Ethics and Professionalism among Village Health Nurses in Tamil Nadu, India

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Abstract

Background: Community Health Workers (CHWs) are the backbone of the public health system in India. They perform several activities at the community level, but little is known about the practice of ethics and professionalism in their work. The CHWs in Tamil Nadu are called Village Health Nurses (VHNs).

Objectives: To explore the experiential wisdom of ethics and professionalism among community health workers in Tamil Nadu.

Methods: We conducted a qualitative study using in-depth interviews and focus group discussions among 125 VHNs in six districts of Tamil Nadu. The data were collected by trained field investigators who were CHWs themselves. Thematic content analysis was done to identify codes, themes and build them into a conceptual model.

Results: The VHNs went beyond the call of their duty to do good to the community. They served as advocates for matters beyond health care in their community. However, overburdened VHNs found it challenging to sustain doing good to the community. Their conceptualization of autonomy ranged from individual autonomous decision making to full paternalistic decision making and this was not uniform across VHNs. The VHNs were sensitive to issues of privacy and confidentiality, but the discussion on these topics were limited. The VHNs reflected the societal norms of gender, class, and caste hierarchies in their work. They had to work amidst difficult power struggles and had their own innovative strategies to subvert power. They faced several ethical conflicts but did not have a standard mechanism for resolving them.

Conclusions: The lack of standard ethical practices among the VHNs indicate that they must be trained in ethics and professionalism and a code of ethics for VHNs is required to help them effectively deliberate on ethical issues during their work.

Introduction

Ethics and professionalism are essential to the practice of any service. The health care profession specifically deals with vulnerable populations and therefore delivery of health care services must be done ethically. There are codes of ethics for medical practitioners, and nurses. Similar codes of ethics for Community Health Workers (CHW) are sparse. One code of ethics for CHWs was disseminated at a conference held in New Mexico, United States in 2008. This code emphasized on honesty, confidentiality, quality of care, cultural humility, trust building, respect for persons, anti-discrimination, keeping knowledge and skills updated and ensuring empowerment of the community. Yet another code was by Stone and Parham who proposed an ethical framework for CHWs based on a set of core ethical principles described later in the methods section.

India has a long history of CHW programs in its public as well as non-profit private health sectors. The Comprehensive Rural Health Project of Jhamked and SEARCH project of Gadchiroli, both in Maharashtra...
are classical non-profit CHW-led programs that demonstrated substantial health benefits. In the public health sector, in 1963, the Chadha Committee recommended Community Health Workers were first introduced to provide basic health care in communities at a ratio of 1 CHW per 10,000 population. The Auxiliary Nurse Midwife (ANM) cadre of CHWs was established even before that to mainly deliver maternal and child health services in communities. In 1975, these ANM’s were designated as Multipurpose workers. In 1975, the Integrated Child Development Scheme was set up with one Anganwadi Worker (AWW) and helper in each village to care for children and provide supplemental nutrition. In 2005, after the launch of the National Rural Health Mission, the Accredited Social Health Activists who are community health volunteers acting as a bridge between the community and the health system were introduced as a new cadre of CHWs. The southern state of Tamil Nadu has a cadre of community health workers labelled Village Health Nurses (VHN) who are the equivalent of the Multipurpose Health Workers at the national level. Throughout this paper wherever we refer to VHNs, it is about the cadre of CHWs in Tamil Nadu and wherever we refer to CHWs it is about any CHW in India.

A review of the syllabus of Auxiliary Nurse Midwife course in schools and colleges of nursing do not indicate any substantial curriculum in ethical reasoning. The ASHA training has Books 5 and 6 which emphasize on values of an ASHA and some aspects of professionalism. However, there is no systematic teaching of ethics and professionalism in either the ANM or the ASHA training. An interview with a senior Village Health Nurse (VHN) in Tamil Nadu in south India, revealed that ethics and professionalism were inherent in her practice and there were several ethics and professional best practices among VHNs.

This qualitative study was conducted to document the experiential wisdom of ethics and professionalism among VHN in the state of Tamil Nadu in India. The main goal of this exploration was to understand the existing attitudes and perceptions of VHNs in Tamil Nadu, India towards ethical practice of community health care. The findings may provide an ethical framework for development of ethical guidelines for CHW in all low- and middle-income settings.

**Methods**

**Qualitative Approach, Research Paradigm and Theoretical Underpinning**

In this qualitative exploration we adopted a social constructivist paradigm with a positivist ontology and subjective epistemology. We adopted the Stone and Parham ethical framework for CHWs and used it to guide our exploration. The key ethical principles in this framework were, equal and substantial respect to individuals in the community, justice, care, beneficence, community feeling, cultural humility and openness, critical reflection, conflicts of interest, trustworthiness, and competence. VHNs work closely with communities and serve as the bridge between the community and the public health system. They play a very crucial role in delivery of primary health care in the community. Doing good, avoiding harm, respecting people and their preferences, maintaining a sense of cultural humility, earning the trust of the
people, negotiating power hierarchies and conflicts of interests are likely to play a very critical role in
delivery of their community health work. We could relate to this theoretical framework based on our own
experiences of working in the communities and so we decided to adopt this framework. Our theoretical
assumption was that such principles, ethical conflicts, and dilemmas are likely to be faced by the VHNs
and over the years of their services, they are likely to have evolved their own strategies and methods to
handle them. We aimed to understand this experiential wisdom of the VHNs.

**Researcher Characteristics and Reflexivity**

The core team of researchers including VG, SD, and PD are physicians trained in Community Health. We
all practice community health and work closely with the health systems. SD works directly with the Tamil
Nadu health system and helped obtain access to the VHNs for the qualitative data collection. All three of
us have prior experience of interacting and working with various VHNs within the public health system in
Tamil Nadu. BP is a demographer working for several years in the field of sexual and reproductive health
and rights through a community based voluntary organization. He also has several years of experience
training, supervising, and working with CHWs. VG and BP are men whereas SD and PD are women. All
four of us framed the research questions, developed the data collection tools, and refined them after
discussions.

