CHAPTER: 11

HEALTH AND HOPE: ASHA WORKERS JOURNEY OF TRANSFORMATION

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ABSTRACT

The flagship program of National Rural Health Mission, the ASHA program is world's largest community health worker program. In Rajasthan, this initiative began with challenge of non-availability of eighth pass ASHA workers and evolved into a program with qualified and empowered ASHA workers. After 18 years of implementation of this program, the study wants to explore current status of ASHA program and capture the stories of success and lessons learned. Qualitative in-depth interviews were conducted using semi structured, pretested checklist. A total of seventy ASHA workers across eleven Districts of Rajasthan and State and District ASHA officials were interviewed. The study results indicate that ASHAs in Rajasthan have come a long way, as 59% of them are tenth grade and above qualified. They have crossed the boundaries of the initial six program areas and are now working in multifaceted areas. Programs designed by the government for their support, not only motivate them but also empower them; now, they see themselves as catalysts of change, not limiting themselves to the role of a health worker. In conclusion the study reveals a positive transformation among ASHAs in Rajasthan, showcasing their educational qualifications and participation in higher education opportunities, expanded roles beyond initial program areas, and a transformed self-perception as catalysts of social change.

Keywords: *Community health worker, Accredited social health activist (ASHA), Primary health care, Rajasthan*

INTRODUCTION

Accredited Social Health Activist (ASHA), has been considered as an important strategic intervention under National Rural Health mission, conceptualized after formal approval of cabinet in year

2005, with launch of National Rural Health Mission. Position of one ASHA has been envisaged per 1000 population of village. She is eighth class pass, married, widowed, divorced, or separated, women resident of that village within age bracket of 25 and 45 years, with effective communication and leadership skills and ability to connect with the community. She is a link between the community and health facility and first point of contact for any health-related demand (NHM, Frame work of Implementation, 2005).

ASHAs work as a health care facilitator, she creates awareness on determinants of health, including nutrition, sanitation, and hygiene. She educates and mobilize the community, facilitate access to health services, especially vulnerable sections of the society, in her role as a service provider, she provides community level care of minor ailment, provide directly observed treatment short-course (DOTS) under Revised National Tuberculosis Control Programme. She has a drug kit and acts as a depot holder for essential health products appropriate to cater local community needs. She counsels pregnant women and their families on maternal and child health, birth preparedness, safe delivery, breastfeeding, immunization, contraception. She conducts home visits (Guidelines for Community Processes, 2013).

Studies have shown that ASHAs were predominantly involved in home-visits, antenatal counselling, delivery escort services, breastfeeding advice, and immunization advice. They were very highly involved in antenatal and intra-natal care service provision, such as counselling support and escort service. Their performance in drug provision for tuberculosis, caring of children with diarrhoea or pneumonia, and organizing village meetings for health action was moderate and their performance was found low on advice for contraceptive-use, obstetric danger sign assessment, and neonatal care (Saxena et al., 2012, Fathima et al., 2015).

In studies for examination of how ASHA workers have played a pivotal role in bringing about a paradigm shift in health awareness within their communities, ASHA shared that main reason for working as ASHA is social work, self-identity, future employment and to earn money. In many studies conducted across various States of India, the major challenges reported by ASHA is transportation, and increased travel time (Saxena et al., 2012), geographical barriers and uneven distribution of the population, which makes access difficult leaving some pockets of population unserved. Where positions of ASHAs are vacant, other ASHAs have to cater the higher number of populations. The lack of protective measures for ASHAs caring for patients with communicable diseases and incomplete medicine kits contribute to concerns about health security (Nandan et al., 2008, Joseph, 2015).

The non-availability of smart phones and non-familiarity with technology is also found as challenge for ASHAs, inadequate support from other healthcare personnel and delayed payment of incentives add to them often feeling overworked and underpaid (Mondal and Murhekar, 2018).

ASHAs are expanding their traditional role and working beyond domain of health. They are actively promoting sanitation and hygiene practices, particularly the use of toilets. They are getting all required support from PRI member (Meena et al., 2020).

In a study to assess the perspectives and beliefs of Accredited Social Health Activists (ASHA workers) regarding a collaborative care mental health intervention (HOPE: **H**ealthier **Op**tions

through **E**mpowerment), mental illness and the health of their rural communities it was found that ASHA workers successfully identified significant barriers to treatment and factors that facilitate effective mental health interventions (Bansal et al., 2021).

As per the guidelines set forth by the Government of India and drawing insights from various studies conducted across the country, the present study aims to comprehensively examine the status of the ASHAs Program in Rajasthan. The primary objective is to capture and elucidate the stories of success and lessons learned.

