Public Health Ethics: Practices And Challenges Of Female Community Health Workers

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Abstract
Practising public health ethics is essential to avert health problems within the community. It guarantees the safeguarding of human lives by preventive actions. Moreover, public health ethics conform to the concepts of transparency, confidentiality, information dissemination, individual autonomy, health enhancement, harm prevention, and the preservation of equity. Multiple socio-cultural and economic factors have been considered to enhance the understanding of the notion. In our country, the responsibility for protecting community health, particularly at the grassroots level, lies with female community health workers (CHWs). GOI launched the National Rural Health Mission to recruit the female community health workers. They are mainly voluntary workers hired to provide reproductive services to women. Our society largely overlooks the reproductive health rights of women. Traditional customs, cultural taboos and gender-biased norms have prevented women from achieving their reproductive rights. Under such conditions, understanding the socio-cultural context of people and addressing public health ethics have been challenging tasks, especially when the CHWs themselves are one of the most deprived sections. Thus, the current study using a literature survey has tried to understand the concept of public health ethics and its implications by the female community health workers and has also tried to elucidate the problems faced by the community health workers in practising public health ethics in our country.

Keyword: Community Health Workers, Community Health, Preventive Measures, Public Health Ethics, Reproductive Health, Socio-cultural Determinants.

INTRODUCTION:

Health ethics denotes a structural regulatory framework that incapacitates human sufferings and promotes good health for all without any discrimination. Observing Health ethics is considered a significant condition that has been acknowledged by its practitioners globally. Health ethics offers us the moral principles and values important for guiding health care decisions and practices (Prasad & Sengupta, 2019). Abbasi et al., in their study of fifty-six papers on public health, have found that most of the papers focused on health promotion, safeguarding of individual autonomy and prevention of harm. The moral principles related to ethical practice in public health have mainly pointed towards protection of the population against any kind of risk, improving their access to health benefits, maintenance of justice and effectiveness, preservation of solidarity and responsibility, and maintaining privacy, trust, transparency, respect and community empowerment along with participation (Abbasi et al., 2017). Since 1990, various ethical frameworks in the field of health ethics have been introduced. This ranged from principle-based to philosophical to justice-based models. But all these models lacked a compounding characteristic promoting choice in public health. Further, Lee, in her study, has also mentioned various practitioners working on both principle-based frameworks and theory-

based frameworks to discuss their work and philosophies that have shaped their ideologies on public health ethics. She has also discussed ethics-of-care feminism, as proposed by Marc Roberts and Michael Reich (2002), to understand public health ethics from a completely different perspective. The focus has been on family life. Policies should be made keeping in mind the family relationship aspect, as it is the core of human experience. Here the principal debate remains: whether public health ethics are to be created independently and not by borrowing principles from bioethics and allied fields (clinical ethics, research ethics), or whether a coalescence is to be created based on various theoretical approaches to construct a common ethical framework (Lee, 2012).

Health ethics generally comprises autonomy, beneficence, non-maleficence, justice, fidelity and veracity. With increased technical advancement and complications within the healthcare system, clinical ethics, bioethics, public health ethics and research ethics have become fundamental aspects of health ethics (Prasad & Sengupta, 2019). In the current study, the main focus has been on public health ethics. Public health ethics may be defined as a targeted intervention at the community level to protect the population from any kind of health risks (Royo-Bordonada & Roman-Maestre, 2015).

In our country, the National Rural Health Mission (NRHM) has engaged Accredited Social Health Activists (ASHAs), who are female community health workers, to promote and protect community health. However, the concept of community health workers, known by different names, existed long before the introduction of NRHM. Addressing the health needs of a diverse population has always been challenging due to barriers such as traditional customs, language differences, cultural practices, and transportation difficulties. To overcome these challenges and ensure outreach at the grassroots level, community health workers were recruited. They are responsible for spreading awareness among people about various preventive health measures. Serving as health advocates, they usually belong to the same community they serve, which enables them to better understand and effectively address local health needs (National Health Systems Resource Centre, 2011).

