.2	45.9	37.3	32.1
5-9 years	47.1	43.2	33.7	29.5
10-11 years	55.0	49.2	38.5	34.1
12+ years	70.2	64.3	51.9	48.2
Wealth quintile				
Lowest	41.9	39.1	29.8	25.6
Second	42.7	40.5	33.0	27.9
Middle	48.1	44.6	36.2	31.3
Fourth	53.4	49.0	38.9	34.8
Highest	67.6	61.9	48.2	44.8
Total	51.5	47.7	37.7	33.4

NFHS, India. 2005-2006

In the state of Uttarakhand, the percentage of women who were allowed to go alone to all three destinations was 42.8 percent, a slightly higher percentage than the national average. A valid argument supporting the education of girls’ can be derived from this figure, by noting a sharp

¹⁹ “Gender Equality and Women’s Empowerment in India.” 64.

increase in the woman's freedom when more than nine years of school have been completed which suggests capability's direct correlation with education. "Education is the only way to come out of the darkness," said a primary school teacher of Misras Patti, when questioned about how to create equality between girls and boys: a group too often overlooked by government empowerment programs. Correlating the continued education of the girl directly with both her ability and confidence to participate in society, Mamta Samajik Sanstha focuses its efforts on educational programs and vocational skill development for adolescent girls, the group they deem "the most neglected by government schemes but the most important to successful women's empowerment."²⁰ The organization feels that mainstream society has the ability to offer promising roles for educated and confident young women, and that with proper preparation, channeled through adolescent girls' groups which are run by Manta-trained peer counselors, these young women will have the self-assurance to enter into society as equals. The NGO understands, too, that if a young woman is able to contribute financially to her family, even in the smallest of ways, she can confront and challenge the conception of the girl child as an inevitable financial burden to the family.

Regarding the education of girls in India, the *India Development Gateway* has reported that:

Illiterate women have generally high levels of maternal mortality, poor nutritional status, low earning potential, and little autonomy within the household... Additionally, the lack of an educated population can be an impediment to the country's economic development.²¹

In response to the disparity in the enrollment patterns between girls and boys, the Indian government has taken significant steps towards ensuring the education of its young. The Right to

²⁰ Singh, J.M. Personal Interview. 26 April, 2011.

²¹ "Girl Child Education." *India Development Gateway*. Available from Govt. of India, DIT.

Education Bill of 2009 ensures free public schooling for every child between the ages of six and fourteen, identifying its target groups as the “child belonging to disadvantaged group,” and the “child belonging to weaker section.”²² It holds accountable every tier of governance by demanding that state and local governments direct earmarked funds properly and efficiently. Universal education is a fundamental means to development and the mitigation of poverty, a necessity to uplift an individual and a society socially, economically, and politically. As Ravi Arole of Comprehensive Rural Health Project (CRHP), an NGO based in Jamkhed, Maharashtra explained, “through the track record [of CRHP], it is easy to see that communities develop faster where the women are empowered.”²³ But the essential question remains: Can guaranteed education alone can lead to the empowerment of India’s women and ultimately a society absent from gender discrimination? “[The government] has given girls education, but not jobs,”²⁴ Urmilla of Kehrigaon, said, when questioned about the government’s provision of services to women.

In Human Capital Attainment and Gender Empowerment: The Kerala Paradox, it is concluded that “high educational attainment alone will not promote gender empowerment unless the social and cultural fabric of a country or state ensures equality of women in all areas of life.”²⁵ The chief barrier to attaining equitable abilities of both sexes thus surrounds the way in which the woman’s role is defined in society, *by* society. Unfortunately, when the root of the problem derives primarily from a mental obstruction rather than a lack of legal support or an adequate societal framework, the process of meaningful empowerment lies in the restructuring of a mindset, rather than in a revision of the system. Today’s challenges of women are not written;

²² “The Right of Children to Free and Compulsory Education Act.” 26 October, 2009.

²³ Ravi Arole, CRHP. Personal Interview. 5 May, 2011.

²⁴ Urmilla. Personal Interview. 21 April, 2011. Kehrigaon.

²⁵ Mitra, Aparna and Pooja Singh. 1127.

they are uncovered only when the day-to-day realities of the woman's functioning in public and private society are uncovered and are then *themselves* challenged. "The first fundamental right," Mr. J.M. Singh, Chief Functionary of Mamta Samajik Sanstha said, "is equal opportunity to grow."²⁶ The first step in restructuring an inequitable society is ensuring that the structure of society allows for the girl child to grow at a pace equal to that enjoyed by her male counterpart.

III. Structural Violence & The Fatality of Hierarchies

The idea of structural violence holds that specific social structures prevent mobilization and development of certain groups, especially those most marginalized. According to Paul Farmer, founder of the renowned NGO, Partners In Health, structural violence is at the heart of the globe's inequities in health. Grassroots health programs must seek to combat structural violence through concerted focus in both economic and social arenas, if the ultimate objective is to break down the barriers which formerly sustained the disparities in access between different groups. Translating policy into practice is where structural violence is addressed. As the skeleton of most programs is established hierarchy, which is meant to demarcate accountability and ensure the functioning of a program's monitoring system. Through this research, it has been found that the hierarchies of the NRHM's programs act more to delineate segregated levels of power, rather than to benignly ensure the proper functioning of the system. "The hierarchy is a fatal thing," stated an experienced NGO spokeswoman who requested anonymity, "everything: the government, NGOs, it is all divided. It is all discrimination, nothing else."²⁷

Discouraging for those who seek amendments of the public sector, is the widespread acceptance of the system's functioning. "Indian people believe in the hierarchies," one man from

²⁶ Singh, J.M. Personal Interview. 26 April, 2011.

²⁷ Gupta, Deepa. NGO, Astitva. Personal Interview. 27 April, 2011.

Bahrabur Village said, “in health, in politics, in the village.”²⁸ Deepa Gupta, a domestic violence outreach worker at the Dehradun-based NGO, Astitva, raised a valid question: “If it is already implemented in the society, how can they fight it?” Although contested widely (especially among NGOs working on agendas of empowerment) it is argued that the individual *does* have the ability to confront the implications of structural violence. Through the work of Astitva, which focuses on the empowerment of female workers from poor socioeconomic areas, it can be seen that, if encouraged and supported, suppressed women have the ability to improve their livelihoods even within an oppressive system. It has been shown that with women, who many times face such severe gender discrimination in their husband’s household that they quite literally have no one to talk to, it is crucial that there exists an intermediary between the woman and her confrontation with the system, whether it be at home or in public. The most difficult step is the first: the step in which an outreach worker, or local health worker can act as the agent of change, to enable the person to question and then themselves challenge the system. “The moment they start to challenge it, change starts,” stated Deepa Gupta, who functions as one of these such intermediaries.

The initiatives of PRAGATI, which focus on strengthening the government program which guarantees women 50% reservation in the Gram Panchayats, seek to ensure political justice at the local level by training elected women *to* challenge these injustices. PRAGATI believes strongly that giving women a 50% reservation of seats in local governments, but not training them to use this position to its greatest potential, does not serve the ultimate purpose of implementing such a decree. Because politics have been historically so male-dominated, the woman must be carefully trained if her position is meant to signify anything. When proper training has been given to teach elected women of their faculties as Panchayat Member, to

²⁸ Anonymous. Personal Interview. 4 May, 2011.

encourage them take initiative in their communities, it has been seen that within “women-led panchayats, there are greater positive structural changes.”²⁹ PRAGATI provides a good example of an NGO’s effort to make government policy, practice.

