Anveshi
RESEARCH CENTRE FOR WOMEN'S STUDIES
Tenth Anniversary Edition

ISSN 2278-3423

Broadsheet on Contemporary Politics

State Capital Nexus: Implications for Labour

No. 15 *Bilingual (English and Telugu)* *March 2021* *Donation : Rs. 25/-*

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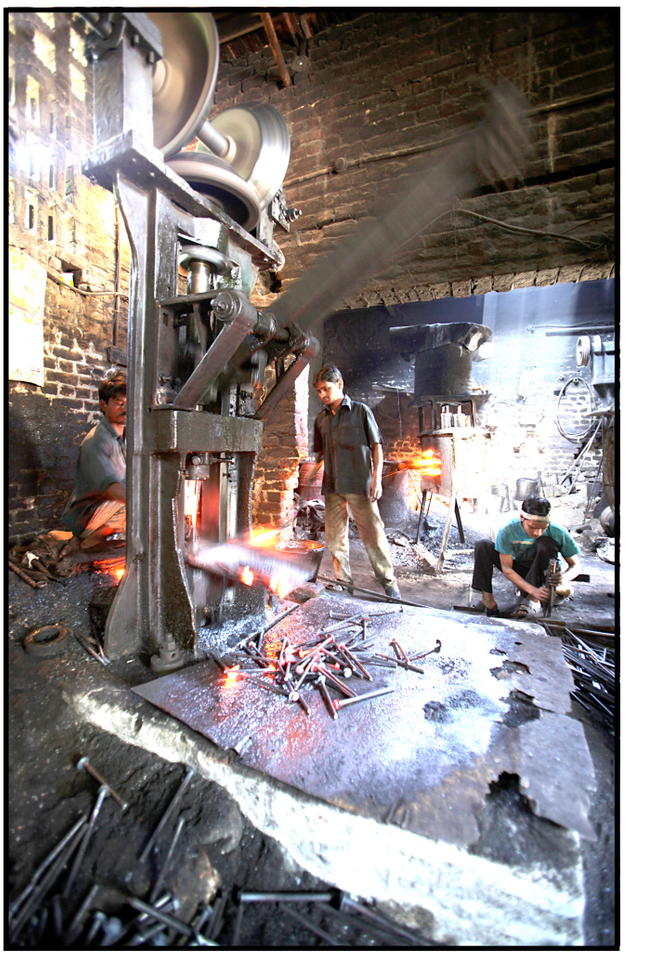

Workers in Indian Factory. (iStock Photo: track5)

Published by: Anveshi Research Centre for Women's Studies, H.No. 1-2-16/11, Block-B, Street No.1,Habsiguda,Hyderabad–500 007

ASHA- the Bearer of Hopes for Others but not Herself!

■ **S. Ramanathan and Vasudha Chakravarthy**

The National Rural Health Mission (NRHM) started in 2005 was meant to be an "architectural change" to ensure the primacy of the public health system. It promised an increase in health expenditure. It also foregrounded the role of the community in health programs[1]. The engagement of all-female Accredited Social Health Activist (ASHA) was a part of this. The NRHM was perhaps a reaction to the neoliberal ideology, rooted in the Indian development paradigm since 1991[2]. However, over the years, the influence of the neo-liberal ideology increased. The public health expenditure hardly increased[3] , and efforts at privatisation increased.

In this context, this paper explores the status of ASHA in the health system, and its impact on her, more so, during Covid-19. It also explores if her engagement has fragmented the health and nutrition services delivery, thus, limiting the workplace bargaining by other women frontline workers.

Part of the data for this paper is from a rapid assessment in five states, during the Covid-19, by the authors.

The Status of ASHA and its implications on her work and personal life.

The ASHAs are activists who interface between the community and the health system. They are chosen "through a rigorous process of selection"[4] involving various community groups, institutions, and health officials. While how she is selected is known, it is not clear who engages her. Over the years, her role has evolved, and she is now responsible for technical and community health care functions[5]. ASHA nearly does everything at the frontlines of health[6] [7]. She is nearly the extension of the formal health system at the community level[8].

