Human Rights Issues Faced By Accredited Social Health Activists (ASHAs)

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Abstract

The government of India introduced Accredited Social Health Activists (ASHAs) in 2005 under National Health Rural Mission, to improve the delivery of basic health services in the rural areas. Over time, they have proved themselves a key link between the rural population and public healthcare, imparting basic health information and services to the poor as well as assisting them in accessing public health facilities. However, they are denied the status of "worker", and as a result, are not entitled to any benefits necessary for a worker to live with dignity. This paper aims to assess the problems faced by ASHAs, particularly the human rights violations that follow these ordeals. A descriptive cross-sectional study was conducted among ASHAs of selected districts of Himachal Pradesh, selected by using a non-probability convenient sampling technique. All participants were interviewed using a semi structured pretested questionnaire. The finding of the study revealed that 80% of ASHAs are not paid regularly. 20% of the ASHAs answered that they are paid regularly. According to their last monthly remuneration, it was found that 41% of ASHAs were paid between Rs. 2000/-, 28.57% were paid Rs. 3000/-, 16.07% were paid Rs. 3500/- and 12.5% were paid Rs. 4000/. Issues such as lack of protective gear, lack of financial assistance, no provision of transport to carry on duties, overburdened responsibilities, ill-treatment by the public, etc. were also reported during the study. The findings showed that the basic human rights of ASHA employees as workers are ignored in the mainstream discourse on ASHA employees. Even throughout the pandemic, ASHA employees dedicatedly performed their duties while putting their lives in danger. It is suggested that the government take some steps to improve the conditions of the ASHA Workers by the means of regularising their jobs and ensuring dignified wages and timely payments.

Keywords

ASHA, National Rural Health Mission, Covid-19 Pandemic, Human rights.

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Introduction

Health is a basic human right. The right to health was included under international law in the Universal Declaration of Human Rights (1948), which was unanimously proclaimed by the United Nations General Assembly as a common standard for all humanity. This right not only envisages the right to attain highest possible level of health but freedom from discrimination, restriction, or exclusion, which has the effect of creating marginalization in terms of not just health but other connected social and economic determinants. To progress towards a universal and accessible health care, a worldwide need was felt to form a health workforce that is aligned with population and community health needs, and which has the ability to adapt to the escalating demand for healthcare caused by rapid changes in the population's epidemiological, social, demographic, economic, and political conditions. Over time, this has been reflected in international instruments such as the International Covenant on Economic, Social and Cultural Rights (1966), Declaration of Alma Ata (1978), Millennium Development Goals, Sustainable Development Goals, and Declaration of Astana (2018).

The introduction of the Accredited Social Health Activist (ASHA) workers was one of the key actions taken by the Government of India in this context. Launched in 2005, ASHA workers are the female health volunteers, promoters of health services, or a new group of community-level health workers who are the pivotal force of action at the grass root level. National Rural Health Mission (NRHM) projects ASHA workers as a health activists, to whom the community accepts and she bridges the gap between the health system and the community. They are provided training for primary medical care, health education on sanitation, hygiene, antenatal and postnatal care (PNC), escorting expectant mothers to the hospital for safe delivery and immunization of children, etc.

Fourteen years down the line, with these existing linkage workers roles, it is now time to assess their overall roles. ASHA has become a fundamental unit of India's health system. This study was conducted during the COVID-19 pandemic, when ASHAs were put on additional COVID-19-related duties in their localities, crumbling under the weight of rising infections and insufficient infrastructure. In an attempt to understand their working conditions, the author interacted with a number of ASHAs associated with different Primary Health Centres (PHCs) in selected areas of rural Himachal Pradesh. ASHAs' work is not salary based, rather it is incentive-based. The study focuses on field challenges and different hurdles faced by ASHA, particularly of the irregular payment of the incentives. It is crucial to address the challenges that they face as employees in order to advance their efficiency and development.

Review Of Literature

In this section, the author has made a comprehensive attempt to understand the various dimensions of the Community Health Workers Programme and Accredited Social Health Activist (ASHA) scheme under the National Rural Health Mission (NRHM). An attempt has been made to locate the gaps and understand the subject to facilitate the study. The review revealed the importance as well as the issues related to ASHAs.

