STAKEHOLDERS' ENGAGEMENTS WITH THE COMMUNITY HEALTH WORKER: THE ACCREDITED SOCIAL HEALTH ACTIVIST (ASHA)

A TALUKA/BLOCK LEVEL RESEARCH STUDY OF CHWs IN INDIA

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This research study is dedicated

to

Late Dr. Rajnikant Arole

And

Late Dr. Noshir H. Antia

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EXECUTIVE SUMMARY

The Community Health Worker has been the subject of several research studies across countries in terms of her performance (Banerji 1985, Berman 1998, WHO 2007). The difficulties of the Community Health Worker have also been explored to an extent but largely with a view of sustenance of the health programmes (Bhattacharya and Winch 2001). Some gender-based studies of women in health work including Community Health Workers have highlighted aspects of gender discrimination and oppression (Jones 1994, Zubia 2003, Sen and Ostlin 2007). However there is little known about the views of the women themselves about their own work. The contentious issues that have persisted in large-scale Community Health Programmes according to available knowledge are: processes of selection and training of Community Health Workers; poor systemic support offered to them; difficulties in the nature of employment including payments; difficulties with the extent of curative services offered by them and their relationships with the local stakeholders from the health services and the community (CHC 2005, Lehmann and Sanders 2007).

In India the Community Health Worker has long been a part of health care services for rural populations across the voluntary sector. As far as India's public health sector is concerned, Community Health Workers have been incorporated in the rural health services with varying degrees of success.

The ASHA Scheme

The current involvement of Community Health Workers (CHWs) in the rural public health sector in India is through the National Rural Health Mission (NRHM 2005-12). Under the NRHM the Accredited Social Health Activist Programme, popularly called the ASHA Scheme, is currently operational in the villages of the country. The selection criteria for an ASHA is she should be a woman, primarily a resident of the village, aged 25 to 45 years of age and educated up-to class eighth . ASHAs are paid incentives for selected tasks.

The ASHA Scheme is a well researched and documented CHW programme (NHSRC 2011, IIPS 2011). However the available knowledge is largely about the ASHAs' performance. To sum up the progression of the ASHA Scheme, about 850000 village women have been selected and trained by the public health services in the country. Their performance has been noted in increasing the rate of institutional deliveries and immunization; care provision of illness episodes; visiting newborns within three days ; and increasing awareness among women . However there have been regional variations in all these activities. Several studies over the years have reported inadequacies in training, delays in paying incentives to ASHAs and delays in filling of drug kits of the ASHAs (NHSRC 2011, NHSRC 2011 [B], executive summary , Gill 2009, IIPS 2011).

Methodology

The study was conducted in Shahapur taluka (block). The data was collected in the year 2011. Shahapur is the largest of the Adivasi (tribal) inhabited talukas of Thane district in the state of Maharashtra in India. Shahapur supplies drinking water to Mumbai but is drought prone. Despite a high literacy rate and some industrial presence, the dominant economic activity is agriculture. There are several Adivasi groups in the area besides a sizable presence of Kunbis (classified as Other Backward Caste). Shahapur taluka has a sub divisional hospital located at the taluka headquarters, and nine primary health centres (PHCs). The ASHA Scheme is fully functional in the area.

Data was collected from three stakeholder groups namely ASHAs; local public health functionaries and members of the community. They were covered in six sequential phases of Data Collection using mixed methods (Box 1).

In the first phase all the ASHAs in the block working in all the nine primary health centres (PHCs) of Shahapur were administered a self answered questionaire in the local language Marathi. This tool was chosen as it was participatory and gave the ASHAs the space to reflect and express. More importantly it retained the 'language' of the ASHAs. The emergent data was analysed before sampling for the second phase of data collection with ASHAs.

In the second phase with ASHAs, a purposive sampling method was used to get a divergent sample of ASHAs. The criteria was firstly representation of ASHAs across nine PHCs; secondly

the demographic profile; and thirdly the reasons written for joining. Semi-structured interviews were conducted with 24 ASHAs until saturation was reached. The interviews were conducted in the local language (Marathi) and care was taken to retain the ASHAs' expressions.

All the data from the ASHAs was analysed before exploring the perspectives of the second group of stakeholders, namely the local functionaries of the public health services.

It was observed that the functions of the ASHAs were associated with the four levels of local health functionaries: ASHA facilitators at the villages; multipurpose workers and auxiliary nurse-midwives (ANMs) at the sub centres; lady health visitors or senior ANMs, health assistants and medical officers at the PHCs; and the block facilitator and block medical officer at the taluka headquarters.

In the third phase, the ASHA facilitators (immediate supervisors of ASHAs) were administered the same self-answered questionnaire as the ASHAs, for comparability. The responses were analysed immediately, before the fourth phase of data collection which was conducted collectively with the other levels of functionaries. In the fourth phase, the convenience sampling method was used until saturation. Local public health functionaries at all levels that were accessible and willing to be interviewed were included in the sample. Although assured of confidentiality, the health functionaries were reluctant to give formal structured interviews, therefore open interviews using a research guide were conducted. Individual and joint interviews were conducted until saturation was reached at 20 interviews.

The data from the stakeholders from the health services was analyzed before embarking on the exploration at the community level.

At the community level, in phase five, five open interviews were held with sarpanchs (heads of village councils) and members of the village water supply, sanitation and health committees from different villages until saturation. The convenience sampling method until saturation was used.

Finally in phase six, a household survey was conducted. The sample size was 120 households . The decision to have a sample size of 120 households was based upon the predominantly qualitative nature of the research design manifested by several open questions in the survey questionnaire. The priority was to select as divergent a sample of households as possible from across the taluka. Multi stage cluster sampling was done (at PHCs, sub centres and villages levels) to select six villages. In each of these six villages, systematic sampling was done to select 20 households from each villages. The total households in the six villages were 661 households.

The total sample size of the study was 120 households from six villages.

Box 1: Stakeholders, Sampling Method, Sample Size and Research Methods

Phase - Stakeholder Group	Sampling Method	Sample Size	Method
One – ASHAs	Census	244 ASHAs	Self-answered questionnaire
Two – ASHAs	Purposive	24 ASHAs	Semi-structured interviews
Three – Health Services	Census	29 ASHA facilitators	Self-answered questionnaire
Four – Health Services	Convenience	20 interviews from three levels of the health services	Open interviews
Five - Community (Sarpanch/VWSHC* members)	Convenience	5 group and individual interviews	Open interviews
Six – Community (Households)	Multi-level cluster and systematic	120 Households	Household survey

* VWSHC: Village water supply, sanitation and health committee

Findings

Findings were presented as analytical themes from each stakeholder group using constant comparison across stakeholders and methods.

Findings from the ASHAs reflected their experiences, motivations and concerns. The main findings that emerged from ASHAs were:

1. The ASHAs aspired and valued the growth and space given to them by their work as Community Health Workers. However, their motivations and their concerns were separate and were co-existent. The ASHAs expressed that they were motivated by the intangible and non-material gains from their work in different ways. Equally, these ASHAs were concerned about their remuneration as well.

2. The task-incentive equation was seen as one-on-one and the aspect of 'voluntarism' in the ASHA's post was seen as "*doing free tasks*" by the ASHAs, their families, the stakeholders from the health services and the stakeholders from the community. This was not only due to poverty but also the local norms where daily labour fetched payment.

3. The family emerged as a stakeholder for the functioning of the ASHAs. This has not been reported in previous studies. The data showed that the women facing the dual pull of the satisfaction afforded by the work on one hand and the need to better their lot on the other hand. Families did not find the work sufficiently compensated and there was evidence of pressure from home due to small incentives. In some families the ASHAs were feeling supported by other women or husbands but the other family members were not supportive.

An exploration into the experiences of these women while undertaking the responsibilities of the ASHAs revealed that they had to undertake various negotiations with their families and communities for creating and maintaining spaces to work. Their daily routines of household and earning responsibilities had been retained and the responsibilities as ASHA were added to these. The ASHAs said that some of the physical strain and pressure could be possibly eased if they were compensated adequately.