Twelve field researchers, who are CHWs themselves, working for various community based voluntary
health organizations, served as interviewers and field data collectors. We conducted a 2-day rigorous
workshop for these 12 researchers in which we introduced the key research questions, the qualitative
research methods including conducting focus group discussions and in-depth interviews and ethics of
conducting research in communities. They were also included in a social media communication
application through which we provided ongoing supportive supervision for them for field data collection.
In addition, we also visited the field sites during the interviews and discussions and without interfering
with the data collection process, debriefed with them and suggested corrections that were required. The
advantage of deploying CHWs themselves to collect data was that they had an insider perspective to the
research question and could easily establish rapport with the interviewees. The VHNs who participated in
the study could easily relate to the interviewers and were able to open up even about sensitive topics
comfortably. However, the downside was that the interviewers could have been perceived as competitors,
and hence some information could have been biased by social desirability in responses.

**Context**

The study was conducted in Tamil Nadu, the sixth most populous state located in the southern part of
India. The state consistently performs well in all health indicators. The state has a well-performing cadre
of community health workers referred to as Village Health Nurses. The VHNs are women who undergo a
2-year training to be an Auxiliary Nurse Midwife and then get selected through the Medical Recruitment
Board into the Tamil Nadu Public Service. Each VHN serves a population of about 5000 people. They are
relatively well paid compared to women in other occupations and enjoy a high level of trust and respect in
the community that they serve. Their main role is to coordinate and deliver maternal, child health, and
family welfare services in the community. After the launch of the Ayushman Bharat National Health Protection scheme, there is a move towards comprehensive primary health care in India, and the scope of their work has expanded to include non-communicable disease services as part of the Health and Wellness Centres (HWCs).(11) The VHN usually lives in the Health Subcentre building within the village and is available round the clock for the local villagers to access first aid and emergency treatments and referrals.(12)

**Sampling Strategy**

We included a total of 125 VHNs from 6 districts namely Thuthukudi, Perambalur, Dharmapuri, Dindigul, Theni and Chengalpet. These districts were selected based on the Human Development Index (HDI) according to which Thuthukudi and Chengalpet were high performing, Dindigul, Theni were medium performing and Dharmapuri and Perambalur low performing districts.(13) We decided that having districts representing various levels of HDI will give a sample that represents various levels of primary health care performance and hence work commitment of the VHNs.

We first obtained permission from the Directorate of Public Health and Preventive Medicine of the State Government of Tamil Nadu to conduct this study. Then with their approval letter we approached the respective Deputy Directors of Public Health in each of these 6 districts and obtained name list of 30 senior Village Health Nurses working in their districts. We specifically sought out senior VHNs, as we wanted to document experiential wisdom in ethics and professionalism. The greater the years of experience in the field, the more likely that they had faced ethical challenges and dilemmas and handled them. We wanted to document these experiences. Our field researchers approached these VHNs, obtained informed consent, scheduled appointments for interviews and focus group discussions and proceeded with data collection. The average age of the participating VHNs was 48.7 years and the average years of experience was 19.3 years. Thus, we had a well experienced group of VHNs in the study. As the subject of exploration was very new, we decided that having a sample of 125 VHNs participating in the study is likely to provide adequate data saturation. Therefore, we fixed the sample size arbitrarily a priori. During analysis we found that there was adequate data saturation and there weren't widely different themes emerging from the data beyond a certain number of interviews.

**Ethical Considerations**

The research proposal was reviewed by the Institutional Ethics Committee of the Directorate of Public Health and Preventive Medicine, Chennai and approved with approval number DPHPM/IEC/2022/03 on 26.03.2022. The committee gave specific recommendations. We followed all these recommendations during data collection. We obtained written informed consent from all participants before the interview and the focus group discussions. We also obtained permission to audio record the interviews and discussions. Wherever permission was refused for recording, we took detailed notes of the interviews and discussions. We refrained from referring to the names and identifying information of the participants during the recording of the interviews and kept the interview transcripts anonymous to protect the
Data collection methods, and instruments

We conducted a total of 60 in-depth interviews with 10 VHNs each in the 6 districts and 12 focus group discussions, two per district. The research was conducted between August to October 2022. The in-depth interviews were conducted by the field researchers in a private space either in the district Deputy Director of Health Services office or at the field level in the health subcentres. Basic demographic and work experience-related data were collected using a separate form for each participant. Then the interviews were audio recorded in the mobile phones of the interviewers with permission from the participants. Two investigators conducted each interview, one of them asking the questions, facilitating the interview / discussion and the other making notes, and recording the proceedings.

We developed the in-depth interview and focus group discussion checklist by an elaborate brainstorming between all the researchers. We organized a deliberative workshop with CHWs who also served as field interviewers and during this workshop we further discussed the checklists and refined them. The interview was started with an open question where we asked the participants to describe their jobs. We included specific probes on doing good, avoiding harms, challenges in doing good and preventing harms, maintaining autonomy and respect to the community, protecting privacy and confidentiality, negotiating power hierarchies in the community, establishing justice within the community and any personal risks and harms that they themselves have faced during their community health work.

The interviewers listened to the audio recording of the interviews and discussions and transcribed them verbatim. The interviews were conducted and transcribed in the local language Tamil. Colloquialisms and local terms were retained in the transcripts. The duration of the interviews and discussions ranged between 30 to 90 minutes and the length of the transcripts ranged between 20–60 A4 size pages each.

Data Analysis

We used a thematic content analysis approach for the data analysis. Three information dense transcripts were read by VG, SD and BP and coded independently. We coded the transcripts in an open inductive manner without any explicit theoretical framework in mind. After this initial coding we developed a coding tree and a rough conceptual framework based on the codes and themes that emerged from this initial process. Following this, VG, SD, BP and PD discussed the preliminary conceptual framework and familiarized ourselves with it. Then we distributed the remaining transcripts among us and coded them in a deductive manner looking for the previously identified codes and themes, while keeping our minds open for any newly emerging codes or themes. While we retained the transcripts in Tamil, we assigned the codes in English language to ensure easy theme building and conceptual framework development. We used a word processing software to assign the codes as comments. Then we used a program to extract the comments along with the texts that these comments were assigned to. We grouped these codes into meaningful themes and then used the themes to build a conceptual framework on experiential wisdom of ethics and professionalism among VHNs.
Strategies to ensure scientific rigor

We attempted triangulation of data analysis by four of us independently coding the data and discussing the codes and themes. We also attempted method triangulation by collecting data using both in-depth interviews as well as focus group discussions. While the in-depth interviews can support in getting individual experiences and sensitive information that can only be shared in private, the focus group discussion helps obtaining shared insights and consensus opinions. We summarized our field notes and take-home messages to the participants after each interview and discussion and actively sought feedback from the participants regarding our understanding of the interview. These measures helped enhance credibility of the research findings. All the field investigators maintained field notes not just on what was said during the data collection, but also about the environment, general affect during the interviews and other relevant factors. This helped gain a detailed understanding of the interview process. The thick descriptions provided by the interviewers helped ensure assessment of transferability of the findings. We also periodically debriefed with the interviewers and met and discussed with them about the interviews and discussions during the field level supportive supervision. This helped maintain a level of reflexivity, thus ensuring dependability. (14)

Results

In the six districts, a total of 60 in-depth interviews among VHNs and 12 focus group discussions were conducted. The characteristics of the research participants in shown in Supplemental Material 1.

