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A CASE STUDY OF VILLAGE HEALTH WORKERS' MOTIVATIONS IN JAMKHED

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Abstract

Across the field of global health, there have been many attempts to cater to the health needs of the most marginalized populations. Community health workers (CHWs) are individuals that live in the communities they serve and are typically low-income women with little to no formal education. After a period of training by their program, they enter their communities equipped as a bridge between the community and the health system. Although CHWs do play a substantial role in health delivery and education, the structure of CHW programs varies widely, but a common characteristic of these programs is that the CHWs are usually unpaid. So, why do they do it? The implications of CHWs' motivations are critical, as they may predict the sustainability and effectiveness of the health programs they serve. This qualitative case study explores one successful CHW program in an attempt to understand what motivates Village Health Workers (VHWs), and how that contributes to the success of CRHP's model of community-based health and development.

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messages, thoughts, and love are always with me. And of course to my beloved family; they are a part of everything I do. To my parents who show me that time and time again, no matter how much I push them out of their comfort zone, they will be there to fully support me. Anything I have accomplished is with them beside me. To my siblings who keep me grounded and high at the same time. To have them as my best friends is something I deeply cherish. Who I am is because of all this love. The love I have experienced from each of you is something I promise to keep flowing.

Introduction

Context

How can we ensure that good things last? At every turn in global health, the question of sustainability is up for debate. This is particularly the case since the shift to focus on providing primary healthcare for all. Community health workers (CHWs) can be found around the world, but primarily in developing countries. The fundamental idea is that a lot of the world's health issues can be reduced by connecting communities to health infrastructure that already exists, using their untapped human resources. CHW programs are an attempt to cater to vulnerable populations in poor, rural areas for whom basic primary healthcare is not a luxury afforded. The concept of the CHW is theoretically sustainable: The CHW is typically a woman from the community that she is trained to serve. Therefore, she is relatable, culturally knowledgeable, and readily accessible. CHWs are people, with little to no formal education, who are trained to connect the communities they live in to existing health resources in various capacities. They make home visits during which they may serve as a health educator, community health liaison, midwife, caring neighbor and counselor, in addition to other social roles. Thus, because CHW programs can vary so widely, it is difficult to define their position in the healthcare system.

Although the idea of a CHW sounds like a great solution to inadequate health access and availability, in many places around the world, it has not actually worked long-term. In order to understand why that is, it can be useful to look at attempts of CHW programs at up scaling to the national level. There are many factors that come to play when it comes to unsuccessful national CHW programs that can be divided into two groups: pre-existing structural deficits and neglected problems that arise. Before the implementation of these

programs, there is often an already weak primary healthcare system at the national and local levels, incomprehensive logistics management, insufficient funding, and ultimately poor integration of all these facets. Subsequent problems that ensue or are prolonged are lack of CHW support and knowledge, inconsistent funding, lack of understanding or cooperation of the CHW's relationship with community, and overall confusion throughout the health system. These underlying causes lead to future issues of sustainability in terms of quality of care and retention of CHWs (Liu et al., 2011).

This alone shows the complexity with which CHW programs are built. For the sake of this paper, the focus is limited to one aspect in the range of issues: CHW retention. There are many reasons for CHW attrition related to monetary incentives, professional prospects, personal development and overall support. Motivations of CHWs are important to consider because of the impact that has on how effective they are being and will be in the future (Bhattacharyya et al., 2001). Even if CHWs are effecting change in their communities, if they are not motivated to continue those efforts, then where does that leave the community? How stable the nature of what motivates CHW is also important. If they are motivated by altruism, religion, or monetary incentives that can affect the effort they exert. Whether monetary incentives should be given to CHWs is being highly debated, because on one hand they are doing valid work, and they are usually of low economic status, and on the other hand, either the quality of work they do may deteriorate or there may not be secure funding to guarantee consistent payments.

The Comprehensive Rural Health Project (CRHP) at Jamkhed is an incredible exception. VHWs are effectively promoting health in ways that a well-educated health practitioner could not match. There is something that simply works about empowering a

community to take an active role in their health, and CRHP's VHW model is an example worth learning from. It operates in rural India where most health concerns are exaggerated by geographic, social and economic factors. In order to improve public health, it means meeting the health needs of the populations that may have otherwise been neglected. CRHP started as an organization working toward community-based primary healthcare (CBPHC). CBPHC is takes a horizontal approach to health, at the community level in an attempt to truly make health attainable to all, especially the poor. Over time and with more experience, CRHP has turned in a community-based health and developed (CBHD). CBHD takes CBPHC to another level by recognizing that, in addition to health, there are other aspects of life that can be improved by empowering communities.

