

ASHA WORKERS IN INDIA: THEIR CONTRIBUTIONS, CONSTRAINTS, AND PATHWAYS FOR IMPROVEMENT

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ABSTRACT

Community Health Workers as a crucial social engineering for attaining the goal of Universal Health Coverage has become the norm in underdeveloped and developing countries since the early 2000s. As the goals of attaining healthcare objectives intersected with the larger goal of achieving gender equality, the centrality of women in spearheading such initiatives was acknowledged with great enthusiasm. This article attempts to formulate a diversified understanding of the functions of Community Health Workers (CHW) within the context of the Accredited Social Health Activist (ASHA) in India. The larger objective is to understand the unique role of ASHA workers in contributing to India's healthcare objectives, easing the accessibility of marginalized masses, and assessing the associated challenges. It also highlights the agency of ASHA in the state and the way forward to make the system more robust.

Keywords: Primary Health care, Community Health Workers, ASHAs, COVID-19

INTRODUCTION

Since the welfarist development model started gaining traction among the democratic and socialist regimes worldwide, the idea of delivering essential services to marginalized social groups became prominent. The welfare regime implies a mandate to provide social assistance for the populace's fundamental sectors like health, education, employment, and pension. The social security mandate is one of the hallmarks of the welfare state. The Constitution of India reflects these provisions. India, a nation that accounts for 17% of the global population, is responsible for 19% of global maternal fatalities and 21% of global juvenile deaths. Nevertheless, it has made substantial contributions, particularly since the introduction of the National Rural Health

Mission (NRHM) program in 2005. "NRHM contains a variety of strategies and schemes, such as a conditional cash transfer scheme, an emergency transport mechanism, improved communitization through the establishment of Village Health, Sanitation, and Nutrition Committees (VHSNC), and investments in health infrastructure and health workforce, which include the establishment of a new cadre of community health volunteers as ASHAs" (Sheila C. Vir, 2023).

National Rural Health Mission (NRHM)

It was introduced in April 2005 as an India for Health project to enhance service quality at the primary and secondary levels. The

Ministry of Health administers this program. The Mission aims to establish a completely community-owned centralized healthcare delivery system. The objective is to deliver accessible, cheap, and accountable quality healthcare services in rural regions. NRHM is acknowledged as the principal initiative encompassing all current Health and Family Welfare programs, including "Reproductive Child Health-2 (RCH-2), the National Malaria Control Programme, Tuberculosis (TB), Kala-azar, Filariasis, Blindness, Iodine Deficiency, and Integrated Disease Surveillance. The Mission is a program sponsored by Central Resources" (Enisha Sarin et al., 2017).

The structure of the annual budget determines the share of funding that the project would receive. The NRHM program necessitates the states to increase by 10% their public health budget each year. The primary healthcare services were extended to urban areas in 2013 when the National Urban Health Mission (NUHM) was introduced. ASHA workers' role is vital in the success of such initiatives. Hence, ASHA, the flagship extension of the NRHM, serves as a foundational pillar for overcoming the enduring challenges of accessing healthcare for the rural population.

Definition of Community Health Workers (CHWs)

They are individuals from the local community who get monetary incentives for volunteering to deliver health services to rural and urban areas in tandem with the existing local system in health care. CHWs are the first line of defense as health professionals in the healthcare system, with an extensive understanding of the population they serve. A crucial connection to healthcare systems at the grassroots level is that they serve as an essential bridge between the healthcare system and their communities (Ballester, 2005). This can enhance access to healthcare services in isolated regions.

CHWs have global recognition, originating from community-based healthcare initiatives. The World Health Organization, in its Alma-Ata Declaration of 1975, formally recognized CHWs as a general designation, defining their global role and emphasizing the critical role of healthcare services at the primary level. 'Health for All' was a mission directive by the World Health Organisation (WHO). It aims to catalyze community development, raise knowledge about health services and their significance, and directly deliver healthcare. In order to provide women in their communities with essential and nutritional services, CHWs are often members of the local community who have undergone minimal training (Walt, 1989). They usually work intermittently as healthcare providers and are expected to stay in their native areas.

