CHAPTER- 5

FORMATION OF ASHA WORKERS

Chapter 5

Formation of ASHA Workers

5.1 Health policy making in India

India has a long and rich history of small and large community health work programmes. A large national community health work scheme was established in the late 1970s that aimed to provide one CHW for every 1000 population in order to "provide adequate health care services at the door steps of the villagers and to educate them in matters of preventive and promotive health care" (Chatterjee 1993, 342-376). "Until 1977 no formal health policy and strategy for the health sector was documented or was in written form" (Ravi Duggal 2001). Government of India adopted a formal and official health policy in 1978 after Alma Ata declaration of world health assembly 'health for all by 2000 AD'.

"Health policy and planning are the part of five year plan in India, and it has been structured and implemented by central government through the council of health and family welfare" (Ravi Duggal 2002, 16-19). "CHWs have and had different titles however; their titles are changed with modification of schemes over time – from Community Health Worker in 1977 to Community Health volunteer in 1980 and Village Health Guide in 1981. The Village Health Guide (VHG) under family welfare program remained till April 2002" (UNICEF 2004). Now the community health workers are known as ASHA workers, which were created under National Rural Health Mission in the year 2005.

Initially Government of India started Minimum Need Programme plan with multipurpose workers for reducing population growth and to increase the accessibility of health services in rural areas and to retain the existing cadre of various programs which were integrated into the primary health care package for rural areas". (Kartersingh committee 1974).

Major innovation in the health strategy was initiated in the year 1977 under fifth five year plan by creating a cadre of village based health auxiliaries called the community health workers. "They were selected by the village members, provided training for three months in simple promotive and curative skills both in allopathy and indigenous system of medicine. They were supervised by multipurpose workers. The programme was started in 777 selected Public Health

Centers where multipurpose workers were already in place." (Duggal 2002, 16-19). This scheme was considered to fill up the lack of trained manpower under health sector in rural areas. The CHW worked as a link between the multipurpose worker and the sub centers and the community. Later this program resulted in less or no visit of doctors in the rural areas. Thus their option for rural areas was the CHW scheme. This attitude clearly indicated the discrimination in the belief that urban population needs curative care and rural population preventive care. Hence the policy remained unsuccessful in achieving health status of the rural population.

"The sixth five year plan was to a great extent influenced by the Alma ata declaration of health for all by 2000 AD. The plan emphasized that horizontal and vertical linkages had to be established among all the interrelated programmes like water supply, environmental sanitation, hygiene, nutrition, education, family planning, maternal and child health" (Duggal 2002, 16-19). The main focus of the plan was to manage epidemics. Mass campaign was started in order to eradicate various diseases with the help of trained health workers (Banerji 1979, 511-519). It would appear that the scheme was not well anchored and unable to reach to the entire target segment. Under Seventh five year plan highly trained and specialized health professionals were encouraged to work in both the public and private sector also in the rural areas. The plan continues to support population control activities and special attentions was given to the diseases like AIDS, cancer and coronary heart diseases. The programmes under the seventh year plan were not sufficient to meet the demands of the people residing in the rural areas (ibid,II.273-276). The core of the existing frame work and ideology of the schemes remained untouched (Chatterjee, 1988). "Over time it was felt that an integrated compressive approach towards the future development of education, research and health services requires to be established to serve the actual health needs and priorities of the country. The need has been felt to evolve a National Health Policy" that would focus on preventive, promotive and rehabilitative primary health care approach with the help of village volunteers (M_0HFW, 1983). The basic goal of the 1983 National Health Programme (NHP) was to provide "universal comprehensive primary health care services relevant to actual needs and priorities of the community. But the NHP fail to reflect the ground realities adequately. The goal of the program was far from being achieved, the reasons being poor facilities, inadequate supplies, insufficient human resource, poor managerial skills of doctors, faulty planning of the health programme and lack of proper monitoring and evaluating mechanisms ((M_0HFW, 1983).

Under eighth five year plan, selective health care approaches had been adopted with a new slogan instead of health for all by 2000 AD. It chose to emphasize health for the underprivileged. Simultaneously it continued its support to privatization.