The VHNs were strongly oriented towards ‘doing good’ to the community. As their main work was maternal and child health, most of the discussions were centered around that theme. They had a sense of pride and responsibility for the health of the women and children in their community. This came out clearly in their narratives of the successful deliveries they conducted, lives of children they saved and several pregnant women, lactating mothers and infants they had reached out to and helped.

Going beyond the call of duty

One thing that emerged from the interviews and discussions was that the VHNs took pride in their job that they often went beyond the call of duty to fulfill their responsibilities to the community. They recalled instances where they had to spend out of their pockets to transport pregnant women in labor to the hospital. This was significant given that they were themselves often the sole breadwinners of their respective families and were struggling to make ends meet.

“It was late in the night and she was in labor pain. Those days there was no 108 ambulance service. I called a local cab service and paid for it myself and took her to the hospital for delivery. We have taken personal risks like these many times” – 45 year old VHN with 22 years of service
They said they accepted the responsibilities of caring for even patients who were abandoned by their families. Though this increased their workload, they found meaning in doing this.

“….she was abandoned by her family. Nobody came to the hospital to be with her after delivery. I took care of her, to the extent of even changing her menstrual pads every day.” – 38 year old VHN with 16 years of service

The VHNs felt that caring for the community was their prime responsibility and they felt a sense of honor and pride in assuming this responsibility.

**Doing good beyond health care**

VHNs naturally assumed the role of community advocates. They helped the community members avail social welfare schemes by creating awareness among them.

“I informed them (referring to her clients) about the cash benefit schemes for parents who have two girl children to support their nurture and education. I also helped them get the cash benefit.” – 52 year old VHN with 30 years service

They served as willing social support systems for many community members. They used the respect and authority they had in the community to fight social evils. They raised their voice against child marriage and reported several instances where they have prevented child marriages and stood up for preventing female infanticide.

“Once when I was visiting the village for my routine work, I was walking past a household where the woman had recently given birth to a girl child. All the windows were shut, and everything was very quiet. I got suspicious and went inside. They were planning to kill the girl child by giving the child ‘kalli paal’ (Tamil word for the poisonous extract of Cleistanthus collinus). I immediately spoke to the family and requested them to not do that. I convinced them to save the child. I was so happy when they decided to keep the child” – 50 year old VHN with 26 years service

Some VHNs reported acting as marriage counselors and advisors. They interacted with married couples and helped them adjust.

“Young married couples will come to me with marital problems. They will have adjustment problems. I will talk to them, counsel them and tell them about how to work out their misunderstandings. It is my responsibility to help them in their marital life.” – 43 year old VHN with 18 years service

A VHN reported that she maintained a list of persons with disabilities and made sure that they received all aid and support offered by the government or non-government organizations.

“I keep a list of all differently abled persons. Whenever the government or any NGO gives any aid like four wheelers, mobility aids etc. I make sure it reaches them. I also ensure that they get their monthly disability...
pension. I think this is my duty.” – 40 year old VHN with 20 years service

Challenges in doing good and avoiding harm

The VHNs reflected on some situations in their work where they were unable to do good to the community to the best of their abilities, and sometimes even ended up doing some harm. They reported a massive rise in work pressure in the recent times. There is a rising population in most of their work areas, with no increase in staff. Therefore, they were forced to care for more people than they can handle. With increasing digitization of data that is collected from the community, they struggle to find online time to feed the data. Added to this, with the advent of social media and rapid and instant communication channels, there are also increasing demands for data at odd hours from health system authorities, which they are forced to fulfil. They complained that there is no distinction between personal and professional hours in a day.

“Now with WhatsApp (a popular social media communication platform) and all, they ask for data at all odd hours. So even at home, we are unable to focus on the family. We sit with the mobile and keep entering the data daily even after coming home.” – 32 year old VHN with 14 years service

This increasing demand of digital work has reduced their hours spent in the community interacting with people. The VHNs felt that this has compromised their work.

“In those days, we used to do a lot of work with the women in the community. We used to visit them, give health education, conduct delivery in the subcentre. Nowadays, we are spending more time with the computer and phone rather than the women” – 30 year old VHN with 10 years service

Sometimes public health activities that the VHN persons with good intentions end up causing harm. One VHN narrated an incident where she upset an elderly lady in a village and got into a serious confrontation with her.

“There was a dengue outbreak in the village. We were going door to door checking if there were any stored water in the households where mosquitoes could breed. There was a mud pot full of water in the house of an elderly lady. We saw that there were several larvae in the pot. I emptied the pot. The lady got very angry and started fighting with me. She had walked a long distance to gather that water. I felt very bad for doing it.” – 48 year old VHN with 26 years service

The VHNs felt a hidden pressure from the health system to increase the number of beneficiaries for various health programs. Though the VHNs never mentioned any targets explicitly in the interviews, their narratives seemed to indicate that they felt a pressure to convince all women with more than two children to undergo sterilization and women after their first delivery to accept postpartum intrauterine device insertion.
“If it is a primi mother, she must get PPIUCD (post-partum intrauterine contraceptive device), if it is a mother with more than two children, she must get a sterilization surgery. Otherwise, it is not good for them. Sometimes they refuse to undergo the surgery. Then I convince and sometimes repeatedly visit them and talk to them and their family and make them undergo these procedures. This increases the stress and pressure on us.” – 44 year old VHN with 24 years service

They felt that they all do not have equal and fair opportunities for career progress. One VHN explained how she continues to do the same work since the past 25 years without any promotion.