Case study in context

There have been several studies on the Jamkhed model, pertaining to the impact of VHWs, their empowerment, community development, etc. While none of those are the focus of this case study, they undeniably arise in discussion about VHWs' motivations. The research question guiding this paper is: what motivates Village Health Workers (VHWs) and how does that contribute to the success of CRHP's model of community-based health and development. The objectives of this study are (1) to understand the nature of VHWs' motivations, (2) to assess how that impacts CRHP's overall model of CBHD, and (3) to contextualize that with the relationship between motivations, CHW retention, and sustainability. This paper is formatted as a qualitative case study, with the motivations of VHWs as the variable of interest, CRHP Jamkhed model as the case, and community-based health and development as the social phenomenon. The primary fieldwork methods are

observations and interviews. Semistructured interviews, one-on-one and focus groups, allowed a starting point for discussion with the flexibility of the interview to take unexpected turns. There were three groups of respondents: CRHP staff and administration, project village members, and VHWs. There were four respondents in the staff and administration category, including a lecturer, social workers/VHW trainers and a physician. There were two focus groups of men and women in project villages (ten and eleven participants). Although this study is most concerned with the VHWs, in an attempt to fully capture the context, other components of the Jamkhed were included. Within the six VHWs interviewed, there were three generations of VHWs represented, which is measured by the year they were trained. There were first-generation (1970s-1990s), second generation (1990s-2010) and third generation (2010-present) VHWs. The respondents were recruited in various ways. The staff were recruited by one of the directors, the VHWs by the VHW trainer, and the village members by their VHW.

The data was analyzed with grounded theory. An inductive approach to thematic analysis was done by first compiling the interviews in MAXQDA, a qualitative data analysis software, and then coding everything and anything that came up. While keeping in mind the topic of VHWs' motivations, this methodology allowed for themes to arise more naturally than being imposed by the researcher. The main finding of this study is that VHWs' motivations are numerous, multi-dimensional, and all rooted in the flow of knowledge. As the concept of CHWs is not a new one, this paper attempts to contribute to understanding the relationship between CHW motivations and retention all under a framework of sustainability. Thus, the aim is that by pinpointing a successful case of a CHW model, other CHW programs can potentially learn from and adapt aspects of their

programs with this in mind. Of course, all models of CHWs are different because they are context-specific, but there is much to gain from hearing success stories, if only to boost optimism.

Structure of this paper

The first section of this paper starts off with a general description of CHWs- who they are, their roles and responsibilities, their impact, and why they exist. Then it goes on to explore some of the challenges related to the nature of employment and incentives CHWs may receive. Next, the specific model of CHWs being studied, the Jamkhed model, is introduced (CHWs have many names. At CRHP, they are referred to as VHWs.). The Jamkhed model is broken down into three parts, the VHWs being one of them, but all three are mentioned in an attempt to provide sufficient context under which this case study is investigating. One part of the model is the village. The village consists of the VHW and her village, and each of their responsibilities is shared. Because a general overview of CHWs is given in the first section, this section only highlights what is unique about Jamkhed's model. The other two parts are the mobile health team (MHT) and CRHP's hospital. This section concludes with the principles of community-based primary healthcare (CBPHC) that are essential to go over in order to fully understand the VHWs of Jamkhed and CRHP altogether.

The paper then goes on to demonstrate the role of empowerment in VHWs' motivations. The ways she is empowered is divided into three categories: identity, economy, and knowledge. The main finding in this section is that the VHW is the immediate beneficiary from this system, and that is then extended to her village. The following section

delves into the range of relationships that VHWs are a part of. They have a relationship with their villages, other CHWs (from government programs), healthcare professionals, CRHP staff and administration, and other VHWs. Each of these relationships is critical to being an effective VHW because the burden is shared. Further motivations are revealed in the next section. There are multiple sources of motivation. Part of VHWs' motivations is external, in the form of moral and social support, visible and continuous success, and opportunities for personal and community development. The other part is internal, which is in her story, altruism, and personal traits.

These sources of motivation exist in both the past and present. Interestingly, motivations also extend to the future, which transitions to the following section. Motivations of CHWs affect their retention and thus the sustainability of the entire scheme. To dive into the relationship between the motivation, retention, and sustainability, first the success of the Jamkhed model is explained in terms of how CRHP measures VHW success, the role of the community, and the role of the institution. The conclusion of this paper begins with lessons from Jamkhed. Before that though another CHW program in India, the ASHA program, is briefly mentioned to expose that it is unrealistic to expect the Jamkhed model can simply be translated to the national scale. Soon thereafter, general lessons from Jamkhed that are perhaps more feasible for other programs to adopt are mentioned. Finally, specific lessons from the nature of VHWs' motivations are summarized. This all comes down to one thing: the flow of knowledge. The paper ends with limitations of this study and recommendations for further study.

Who is She? Understanding the CHW

A link. A bridge. An agent of transformation. These terms are commonly used across the board to define CHWs, yet CHW models can vary dramatically. There are many decisions in place when it comes to designing a CHW program: gender, education level, recruitment, employment status, incentives, size of the beneficiary population, training, monitoring and evaluation and role of community (BM and Muraleedharan, 2008). In India, although men have in the past acted as CHWs, there has been a deliberate switch to reserve these roles for women (GOI, 1997). This is also the case in many present CHW models, so this paper will follow that context. Globally, there is an overwhelming consensus that primary healthcare is essential for all. Unfortunately that is not yet a reality for much of the world, but the CHW model aims to undertake at least part of that burden. CHW programs should be feasible to carry out and sustainable to continue, although, that is not always the case.