The study using an extensive literature survey has tried to understand the concept of public health ethics and its implications by the female community health workers and has also tried to elucidate the problems faced by the community health workers in practising public health ethics in our country.

Development of Public Health Ethics:

The primary focus of public health ethics has been preventing diseases, promoting health security, and creating health awareness among people. Public health ethics also addresses the economic, social, and environmental factors that influence the health risks in the community. Practicing public health ethics is different from practicing clinical ethics. The latter denotes direct patient care, whereas public health emphasises the health of the community as a whole. The state and governmental policies are also crucial here in safeguarding health security for all. From this viewpoint, public health thus has paternalistic, utilitarian and communitarian essence (Royo-Bordonada & Roman-Maestre, 2015). Faden et al. have also discussed public health from two standpoints, i.e., justice and legitimacy. Understanding justice calls for debate between utilitarian and egalitarian approaches. While the utilitarian approach focuses on reaching the maximum number with efficiency even with limited resources, the egalitarian approach draws attention to health injustices (gender, race, class, and various other social groups) and maintaining equality in receiving public health resources and opportunities. Legitimacy, on the other hand, talks about the rationale of establishing government regulatory frameworks and policies. It is considered beneficial as a whole for the population. Although sometimes particular decisions might be detrimental to the overall health of the population, it is still necessary

to establish a policy framework to maintain a common order. Without proper government health policies, it is difficult to maintain public health ethics (Faden et al., 2013).

There has been a change in the traditional idea of medical ethics. Previously, it centred on the conduct and duties of the physician. But with changing technological and medical advancements, the dominant discourse on bioethics focused on the individuals and their relationship with the medical health practitioners. With this change the empowered patients are now able to question the paternalistic nature of medical practice. Further, ethical discourse has extended the horizon to include the community to which individuals are part. Benatar has considered a globalisation of public health ethics that goes beyond parochial contemplations (Benatar, 2003).

Further, Childress et al. argue that safeguarding public health while also preserving individual liberty can be inherently conflicting. Therefore, public health should be promoted by honouring general moral principles rather than by overriding them. They suggest that relying on voluntary strategies instead of coercive measures is preferable. Additionally, it is essential to protect people's confidentiality and seek to understand them, rather than impose requirements on them. Promoting health and valuing other general moral principles should be mutually exclusive in nature to create health policies that would lessen the conflict and create a comprehensive health care system beneficial for all (Childress et al., 2002).

The evolution of public health ethics can be traced back to a series of events that marked gross misconduct in the healthcare system. The mass genocide and experimentation on human bodies during World War II and the Tuskegee experiment were the most noteworthy. These incidents further resulted in the Nuremberg Code on research ethics in 1947. Following this, several other human rights interventions were made, like the 1948 Declaration of Human Rights, the 1964 Helsinki Declaration, and the 1978 Alma Ata Declaration (Pati et al., 2014). In 1960, a huge shift in ethics was noticed, especially when a generation suffered from the horrors of the Vietnam War and other civil rights movements. Soon there was a new kind of change in bioethics, replacing the older one. A patient-based movement concerning informed choice, women's health, individual participation, and medical information made the ethical practice of public health more prominent. Key issues like the trials of Nuremberg conducted by the Nazi doctors, the syphilis study at Tuskegee and many such medical experiments raise the growing concern for the ethical practice in medical science. New scientific and technological discoveries also raised various ethical queries. Under such circumstances, it became necessary to develop a framework for the study of ethics. Many trained professionals joined the program, which enriched the ethical field at both the applied and practical levels (Bayer et al., 2007).

Lerner and Bayer also pointed out that the formal recognition of public health ethics is relatively recent, emerging less than two decades ago. Nevertheless, medical professionals and community leaders had been making value-based health decisions long before its formalisation. In the United States, beginning in the early 1900s, several contentious public health practices prompted the development of ethical standards specific to the field. Over time, public health ethics evolved into a framework distinct from clinical ethics and bioethics. At its core, it continues to grapple with the fundamental tension between protecting the health of the broader community and upholding the rights of individuals within it (Lerner & Bayer, 2008).