Preeti Padda (2013) in the district study evaluated the role of ASHA workers in rural areas with the use of maternal health indicators by making urban-rural comparisons. The region chosen by the author that is Malwa, Punjab, though performing satisfactorily on some scale, had some areas of concern including anemia in children, and women, poor post-natal care, breastfeeding practices, use of supplementary food, etc. For studying such areas, a well-self-structured baseline survey covering pregnant women from two rural development blocks and three towns was conducted. It concluded that in rural areas, the maternal and child health service delivery has definitely improved after the introduction of ASHA workers.

Thiagrajan Sundararaman (2012) adopted a realistic approach with both qualitative and quantitative inputs. Community health workers including ASHAs, Auxiliary Nurse Midwives (ANMs), Anganwadi Workers, and members from Panchayati Raj Institutions were chosen from eight Indian states. The evaluation stated that there is wide variation in the tasks they perform. Education qualifications do not impact the health outcomes, rather duration and content of training do. The author in a conclusion recommends that for an effective ASHA, beyond the provision of timely incentives, the provision of competency-based training with the health rights dimensions, adequate resources, mentoring and motivation should be emphasized.

R. Ved (2019) explored the gendered design, evolution and ongoing adaptation of the ASHA programs through an analysis, conducted by internal program leaders and external academic partners, The objective was achieved by taking into consideration the published world, policy documents and key informal interviews. Forming an all-female program was considered appropriate because maternal and child health was a female-centric sphere and women had high unmet reproductive health needs. Also, the paper drew a concern among some members of civil society that "the NHM did not create salaried government positions for ASHAs and suggested that the voluntary nature of position was only considered appropriate because ASHAs were women." On the contrary, the policymakers noted that administrative and monitoring structures in the rural health systems were already strained and there

were concerns that ASHAs would underperform if guaranteed a salary, as happened with Anganwadi workers and front-line nurse midwives. The ASHA program has given opportunities to rural women to gain knowledge, status and exposure beyond the village through work. Despite that, ASHAs face gendered challenges. Heavy domestic responsibilities and limited movement outside the home act as barriers for them to perform their professional role. Delayed remuneration, and low incentives exacerbate their situation something which the author's findings extensively documented an analysis. ASHAs are victims of harassment, often of sexual need, by other health workers and community members, linked to their mobility and public profile. As a result of these concerns, government health policy is working to improve ASHA well-being by boosting ASHA economic stability, promoting career advancement initiatives, and addressing gender-based violence.

Abhay Mane (2014) through their evaluative research addressed the involvement of ASHA in key principles of health care- 1. Equitable distribution 2. Community participation 3. Intersectoral coordination. The health indicators like Infant Mortality Rate, Maternal Mortality rate and Total Fertility rate from the year 2005 to 2012 were traced. More than 6 years of the launch of the program, ASHA has emerged as a significant contributor to improving health situations, particularly among women and children.

Pragya Kumawat (2020) examined the challenges and hurdles faced by ASHAs in two selected blocks of District Jaipur, Rajasthan, through a cross-sectional observational study. Multiple ASHAs were engaged through in-depth interviews from from September 2018 to April 2019. The research culminated in the finding that financial incentives, working for society and self-identity were motivations for joining the program. However, it was also concluded that delayed and inadequate payment, unspecified responsibilities, poor transport and conflict between ICDS (Integrated Child Development Services) and health staff were common challenges faced by the ASHAs.

Vaishali DeoraojiTaksande (2021) concluded through their study that 66% of ASHA workers were satisfied with their jobs whereas almost 52% of ASHAs were dissatisfied with their job and 61% of them were unhappy with their remuneration. A descriptive survey approach was used in this study and the sampling technique was purposive technique. The study sample was 50 ASHA workers from Anganwadi of a rural area, under the child development project, office Tehsil Samudrapur, Maharashtra.

Lori Heise (2019) examined the relationship between gender inequality, restrictive gender norms, and health and well-being. The paper emphasized that

establishing gender equality and changing restrictive gender norms are a priority to accomplish the SDGs' global health targets. Paper four of this series explains in detail the reality of gender bias in the health system. As discussed in previous studies, it is observed that female-coded jobs (nurses and midwives, ASHAs in this case) are given inferior status, than male-coded jobs (physicians and surgeons). Also, within the same job type, women get lower pay than men. Women are underrepresented in higher positions in their respective fields. This is due to barriers to women's advancement and retention in the healthcare industry, as well as incidences of harassment and assault by coworkers and patients. What is noteworthy is that this is not limited to poor countries.