Both the 50% reservation for women in the Gram Panchayat and the ASHA program represent initiatives of the government which defy elements of the current social fabric of the nation and which therefore require great attention to implement successfully. In an article in “Towards Empowerment,” an article published on the 3rd of November, 2008 in *Garhwal Post*, it is stated that, apart from ensuring women the 50% reservation in the village Panchayats, the state must also “increase women’s literacy rate, improve road connectivity and make available other basic amenities like health, water, and electricity in the villages. For without these, true empowerment of women representatives in panchayatraj bodies would be meaningless.”³⁰ Due to the gender violence, whether it be direct or indirect, visible or not, policy measures cannot be taken in a cursory manner. Gender equity must be promoted through *enforced* legislation in order to restructure the current framework which so tactfully disempowers individuals based on caste, class, and gender.

IV. The ASHA Program in Context: Dehradun District, Uttarakhand

The Accredited Social Health Activist (ASHA) program is a community based functionary plan developed by India’s National Rural Health Mission, formally implemented in the state of Uttarakhand on the 27th of October, in the year 2005.³¹ The description of the

²⁹ “Women assert power in Uttarakhand hills.” *The Times of India*. 5 November, 2008.

³⁰ “Towards Empowerment.” *Garhwal Post*. 3 November, 2008.

³¹ “Mission Flexipool Text.” *Section-2, NRHM Additionalities*. Ministry of Health & Family Welfare. 2007.

ASHA, as outlined by the NRHM, classifies her as the link between the village and the public health provider.

ASHA will be the first port of call for any health related demands of deprived sections of the population, especially women and children, who find it difficult to access health services... [She] will be a health activist in the community who will create awareness on health and its social determinants and mobilize the community towards local health planning and increased utilization and accountability of the existing health services. She will also provide a minimum package of curative care as appropriate and feasible for that level and make timely referrals.³²

ASHAs are given, Mr. Tej Ram Jat reported, very deliberately constructed positions and are stationed at very strategic locations within which they enjoy good rapport and familiarity with local customs. The female health workers are then given formal legitimacy by supporting public and legal institutions, thus establishing their position within a public framework that is supportive of gender equity and which promotes women's access to health resources.

It is the general understanding that there is to be one ASHA per 1,000 population, but this does not remain true across the board due to geographical differences and failures in implementation, mostly in very rural or hilly areas. The ASHA program, as it is implemented by the state government and further executed at the district-level, holds few similarities across states and even districts. The successes and failures of the ASHA program depend on the proper or improper implementation at these two levels. Uttarakhand, for instance, has given sufficient time and effort to ensuring that the ASHA program is active in most parts of the state, whereas Maharashtra, has failed to do so in many rural areas. It is preferred that the ASHA is between the age of 25 and 45 years, married, and has completed formal education through eighth class. This, too, is relaxed

³² "Guidelines on ASHA- Annex 1" NRHM. 29 July, 2010. 1.

depending on the context. The NRHM requires that “adequate representation from disadvantaged population groups [is ensured]” with the objective that the ASHA program truly serves those most marginalized.³³ The ASHA is to be closely linked to the system of local governance within her village and Panchayat so as to ensure the program’s support and monitoring.

Because the ASHA program is inextricable from the context in which it exists, it is important first to be familiar with the setting, on state and district levels especially, before hoping to understand fully the grassroots workings of the ASHA program itself. Within the state of Uttarakhand, which is bordered by the Indian states of Himachal Pradesh and Uttar Pradesh to the west, there are thirteen districts.

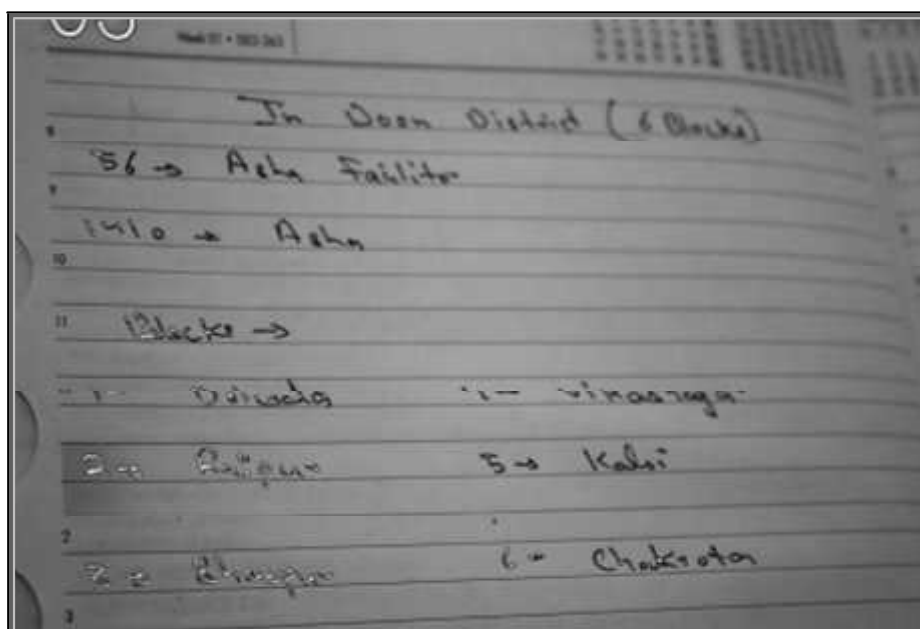


Source: PRAGATI pamphlet

Within Dehradun district, the district in which the majority of this research was conducted, is Dehradun city, the capital of Uttarakhand. As required by the NRHM agenda, there is one district

³³ “Guidelines on ASHA- Annex 1” 3.

hospital within Dehradun: the Doon District Hospital. Also within Dehradun district are six blocks as represented in the below image:



Source: Shobhit Rawat Singh, 25 April, 2011

Within each of Dehradun's six blocks there is one Community Health Center (CHC) and branching from each CHC are a certain number of Primary Health Centers (PHCs). Under the Doiwala block, for example, there are five PHCs: Balawala, Dudhuli, Bhaniyawala, Chidarwala, and Raiwala. Under the PHCs are sub-centers, where one Accredited Nurse Midwife (ANM) is posted. Within Doiwala block, there are twenty-seven sub-centers. The sub-center is "the most peripheral level of contact with the community under the public health infrastructure"³⁴ and is meant to serve a population of 5,000, although in many cases it serves a greater population.

Dr. Chandra Pant, Chief Medical Officer of Community Health Center Doiwala, explained the required reporting schedule which exists between the public centers and is organized by the federal government through the NRHM scheme. On the third Friday of each month, required reports (the foundation of which comes from the joint effort of ASHA and

³⁴ "Guidelines on Accredited Social Health Activists (ASHA)." NRHM. 1.

ANM) are collected by the sub-centers and delivered to each PHC. In the case of Dehradun's Doiwala Block, this means a total of 27 reports are given to the five PHCs listed above. The reports are then passed to the CHCs by the PHC supervisor, the Medical Officer in Charge (MOIC). After compiling the reports from periphery PHCs, the CHC is responsible for sending the reports to the state level by the end of each month. The process is completed with the final district meeting, organized the first week of every month, which all PHC MOICs and CHC CMOs are meant to attend. Each of these reports, which make their way (within a period of two weeks) from village-level to state-level, begin with the local surveys and reports compiled in the village by the ASHA and ANM.