Further, Darragh and McCarrick highlighted that the Public Health Act of 1848, first introduced in England, was prompted by the surge in cholera and typhoid cases that severely disrupted industrial growth. The motivation behind this reform was not primarily humanitarian; rather, it stemmed from the recognition that unhygienic living conditions

could impede industrial productivity and, consequently, the nation's economic development (Darragh & McCarrick, 1998).

Understanding Public Health Ethics and the Problem of Implementation:

Despite various initiatives, public health practitioners have encountered numerous dilemmas and challenges in implementing ethical practices. It is extremely essential for the healthcare personnel to have proper training on public health ethics.

A study conducted by Pati et al. showed that the majority of the courses on public health ethics focused mainly on either research ethics, bioethics, or clinical ethics. But there remains a significant absence in the courses that exclusively focused on public health ethics (Pati et al., 2014). Weed, on the other hand, pointed out that a combined interdisciplinary approach in the field of public health is essential for precaution and prevention of diseases. Healthcare professionals should have a proper understanding of philosophy and ethics along with their medical training in public health. Such an approach will make the healthcare system much more effective (Weed, 2004).

Practitioners of public health ethics often face challenges dealing with patients coming from diverse cultural backgrounds. For example, informed consent is important in bioethics, but it is difficult to implement the same in the case of public health services due to the diverse nature of the population. Hence, it is extremely crucial for the healthcare professionals to have proper training on public health ethics. This will enable them with proper decision-making skills about various aspects like allocation of resources so that everyone can have equal access to healthcare, tackling of environmental issues that can cause health hazards or natural disasters, etc. Developing an 'internationally standardised curriculum' on public health ethics might serve the purpose. However, focus should be on broadening their understanding of public health and generating action based on morally sanctioned values in the field (Pati et al., 2014). But in our country, most of the community health workers lacked adequate training on public health ethics. They mostly receive training on precaution-based health practices. Their low level of education further makes the entire process of training difficult. Such behaviour has resulted in poor performance among the CHWs. Moreover, they also face the problem of overwork and poor remuneration. This further complicates their situation. (Gohel et al., 2015). CHWs mostly lack understanding of the concept of ethics in public health. They remain under tremendous pressure to perform. This poses a serious challenge for them in practicing public health ethics. The training they receive should also focus on ethical practices.

Further, Marcellus in a study has discussed 'relational ethics', which has been suggested by various nurses and philosophers. The notion of relational ethics is quite different from the concept of bioethics. The former suggests a mutually exclusive relationship between healthcare practitioners and patients, where respect, freedom of choice, deep interaction, and trust are the guiding principles. But ethical decision-making in the public health sector is a far more complicated process in reality. This is especially true for community health workers at the grassroots level. They face everyday tension and contradictions between the socio-contextual aspects of ethics and their personal experience as professional nurses. Henceforth, it is necessary to establish a relationship with the patient based on care and a non-hierarchical power relation. Such an arrangement will reduce the risk of exploitation. Sometimes it is even confusing for the mothers of newborn babies to understand the difference between policing and support provided by the nurses. Further studies have also shown that some patients and their families who are at risk often avoid establishing relations with the healthcare providers. They often cancel appointments or express disregard through bodily gestures. Under such circumstances nurses often fail to eliminate oppression due to their legally bound roles within the healthcare system. But to establish a

relationship based on respect and care, it is important for the healthcare providers to understand the family situation and socio-cultural circumstances of the patient. It is only then that a mutually exclusive relationship can be formed that will promote the idea of relational ethics (Marcellus, 2005).