METHODOLOGY

Study design: A cross-sectional study has been conducted to understand the ASHA Workers Journey of Transformation. Study has been conducted in Rajasthan State. State and District level ASHA Coordinators (N=11) and Seventy ASHA (N=70) in these eleven Districts have been Interviewed. Distribution of these 11 districts was such that minimum one district was taken from each of the seven zones. These districts are Kota, Jhalawar, Bikaner, Barmer, Jhalawar, Hanumangarh, Jaipur, Bhilwara, Jodhpur, Rajsamand and Bharatpur.

Predesigned, pretested and structured checklist were used to collect Qualitative information from ASHA Officials and ASHAs. There were open ended questions which were later categorized as per responses received from ASHA workers. A structured interview checklist was developed and tested on five ASHA workers, there were open ended questions which were later categorized as per responses received from ASHA workers.

Ethical considerations: Informed Consent was taken from all the study participants. All the participants were fully informed about the study, its purpose, procedures. Consent was obtained from all ASHAs featured in the case studies before sharing their stories. Each participant was free to withdraw from the study at any point in time and was ensured confidentiality of the responses.

RESULTS AND DISCUSSION

There are 53200 ASHAs working in the Rajasthan State, at the beginning of the ASHA Program, it was very difficult to get 8th pass ASHA, now after almost two decades of implementation of this important program of community Processes, more than 59% of State are tenth Standard and above qualified (Pragati Prativedan DM&HS, 2022-23). With reference to the present study, almost all ASHA interviewed were graduate (BA) or postgraduate (MA) in qualification (62 ASHA workers).

All ASHAs have undergone induction training of 8 days at the time of selection and more than 90% ASHAs are trained in all four rounds of Module 6 and 7, which reflected in the highest level of skills sets acquired by these ASHA including making blood smear (blood slide for testing of malaria). They were also trained in HBYC and HBNC. Those in the desert districts and hilly regions responded that their basic communication skills were also refined through Social and Behavior Change Communication (SBCC) training. All of them replied that training has helped them grow in their personality and has contributed by adding onto their tasks and thereby increasing their incentives.

During Qualitative Interviews with ASHAs, they shared that they are engaged in all 65 types of activities through which they can serve the society as well as earn incentives. For fulfilling these responsibilities, they overcome challenging situations also, a case study of Bhilwara was shared by ASHAs.

Box 11.1: Together we can!

Village Jaisingh ji ka Jhopra, S/C Rajpura, Block Jahajpur, District Bhilwara, ASHA worker's names are Asha Meena and Seema Meena

Geographical scenario of this village is a challenge because there is a dam between the village and Subcenter. Every time, health providers face a great challenge in ensuring outreach services. These two ASHAs, teamed up together and took help of a boatman to take them across deep waters of the dam reservoir. Specially for the Pulse polio drive, this initiative was taken by these two ASHA, and they became trendsetters, since then this is a routine for these ASHA. Along with ensuring immunization outreach they also organize awareness talks for care of pregnant women, about various government schemes and programmes such as Chiranjeevi Health Insurance schemes, Seasonal diseases and other surveys etc. Who else can better understand value of Polio vaccines than these two ASHAs, since they are disabled physically because of childhood infection from Polio disease. Overcoming their special ability, they have proven that together we can!

ASHAs shared that as their role of link worker and facilitators, they not only educate and mobilize community for availing health services, but also facilitate life saving services, which is quite satisfying and fulfilling. District ASHA Coordinators also shared that other than major 6 programme areas defined in ASHA soft, these ASHAs are also working in creating awareness of Cheeranjivi Swasthya Bima Yojana, surveys for screening of Non communicable diseases, Screening of Mental health cases, extending home based care for palliative care patients and educating families of such patients. They are actively involved in creating awareness for making village open defecation free (ODF). Other works also include social mapping of village resources through Participatory Learning Approach (PLA) technique and Reviews of Maternal and Child Death. ASHA have now started to work beyond RMNCH+A components (Reproductive, Maternal, New Born Child Health+ Adolescent) and this confirm a paradigm shift from continuum of care only to maternal and child health to all further age groups starting from adolescent, adult and geriatric age groups. One ASHA shared the case of RBSK.

Box 11.2: Saving a life under RBSK!

Village 56 LNP, Block Palampur, District Sri Ganganagar, ASHA worker is Krishna Devi

Annesh, son of Kaluram was born to a poor family of shepherd. Child had a birth complexity of Heart deformity. His heath problem was diagnosed (free of cost) in a screening at a camp (at government school) under RBSK. After screening, Annesh was referred to District hospital, where further tests were done and surgery was prescribed. But family denied any further treatment because of lack of money. This is the moment when ASHA worker Krishna played a critical and life saving role, she counseled Kaluram and his family on benefits of RBSK and Chiranjeevi scheme, as a result Annesh was operated at a private

hospital in Jaipur, free of cost. Kaluram and his family express Gratitude to the entire health team and ASHA Krishnadevi, for timely guidance they received and as a result, Annesh is living a health life today.