Within each of Dehradun District's six blocks, there are roughly 300 villages. In total, there are 1,410 ASHAs in the district of Dehradun, with each block representing approximately 1/6th of the total ASHA population, with slight disparities between villages resulting from geographical differences. The grassroots workings of the ASHA program are closely linked to the systems of local governance, which provide both support to and monitoring for local-level NRHM initiatives. In the NRHM's "Guidelines of ASHA- Annex I," it is stated that: "The compensation to ASHA based on measurable outputs would be given under the overall supervision and control by Panchayat. For this purpose, a revolving fund would be kept at Panchayat."³⁵ In each block, there exists an average of thirty to forty *gram* (village) Panchayats, which oversee the activity and address problems faced by villages in their catchment area. Misras Patti, for instance, is one Gram Panchayat in the hills north of Dehradun city, consisting of seven villages. The *pardhan* or leader of the Misras Patti Panchayat is a female by the name of Gita Devi. Under the Misras Patti gram Panchayat, in which the population totals approximately

³⁵"Guidelines on ASHA- Annex 1" National Rural Health Mission (NRHM). 29 July, 2010. Accessed 29 April, 2011. 9.

1,600, there is one ASHA, even though the population exceeds 1,000: the maximum population over which an ASHA is meant to serve.

Along with the 1,410 ASHAs of Dehradun District, there are 56 facilitators: a recent program executed in 2010 to establish another tier within the ASHA program with the goal of providing better monitoring and support for the ASHA. According to Shobhit Singh Raawt, a Social Worker and Psychology student who has been working with DARC for the past year, explained the facilitator as the one who “monitors the ASHA, solves the problem of the ASHA, and informs the DARC”³⁶ of concerns at the village level. Another recent and applicable program, which began in 2008, is the District ASHA Resource Center (DARC), a national initiative which functions as a public-private partnership under the NRHM. It is supported by the District Health and Family Welfare Society (DHFWS). The DARC is responsible for two essential components of the ASHA program: the training and the monitoring of all ASHAs within the district. The increasing popularity of establishing public-private partnerships under the NRHM seeks to ensure the proper allocation of specifically earmarked funds; it is the goal that such public-private partnerships will help ensure the increase in public spending on healthcare to 2-3% of the GDP and also ensure proper financial monitoring on the block and local level. In an article from the *Economic Times*, published on the 25th of February, 2010, the 2010 NRHM annual report is cited: "Release of funds to state health societies and consequently to district and block levels require further streamlining to ensure prompt and effective utilisation of funds,"³⁷ states the article, voicing their support for such methods that aim to strengthen such monitoring tiers.

³⁶ Singh, Shobhit Rawat. Personal Interview. 27 April, 2011.

³⁷“India Needs 6800 More Hospitals, NRHM Has Many Glitches.” *Economic Times*. 25 February, 2010.

V. Understanding the ASHA

Selection of the ASHA

As per NRHM guidelines, the ASHA must be a resident woman of one village within her catchment area, she must be married, widowed, or divorced, at least 8th standard pass, and must be willing to work with and represent all classes and castes. It is encouraged by the NRHM that the ASHA be herself a member of SC/ST, but it is not required. The idea is that she be an available resource to all groups, especially those who are most marginalized and thus experience the most difficulty in accessing and seeking proper health treatment. The ASHA is to be selected through a democratic election, coordinated by her Gram Panchayat, with the assistance of the local ANM and the Block Development Officer/Block Coordinator. In many cases, he or she heading the election will inquire whether there is any village woman interested in the position, and the election moves forward from that point. When questioned about what motivated her to take on the elected role as her community's ASHA, Mrs. Pitambari Godiyal of Baniyawala replied that it had been her "own self-motivated dream to do social work."³⁸ Many other ASHAs responded that they had a desire to help connect the members of their community to health services.

There does exist suspicion surrounding the justice of the selection process, as there does surrounding the election process of the Anganwadi and ANM. In an attempt to maintain the nature of NRHM initiatives as grassroots and community-driven, the election processes are kept under the supervision of local governments. Centralizing programs within the system of local governance seeks to increase transparency, ensure local accountability, and support the familiar hierarchy rather than intrude with a foreign system. In the negative sense, it leads to great

³⁸ Godiyal, Pitambari. Personal Interview. 26 April, 2011.

variation in the levels of commitment and the program's successes across Gram Panchayat levels. According to an anonymous NGO spokesman, one of the greatest concerns with placing the program in the hands of the local governance is that the required democratic procedure of election, the one which is meant to ensure that the chosen ASHA is the best candidate for the job, is not employed. "Powerful people sometimes choose the ASHA, choose someone they are interested in, even someone who herself is not interested in being ASHA."³⁹

Training of the ASHA

Wednesday, 27 April, 2011, was the final day of a five-day ASHA training of the Raipur Block ASHAs at the Mehuwala Panchayat Ghar. The training was provided by two master trainers of Dehradun's DARC. The five-day training (each day consisting of seven hours of training with travel stipend and lunch provided) consisted of Module's 6B and 7, both of which focus on Home Based Newborn Care (HBNC). The modules are designed at the national level by the NRHM and are then provided to a state's ASHA trainers, which can include DARCs, hospitals, and NGOs. It is the intent that "with adequate training [the ASHA worker] can mitigate such medical cases"⁴⁰ that result from preventable causes yet amount for the majority of India's poor health indicators. Participating in the Raipur Block training were thirty-three ASHAs, representing approximately thirty villages within within the Block. Fifteen out of the thirty-three ASHAs had just begun their training that week.

³⁹ Anonymous Interview. 26 April, 2011.

⁴⁰ The Tribune, Chandigarh, India, Dehradun Edition. "Five-day training for ASHA workers begins." 21, March, 2011. Mussoorie.



Harriet Napier, 27 April, 2011

Pancham Singh, the Community Mobilizer of DARC, who has been working for the last ten years, is in charge of overseeing the training of ASHAs in all six blocks of Dehradun District, which is conducted by the individual DARC Block Coordinators. The training sessions began the 22nd of February, 2011, and after Wednesday, the 27th of April, five-day trainings in all six blocks would be completed. The training appeared to be very active, with communication between ASHA and Raipur Block Coordinator throughout. While conducting this research, all interviewed or surveyed ASHAs were questioned about the quality of their training, and no complaints were heard; the words “comprehensible,” “active,” and “engaging,” were common adjectives used to describe the training. The ASHAs *at* the Raipur Block training were not questioned regarding the quality of the lessons, but all appeared to be actively involved and engaged. For example, during one part of the Raipur Block training, the ASHAs were being shown how to properly wrap a newborn after birth. The Block Coordinator ensured that each and every ASHA came to the front of the room to practice the proper swaddling technique. He was responsive to each, providing both criticism and praise.



Block Coordinator trains ASHA. Harriet Napier. 27 April, 2011.

The Community Mobilizer, too, paid a short visit during the attended ASHA training session to question the ASHAs about their experiences with the week's training, and about other concerns that they may be having in the field. Multiple ASHAs and the single present Facilitator stood to share their problems, the majority of which surrounded their treatment and the manner in which they were received in public health facilities by senior doctors and nurses. The Community Mobilizer, who ideally acts also as an advocate for the ASHA, promised to report their concerns at the upcoming district meeting, at which other Block Coordinators and Chief Medical Officers (CMOs) would be present.

Supplementary or additional trainings provided by NGOs are quite common in Dehradun District. RLEK, PRAGATI, Astitva, and Mamta, all provide additional training or support for the ASHA. Mamta, in particular, works to provide the ASHA with a "platform where she can get women together to talk,"⁴¹ claiming that one of the greatest problems of the ASHA program remains her struggle to motivate groups to come together and talk about health issues. This essential part of the ASHA's work, her role in creating health awareness, falls all too often by the wayside, or is even completely ignored, because there exists no formal platform by which to

⁴¹ Singh, J.M. Personal Interview. 26 April, 2011.

initiate such discourse. Through Mamta's health camps, the NGO works to "involve the ASHA, and keep her active as a health promoter"⁴² by encouraging her to take a leading role alongside the Mamta-trained Gender Resource Coordinators (GRCs). Like Mamta, many of the supplementary trainings provided to the ASHA by local NGOs seek to involve the ASHA more actively in preventative work. The ASHA designation is seen as a perfect opportunity to create local awareness and momentum for community health projects, but it is believed by many that the ASHA is not performing (as per her training) to her full potential.