Public health ethics is generally a community-driven strategy; hence, the focus is not on the individual aspect of health. But since our community is heterogeneous in nature, with people coming from diverse socio-economic locations, they share different privileges and opportunity structures. Social inequalities based on gender, class, caste, and race are considered natural in our society and are found to be highly prevalent in all aspects of our social life. Under such circumstances, practicing public health ethics has been a difficult task. But it is not inequality that challenges the practice of health ethics. Rather, it is the policies and socio-cultural arrangements that benefit certain groups over others which make ethical challenges more pertinent (Mishra & Subbiah, 2018).

Macklin has discussed ethical relativism and cultural relativism to understand how the concept of ethics varies across different cultures. It has questioned the universality of the notion of ethics. But when the matter comes to human acts like female genital circumcision, performing of sacrificial rites on women, and killing of one's own child, does cultural relativism matter? Some anthropologists have supported cognitive relativism in these aspects, but anthropologists like Herskovits and Brown have provided explanations in favour of cultural universals. Here they have mentioned that although human nature, mind, and experience vary, they also share universal characteristics at the same time. An inherent contradiction lies between which acts can be morally justified and which acts cannot. Thus, anthropologists and philosophers have continued their argument on ethical relativism over a long period of time. Later attempts have been made by relativists at framing more consensual moral rules and norms that will remain common to diverse societies. Epidemiologists and anthropologists still face problems in maintaining ethical practices. They have to consider both contextual factors and narratives of the people and treat them accordingly. Ethics should be practiced from a more non-hierarchical power relations perspective (Macklin, 1999). In our country, community health workers face similar challenges in practicing public health ethics. Explaining preventive measures to rural folks is not only difficult, but breaking the gender norms of society that hinder healthcare practices, especially among rural women, is also challenging for them.

Gendered ideologies have restricted women from open communication for long. Patriarchy has shaped women's reproductive health and sexual behaviour, resulting in discriminatory practices. Further, to control women's sexuality, harmful unethical practices like female genital mutilation, hymen fixing and forced virginity tests are observed in many parts of our country. They are also coerced and violated against their will. They do not own control over their reproductive health (Shalev, 2000). This has not only infringed their reproductive rights, but it has also posed a major problem for the CHWs to go beyond the patriarchal power structure and treat women ethically, especially when CHWs are themselves part of that social structure.

Public health practitioners often face ethical challenges working in the field with diverse populations in their everyday life. They need to make every day ethical decisions and address difficult situations 'informed by ethical reasoning'. Thus, public health ethics should also involve contextual understanding of people placed in different hierarchical positions in our society (Mishra & Subbiah, 2018). According to the Keynesian model of the welfare state, getting health care is a social right for a person and a very important constituent of social citizenship. Public healthcare is a systematic approach of disbursing, provisioning and providing equal access to healthcare facilities for all without discrimination. This understanding is also envisaged in the discipline of public health.

When public health care is considered a social right, the perspective on ethics determines two dimensions of this right: (i) easy access to the public health care system and (ii) balancing of the power relation between the citizens seeking health and health care providers (Pinto, 2018). But in our society, women's bodies have increasingly become a source of profit for healthcare practitioners. In the public sector, effective services are rarely available free of cost, and even when they are, doctors often impose user fees if women have not adopted family planning methods. At the same time, accessing care in private hospitals is far beyond the reach of poor rural women due to exorbitant costs. Although primary health centres and rural hospitals are supposed to provide reproductive healthcare services, they frequently fail to do so adequately (Duggal, 2004). Practising public health ethics entails considering family and other socio-economic determinants so that nobody is discriminated against. But women, including female community health workers, are themselves devoid of such considerations because of their status as women. Various social science literature, including the Black Report of UK (1980) and the WHO commission on social determinants of health, considers that public health cannot be confined only to health care alone. Other social determinants should also be considered for the cause of ill health among people. These social determinants can be gender-based violence, a faulty health care system or the unequal power structure of our society. Thus, public health ethics should move beyond medical and bioethical perspectives and also take into consideration the community sentiments and belief system (Mishra & Subbiah, 2018).