Carmel Williams (2019) highlighted the importance of law as a determinant of health and health care. The report discussed the 'right to health' as a part of international human rights law and its legislation and the states obligations to it. If this legal entitlement is confined to everyone, it could promote its relevance in the case of health workers. The report also shed light on rights-based approach to achieve greater equity and Universal Health Coverage (UHC). The discussion made in the report is particularly relevant in the times of COVID-19.

Jody Heymann (2019) reviewed the literature for programs that will reduce gender inequity and restrictive gender norms while also increasing health. The study conveyed some crucial messages. Paid maternity and parental leave policies, as well as tuition-free elementary education, promoted gender equality in decision-making and improved health outcomes. These policies had both direct positive health effects and impact on health facilitated by more gender equality in decision-making. The study also pointed out that women's increased representation in politics has had a positive effect on the delivery of public health services, in terms of more community health centers, primary health centers, government clinics, and government hospitals, and other health-related outcomes, including a reduction in neonatal mortality.

Purva Chowdhury (2021) assessed the knowledge, attitude and practices of ASHAs during the COVID-19 pandemic. For the study, ASHAs from four randomly selected Community Healthcare Centres under the West Tripura district were included. Among many, one of the findings gave that more than 50% of the ASHAs feared of getting infected and being implicated as disease spreaders in the community. More than 80% of ASHAs affirmed of practicing COVID-19-appropriate habits like washing hands, wearing masks and maintaining physical distance during field visits.

There are many studies on community health workers and Accredited Social Health Activists. The above-mentioned studies are conducted globally as well as in

India. During the review of the literature, the author did not find any study conducted on the role of ASHAs in providing access to health services with reference to the state of Himachal Pradesh. Therefore, the researcher has attempted to explore and study this area. Also, literature related to ASHAs during the ongoing pandemic was scarce.

Objectives

ASHAs in India has proved to be the cornerstone of NRHM's strategy to enable effective community involvement and participation in healthcare services that use the primary healthcare approach and pursue the Sustainable Development Goals (SDGs). Thus, it is essential to research and formulate policies for ensuring their productivity as well as for addressing the hurdles that will influence their work.

Specific Objectives

- To study the work profile of ASHA workers
- To explore the problems faced by ASHAs while performing duties

Methodology

Study Setting:

During the time of the study, India was witnessing the second wave of COVID-19. Therefore, four districts of Himachal Pradesh were randomly selected for the study.

Sample Design and Sampling Technique:

The study sample was 56 ASHA workers from four districts. The sampling technique was convenient and snowballing due to limited resources with the author.

Name of Districts	Name of Villages	Number of Participants
Shimla	Rayoghati	12
	Baghal	
	Kotkai	
Mandi	Pungh	14
	Sundernagar	
Una	Pandoga	20
	Haroli	
	Lal Singhi	
Lahaul and Spiti	Damar	6
	Demul	
	Rangrik	
	Kaza	
TOTAL		56

Table 1 List of Selected Study Areas

Method for Data Collection:

A questionnaire was constructed and data was collected through in-depth telephonic conversations with the participants. Part 1 probed the demographic particulars of respondents and contained their consent to participate. They were explained about the objectives and the nature of the study. Part 2 consisted of subjective questions (open-ended) related to their work, practice,and job-related challenges. The interview was conducted in the regional language.

Data Analysis:

The data collected was organized and analyzed using pivot tables, percentages and frequency, in Excel 2016. Text Analysis was also used to support the study.

Findings And Discussions

Demographic Profile of the Participants:

Age	Frequency	Percentage
21-30	10	17.87%
31-40	38	67.85%
41-50	8	14.28%
Total	56	100.00%

Table 2 Age Distribution of the Respondents

Education	Frequency	Percentage
Up to 8th	5	8.92%
Secondary	17	30.35%
Higher Secondary	28	50%
Graduation	6	10.71%
Total	56	100.00%

Table 3 Education Qualification of the Respondents

Village Assigned	Frequency	Percentage
1-4	39	69.64%
5-8	17	30.36%
Total	56	100.00%

Table 4 Number of Villages Assigned to the Respondents

ASHAs rural is assigned to number of villages for conducting their duties. It was found that 69.64% of ASHAs were assigned 1-4 villages while 30.36% were assigned 5-8. It was noted by the author that most of the ASHAs from Lahaul and Spiti belonged to the latter part. That can be because of the less dense population of

the district. However, more villages may put an unnecessary burden on them which may affect their performance.