Payment of the ASHA

The ASHAs receive incentive-based pay, which they can theoretically collect from any government medical facility. The incentives themselves are determined by the federal government and depend on which matters of health are seen to be at the vanguard of India's public health crisis. It is the state's responsibility to accompany a financial compensation to each incentive that they deem appropriate. In order to motivate both ASHA and village member, the incentive provided to the ASHA is, in most cases, paralleled by an incentive provided to the patient: for instance, if a delivery is taken to a government hospital, both ASHA and mother are provided payment. In Uttarakhand, these government-issued incentives include: 600 rupees for bringing a safe delivery to the government hospital, 250 rupees for registration, vaccination, and neonatal care of the delivered infant, 150 rupees per child for providing BCG, Measles, and other vaccinations, 350 rupees for completing the DOTs treatment of one Tuberculosis patient, 200 rupees for the sterilization of a male within their catchment area, 150 rupees for the sterilization of a female within their catchment area, 500 rupees for bringing an extreme Leprosy case to the government facility, and 50 rupees for constructing a public latrine in the village. Her primary

⁴² Singh, J.M. Personal Interview. 26 April, 2011.

payment is that which she receives for bringing a delivery to the institution: 600 rupees paid in the form of a check, written directly after the delivery.

The other payments are more fragmented in their distribution, and, according to Mr. J.M. Singh, “the government process [of their payment] is long and frustrating.”⁴³ The motive behind incentive-based pay is to ensure the continued activity of the ASHA within her village. In a conversation with Sareeta, Kamlesh, and Rukmau (12th pass or BA degree holding ANMs with over 20 years of service, all of whom receive a fixed salary of 25,000 rupees per month) at the Doiwala CHC, all three ANMs vouched for incentive-based pay of the ASHA worker. When questioned about the average monthly salary of an ASHA worker in the Doiwala area, the ANMs responded that it normally fell between 2,000 and 3,000 rupees. Although a few surveyed ASHAs reported that they sometimes made 2,000 rupees in a month, the monthly quota rarely fell above 2,000. The implications and critiques, both negative and positive, of using incentive-based pay will be further discussed in another section of this paper.

The Role of the ASHA

In a statewide figure calculated in 2009 through an evaluation of the NRHM program in Uttarakhand state, 74% of women surveyed were aware of the ASHA program.⁴⁴ Creating awareness of the ASHA herself is a crucial step that must be undertaken by the NRHM, and must be paralleled by solidifying the ASHA’s position and its corresponding entailments in her community. The role of the ASHA is one which itself is debated widely in both public and private forums. Who is she responsible to, both as a member of the NRHM hierarchy, and as a service-provider for a specified population? What is she responsible for? Where is the line drawn

⁴³ Singh, J.M. Personal Interview. 26 April, 2011.

⁴⁴ Concurrent Evaluation of NRHM (2009) Uttarakhand. 202.

between the work of an ASHA and the work of an ANM? How much work is she *really* expected to do as primarily a volunteer? In many cases, the answers depend on who is questioned.

One common claim that evidences a clear impediment of the NRHM initiative is the ASHA's steadfast affiliation with the pregnant woman. According to Deepa Gupta of Astitva, "the ASHA does not work with the man, does not talk with the man."⁴⁵ As demonstrated by research findings, the only instances in which the female health worker is used equally by men and women appear to be in rural areas. The bandaging of wounds, particularly those from accidents with livestock and farming machinery, and first aid attention, constitute the majority of services provided by the ASHA to the male village members. Reena, an ASHA of two years from Patti Misras, a hilly area approximately 20 kilometers from the closest PHC, asserts that she is consulted by both men and women from the seven villages of her catchment area. The men come most often seeking first aid treatment, and the women, for antenatal care and check-ups. In urban areas, the ASHA is often only used as a resource for women, pregnant women especially. Through a survey and a set of short interviews conducted in Kehrigaon, an area of Prem Nagar, arose an interesting distinction between the role of the rural and semi-urban ASHA. In one house, there were two village women, one of whom was pregnant, the other, an elderly woman, who was not. When questioned about the presence of an ASHA in the area, the elderly woman responded there was no ASHA, and was hastily interrupted by the younger, pregnant woman, who responded that there was: she was, in fact, helping her with this pregnancy.

In an interview with Pinki, a mother of two children, living in Ruhalki, a small village two hours from Dehradun, the ASHA was described as a health worker who is "just for the pregnant woman."⁴⁶ In support of this argument, are the results compiled from a survey of 12

⁴⁵ Gupta, Deepa. Personal Interview. 27 April, 2011.

⁴⁶ Pinki. Personal Interview. 21 April, 2011.

women (between the ages of 16 and 50), taken on the 21st of April, 2011, in Kehrigaon, Prem Nagar. Only those women who were pregnant or in their child-bearing years consulted the ASHA for health advice; all others consulted a female family member or went directly to the PHC.⁴⁷ Even those who had small children chose to consult the Anganwadi or ANM before the ASHA. One quite popular critique of the ASHA program, especially among critical NGO bodies, is that the ASHA is “not a primary health worker, but a service-oriented worker,”⁴⁸ completing only the duties for which she receives honorarium: pregnancy being the most significant and thus the most common. Similar such critiques will be discussed later.

Unlike the ANM, who spends an average of two to three days per week in a medical facility (usually the sub-center at which they are posted), the ASHA’s work is generally confined within the perimeters of her catchment area. Depending on her proximity to health centers, though, she may visit a health center a few times a week to meet with ANMs and/or accompany patients. During this study it was observed that the ASHA both pays visits to village members’ houses and is visited in her own home by village members. In the very rural areas, in Misras Patti in particular, it was discovered that the ASHA visits the most remote villages (up to an hour’s walk) only once a month to conduct the demographic survey which is required of her by her superiors. In villages where there is an established Anganwadi center, the ASHA could often be found posted there, assisting the Anganwadi with the care of children, and being available to assist the ANM with outreach activities, vaccinations, and survey collection. Because the ASHA is responsible only to a population of 1,000, in comparison to the ANM’s population of 5,000 to 8,000, she is able to work more intimately with the people. Because of the abridged size of the ASHA’s population, Rukmanu (an ANM of 23 years, posted at the Doiwala CHC) says, “it is

⁴⁷ Survey. 21 April, 2011. Kehrigaon, Prem Nagar, Dehradun District.

⁴⁸ Anonymous NGO Interview. 26 April, 2011.

necessary to meet [with our corresponding ASHA] every day.”⁴⁹ According to Anita Thapa, an ASHA of six years, based in Badon Wala, there is also close communication between ASHAs of different areas; a closeness she holds which derives from the consistency of group trainings.

In conclusion, although the *actual* role of the ASHA in her community is highly debated, and providing any general description of her activities will inevitably invoke disagreement among one contender or another, her position *does* offer undeniably great potential as a social development agenda. Below is an array of short responses provided by ASHAs, ANMs, Anganwadis, village women, village men, NGO workers, and government officials, all of which, in one way or another, accurately answer the question:

What is the role of the ASHA?

“The ASHA is the messenger and the motivator.”

“The ASHA brings awareness.”

“The ASHA is acting like the coordinator between the hospital and the village.”

“The ASHA is for the pregnant woman.”

“The ASHA is not a not a primary health worker, but a service-oriented worker”

“The ASHA is the ANM’s helper.”

“The ASHA program is like a link between the city and the village.”

“The ASHA is the bridge.”