Community Health Workers and the Problems of Ethical Decision Making:

In our country, health decisions are often influenced by personal and community experiences rather than professional medical advice. Families' limited knowledge largely shapes people's health-seeking behaviour, and traditional beliefs and practices have guided healthcare choices for generations. Historically, only a small wealthy section sought professional medical assistance, making this approach ineffective for the larger population (Vemula, 2019). Under such conditions, practicing public health ethics becomes a difficult task for the community health workers of our country.

In our country, community health workers are mainly recruited to provide reproductive health services to women. They are also accountable for delivering care services to newborn babies. Reproductive health is a fundamental aspect of women's health. It denotes women's bodily autonomy in determining their reproductive choices. Nonetheless, inadequate socio-economic conditions and diverse cultural factors have prevented a segment of women from realising their reproductive rights. Since 1994, subsequent to the Cairo Conference on Population and Development, women's reproductive health has garnered considerable focus. The primary purpose of the program has been to transcend population control goals and provide a holistic healthcare framework for women (Wang & Pillai, 2001). Moreover, the conference has reiterated the complex relationship between women's reproductive health and a multitude of factors, including poverty, education, population dynamics, and various environmental considerations. Eliminating gender inequality and liberating women from various forms of coercive practices has been a key focus (Glasier, 2006).

Despite such ethical consideration and hard work by the community health workers to remove gender inequality in health, they often face crises and sometimes even fail to establish bonding with the rural masses. Ethical relativism often poses a hindrance for community health workers in making ethical decisions. In the remote villages where culture defines the way of life, it becomes difficult for them to implement a government-regulated ethical framework. Often modern medicine and reproductive technologies collide with the

traditional ones. Forced implementation of health programs can jeopardise the basic essence of practicing ethical values in public health.

The existence of gender disparity has led to an inequitable allocation of resources and opportunities for women. Systematic denial of essential resources since early childhood has exacerbated their already precarious situation. Furthermore, the process of gender socialisation has imposed limitations on their development. They are perpetually subjected to the prevailing cultural and traditional norms of society, which has consequently placed their bodies in jeopardy (White et al., 2006). Furthermore, in rural India, various cultural and traditional limitations have hindered the free expression of women. Their diminished authority has rendered them susceptible to the influence of men who possess a limited understanding of their health requirements. Moreover, their limited educational backgrounds have contributed to a lack of awareness and an inclination towards bias regarding contemporary healthcare treatments. Women in our country, especially those hailing from rural regions and economically disadvantaged backgrounds, continue to face significant health challenges. They are also more susceptible to health infections and diseases in comparison to their male counterparts. They frequently engage in a range of reproductive activities that necessitate maintaining clean and hygienic environments. However, the nature of their everyday work and the prevailing healthcare infrastructure have rendered them devoid of alternatives. Furthermore, the lower-level of literacy rate among women has contributed to a lack of awareness regarding the indicators of various diseases. At times, they have remained entirely unaware of the presence of specific infections and pathogens in their environment (Manderson, 1999). Under such circumstances it is necessary to impart proper health literacy among people through a proper health communication process. Practising public health ethics is only possible via a successful health communication process. Without developing proper communication, it is difficult to reach the minds of the people and therefore change their everyday practices and behaviours. Patriarchal customs have made women self-regulate their behaviour according to traditional norms and belief systems. This process has further confronted them and deteriorated their health. They have become their enemies. In such a situation, it is important for the community health workers to reach the women through ethical understanding.