Field Hours Duration:

Number of hours per day on a field day	Frequency	Percentage
2 to 3	20	35.71%
3 to 4	10	17.85%
4 to 5	12	21.42%
5 to 6	14	25%
Total	56	100.00%

Table 5 Number of Hours of Fieldwork

The majority of ASHAs spent 2-3 hours in the field, followed by 5-6 hours, then 4-5 hours and 3-4 hours. It was also noted by the author that 80% of the respondents from the Lahaul and Spiti districts answered that they spent 5-6 hours in the field. Some respondents from Una District also replied that they have to use their own vehicle to go to the beneficiaries' residences or sub-center. Expenses of which have to be bored out of their own pockets. This can be because of the sparsely scattered population in the areas.

Personal Protective Equipment:

Received Personal Protective Equipments	Frequency	Percentage
No	34	60.71%
Yes	22	39.28%
Total	56	100.00%

Table 6 Received Personal Protective Equipments

As ASHAs are discharging their duties amid COVID-19, they were asked if they were being provided with personal protective equipment like masks, gloves, and sanitizers. It was found that the majority of ASHAs i.e. 60% were not being provided with these equipments on regular basis. 40% responded that they were being provided with these equipments regularly. Most respondents from Lahaul and Spiti , and Mandi answered the question with a yes. Lack of protective gear was much more prevalent in the other two districts. There was no distribution of scrubs or overalls in any of the areas.

It was also learned that some of them were provided with masks, gloves and sanitizers at the start of the pandemic. Currently the expenses to buy them have to

be borne out of their pockets. It is state negligence, jeopardizing the health of the front-liners. They hold responsibility not only to regularly monitor the health of COVID-19 patients, but also to conduct door-to-door surveys.

Remuneration:

Payment	Frequency	Percentage
Not Regular	45	80%
Regular	11	20%
Total	56	100.00%

Table 7 Frequency of Payment

For the details of remuneration, the respondents were asked about the amount as well as the regularity of the payments. It was found that the majority of ASHAs are not paid regularly. 20% of the ASHAs answered that they are paid regularly. Irregularity in payment can lead to dissatisfaction among ASHAs, which may affect their performance.

Amount in ₹	Frequency	Percentage
2000/-	23	41.07%
2300/-	1	1.78%
3000/-	16	28.57%
3500/-	9	16.07%
4000/-	7	12.5%
Total	56	100.00%

Table 8 Amount of Payment

It was also learned that the amount they receive is not fixed. According to their last monthly remuneration, it was found that 41% of ASHAs were paid between Rs. 2000/-, 28.57% were paid Rs. 3000/-, 16.07% were paid Rs. 3500/- and 12.5% were paid Rs. 4000/. There was even a respondent who was paid Rs. 2300/-. The amount of Rs. 2000/- is fixed and the remaining amount is added on the basis of incentives earned. This is a very small amount, considering the fact that their duties have added on during the pandemic. Therefore, it is felt that the remuneration of ASHAs should be revised. These payments are not directly released to the accounts of ASHAs, rather they have to go to PHCs/sub-centers for the collection.

Qualitative Observation

Roles and Responsibilities of ASHAs:

The respondents were asked about their roles and responsibilities. The questions formed a descriptive part of the questionnaire. The answers have been

summarized as below, under two categories: COVID-19-related and others. During the months from April 2019 to May 2021, the following duties were performed by the ASHAs.