“I have been working here for more than 25 years. In other jobs, before retirement people get at least three promotions, but I am still doing the same work that I started with. At this age, it is not easy for me to travel too much and run around like how I used to before. So, it is frustrating. Still, I console myself saying, I have come to do service and so I should be happy to do service.” – 51 year old VHN with 31 years service

One VHN mentioned that it is very challenging to raise voice against evil social practices like child marriage, as the whole society considers it normal, and it will become difficult to earn their trust and cooperation if she goes against their wishes.

“If I come to know that a child marriage is happening, it is not easy for me to raise my voice against it or report it. Let us assume I report it and stop the marriage. They will temporarily stop the ceremony, but after all the police and authorities leave, they will send the child away to the married home. The authorities will go away, but I must stay back and continue serving the community. The same girl will become pregnant, and I must provide pregnancy and childbirth services to her. It is very difficult.” – 49 year old VHN with 26 years service

A VHN recounted an episode of security threat to self when she attempted to do COVID 19 vaccination in her village.

“The young man was drunk and violent. He brought his wife for vaccination in the middle of the night. It was not appropriate to administer an injection at night. So, I asked them to return the next day. But I was scared to send him away, fearing how he would react, as he was fully drunk and violent.” – 44 year old VHN with 15 years service

Working in rural areas as a young woman was challenging to the VHNs. They had to face the threats of eve-teasing, bullying by the men in the village. One VHN narrated how she was constantly teased and bullied when she first started going to the village in a bicycle.

“I was so scared those days when I first bought my bicycle. Young men of the village would tease me and mock me and follow my cycle. It used to be uncomfortable. But I continued the work because of my sense of duty.” – 50 years old VHN with 18 years service
A VHN narrated how she felt unsafe following untoward incidents happening in her village. There was an infant death in the village she was serving. The father of the child got angry and violent and held her responsible for the death of the infant. He even took control of her two wheeler and did not allow her to leave the spot. The VHN reported feeling very unsafe during this incident.

“The guy took over my vehicle and did not allow me to leave. He was continuously threatening me. I felt unsafe. There was no protection for me during that time.” – 54 year old VHN with 31 years service

**Upholding autonomy**

The VHNs did not spend much time during the interviews or discussions talking about autonomy. However, from the narratives, various levels and stages of autonomy could be understood. The spectrum of autonomy among them ranged from an awareness and a conscious struggle to uphold individual autonomy on one end to a subtle coerced decision making in the middle to a full-blown paternalistic decision making on the other end.

“The girl wanted to undergo an abortion. I know well that it is her body and her right to abort the baby. But I had to consult the family. If not, it will be difficult to work in the community. In the community, the decisions are made by the elders in the family and the husband and not just the woman.” – 52 years old VHN with 32 years service

This VHN demonstrated an awareness about autonomy of the woman, wanted to uphold it, but was forced by existing social norms. If she violated these norms, she could not effectively function as part of the society.

One VHN narrated an incident where she assumed that there was implied consent and had to face a consequence of it.

“The child came along with other children for the COVID 19 vaccination. As all the children had come together to the vaccination center, I assumed that they all had consented to be vaccinated. I vaccinated that child and sent him home. That evening the father of the child came to the center and started shouting at me for vaccinating his son. He said he had never agreed to his child being vaccinated.” – 50 year old VHN with 25 years service

A VHN mentioned that it is not enough to obtain the consent of the woman for inserting an intrauterine device, but the permission of her husband and mother-in-law must also be obtained. This strongly supported the patriarchal norms in the society.

“Even if we do something in the best interest of the woman, it is safe to get the permission of the husband and mother-in-law. Otherwise, they will turn against us and create trouble for us. So before inserting intrauterine device, I will get permission from the mother-in-law as well as husband.” – 48 year old VHN with 22 years service
One of the VHNs spoke in support of the mandatory insertion of intrauterine device after delivery. She believed that when awareness is poor mandatory interventions are useful.

“After delivery of a primi mother, it is mandatory to insert intrauterine device for contraception. They don’t know, we must only do this for them” – 42 years old VHN with 12 years service

In another important discussion of autonomy, one of the VHNs mentioned an anecdote where she hid the diagnosis of cancer from an elderly woman and her family. She felt that revealing the information would have been detrimental to the wellbeing of the family.

“The elderly woman had cancer of the uterus. I did not want to upset her or her family. So, I did not tell them about the diagnosis. Then I took them to the hospital. There the doctor will tell the family, but the woman need not know” – 44 years old VHN with 20 years service

One VHN, while talking about counseling women to accept contraceptive methods, mentioned that although it is very important to prevent higher order births by compelling women to undergo sterilization after two children, she will refrain from compelling them because if she compels them, she will lose their trust. For her autonomy is a strategy to earn community cooperation and trust.

“If we compel them or force them, they will develop mistrust on us. They will then stop cooperating with us for any public health activity. So, I will tell them repeatedly but will not compel them.” – 53 years old VHN with 22 years service

Ensuring privacy during community work

The VHNs found it difficult to understand the question on privacy during the interview. They needed extra details and explanation before they could engage in an active discussion on the topic. The VHNs considered that ensuring privacy was not very difficult. Being used to working in the busy crowded environment of the villages, they had evolved their own innovative strategies to ensure privacy in the community.

“The body language of the woman itself will indicate to us that she is expecting privacy. I can understand this clearly just by looking at her and from seeing the way she approaches me.” – 48 years old VHN with 26 years service

Talking on the mobile phone with the client was a common strategy that the VHNs used to ensure privacy.

“I give them my mobile number and ask them to call me when they have a private moment. That is the best method to talk without others overhearing us.” – 59 years old VHN with 32 years service

One VHN said that she makes all clients sit outside the health center below the shade of a tree and examines the pregnant women one by one inside the center. This way, she can ensure privacy while
examining the woman. Similarly, VHNs found their own safe spaces with adequate privacy including the health sub center in the village, the Anganwadi Centre (child care center) and the school classrooms after school hours. One VHN narrated an incident where she successfully negotiated privacy while in a crowded community setting.