4. There were concerns of reputation and safety with regard to the mobility demanded by the work among the ASHAs.

These were all seen as hardships of efforts and created a sense of entitlement for the ASHAs from the health services across ASHAs, the community and the local public health functionaries as well.

5. The nature of the ASHAs' post also created a sense of entitlement. ASHAs identified their post with the health services system because the manner of selection, training, ongoing

supervision and payments were all by members of the system. They were given uniforms and identity cards. This association also enhanced their status within their families and the community.

5. Regarding the ASHAs' equation with the health services functionaries, there were several ‘unaccounted’ stakeholders from the health services (that were included inductively in the study). There was a sense of entitlement for the ASHAs across stakeholder groups which came from the fact that they were interacting with four different levels from the public health services. All their tasks were also to do with the health services.

The ASHAs' equation with the other stakeholders is a cause for concern because a previous national CHW Scheme of 1977 had suffered these contentious issues (NIFW 1977, Chatterjee 1993) and it had dwindled to a halt within some years. The ASHAs were motivated and willing to work, and were also performing well (with scope for improvement) but were being held back from fulfilling their potential by the same contentious issues.

The 'other side' of the story was also explored in this study. An exploration of the perspectives of stakeholders from the health services and the community about the responsibilities of the ASHAs showed that each stakeholder group had distinct perspectives. The exploration was initially on the stakeholders’ perspectives of ‘the duties of the ASHA Functionary’. However perspectives of ‘the location of the ASHA Functionary within the health system’ also emerged from the data as the second theme.

The ASHAs’ engagements with the public health functionaries at the block/taluka level showed the following main findings:

1. It was revealed that in the journey from policy to implementation, the ASHA’s duties had increased significantly. The original mandate of the ASHA Scheme where the ASHA was envisioned more as a facilitator than an implementer of every public health programme was lost.

2.The status of ‘volunteer’ and ‘activist’ as well as mandated by the policy had put the ASHA Functionary in a double bind. She was held accountable for increased duties under the National Health Programmes at the local level. by the health functionaires and the community.However the stakeholders from the health services at the local level did not take

ownership for the other mandates of the ASHA Scheme like ensuring that the village health committees were engaging with ASHAs or that ASHAs were receiving timely payments.

3. Remuneration was the most visible symbol of this dichotomy and the ASHAs were the most vocal about this aspect of their engagement vis-à-vis the health services system. Delays in receiving payments, small amounts as incentives and being 'handed over' several unmandated and unpaid tasks were the three main difficulties expressed with regard to incentives. Some of the incentives like travel expenses were to be received through the village health committees and were not being received.

4. A high rate of absenteeism/attrition was seen in the study area among the ASHAs and there were linkages with the dissatifaction with remuneration by the families and the ASHAs.There were 340 ASHAs in the taluka according to the records of the block medical officer's office. However only 244 ASHAs were present on the monthly ASHA meeting days in the nine PHCs when the self administered questionnaire was administered. The common reasons for the absebce of ASHAs given by the PHC staff were ‘absent today’ , ‘gone on leave', and 'gone for delivery' . In some PHCs, there was no response to a query on the reason for the absenteeism of ASHAs.

4. The ASHAs did not want jobs but asked for some 'fixed amount' in addition to any incentives. There was some evidence of union activities in the area as well. Some states in the coutnry have now started to give a fixed amount but Maharashtra is not one of them. Addressing remuneration concerns and giving a sense of stability to the ASHAs across the states should be a prime concern of all concerned. However this did not imply that the ASHAs did not acknowledge the inherent altruism and benefits of their work. ASHAs demonstrated a high degree of confidence in their ownership of their own work as benefits to their community.

An exploration of the ASHAs’ engagements with the community showed the following main findings:

1. On an individual level, the ASHAs narrated several expressions of appreciation from the community members. On the other hand they were also being held accountable for the public health services by the community. As a stakeholder group, the ASHAs were deprived of valuable

support from the community. The village health committees had been formed but were not engaging with the ASHA Functionary in terms of information or participation.

2. Most of the household heads in the sample were aware of the ASHA in their village. Their description of the duties of the ASHA triangulated that of the ASHAs. However the ASHA's location and duties were both placed within the public health services by the village health committees as well as the households. She was seen as a conduit for the free services from the government.

3. The most urgent health need and priority according to the largely male heads of households was for curative services. This was only natural considering their poverty and lack of social determinants of health in the region. The data indicated that the households were using the public health services for about half of all their curative health needs. This is an encouraging figure which must be explored in further research efforts and improved as well. The curative services of the ASHAs were rightly identified as being useful only for minor illnesses by the community. On the other hand, the community mentioned non incentivised activities of information-giving, referrals and home visits being carried out by the ASHAs.

4. This did not necessarily translate to a better status for the ASHA in the community because the ASHA was seen as working for the health services and there was poor awareness about her 'voluntary' post and incentives. However the ASHAs did mention that their services for referral in the case of emergency situations were appreciated by the community.

5. There was an indication of personal discrimination by the community towards a ASHA from a Dalit (Backward caste) background. However the case study showed that the upper castes still availed of the escort services for institutionalised deliveries and the medical kit of the Dalit ASHA as she was located as a conduit for government services. This implies that the association of the ASHAs with the public health services is empowering for her in terms of response from the community while also making her accountable as a frontline worker. Stronger and visible ownership by the health services system of the ASHAs is indicated as the way forward.

6. The question of prioritisation of tasks by the ASHAs in the community was also explored. The data revealed that while the ASHAs were dependent upon the Janani Suraksha Yojana (a government programme for encouraging institutionalised deliveries that gives the

highest incentive among all ASHA incentives) for an acceptable payment, they were also conducting various other tasks. This was reported by all the stakeholder groups except the medical officers. This finding was ratified by other studies as well (NHSRC 2011, IIPS 2011). The current study revealed that the ASHA's package of services for women and children was in fact given a low priority by the largely male heads of households.

The current study also showed an element of coercion for universal institutionalised deliveries to the ASHAs from the health services functionaries and through the ASHAs to the community. There was also resistance of the same from the women of the community particularly the Adivasis. This aspect needs to be explored further.

Meta inferences: Gender, Hierarchy, Gender-Hierarchy

Meta inferences of these emergent themes including a perspectives mapping across all stakeholder groups showed that the stakeholders' understandings of the ASHAs were influenced by Gender, Hierarchy and Gender-Hierarchy in several ways. These factors also increased the vulnerability of the ASHAs . Most notably in the Janani Suraksha Yojana (a programme for encouraging institutional deliveries) where the gender of the ASHAs was an advantage, their gender was the most overlooked aspect when it came to the ASHAs themselves. The extreme manifestation of the gender-hierarchy power play was seen in the reported harassment of ASHAs for sanctioning payments and the spectre of sexual harassment in one primary health centre out of the nine primary health centres of Shahapur.

A key finding was the feeling of personal empowerment experienced by the ASHAs after joining this post despite the difficulties. The ASHAs' personal empowerment from the work however did not translate to changes at home and at work in the face of the unequal power balances.

The words of the ASHAs reflected a new reality where their gender was not a deterrent to their aspirations for space and growth. They were determined to work but their aspirations were not for a job in the government. Their overwhelming preference was for stability and improvement in their posts as Community Health Workers. They did not want to be employees. They preferred not to relinquish their pre-existent roles which they were currently powerless to give up.

The Emergent Theoretical Framework

The theoretical framework of this study at the beginning of this study placed the ASHA within the Human Rights Perspective. The ASHA as a Community Health Worker was seen as the foundation of a responsive public health system. However the rights of the woman Community Health Worker ASHA herself emerged as a key factor from the study. The analysis showed that any efforts towards the Right to Health for the community can only be achieved if the rights of the Health Workers are preserved. Therefore the emergent theoretical framework from this study has given equal spaces to the Right to Health for all and the Rights of the Health Worker. This would ensure Human Rights for all. Finally this study suggested the directions for changes towards such empowerment. This included reforms within the health services, within the ASHA Scheme, action towards the social determinants of health and improved awareness about the ASHAs in communities.

LITERATURE REVIEW

The traditional Indian view of health is broad and holistic. The Sanskrit word "*Swasthya*" commonly used for health indicates that the pursuit of well-being goes much beyond the medical cure of disease (Antia and Bhatia 1993). The traditional Indian systems of medicine, Ayurveda, Siddha and Unani, all see health in a holistic manner.