SHAs are breaking the barrier of traditional role as ASHA, they actively participated in COVID Prevention, Screening and Management activities. In the States like Jharkhand, Madhya Pradesh, Odisha, and Uttar Pradesh also, ASHAs supported vulnerable individuals/families, especially migrant returnees during COVID. They were engaged line listing, counselling, facilitating quarantine, and ensuring access to health services. In Delhi and Kerala also, ASHA provided local support to migrant workers during lockdown. Additionally, ASHAs actively contributed to COVID-19-related services, including setting up quarantine centres, distributing home care kits, monitoring patients during home isolation, and mitigating stigma associated with recovered patients. Some states involve ASHAs in screening at state/district borders (National Health Systems Resource Centre [NHSRC], 2022).

Box 11.3: 24x7 dedicated work by ASHA workers!

Village - Dhanwa, District - Barmer, ASHA worker is Pushpa Devi

During the Covid pandemic, apart from creating awareness about the diseases, ASHA workers were also identifying Covid suspects, exploring travel histories, and advising isolations. Full day working in the neighbourhood, ASHA worker Pushpa Devi did innovative work by stitching masks at night. She stitched masks and distributed them to villages free of cost, she also provided them to other health functionaries. This inspired other ASHA workers and they all followed her steps, and it turned out to be a mass campaign of mask stitching and distribution, very soon the resource crunch of masks was narrowed.

ASHA has a very good supportive system, as shared by most of ASHA interviewed that they are well supported by Supervisors, ANM and Medical Officer In-charges of their health facility as well as from District ASHA Coordinator at the district level. Similarly, in other states also, many Innovations have been done like Project MANCH for improving Maternal, Neonatal, and Child Health (MNCH) outcomes in tribal areas in Madhya Pradesh , supported by HCL Foundation clearly indicate that ASHA Supervisor Mentors (ASMs) play a crucial role by providing supportive supervision and mentoring to ASHA Supervisors and ASHAs. The project involves group sessions to identify personal gains, challenges, and strategize for intervention strengthening [National Health Systems Resource Centre (NHSRC, 2022).

ASHA soft was also shared as supportive mechanism by all the ASHAs interviewed. All the ASHA replied that they are getting regular payments of incentive-based works through ASHA soft, but they are long waits for their regular monthly stipend. They are confident in filling out and submitting claim forms for incentives as per time schedule. This system is now well established.

On asking for suggestions, they all demanded a system of promotion and said they shall be treated as employees, this shall start after working as a volunteer worker for 5 years. In a study done in 2016 it was found that performance of ASHA has significantly improved by use of ASHA soft. It is a transparent system and it keeps them motivated (Jain et al., 2016)]. This is also clearly evident from interviewed following ASHA worker and ANM:

Box 11.3: Kamla-ASHA Sahyogini

Village -New Bedana, Sector - Gudhamagla, Block - Ahore, District - Jalore (interviewed on an MCHN day)

My name is Kamla, I am standard eight pass and working as ASHA since 10 years. Earlier I had to go to PHC many times to follow for my payments, which I used to get after many months of doing the work. That too many payments were cut. Now after having ASHA soft, I am getting regular monthly payments exactly of all the works I do. I have learnt filling of Claim form, ANM verifies it and I submit it to supervisor in monthly meeting. District ASHA coordinator has informed us that now it is not compulsory to accompany pregnant women to hospital for delivery and if we work more, we will be paid more. Hurriedly glancing through the due list, in discussion with the ANM, she left for mobilizing the mothers of children due for Immunization.

Another milestone that indicates transformation is coordination between ASHA workers and members of Panchayat Raj. All the ASHA interviewed in present study have good rapport with members of Panchayat Raj. They were able to interact with Sarpanch, ward panch and Parshad etc. Those exceptionally confident responded that they never needed help from any PRI member. ASHA shared success stories that with help of PRI members they were able to reach many beneficiaries avail benefits under Chiranjeevi swasthya bima yojana, RBSK and even get physically challenge certificates.

INNOVATIONS AND BEST PRACTICES

Many innovations have been initiated by the Medical and Health Department with support of Ministry of Health and Family Welfare, where ASHA workers taking the lead in implementing these exemplary practices. In an instance in a particular block, ASHA initiated a unique approach in which an individual successfully treated with tuberculosis serve as volunteer and counsel other patients to take regular medicine.

For keeping her future secure and motivating her, numerous schemes have been initiated by the Government and ASHAs are not only aware of these schemes but also getting benefitted from these schemes.