VI. Where the ASHA Does Not Reach

According to a recent publication in *The Economic Times*, rural India is considered to be short 16,000 doctors, with an average patient-doctor ratio of 1/30,000, regardless of the NRHM’s

⁴⁹ Rukmanu. Personal Interview. 19 April, 2011.

attempt to incentivize practice in rural areas.⁵⁰ Not only do rural settings prove inferior in the provision and availability of health services, they also prove detrimental to poorly implemented grassroots initiatives, such as the ASHA program. Because the ASHA program seeks to extend health services to rural areas, and to establish better connections between rural areas and medical facilities, the program must ensure the existence of areas in which health services originate. If health services are unavailable, if CHCs and sub-centers are empty or closed, it is impossible for the ASHA to complete her work. Because of the ASHA's limited medical training, she can provide only a limited scope of services, at which point she requires the assistance of higher-trained health providers. Two case studies presented below offer a preferable model to the government ASHA scheme; one which is better accommodated to the context.

Misras Patti, Uttarakhand (CFHI & IGHEF)

In Misras Patti, a hilly area about an hour and a half outside Dehradun, the Indian Global Health and Education Forum (IGHEF), with funding from the international NGO, Child Family Health International (CFHI), manages a Basic Health Promoter (BHP) Program. The base of the BHP program is the CFHI clinic, which provides services five days a week, and is run by one doctor, Dr. Paul, one pharmacist, Virender Singh, and the “nurses”: BHPs who come to the clinic for thirty-day rotations every four months. Although the ASHA program is functioning in the area, CFHI feels that that the distance between the villages discourages and even disables the ASHA from working closely with her assigned population. The over 1,000 population to which the Misras Patti ASHA is required to provide services, is spaced over 15 kilometers, by precipitous dirt roads and no cell-phone network. In areas such as Misras Patti, the ASHA program must be amended to reflect the limitations of such topography, in order to reach its full

⁵⁰ The Economic Times. 9 March, 2011.

potential. Because of the proven benefits of having local health workers, CFHI began the BHP program, the model of which is quite similar to the ASHA program. As of May, 2011, Dr. Paul has trained five BHPs, each from a different village surrounding the CFHI clinic. The training was initially provided by CFHI, through the consultant NGO, SBMA, under the supervision of Dr. Rajeev Prasad Bijalwan. The BHPs also received an additional exposure training through the Himalayan Institute of Medical Sciences at Jolygrant, a training coordinated by CFHI. The supplementary trainings are seen not only as experiences which can further develop the skills of the BHP, but also as opportunities for the BHP to leave her village, to increase her self-confidence and understanding of government health programs. Furthermore, CFHI presents the BHP's rotations in the clinic as follow-up trainings and they are seen as such by the BHPs as well.



Certificates provided to the BHP for completing HIMS and SBMA trainings. Harriet Napier.

CFHI and IGHEF's BHP program acts to extend basic health services to rural villages and simultaneously to sustain the functioning of the small one-room clinic itself through the BHP's in-clinic rotations. One of the primary ways in which the BHP program has adjusted to the context is seen through the program's educational requirements: Sunita Devi, a BHP of five years, completed 5th standard, and Nirmala Devi of Bahrabur, a more senior BHP of five years, has received no formal education and is illiterate. CFHI's program also differs from the NRHM

ASHA initiative in its perspective on pay: BHPs are given a fixed salary of 1,200 rupees a month both because CFHI believes that a fixed salary is important in ensuring financial security, in avoiding exploitation, and because incentive-based pay frankly would not work in such a context. When questioned about the differences between the ASHA model and the CFHI/IGHEF model, Nirmala Devi responded as follows:

Our program is different than the ASHA program in the *working way*. We are much more attached to the village people in comparison to the ASHAs... Our center of control is much closer than it is for the ASHA since the ASHA program is a government program.⁵¹

When reading this quote it is important to take note of the way in which, by referring to the program as “our” program, the BHP took joint possession of CFHI’s project. When questioned about whom she goes to with concerns about her work, Sunita Devi responded, without hesitation, that she calls or visits Dr. Paul directly. When the same question was asked to Reena, the area’s designated ASHA, she initially responded that she “had been trained and understood [her job].”⁵² The question was asked again and phrased as: “If you have any questions, concerns, problems regarding your work, who would you speak with?” Reena responded hesitantly that she would seek the help of the ANM, posted 7 kilometers from Patti in Dunga. To the inquiry of the name of Dunga’s ANM, Reena responded that she could not remember. This significant disconnect between the health worker (who has, on multiple occasions, been deemed the pedestal of the NRHM mission) and those from whom she is meant to receive support, radically changes the objective and reduces effectiveness of such a program. As observed through staggered visits to varying degrees of rural, “detached” society in which the ASHA program is running, this

⁵¹ Nirmala Devi. Personal Interview. 4 May, 2011.

⁵² Ms. Reena, ASHA. Personal Interview. 4 May, 2011.

disconnect only worsens as the setting becomes more rural or hilly: the very areas in which the ASHA program must, in order to improve health indicators, function to its greatest capacity.

Jamkhed, Maharashtra (CRHP)

An exemplary model highly pertinent to this research, and a further reflection of the NRHM's limitations, is the Village Health Worker Program of the Comprehensive Rural Health Project (CRHP), an NGO based in Jamkhed, Maharashtra. Although nowhere in proximity to Uttarakhand, and implemented in a context quite dissimilar to Dehradun, CRHP's VHW program has acted as an internationally-recognized Community Health Worker model for decades, and has subsequently provided training to national and international health workers both in India and outside. The VHW model is described in the following words by CRHP:

The Village Health Worker acts as the local agent of positive health and social change. She is selected by her community and receives training in health, community development and organization, communication skills, and personal development from CRHP. Her primary role is to freely share the knowledge she obtains with everyone in the community, to organize community groups and to facilitate action, especially among women, the poor and marginalized. At the outset, many of these VHWs were often illiterate women from the untouchable (Dalit) caste. The concept and utilization of the VHW has been internationally recognized and often emulated for its dramatic positive impact on public health at the community level.⁵³

CRHP runs its VHW program under the conception that “most illnesses can be prevented at the village level itself,”⁵⁴ and that the best agenda for bottom-up prevention is to train and endorse an able village woman as a primary health care provider. In order to maintain the momentum of the program, VHWs return to the CRHP campus every two weeks for training and support groups. Equally as important to CRHP as improving health among the rural population is

⁵³ Community Rural Health Project. Web. Accessed 2 May, 2011.

⁵⁴ Arole, Ravi. NGO, CRHP. Personal Interview. 5 May, 2011.

the empowerment of women of Scheduled Castes and Tribes and the improvement of discrimination at the village level.

An important element of CRHP is its intentional disassociation with the government. The continued momentum of their VHW program over the past forty years results from the organization's unwavering commitment to the morals of equity and integrity which guide the work of CRHP's staff and volunteer health providers. Although approached many times, the organization refuses to solidify a relationship with the government, in fear of diluting the very philosophy which sustains their grassroots social and medical successes. "We will work with the government," concluded Ravi Arole, son of the CRHP's founders, who now oversees finances and functioning of CRHP programs, "we will support the government programs, but we will not work *for* the government."⁵⁵ Because of their disconnection from the government, CRHP struggles under the tight budget inextricable from a high-functioning, local NGO, the services of which are pursued by thousands.

⁵⁵ Arole, Ravi. Personal Interview. 5 May, 2011.

The following account was written by the staff of CRHP, in response to a moving speech made by Village Health Worker, Muktabai Pol, at the 1989 National Council of International Health (NCIH) Conference in Washington D.C., USA, which Muktabai attended alongside Dr. Arole. The short and poignant speech exemplifies not only the mission of CRHP through the eyes of a VHW, but also illustrates the necessary features of a grassroots health program.