CHWs are crucial in bridging the healthcare system and community gap. Their interventions are often more effective than those driven solely by healthcare professionals in identifying and leveraging the community's strengths to promote health improvement (Bishop C et al., 2002). CHWs can understand, harness, and maximize the community's resources, leading to enhanced health outcomes through improved access and cultural engagement, particularly for underserved populations.

Despite the Indian Government's commitment to enhancing healthcare in rural regions through NRHM, delivering adequate health services remains a significant challenge. It is crucial to recognize the need for improved training and resources for ASHA workers at the forefront of this Mission.

In 2002, Chhattisgarh introduced an innovative community health care model by appointing women as Mitani, or Community Health Workers. These women served as intermediaries for marginalized groups, bridging the gap between the needs of local populations and distant health systems. The

national government launched the Accredited Social Health Activist (ASHA) program in 2005-06 as part of NRHM, which was later expanded to urban areas by establishing the National Urban Health Mission in 2013.

Accredited Social Health Activist (ASHA)

NRHM in India established the ASHA program in 2005 to enhance women's engagement in specialized work attendance. ASHAs are chosen from the local community and are committed to providing healthcare facilities. They are instructed to link the public health care system and the local community. The subjects are predominantly rural women between the ages of 25 and 45 who have completed up to Class 10. Typically, there is one ASHA per 1,000 individuals. This ratio may be adjusted to one ASHA per residence in tribal, hilly, and arid regions, contingent upon the workload.

Joshi, R.S., and George, M. (2012), from Thane district, Maharashtra, highlight the diverse role of ASHA workers within the health system as "agents of change," encompassing awareness, health services, family planning, and the door-to-door dissemination of information regarding maternity schemes and child development programs. According to the Policy Brief (2018), India is ranked 150th out of 153 nations regarding women's health and survival, indicating poor standing. The survey also reveals that domestic violence against women in Western India exceeds that experienced by 82% of males. In this context, ASHA workers offer counseling, attentively consider women's circumstances, provide guidance, and enhance their awareness, especially when family members exhibit conservative tendencies. Additionally, ASHA's primary tasks include "advocating for prenatal and postnatal services, facilitating institutional births, promoting regular vaccination in children, distributing condoms and oral contraceptive pills, and encouraging healthy

behaviors within communities" (USAID India, 2008).

The national Janani Suraksha Yojana (JSY) impacts ASHAs and new mothers significantly. Under this mandate, most ASHAs advocate for institutional delivery, incentivizing institutions to deliver services. A new mother in a rural area is entitled to Rs. 1400 and Rs. 700 in different state settings. ASHAs receive Rs. 600 and Rs. 200 as an incentive for institutional birth. In urban settings, a new mother is entitled to Rs. 1000 and Rs. 600, while ASHAs receive Rs. 200 as an incentive for institutional birth (Table 1)

Table-1: Monetary incentives for institutional deliveries.

Category	Rural Area		Urban Area	
	Mother's Package	ASHA's Package	Mother's Package	ASHA's Package
Low-performing States (LPS)	1400	600	1000	200
High-performing States (HPS)	700	200	600	200

Source – Janani Suraksha Yojana, National Rural Health Mission website.

ASHA is a critical organization in the Anganwadi community, as it promotes health awareness, provides medical care, and encourages community involvement. They guide various health-related matters, including diet, lifestyle, and work-related circumstances. In addition, they establish a local health plan and enable children and expectant mothers to access medical care at their convenience. Anganwadi officials conduct meetings with ASHA workers, function as reference persons for training, and provide them with information about outreach sessions. Additionally, they guarantee that employees receive compensation and participate in training. ASHA also organizes health days at the Anganwadi Center.

The ASHA program requires ASHAs to act as "link workers," facilitating the connection

between rural residents and health service facilities. They serve as "service extension workers," providing instruction and essential materials to encourage the preservation of life.

ASHA workers occupy a very unique role in making healthcare accessible to the most marginalized and vulnerable communities. They significantly contribute to raising awareness on health-related issues, mobilizing local communities for healthcare planning, and ensuring accountability and proper utilization of existing healthcare infrastructure.

Their role is essential in reducing the maternal mortality rates (MMR) in India. According to the Sample Registration System's (SRS) data (2022), the mortality rate was 374 deaths per 100,000 live births from 2014 to 2016, which declined to 97 fatalities per 100,000 live births from 2018 to 2020.