ASHAs have been encouraged for their regular health checkups, when State level NCD screening rounds were started, initially screening of all ASHAs were done Statewide. Additionally, a campaign focused on screening for cervical cancer has been introduced exclusively for ASHA workers. Regular check-ups for ASHA workers are conducted every Friday at Urban Community Health Centres (CHCs) and Medical College Hospitals

For providing financial security she is being covered with two unique insurance schemes. One is Pradhan Mantri Suraksha Bima Yojana, in which a premium of rupees twelve was collected, and in the event of an accidental death of an ASHA worker, her family receives the insured amount from an insurance company. Similarly, through the Pradhan Mantri Jeevan Jyoti Bima Yojana, ASHA workers aged eighteen to fifty years are eligible for a claim of rupees two lacs in the event of a physical disability due to any unfortunate incident. This coverage is available with an annual premium of rupees three hundred.

Along with financial assistances, encouragement is provided for growing in terms of education, career wise growth to become ANM. For promoting completion of school education up to the standard of ten and twelve, a financial assistance of rupees four thousand was provided to the ASHAs, all District ASHA coordinators interviewed shared that from the initiation of this scheme every year four to five ASHAs are getting benefitted from this scheme.

For ASHA workers who are trained in Health and Wellness Centres (HWC) and Home-Based Care for Young Child Programme (HBYC), will be supported to get NIOS Certification. For their career growth ASHA are provided an opportunity to become ANM. ASHA are given 10% weightage in recruitment as ANM. As interviewed from DAC Kota, recently 2 ASHA were selected and trained as ANM. Two ASHA were also selected from nearby Bundi district. Same as responded by DAC Bikaner, about fifteen ASHA are now trained as ANM, as and when there will be a vacancy of ANM they will be recruited.

To maintain their distinctive identity, ASHA workers receive two sets of blue sarees with unstitched blouses annually

In Rajasthan, innovative technologies aim to empower ASHA workers in their healthcare roles. The PCTS App is a mobile application tailored for ASHA workers in Rajasthan. To facilitate its use, financial support of rupees six hundred per month is allocated for mobile recharge. This assistance extends to ANMs as well. ASHA workers utilize the app for data entries in the PCTS, a process verified by ANMs. The verified information seamlessly reflects in ASHA Soft, ensuring a streamlined and paperless claims process, guaranteeing smooth incentive payments for ASHA workers. This initiative marks a progressive step towards efficient incentive availing and improved data management.

CHALLENGES FACED BY ASHA WORKERS

ASHA worker encounters multifaceted challenges, while delivering the services**.** The biggest problem area or challenges they face is getting community insured under health insurance scheme such as Cheeranjeevi swasthya bima yojana, since community demands free of cost services with zero out of pocket expenditures. Other challenging task is that community demands ASHA worker to be present at every delivery, which at times is not feasible. Though it is not mandatory for ASHA to accompany pregnant women, but many ASHA are doing this practice to gain faith of community.

ASHAs advocated for the reconstruction of Anganwadi Centers (AWC), repair and maintenance of Sub Centres, and regular upkeep of equipment at health centers, including weighing machines and blood pressure instruments. A notable challenge they faced was the absence of a Gynecologist at the nearest Community Health Center (CHC). This absence made it challenging for ASHAs to persuade the families of pregnant women, as complicated deliveries required referrals to the District Hospital. Due to this, the community preferred private hospitals, resulting in substantial financial losses for ASHA workers who forfeited incentives for institutional services and related benefits. To address these challenges, ASHAs emphasized the need for a consistent flow of resources, including essential machines and equipment such as Salter weighing machines and digital thermometers.

ASHAs have been provided a customized reporting and communication tool, the ASHA Diary. This diary includes tables for home visits, due lists, a record of provided services, and prominently features coloured and printed key Information, Education, and Communication (IEC) messages. However, a notable challenge lies in ensuring a steady supply of these tools. Often, the distribution process encounters obstacles at the district offices, preventing the seamless delivery of these essential resources to the end users—ASHA workers.

CONCLUSION

ASHAs have become the inevitable part of public health care system of India. They have successfully navigated initial community resistance and emerged as catalysts for change, driving development in rural communities not only within the medical and health sector but also across diverse developmental spheres. They serve as examples of women empowerment, particularly for girls and women in rural areas. Governments and policymakers should prioritize ongoing investment in their capacity building and multi-skilling to enhance their ability to address diverse health needs.

Drawing from plentiful experiences, ASHA workers effectively identify their requirements and articulate demands to bridge resource gaps. While the department has policies in place to provide due support and recognition, the challenge lies in the qualitative monitoring and maintenance of these interventions to uphold the morale of the 53000 ASHA workers. Additionally, ASHA workers express anticipation for more training programs and refresher courses, highlighting the ongoing commitment to their professional development and the enhancement of their capabilities.