For her various tasks, she is incentivised. Over time, the number of tasks incentivised has steadily increased from six in 2005 to 38 in 2017[9]. ASHA is primarily incentivised for the outputs such as institutional delivery and less for the processes[10]. Other than ASHA, no one in the health system is paid based on performance. The incentivisation of ASHA is an effort to use market principles in public health and monetise health services. The incentives are also a reflection of the health system priorities. While the incentive for sterilization is Rs 1000, the case detection of leprosy is Rs 250.

To earn her incentive for say institutional birth, ASHA will have to persuade and/or accompany a mother. In other words, to earn an incentive, the ASHAs may have to work variable and long hours. Thus, while potentially, she can earn incentives for several tasks, she, at best, can complete only a few routine tasks, limiting her earnings. There are reports of ASHAs chasing bigger incentives than the lesser ones. Most ASHAs, on average, receive monthly incentives of Rs. 3000-4000, for routine and recurrent activities[11]. Often, these are delayed.

That ASHAs work within deeply patriarchal systems also has its implications. They must balance domestic and professional responsibilities [12] [13], are discouraged and belittled by their communities, and often held accountable for health system failure[14] [15]. They face sexual harassment by other health workers and community members[16].

The ASHAs are thus under constant pressure – at a (i) personal level, to balance domestic and professional responsibilities, while also seeking to earn as much as feasible[17], (ii) community level, to ensure that relationships are maintained, and persons access services, and, (iii) health system level, to ensure that they fulfill their responsibilities and meet the desired outputs. The absence of a regular income, delays in receipt of incentives, lack of job security and career progression, and lack of adequate social support and grievance redressal mechanisms, all add to the pressure on the ASHAs.

The pressure of Covid-19 on the ASHA

These pressures increased during the current Covid-19 pandemic. Also, they got limited support from the health system.

In almost all states, ASHAs were engaged in the community-based response. Their roles ranged from undertaking community surveillance and surveys, accompanying suspect cases to health facilities, visits, and follow-ups with any positive or symptomatic

ANM
Monitoring and collation of surveys and assessments done by the ASHA
Enabling treatment and care to suspect and confirmed cases
Provision of routine/essential health care - at the health facilities

Aanganwadi worker
Distribution of ration to pregnant and lactating women, children, vulnerable families, pensioners and widows
In some states-support with community kitchens for elderly and destitute

ASHA
Door to door surveillance and survey - to gather information on suspect cases Survey of migrant labor
Counselling of migrants/others to test for Covid-19
Home visits to monitor those under home quarantine
Awareness on Covid 19
Gather information on any issues related to pregnancies, immunizations and other serious illnesses.
Provide post-natal and home-based newborn care services; accompany women to hospitals.

Figure1: Role of frontline workers in the Covid-19 pandemic response

cases, support with the establishment of local quarantine facilities, and enabling information and awareness on the disease. Among the three frontline workers, it is the ASHAs who have the most diversified role in this pandemic response. The Anganwadi workers and ANMs, who are employed by the nutrition and health systems, have more defined roles in enabling access to nutrition and primary healthcare, respectively (see Figure 1[18]).

There is primary reliance on the ASHAs, to lead and enable the Covid-19 response at a community level. They were often motivated to perform a 'noble' role for the country and the community, reflective of the gendered differentiation of work[19]. And, despite being not part of the system, and not being incentivized, at least in the early stages, ASHAs were in no position to refuse this.

While the ASHAs have been working on the Covid-19 response since February 2020, it was only in April 2020, after the media highlighted their concerns, the Ministry of Health directed the states to pay an additional incentive of Rs. 1000 per month from January 1 to June 30, 2020. This translates to Rs. 30 per day for the ASHAs to undertake their tasks in a potentially life-threatening environment.

The challenges, pressures, and struggles of the ASHA's, during the Covid-19 pandemic, as articulated by them[20] are as follows:

Working in a hostile environment – *"The pandemic has led to a state of fear and distrust among communities"* said an ASHA, leading to non-cooperation and abusive behavior. Instances of verbal abuse when the ASHAs undertake surveillance, refusal to share information, and non-adherence to advice were reported. In some states, ASHAs said that community members were not allowing them even to enter their houses, owing to fear of virus transmission!