The globalization of the CHW is popularly associated with the Alma Ata conference in 1978, although CHW programs have been around for some time prior to that. At the conference, the Jamkhed model was referenced as an example of community-based primary health care (CBPHC). It was on that global stage that primary healthcare was determined to be something to strive for in order to build a solid foundation upon which to maintain and sustain health (Joshi and George, 2012). Thus, CHW programs align with a horizontal approach to health. Where vertical programs target a specific disease and have an expected end date, horizontal programs attempt to create long-term, sustainable health for all. In line with the millennium development goals (MDGs), the promising potential of CHWs is widely accepted in the relevant health goals,

There is a wide range of services offered by the CHWs to the community, ranging

from provision of safe delivery, counseling on breast-feeding, management of

uncomplicated childhood illnesses, from preventive health education on malaria,

TB, HIV/AIDs, STDs and NCDs to their treatment and rehabilitation of people

suffering from common mental health problems. The services offered by CHWs have

helped in the decline of maternal and child mortality rates and have also assisted in

decreasing the burden and costs of TB and malaria (Bhutta et al., 2010).

Although the MDGs have been updated with the sustainable development goals (SDGs), the

work that CHWs contribute is still very much relevant. There are global and India-specific

CHW models that exemplify just that. Contexts may change but the challenge to make

health a true human right prevails. So, does the CHW have a place in that endeavor?

This is the part where it is integral to define the nature of employment of CHWs. Are

they paid workers or volunteers? Although, they may be labeled as volunteers, there is a

discrepancy in how they are treated. What is expected of them is fitting for a salaried

employee, which they are not, and can be critiqued from a rights-based perspective (Bhatia,

2014). Being labeled a volunteer, while it can be rewarding in many ways, it also discredits

CHWs' ability to assert boundaries. Additionally, CHWs usually do not have a set schedule.

This lack of structure prevents CHWs from getting a clear idea of what is expected of them

and for what they can and should hold the government or organization accountable. This is

a tough position to be in. CHWs are seen as a voice of the community as well as an

extension of health services, which is perceived by the community as the government.

Although that may sound like an ideal medium, the other side of that is how they are now a

part of an in-between group; not fully-fledged government employees nor common

community members. And from that position, how and to whom do CHWs negotiate their position?

Monetary incentives for CHWs, although a seemingly straightforward decision, have proven to have unintended consequences. It can adversely affect CHWs' relationships with their communities and CHW retention. A once nurturing, supportive and open relationship between a CHW and the community can become obscured when the CHWs receive remuneration, because if CHWs are getting paid then that makes community think they are disingenuous, only pushing for the agenda of the government. This further removes them from being a voice of the community, which is the greatest thing they offer. So, what was once an incentive becomes a popular reason CHWs leave their positions. There is also a matter of the institution deciding how to distribute the money. It could be provided on the basis of each service done, the CHW's training and experience, or numerous other ways. It is almost guaranteed that whatever method of monetary distribution is chosen, it will create tension among CHWs. These are possible consequences assuming that the money is there to give. When it is not, there are even more problems to consider. If money is the primary reason CHWs do their work, and there is no consistent funding by the government or organization providing the monetary incentive, it can lead to higher CHW attrition. In most cases, though, CHWs are not solely in it for money, which allows for other avenues of compensation such as in-kind payments, recognition, opportunities, training, and social support (Bhattacharyya et al., 2001).

The Jamkhed Model at a Glance

As the names suggest, CRHP's model of community-based health and development is built on being comprehensive- the idea that health is not separate from other parts of life and thus measures should be taken with this in mind. There are three parts that comprise this model: the village, the Mobile Health Team (MHT), and the Julia Hospital. The village includes community groups and VHWs. There are women's self-help groups that primarily revolve around income-generating activities. The men's groups are farmers' clubs. There are separate programs for adolescent boys and girls. They both learn about health and social issues, but differ in some ways. For one, the girls have a karate class for self-defense and to boost confidence. The VHW helps out where needed, especially in the adolescent programs, but the idea is that the people in the village take an active role in their wellbeing- mentally, socially, physically, and economically. The VHW is only one part of the village; she is not meant to replace the village members. Their participation is key for this to work.

The VHWs are women chosen by their village to serve on a voluntary basis. They are married, relatable and accepted by the poor, rooted in the community, excited to learn and motivated (M. Arole, Arole, R., 1999). They are trained in relevant health topics at the CRHP campus twice a week for which they are compensated with an honorarium that covers transportation, meals during the training days, and a day's wages they missed out on by attending the sessions. Some of the course topics include antenatal care, family planning, child malnourishment, communicable and noncommunicable diseases and animal care. This is in no way an exhaustive list of what they learn. Like most CHW models around the world, the VHW is a change agent and a bridge between the health center and her village. Her job is four-fold: promotion, prevention, cure, and rehabilitation. What is unique about the Jamkhed model is that it started out with all illiterate and low caste

women when it began in 1970. With the newer generations of VHWs, because there is less casteism and illiteracy than before, the demographics of VHWs are indeed changing. What is also unique about the VHW model is the support VHWs receive. They work side-by-side with healthcare professionals, community members, CRHP staff, and other VHWs. This increases their knowledge, self-esteem and ultimately empowers them.