ASHA has contributed to this significant reduction in several ways: (a) By facilitating hospital deliveries and providing prenatal and postnatal care, (b) by regularly paying home visits to pregnant women for their health assessment and detect any possible complications, (c) disseminating knowledge related to women's health and guide during crises, (d) collaborating with governmental programs to improve healthcare accessibility such as Janani Suraksha Yojana (JSY) which provides monetary incentives for mothers and promotes hospital births, (e) enhancing community spirit, addressing socio-cultural barriers and raising awareness on health-related matters. Consequently, hospital births in India saw a significant rise from 78.9% (National Family Health Survey (NFHS)-4, 2015 to 16) to 88.6% (National Family Health Survey (NFHS)-5, 2019 to 21). Moreover, the MMR significantly decreased from 556 per 100,000 live births in 1990 to 103 per 100,000 live births in 2022.

In the same spirit, ASHA workers have also contributed to decreasing malnutrition among children aged five and below. The NFHS-4 (2015 - 2016) reported the malnutrition level to be 38.4%, which was reduced to 35.5% in NFHS-5 (2019-2021). They effectively contribute in promoting neonatal care practices and guiding families on the importance of breastfeeding. This contributed to the drastic decrease in the Infant Mortality Rate (IMR) in India from 89 per 1000 live births in 1990 to 27 per 1000 live births in 2022. Furthermore, ASHA workers disseminate knowledge on the importance of getting vaccinated and address reluctance regarding vaccines among the populace. They were involved in conducting door-to-door visits, organizing village meetings, and engaging in health campaigns to notify people about the schedule for vaccination, especially for children under two. They actively engaged in the government's flagship program, Mission Indradhanush (2019). The objective of the Mission was to achieve comprehensive vaccination coverage for all children under two years and pregnant women. ASHA workers were equipped with digital instruments like the MCTS to track mothers and children and the RCH portal, where information about vaccination coverage and schedules could be monitored. The significant contribution of ASHAs leads to a dramatic increment in India's comprehensive vaccination coverage for children 12 to 23 months old, from 62% in NFHS-4 (2015 to 16) to 76.4% in NFHS-5 (2019 to 21). This remarkable achievement is accredited to the direct engagement of the ASHA workers in ensuring that children adhered to the prescribed vaccination schedule, including those for diphtheria, pertussis, tetanus (DPT), polio, measles, and other preventable diseases. Enhanced vaccination coverage can be directly correlated with the reduction in child mortality rates as reflected in the assessment of IMR,

which is decreased compared to the national average in regions where ASHA workers were highly active, namely Kerala, Tamil Nadu, and Himachal Pradesh.

In 2022, Kerala's IMR was substantially lower than the national average of 27 per 1,000 live births, at just 6 per 1,000. In the underprivileged districts targeted by the Aspirational Districts Programme, where IMR was previously high, ASHAs have played a crucial role in enhancing healthcare delivery, resulting in noteworthy declines in infant mortality.

However, there has been substantial research that has critically mapped the performance of ASHA. Jan exhibited sub-par performance in the immunization program, wherein the health workers required a better understanding of the dosages of common medications. In a seminal work, Mahyavanshi et al. (2011) investigated the knowledge, attitudes, and practices of ASHA workers related to child health in Surendranagar district, Uttar Pradesh, revealing that 86.2% of ASHAs possessed inadequate knowledge about newborn care, while 90% were unaware of the appropriate advice to provide mothers for preventing hypothermia and administering Kangaroo Mother Care. Seventy percent of individuals were aware of the signs of diarrhea, although 91.5% were uninformed about the indications of dehydration; also, 68.46% lacked knowledge regarding measles and pneumonia. 96.92% of ASHA staff had a positive attitude. Furthermore, he mentioned that although ASHAs receive training, there is still room for improvement in their understanding of various aspects of childhood illness and mortality. Therefore, enhancing the frequency and quality of training for ASHAs is essential.

