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Review Article

ASHA - World's Largest All-female Frontline Community Health Worker: Features and Challenges

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A B S T R A C T

India accounts for the second-highest number of maternal deaths all over the world. India has shown a remarkable decline in MMR (Maternal Mortality Ratio) during the last two decades. According to the SRS (Sample Registration System), MMR dropped from more than 556 per 100,000 in 1990 to 113 in 2018 and the proportion of deliveries attended by skilled health personnel has increased from 58% in the 1990s to 81% in 2019. In the year 2005, the Government of India launched the National Rural Health Mission (NRHM) with the purpose of improving the existing health facilities provided to the community with a special focus on the poor and vulnerable states and societies. NRHM identified ASHA (Accredited Social Health Activist), a voluntary community health worker, to provide services to the community on incentives. ASHA workers are the female health workers who have hailed from the same community where they serve. An ASHA worker acts as a link person between the health system and the community. At present, ASHA services are utilised in a number of programmes including maternal and child health, Various studies have extensively documented about ASHAs dissatisfaction with their pay and workload. ASHA services are widely accepted by societies, especially the poor, but issues like sexual harassment, violence, unsafe working conditions, and cast discrimination were also reported.

ASHA programme plays a critical role in implementing Government health programmes, especially on MCH. Therefore keeping the ASHA updated and motivated is very important for performing her duties efficiently and effectively.

Keywords: ASHA, National Rural Health Mission, Female Frontline Community Health Worker, Features, Challenges

Introduction

NRHM (National Rural Health Mission) was launched in 2005 by the Government of India for providing primary health care with the purpose of improving accessibility, availability, and acceptability of the existing health facilities to the community with a special focus on the poor and

vulnerable sections. NRHM identified one ASHA (Accredited Social Health Activist) per 1000 population in the rural areas as a Community Health Worker (CHW).

Background

Despite advances in the healthcare system, pregnancy and childbirth remain a risky period for women. Worldwide, India accounts for the second-highest number of maternal deaths. India has shown a remarkable decrease in MMR (Maternal Mortality Ratio) during the last two decades. According to the SRS (Sample Registration System), MMR dropped from more than 556 per 100 000 in the 1990s to 122 in 217 (Figure 1) and 113 in 2018[1] and the proportion of deliveries attended by skilled health personnel has increased from 58% in the 1990s to 81% in 2019.[2] According to the SDGs (Sustainable Development Goals) of the UN, the global target is to bring down MMR below 70 per 100 000 live births by 2030.

Many women in India die due to direct complications in pregnancy and delivery. Most of such complications are preventable or treatable. The major complications that cause about 75% of deaths of mothers are severe post-partum haemorrhage, high blood pressure, complications from delivery, infections and unsafe abortions. The solutions for these complications are well known. Women just need access to good quality care during pregnancy, childbirth and puerperium.[3,4]

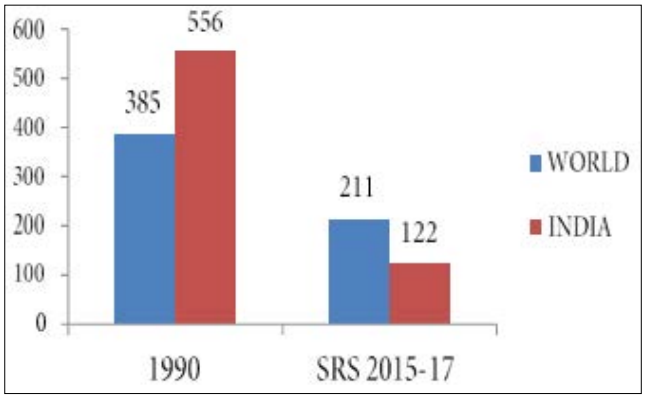

Figure 1. Trends in Maternal Mortality[4]

The launching of NRHM and ASHA programme was a cornerstone[5] in improving the utilisation of health care facilities by women especially the poor. After launching NRHM, a number of programmes were implemented for improving maternal and child health, including the Janani Suraksha Yojana (JSY) in 2005. JSY has been implemented in all states in India, with a special focus on some states with low institutional deliveries. These states are known as low-performing states (LPS). JSY provides cash incentives to the mothers and ASHA workers for institutional deliveries. JSY also makes available quality antenatal and postnatal services, referral services and transport services.[6]

Features of ASHA Programme

ASHA workers are female volunteer health workers at the grass-root level.[7] They act as link persons between the health system and the community. It is expected of ASHAs to generate awareness on health-related factors, mobilise the community for health planning, and aid in the utilisation of the available health services.