The Jamkhed model is such that no one entity functions without support and facilitation from the others. The MHT consists of a doctor, nurse, social worker, and lab technician, but changes based on the present need of the project (e.g. there could be a pharmacist, civil engineer, or hydrologist). The MHT facilitates many processes. For example, they are involved in the selection, training, and support of VHWs. The MHT does house-to-house needs assessment surveys once a year, with regular updates from VHWs year-round. They develop curriculum for VHW training, which entails making the health education relevant and understandable, and then they may lead the training sessions using adult learning principles. They introduce programs and the VHWs pass it on in their villages. According to a MHT member and VHW trainer, "Any organization, any NGO whenever they are working, they are working to make any type of program as a movement, and it is VHWs who were able to make this type of program as a movement," (CRHP staff, personal interview, 2017). The key thing to notice is that movement implies that it is continuous, and it is the VHW's responsibility to keep the momentum alive in her village, alongside her neighbors. Past programs include immunization and child and maternal nutrition. Present programs include diabetes screening and awareness. MHT and VHWs work closely whether they are conducting village meetings to hear people's concerns, presenting health education through dramas, or supporting the adolescent programs.

The MHT also serves to connect the village to the CRHP secondary healthcare facility- the Julia Hospital. The hospital takes a holistic approach to health so that the mind, body, and spirit are all healed. Sometimes this means mixing allopathic and alternative methods. That way, health-seekers' perceptions and practices are considered in their care. Additionally, everyone is involved in the process: health seeker, family members, VHW, and practitioner. For example, a health-seeker with his or her family come to the hospital with their VHW. The health-seeker and family go through their reason for coming and the VHW explains to the practitioner what she has already done and what she thinks the diagnosis is. Then, relatives are brought in to the intensive care unit or operating theater so that they know what is happening. This reassures them during the treatment, and informs them of how to care for their loved ones afterward. The hospital operates in a cost-effective way that allows them to provide care for a fraction of the price of private hospitals, based on the economic ability of the family, as well as free meals during their stay.

Every aspect of the Jamkhed model has much to learn from. While this project focuses on VHWs' motivations, this context serves to demonstrate that all parts are connected, and thus would be foolish to try to isolate one part of the Jamkhed model from the others. Fundamentally, CRHP is based on the four principles of CBPHC: equity, integration, appropriate technology, and empowerment. Equity is social justice. It asks "Who has been deprived of health and development opportunities?" And the answer is women, children, people with stigmatized conditions (i.e. leprosy, TB, AIDS), Dalit caste, tribal groups, and the poor. It means that needs vary, and those different needs should be met. Then, the root causes of ill health can be tackled. Integration is about addressing the multi-dimensional nature of health with multi-dimensional solutions. Promoting sectors

such as agriculture, water, education, and economic stability improves health. In the promotion of these activities, it is carried out with appropriate technology. "Appropriate" means the methodology is scientific, practical, socially acceptable, and relevant. The VHW is a prime example. Empowerment manifests in many ways. One way it does in the Jamkhed model is in the role of the community. A village can only become one of CRHP's project villages by organizing themselves and coming forward to prove that they are willing and ready to engage in partnership for the wellbeing of their village. This is demonstrated through the woman they select to be their VHW. Ultimately, the underlying principle of CBPHC is community participation (CRHP lecturer, 2017).

She's the First

Prior to arriving in Jamkhed, from background research, it was clear that VHWs have done great work with their communities (Perry et al., 2017). What was clear only after a month of interviews, observations, and informal interactions, is that VHWs, as individuals, are the first to benefit from their roles; she does not solely benefit others in the community. This is key to understanding Jamkhed's model of VHWs (Kaysin, 2010). The VHWs' life stories are what brought them to CRHP and keep them there. Many VHWs' stories depict incredible adversity (i.e. casteism, inter-partner violence, starvation, poverty, stigmatized diseases, death of loved ones) that led to crippling physical, mental, and social wellbeing (i.e. isolation, depression, multiple attempted suicides). Each and every story is different but the common thread is that they reached rock bottom before they rose, and CRHP supported them through it.

CRHP emphasizes VHW empowerment through multiple avenues. One such avenue is individual identity. The VHW's identity matters, "For the first health workers, they were people who had no clue to their own name, no clue that they existed as an entity except to be the wife of someone, the mother of someone. That's really very touching because what do you do when you don't even have a self-identity?" (CRHP staff, personal interview, 2017). To be a (good) VHW, she has to have a deep-rooted sense of who she is. She must have her own voice before she can be the voice of the community. Only then can she be of service to others. This change within one's self is evident from speaking to VHWs,

> Previously when I was staying in village I never helped anyone … Why should I? But [after] I got training at CRHP, I will go run and help them… I started thinking about others. If any death, if they are crying, we also have to cry with them so that it can be less. Before, I didn't think about others. I used to fight from others. If anyone had food I didn't think. Now, I give my food to others. If I don't have [enough] food still I will give it to another person (VHWs, personal interview, 2017).

This demonstrates that in times of adversity, the person facing the challenges are often caught up in their own headspace, that they often do not consider the needs of others. It also implies that people need people. VHWs are keen of that fact, from their own experiences, so then their journey of personal wellbeing is extended for the wellbeing of others. This way, VHWs build a sense of individual and community identity.

