Medicus Mundi Schweiz
Netzwerk Gesundheit für alle
Réseau Santé pour tous
Network Health for All

MMS Bulletin #162
Community Health Workers - Wegbereiter:innen für Gesundheit für alle

Interrogating the position of ASHAs, the community health workers in India

A cog in the health system or a social activist?

Von Jashodhara Dasgupta, Dipa Sinha und Deepika Joshi

Across the world, Community Health Workers (CHWs) constitute a diverse group of health workers whose common characteristic is their work outside of health facilities directly with people in their homes, neighborhoods, communities, and other nonclinical spaces where health and disease are produced (Perry et al, 2014). The CHWs in India comprise an all-female cadre called the Accredited Social Health Activist (ASHA). ASHAs have been termed 'volunteers' for over 15 years now and the health system refuses to see them as regular workers despite relying on them to bridge the last mile gap in the delivery of health services and information, a role that was substantially expanded during the COVID 19 pandemic. Within the framework of comprehensive primary health care, this article will examine the situation of ASHAs within the health system as well as their accountability to the community they serve, highlighting the inherent duality of their position.

Fight for decent work for India's Anganwadis and ASHAs. Photo: Public Services International/Burhaan Kinu/flickr.com; CC BY-NC 2.0

The ASHA programme in India

One of the crucial elements in the Alma Ata declaration with its focus on Primary Health Care was the role of community health workers in providing Primary Health Care (Abosede et al, 2014; Alma Ata, VII, 9, 1978). The Community Health Workers or 'ASHA' programme in India was started in 2005 with currently about a million ASHAs working across the country. ASHAs play a crucial role within the framework of comprehensive primary health care as they are the first point of contact with the health system for the community. They are women of the community who are always available providing advice, first aid as well as helping people access emergency and referral health care. ASHAs can also be trained to work with a public health perspective where they address social determinants including nutrition, sanitation, gender-based violence etc. Therefore, ASHAs are the cadre who can bring together the two objectives of "people's health in people's hands" and access to universal health care at all levels.

Various studies have talked about how the ASHA programme in India has bridged the last mile gap in the delivery of health information and services. The work of ASHAs has been found to improve institutional delivery (Bhatia, 2014), antenatal care utilization and quality, early initiation of breastfeeding, and infant mortality (Nadella, 2021). The increase in proportion of

villages with an ASHA worker is found to be associated with reduction in unmet need for family planning and increase in child immunization (Wagner, 2018). In the state of Chhattisgarh where the programme is known for relatively better implementation, the ASHA workers, locally known as the *Mitanins*, have been known to mobilize, raise awareness and act on local issues around social determinants of health such as food and nutrition, forests and gender-based violence (Nandi, 2014; Nandi and Garg, 2017).

> *ASHAs have been termed 'volunteers' for over 15 years now and the health system refuses to see them as regular workers despite relying on them to bridge the last mile gap in the delivery of health services and information, a role that was substantially expanded during the COVID 19 pandemic.*
>
> —

However, CHWs in India, as in many countries, being at the "lowest rung of the health care hierarchy" and neglected by national governments, continue to face various issues. Across contexts, CHWs complain of being under-recognised, underpaid, poorly respected and supported by formal health sector players (Kok, 2015; Mishra, 2014; Scott, 2010). Gender biases, lack of power, and discrimination shape the ways in which CHWs are treated (Schaaf, 2020; Steege 2018; George, 2008). Others have pointed out that governments may have been using CHWs to compensate for the overburdened and ill-performing health systems (Haver, 2015) or as a remedy for lack of health system capacity (Schaaf, 2018). In women's provision of this 'community service' we find public policy instrumentalizing the labour of these women to extend their unpaid domestic work and care-giving responsibilities into 'government work', but without any concomitant assurance of formal employment (Dasgupta and Kingra, 2022).