"*When we undertake surveillance and ask people if they are experiencing any symptoms; they abuse us and ask us why we come every day to ask for the same information*" – ASHA, UP

"*Even people who know us well, do not let us come into their homes. How do we provide them information on the virus and how do we monitor their behaviors when we cannot even talk to them properly*" – ASHA, Bihar. In some instances, ASHAs faced hostilities from their families as well. Not all families were comfortable with the tasks they were undertaking and the risk to which they were putting themselves and their families.

"*The elders in our family berate us, saying that we may infect them"* – ASHA, Jharkhand.

Lack of safety and personal protective equipment (PPE) – The tasks performed by ASHAs were categorized as low risk[21] , and they were recommended to use triple-layer masks and gloves as PPE. Approximately 50 percent of frontline workers surveyed in five states reported receiving PPE [22]. Differential availability and distribution of PPE was reported, with priority being given to ANMs and those in health facilities and check-posts. Insufficient quantity and irregular supplies were the challenges. ASHAs reported that they had begun using home-made masks, or dupattas/ scarves/ handkerchiefs to cover their face.

"We were given masks once earlier; now we have our home-made masks. We don't have any gloves or sanitizer" - ASHA, Odisha.

"We have been given soaps and not sanitizers. How are we expected to use soap after every house visit, when people don't even let us come in?" - ASHA, Uttar Pradesh.

"We are working in the field without any safety gear or masks. We have bought the sanitizer for our safety. The least the Government can do is provide us with such basic amenities."- ASHA, Bihar.

Workload and role management – ASHAs said that they were overworked, managing the Covid-19 response and following up with routine cases of pregnancy, childcare, and emergencies if any. Multiple orders and their revisions added to the confusion, leading to a lack of role clarity, and the services to be provided. Besides, they had to manage and balance their domestic responsibilities, as well.

Delay in receipt of incentives – 87 percent of the ASHAs surveyed in Jharkhand, 30 percent in Uttar Pradesh, 89 percent in Rajasthan, and 45 percent in Bihar reported not having received their incentives and dues for the month preceding the survey (April 2020). While delays in receipt of incentives are almost the norm, in the current economic crisis, its consequences were dire.

ASHAs, across states, reported suffering from stress and anxiety stemming from the roles they undertook, with limited resources and support[23]. They were concerned about the risk they were putting themselves, their families, and especially their children. Despite their anxieties, they had to engage with and manage hostile communities in some instances; without necessarily knowing how to do so. The health system expected them to undertake these tasks, and in some instances, taunted[24]if they expressed concerns. Many said that they felt a sense of loss of dignity and respect!

"I stay and sleep away from my husband, children, and family, in a separate space. While it is difficult to do so, I do not want to risk them" – ASHA, Jharkhand.

Fragmentation of health and nutrition services delivery and antagonism among frontline workers

As mentioned above, engaging ASHAs was a part of the efforts to ensure that the community was "involved" in health care management. However, engaging 0.9 million informal ASHA workers helped dual purposes- it increased the workforce without a substantial increase in the wage bill.

The engagement of ASHAs also fragmented the health and nutrition services delivery. Before her engagement, ANM was dependent on Anganwadi workers (AWWs) for community outreach. With the gradual expansion in the role of ASHAs, the relevance of ANMs and Anganwadi workers, has, to an extent, minimized. It has led to antagonism between the frontline workers. A survey in Madhya Pradesh reported that 36 percent of the ASHAs said that AWWs did not cooperate, 35 percent reported that AWWs took away the JSY cases without informing them. The survey also mentioned that the ANMs resented the incentives paid to ASHAs and did not certify the payments[25]. An ethnographic study in Rajasthan also documents the complex relationship between ANM and ASHA, with the power more vesting in the former. Between ASHAs and AWWs, who often are from the same village, there are instances of jealousy due to earnings[26].

ASHAs and AWWs are both informal workers. While ASHAs are incentivised, AWWs are paid an honorarium. By fragmenting the health and nutrition delivery, the State has perhaps ensured their continued informalisation. The antagonism between the two, may perhaps, also ensure that they do not combine for their rights. The ANM is a part of the formal workforce. However, with ASHA gradually being made to undertake many tasks, the bargaining power of ANM may have considerably reduced.