"A person, who is free from physical disease, psychosomatic disease and has a satisfied and contented mind, is called healthy." This is the definition of health given by**Yogavasisthya**,an undated ancient yoga scripture (Vyavahare and Natu 2006).

The widely disseminated World Health Organization (WHO) definition of Health declared in the Alma Ata Declaration in 1978 echoes the same holistic view of health as the traditional Eastern philosophies:

"Health is a state of complete physical, mental and social well-being, and not merely an absence of disease or infirmity." (WHO 1978)

1. Health and Development

The development of modern medical sciences has been tracked from 'empirical symptom centered philosophy' around 1850 to a 'disease-oriented diagnosis philosophy' around 1900. Five decades later around 1950, the philosophy of Western medicine changed to a 'patient oriented treatment philosophy'. The vision of health with a 'community centered philosophy' entered into the medical sciences around 1975. The community orientation of medical sciences is associated with an understanding that there are intricate linkages between health and development. Around the decade of 2000, the health sciences further turned towards a political and people-centered orientation. As a consequence currently social and economic indices are considered as important factors for the attainment of health (WHO in Goel 2002). Box 1.1 depicts this journey of the medical sciences towards an inter-sectoral understanding of activities and processes leading to the attainment of health in a community.

Box 1.1

Development of Medical Sciences

	Empirical Health ***Era 1850***	***Basic Science*** ***Era 1900***	***Clinical Science*** ***Era 1950***	***Public Health*** ***Era 1975***	***Political Health Science*** ***Era 2000***
Purpose and Philosophy	Symptom – centered	Bacteria or Disease-centered	Patient-centered	Community-centered	**People-centered**
Treatment	Empirical diagnosis and treatment	Diagnosis and treatment of the disease	Diagnosis and treatment of the individual	Diagnosis and treatment of the community	**Diagnosis and treatment of total body politic**
Education	Lectures, Authoritarian instruction	Laboratory instruction	Clinical instruction, 'bedside teaching'	Clinical public health instruction, 'community-side' teaching	**Social and Economic understanding, managerial acumen, political psychology and country health programming**
Research	Historical	Basic Laboratory Development of new tools	Clinical development of techniques	Community Development Measurement and Criteria Planning techniques	**Social and Economic indices for health, development subjective indices for quality of life, inter sectoral activity process**

Source: WHO in Goel 2002.

Thus "*complete well-being*" cannot be achieved as an individual pursuit because there are common conditions of living that universally affect the health of all the individuals in a community. These conditions that commonly affect the health of all are generally called 'the social determinants of health.' The report of the World Health Organization's (WHO) Commission on Social Determinants of Health (2008) says:

"*The social determinants of health are the conditions in which people are born, grow, live, work and age including the health system. These circumstances are shaped by money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities*." (WHO 2008 page 1)

Subsequently at the World Conference on Social Determinants of Health in 2011, the Rio Political Declaration on Social Determinants of Health made three overarching recommendations for participating nations:to improve daily living conditions; to tackle the inequitable distribution of power, money and resources; and to measure and understand the problems and assess the impact of action on problems. Thus, there is an acknowledgement that apart from aspects of development, the politics of development as manifested by the policies of nations also affect the status of health.

Community Health

A community has been defined as "… *a small group of any size whose members reside in a specific locality, share government, and often have a common cultural and historical heritage.*" (http://dictionary.reference.com/browse/community). Based in the understanding that Health and Development are irrevocably linked, *Community Health* is a discipline that concerns itself with the collective health concerns of communities.

"Community Health is a discipline that concerns itself with the study and betterment of the health characteristics of communities." (www.nacho.org./topics/ environmental/CEHA/resources/module/keyterms/index.cfm downloaded on 15th November 2012)

In practice, this discipline largely concentrates on the study and improvement of the health of populations that are deprived. In these endeavors, the "*involvement*" of the members of the affected community is a given factor. The "*transfer*" of information and interventions from health professionals to the general public is an integral part of community health programmes; indeed it defines the discipline (www. nacho.org).

Community Health Workers

The involvement of Community Health Workers (CHWs) in public health originates from an understanding of people-centered community health, where the community itself is seen as a resource in its own health care. This is illustrated in the definition given by the World Health Organization:

"Community Health Workers are men and women chosen by the community, trained to deal with the health problems of individuals and the community, and to work in close relationship with the health services. They should have had a level of primary education that enables to read, write and do simple mathematical calculations" (WHO 1990 in UNICEF 2004, page 3)

Walt (1989) has further elaborated on the working conditions of the CHWs in her definition. She says CHWs are:

"…generally local inhabitants given a limited amount of training to provide specific basic health and nutrition services … They are expected to remain in their home, village or neighborhood and usually work only part time as health workers. They may be volunteers or receive a salary. They are generally not, however, civil servants or professional employees of the Ministry of Health." (Walt 1989 in UNICEF 2004, page 3)

CHWs are found effective in developing countries to reach out to the poor especially in rural areas; as well as in developed countries to reach out to the ethnic and migrant communities. They are thus associated with the health care of poor, marginalized and geographically distant populations, typically being members of the same community themselves. It is now accepted that right from area-bound voluntary health programmes to national health programmes, health services are rarely planned for such communities without involving CHWs. There are expert perspectives that indicate the indispensible nature of the CHWs' contribution to health care.

"Given present pressure on health systems and the proven inability to respond adequately, existing evidence overwhelmingly suggests that CHW programmes remain a good investment, since the alternative in reality is no care at all for the poor living in geographically peripheral areas." (Lehmann and Sanders, 2007, page 6)

It is not possible to trace all the countries that are or have implemented CHW – based rural health programmes. This is a practice that has been followed across countries for at least 50 years. Recent studies (Lehmann and Sanders 2007, UNICEF 2004) list around 40 different terms by which CHWs are known in different countries, which is not exhaustive (Box 1.2).

2. Overview of the Chapter

The discussion so far was an introduction to the Community Health Worker. The discussion in the rest of this Chapter has eight sections. The first section is on global studies on the Community Health Workers. The second section is on Indian studies on the Community Health Workers. The third section is on the studies on the service conditions of Community Health Workers. The fourth section discusses gendered studies on health workers. The next two sections are on national Community Health Worker Programmes. Thus section five is on national Community Health Worker Programmes in some countries. Section six is on national Community Health Worker Schemes in India which is presented within the context of policy analysis. The ASHA Scheme is introduced here. The section seven presents the gaps in available knowledge about CHWs and ASHAs taking into account the preceding discussion. The last section of this Chapter, that is, section eight, presents the conceptual framework of the current study.

3. Global studies on the Community Health Workers

There are scores of global studies on Community Health Workers (CHWs). Some important studies are discussed below. One of the early comprehensive documents is a training guide for the community and village health workers in Mexico and Latin American countries. Based upon David Werner's experiences in western Mexico, it was originally written in 1970 but has since been revised and translated several times. A health studies classic originally written in Spanish, '*Where there is no doctor'* (Werner and Maxwell 1970) went on to be translated in around a 100 languages.

Box 1.2

Alternative Titles of Community Health Workers

Title	**Country**
Activista	Mozambique
Agente comunitario de salud	Peru
Agente comunitário de saúde	Brazil
Anganwadi (worker)	India
Animatrice	Haiti
Barangay Health Worker	Phillippines
Basic Health Worker	India
Brigadista	Nicaragua
Colaborador voluntario	Gautemaal
Community Drug Distributor	Uganda
Community Health agent	Ethopia
Community health promoter	various countries
Community health representative	various countries
Community health volunteer	Malawi
Community health worker	India
Community nutrition worker	Uganda
Community resource person	Nepal
Female community health volunteer	Honduras
Female multipurpose health worker	Ethopia
Health promoter	various countries
Kader	Indonesia
Lady health worker	Pakistan
Maternal and child health worker	Nepal
Monitora	Hondural
Mother coordinator	Ethopia
Outreach educator	various countries
Paramedical worker	India
Promotora	Honduras
Rural health motivator	Swaziland
Shastho shebika	Bangladesh
Shastho karmis (leaders of *shastho shebika*)	Bangladesh
Sevika	Nepal
Traditional birth attendant	various countries
Village drug-kit manager	Mali
Village health helper	Kenya
Village health worker	various countries

Source: Bhattacharyya et al., 2001; Gilroy & Winch, 2006 in Lehman and Saunders, 2007.