Fight for decent work for India's Anganwadis and ASHAs. Photo: Public Services International/Burhaan Kinu/flickr.com; CC BY-NC 2.0

> *In women's provision of this 'community service' we find public policy instrumentalizing the labour of these women to extend their unpaid domestic work and care-giving responsibilities into 'government work', but without any concomitant assurance of formal employment.*

—

What are the consequences of this "volunteer" status or a lack of formal arrangement with the government? ASHAs in India continue to be poorly paid. According to NRHM (National Rural Health Mission of 2005, currently called the National Health Mission) guidelines ASHA is an 'honorary volunteer', not receiving any fixed salary (except a few states which use the state budget but this amount too is much lower than the minimum wage) (National Health Mission document, undated). Their wages are linked with task-based incentives payments, for example a fixed amount for facilitating institutional delivery or antenatal check-up, where the amount has remained more or less static for about 15 years despite high rates of inflation and several large increases in the salaries of public servants. Meanwhile, since 2005, the number of tasks to be covered by ASHAs has increased from 6 to 43 (Srivastav et al, 2020) in 2019 which is the pre-COVID-19 era. ASHAs for long have been demanding better incentives/ payments as well as 'regularisation' (employment under government which comes with better payment and social security).

> *What are the consequences of this "volunteer" status or a lack of formal arrangement with the government? ASHAs in India continue to be poorly paid. According to NRHM (National Rural Health Mission of 2005, currently called the National Health Mission) guidelines ASHA is an 'honorary volunteer', not receiving any fixed salary (...).*

—

During the COVID-19 pandemic, being the first point of contact, ASHAs played and have been playing a crucial role in supporting the health systems including spreading awareness on COVID-19 safety practices, tracing and monitoring incoming migrants, conducting door-to-door screening, doing community surveillance, tracing contacts and managing and supporting quarantine centres as well as providing referral for COVID testing (Dasgupta and Kingra, 2022). Later they have played a role in the awareness-raising, community mobilization and local-level management of the national Covid vaccination programme (Dasgupta and Kingra, 2022).

This, however, came along with many problems and hurdles. Their incentives have been low and they have not been properly compensated during the pandemic despite the risks (Rao, 2020) while they have had to face longer working hours and poor working conditions (Dhaliwal, 2021; Sinha 2021). Along with other health care workers, they have been facing issues like shortages of PPE (Personal Protective Equipment) and increased risk of infections (Godlee, 2020; Amnesty International India 2020; Sinha, 2021), violence (Rao and Tewari, 2020; Majumder, 2020), mental health issues and even stigmatization and ostracization (Rao and Tewari, 2020; Menon, 2020; Dhaliwal, 2021). To resist this, Community Health workers (along with other health workers) in many countries have also been protesting against this situation (Rao, 2020; Amnesty International India, 2020; Chitlangia 2020; Sinha, 2021).

Wall writings for awareness building facilitated by the ASHA programme in Kabirdham, Chhattisgarh. Photo: © Deepika Joshi

Duality of the role of the ASHA

While the role of the ASHAs was more oriented towards being the 'activist' who represented people's health needs while also helping them take control over their own health, over time it has been seen that her role has become more of a service provider. The health system has sought to use the ASHAs to fill the gaps in delivery of services that arose because of inadequate health staff in the primary health care centers and sub-centres. Therefore, ASHAs' tasks have been expanding with more clinical tasks such as distributing medicines, conducting tests and so on. A major task that the ASHAs carry out is record-keeping - records related to births, deaths, communicable and non-communicable diseases, immunisation and more. ASHA is now seen by both the health system and the community as a last mile health provider - a representative of the state in the community rather than a representative of the community within the state.

> *While the role of the ASHAs was more oriented towards being the 'activist' who represented people's health needs while also helping them take control over their own health, over time it has been seen that her role has become more of a service provider.*
>
> —

As a result, the accountability of the ASHAs are also now primarily to their superiors in the health department rather than to the community they serve. It has been found that this adds to the vulnerable position of the ASHAs as they are in the lowest rungs of the hierarchy with no job security and therefore can be ordered around by everyone. Many ASHAs across the country complain about the poor treatment meted out to them by the ANMs (Auxiliary Nurse Midwife) (1) who they directly report to - often the ANMs pass on their work to the ASHAs and threaten them with disciplinary action if they are questioned. This situation could have been addressed if there were a sufficient number of ASHA supervisors, who were supposed to provide supportive supervision to the ASHAs - but this is not the case in most parts of the country. In one of the states (Chhattisgarh) where there is a separate organisation, the State Health Resource Centre (SHRC), which provides the training and supervision to the ASHAs, it is seen that they are able to provide better support and also to an extent then maintain the activist-role of the ASHA.