COVID-19 related:

- Sensitization of the communities about the COVID-19 preventive measures to be adopted.
- Daily monitoring of identified patients either telephonically or through field visits, and subsequent reporting to the PHCs/sub-centers.
- Supply of medicines and aid to the patients.
- Conduction of door-to-door surveys in the months of April, 2020 and January, 2021.
- Assistance in vaccination drives.
- Create community awareness of vaccination Others (Non-Covid19 related):
- Accompany pregnant mothers to hospitals
- Depot holder of medicine and also delivery of Oral Rehydration Therapy (ORS), Iron Folic Acid Tablet (IFA), chloroquine, Disposable Delivery Kits (DDK), Oral Pills & Condoms, etc.
- Distribution of sanitary napkins
- Inform AWW/ANM about birth and deaths
- Counsel community on safe delivery, ANC/PNC, breastfeeding, immunization, contraception and prevention of RTI and STI
- Register of all details specific to Non-Communicable Diseases and completion of health cards
- Provide care for minor ailments Problems faced by ASHAs:
- Lack of timely guidelines and irregularity in capacity building trainings.
- No defined responsibilities, often leading to overburdening of work.
- Lack of protective gear to protect themselves from the transmission of the COVID-19 virus. Masks, gloves and sanitizers are not regularly distributed, which often leads to them buying these gear at their own expense.
- Lack of support from family was also identified when they conducted a door-to-door survey amid the pandemic
- Some ASHAs need to go far from their place of residence to the beneficiaries residence. Of the they have to reach there on foot or by arrangement of taxis, expenses of which have to be again met from their own pockets.
- The entire compensation received by ASHAs per month is very low which is quite inadequate for their sustenance.

- Delays and uncertainty about payments.
- Familial pressure against working due to their low or delayed pay
- Ill treatment and attitude of lack of willingness to cooperate by the community towards ASHAs. This leads to the non-delivery of their work as well as sense of demotivation among them.
- The sub-center is not equipped with the required infrastructure, logistics and instruments. Most ASHAs face difficulties in preparing their reports and getting stationery. They often have to pay from their own pockets.
- No scheme for financial assistance to widowed ASHAs and other vulnerable groups.
- The situation of COVID-19 has led them to depend upon their mobile phones to conduct their duties. The government has provided with android phones for this purpose. However, ASHAs face issues like bad network coverage, internet pack expenses, non-functioning of the phones, etc, which hamper their work.

"*Mujhe bahut kuch sunne ko mila*" one of the respondents replied." *Kisi ne kaha ki Corona toh tumhi se hota hai.*" She further adds that, " *Sab hum pe hai ki hum mei sun ne ki shamta honi chahiye aur kaam karna chahiye*."

"*Hamari Sunday ko bhi holiday nahihoti*."- one of the ASHAs

Conclusion

ASHAs have becomes an inevitable component in providing primary health care at the village level in India. They have mobilized the community towards local health planning that increased the utilization of primary health care and thus placed the health in the hands of the people. In the pandemic also, jeopardizing their health and safety ASHAs have been at the forefront of India's response to COVID-19. From August 2020 until now, ASHA workers along with Anganwadi and midday meal workers went on strike multiple times, demanding a raise in pay, timely payment, access to better protective equipment, insurance, travel allowance, regular testing, and legal recognition that allows them access to worker benefits, especially minimum wages. "As evident from the study, the ASHAs of Himachal Pradesh were also grappling with these struggles."

Recognizing ASHAs and giving them a greater role in activism and advocacy would provide them with greater recognition in their communities. More than 15 years after the launch of the NRHM, the ASHA has emerged as a significant factor in improving the health situation, especially among women and children. Further improving and strengthening of the program can bring India's targets closer to SDG.

ASHAs can be seen as agents of women's empowerment. Throughout the study, it was observed that their understanding of financial issues, banking, travel,

etc., instills a sense of empowerment and independence which is unprecedented for women in their communities. This, along with their new financial contribution to the family, gives them better decision-making ability and the right to exercise their autonomy. There is a clear need to continue training and supporting these women who are more rooted in their communities than any trained family care practitioner.

Human rights are not aspirational. They represent a minimal set of freedoms and entitlements that we share, as workers, citizens, and human beings. We are not at the end of the pandemic. It is essential that the human dignity and *human rights* of community health workers are upheld during pandemic and sans the pandemic. In the long months to come, as the applause fades and essential workers seek the personal and professional resources to respond to the pandemic's long game, it is critical that the fundamental rights of ASHAs are honored. It should be seen by states that the human rights be implemented, using the principles of transparency, proportionality and solidarity. If we do not ensure these basic rights, if the state cannot honor even its ordinary obligations, all of us will be far less safe.

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