Miester (1990) presents various early models for CHW programs in USA including the Navajo Community Health Representatives in the late 1950s for migrant farm workers in Palm Beach County Florida; and migrant farm worker programmes in Kern and Santa Barbara Counties in California in early 1960s. This study records how Legal Acts were passed in 1962 and 1964 that led to a proliferation of lay indigenous worker programmes in the USA by mandating outreach services in poor neighborhoods and migrant labour camps. The study records the experiences of Local Lay Workers called Promotoras, with Mexican farm workers. These Promotoras found an overwhelming response from pregnant women and families for information. The study also records that the Promotoras were empowered and wished for better-paying and higher status employment. A 'newer' study based in USA by Dower (2006) gives information regarding CHW schemes in Minnesota, USA and characterizes the CHWs as an emerging resource to deliver quality care which is affordable, accessible and culturally competent. This indicates that the CHW concept sustained within the public health sector in the comparatively developed nations like USA for decades but for marginalized populations.

Frankel (1992) discusses several country experiences of CHWs namely Indonesia, China, Nepal, India, Tanzania, Zimbabwe, Nicaragua, and Honduras in the 'eighties. Frankel's (1992) analysis is that Community Health Workers have achieved much in many countries at different times. This study says that disappointment with the outcome of CHW programmes is often attributed to inadequacies in the CHW concept. Frankel separates the two issues and asserts that there is no longer any place for discussion of whether CHWs can be key factors in achieving adequate health care. The question is only how to achieve their potential. Disappointments with outcomes are thus placed upon factors external to the concept of the effectiveness of CHW interventions.

The viability of investment in CHWs is widely propounded currently also. '*The World health report 2006: working together for health'* for instance, identified as a research priority the feasibility of successfully engaging Community Health Workers. Lehmann and Sanders (2007) wrote a review paper on the state of evidence on programmes, activities, costs and impact on health outcomes using Community Health Workers. This is a paper commissioned by the WHO as a follow up to the Report '*The World health report 2006: working together for health'*. This review finds consensus in world literature across a number of issues with regard to the contribution of CHWs but adds that for CHWs to make an effective contribution, they must be carefully selected, appropriately trained and most importantly, adequately and continuously supported. The study says that numerous programmes have failed in the past because of unrealistic expectations, poor planning and an underestimation of the effort and input required to make them work (Lehmann and Sanders 2007).

Prasad and Murleedharan (2007) conducted a review of 110 global studies on Community Health Workers. Their review shows that available evidence supports the view that a carefully designed and implemented CHW programme could have far reaching implications. Results could be beyond better health outcomes towards increase in health seeking behavior.

Positive health outcomes across countries are presented ranging from increased usage of health services, usage of contraceptives, better knowledge levels among community, early detection of diseases, to decrease in morbidity and mortality rates. Box 1.3 shows some of the country studies reviewed by the authors, with outcomes of CHW schemes.

UNICEF (UNICEF, 2004) conducted a review of policies, practices and lessons learnt in involving CHWs in the public health sector, in five South Asian countries including India. This review asserts that the CHW can be extremely effective to work as a complementary force to a functioning health system.

A number of individual country studies in Vietnam (Barrett et al 2001), the Africas (Friedman 2007, Clark 2008), the Americas (Ingam 2008, Boutin-Foster 2008) and in Asian countries like Bangladesh (Chowdhary et al 2007) re-establish the utility of CHWs in ‘newer’ literature.

Thus globally the studies on CHWs have largely discussed their effectiveness as service providers to the community. Success has been seen in several curative, preventive and promotive health functions by CHWs. The fact that they successfully serve the underserved particularly the marginalized populations has also been repeatedly underscored. However appropriate selection, training and support have been seen as the underlying factors for their success (Lehmann and Sanders 2007) therefore the failings of CHW programmes have been separated from the success of the CHW concept (Frankel 1992). These are the perspectives of the experts whose findings largely center on the performance of CHWs.

Box 1.3

Summary of Some Research Studies Showing Health Outcomes in Various Countries with the Introduction of Community Health Workers

COUNTRY	RESEARCH QUESTIONS/ CONCEPTUAL FRAME	METHODOLOGY	RESULTS/ISSUES
Iran (Zeighami, Javidian, & Zimmer, 1977)	To determine the health workers knowledge, attitude and practice about family planning and also to know the gender differences in effectiveness of family planning	A KAP survey was conducted after 14 months of training. The total samples of 1308 eligible couples were from two sites, project (658) and control site (650).	The health workers were able to double the usage of pills among the eligible couples and this was true for both sexes of health workers, maximum between the age groups 25 to 34 years.
Costa Rica (Bender & Pitkin, 1987)	The paper examined the evolution and current status of Village Health Workers (VHWs)	An analysis of country's progress is done	IMR 61.5/1000 in 1970 decreased to 19.1/1000 1980; U5 mortality decreased from 5.1/1000 in 1970 to 1.1/1000 in 1980
Nicaragua (Bender & Pitkin, 1987)	The paper examined the evolution and current status of VHWs	An analysis of country's progress is done	Malaria decreased 39% from 1977-1983, polio eradicated, measles, whooping cough and tetanus extinct
Colombia (Bender & Pitkin, 1987)	The paper examined the evolution and current status of VHWs	An analysis of country's progress is done	From1978-1982, extend basic service to 82% of popln. Polio vaccination 23% - 43%, DPT 22% - 37%, BCG 36% - 71% and measles 21%-50%

Continued…

COUNTRY	RESEARCH QUESTIONS/ CONCEPTUAL FRAME	METHODOLOGY	RESULTS/ISSUES
Rural South Africa (Chopra & Wilkinson, 1997)	Evaluate the immunization coverage among the rural south African children with use of Community Health Workers (CHWs)	The study took place in Hlabisa health district of KwaZulu/Natal, South Africa, population of around 205,000 people. The programme has been running for 9 years, 1 CHW/100 households.	The immunization coverage was generally high. Immunization coverage was highest for all antigens in children who lived in areas with CHWs. There are no significant difference b/w two groups for BCG and measles coverage.
Australia (Homer, Davis, & Brodie, 2000)	Evaluation/ St. George Outreach Maternity Project (STOMP)	A randomized controlled trial was conducted with 1,089 women (550 in the experimental group and 539 in the control group)	STOMP group women reported a higher perceived 'quality' of antenatal care compared with the control group. STOMP group women saw slightly more midwives and fewer doctors than control group women did.

Source: Prasad and Muraleedharan, 2007.

4. Indian Studies on Community Health Workers

India has a long tradition of including Community Health Workers in health systems particularly in rural areas. The contribution of the CHW in providing health services to her community has been well acknowledged in the Indian voluntary health sector by the health professionals/activists that were heading several such programmes in the decades of the 'seventies and 'eighties. In the state of Maharashtra alone more than a hundred field projects in rural areas were identified that had health programmes in the decade of the 'eighties (Jessani, Gupte and Duggal 1986). These programmes were conducted within a limited population and geographical areas and several engaged CHWs to enhance the health of the community.

Studies from the Voluntary Sector

There are several early documentations of voluntary experiences in rural health care where the uses and the qualities of effective village health workers are defined (Ford Foundation Anubhav series 1987-88, Antia and Bhatia 1993, Pachauri 1994). These narrative studies have presented very positive accounts of the role of CHWs in enhancing health and development in their own areas within the voluntary sector.

One notable Indian voluntary project is The Comprehensive Rural Health Project at Jamkhed in the state of Maharashtra. It was started in 1970, and selected, trained and worked with women as CHWs. It was a forerunner of several other projects that came up in the same decade in various parts of the country and is functional to date. There are several examples of other successful Indian voluntary CHW based health interventions of that era. Annexure 1.1 presents three case studies of NGO experiences in CHW-based primary health care in rural India in three different parts of the country and within three different ideologies and frameworks that grew and flourished in the same era.