Conclusions

Our recommendations/thoughts on regularization of ASHAs begin with a caveat that it is the ASHA workers themselves who decide and negotiate their terms of employment with the government, in terms of regularization, contractualisation and so forth.

The duality of the activist-health worker role and the accountability to community vs state overlaps with the volunteer-regular workers' role. Governments/state would be reluctant to regularise health workers under its payroll if their role is that of an activist answerable to the community and demanding accountability from the state for gaps in health services, food entitlements, employment wages and so forth. There appears to be an added fear that should ASHAs be regularised as 'government workers', they would be even less accountable to the community. The question of how they can remain answerable to the community while they are assured better working conditions is a pertinent one. Systems such as incentive-based payments and lack of recognition as employees, do not automatically make the ASHAs accountable to the community. At best, these are ways for the health system to have a tight-leash on them. Systems for accountability to the community need to be put in place, which can be quite independent of working conditions (just as these are required for better paid positions such as school teachers).

> *The question of how they can remain answerable to the community while they are assured better working conditions is a pertinent one.*

—

Mitanin conducting Malaria test through a rapid test kit in Kabirdham, Chhattisgarh. Photo: © Deepika Joshi

An optimal option would be to have ASHAs made formally accountable to local institutions such as the village health, nutrition and sanitation committees (VHSNCs) which are currently not very effective. For this, the VHSNCs need to be empowered by being given greater control over the three Fs (funds, functions and functionaries). In the case of ASHAs, there can be mechanisms in place where the community through the VHSNC certifies her work each month, holds her accountable to the village health plan and so on. Other than wages, the power to terminate one's employment also determines the power differential between ASHA and state. In states like Chhattisgarh (where too they are considered volunteers),

Mitanins/ASHAs can only be removed from their work by the hamlet/community (which also selects them) and not by the government or SHRC. This, to some extent determines that the accountability of ASHAs remains towards the community rather than the state.

In order to bridge the inherent duality of their position, these volunteers should be treated as workers in the health system and in public service, as critical elements of the health workforce. An issue requiring urgent attention is the improvement of the working conditions, including wages, and representation of rights of workers in essential care services (ILO, 2020) Related to this would be regular contracts, living wages for their skilled care work, social security and protection, and opportunities for growth, promotion and up-skilling (Dasgupta and Kingra, 2022). Alongside this, there should be strong policy and institutional support to ensure that they have safe and enabling working conditions, be it freedom from violence and harassment, the access to grievance redressal mechanisms or the right to organize and have a seat at relevant decision-making fora (Dasgupta and Kingra, 2022).

Footnote

1. Auxiliary Nurse Midwife (ANM), a peripheral health functionary just above the ASHA workers in the hierarchy of the health System.