In a huge conference hall in Washington DC, over a thousand participants listen with rapt attention to Muktabai Pol, a village health worker from Jamkhed, India.

The listeners include officials from WHO and UNICEF, ministers of health, health professionals and representatives of universities from many parts of the world.

Muktabai shares her experience of providing primary health care in a remote Indian village.

She concludes her speech by pointing to the glittering lights in the hall.

“This is a beautiful hall, and the shining chandeliers are a treat to watch,” she says. “One has to travel thousands of miles to come to see their beauty. The doctors are like these chandeliers, beautiful and exquisite, but expensive and inaccessible.”

She then pulls out two wick lamps from her purse. She lights one.

“This lamp is inexpensive and simple, but unlike the chandeliers, it can transfer its light to another lamp.”

She lights the other wick lamp with the first. Holding up both lamps in her outstretched hands, she says,

“I am like this lamp, lighting the lamp of better health. Workers like me can light another and another and thus encircle the whole earth.”

“This is Health for All.”⁵⁶

⁵⁶ Community Rural Health Project. Web. 2009.

VIII. The Inadequacy of the ASHA: A Popular Critique

One of the most common critiques of the NRHM's ASHA program, is that the ASHA does not function to her greatest capacity, and that her actual focus is on those activities for which she receives pay, not those from which her community will most benefit. She is meant to be a health resource and advocate for her community, but is often inactive. Mr. J.M. Singh of Mamta raised a valid point, which provides a dependable gauge by which to judge the functioning of a grassroots health worker and the program as a whole. "Being an able person is one thing, but being able *and* available is another. You must be available," argued Mr. J.M. Singh. "[The ASHA] has the knowledge," he continued, "but if she is not willing to share the knowledge, nothing can be gained."⁵⁷ The question must be raised, however, as to whether this disengagement is actually the fault of the ASHA herself, or of the system? In a program that seeks ultimately to improve the livelihoods of those most marginalized populations in the nation of India, it is essential that all possible measures are taken to ensure the engagement of the health worker. The potential of the village health worker model to improve health indicators is uncontested, but equally so is the potential of the program to fail. There are frequent criticisms of the ASHA program, but few are able to present a preferable program of comparable scope.

The second most widely disputed matter regarding the ASHA surrounds how she should be paid appropriately for her work. Rukmani, an ANM of over twenty years, working in close contact with the Doiwala CHC provided an interesting perspective on the benefit of incentive-based pay for the ASHA. Her critique also suggests an unfortunate disengagement between the ASHA and the ASHA's closet adviser: the ANM. "If [ASHAs] got a fixed salary, they would not work. They would sit in the home," she stated, laughing. "We are the workers," she continued,

⁵⁷ Singh, J.M. Personal Interview. 26 April, 2011.

“and the ASHAs, our helpers.”⁵⁸ Although she claimed to be joking, this was not the first instance in which such an account had arisen. The limit of the ASHA’s training is such that she views her role as less significant when compared to the ANM, with whom she is meant to work closely: she holds herself responsible for a less significant workload than does her ANM partner, who has received a much more extensive training, and thus holds greater expectations for herself, considering her work to have greater value and importance in the community. Furthermore, in the urban areas of Dehradun District, many of the ANMs have completed their Bachelors Degree, and subsequently demand more respect from the ASHA, who, on average, has completed up to tenth standard in urban and semi-urban areas. The difficulty is finding the balance between demanding too little and demanding too much: low training requirements of the ASHA ensure that the most marginalized women can be employed, but demanding enough commitment of the female worker to her training is essential in order to present the role as ASHA as valuable both to her superiors and to the ASHA herself. In the end of her interview, Rukmani again vouched her support for the incentive-based pay for ASHAs, based on the fact that the role of an ASHA *requires* the presence of incentives in order to be sustainable and in order to ensure the active work of the ASHA within her community.

Because the ASHA is guided by financial incentives, she is seen by some not as a “primary health worker, but a service-oriented worker.”⁵⁹ An association that invites contempt among NGOs especially. Mr. J.M. Singh of Mamta explains that due to her status as an incentive-driven health worker, “curative services are somehow enhanced, but not preventative issues.”⁶⁰ Those indicators which are improving, Mr. Singh explained, are those for which the ASHA is getting money. Unfortunately, it is rare to see an ASHA fulfilling other roles (such as

⁵⁸ Rukmani. Personal Interview. 19 April, 2011.

⁵⁹ Singh, J.M. Personal Interview. 26 April, 2011.

⁶⁰ Singh, J.M. Personal Interview. 26 April, 2011.

active health *educator*), which are theoretical, written expectations of the ASHA, but are not linked to any financial incentive and the progress of which cannot necessarily be monitored by collecting raw data, as polio drops or hemoglobin can. Many NGOs, Mamta most acutely, feel that the ASHA should be expected of more, and should offer more to her community with the materials and training provided to her. They see the potential of the ASHA program to ignite development and healthy decision-making within the community, and recognize the importance of utilizing human resources at the village-level, but claim that due to the realities of the program, “we waste our energy to ASHAs.”⁶¹

⁶¹ Anonymous. Interview. 23 April, 2011.

Sunita Devi



Seoli Village
Arcadia Grant
Sanaspur Block
Dehradun District, Uttarakhand

Sunita Devi is in her sixth year working as the ASHA of Seoli village, in which she serves a total of 150 households, amounting to a population of approximately 1,000. She says her work can be summed up by three steps: “counseling, motivation, and awareness.” The closest Community Health Center (CHC) is five kilometers away in Prem Nagar. Her primary honorarium is the 600 rupees she receives for bringing a safe delivery to the district hospital, in this case, the Doon District Hospital. Her story sounds like that of any other ASHA; she is on call to a population of 1,000 at all times of day and night, she is overworked, underpaid. What is unique about Sunita’s story is that she lives in an area in which the majority of families are from a military background. How does this transform Sunita’s work? Because the majority of families are military families, 90% of deliveries are taken to the Doon Military Hospital, a center which offers free services to military families. Unfortunately, the Doon Military Hospital is also a hospital in which the ASHA does not receive a 600 rupees salary for a safe delivery.

The 600 rupees, Sunita explained, is seen not only as pay to the ASHA for bringing the delivery to the institution, but also as pay for the treatment provided to the mother in the six to eight months before the delivery: it is the culmination of many, many months of care provision. Therefore, in 90% of pregnancies, Sunita spends six to eight months (on average) caring for the mother, and is paid nothing. Yet, what really angers Sunita is not her lack of pay, but the way in which she is treated by hospital staff. “The system is not caring for ASHAs,” she told me, “it de-moralizes us.” The conditions at Doon District Hospital, in comparison to private or military hospitals, are bad; they are under-staffed, short with patients, and sometimes do not have enough beds. “Nobody likes to send their wife to Doon because of conditions. We are the only ones who encourage people to go to Doon, and the doctors still do not have so much respect.” She explained that she feels her role is “well-identified” by the people of her village, but not by the supervisors. “Only ASHA can tell the frustration of ASHA,” she told me, when I asked her how she would change the system. “The ASHA is the bridge,” she said. “Earlier the death rate, the MMR, IMR, were higher. They are now reduced because of us. So why is the system trying to weaken the bridge?” The ASHAs deserve more pay, consistent pay, because of their importance as grassroots mobilizers. They deserve respect that extends beyond the borders of their village. They deserve to be recognized publicly as *accredited* social health activists, as their title implies. Our interview finished with the following correspondence:

Sunita: “Now all ASHAs are thinking we should leave the job.”

Me: “You are thinking of striking?” I asked her.

Sunita: “No,” she responded, carefully straightening her sari across her lap, “stopping our work entirely.”

