ASHA: SUCCESSFUL PUBLIC HEALTH EXPERIMENT ROOTED IN VILLAGE COMMUNITY

The World Health Organisation (WHO) has recognized the contribution of India's 1 million Accredited Social Health Activists (ASHAs) during the Covid-19 pandemic. It is acknowledged that ASHAs facilitate linking households to health facilities, and play pivotal roles in house-to-house surveys, vaccination, public health and Reproductive and Child Health measures.

In many states, ASHAs are involved in national health programmes, and in the response to a range of communicable and non-communicable diseases. They get performance-based payments, not a fixed salary like government servants. There have been agitations demanding employee status for ASHA workers. The idea of performance-based payments was never to pay them a paltry sum – the compensation was expected to be substantial.

Genesis & evolution

The ASHA programme was based on Chhattisgarh's successful Mitanin programme, in which a Community Worker looks after 50 households. The ASHA was to be a local resident, looking after 200 households. The programme had a very robust thrust on the stage-wise development of capacity in selected areas of public health. Dr T Sundararaman and Dr Rajani Ved among others provided a lot of support to this process. Many states tried to incrementally develop the ASHA from a Community Worker to a Community Health Worker, and even to an Auxiliary Nurse Midwife (ANM)/ General Nurse and Midwife (GNM), or a Public Health Nurse.

Important public policy and public management lessons emerge out of the successful experiment with Community Workers who were not the last rung of the government system – rather, they were of the community, and were paid for the services they rendered. The idea was to make her a part of the village community rather than a government employee.

Over 98 per cent ASHAs belong to the village where they reside, and know every household. Their selection involved the community and key resource persons. Educational qualification was a consideration. With newly acquired skills in health care and the ability to connect households to health facilities, she was able to secure benefits for households. She was like a demand-side functionary, reaching patients to facilities, providing health services nearer home.

Building of a cadre

It is a programme that has done well across the country. As skill sets improved, recognition and respect for the ASHA went up. In a way, it became a programme that allowed a local woman to develop into a skilled health worker.
The ASHAs faced a range of challenges: Where to stay in a hospital? How to manage mobility? How to tackle safety issues? The solutions were found in a partnership among frontline workers, panchayat functionaries, and community workers. This process, along with the strengthening of the public infrastructure for health with flexible financing and innovations under the Health Mission and Health and Wellness Centres, led to increased footfall in government facilities. Accountability increased; there would be protests if a facility did not extend quality services.

The Community Worker added value to this process. Incentives for institutional deliveries and the setting up of emergency ambulance services like 108, 102, etc. across most states built pressure on public institutions and improved the mobility of ASHAs. Overall, it created a new cadre of incrementally skilled local workers who were paid based on performance. The ASHAs were respected as they brought basic health services to the doorstep of households.

Issue of compensation

There have been challenges with regard to the performance-based compensation. In many states, the payout is low, and often delayed. The original idea was never to deny the ASHA a compensation that could be even better than a salary – it was only to prevent "governmentalisation", and promote "communitisation" by making her accountable to the people she served.

There were serious debates in the Mission Steering Group, and the late Raghuvansh Prasad Singh made a very passionate plea for a fixed honorarium to ASHAs. Dr Abhay Bang and others wanted the community character to remain, and made an equally strong plea for skill and capacity development of Community Workers. Some states incentivised ASHAs to move up the human resource/ skilling ladder by becoming ANMs/ GNMs and even Staff Nurses after preferential admission to such courses.

The important public policy lessons are the need to incrementally develop a local worker keeping accountability with the community, make performance-based payments, and provide a demand-side push with simultaneous aug-

mentation of services in public systems. The system can sustain and grow only if the compensation is adequate, and the ASHA continues to enjoy the confidence of the community.

Debate over status

There is a strong argument to grant permanence to some of these positions with a reasonable compensation as sustaining motivation. The incremental development of a local resident woman is an important factor in human resource engagement in community-linked sectors. This should apply to other field functionaries such as ANMs, GNMs, Public Health Nurses as well.

It is equally important to ensure that compensation for performance is timely and adequate. Ideally, an ASHA should be able to make more than the salary of a government employee, with opportunities for moving up the skill ladder in the formal primary health care system as an ANM/ GNM or a Public Health Nurse. Upgrading skill sets and providing easy access to credit and finance will ensure a sustainable opportunity to earn a respectable living while serving the community. Strengthening access to health insurance, credit for consumption and livelihood needs at reasonable rates, and coverage under pro-poor public welfare programmes will contribute to ASHAs emerging as even stronger agents of change. ■

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