References

- Abosede, O.A. and Sholeye, O.F., 2014. Strengthening the foundation for sustainable primary health care services in Nigeria. *Primary Health Care: Open Access*, *4*(3), pp.1-9. https://www.iomcworld.org/open-access/strengthenin...
- Amnesty International India, 2020. *The Women Warriors Fighting COVID-19 At The Frontline: ASHA Workers Left Without Hope*. Amnesty International India. https://amnesty-indien.de/2020/05/the-women-warriors-fighting-covid-19-at-the-frontline/
- Bhatia, K., 2014. Community health worker programs in India: a rights-based review. *Perspectives in public health*, *134*(5), pp.276-282. https://www.researchgate.net/publication/265175277...
- Chitlangia, R, 2020. Asha workers on Covid-19 duty demand timely, better wages. 19 April 2020. *Hindustan Times.* https://www.hindustantimes.com/delhi-news/asha-workers-on-covid-19-duty-demand-timely-better-wages/story-x3g8ewZPlDzFe89ceNhu8J.html
- Dasgupta, J. and Kingra, K.J., 2022. Women Workers at the Forefront of COVID-19: A Roadmap for Recovery and Resilience in India. In *The Political Economy of Post-COVID Life and Work in the Global South: Pandemic and Precarity* (pp. 105-131). Palgrave Macmillan, Cham. https://link.springer.com/chapter/10.1007/978-3-03...
- Dhaliwal, B.K., Singh, S., Sullivan, L., Banerjee, P., Seth, R., Sengupta, P., Bhattacharjee, I., Mehta, K., Reddy, K.S. and Shet, A., 2021. Love, labor and loss on the frontlines: India's community health workers straddle life and the COVID-19 pandemic. *Journal of Global Health*, *11*. Available at: https://jogh.org/2021/jogh-11-03107

- George, A.J.G.P.H., 2008. Nurses, community health workers, and home carers: gendered human resources compensating for skewed health systems. *Global Public Health*, *3*(S1), pp.75-89. https://www.tandfonline.com/doi/abs/10.1080/174416...
- Godlee, F., 2020. Protect our healthcare workers. *British Medical Journal* Available at: https://www.bmj.com/content/369/bmj.m1324/rr-4
- Haver, J., Brieger, W., Zoungrana, J., Ansari, N. and Kagoma, J., 2015. Experiences engaging community health workers to provide maternal and newborn health services: implementation of four programs. *International Journal of Gynecology & Obstetrics*, *130*, pp.S32-S39. Available at: https://www.sciencedirect.com/science/article/pii/S0020729215001356
- ILO, 2020. The COVID-19 response: Getting gender equality right for a better future for women at work. International Labour Organization. Geneva https://www.ilo.org/wcmsp5/groups/public/---dgrepo...
- Kok, M.C., Kea, A.Z., Datiko, D.G., Broerse, J.E., Dieleman, M., Taegtmeyer, M. and Tulloch, O., 2015. A qualitative assessment of health extension workers' relationships with the community and health sector in Ethiopia: opportunities for enhancing maternal health performance. *Human resources for health*, *13*(1), pp.1-12. https://human-resources-health.biomedcentral.com/a...
- Majumder, M, 2020. It's Time to Recognise that Govt Plans Are Oblivious to the Realities of Care Workers. 29 April 2020. *The Wire*. https://thewire.in/rights/covid-19-asha-anganwadi-workers-nurses
- Menon, V., Padhy, S.K. and Pattnaik, J.I., 2020. Stigma and aggression against health care workers in India amidst COVID-19 times: Possible drivers and mitigation strategies. *Indian Journal of Psychological Medicine*, *42*(4), pp.400-401. Available at: https://journals.sagepub.com/doi/10.1177/0253717620929241
- Mishra, A., 2014. 'Trust and teamwork matter': community health workers' experiences in integrated service delivery in India. *Global public health*, *9*(8), pp.960-974. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC41669...
- Nadella, P., Subramanian, S.V. and Roman-Urrestarazu, A., 2021. The impact of community health workers on antenatal and infant health in India: A cross-sectional study. *SSM-Population Health*, *15*, p.100872. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC83195...
- Nandi, S. and Garg, S., 2017. Indigenous women's struggles to oppose state-sponsored deforestation in Chhattisgarh, India. *Gender & Development*, *25*(3), pp.387-403. https://www.researchgate.net/profile/Sulakshana-Na...
- Nandi, S. and Schneider, H., 2014. Addressing the social determinants of health: a case study from the Mitanin (community health worker) programme in India. *Health policy and planning*, *29* (suppl_2), pp.ii71-ii81. https://watermark.silverchair.com/czu074.pdf?token...
- National Health Mission. Guidelines on Accredited Social Health Activists (ASHA). Available at - https://nhm.gov.in/images/pdf/communitisation/task-group-reports/guidelines-on-asha.pdf (last seen on 20 May 2022)
- Perry, H.B., Zulliger, R. and Rogers, M.M., 2014. Community health workers in low-, middle-, and high-income countries: an overview of their history, recent evolution, and current

effectiveness. *Annual review of public health*, *35*, pp.399-421. https://www.annualreviews.org/doi/10.1146/annurev-...