26 April, 2011

X. The Negligence of the Administration

“ASHA ke pas asha hai”



Source: Dehradun Jagran, 27 April, 2011.

“Negligence of the Administration.” The above title of newspaper article, depicts the obvious struggle to jump over a leaking sewer in front of a government official’s office. The article compares the struggle of leaping over the exposed sewer, to that of the ASHA’s work; if the conditions are such in front of a political institution, how do we expect them to be in the villages: the environment in which the ASHA must work, advocate, and bring about positive change? The below photographs are from the 26th April, 2011 ASHA protest, which consisted of a march from Gandhi National Park to the Dehradun District Secretariat Headquarters. Karmo Devi, an ASHA working in Badripur since 2005, explained that the ASHAs had gathered to demand a fixed salary for their work: 2,500 rupees per month as their suggested standard. “If we

were given more pay, we would have more strength to do our work sincerely,”⁶² Devi said, as she pushed past police, standing at the border of the protest.



Harriet Napier

An article published in the “Daily Pioneer,” on 27 April, reported:

Furious ASHA workers from across the State gathered at Gandhi Park in Dehradun on Tuesday and shouted anti department slogans... agitators took out rally to secretariat via Astley Hall and Subhash road. Workers expressed their concern over the issues that memorandum was submitted many a times to officials but they are not fulfilling their pending demands. As agitators were stopped by the police personnel through barricades near secretariat, ASHA workers sat on dharna and shouted anti-Government slogans.⁶³

Rukmani, the Doiwala CHC ANM who opposed the idea of providing the ASHA with a fixed salary, claiming that it would lead to her inactivity, felt, however, that the incentives were too low. In a similar way in which she felt a fixed salary would discourage the ASHA from committing time to her work, she claimed low incentives do the same. With market and fuel prices rising every day, it is becoming very difficult for the ASHA to continue her work, one

⁶² Devi, Karmo. Personal Interview. 26 April, 2011.

⁶³ “ASHA Workers Protest at Gandhi Park.” *Daily Pioneer*. 10 May, 2011.

which often requires she replace traditional income generating activities such as farming, with her expected duties as ASHA. According to the “Guidelines on ASHA- Annex 1,” it is stated that the work of ASHA, as “honorary volunteer,” will be “so tailored that it does not interfere with her normal livelihood.”⁶⁴ Yet if an ASHA is the one woman on whom a pregnant woman can rely, on whom the system tells all pregnant women they *should* rely, how can she *not* interfere with her normal livelihood if she must be available to all pregnant women regardless of the time of day?

Although referring to the payment of physicians, the following statement by S. Sunder Raman, an Indian public health expert, can be applied to any health provider, including the ASHA: “Merely giving allowances as incentives won’t work in the long run,” Raman contended, “The remuneration is not comparable to the times we live in.”⁶⁵ Kamla Sen, an ASHA working in the village of Pratipur, further explained the problem of incentive-based pay, using her own experience as her example. When questioned about her average monthly pay, she responded, “sometimes zero rupees, sometimes two thousand.” With the primary financial incentive of the ASHA that from bringing a pregnant woman to the CHC or PHC for her delivery (for which she is meant to receive 600 rupees) her absolute salary is greatly dependent on the number of pregnant women within her 1,000 population catchment area. In recent years delivery payments have become even more unpredictable: “So many times I have been taking care of a lady for eight, nine months, then the family has saved and delivers the child in a private hospital. So I receive no pay,”⁶⁶ explained Manju Rawat, a highly educated ASHA of Gorakhpur.

Considering the dilemma of pay in the context of women’s empowerment, one can argue that inconsistent pay, in fact, is more disempowering than low, consistent pay; one which the woman

⁶⁴ “Guidelines on ASHA- Annex 1” NRHM. 29 July, 2010.

⁶⁵ “Rural India is short of 16,000 doctors.” *The Economic Times*. 9 March, 2011. Accessed 2 May, 2011.

⁶⁶ Rawat, Manju. Personal interview. 26 April, 2011.

may be more likely to secure through more traditional profitable activities, such as assisting in agriculture. As the woman's status within the family is often associated with her ability to provide stability; stability in bearing children, in raising the family, in cooking, and in keeping the house, an unstable income, one which additionally requires she give up other such contributions, can injure the well being of her family, and consequently, her status. In short, unintentionally emphasizing an inability of the female to provide a stable income could further exacerbate her status as a monetary burden to her family. Policy makers must thus identify their goals of the intended program of empowerment: *How* is it envisioned that empowering a woman with the job as ASHA will *change the way in which she is received by her family and by society?* If the ultimate aspiration is to train a village woman with basic health expertise, producing a figure who can both assist her community in maintaining good health at the grassroots level and connect villagers with primary health services when necessary, who is driven by very specific missions such as immunizing a set number of children, bringing a set number of deliveries to the hospital, incentive-based pay can be used. Incentivizing her work will ensure her focus on the improvement of specific indicators, and will allow for transparency in her work, but may risk her financial security.

Conversely, if the ultimate or equal goal is that of combating gender discrimination, the techniques of her pay must be more closely considered. If the objective is to bestow on the female the status of *consistent provider*, equal to that of her male counterpart, it is essential that a level of reliability in her income-generation activities is secured. A simple policy adjustment could be ensuring monthly events (a *swast mela* or a Village Health and Sanitation Day), which are paralleled by fixed incentives. Requiring certain activities of the ASHA linked to fixed dates also invites greater transparency and accountability; if the ASHA is required to send an ensuing

report to the government center where she will receive her pay, an evaluation can simultaneously be made of her progress and the progress of the program itself. It also demands more responsibility from the ASHA, increasing the value of her work, and the value of the health services themselves.

Equal to the ASHA's concern regarding the financial compensation for her work is her frustration with the way in which she is received and treated by nurses and doctors. The work of the ASHA has undoubtedly changed the work of public sector doctors and nurses. As Mrs. Pitambari Godiyal, an experienced ASHA of Baniya Wala said jokingly, "before the ASHAs, the doctors were clapping flies."⁶⁷ In all PHCs and CHCs visited during this research, it was declared that there had been an increase in the patient population, especially women, since the ASHA program began. The State Women's Commission of Dehradun, which acts as a court for cases of sexual harassment and domestic violence, said that more women have been seeking their support since the ASHAs began their work. In 2003, the first year of the State Women's Commission, only forty cases were reported, whereas in the recent fiscal year (31 March, 2010 to 31 April, 2011) there were 1,155 cases. In many of these cases, Sushina, the SWC chairman said, the survivor was accompanied to the SWC office by an ASHA.⁶⁸ ASHAs have proven to be both a way to outsource information as well as a way to increase the care seeking behavior of formerly hesitant populations.

With the increasing popularity of seeking treatment in private facilities, the ASHAs expressed confusion as to why public doctors treated them so badly when the ASHA is "the only one"⁶⁹ bringing business to the public sector facilities. As is written in the "National Rural Health Mission Additionalities, 2011-2012," "patients are the best ambassadors of our PHCs

⁶⁷ Godiyal, Pitambari, ASHA. Personal Interview. 26 April, 2011.

⁶⁸ Ms. Sushina. State Women's Commission Chaiman. Personal Interview. 25 April, 2011.

⁶⁹ Devi, Sunita. Personal Interview. 26 April, 2011.

and Hospitals... it is important to take care of their needs and provide them with best possible care. Their apprehensions should be addressed so that they have the courage to come back to the same facility. In this business, every satisfied customer brings thousand new customers.”⁷⁰ This is especially so when considering the treatment of the ASHA: the woman whose job it is to advocate for government services. If the ASHA is not pleased with the behavior of the nurses and doctors, why should she act as an advocate for them to her sisters, brothers, cousins, and auntys for whom she works in the village?