Another way VHWs are empowered is through skill building. CRHP promotes economic independence by giving them the skills for income-generating activities. When the VHW is equipped with some skills to contribute to the economic output of the household, aside from the thankless ways she already maintains it, she can put her abilities

to use outside the confines of her home. By teaching skills in farming or goat hoarding, for example, VHWs gain the ability to stand on their own feet; first economically, then in other ways. Having these new roles and responsibilities inadvertently prepares her to begin her official VHW training, which is primarily concerned with arming her with health knowledge.

CRHP equips VHWs with information. From their training sessions, VHWs are taught signs and symptoms of prevalent diseases. They know what solutions to offer. They are well-versed in what they can and cannot do. In the interviews, they proudly proved this information. Of course, there is more to their role than memorizing these facts. Her role is technical, practical, and activism (i.e. to learn, to do, and to change). What is most impressive was the VHWs' responses to the question, "What all is needed to keep your community healthy?" Here is the compiled list of their responses: safe water, proper sanitation and waste management, complete nutrition, gender equity, physical activity, political participation, prosperous agriculture, economic stability, clean air and environment, harmony in community, education. This comprehensive list exemplifies their understanding of the multi-dimensional nature of health that goes beyond information. Information gives them the facts, but VHWs' knowledge is what makes them aware of the needs, priorities, and challenges in their villages. Their knowledge is a combination of the information they receive from CRHP and the experience they can only get from their intimate relationship with their community.

VHWs have changed in terms of their self-image, economic status, and education, which have in turn impacted their social consciousness and personalities, "I have changed inside and out," (VHW, personal interview, 2017). A VHW explains further that she used to

be short-tempered but is now patient and peaceful because of being a VHW. As the VHWs

have undergone their own transformation, so too do their villages. VHWs noted changes in

infrastructure (e.g. toilets and paved roads), politics (e.g. less corruption), agriculture (e.g.

better crop yield) and society (e.g. less casteism). These incredible changes are an

illustration of what the VHW and community can do together. More importantly, though, it

portrays the succession with which these changes come about, "[I] improved myself, my

health improved, my family improved, … [improved] economic status. So personally, happy,

then can focus on community also," (VHW, personal interview, 2017). A mutually beneficial

relationship indeed, but not the only one involved in the VHW's versatile role.

The Network of VHWs' Relationships

VHWs are engaged in a wide network of people. They have a relationship with their

village, other auxiliary health workers, CRHP staff and administration (e.g. MHT and

directors), health professionals, and other VHWs. The VHWs often accredit their senior

VHWs as their motivation to become a VHW at the start, and the atmosphere of support,

love, and care that keeps them here. From observing the VHWs' training sessions, the bond

they share is clear. At the start of one session, they all held hands, ran in a circle singing in

Marathi, smiling the whole way through. The way they interact during and outside of class

is like a family. They enjoy each other's company and that harbors a positive learning

environment. With the CRHP staff and administration, VHWs have a similar, close

relationship. This has existed since the early years of CRHP with Drs. Raj and Mabelle Arole.

They took the time to communicate that they truly want to work, not just for, but with, the

most neglected groups of people (Arole and Arole, 2010). That was well worth it because

although the two have passed away, not a day goes by when they are not mentioned. Their leadership still inspires VHWs. They refer to each other as family, friends, team members. A social worker said of her relationship with VHWs that there is "No domination or hierarchy. I'm always, always learning from them whether senior or junior, no problem," (CRHP staff, personal interview, 2017). To have that mutual respect among people of different positions throughout the organization promotes teamwork.

Similarly, it is evident in the relationship between VHWs and health professionals that their level of formal education will not affect the way they treat one another. A VHW portrayed her relationship with health professionals, "Government doctors visit me also. He is asking, 'What's going on, any problems? What new knowledge do you have?'" (VHW, personal interview, 2017). The fact that professionals consult her shows that they trust VHW knowledge. Beyond that, VHWs are further empowered in being comfortable enough to challenge doctors. Another VHW said, "So we have nice relationship, but if the doctor is unnecessarily doing Cesarean sections, I won't tolerate that. Or if unnecessarily doing hysterectomies, then we are opposing," (VHW, personal interview, 2017). This confidence is an important quality in a VHW. By speaking up in these kinds of circumstances, it allows her to spread knowledge and make a difference at multiple levels.

As the VHW is specific to Jamkhed's model, there are other government-employed health workers that VHWs come across in the villages- accredited social health activists (ASHAs), Anganwadi workers, and auxiliary nurse midwives (ANMs). A VHW said of her relationship with these other CHWs, "Like our family members. We are from same village, they are also working for community. Together, we are working for community." While several VHWs shared the sentiment of close rapport with other CHWs, when asked to

compare their roles to that of other CHWs, the differences were clear. The same VHW

shared, "I am working more than them. Every time for my work, when I walk, anytime and

anywhere I give health education; they have fixed time. When I try to give health education,

they say 'Why are you always giving health education?'" (VHW, personal interview, 2017).

This VHW also works as assistant to a government nurse and has more interaction with

and understanding of how the roles differ. Other than CHWs having set work hours, being

paid by the government for their services, and having a specific to-do list, another big

difference between CHWs and VHWs in CRHP's project villages is in the relationship they

have with the community they serve. This was confirmed in one of the village focus groups,

when comparing their CHWs and VHW, they realized they have no clue who there ASHA is.