Dasgupta et al. have pointed out that community health workers have been a crucial component of rural development programs in India. Although they occupy the lowest tier within the health department, they have still executed the most vital healthcare responsibilities for their community members. Despite their limited education, poor compensation, and low employment status, they have persistently advocated for the impoverished rural women of the communities. They have undertaken several significant responsibilities, such as educating rural women about contraception and family planning methods and facilitating institutional births for pregnant women at any hour without support from the health department. Additionally, they have been responsible for delivering prenatal care, postnatal care, child immunisation and generating awareness among the husbands regarding their wives' reproductive health requirements. Furthermore, they have been accessible to community members at all times. Their phone numbers are publicly available, and it is frequently overlooked that they are also impoverished women from the same community. Their requirements are frequently overlooked (Dasgupta et al., 2017). Under such circumstances, CHWs often face difficulty in understanding and implementing the concept of ethics in public health. Their condition and pressure from authority make them unaware of their deprivation. Despite feeling considerate towards one community, their poor socio-economic condition often makes them helpless. The training program for CHWs must encompass discourse on public health ethics, address all

determinants of public health, and establish a curriculum that aids CHWs in making ethical decisions.

George, in her study, has discussed how the growing mistrust between healthcare professionals and rural communities is closely linked to institutional pressure to meet preventive health targets. Government mandates require community health workers to achieve objectives related to sterilisation, immunisation, and family planning, and failure to do so often results in strict reprimands. This pressure undermines ethical practices in public health and damages relationships with villagers, who may resist or scrutinise preventive interventions due to superstitions, gender norms, and cultural beliefs. Consequently, health workers are compelled to persuade or selectively identify beneficiaries, further compromising trust. Community health workers face substantial structural and social challenges that hinder effective health communication. Inadequate infrastructure, poor working conditions, inconsistent medical supplies, insufficient housing, limited transportation, and inadequate educational facilities for their children contribute to professional dissatisfaction and demotivation. The neglect of these workers' welfare by policymakers weakens the broader healthcare system. Additionally, the blurred boundary between the personal and professional lives of health workers exacerbates their vulnerability. They are frequently held responsible for systemic failures, including shortages of medical supplies, inadequate treatment by physicians, and corruption within the health department. Their professional credibility is often undermined both within the workplace and the community. Resistance from patients' families, reliance on traditional authority figures within the family, and a preference for curative medical interventions over preventive care further marginalise community health workers, despite the government's emphasis on preventive health strategies in rural areas (George, 2010).

Malatzky et al. have further pointed out how a culturally inclusive health care system needs to be developed. The defined institutional role of maternal and child health nurses should not hinder the culturally inclusive health care system. Despite being bound by the institutional role, the nurses should also consider the cultural context of the patient while treating them (Malatzky et al., 2020). But in most cases, the nurses and CHWs are the most deprived. They are always kept under pressure to meet the target, following the general rule and going beyond the ethical concern. This imbalance has also resulted in the development of a hierarchical healthcare system where the privileged sections are given priority over other segments.

The growing inequality in the health sector has further raised serious ethical concerns in our country. Various factors, including economic processes, global politics, and policy decisions favouring the privileged, have increased human suffering and enhanced inequality more prominently among people. Despite this, ethical practice is still in oblivion in our country. Health care is the basic human right of people, and government should pay heed to it. Making health care a business and extracting profit from it should be stopped. The healthcare system should benefit all sections of people, not just a particular one. Economic growth at the cost of people's health is not only unethical practice but also dangerous in the long run (Prasad & Sengupta, 2019).

Workplace Participation vs Ethical Practice in Public Health:

The government has introduced several health initiatives at the grassroots level to achieve universal health goals. However, the obligation of reaching widely dispersed populations has mostly rested on community health workers. In rural areas, the persistent lack of healthcare personnel has further intensified their workload, making it difficult for them to address the immediate health needs of the rural population. As a result, many studies have highlighted increasing dissatisfaction among community health workers regarding their

roles and responsibilities. They were mostly dissatisfied with the poor remuneration structure of their job. Even the incentives they received were meagre. In the majority of the cases, CHWs were the sole breadwinners of the family, which made it even more difficult for them. In many instances, they also encountered inhospitable behaviour from the villagers, especially those from the backward class. The complex division of caste, class, and religion of the rural society has posed a threat for the CHWs in the health delivery system (Das & Dasgupta, 2015).