History shows that Community Health Workers (CHW) were utilised to provide priority services and to mitigate the shortage of medical staff in the rural areas of low- and middle-income countries.[8] China had adopted the concept of CHW in 1952. They were called barefoot doctors, but as a result of structural reforms (1978), the community health work system of China suffered from low-quality healthcare services by uneducated and poorly trained health providers. On the other hand, Iran had given a thorough two-year, in-depth training programme to CHWs which resulted in positive health outcomes including decreased maternal mortality.[9]

ASHA can be considered as a community health worker. According to WHO, CHW should be a member of the communities where they work. They should be selected by the communities, and supported by the health care system but they need not necessarily be a part of its organisation and have shorter training compared to professional workers.[8] ASHA is a trained woman resident of the community. She is selected by the community and functions to improve the health status of the people of her own village. An ASHA worker has a minimum of 8 years of school education and receives an initial training of 23 days. Her job responsibilities include functioning as a link-worker (between healthcare facilities and people), conducting home visits, conducting meetings, maintaining records, facilitating outreach services like depot-holder for selected essential medicines and treatment of minor ailments, creating health awareness, and mobilising the community. ASHAs are present in India at a ratio of one per 1000 rural population. They are also selected in marginalised urban population.[5,9]

'Married/ widow/ divorced' women, preferably between the age group of 25 to 45 years are selected as ASHA.[10] A female volunteer cadre of CHW was found appropriate as ASHA because maternal and child health are female areas and female CHWs can meet women's health needs in a better and more culturally appropriate manner. ASHAs are volunteers for specific tasks on small incentives, who help to provide the best services to the people in an affordable and sustainable manner.[5]

ASHA programme created opportunities for women empowerment in rural communities and they are role models for many rural women.[11] Also, it is ensured that they

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are able to receive training close to their villages, which helps to increase the likelihood of attending the training. ASHA is the member secretary of village health committees. This helps in developing leadership quality in them beyond the feminised-sphere of activities.[12] To improve ASHA's skills and growth, the Government has implemented residential training programmes which provide crèche facilities.[13]

Social Security Measures

Social security measures for ASHA were also introduced for availing pensions and health insurance. The Cabinet Committee on Economic Affairs has approved a new ASHA Benefit Package from 2018. With this, all eligible ASHAs and their facilitators are enrolled in social security schemes: Pradhan Mantri Jeevan Jyoti Bima Yojana and Pradhan Mantri Suraksha Bima Yojana. The Government is paying the premium for these schemes. Also, the amount of routine and recurring incentives increased from INR 1000 to INR 2000 per month.[14] A pension of INR 3000 is provided per month under Pradhan Mantri Shram Yogi Maandhan (PM-SYM) after 60 years of age (50% contribution by beneficiaries).[15] The Government encourages ASHAs by helping them complete secondary school through the open school and enrolling eligible ASHAs in ANM schools.[16]

Considering their contribution in the management of COVID-19 pandemic related works, it was advised to the states to provide an additional incentive of INR 1000 per month to them. ASHAs are also eligible for an amount of INR 50.00 Lakhs under the Pradhan Mantri Garib Kalyan Package (insurance scheme for all health workers), in case of loss of life while being on COVID-19 duty.[15]

The tasks performed by ASHAs and the performance linked incentives have increased. By 2019, there were about 40 nationally approved performance-based incentives, which varied across states. The incentives for recurring activities increased from INR 1000 per month to INR 2000 per month in 2018.[17] In addition, there are some recurring monthly activities, that would help ASHAs to get a predictable monthly income, that in some way, may simulate a salary.[17] ASHA payments are now changed to bank transfers from cash payments.[18]