There is a distinct change in the manner in which the CHW is seen in the voluntary sector from the earlier narrative studies to more recent empirical studies. From the Indian voluntary health sector, there is a study on behavior change management for home based births through CHWs in UP (Vetal, 2008). It describes the crucial preventive services given by CHWs in a rural area. By educating mothers in healthy practices CHWs were successful in bringing about behavior changes to the advantage of the health of newborns.

Similarly there are two studies from Gadchiroli, a tribal dominated area, in the state of Maharashtra showing empirical evidence of successful interventions by CHWs. In one study there were improvements in home-based neo-natal care which decreased morbidities. In the second study, early identification of neonates at risk of pneumonia also decreased morbidity. In both cases, the interventions were through trained village health workers from the non-government organization SEARCH which has initiated the work in Gadchiroli. Notably the village health workers, who carried out the interventions, are not interviewed in both the studies. (Bang et. al, 2005 and Bang et. al, 2005).

Studies on Community Health Worker Programmes in the Public Health Sector

In the same decade of the 'seventies when the CHW programmes grew in the voluntary sector, a national Village Health Worker Scheme for rural areas was launched in the public health sector in the country. This Scheme did not sustain for long in the health services. The

health literature of the late 'seventies and early 'eighties shows several critical articles on this Scheme. A detailed discussion of these studies is presented later in this Chapter. In this sub – section it is important to note that there was a gap of several years before CHW Schemes reappeared prominently in the public health sector in the form of state level schemes for rural areas. Empirical studies were conducted on some of these state level schemes.

A study on a government CHW programme in Madhya Pradesh named the Jana Swasthya Rakshak Yojana (Community Health Cell 2001) studies the areas of selection, training, work content and community related issues. The study sees CHWs as the primary respondents. Data is also collected from other stakeholders from District to Village level. It covers issues like selection, training, work content and community. Findings focus upon the performance of the programme and the male Swasthya Rakshaks. This study also presents projected perceptions of various stakeholders in different primary health care models. However the perspectives of stakeholders are projected by the expert and are not co-related to the actual data collected for the study.

A later study takes the same concept of perceptions of stakeholders of CHW Schemes into the research design (Community Health Cell 2005). The Mitanin scheme of Chhatisgarh which is a state level CHW scheme for rural areas was investigated in this study. This study has included various stakeholders as respondents including the CHW, in this case the Mitanin herself. It finds that the Mitanins' potential was not fully realized. The Mitanins' concerns were for the amount of time spent at work, and nature of remuneration and support offered at work. The study comments that the neglect of the Mitanin's aspirations could lead to high attrition.

The local public health staff is reported in the study to be in an 'adversial engagement' with the Mitanins but the reasons are not explored in detail. However the study does report that neglect of the health staff's concerns can lead to poor support of the Mitanin. There are several recommendations like improving the Mitanins' skills for community mobilization and health education and giving the Mitanins performance based incentives. However the study does not discuss the factors that could help or hinder the implementation of these recommendations as intended by the researchers.

The Mitanin scheme of Chhatisgarh is also reviewed by Sunderaraman (Sunderaraman 2007) where he represents the scheme as a unique Public-Private Partnership. It is a positive depiction where the CHW Mitanin is recorded as demonstrating improvements in child survival, community action and better health seeking practices by women.

To sum up, although the country has a long history of involving CHWs, there is a paucity of Indian empirical studies on CHWs as compared to narrative studies. Secondly the literature shows that CHWs have been largely studied as service providers. Within the empirical studies on CHWs working in the public health sector, there are varied interpretations with no consensus about the effectiveness of involving CHWs in large-scale public health services systems (CHC

2001, CHC 2005, and Sunderaraman 2007). In the voluntary health sector on the other hand, largely the studies across decades report the CHW as effective in health work. However several of these studies also emphasize upon the logistics, training and moral support required for a 'successful' CHW programme (Ford Foundation Anubhav series 1988, Antia and Bhatia 1993, Pachauri 1994). The same conditions for success are corroborated from global studies as well as seen in the preceding discussion.

5. Studies on the Service Conditions of CHWs

While there are scores of studies on the performance of CHWs as seen in the previous section, there are comparatively fewer studies on the service conditions of CHWs. One of the earliest Indian voluntary projects to document the positive experiences of the CHW was the Comprehensive Rural Health Project of Jamkhed in Maharashtra. There is a narrative report, but no supporting data, of the CHWs feeling an increase in her own self-esteem and winning over the trust of the community. This happened after several years of hard work where the CHW was supported by the organization. She was never seen as working in isolation by the community. The CHW was granted visible support in terms of visibility of project staff in the villages, adequate supplies for the CHW and prompt response from the project for referrals made by her. The CHWs were supported in their initial struggles by the organization by regular meetings with space to share experiences. This was a narrative study by the Founder-Member (Arole 1993). The Mandwa project also located in Maharashtra similarly narrated the same positive gains to the CHW by the Founder-Member (Antia 1993).

'Recent' Studies on Motivation of CHWs

High attrition rates among CHWs have attracted the attention of recent researches. Bhattacharya and Winch (2001) have reviewed several global CHW studies that discuss factors to retain and motivate CHWs. These studies show that the factors include monetary and non-monetary incentives, community involvement and supportive policy/legislations. This review highlights the place of *"inter-relationships*" and "*trust*" among health professionals in building an effective feedback and referral system. The recommendations are aimed at sustaining the CHW within the existing structures.

Prasad and Murleedharan's (2007) review of more than a hundred global CHW studies "*identifies critical factors that influence the performance as pointed by empirical evidence*" as follows:

Gender: More countries have largely female CHWs and there is a collective impression that female health workers are able to deliver care more effectively than males.

Selection: Most studies highlight the need to recruit CHWs from the communities they serve.

Nature of employment: In several countries, particularly in the government sector, CHWs were employed in a voluntary basis or on a full time basis. The critical question raised by Prasad and Murleedharan was whether only the nature of employment per se influences the CHW's performance.

Educational status: In most countries the CHWs were school-educated. Effective performance in functions like diagnosing diseases was not related to education, age, sex or number of offspring's. However more educated CHWs were likely to look for better opportunities and to migrate to other jobs.

Career prospects: Career prospects for CHWs and their aspirations do influence performance with significant drop out rates.

The relationship between nurses and CHWs can be mutually seen as "*a threat*" and there can be "*unhealthy competition*". Mutual understanding of roles can avert this.

Feedback and rewards from the community are significant in overall motivation and performance of CHWs.

Lehmann and Sanders (2007) also reviewed several global CHW studies and their review has brought out the same issues as Bhattacharya and Winch (2001) and Prasad and Murleedharan (2007). Like Bhattacharya and Winch (2001), this review study reveals that existing knowledge does not give conclusive observations on the question of the satisfactory incentives and motivations for retention of CHWs. It also gives no conclusive observations on the question of whether CHWs should be volunteers or employed.

An Indian study on Mitanins (CHC 2005) has identified three contentious issues which have dogged CHW programmes the world over: selection, payment and the extent of CHWs' involvement in curative care.

It is notable that none of the studies investigate the causes for the persistence of the contentious issues. The effects of these issues are also studied more in terms of the sustenance of CHW programmes and not in terms of the effects upon the CHWs themselves.

In this context of incentives and motivations, it is pertinent to refer back to the narrative studies from the Indian voluntary sector, where the Founder Members had reported a rise in self-esteem and stature within the community with the passage of time (Antia 1993, Arole 1993, Parikh 1993).

Studies on the Relationship of CHWs with Full Time Functionaries

The poor relationship of the CHWs with the local full time health functionaries is an important dimension of the service conditions of CHWs in public programmes. This aspect has

been highlighted by Indian and global studies (CHC 2005, Lehmann and Sanders 2007). The poor acceptance of CHWs by health personnel is located within a hierarchical disease-oriented medical system as brought out by Lehmann and Sanders (2007). This discussion is quoted in full below:

"Many health personnel lack the background and orientation to provide a supportive environment for CHW programmes. They are socialized into the hierarchical framework of disease-oriented medical care systems and have a poorly developed concept of primary health care. Such paradigms are ill-suited to providing an environment supportive of partnerships and teamwork between different health workers, particularly if some categories are thought of as less important.