One ASHA participating in the DARC training of Raipur Block said that when trying to advocate for a patient in the hospital, she is often scolded by the doctor: “I am the doctor, you are not the doctor. This is not your job.”⁷¹ The doctors frequently undermine the ASHA, “equaling [her] to a village woman.”⁷² The ASHAs said they guessed their mistreatment was due to the senior doctors feeling frustrated by the increase in work. Anita Thapa, ASHA of Badon Wala, too, claimed that she had been, on many occasions, “emotionally hurt” by the attitude of her superiors. Shobhit Singh Rawat, a Social Worker and Psychology student who has been working with DARC for the past year, explains the dilemma from his perspective. “The main problem we see is that the doctor is not cooperating with the ASHA. And they are both working for health,”⁷³ he stated. Sunita Devi expressed another related and very interesting concern: the system of pay is frequently such that it appears to reduce the legitimacy and formality of the ASHA’s role. At the time of pay, the superiors become very strange, Devi explained. “The pay does not always feel official. Sometimes they pay 210, sometimes 220... it comes like the official is paying from

⁷⁰ “NRHM Additionalities, Part B.” 2011-2012. NRHM Program Implementation Plans 2011-2012. 52.

⁷¹ Anonymous ASHA. Focus Group. 27 April, 2011.

⁷² Mrs. Rawat, Manju. Personal Interview. 26 April, 2011.

⁷³ Singh, Shobhit Rawat. Personal Interview. 27 April, 2011.

his pocket. It is de-moralizing.”⁷⁴ If the superiors do not treat the role of the ASHA seriously, and themselves express a shared value for the benefits of the program, how is the ASHA expected to take seriously her work? “Overall, the system is not caring for the ASHA,”⁷⁵ Sunita Devi concluded.

Translating policy into practice is again where the predicament dwells. Because the examination of women’s empowerment must include a holistic consideration of gender-based discrimination that is still a driving force in Indian society, we must equalize the ultimate goal of improving targeted indicators with successfully empowering the female health worker. Due to the familiarity and trust that ideally exists between ASHA and beneficiary, the result of her identification as a village member, she can too easily be exploited as a means by which the public health system can improve health indicators. Combating structural violence, from top to bottom, from the center of control and policy to the village itself, must remain a crucial motive of all grassroots health programs. If the goal of the ASHA program is to empower the benefactor herself, through her employment as valued health provider, the formula for her empowerment must be carefully structured, secured, and her compensation, unvarying. In order for the program to reach its greatest potential, it is essential that the position of the ASHA is presented by the system as one of great value and importance, and upheld as such without fail.

XI. Globalization & Empowerment: A Conclusion

What is empowerment without reward? The purpose of fighting for empowerment is that there exists something better on the other side. Because empowerment is so directly connected to the human rights of a person, theoretical empowerment, if not translated efficiently, means a

⁷⁴ Devi, Sunita. Personal Interview. 26 April, 2011.

⁷⁵ Devi, Sunita. Personal Interview. 26 April, 2011.

further denial of one's human rights. As Sen explains, it is not the "goods" which one theoretically has (here we must consider "goods" to be the title as ASHA/BHP/VHW and corresponding training) but the way in which the society invites and allows the individual to employ such goods.

If the object is to concentrate on the individual's real opportunity to pursue her objectives, then account would have to be taken not only of the primary goods that persons respectively hold, but also of **the relevant personal characteristics that govern the conversion of primary goods into the person's ability to promote her ends.**⁷⁶

It is thus not a question of the gamut of resources that are present within society as a whole, but rather the manner in which the individual is, as defined by her role- expectations and limitations, able to access and utilize said resources. The resultant question is: How can we ensure that initiatives of empowerment are, in fact, empowering? A context in which federally- deployed initiatives targeting women's empowerment are deemed vital will inevitably be one in which natural progression of empowerment has been impossible. This being said, it is crucial that all factors hindering the development of the woman within both society and home are identified and addressed within the empowerment agenda in order for said agenda begin to amend the current status of women. Giving girls the opportunity to complete their education is essential, but not giving women a safe or culturally- appropriate environment in which they can work when they have completed their schooling, defeats the purpose of giving them education, Urmilla, mother to three young girls, and resident of Kehrigaon, argued.⁷⁷ In a survey of fifteen young women living in Kehrigaon, it was concluded that the greatest difficulty faced by the educated women remains the mere ability to leave the home. It is important to note that approximately one third of the women whose inputs led to such a conclusion had completed their Bachelor's Degrees. "They

⁷⁶ Sen, Amartya. 74.

⁷⁷ Urmilla. Personal Interview. 21 April, 2011.

have given education,” Urmilla stated, referring to the government, “but not jobs.”⁷⁸ Giving a female a certificate or diploma identical to that of her male counterpart is important in developing a mindset of gender equality, but if the society in which this certificate theoretically gives her equal opportunity is not prepared for her, written equality, too, becomes worthless.

In order to present a compelling argument for women’s empowerment, the proper discourse must be utilized. Globalization invites, or better yet, demands that governments consider the health of their people in an evolutionary manner. With the idea that distance between two subjects inhibits interaction becoming obsolete, the demand on governments to implement effective, all-inclusive programs is becoming greater. The Millennium Development Goals, for instance, are a valid representation of the interaction between globalization and global health. Health activists can use the rhetoric of globalization to demand the recognition that all persons share a set of common rights independent of geography and their apparent connectedness to the outside world. Health and social indicators are becoming progressively less difficult to track, and yet, the marginalized still find themselves without proper public health services. Implemented programs do not reflect a holistic consideration of the implications of structural violence, and thus fail to amend the very structural impediments which endorse inequity among groups. Development discourse must comprise not only of the economic and technological benefits of globalization, but also of the accompanying ideological strain that is necessary to activate associated benefits, such as equal status and pay within the workplace.

After policy has been written and implementation has begun, a third equally important affair must be considered. What sustains the momentum of global and local development agendas? As much as policy makers would like believe otherwise, pay is an essential mode by which to sustain grassroots programs. Relying on volunteerism as a means of improving health

⁷⁸ Urmilla. Personal Interview. 21 April, 2011.

requires an extent of commitment on the part of the health worker that is unreliable and exploitive. The WHO's dialogue on the importance of payment in community health worker programs cannot be phrased better.

“Early community health worker programmes assumed a pool of willing volunteers but, in time, lack of payment proved to be a major cause of workforce attrition. There is virtually no evidence that volunteerism can be sustained for long periods. Most of the evidence reflects low activity rates and high drop-out leading to the ultimate collapse of community health worker programmes where payment, or other appropriate and commensurate incentives, are not adequate. The question of what represents adequate remuneration remains controversial and there is a paucity of evidence to indicate what combinations of incentives, including financial and non- financial incentives, are sufficient to motivate and retain community health workers. The burden of evidence indicates that stipends, travel allowances and other non-financial incentives are not enough to ensure the livelihood of health workers and that the absence of adequate wages will threaten the effectiveness and long- term sustainability of community health worker programmes”⁷⁹

Successful Community Health Worker programs are not, as many wish to believe, low-cost initiatives. They can be, however, extremely sustainable, and the most culturally sensitive way in which to extend the right to health to those most marginalized populations. The proper treatment and pay of local health workers has the ability to render outstanding improvements in both health outcomes and gender relations at the grassroots level, with formally suppressed women at the vanguard of such initiatives. If carefully implemented, the community health worker model (whether it be that of the ASHA, the BHP, or the VHW) can concurrently break down the structural, social, economic and medical impediments that maintain the succession of poverty.

⁷⁹ WHO, PEPFAR, & UNAIDS. (2006, August). Task Shifting: Global Recommendations and Guidelines. WHO. 36.

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