Utilisation of ASHA Services and Challenges

According to the NHM report in September 2019, 1047324 ASHAs were engaged in service. At present, ASHA services are utilised in a number of programmes including maternal health, child health, family planning, adolescent health, mobilising the community by conducting and attending various meetings, DOTS programme, National Leprosy Eradication Programme, National Vector Borne Disease Control Programme (malaria, filariasis, encephalitis syndrome/ Japanese Encephalitis) and Kala Azar elimination. Dengue and chikungunya, National Iodine Deficiency Disorders Control Programme, drinking water and sanitation, screening and follow up of some non-communicable diseases etc.[19]

Several kinds of research have been done related to ASHA services, especially related to MCH services. Farah N Fathima in 2018 found that more than 80% of ASHAs are doing home visits, ANC counselling, escort services for delivery, managing minor ailments, participating in DOTS for tuberculosis patients and organising village meetings for health action. About 60% of women who had institutional delivery was a result of the motivation by the ASHA.[9]

A study by Garg et al. (2013) in rural Haryana found that 100% of ASHAs helped in immunisation, 98% accompanied delivery cases, 96.40% helped in family planning, and 17% in birth and death registration.[20] Bhattacharya H et al. (2013) found that ASHA service utilisation by pregnant women was 89.7%. The pregnancy registration rate was 95% among the sample and 90% of these registrations were helped by ASHA. The study also found that the majority got benefited from ASHA services for antenatal check-ups, iron and folic acid prophylaxis, laboratory tests, and JSY utilisation.[21] A study by Smisha Agarwal (2019) also found that receipt of ASHA services was associated with a remarkable increase in ANC visits, SBA, and facility births. Women who were poor, and belonged to scheduled castes and other backward castes had received more ASHA services.[22]

Becoming an ASHA, empowered poor rural women by gaining remuneration, knowledge and status.[11] Increased empowerment and personal growth were reported by ASHAs.[5] ASHAs have been accepted as public speakers, activists, or meeting conveners on various issues by numerous communities.[1]

At the same time, numerous studies have extensively reported about ASHA's dissatisfaction with their pay and workload.[11] Bhatia K (2014) reported that ASHAs were discouraged from working by family members because of low payments and delay in receiving incentives.[23] A study conducted by Guha Ishita et al. reported that ASHA workers complained about a delay in receiving incentives.[24] Shet et al. reported in 2017 that most of the ASHA workers were demanding monthly salaries in place of activity-based incentives.[25] Saxena V et al. (2012) reported that ASHA workers experienced difficulties in travelling for work.[26] Agrima Raina (2020) reported that ASHA workers were hailed as COVID warriors for COVID management but only 62% had been given gloves. 25% had not been given masks. The survey was conducted in four Indian states. Only 23% had received bodysuits, only 76% had received training on PPE and infection control, and 33% were subjected to some kind of discrimination or violence. They worked without any provision of weekly leaves.[27]

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The studies reported that ASHAs faced gender issues including gender-based violence and sexual harassment including gang rapes.[5,28] ASHAs also reported experiencing class and caste-based issues and poor work ethics from co-workers including bribery, cheating, and corruption.[29] Gender-based harassment and violence had been discussed at the government level.[28] Health facilities are advised to create safe overnight restrooms at health care institutions for ASHAs who have accompanied clients, to discuss the sexual harassment issues during monthly staff meetings with higher-level staff and to take action if threats or harassment are reported.[30,] However, these guidelines are issued at the central level and it is up to the state governments to implement them.[5]

Other challenges reported by ASHA's were poor orientation about the programme and lack of quality training. Ishita Guha et al. (2018) reported that ASHA's perception about their job responsibilities was incomplete. Although their awareness about the role as a link worker was good, they had less clarity about their roles as facilitators, social activists, and direct service providers. Most of them were ignorant about newly launched programmes. They were mostly interested in higher incentive programmes. The positive factors were regular supervision and appraisal by supervisors and the community.[24]

During a study in 2014, Sunil Kanth Guleri et al. had observed a delay in the running of training sessions. Although 94% of ASHAs agreed with the adequacy of course materials, only 65% were satisfied with the overall training facilities.[31] Reviews of the ASHA programme have many times reported the need for a strong support structure for monitoring and mentoring ASHAs at the state, district, block and village level for effective utilisation of the programme.