Health professionals often perceive CHWs as lowly aides (WHO, 1989; WHO, 1990; Walt, 1992) who should be deployed as assistants within health facilities, often completely misunderstanding their health promoting and enabling role within communities. A sense of superiority of health personnel has been observed as a problem (Sanders, 1992)."

(Lehmann and Sanders 2007, page 23).

In this context it is interesting to recall that an early Indian study (NIFW 1978) had presented the same analysis for poor acceptance of CHWs by local health functionaries in an early national Indian CHW Scheme namely the Village Health Worker Scheme of 1977. This aspect is also discussed later in this Chapter.

Studies on Community Participation in CHW Programmes

Community participation is another dimension that has been explored in early Indian studies with regard to the NGO Sector (Jessani and Ganguli 1990). This dimension has been studied specifically in CHW Schemes and the major concerns are captured effectively by Lehmann and Sanders (2007). They report that experiences of several countries show that community participation and ownership of CHW programs particularly state-initiated ones, is not successful. Village Health Committees also play an ambiguous role.

"This (participation) *appears to be easier to achieve in small-scale programmes initiated within and by communities, often with assistance from an NGO or a church group. National or state-wide programmes are usually initiated from the centre (Brazil, China, Ghana, India, Indonesia, to name but a few). While in these cases, too, community participation is explicitly part of the agenda, for a number of reasons it is much more difficult to achieve." Rifkin argues that a key reason is that "community participation has been conceived in a paradigm which views community participation as a magic bullet to solve problems rooted both in health and political power…"*

Where community participation is institutionalized, it is usually through village health committees (VHCs), known often by different names, which are charged with managing and guiding the work of community health workers. But VHCs also play an ambiguous role within CHW initiatives. The position of VHCs within village hierarchies is not always clear and is often contested, leading to tensions between VHC members and other community leaders or becoming the site of political contestation (Sanders, 1992; Sauerborn, Nougtara & Diesfeld, 1989; Twumasi & Freund, 1985; Streefland, 1990; Ebrahim, 1988)…

The character, role and organization of community participation in health care in general and in the running of CHW programmes in particular form an immensely complex and contested area with a vast literature of its own. This section barely scratches the surface of this rich debate." (Lehmann and Sanders 2007, pages 21-23)

To sum up the discussion, findings of recent global studies on service conditions show that school educated village women are the preferred profile of CHWs in health services to avoid drop out and migration (Prasad and Murleedharan 2007). Several studies show that more educated CHWs tend to look for better opportunities (Prasad and Murleedharan 2007). However both good performance and attrition rates are high across CHWs regardless of their personal profile (Bhattacharya and Winch 2001, Prasad and Murleedharan 2007) indicating that there is a potential which is not being fulfilled (CHC 2005).

Some of the possible reasons identified are the lack of involvement from both the health services (NIFW 1978, CHC 2005, Lehmann and Sanders 2007) and the community (Lehmann and Sanders 2007).

Along with the questions of selection, payment and extent of the CHW's involvement in curative care (CHC 2005), these questions of acceptance by the health personnel and community too are long standing issues. The last two issues are particularly pertinent in public CHW schemes and have not been resolved despite cropping up time and again over decades and across countries. However the analysis in existing studies is almost entirely from the perspective of the policy and focus on retaining the CHW in order to forward the aims of the policy.

6. Gendered Studies on Woman Health Workers

Women form a large proportion of the human force in the health care sector. In the rural health services in India, women are engaged largely in the nursing and outreach services. The proportion of lady medical officers in the rural public health services was 24.4% in India in 2010 (Family Welfare Statistics in India). Comparatively the strength of the all-woman Integrated Child Development Scheme was much higher. There were 11.71 lakh Anganwadi

Workers and 10.97 Anganwadi Helpers as on Dec 2010 (Press Information Bureau, GOI). Additionally there were 1,70,742 Auxillary Nurse Midwives (Family Welfare Statistics in India 2012) and 15,908 Lady Health Visitors at Primary Health Centres as on March 2011 (http://nrhm-mis.nic.in). There were 8,46,309 Accredited Social Health Activists (ASHAs) selected by December 2011 in the all woman ASHA Programme (Update on ASHA Programme January 2012).

The National Rural Health Mission has spurred a 300% increase in nursing institutions within five years (NHSRC 2011 [C]) therefore the woman force is expected to increase exponentially. Yet there is far less information about the life and working conditions of these women functionaries than about their performance in various Schemes.

Gender issues have been explored regarding the frontline workers and nurses globally to some extent. The first issue has been the experiences of women health workers during the course of conducting the work. Mumtaz et al (2003) have identified gender based constraints faced by female health and family planning workers in Pakistan. These workers faced disrespect from male colleagues, lack of sensitivity to women's gender-based cultural constraints and conflict between domestic and work responsibilities. Sen and Ostlin (2007) have reported that women are often expected to confirm to male work models that ignore their special needs such as child care or protection from violence. Sexual harassment from the community on the way to work or while working has been reported by community health workers (Sen and Ostlin 2007) and discussed by ANMs (Iyer and Jessani 1995). The impacts of their work upon their lives are not well documented with regard to the women working in the health care sector. A George (2008) has postulated that outreach workers like home carers are often compromising with their own health to fulfil the requirements of their work.

One of the earliest documentations of gender issues of women community health workers is in a study of the early experiences of the Comprehensive Rural Health Project in Jamkhed, rural Maharashtra. This project found that neither ANMs nor school teachers were able to function satisfactorily when they set up a Community Health Workers Programme. Therefore the project decided to work with local women. One of the difficulties was, " *A woman who walked freely in the streets and talked to strangers was looked upon with contempt*." (Arole and Arole 1994, page 147). The health team of this voluntary project sought to enhance status of their woman Community Health Worker by a number of measures. The women themselves were supported by regular trainings, peer discussions and sharing sessions. The health team accompanied them to the villages to explain the technical details of health programmes and demonstrated support by honouring the referrals made by the women. Although the women were paid a small stipend, they were facilitated with bank credits for self employment. Above all "*hierarchical attitudes have to be replaced by a team spirit and equality*" (Arole and Arole 1994 page 248) according to the health team.

In contrast, Sunderaraman et.al. (1996) have reported the difficulties of ANMs in the rural public health services in India as trained nurses who are expected to live and work in sub centres which are in distant rural areas. Difficulties with regard to transportation to remote hamlets, pressure to perform, and susceptibility to sexual harassment by the community are reported. This study reports that the ANM is vulnerable due to gender, caste, alienation from the health system and the community and her living conditions where she is away from her family. This study also reports that the doctors lack a community orientation or empathy for non medical workers. The importance of the decentralisation of the health services is not understood because of an overwhelmingly hierarchical approach within the public health services.

Jeffrey (1988) tracks how government programmes in India are bound by occupational boundaries and the health services are a bureaucratic structure. He traces this nature of the Indian public health services to its origins as the Indian Medical Services set up by male British doctors for the service of the fighting forces. There is a linkage with the findings of Jones (1994) and Iyer and Jessani (1995). These studies found nurses' work and status being relegated to a subordinate position in the medical hierarchy and the rural public health services in Britain and India respectively. This is seen in context of patriarchal control over the female nurses by Jones (1994). Narayan (2002) has discussed gender discrimination and sexual harassment faced by woman medical students in India indicating that gender- patriarchy linkages persist even when women are doctors.

Another gender issue that has been discussed is regarding the nature of the work of women health workers. A common perception among health professionals and administrators of the work of woman nurses and informal caregivers is that it is natural to their gender. This is linked to psychological theories of mothering according to Jones (1994).

Thirdly, a gender-based analysis of the ‘unstructured’ work of the woman outreach workers has been made. Taking the premises of patriarchal control over health care services further, Sen and Ostlin (2007) analyse the work of outreach workers as deprivation of the opportunity to participate in the labour force. George (2008) analyses the existence of workers like home-carers and community health workers to be skewed responses to the inadequacies of the medical and health care system. Elwer et.al. (2012) report that in Sweden, caregivers in elder care advocated gender equality in principle but did not see connections between gender equality in principle and their own experiences. A perspective of stressing individualism and gender differences in the work place justifies gender inequalities according to Elwer et al (2012). The individual solutions might have negative structural consequences (Elwer et al 2012).