Conclusion

Engaging ASHA was part of the effort to make the community responsible for health care services. However, by keeping its accountability opaque, the health system has been extracting the labour of ASHAs to meet its needs at a very low cost. This extraction was starkly evident during the Covid-19 pandemic, where the ASHAs were pushed into the frontlines to manage it. Both in normal times and during the pandemic, the State has extracted a heavy price from the ASHAs. Besides, by engaging her, it perhaps also fragmented the health and nutrition services delivery, thus ensuring that roughly 3.3 million women workers (0.9 million ASHA, 1.28 million AWWs, and 1.16 helpers) would continue to be informal workers. Their informal status serves the State the dual purpose of reaching services to the lowest level at the least cost. However, while the State saves, the cost is borne by the women workers. The ASHAs, for instance, bear the burden of negotiating with their families, peers, communities, and superiors to earn their incentives. The cost that they incur in the process can perhaps never equal the incentives that they earn.

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Notes and References

1. The formation of village health and nutrition committees and community monitoring are evidence of this foregrounding.

2. See Baru. R and Mohan. M. *Globalisation and neoliberalism as structural drivers of health inequities. Health Research Policy and Systems* 2018, 16(Suppl 1). https://health-policy-systems.biomedcentral.com/track/pdf/10.1186/s12961-018-0365-2 (accessed on July 4, 2020).

3. See Sengupta, Amit. The health budget and neoliberal ideology. May 2013. https://www.newsclick.in/india/health-budget-and-neoliberal-ideology (accessed on July 5, 2020).

4. Selected from the village itself and accountable to it, the ASHA will be trained to work as an interface between the community and the public health system. See About Accredited Social Health Activist (ASHA) https://nhm.gov.in/index1.php?lang=1&level=1&sublinkid=150&lid=226 (accessed on June 19, 2020).

5. About Accredited Social Health Activist (ASHA), National Health Mission; https://nhm.gov.in/index1.php?lang=1&level=1&sublinkid=150&lid=226, accessed on June 22, 2020

6. As of January 2019, the ASHAs support health programs on maternal, child, and adolescent health, family planning, tuberculosis, leprosy, vector-borne diseases, non-communicable diseases, comprehensive primary healthcare, and drinking water and sanitation. Also, they are expected to conduct community engagement activities and participate in meetings at the village and block levels.

7. See also the update on the ASHA Program, National Health Systems Resource Centre, January 2019; http://nhsrcindia.org/sites/default/files/Update%20on%20ASHA%20Programme_2019_for%20Web.pdf, accessed on June 23, 2020

8. See also Roalkvam. S. Health governance in India: Citizenship as situated practice. Global Public Health. September 2014. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4166913/ (accessed on July 3, 2020).

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16. Ibid

17. See also Padmini. S. The formal creation of informality and therefore, gender injustice: Illustrations from India's social sector. *Indian Journal of Labour Economics*. Volume 8. No.1. 2015.

18. This was the pattern observed in the five states that were surveyed. However, from the newspaper reports and other sources, it appears that this is largely the pattern across states.

19. See ILO. 2017. Improving Employment and Working Conditions in Health Services: Report for discussion at the Tripartite Meeting on Improving Employment and Working Conditions in Health Services, Geneva.

20. The rapid assessment in five states (Bihar, Jharkhand, Odisha, Rajasthan, and Uttar Pradesh) on access to health and nutrition services in rural contexts, was undertaken by Development Solutions, with support from Population Foundation of India.

21. MoHFW, Novel Coronavirus Disease 2019 (COVID-19): Guideline on rational use of Personal protective Equipment, issued on March 24, 2020

22. Ibid (xv)

23. Ibid (xv)

24. This is reminiscent of what happened during Ebola pandemic in 2014 in West Africa. see ILO 2017. Op.cit.

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26. See Gjostein D K. Negotiating conflicting roles: Female community health workers in rural Rajasthan. A perspective on the Indian ASHA programme. Thesis submitted for Master of Arts. University of Oslo. 2012. https://www.duo.uio.no/bitstream/handle/10852/16278/MASTERxDKGJOSTEIN2012.pdf?sequence=1&isAllowed=y