A related finding is that no single VHW who was interviewed thought that VHWs should be

paid a salary for their work- by the government, CRHP, or the community. One VHW

explained,

> No, if we are paid, then we will look at the watch; we will be just like salaried people.
>
> Government nurses they are fixed time and the information we have, they don't
>
> have that much. If Dr. Arole paid us, we wouldn't have been working so much or
>
> paying attention to the training. It would have been asking 'How much salary?' 'Who
>
> has a raise?' We have improved our families, communities. That is the big salary for
>
> us. Why would we need more? And this knowledge won't end. Just like old VHWs, I
>
> will train another one. That is not salary, (VHW, personal interview, 2017).

This VHW illustrates that expecting a salary would imply that the work they are doing does

not offer much else, when in fact the work they do and the people they do it for is highly

valued. Relationships garner the love, support and confidence that motivate VHWs, and perhaps the most important relationship VHW has is with her village.

The VHW can understand her village in a way that would be absurd to expect from an outsider or a specialist, which makes her an effective agent of transformation. From one village focus group, it was agreed upon by participants that their VHW gives care and support to their village like a family. One participant compared their VHW relationship with other CHWs, "She is closer to us; they are not. [VHW] is taking good care. If kids are not there, [other CHWs] are not worried about that. She doesn't only focus on one thing, for whole of village, any problem." (Project village members, focus group, 2017). This demonstrates that VHWs are involved in the lives of her fellow community members. One VHW exemplified that this is not limited to lay community members, "Like a family ... if they have problems they visit my home. So all the government officers are my friends and even the mayor, she is a woman, they are my friends. Husband of mayor is my husband's good friend," (VHW, personal interview, 2017). Part of being a VHW means being vocal, and engaging with people across all sections of the community is the best way to hear and communicate everyone's needs.

The most commonly mentioned themes around relationship between the VHW and her village were respect, value, and trust. Respect is demonstrated through the nicknames that people in the village refer to her as. One VHW shared, "As my birth village, they all call me elder sister, auntie, Madame, doctor and I relate with them," (VHW, personal interview, 2017). This is a relationship that started before she became a VHW, but expanded once she did. They respect her as a person, and the newfound knowledge that she shares. These relationships demonstrate that they value the VHW for her knowledge and her role in their

lives, "They are confident that I will definitely solve their problems. If I didn't serve village and got education, I would be common woman. When I leave my house they say, 'Come here, what is this?' 'Dine with me,' because we serve and give education to them," (VHW, personal interview, 2017). Showing interest and favor toward her validates the VHW's efforts and impact in the community. The foundation of the relationship between VHW and village is trust. The VHW is trusted with her village's health and economic and social change. By no means does she accomplish these tasks as a sole actor. In many ways she has to lead and then inspire others to follow. Every time they show interest or participate in work, it motivates her.

Internal and External Sources of Motivation

Understanding the VHW as an individual and the relationships she engages is in gets at VHWs motivations. Furthermore, it reveals that VHWs' motivations are both external and internal. External sources of motivation include outcomes, support, and opportunities. Continuous success motivates VHWs. To be able to witness that their actions lead to positive, visible outcomes builds confidence and momentum, "If any patient because of myself, my help, if they're cured, then also it motivates me," (VHW, personal interview, 2017). Having tangible results reinforces that what VHWs do is making a difference in other people's lives too. This satisfaction partly comes from the fact that VHWs' roles are not just preventive. Many respondents mention that the support they receive also serves as motivation. Support from husbands, relatives and community is important. Whether the support is moral or active does not matter. A husband's act of allowing and encouraging his wife to be a VHW is supportive in the same way that a village's act of cooperating in the

VHW's work is supportive. This is also true of the support they get from CRHP as an institution, in the form of compensation for training days and a nurturing learning environment.

The knowledge itself is a source of motivation. Especially in this context of training semi-illiterate and illiterate women, the opportunity to learn is not taken for granted, as it may otherwise be, "Education was useful and beneficial... We got education about physical health, politics, agriculture. If we have paid for some tuition class then we wouldn't have got this education. On the contrary, they gave us honorarium, food, and education," (VHW, personal interview, 2017). The sentiment that the VHWs share is that they get so much out of being a VHW, for themselves and others. Thus, they stressed the importance of having training that is useful, practical and updated, as it improves their knowledge and ability to do their work. Knowledge has given VHWs the opportunities that they otherwise would not get, whether it is teaching health education to local government officers or sharing their stories at international conferences. Although these benefits are great, it seems the most effective motivations come from within.