These perspectives ignore the unique nature of the community health worker/frontline health worker concept as discussed in the experiences of health care globally. The uniqueness lies in the acknowledgement of the indispensability of non medical interventions for effective health care; the importance of women for the outreach work; and the flexibility from bureaucratic structures

offered to both the health system and the community health workers themselves due to the 'unstructured' work of these functionaries.

7. National Community Health Worker Programmes in the Public Health Sector

The discussion showed that while the capabilities of the CHW concept are acknowledged across public and private sectors, the relative success of the national CHW programmes is still a matter of debate.

"In recent years, many countries have expanded their health system by training Community Health Workers (CHWs) on a large scale. They are a part of government or national programs and differ from the CHWs trained in small-scale, often non-government projects influenced by charismatic leaders and funded externally. However it is much less clear how the large scale national CHW programmes are effective and making a difference in peoples' lives." (UNICEF 2004, page 1)

The best known example of a CHW programme in the national health services perhaps is the barefoot doctor of China (Box 1.4) which rose and subsequently fell into disuse following the changes in health policy. It is an example of what can be achieved in a rural public health care by community health workers at the national level and what can neutralize the same. However, there have been other early examples of the involvement of Community Health Workers in the rural public health sector like Thailand that had also made use of village health volunteers and communicators since the early 1950s (Lehmann and Sanders, 2007). Nepal also has a long history of community health volunteers in the public health sector.

Currently there is one large-scale national CHW programme that has been seen to successfully address these contentious issues within its own environment. This is the Family Health Program of Brazil that serves 50 million people (Box 1.5). Several features make this programme different from most others. Brazil took the bold decision to fully integrate CHWs into their primary health care services, making them paid members of the Family Health Teams. The issue of local ownership is addressed with decentralization where municipalities are responsible for delivery of services at primary level. Municipalities are given the responsibility to actively ensure the existence of community health committees (Lehmann and Sanders 2007). However conditions are different in every state and the answers that Brazil has found may not apply to every national CHW program.

The previous section had discussed national CHW schemes in other parts of the world. The discussion now turns towards the status of the national CHW Schemes in India.

Box 1.4
The Co-Operative Medical System of China

Background: After the establishment of the People's Republic of China in 1949, the government owned, funded, and ran all health care facilities. In the rural areas, the commune was the keystone of all aspects of life.

Local ownership: Health care was provided in the Cooperative Medical System (CMS), which was mostly financed through a commune's collective revenue and was minimally supported by the central government in the form of low-priced medicine and equipment.

CHWs: The CMS operated village and township health clinics that were staffed mostly by practitioners who had only basic health care training. Thousands of "village doctors" were selected by county health authorities to perform the tasks of primary health care. Special attention was paid to training health care personnel. Three to four months of initial training as well as additional, annual training was provided to upgrade their skills.

Support to the CHWs: Health care delivery was organized as a three-tier, bottom-up delivery system. At the lowest level, rural village or urban street health clinics provided basic preventive and curative care through the CHW and referred patients who needed additional treatment to township or community health centers. County or district hospitals provided specialized care to the sickest patients through an extensive network of hospitals in both urban and rural areas.

Performance: Although the economy grew very slowly, the Chinese health system achieved enormous improvements in health and health care between approximately 1950 and 1990: Life expectancy almost doubled (rising from 35 to 68 years), and there was a dramatic drop in infant mortality (falling from 200 to 34 per 1,000 live births) (Blumenthal and Hsiao, 2005). These improvements coincided with major investments in public health. Between approximately 1950 and 1990, nutrition, hygiene, education, living standards, and even culture changed dramatically in China (Hsiao, 1995). These changes could have greatly affected improvements in health.

Current situation of primary health care: After 1982 the rural economic system changed from the collective economy under the communes to one based on individual household decisions. As a result of this change, the CMS collapsed rapidly as it lost its institutional base for fund-raising (Project Team of the Development Research Center of the State Council of China, 2005). According to a national rural health service survey in 1985, only 5 percent of administrative villages still implemented the CMS, compared with 90 percent in the past (Cai, 1998).

Current situation of CHWs in China: Post the eighties, the barefoot doctors became unemployed and were forced to become private health care practitioners**.** They began working without regulations or continuous training, and their interest shifted from providing a public service to making a profit (Blumenthal and Hsiao, 2005). Drug prices and sales soon exploded in rural areas because former barefoot doctors and clinics found that selling drugs was an easy way of generating profit (Bloom and Gu, 1999)

Source: Sai Ma, Neeraj Sood 2008.

Box 1.5

The Family Health Program of Brazil

Background: This programme started in the mid-1980s in the north-eastern state of Ceará (Cufino Svitone et al., 2000), but was integrated into the national Family Health Programme by 1994. The Family Health Program (Programa Sáuda da Família or PSF in Portuguese) can be considered the main government effort to improve primary health care in Brazil.

The team: The Family Health Program provides a broad range of primary health care services delivered by a team composed of one physician, one nurse, a nurse assistant, and (usually) four or more Community Health Workers called community health agents. In some places, the team also includes dental and social work professionals.

The CHW's tasks: She is assigned to make monthly visits to 50-250 households to provide prenatal care, vaccinations, and checkups, as well as to promote breastfeeding and oral rehydration. By 1992, 7,300 community health agents had been hired, along with 235 half-time nurse supervisors.

The CHW's job status: The state hired community health agents, mostly women, as part of a job-creation programme. Brazil took the bold decision to fully integrate CHWs into their PHC services, making them paid members of the Family Health Teams.

Training: Each of the new health agents was given three months' training.

Support to the CHW: Each team is assigned to a geographical area and is then responsible for enrolling eligible people into health programmes and monitoring the health status of the population living in this area, providing primary care services, and making referrals to other levels of care as required. Each team is responsible for an average of 3450 and a maximum of 4500 people. Physicians and nurses typically deliver services at health facilities placed within the community, while community agents provide health promotion and education services during household visits.

Local ownership: The issue of local ownership has been and is challenging, and is addressed by firstly making the municipalities responsible for delivery of services at primary level.

Performance: The results showed that expansion of the programme, along with other socio-economic developments, were consistently associated with reductions in infant mortality. The policy implication is that a broad based approach to improving child health, with primary health care at its core, can make considerable improvements in outcomes (Macinko et al., 2006).

By early 2006, 60% of the population was looked after by 25,000 health teams. In areas covered by family health teams, hospitalization has dropped from 52 to 38 per 10,000 in the past three years.

Source: WHO 2007.

8. National Community Health Worker Schemes in India

So far there have been two national CHW Schemes in the country namely the CHW Scheme of 1977 and the ASHA Scheme of 2005. Both are for rural areas and best understood against a historical analysis of health policy in India with major developments in rural primary health care.

A Historical Analysis of Health Policy in India

The access of the rural population to the public health services has been a major issue in health policy and expert debates since independence (Shrivastava Committee 1975, Batliwala 1978, ICMR/ICSSR Committee 1981, National Health Policy 1983 and 2002, Sanjivi 1988 and Antia and Bhatia 1993). A historical analysis of the health policies in India begins with the pre-colonial era as seen in Box 1.6. The analysis and discussion is drawn from several studies (Banerjee 1985, Ritu Priya 2005, Duggal 2005 and 2008 and Quadeer 2001).