“I could clearly see that the lady wanted to speak to me in private. She also came near me and whispered that she wanted to speak to me alone. So, I stood up and announced that I want to go to have some tea and invited her to walk with me. This way, I could take her away from the center and ensure privacy in the tea shop. There we discussed her problem.” – 44 years old VHN with 22 years service

Maintaining Confidentiality

The VHNs were highly sensitive to the issue of confidentiality. They clearly mentioned that the community trusts them to maintain confidentiality of sensitive health information and so they do not discuss the health-related information with anyone. They mentioned abortion, unmarried pregnancies, tuberculosis, HIV/AIDS, sexually transmitted infection, and contraceptive choices as matters which required strict confidentiality. Sometimes people in the community force them to reveal health related information of others. During such situations, the VHNs evade the question, or sometimes lie to protect the confidentiality.

“Others in the village asked me about disease that the lady has. I refused to tell them. When they forced me, I told them some lie to shut them up. But I never revealed the diagnosis to them.” – 49 years old VHN with 26 years service

They even avoided visiting the house of a person with a stigmatizing illness to protect the confidentiality. They asked them to visit the health center or met with them in other public spaces.

“The girl had become pregnant. They wanted an abortion. I arranged for the abortion. But they asked me strictly not to come to their home to visit them. So, I followed up on her over phone” – 57 years old VHN with 16 years service

Sometimes maintaining confidentiality was challenging due to the job requirement of the VHN that mandated reporting of the disease. Once a young girl had tuberculosis and the family did not want the VHN to report the illness. But she had to report it due to her job responsibilities and this led to dissatisfaction among the family members.

Another important observation was that when asked about conditions for which the community prefers confidentiality, the VHNs reported social issues such as marital problems, sexual problems, extra-marital affairs, unwed pregnancy etc. as requiring stricter confidentiality compared to medical conditions.
Social injustices inherent in the society reflect on the VHNs work

When asked about social justice and discrimination, the VHNs declared that they never discriminated against anyone. They mentioned that they treated people of all genders, class, and caste equally. However, several of their narratives indicated that the social maladies introduced by caste, class, and gender did influence and reflect on their everyday work and their attitudes towards the community.

The VHNs endorsed patriarchal norms in the society. One VHN mentioned an anecdote where a woman had become pregnant outside of the wedlock due to a relationship with her own brother-in-law. The VHN said,

“I came to know that her own brother-in-law was the reason for her pregnancy. So, I convinced her elder sister to agree to get her husband married to her younger sister. This way the girl’s life and honor will be saved.” – 41 years old VHN with 5 years service

Another VHN narrated an incident where she arranged for a girl who got pregnant due to a rape to be married to the rapist himself as she believed that was the right thing to do. Some of the VHNs also believed that the husband must be informed in case his wife wanted to terminate an unwanted pregnancy.

“The girl came asking for an abortion. She told me not to tell her husband. I convinced her that it is important that she gets permission from her husband.” – 42 years old VHN with 6 years service

One of the VHNs had strong beliefs of caste-based stereotypes and this clearly emerged from her narrative. She explained how her responsibility to care for a particular tribal community is so difficult because the community is primitive and backward in terms of health.

“The tribal people are very backward; they get pregnant out of wedlock. They don’t undergo antenatal checkup. They don’t come for follow up. They don’t listen to what we say. They don’t take care of themselves. It is difficult to work with them. These tribal people are always like this.” – 49 years old VHN with 26 years service

When asked whether they gave importance to the caste of the community they served, they said they do not. However, their narrative indicates that they did indeed know and worked with the caste-based distinctions, but only avoided using caste names.

“I don’t even know their caste name. They live segregated in a separate area in the village. Rather than referring to them by the name of their caste, we refer to them by the name of the street in which they live. If we say the name of the street, everyone will know that they belong to the lower caste.” – 44 years old VHN with 15 years service
Another VHN reported that she faced difficulties in providing care for people belonging to the scheduled castes as her center was in the upper caste area of the village.

“I am working in a rented center which is in the upper caste area of the village. So, when scheduled caste women come for checkup my landlord prevents me from having them in and providing them care. What can I do? I must go along with these norms.” – 48 years old VHN with 22 years service

**Negotiating power hierarchies and conflicts of interest**

VHNs often faced conflicts and pressures from politically powerful people in the villages. The village leaders used them as scape goats for their political power play. One VHN narrated an incident where her husband had won the local governance body elections against a powerful political opponent.

“My husband won the elections. The guy who lost filed a petition against me in the District Collector’s office to transfer me from this village. I had to suffer a long struggle to fight against that political game.” – 43 years old VHN with 18 years service

A VHN narrated an incident where a politically powerful leader brought ten of his relatives, not belonging to the village, for COVID 19 vaccination and demanded that she vaccinate them. She did not have adequate stock to vaccinate her community members completely. So, she took a firm stand and opposed the power domination.

“The leader brought ten of his relatives and demanded to vaccinate all of them. First of all they were not part of my beneficiaries list. Other people of my own village were waiting outside to be vaccinated. How can I vaccinate this man’s relatives? I spoke politely and firmly to the leader and explained how I have only limited supply of the vaccines and so I can only vaccine my village people. The leader was very angry and disappointed but could not say anything and so he left.” – 43 years old VHN with 18 years service

They also practiced a subversion technique to resist power dynamics in the village. A VHN explained how a powerful elderly man kept asking her to make home visits to examine him and check his blood pressure. She gave in the first time and visited him. This kept him calm and did not enrage him. During the visit, she explained to him politely that she cannot come again because this was not her job. She explained how subversion by being passive and at the same time firmly working from within the system to overthrow the power hierarchy is an important tool.

“If I had refused to go and check his blood pressure at his home, he would have become angry and hostile. That would have made my work in the community difficult. But going to his home once and then making him understand was a more friendly approach.” – 41 years old VHN with 5 years service

One VHN narrated a difficult incident where she had to negotiate with a very powerful doctor in her village.
“The doctor brought his wife very close to delivery. They had never undergone any antenatal checkup, nor taken any iron tablets or immunizations during pregnancy. The doctor refused to even go to the Primary Health Centre. He conducted the delivery himself at home. When I came to know this, I rushed to their home to check the mother and child. I was in a tough situation because the doctor was refusing for any checkup or any visits, but my senior officials will initiate disciplinary action against me if I fail to provide post-partum care. Then I told him that we will not be able to produce a birth certificate unless he agrees to a checkup. Then I politely and kindly negotiated with the doctor and convinced him for a checkup. It was very difficult.” – 59 years old VHN with 34 years service

**Ethical dilemmas and their resolution**

VHNs face several ethical conflicts. Some of these are conflicts between the VHNS role as advocate of the community and a servant of the health system, and some are conflicts between community needs and power hierarchies within the community. The VHNs have their own innovative strategies to resolve these conflicts. However, these are not uniform. Some of these ethical conflict resolution strategies are positive and some are negative. The health system compels the VHNs to deliver some interventions like contraceptive use or sterilization surgeries. However, communities do not accept these interventions. In these conflicts some VHNs prioritizes the needs, preferences, and welfare of the community, thus protecting the interests of the community.