In ninth five year plan a number of innovative ideas were included. The initiatives were to provide improved medical health education. The ninth plan has made provision to speed up this process and proposed horizontal integration of all vertical programs at district level to increase their effectiveness as also to facilitate efficiencies. The core of this programme was maternal and child health services, "assuring maternal care, safe delivery, immunization and reducing infant and maternal mortality. The government started health programme with a new cadre called Village Health Guide (VHG). He/she (VHG) was to live in the village, have minimal schooling and be willing to devote two to three hours a day to community health activities. They had to be accepted by all the groups forming the community and should not to be members of any political organization. The Village Health guide should know the health needs of their community and able to provide basic health services, minor treatment and preventive measure" (Jobert 1985, 1-28). Review of the ninth plan shows failure of the programme at the ground level.

India has the largest number of births per year (27 million) in the world and highest maternal mortality of about 300-500 per 100000 births. Hence India's progress in reducing maternal and infant death became one of the crucial factors to the achievement of Millennium Development Goal (MDG) (WHO, 2003). Therefore in the tenth five year plan the government of India tried to strengthen the functioning of its health care system by launching National Rural Health Mission (NRHM) in 2005. The goal of the mission was to improve the availability of health care services, especially the rural population to reduce maternal mortality rate, infant mortality rate, control of epidemics, improvement of nutritional status of children and mothers, prevention of water- borne diseases and to make available reproductive and other health related services to the under privileged rural community. In order to achieve the health related millennium development goals, Accredited Social Health Activist (ASHA) workers were created under NRHM.

5.2 Formations of ASHA workers

When government failed to take off CHWs programme a number of Non Governmental Organizations (NGOs) and state driven efforts developed across the country that led to a number of successful projects, such as SEARCH (Society for Education, Action, and Research) in Maharashtra state and Mitanin in Chhattisgarh state.

The SEARCH NGO initiated to provide home-based neonatal care in tribal districts of Maharashtra in the 1980s, that included Village health workers (VHW), who conducted antenatal and postnatal counseling and birth attendance (Bajpai and Dholokia 2011, 10). Research result (Bang et al. 2005, 72-81) reveals decreased neonatal mortality up to 20% compared to the control population. The nutrition counseling interventions led to a significant decrease in the birth of low birth weight babies, and other interventions resulted in a significant decrease in case fatality (60% decrease for preterm, 70% decrease for LBW babies) with a substantial decrease in the incidence of co-morbidities such as sepsis, asphyxia, hypothermia, and feeding problems. This resulted in a visible improvement in health scenario of the target segment.

The project Mitanin was launched in Chhattisgarh in the year 2002. This project sets a dedicated structure. Mitanin referred to women, selected from the communities, who received altogether 20 days training and worked with primary health staff. They conducted household survey, including essential care of newborns, nutritional counseling, case management of childhood illness, and rights-based activities (e.g. access to basic public services, women‘s empowerment activities, and mobilization around ICDS and mid-day meals). “Mitanin were not salaried, but received a piece of land for cultivation or by other means, as decided by the villagers. Over 60,000 Mitanin serve in over 70,000 villages, and are supported by 3,000 women engaged as middle-level supervisors. The Mitanin is widely credited for lowering IMR from 85 in 2002 (the second highest in the country) to 65 in 2005. During the same time period, the state‘s proportion of underweight children has dropped from 61 to 52%, and full immunizations rose from 22 to 49% in the 12-24 month age group. Mitanin programme served as a model to the ASHA programme” (Bajpai and Dholokia 2011, 12).

The ASHA programme has been created under NRHM to provide primary medical care, advice the villagers on sanitation, hygiene, ante natal and post natal care, escorting expectant

mothers to hospital for safe delivery etc. ASHA serves an integral role in the public health system. They are considered as change agent. They were selected from the village itself between the ages 25-45 with a minimum 8th standard school education and are imparted 23 days training. They provide health education through household visits and community outreach activities, and are engaged in health promotion activities in their community. ASHA workers counsel women on birth preparedness, importance of safe delivery, breastfeeding and complementary feeding, immunization, contraception, prevention of common infection including reproductive tract infection, sexually transmitted infection and care of the young children. They also provide primary medical care for minor ailment such as diarrhea, fever, and first aid for minor injuries. She also provides Directly Observed Treatment Short-cut course (DOTS) under Revised National Tuberculosis Control Programme. They also develop a comprehensive village health plan with the village health and sanitation committee (VHSC). "ASHA coordinate with the community and work as bridge/ link between the health system and the community people. ASHA workers are not paid any salary but they receive performance based compensation for their performance under different programmes. ASHA provides an important opportunity to link community with the health care system, which brings a systematic change in health service" (Ramini & Mavalankar 2005, 1-13).