Conclusion

ASHAs play a critical role in implementing government health programmes especially related to maternal and child health. Therefore, it is highly essential to ensure that ASHAs are continuously motivated and updated, for which, refresher courses and periodic regularisation of the incentives are imperative.

Conflict of Interest: None

References

1. Horwood G, Opondo C, Choudhury SS, Rani A, Nair M. Risk factors for maternal mortality among 1.9 million women in nine empowered action group states in India: secondary analysis of Annual Health Survey data. BMJ Open. 2020;10(8):e038910. [PubMed] [Google Scholar]
2. World Health Organization [Internet]. Maternal health; 2020 [cited 2021 Aug 18]. Available from: https://www.who.int/health-topics/maternal-health#tab=tab_2
3. World Health Organization [Internet]. Maternal mortality; 2019 Sep [cited 2021 Jul 20]. Available from: https://www.who.int/news-room/fact-sheets/detail/maternal-mortality
4. MoHFW [Internet]. Maternal and adolescent health care. Annual Report 2017-18; 2018 [cited 2021 Aug 16]. Available from: https://main.mohfw.gov.in/sites/default/files/03Chapter.pdf
5. Ved R, Scott K, Gupta G, Ummer O, Singh S, Srivastava A, George AS. How are gender inequalities facing India's one million ASHAs being addressed? Policy origins and adaptations for the world's largest all-female community health worker programme. Hum Resour Health. 2019;17(1):3. [PubMed] [Google Scholar]
6. Wang H, Juyal RK, Miner SA, Fischer E. Performance based payment system for ASHA's in India: what does international experience tell us? USAID. 2012:1-36.
7. Panda M, Nanda S, Giri RC. A study on the work profile of ASHA workers in a district of Odisha in eastern India. Int J Comm Med Public Health. 2019 Feb;6(2):675-81. [Google Scholar]
8. Dholakia RH, Bajpai N. Improving the performance of accredited social health activists in India. Columbia: Academic Commons; May 2011. [Google Scholar]
9. Fathima FN, Raju M, Varadharajan KS, Krishnamurthy A, Ananthkumar SR, Mony PK. Assessment of 'Accredited Social Health Activists'- a national community health volunteer scheme in Karnataka state, India. J Health Popul Nutr. 2015 Mar;33(1):137-45. [PubMed] [Google Scholar]
10. National Health Mission [Internet]. Guidelines on Accredited Social Health Activists (ASHA); [cited 2021 Jul 20]. Available from: https://nhm.gov.in/images/pdf/communitisation/task-group-reports/guidelines-on-asha.pdf
11. Gopalan SS, Mohanty S, Das A. Assessing community health workers' performance motivation: a mixed-methods approach on India's Accredited Social Health Activists (ASHA) programme. BMJ Open. 2012;2(5):e001557. [PubMed] [Google Scholar]
12. Scott K, George AS, Harvey SA, Mondal S, Patel G, Sheikh K. Negotiating power relations, gender equality, and collective agency: are village health committees transformative social spaces in northern India? Int J Equity Health. 2017;16(1):84. [PubMed] [Google Scholar]
13. NHM [Internet]. Guidelines for accreditation of training sites and trainers for ASHA training under the National Health Mission; 2015 [cited 2021 Jul 20]. Available from: https://nhsrcindia.org/sites/default/files/2021-03/Certification%20of%20ASHA%20Guidelines18.05.2015.pdf
14. Press Information Bureau, Government of India, MoHFW [Internet]. Cabinet approves ASHA Benefit Package; 2018 Sep 19 [cited 2021 Aug 1]. Available from: https://