COVID and ASHA

ASHA workers were crucial to India's COVID-19 response, particularly in rural regions, by

doing health surveillance, contact tracing, and public health education. Over 1 million ASHA workers engaged in pandemic-related activities, including door-to-door surveys and identifying possible COVID-19 cases. They significantly contributed to implementing vaccination programs, which increased vaccination rates in rural areas of India. However, they also encountered significant vaccine reluctance (Nair, 2024). Nevertheless, numerous ASHAs needed to be more adequately equipped with the appropriate personal protective equipment (PPE). Research indicates that 60% of them lacked sufficient personal protective equipment (PPE) during the early phases of the COVID outbreak (Mishra & Rai, 2021). The workload for ASHA employees experienced a significant increase, and some of them worked extended hours for minimal pay based on their success, with an average of only INR 2,000 to 4,000 per month (Ghosh, 2021). Despite their challenges, their efforts to improve sanitation, implement quarantines, and provide information significantly reduced the virus spread in rural spaces, highlighting their importance during the pandemic (*ibid*).

The usage of 'war' analogies in public discourse during the COVID-19 epidemic had a significant impact on the perceived duties of community health workers in India, particularly ASHA workers. Political leaders used war metaphors to explain the complexities of the epidemic and encouraged public participation by portraying COVID-19 as an adversary that required a collective response (Bates, 2020). These metaphors utilized familiar concepts such as enemy, combatant, and home spaces to support specific policy actions and evoke a sense of urgency, concern, and danger (Flusberg et al., 2018). This portrayal presents healthcare workers as "soldiers" in the fight against the disease. As a result, they are expected to follow the directives of their superiors and

recognize that specific individuals may be injured or required to sacrifice for the greater good of the group (Taylor & Lohmeyer, 2020). The political aspects of the employment of ASHA employees were brought to light by the COVID-19 outbreak. The government failed to adequately address their requests, even though they were extolled as “frontline warriors” for administering public health at the local level. A significant number of ASHAs were compelled to work without adequate personal protective equipment (PPE) and risk pay due to the ongoing risk of long-term viral transmission (Nanda, 2020).

However, the research indicates that the COVID-19 epidemic has altered the role of hope, possibly generating new chances for individuals to reconfigure their agency and interactions with the state. Conventional narratives emphasize female responsibilities, but new discourses around pandemic-related securitization may affect the subjectivity of community health workers in unprecedented ways (Pfrimer & Barbosa, 2020). The public image of impermanent workers, equal pay for men and women, and worker rights are all interconnected with the politics of ASHA workers. These concerns necessitate an examination of the future of healthcare work within India’s political and social framework.

LIMITATION

The ASHA program has been extensively researched since its inception; however, its implementation could be more consistent at the state level due to stakeholders’ varying perspectives and notions. ASHAs must possess comprehensive knowledge and imparted training for their numerous responsibilities in various Indian contexts to fulfill their obligations effectively. In a nation as varied as India, it is essential to comprehend the primary health facilities linked to ASHAs. They need to be better furnished with sufficient facilities. Moreover,

little and unregulated financial incentives are provided to aspirants, which tend to dissuade rather than encourage them (Saprii L. et al., 2015).

CHWs have proven to be effective worldwide in several areas related to mother and child health, including the encouragement to breastfeed by new mothers, timely and proper vaccination, critical care for newborns, health education, and reduction in IMR and MMR (Enisha Sarin et al., 2017). Nevertheless, challenges persist in the performance of CHWs. Glenton C. et al. (2013) identified organizational, social, and interpersonal factors facilitating or impeding community health. Although social acceptability and organizational support were essential for CHWs, the program’s effectiveness obstacles were linked to the interactions between beneficiaries and the health system, existing socio-cultural factors, and institutional variables (Enisha Sarin et al., 2017). The socio-cultural norms regulating the services of female CHWs have been deemed as essential for the proper execution of their duties (Khan, MH et al. 2006).

Interpersonal barriers encompass interference leading to fear of blame in the event of failure due to delays in accessing healthcare facilities, time constraints, inability to fulfill community needs, or a lack of understanding. All of these may effectively hinder the work of ASHA, who are locally situated women and know the community well. Additionally, ASHA workers might be a target of community members due to Institutional hurdles, which may encompass restricted supplies (Low, L.K., et al. 2006), unnecessary documentation (Javan Parsant, 2009), and inadequate assistance from a rigid and hierarchical healthcare system (Scott, K, 2010).