- Rao, B and Tewari, S, 2020. Anger, Distress Among India's Frontline Workers In Fight Against Covid-19. *Article 14*. June 2020. https://www.article-14.com/post/anger-distress-among-india-s-frontline-workers-in-fight-against-covid-19
- Rao, B, 2020. Promised, Mostly Never Paid: Rs 1,000 Covid Wage To Million Health Workers. *ARTICLE14*. June 2020. https://www.behanbox.com/promised-mostly-never-paid-rs-1000-covid-wage-to-million-health-workers/
- Schaaf, M., Fox, J., Topp, S.M., Warthin, C., Freedman, L.P., Robinson, R.S., Thiagarajan, S.,Scott, K., Maboe, T., Zanchetta, M. and Ruano, A.L., 2018. Community health workers and accountability: reflections from an international "think-in". *International journal for equity in health*, *17*(1), pp.1-5. https://equityhealthj.biomedcentral.com/articles/1...
- Scott, K. and Shanker, S., 2010. Tying their hands? Institutional obstacles to the success of the ASHA community health worker programme in rural north India. *AIDS care*, *22*(sup2), pp.1606-1612. https://www.tandfonline.com/doi/abs/10.1080/095401...
- Sinha, Dipa, 2021. India's community health workers' struggle for recognition. RoarMag. Available at: https://roarmag.org/essays/india-community-health-worker-struggle
- Srivastav, N, Priya, A, Hathi, P, 2020. Our Essential Workers Need Essential Care. *Economic & Political Weekly*. August 1, 2020 vol 55 no 31:15-16 https://www.epw.in/journal/2020/31/commentary/our-...
- Steege, R., Taegtmeyer, M., McCollum, R., Hawkins, K., Ormel, H., Kok, M., Rashid, S., Otiso, L., Sidat, M., Chikaphupha, K. and Datiko, D.G., 2018. How do gender relations affect the working lives of close to community health service providers? Empirical research, a review and conceptual framework. *Social Science & Medicine*, *209*, pp.1-13. https://www.sciencedirect.com/science/article/pii/...
- Wagner, A.L., Porth, J.M., Bettampadi, D. and Boulton, M.L., 2018. Have community health workers increased the delivery of maternal and child healthcare in India? *Journal of Public Health*, *40*(2), pp.e164-e170. https://academic.oup.com/jpubhealth/article/40/2/e...
- World Health Organization, 1978. *Declaration of alma-ata* (No. WHO/EURO: 1978-3938-43697-61471). World Health Organization. Regional Office for Europe. Available at: https://apps.who.int/iris/handle/10665/347879

Jashodhara Dasgupta *is an independent feminist researcher on gender, rights and public health. She has worked on issues of rural communities for over 30 years with several feminist organizations and networks and has served on many academic and public policy committees. She is associated with the People's Health Movement, the Right to Food Campaign India and the Feminist Policy Collective. Email*

Dipa Sinha *teaches Economics at the School of Liberal Studies, Ambedkar University Delhi. She works on issues related to public health, food security, gender and social policy.*

She is associated with the Right to Food Campaign India and the Feminist Policy Collective. Email

***Deepika Joshi** has been working in Chhattisgarh on health systems, social determinants of health, food security and forest rights through research, advocacy and community engagement. She is a member of the People's Health Movement, Right to Food Campaign and People's Union for Civil Liberties, Chhattisgarh. Email*

Kontakt

Deutschschweiz
Medicus Mundi Schweiz
Murbacherstrasse 34
CH-4056 Basel
Tel. +41 61 383 18 10
info@medicusmundi.ch

Suisse romande
Route de Ferney 150
CP 2100
CH-1211 Genève 2
Tél. +41 22 920 08 08
contact@medicusmundi.ch