5.3 ASHA workers in Assam

She is the negotiator between the rural population and health system. She is the representative of a happy healthy life to the future children by protecting the mother of present. She is ASHA, hope for a better life.

Many a time, the villages are not connected by any mode of transport system thereby making it difficult to achieve the objectives and goals of providing quality health care to the poor and oppressed. Thus a new band of community based health activist named Accredited Social Health Activist (ASHA) is introduced to fill the void in the community processes. ASHA is positioned as health activist for 1,000 populations who create awareness on health and social determinants, and mobilize community towards local health planning and increased utilization and accountability of the existing health services.

In Assam, ASHA was created in the year 2006 and till the year 2012 twenty five thousand nine hundred seventy five ASHA workers have been recruited against its target of twenty six thousand six hundred ninety three ASHA. The backlog of 3% is due to the inability to identify suitable candidates in certain areas. Areas affected by insurgency tribal and hilly terrains are some reasons for an inability to identify suitable candidates for the position of ASHA. As per facility survey (2012) there are 1780 ASHA workers working in Sonitpur district, 4753 ASHAs are working in the Nagaon district and 2490 ASHAs in Sivsagar district.

ASHA must primarily be a woman resident of the village married/ widowed/ divorced. Women are preferred over those who are yet to marry, since in Indian culture norms after marriage a women leaves her village and migrate to her husband's place. She should be literate women with formal education up to class eight, preferably in the age group of 25-45 years. Members of gram panchayat suggest few candidates from the village for the recruitment of ASHA on the basis of their skills and knowledge, credential of these are further verified by health officials of the health development block. On the basis of their verification the most eligible one is recruited as ASHA worker. Block office passes information regarding the recruitment of ASHA to NRHM district office and accordingly registration of ASHA is done at the district level. If there is no suitable literate candidate, semi literate women with formal education lower than eight standard are selected. ASHA receive performance based incentives for promoting universal immunization, for referral and escort services, for work related to reproductive and child health (RCH) and other healthcare programmes. They are provided honorium of Rs. 600/- for every live birth and Rs. 400/- for mortal birth under Janani Suraksha Yojana. They are provided Rs. 100/- for organizing health mela (health fair) in their village once in a month. Rs. 150/- is given for motivating women to sterilize after two live births and Rs. 200/- if they convince men to sterilize after their two children. They are provided Rs. 150/- for organizing Vitamin doses/ vaccination camps monthly and Rs.150/- for creating awareness regarding convincing people for construction of household toilets. Capacity building of ASHA is being seen as a continuous process, ASHA have to undergo series of training episodes to acquire the necessary knowledge, skills and confidence for performing her spelled out roles. To upgrade ASHAs knowledge level regarding various aspects of health issues and to provide relevant and current information on NRHM activities to the ASHA, government of Assam initiated ASHA radio programme of NRHM from August 2007. All ASHAs have been

provided with a radio set to encourage programme promotion. The programme is broadcast on Wednesday during VHND session. It has provided an opportunity for the ASHAs to have the village women who have gathered at the Anganwadi centre for listening to VHND programme. Hence ASHA radio programme is an innovative step taken by Assam government to help ASHAs to work effectively.

5.4 Roles and responsibility of ASHA workers

ASHA play a vital role in empowering the community in local health planning and facilitate the accountability and increased utilization of the existing health care services. She creates awareness in areas like nutrition, sanitation and hygiene, healthy living and working conditions, provides information on existing health services and their timely utilization. ASHA help and mobilize the community and assist them in accessing the services already available at Anganwadi centers, sub centers, PHCs and CHCs. She works with Village Health Sanitation Committees of Gram Panchayat to develop a comprehensive village health plan. She promote construction of household toilets under Total Sanitation Committee

She counsel women on birth preparedness, breastfeeding, immunization, contraceptive and care during illness. She arranges escort or accompany pregnant women to hospital for antenatal checkup and institutional delivery. ASHA is provided with a drug kit which contains medicines for minor ailments such as fever, diarrhea and first aid for minor injuries. She has been recognized in her village as a provider for DOTS and a depot holder for ORS, chloroquine, oral pills and condoms.