The role of ASHAs within India’s health system and labor initiatives is deeply intertwined with the political landscape in which they operate.

Their role as informal leaders in the healthcare domain situates them at the crossroads of labor rights, gender politics, and public health. The ASHA workers have contributed significantly to the national agenda of public health initiatives like the National Health Mission (NHM). However, it has been noted that the official label of “volunteers” for the ASHA workers puts them in a vulnerable position regarding monetary compensation, labor rights, and societal recognition (Scott, 2019). The official designation of “volunteers” implies that the monetary compensation of the ASHA workers would be based on performance-based incentives. The denial of a fixed salary package and the uncertainty of receiving regular income contributed to the widespread dissatisfaction among the ASHA workers. It was highlighted that their income often falls below the subsistence level threshold, typically between INR 2000 and 4000 per month (Nandi & Schneider, 2020). Despite their substantial contributions to the public health objective and their tireless work for public services, denying a formal work designation excludes ASHA workers from the protection and benefits of many social security nets like labor laws, health insurance, pensions, and so on.

The gendered demography of the ASHA workforce, which is an all-women collective, essentially implicates them within the broader issues of gender inequality, such as the undervaluation of care work and societal expectations for women to undertake caregiving roles. These narratives of unrecognized labor necessitate them to organize politically and meet the demands of formalizing their work or providing adequate financial compensation (Ved, 2019). Their selfless contributions throughout the horrors of the COVID pandemic justify their demands for the formalization of work, enhanced monetary compensation, legal contracts, and

greater inclusion in the social security systems (Ghosh, 2021).

CHWs in underdeveloped and developing countries are subjected to significant stress stemming from job demands, inadequate remuneration, poverty, gender discrimination, and their position at the lower echelons of systemic hierarchies. These risks are further intensified by circumstances such as a family member’s unemployment, children’s education, a history of mental illness, and marital discord. ASHAs must regulate their emotions in response to job pressures and interact with diverse community members and the health system. They engage with beneficiaries and their families in the combined capacity of an advisor and health care provider, potentially exhibiting a spectrum of emotions, from elation to grief.

Knowledge, Attitude, Encouragement, and Additional Skills of ASHA Workers: Way Forward

Dieleman M. et al. (2003) state, ‘to ensure high-quality healthcare services, it is essential to formulate strategies that enhance employee motivation for improved performance.’ Research suggests that while financial incentives are significant, they are insufficient to enhance employee performance. Various performance management techniques may accomplish this. Further, Dieleman M. et al. (2003) observed in their study that acknowledgment is crucial for healthcare worker supervisors, colleagues, and the community. Mundhra (2010) categorizes motivation as extrinsic and intrinsic motivation. External elements quantifiable in monetary terms, like salary and bonuses, are defined as extrinsic motivation. Intrinsic Motivation manifests via qualities such as interest, enjoyment, preference, and perceived aptitude. Wichita et al. (2007) highlight Motivation, attitude, and aptitude as crucial for good outcomes. The socio-cultural

norms regulating the services of female Community Health Workers have been recognized as essential for the proper execution of their duties (Khan, M.H et al. 2006).

Franco and colleagues (2002) established a conceptual framework for elucidating worker motivation, which this article reflects upon. This framework identifies internal and external elements like self-concept, social influences, organizational systems, and structures. Culture and community may serve as motivating variables in assessing employee motivation. One cannot operate in opposition to the culture that influences one's capacity to execute organizational support frameworks and fundamental procedures (Franco. LM et al., 2002).

Further, the article bases its argument on the NCHA's (National Health and Advisory, 1998) work, whose research indicated that CHWs should possess proficient communication abilities, instructional and presentation skills, advocacy, organizational service coordination, and a comprehensive understanding of the social service system. CHW needs continuous training and supervisory assistance to make practical judgments during crises. Occasionally, healthcare professionals possess the capability to fulfill their duties but may need more drive to exert the necessary effort to complete all essential tasks. Worker motivation denotes an unactualized process that influences behavior's direction, intensity, and persistence (Vroom, 1996). Individual Motivation and sufficient support from executives and coworkers influence employee performance (Mishra, 2014).

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