“I am supposed to tell them to accept Copper T (intrauterine device) insertion. But if the community is very much opposed to it, I let it go and protect the interests of the community.” – 43 years old VHN with 16 years service

Some VHNs go out of the way sometimes to uphold the best interests of the community. At their own risk they administer treatments that they are not authorized to give. A VHN narrated one such incident.

“There was severe Chikungunya outbreak in the village. Many people developed severe joint pains and were lying in their homes writhing in pain. I am not allowed to give them pain killer injections. But I was not able to tolerate their suffering. So, I spoke to our Deputy Director of Health Services in the district myself and requested permission to give the diclofenac injections at their homes for the patients. He reluctantly authorized me after understanding my intentions. This was one instance where I balanced the needs of the community with the rules of the health system” – 52 years old VHN with 33 years service

**Conflicts**

arise when the cultural and religious beliefs of the VHN are opposed to the requirements of the community. A VHN mentioned how she actively discouraged a woman from undergoing medical termination of pregnancy because the VHN's own religious belief prevented her from advising it.
“Since I belong to ********** religion, I advised the lady to carry the pregnancy, have the child and then undergo sterilization. My belief is against doing abortion, as abortion takes away a precious life given by God” – 51 years old VHN with 25 years service

Sometimes the ethical dilemma happens when the health system insists on interventions, but the community is reluctant to accept it. A VHN narrated an incident where she dismissed and denied the reported adverse effects of an intervention.

“I was distributing iron and folic acid tablets to schoolgirls as part of the anemia program. One of the girls came to me and complained that she was feeling dizzy and nauseous. I made her sit down, told her the tablet will never cause dizziness and nausea and after some time sent her home. These girls pretend just because they don’t like the tablets.” – 48 years old VHN with 18 years service

She used denial of the symptoms as her tool to resolve the conflict in interests of the community and the iron tablet distribution program. Another VHN dismissed and denied an adverse effect of intrauterine device in a woman.

“The woman came back after a week of inserting the Copper T (intra uterine device) and said that she is having pain and irritation in her private parts. She requested me to remove the Copper T. I told her that the pain is not due to the Copper T and sent her away. I refused to remove the Copper T. These women will ask for removal of Copper T. They lie about the symptoms. If we remove the copper T, they will immediately get pregnant and that is not good for them.” – 50 years old VHN with 17 years service

Not only was there denial of her adverse symptoms, the VHN also did stereotyping and judgment of the woman who complained about the intrauterine device. This was a strategy she used to resolve her ethical conflict between the demand of the system and the complaints of the patient. One VHN said that she counselled her clients regarding intrauterine devices sometimes even against the VHN's own beliefs.

“The woman will come complaining that she is having heavy bleeding and irritation because of the copper T. Even though I believe that it may be true and the irritation and bleeding may be because of the copper T, I will not remove it. I will counsel her and send her away.” – 51 years old VHN with 26 years of service

One VHN narrated an incident of an infant death in her village. When the parents and the family blamed her for the infant death she shifted the blame to the mother. This was a negative strategy she used to handle the conflict.

“They kept blaming me for the death of the child. I then told the mother that it was she who put the baby on the crib alone in the supine position. I advised her never to do that. But still she did that. That is why the baby died. And now she is blaming me.” – 52 years old VHN with 15 years service

Many VHNs reported seeking the advice and counsel of the Medical Officers in charge of the Primary Health Centre to which they are affiliated to resolve ethical conflicts. One VHN reported that she took the
help of the VHN Association, which is an organized body of VHNs and provided support to the VHNs in times of need. The VHN Association supported VHNs to resolve such ethical conflicts. However, there was a lack of a standard process for resolution of ethical dilemmas and no systematic thought process for such a resolution among the VHNs. The various strategies adopted by the VHNs to resolve the ethical conflicts is depicted in Fig. 1.

**Practice of Professionalism**

The VHNs identified several characteristics of professionalism. They mentioned that these characteristics are important in a VHN. These include

The VHNs identified several characteristics of professionalism. They mentioned that these characteristics are important in a VHN. These include

a. Being a lifelong learner who is updated in knowledge and skills
b. Living in the same village and being always available
c. Being brave and bold to face difficulties, stand up for the wellbeing of the community
d. Being humble
e. Not getting into unnecessary fights and arguments with the community and avoiding anger
f. Maintaining high integrity, not taking bribes
g. Maintaining punctuality and acting in a timely manner
h. Being patient and kind
i. Being a good communicator and patient listener
j. Having an attitude of altruism and sacrifice
k. Leaving frustrations and anger at home and coming to work with a smile on the face.

Figure 2 summarizes the various considerations of ethics and professionalism of the VHNs.

**Determinants of practice of ethics and professionalism**

The VHNs practice of ethics and professionalism operated in the community practice environment. Several factors in this environment enabled and several demotivated the practice of ethics and professionalism. The VHNs mentioned awards, recognition for their work, a sense of pride and honor, support of her husband and respect in the community as motivating factors.

“My husband left his job and became a full-time home maker. It is only because of his support that I can do good work in the community and help so many people” – 49 years old VHN with 26 years of service
“The health center and the village health nurse are like the temple and Goddess in the village. They are a constant presence, and they guard and protect the village. This feeling motivates me.” – 54 years old VHN with 31 years of service

One VHN mentioned that the respect and recognition that they got from the communities that they serve greatly motivated them to do maximum good to the community.

“When they recognize us when we bump into each other randomly, it makes us feel high (gethu). When they offer to give us a lift when we are waiting in the bus stop, it makes us feel high. Sometimes when we are walking in the village with our senior officials, but the community recognizes us and acknowledges us more than them, it gives us a high. When our senior officials say that the community respects us more than them, that gives us a high.” – 50 years old VHN with 23 years of service

VHNs mentioned that they face the brunt from both communities as well as their higher authorities. They are caught between the two and feel very stressed. It is because of this that they feel demotivated and unable to deliver good quality care.