Internal motivation originates from the VHWs, and manifests in life stories, altruism, and personal qualities. Each VHW's unique life story is central to her journey at CRHP. It at first seemed counterintuitive that in many of the interviews, the VHWs would speak a lot about their past, although it was explicit that the study is focused on their motivations, which is presumably concerning the present. Now, it is clear that they use their past hardships to remind them why this matters and why they are uniquely qualified to be the one to carry out this work. It is another form of empowerment. Another motivating factor for VHWs is altruism. Altruism is positive feeling VHWs get from helping others, "As

patients I cure pass by, looking at them, I feel good. He might not feel like I have helped him. He may not thank me. I don't care for that. But, I myself feel good. He was in such condition, and now seeing him working. So I feel, in my mind, happy," (VHW, personal interview, 2017). This VHW demonstrates that altruism is not about being completely selfless; it is about herself too. Respondents emphasize that there are qualities that a VHW should have. Other than being altruistic, she, herself, should be willing to learn and to change, humble, empathetic, persuasive, and innovative. These are intrinsic factors; they are dependent on the VHW as an individual. Similarly, VHWs have in them a sense of responsibility that cannot be taught, "If I stop, how is my community going to develop? I'm responsible, like a mayor is responsible for whole villages, I am responsible for health and other sectors." (VHW, personal interview, 2017). This responsibility comes from within, but is not only going to affect her; it is associated with something greater- community. It is important to note that the motivations occur at multiple levels in order to understand how it affects VHW retention, and ultimately, sustainability.

Motivation, Retention, and Sustainability

The challenge with motivations is that if the thing that motivates a CHW is interrupted or no longer available, then the work she does suffers. It may lead to a lower quality of care or CHW attrition altogether (Liu et al., 2011). For that reason, it is necessary to ensure that CHWs are motivated in many ways, as is the case with Jamkhed's VHWs. VHWs' motivations are rooted in the past, through their life stories, and present, through the visible transformation in themselves and their villages. Likewise, the prospect of the future also motivates VHWs. To be a part of something that will have an impact, even if it

has yet to materialize is internalized by VHWs, "Knowledge is easily transferrable; I can give it to my daughters, my daughters to their children. So, it improves generations- all … I care for that," (VHW, personal interview, 2017). It is implied that this kind of motivation sustains itself because it will go on beyond the individual VHW.

The relationship between motivation, retention, and sustainability is an important one when implementing, evaluating, and improving CHW programs. The success of the Jamkhed model illustrates how the three are interrelated. First, though, it is useful to unpack what it means for the Jamkhed model to be "successful". This paper is particularly concerned with VHWs' motivations, but the way CRHP measures VHW success provides insight into their practice of CBHD. The perspective of CRHP staff and administration is best captured when one respondent listed, "Infant and maternal mortality- main things. Then, other health indicators: leprosy, TB, all that. Then, development indicators: women's and men's organization, as per need of community… to build community," (CRHP staff, personal interview, 2017). Every respondent, to this question, included a way to measure the social, physical, and mental changes that occur as a result of VHWs. Physical is measured in disease prevalence. Social is measured in the stigma of diseased persons and empowerment in her village through participation and action in community groups. Mental is captured in the VHW's self-image and empowerment in herself.

CBHD inherently recognizes the vast possibilities that arise when communities take charge of their own health. Of course communities are not homogeneous, and all sections of a community should have a seat at the table. That includes those who are marginalized and those who hold political power because "community" means individuals in the village, local government officers, and community groups. For instance, at CRHP, for VHWs, their village

selects the woman, because they know what makes sense for them. When the community

has an active, central role in their health and development, questions of sustainability tend

to resolve themselves. Although, this does not happen alone. There is a role to be had by

the institution that implements the CHW program. They provide supervision and

facilitation for CHWs, so that she does not feel like she is taking on the burden alone and

consequently becomes overwhelmed (Bhattacharrya et al., 2001). The goal is to keep the

CHW motivated in various ways so that she continues to do her work well, and can sustain

the mission of CBHD.

Conclusion

Lessons from Jamkhed

The success of the Jamkhed model has received recognition around the world and

has served as an inspiration to other CBHD models, but there is no one-size-fits-all CHW

model. One CHW model that was taken up by the Indian national government is the

Accredited Social Health Activist (ASHA) program introduced in 2006. An ASHA is a woman

from the same village she serves, who is married, and maintains good social relations.

CRHP, although not a national scale program, aided in the planning of ASHA, and inspired

many more like it around the world. ASHAs, compared to VHWs, have less training, fixed

monetary incentives, and push for different things. One of ASHA's characteristic

responsibilities is to promote mothers to have institutional deliveries. The amount of

deliveries at health centers have, in fact, increased as a result of the ASHA program, but

that has not guaranteed success of the CHW program according to other indicators of

health (Bhatia 2014). Although the VHWs of Jamkhed is a success story of a CHW model,

the fact that its success has not translated in kind in the ASHA model demonstrates the complexity of accommodating a population's needs at the community-level, even within the borders of a single country.

Understandably, it is difficult to systematize some of the incentives that motivate VHWs such as altruism, relationships, and life stories; to a certain extent, that has to arise naturally, with limited fabrication. There are, however, other areas of improvement that Jamkhed can offer. One lesson is to value and take up partnerships, with the government and with the community being served. When working toward such a noble cause, being open to any lines of support to make change happen and stick is essential. Community engagement is sometimes sought out with little or no recognition of the government. A respondent explains this as a lesson to learn from Jamkhed, "And [other CBHD organizations] go for too much activism. We can work with government. Government is trying. It is a big institute. We give [the government] a model. Because we are small, we can give model. That's what I saw. [Other CBHD organizations] can network," (CRHP staff, personal interview, 2017). There already exists some government schemes that can improve the wellbeing of the community, but it is often untapped, mostly because of lack of access to the information. It is VHWs who fill that gap by spreading the information and walking village members through different processes. Then, the community gradually becomes self-sufficient; the goal of CRHP is not to be totally dependent upon the government or VHWs or CRHP. Partnering with the government is seen as a conflicting decision to make when aiming to create change at the community level for marginalized groups, because often times the government historically has a place in putting them there and/or neglecting to ameliorate their situation. CRHP's stance is that the most important

thing is to remain politically neutral so that they can focus on their ultimate vision-enabling people to actively pursue true health (CRHP staff, personal interview, 2017).