The persistent growth in population has intensified the challenges faced by CHWs, compelling them to serve populations far exceeding the prescribed limit of 1,000 individuals. It is essential for the government to first address the unmet needs of CHWs. An effective monitoring and evaluation system is needed to guarantee their optimal performance, along with clearly defined supervisory strategies to guide and support their work. These problems are made worse by the fact that there are not enough qualified trainers and the institutions do not have enough resources. Therefore, it is imperative to establish a structured and standardised training framework that enhances the competencies of health communicators responsible for training CHWs. The selection of community health workers in our country is also flawed. Women, often illiterate, are selected either on the basis of preference by some political leaders or due to a shortage of qualified married women who had completed the eighth standard. The training CHWs receive is inadequate for a proper health delivery system. The absence of a clear and systematic evaluation mechanism further hampers the assessment of community health workers' competencies and effectiveness (Bajpai & Dholakia, 2011).

CHWs have not only reduced the workload of healthcare professionals but have also assisted in generating better connections with the community members by mitigating the social gap that has existed for long (Hoff, 1969). Even during the COVID-19 pandemic, most of the CHWs not only performed their reproductive services, but they were also associated with screening, testing, and monitoring of COVID-19 patients. They have worked without proper safety kits, which further put their health at risk. Little consideration has been given to their requirements, and they still continue to suffer from poor remuneration. In some cases, incentives remain unpaid, making their situation even more challenging (Nanda et al., 2020). Further, Shanthosh et al. have also mentioned a similar situation faced by the community health workers during the COVID-19 pandemic. In addition to a significant increase in their workload, they also faced discrimination and stigma from their community members. Their bodies were at constant risk associated with the disease. The situation made them extremely vulnerable (Shanthosh et al., 2021). Their mental and social well-being was also affected during this phase, especially when they had to make decisions about patients under severe dearth of supplies and poor infrastructure. Moreover, pressure from household tasks further complicated the situation for them. Social distancing made it difficult for them to arrange for house help. Overall, this situation compromised their physical and mental well-being (Miyamoto, 2020).

CHWs not only face ethical challenges in treating people because of government-defined roles and culturally defined social structures but also face challenges from their own community and family members. Unethical practices in public health, a poorly designed work culture, and gender stereotypes have negatively impacted their lives. In a situation like this, following public health ethics is a difficult task for them.

CONCLUSION

Public health ethics has gained its prominence with the growing injustice in the health care system. For long, it has been attached to other ethical practices in the fields of bioethics,

research ethics, and clinical ethics. But the constant debate over separating public health ethics from its allied discipline established public health ethics as an independent entity. It is mainly designed with the view of protecting community health. Here, the individual is the least concerned. However, protecting community health requires a profound understanding of community sentiments and their belief system. Culture plays an important role in shaping the belief system of the community. Therefore, understanding cultural relativism is crucial in this context.

In India, the patriarchal structure has also defined the gender-biased cultural system, which has further impacted women's lives. The unequal opportunity structure made women vulnerable in almost every sphere of their life. Their healthcare needs have often been ignored. Despite initiatives from various international bodies, their reproductive rights remained unachieved. Under such conditions, the Government of India (GOI) introduced the NRHM program and recruited female community health workers, or ASHAs, to provide reproductive services to women. It is expected that they will follow the government regulatory framework and meet the target. But here, the question of practicing public health ethics comes to the forefront. Government-predefined rules sometimes force the community health workers to forgo ethical concern in health. Following ethical practices in public health is an entirely different scenario. Here several elements like family, culture, education, economy, and environment should also be considered before taking any ethical decisions. Government-defined ethics in public health might contradict with the general value system of the population. Applying force to meet government targets only compromises their situation.

Thus, it is necessary to understand the sentiments of people and design a proper health communication tool to reach the rural masses, especially women who are the most deprived section. This will ensure ethical practice in public health. But for this, proper training on public health ethics is required for the community health workers. Moreover, to achieve better results with public health, it is essential to address the everyday needs of the community health workers first. This would motivate them to work and bring an all-round change in the ethical practices.

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