“The community will also scold and abuse us, and if we don’t meet targets our higher officials will also scold and abuse us. We are like the drum which faces beatings from both sides.” – 54 years old VHN with 34 years of service

If any adverse event or negative health incident happens in a community, it leads to immediate breach of trust and the community stops cooperating with the VHN. It takes a long time and effort to regain trust. This greatly hampers their ethical work.

“Once a young woman died during delivery. After that the entire village was very angry with me. They stopped accepting my services. They refused to believe me and come for checkup. It took a long time to regain the community trust and cooperation” – 43 years old VHN with 5 years of service

Some of the VHNs are stationed within the same village and live within the village. So the villagers expect her to help them at any time of the day. Sometimes they access the VHN at odd times asking for tablets for fever, cough, cold and other minor illnesses. If the VHN has short supply of these drugs they lose trust. This frustrates the VHNs.

“At nighttime and all odd times, they will knock the door of the health center and ask for tables for headache, fever, cough or cold. But government supply of these tablets will be limited. So, I may have to turn them away without tablets. This will upset them.” – 52 years old VHN with 32 years of service

The VHNs felt that handling of cash disbursement for the maternity cash benefit scheme created a sense among the community that the VHNs are misappropriating the money. They even get angry and scold the VHNs when their payments get delayed. They felt frustrated that this tarnished their image in the community and interfered with the ethical practice of their service.
"We have to arrange for the women to get the cash benefit for the Muthulakshmi Reddy scheme. Sometimes the payments will be delayed. The husbands of the pregnant women will shout at me and even abuse me verbally. They think I have stolen their money. This creates a lot of distress for me." – 42 years old VHN with 12 years of service

The factors motivating and discouraging ethical practices of the VNHs is shown in Fig. 3.

Discussion

This qualitative exploration revealed that the VHNs often went beyond the call of their duty to help their clients and served as advocates in matters of health and other social issues. They felt that the quality of their work suffers because of the overburden of work, rising population load served by each VHN and increased demands on her time due to digitization of community health work. While the VHNs were sensitive to issues of privacy and confidentiality of their clients’ health information, they did not give much importance to the autonomy of their clients, especially the women. Social injustices in the form of gender, caste and class discrimination were embedded in their work and some of the VHNs involuntarily reflected these biases in their work. The VHNs adopted unique strategies to manage power hierarchies that hindered their work. They faced several ethical dilemmas but did not have the appropriate tools and techniques to handle them in a standard manner. Several social and political factors motivated as well as hampered their practice of ethics and professionalism. In the following paragraphs we will discuss some of these themes that emerged in this exploration in detail.

The difficulty of doing good

The fact that the VHNs perceived going beyond the call of duty as good, goes to say how much they have to stretch themselves to obtain the satisfaction of having done something good for their clients. In a low resource setting, doing good becomes a challenge and often this challenge is borne by the people who work at the grassroots. While decisions related to resource allocation and budgeting happen at the higher policy level, the frontline workers often bear the cost of having to deliver the services, despite resource constraints. A study from Rwanda showed that CHWs compromised substantially on their personal income due to their volunteering activity and had to spend substantially out of pocket for providing optimal care for their clients.(15) With increasing digitization of health care services at the community level, CHWs are also forced to spend out of pocket for maintaining their digital devices, purchase internet data out of their own expenses and also sometimes use rented computers and internet from internet parlors for their work.(16) The overburdened CHW faces high levels of job stress and burn out. This was particularly high during the pandemic.(17) A stressed and burnt out CHW struggles to do good to the community. The high levels of stress and burn out also led to poor job satisfaction and increased attrition of CHWs, this hampers the common good that is produced by the CHW program in the community.(18) The rising population that they serve, expansion of their roles in the community and inadequate training and supportive supervision have been reported to be demotivators for CHWs in a study from Malawi.(19)
Similar demotivators were also observed from this study. All these factors make ‘doing good’ a challenging proposition to the VHNs.

**Challenges of earning and maintaining community trust**

Successful delivery of community health work greatly depends on the trust that the community places on the CHW. Greater the trust, greater the engagement of the community with the various interventions led by the CHW. While many VHNs in this study reported that they enjoyed a high level of trust in the community, they also said that the trust is breached easily with a simple mistake, and then it becomes challenging to earn the trust back. The VHNs were very careful about maintaining confidentiality of their clients’ medical information, as they felt that it is important to build trust. They also reported that when any adverse health event, such as an infant death, happened in the community, it led to breach of trust and then it becomes an uphill task to rebuild the trust. In a study from rural Uganda, it was found that CHWs who often belong to the same community that they serve, face challenges in earning the community trust due to poor training, poor supportive field level supervision, low level of confidence, and low remuneration. Such factors operate in all similar low resource communities and greatly influence the level of trust that the community has on the CHW. In this study the VHNs further reported the frustration that they faced due to low medication supplies that they received, which led to low stock of drugs and hence inability to help the needy sick people in the community that they serve. Such logistic inefficiencies can also greatly hamper trust in the CHW.

**We don’t worry about what we don’t know – privacy and confidentiality issues**

The discussions about privacy and confidentiality during community health work were surprisingly free of any difficulties or challenges. When we entered the field to explore these issues, we anticipated that the VHNs would discuss in detail about the challenges in maintaining privacy and confidentiality. When going door to door for home visits in the community, privacy and confidentiality are likely to be highly challenging. But this was not brought up in the interviews. The VHNs mentioned that they have their own unique strategies for ensuring privacy. They said it with ease. Similarly, they believed that information related to stigmatizing conditions like tuberculosis, HIV/AIDS, sexually transmitted infections, and unmarried pregnancies only had to be kept confidential. The discussions did not delve deep into these issues. One possible reason for this could be low level of sensitivity to privacy and confidentiality. In a study from Swaziland, it was seen that the community members did not trust the CHWs to protect confidentiality of their health information. Our study only explored the extent to which VHNs practiced confidentiality. However, it is important to see how communities perceive the level of confidentiality that the VHNs maintain in our setting. It is likely that it influences their trust in the VHNs.