Another important task for ASHA is to mobilize women , children and vulnerable population of her village for the monthly 'health and nutrition day' where the activities like immunization, careful assessment of nutritional status of pregnant and lactating women, new born children, taking weight of babies and pregnant women are conducted. She maintain records, registration and health information of the community .She counsels all the eligible couples for contraceptive choices and coordinate with ANM and Anganwadi worker in providing health care.

Reference:

Bajpai, N., and R.H. Dholakia. *Improving the Performance of Accredited Social Health Activists in India*. Columbia University New York. May 2011. Web. May 2011. < globalcenters.columbia.edu/articles and www.iimahd.ernet.in.

Bang, A.T., Baitule S.B., Reddy, H.M, Deshmukh, R. A. "Low Birth Weight and Preterm Neonates: can they be managed at home by mother and a trained village health worker?" *Journal of Perinatology* 25 *(*2005):72-81. Print.

Banerji, D. "Place of the indigenous and the western systems of medicine in the health services of India". *International Journal of Health Service in India* 9.3 (1979): 511-519. Print.

Chatterjee, Meera. *Implementing Health Policy*. Centre for Policy Research, Delhi: New Delhi Monohor Publication Private Limited. (1988). Print.

Chatterjee, M. *Health for too many: India's experiment with truth. Reaching Health for All*. Edited by Jon Rohde, Meera chatterjee and david Morley, 342-376. Oxford University Press, New Delhi: 1993. Print.

Duggal, R. "Evolution of Health Policy in India". CHETA Santacruz, Mumbai. 2001. Web. 2001. www.cheta.org/rthc/rthpaper.htm >.

Duggle, R. "Draft National Health Policy -2002, Resource generation without planned allocation" *Economics and Political weekly.* 37.1(2005):16-19. Print.

Ghill, S. S and Ghuman, R. S. "Punjab: Rural Health – proactive role for the state." *Economic and political weekly* 35.51(2000): 4474-4477. Print.

"Human Development Report." Ministry of Health and Family Welfare, Govt. of India. Delhi: 2005-2006,

Jobert, B. "Populism and health policy: the case of community health volunteers in India." *Journal of Social Science and Medicine* 20.1 (1985): 1-28.Print.

Kalita, A., Baruah, A. “Rapid Appraisal of National Rural Health Mission Implementation”. Population Research Centers, Department of Statistics , Guwahati University Assam. 2009. Print.

“Karter Singh Committee Report”. Committee on Multipurpose Worker under Health and Family Planning, MoHFW, New Delhi. 1973.Print.

“M_OHFW”. National Health Policy, Government of India, Ministry of Health and Family welfare. 1983. Print.

“MoHFW”. *Rural Health care System in India*, Ministry of Health and Family welfare, Govt. of India, New Delhi. 2005. Print.

NRHM-ASHA guideline. “National Rural Health Mission, ASHA guidelines l” Centre for health promotion. National Rural Health Mission: identify the gaps, Rural Technology Development Centre, Himanchal Pradesh. 2005. Print.

Ramani, K.V., Mavalanker, D. “Health System in India: opportunities and challenges for improvements”. Indian Institute of Management, Ahmadabad: working paper series, 2005. 1-13. Print.

“SHRC”. State Health Resource Centers, Chhattisgarh. Mitanin Programme, Conceptual issues and Operational Guidelines, SHRC: Raipur. (2003). Print.

“UNICEF”. *What Works for Children in South Asia: Community Health Workers*. In UNICEF, South Asia (Ed.). Katmandu, Nepal: (2004) Print.

Vora, K., Mavalankar, D., Prakasamma, M. “Achieving Millennium Development Goal: 5 is India serious?” *Bullitine of World Health Organization*. 86.4 (2008): 241-220. Print.

World Health Report. “Make every mother & child count,” World Health Organization. 2005. Web. April 2005 <http://www.who.int/whr/2005/whr2005_en.pdf>.

“World Health Report”. *Shaping the Future*. World Health Organisation. 2003. Web. 2003 < http://www.who.int/whr/2003/en/whr 03_en.pdf , 2003.