ISSN: 2348-2133
DOI: https://doi.org/10.24321/2348.2133.202111

pib.gov.in/Pressreleaseshare.aspx?PRID=1546619
15. Ministry of Health and Family Welfare [Internet]. Welfare of ASHA workers during COVID-19 pandemic; 2021 Jul 27 [cited 2021 Aug 18]. Available from: https://pib.gov.in/pressreleaseiframepage.aspx?PRID=1739461
16. NHM [Internet]. Update on ASHA programme; 2014 Jan [cited 2021 Aug 20]. Available from: https://nhsrcindia.org/sites/default/files/2021-03/Update%20on%20ASHA%20Program%20January%202014.pdf
17. NHM [Internet]. Update on ASHA Programme; 2019 Jul [cited 2021 Aug 1]. Available from: https://nhsrcindia.org/sites/default/files/2021-06/ASHA%20Update%20July%202019.pdf
18. NUHM [Internet]. ASHA payment implementation process; [cited 2021 Sep 5]. Available from: http://asha.mp.gov.in/User%20Manual/User%20Manual%20(ASHA%20incentive).pdf
19. Ministry of Health and Family Welfare [Internet]. ASHA workers, Lok sabha unstarred question no. 3418 to be answered on 13th March, 2020; [cited 2021 Sep 6]. Available from: http://164.100.24.220/loksabhaquestions/annex/173/AU3418.pdf
20. Garg PK, Bhardwaj A, Singh A, Ahluwalia SK. An evaluation of ASHA worker's awareness and practice of their responsibilities in rural Haryana. Natl J Community Med. 2013;4(1):76-80. [Google Scholar]
21. Bhattacharya H, Luwang N, Sarkar M, Chakraborty T, Baidya S. Utilization of ASHA services by the pregnant women of rural Tripura, India. Int J Res Med Sci. 2015;3(9):2223-7. [Google Scholar]
22. Agarwal S, Curtis SL, Angeles G, Speizer IS, Singh K, Thomas JC. The impact of India's accredited social health activist (ASHA) program on the utilization of maternity services: a nationally representative longitudinal modelling study. Hum Resour Health. 2019;17(1):68. [PubMed] [Google Scholar]
23. Bhatia K. Performance-based incentives of the ASHA scheme: stakeholders' perspectives. Econ Polit Wkly. 2014;49(22):145. [Google Scholar]
24. Guha I, Raut AV, Maliye CH, Mehendale AM, Garg BS. Qualitative assessment of Accredited Social Health Activists (ASHA) regarding their roles and responsibilities and factors influencing their performance in selected villages of Wardha. Int J Adv Med Health Res. 2018;5(1):21-26. [Google Scholar]
25. Shet S, Sumit K, Phadnis S. A study on assessment of ASHA's work profile in the context of Udupi Taluk, Karnataka, India. Clin Epidemiol Global Health. 2018;6(3):143-7. [Google Scholar]
26. Saxena V, Kakkar R, Semwal VD. A study on ASHA - a change agent of the society. Ind J Comm Health. 2012;24(1):15-8. [Google Scholar]
27. Agrima R. ASHA workers are hailed as COVID warriors but only 62% have gloves, 25% have no masks. The Print; 2020 Sep 21.
28. Gangotri, Pritisha, Bhargava R, Adib R, Velankar J, Dasgupta J. Report of independent fact-finding into the incident of gang-rape and death of an ASHA worker Somwati Tyagi in Muzaffarnagar District, Uttar Pradesh, India. National Alliance for Maternal Health and Human Rights & Healthwatch Forum Uttar Pradesh; 2016.
29. Sharma R, Webster P, Bhattacharyya S. Factors affecting the performance of community health workers in India: a multi-stakeholder perspective. Glob Health Action. 2014;7(1):1-8. [PubMed] [Google Scholar]
30. NHM [Internet]. Safety measures for ASHAs; 2016 [cited 2021 Sep 3]. Available from: https://nhsrcindia.org/sites/default/files/2021-03/Safety%20measures%20for%20ASHAs_29.01.2016.pdf
31. Guleri SK, Dixit S, Sakalle S, Bhagwat AK, Yesikar V, Pandey D. A rapid appraisal of training issues of ASHAs (Accredited Social Health Activist) in Madhya Pradesh. Int J Public Health Res. 2014;1(1):3-8. [Google Scholar]

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