**Disadvantages of the VHN belonging to the same community she serves**
While several studies have shown the advantages of the CHW belonging to the same community and living in the same village that she serves, there are also disadvantages to this. As they belong to the same community that they serve, there may be challenges in establishing trust. There may be conflicts of interest. For example, the CHW may have to protect the confidentiality of a community member, but she may have conflicting interests in the community which may compel her to reveal the information and breach the confidentiality. Such complex relationship dynamics are not uncommon. (24) There are inherent power hierarchies within communities. Such power hierarchies may hamper the work experience of the CHW. A conceptual framework of what enhances and what hampers the performance of CHWs outlines contextual factors, health system hardware and health system software as the key determinants. The software elements that influence the performance of a CHW are interest, relationships, power dynamics, values and norms in the community. (25) These factors make belonging to the same community a disadvantage when it comes to CHW performance.

**Representing the community also means reflecting the attitudes of the community**

The VHNs are from the same community that they serve. As pointed earlier, this can have its own advantages and disadvantages. One unique disadvantage perpetuates the social injustices that are inherent in the community. The VHN being a person from the same community, is also rooted in the social structures, power hierarchies and biases. This was seen clearly in the interviews. In a study from Brazil, it was seen that CHWs had perceptions about the level of vulnerability of the community members and this perception reflected on their referral services. (26)

**Resolution of ethical dilemmas faced by the VHN**

In this study it was clearly seen that the VHNs faced several ethical dilemmas. However, they did not have a standard process to resolve these ethical conflicts. Some of them adopted negative strategies like ignoring and denying any adverse events related to public health interventions like contraceptives or immunization. Sometimes, they did this even against their own personal beliefs. They seemed to feel that ethics and professionalism are learned over years of experience. The lack of training on ethical reflection process and balancing ethical principles to address ethical dilemmas is evident from this finding. The goal of training and capacity building in ethical reasoning is to impart the skills of ethical reflection and analysis among community health workers. It is in this context that training in ethical reasoning and a well drafted ethical code of conduct will be useful.

**Gender dynamics and its influence on ethical practice**

The VHNs brought out some important gender dynamics in their work and this influenced the way they practiced ethics and professionalism. They reported challenges in safety of a young VHN in the village. They also reported being abused verbally during their field work. Several studies have looked at the safety of CHWs in rural areas in India. (27) There is a need to ensure safety measures to protect the CHWs in order to enhance ethics and professionalism in their work.
Strengths and weaknesses of the study

To the best of our knowledge this is the first attempt to document the experiential wisdom of ethics and professionalism among CHWs in India and the low- and middle-income country settings. The study is grounded in the theory of community health worker ethics and professionalism and has explored the field in the context of Tamil Nadu with an open-ended approach. The other important strength is that the field investigators and interviewers were CHWs themselves with a sound grasp of the ground realities of community health work in rural Tamil Nadu. As a by-product of this research initiative, we trained and built the capacity of the CHWs who were engaged in data collection, to conduct qualitative interviews. We believe that this has contributed to empowerment of the CHWs in Tamil Nadu across the six districts where this study was conducted. We ensured that we sampled senior VHNs from the various districts, who had good field experience in handling ethical dilemmas. We systematically explored and documented their strategies to handle these ethical issues. We also realize that our study had its own set of weaknesses. Many of the CHWs that we approached, were apprehensive to be interviewed due to the sensitive nature of some of the discussions on ethics and their work. Therefore, much valuable information could not be documented. It was challenging to explain the principles such as confidentiality, privacy, conflicts of interest and have them engage in discussions on these topics. Despite these weaknesses, the findings of the study are important. They establish the need for guidance for VHNs in carrying out their job in an ethical manner.

Conclusion

Community Health Workers practice ethics and professionalism in their everyday work. However, their practices are not standardized as there is no code of ethics and professionalism for them in India. Developing a code of ethics will standardize ethical practice of community health work. Community Health Workers programs in India, are expanding with increasing digitization of their work. In this context developing a code of ethics of ANM’s, Multipurpose Health Workers, ASHAs and Anganwadi Workers is an ethical imperative.

Declarations

Ethics approval and consent to participate

The research proposal was reviewed by the Institutional Ethics Committee of the Directorate of Public Health and Preventive Medicine, Chennai and approved with approval number DPHPM/IEC/2022/03 on 26.03.2022. The committee gave specific recommendations. We followed all these recommendations during data collection. We obtained written informed consent from all participants before the interview and the focus group discussions. We also obtained permission to audio record the interviews and discussions. Wherever permission was refused for recording, we took detailed notes of the interviews and discussions. We refrained from referring to the names and identifying information of the participants during the recording of the interviews and kept the interview transcripts anonymous to protect the
confidentiality of the participants. Nobody other than the core research team had access to the transcripts.

**Consent for publication**

Not Applicable

**Availability of data and materials**

All the transcripts in Tamil language are accessible at this link - https://drive.google.com/drive/folders/1bRp56c_5doHqj99QZuGXt9TWHMo24qua?usp=sharing

**Competing interests**

The authors have no competing interests to declare.

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**Authors' contributions**

VG, SS, BP and PC conceptualized and designed the study. VG, SS and BP participated in data collection and supervision of data collection. VG, SS, BP and PC analyzed the data. VG drafted the manuscript. SS, BP and PC reviewed the manuscript and substantially revised it. All four authors have read and approved the final manuscript.

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**Figures**
## Strategies used by VHNs to resolve ethical conflicts

<table>
<thead>
<tr>
<th>Positive strategies</th>
<th>Negative strategies</th>
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<tr>
<td>Prioritise community needs, Do what is best to community despite risk to herself,</td>
<td>Stick to personal beliefs and values in contrast to community values,</td>
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<tr>
<td>Take support of Medical Officer, Take support of Village Health Nurse’s Association</td>
<td>Dismiss community concerns, Judge and stereotype those who complain or have concerns,</td>
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<td>Shifting blame to the community</td>
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**Figure 1**

Strategies adopted by the VHNs to resolve ethical dilemmas.

**Figure 2**

Considerations of ethics and professionalism of the VHNs
Determinants of ethical practice of the VHNs

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<th>Motivators</th>
<th>Demotivates</th>
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<tr>
<td>Respect by community, Acknowledgment and recognition by authorities, Awards</td>
<td>Short supply of drugs and essentials, Loss of personal-professional boundaries in community, Lack of career progress, Threats to personal safety</td>
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Figure 3

Factors motivating and demotivating the VHNs from ethical practice of their work.

Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- SupplementalMaterial1.docx