That being said, it is equally useful to hone in on the lessons that can be learned from the motivations of the VHWs of Jamkhed. The first thing is that it is good to have multiple sources of motivation. That way VHWs' success is not contingent upon one, possibly unreliable, volatile factor. Additionally, it recognizes that all VHWs may have different priorities within the sources of motivations, so by having multiple, it caters to their different priorities. For instance, identity empowerment may be the most appealing or relevant motivation to a Dalit VHW, while it is altruism to a higher caste VHW. Either way, it does not matter, because both are available to all VHWs. As there is a range of motivations, each of them is multifaceted. They are not bound by time and space as VHWs identified motivations that lie in the past, present, and future as well as within and outside of herself. Because the VHWs are motivated in more ways than one, it strengthens their impact in the Jamkhed model of CBHD as a whole because all parts are connected, and it is sustainable because they have many reasons to do this work.

This study explored the nature of VHWs' motivations, assessed its impact on CBHD at CRHP, and explained the relationship between VHWs' motivations, retention, and sustainability. So, what motivates VHWs and how does that contribute to the success of CRHP's model of community-based health and development? Well, what was clear from every conversation with and about VHWs is that the underlying motivation is the flow of knowledge. Every individual is a source of knowledge, but what distinguishes VHWs is their every stride to pass it on, to spread it, to let it flow. The model of CBHD is successful because VHWs' motivations are such that the knowledge keeps flowing. Ultimately, the

greatest takeaway from this is embedded in what the Jamkhed model was referred to in the

early years: "A river flowing with knowledge freely available to all," (Arole and Arole,

2010).

Limitations

As with all case studies, studying one case is not generalizable. However, this

research is explicitly not about studying VHWs' motivations to generalize that all CHW have

the same motivations. Rather, it is exploring a successful model that can be taken for what

it is and adapted, if appropriate, in another CHW program. The greatest limitations of this

study arose from the interviews. Starting with recruitment, as the the staff were recruited

by one of the directors, the VHWs by the VHW trainer, and the village members by their

VHW, there was a power dynamic that may have affected the representation within the

study; it is possible the superiors chose people who would give favorable answers. It was

made clear by the interviewer that this is voluntary, and respondents seemed excited to

share their opinions. All of the interviews, except the ones with CRHP staff and

administration, were conducted with the help and presence of a translator. All of the

translators on campus are affiliated with CRHP in multiple capacities (e.g. social worker,

VHW trainer, etc.), so their presence may have influenced the responses given by VHWs

and village residents. However, the interviewers seemed comfortable and candid during

the sessions. Additionally, for the duration of this month-long project, there were four

different translators due to the hectic schedules and limited number of Marathi-English

bilingual speakers on campus. This could introduce bias in that each person may have a

slightly different way of translating certain words or phrases. Initially, the interviews with

village members were expected to be one-on-one but upon arrival to CRHP, it was clear

that it was not possible to do so because of their unpredictable schedules. The only way to

speak to people in CRHP's project villages was to do so in focus groups. Unfortunately, the

interviewer had no experience moderating a focus group, and that coupled with the fact

that it had to be translated to Marathi, interrupts the flow of conversation that may have

gone smoother with an experienced, bilingual moderator. Despite these limitations, it was

all a positive experiential learning process.

Recommendations for further study

From the data gathered, there was much to learn, but because of the scope of this

project, there are other interesting variables that were not explored and are missing from

the literature. For one, it would be interesting to monitor CHW attrition rates around the

world. That way, specific CHW programs can internally pinpoint which factors are weaker.

This paper chose to focus on motivations but if there was a way to monitor, that could

allow evaluation to see where and how to improve specific programs. Aside from a global

scale, there is much more that can be studied about the Jamkhed model itself. This study

highlights the success of Jamkhed's model of VHWs and CBHD, but it has been almost 50

years since the start of the Jamkhed model. In that time, much has changed, and rightly so.

As the needs, priorities and challenges change it would be interesting to see how Jamkhed

adapts. For instance, one thing that surfaced in a couple of the interviews is that the VHW

demographics of the newest group of VHWs is vastly different than that of the original

group of VHWs. The effect that has on their success in the near future would be interesting

to follow. As this study proves, there is much value in listening to lived experiences, to expand the ways that we explore, see, and understand the world.

"[Health professionals] should share knowledge freely, not by providing a few filtered messages that they think are best for the people. Knowledge should be shared in such a way that people can be empowered to assess, analyze, and make the right choices. The knowledge should liberate them and not intimidate them."

-Mabelle Arole

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