Box 1.6

Contextualising Rural Primary Health Care Services: An Overview of Health Policies in India

PERIOD	**MAJOR DEVELOPMENTS IN PRIMARY HEALTH CARE IN RURAL INDIA**
Pre-Colonial	Health care was seen as a social responsibility and thus state and philanthropic interventions were significant. Most of the facilities were urban. Class, caste and occupation limited the access.
Colonial	Most hospitals were state owned but individual private health practice was large and well established indicating early commoditization of health care delivery.
1943- The Health Survey and Development Committee (Bhore Committee Report)	– Considered a landmark in public health policy, the Bhore Report recognized the vast rural-urban disparities and based its plans specifically for the comprehensive health care of the rural population. – Major recommendation was the District Health Scheme, a 3-tier system providing comprehensive health care in rural areas. At the periphery was a primary unit (one for every 10,000 to 20,000 population) with 75 beds, 6 doctors, 20 nurses and other paramedic and support staff. The secondary unit was to have 650 beds with all major specializations and the third level at the district was a district hospital with 2500 beds providing tertiary care – *Although there is mention of the paramedics and of cooperation between health personnel and people in the Bhore Report, there is not much elaboration on the role of Community Health Workers.*

Continued…

PERIOD	MAJOR DEVELOPMENTS IN PRIMARY HEALTH CARE IN RURAL INDIA
Post-Independence Period 1950-65	– A period of institutional growth with the coming up of research institutions and medical colleges with tertiary hospitals. – Landmarks in rural health programmes by the government included vertical programs that were successful in controlling malaria and smallpox; improved economic conditions and standards of living improved; mortality rates declined; setting up of Primary Health Centres; programs like Family Planning, water supply and sanitation, indigenous systems of medicine and Minimum Needs Program. – However, while Primary Health Centres were set up rapidly, the village level sub centres lagged behind. Similarly, while vertical services grew while general health services lagged behind. The stage was set for techno-medical and not development oriented health care.
1966-1980	– Economic crisis led to a questioning of the techno-medical model. **Alma-Ata Declaration's Principles of Primary Health Care** were universally accepted in 1978 while significant voluntary initiatives in the country like The Comprehensive Health Project in Jamkhed preceded it. – In the public health sector, the resurgence of malaria and the idea of population explosion resulted in a rethinking. As a result, the Community level workers in the form of Multi-Purpose Workers that were meant to provide a holistic range of community level health care services were forced to focus on Malaria Control and Family Planning. – The Community Health Workers Scheme was launched in 1977. Almost 400,000 CHWs were selected and trained. However, the Scheme was scrapped within years of its existence. – The coverage of health needs by both the sectors was limited. As the un-met demand for health care grew, private services grew in the country too.

Continued…

PERIOD	MAJOR DEVELOPMENTS IN PRIMARY HEALTH CARE IN RURAL INDIA
The 1980s	– The vision of Primary Health Care was narrowed to Selective Health Care internationally and in India as well. In the rural public health sector, disease control and population control got international professional support and funds and primary health care remained restricted to these, ignoring the larger perspective. The role of other sectors for improving the health of the population was ignored. – There was an advocacy for expansion of public health services by civil and professional bodies like the ICMR-ICSSR Study Group on "Health For All". There was an increase in the number of Primary Health Centres in rural areas serving a population of 30,000 rather than the 100,000 level they were earlier placed at. Community Heath Centres were set up but with inadequate sanction of medical posts resulting in their not working up to potential. – Economic growth brought down the poverty levels and Infant Mortality Rates too declined but changes in livelihood patterns brought about high morbidity with the return of communicable disease epidemics as well as the rise of non communicable diseases. – This period was marked by a move away from the social dimensions of health towards techno centric and commercial orientation. By the end of the 1980s the public health sector was in a crisis with increasing but poorly functioning primary level institutions and a competitive, expanding private sector. – *Voluntary health sector continued to work on a more holistic concept of primary health care and continued to find the Community Health Worker as a key functionary.*
Late 1980s	– The Structural Adjustment Programme (SAP) was agreed upon by the Indian government led by the International Monitory Fund-World Bank combine that included Health Sector Reforms. The major premise of Health Reforms was the withdrawal of the state from social welfare sectors including health. – The large number of trained medical personnel including the Indian Systems Of Medicine not absorbed by the public sector got into the private sector to cater to the demands at all levels of care and for all sections. This included non formal practitioners at slum and village levels.

Continued...

PERIOD	MAJOR DEVELOPMENTS IN PRIMARY HEALTH CARE IN RURAL INDIA
The 1990s-	– The Health Sector Reforms resulted in a cut back in expenditure for the

2000s	public sector general health services while the private health sector had experienced a boom since the 80s. The Reforms instituted user fees for public services and dependence on technological approaches but a decline in the ability of all to access even the technological services. National Sample Survey data shows an increase in 'not taking treatment due to financial reasons' increasing from 15% in rural areas in 1986-87 to 25% in 1995-96 and from 10% to 20% in urban areas for the same time period. - Primary level infrastructure had been strengthened in rural areas, but under the Reproductive and Child Health (RCH) Programme. Primary Health Care in rural areas was reduced to isolated disease control programs and general health services had deteriorated further. - This is exemplified by the decrease in recruitment of Multi-Purpose Workers and increase in the number of Auxiliary Nurse Midwives in rural areas. However, newer forms of the Community Health Workers showed up in different designations in various states, like the Mitanin in Chhatisgarh. - *In the current health scenario, the community health worker in the voluntary health sector may be working in a range of functions depending upon the organization's interventions i.e. as a holistic health worker or for specific interventions like child health or as a village level monitoring agent of the local Primary Health Centre and its staff.*
2005 onwards	- **The National Rural Health Mission (NRHM) 2005-12** is introduced in 2005. The National Rural Health Mission (2005-12) is a flagship programme of the Government of India and seeks to provide effective healthcare to the rural population throughout the country with special focus on 18 states. - *The voluntary health sector has also changed its orientation. If we correlate the movement of health care of the country with the global history, we find that in the seventies, the most important concept was that of "community participation" in both the public and the voluntary health sectors. Today the* ***"right to health"*** *has become the key concept around which the voluntary health sector revolves. The focus has largely changed from advocating a more broad-based participative health system that was not totally dependent upon the public health system, towards a near total emphasis on the public health system and its provisions.*

Continued...

PERIOD	MAJOR DEVELOPMENTS IN PRIMARY HEALTH CARE IN RURAL INDIA

2005 onwards	A Key Strategy of NRHM is to promote access to improved healthcare at household level through a new Community Health Worker called **ASHA** in every village of the country.

Source: The Chart above is collated from Bannerjee 1985; Ritu Priya 2005; Duggal 2005; Duggal 2008; Quadeer 2001 and http://mohfw.nic.in/NRHM.htm.
The observations in italics are the researcher's observations

9. The National Rural Health Mission (NRHM)

In 2005, the National Rural Health Mission 2005-12 (NRHM) was introduced to provide effective health care to the rural population throughout the country with special focus in 18 states. Box 1.7 gives the objectives of the NRHM. "*A key strategy of the NRHM"* was to provide access to improved health care at the household level through a new CHW called Accredited Social Health Activist (ASHA) in every village of the country under the ASHA Scheme.

Box 1.7

The Objectives of the National Rural Health Mission

The Objectives of the Mission

- Reduction in child and maternal mortality
- Universal access to public services for food and nutrition, sanitation and hygiene and
- Universal access to public health care services with emphasis on services
- Addressing women's and children's health and universal immunization
- Prevention and control of communicable and non-communicable diseases, including
- Locally endemic diseases.
- Access to integrated comprehensive primary health care.
- Population stabilization, gender and demographic balance.
- Revitalize local health traditions & mainstream AYUSH.
- Promotion of healthy life styles.

Source: National Rural Health Mission: Mission Statement

http://mohfw.nic.in/NRHM.htm.

The historical analysis was presented in order to contextualize the two main national CHW Schemes in the country. There were several proposals for CHW Schemes preceding the 1977 CHW

Scheme that did not fructify. There were also several state level CHW Schemes between these two national schemes. Box 1.8 shows the Community Health Worker Schemes in the country. All the schemes were meant for the rural health sector.

A Historical Analysis of National Community Health Worker Schemes in India

The discussion in this sub section is about the two main national CHW Schemes in India introduced respectively in 1977 and 2005; both within the rural public health services. It is seen context of a historical analysis of CHW Schemes (Box 1.8). In 1977, the *Rural Health Care Scheme* was announced in India. This Scheme was envisaged to strengthen rural public health services. Within this scheme a Community Health Worker called *Swasthya Rakshak* was appointed per every 1000 population. The nomenclatures of this worker changed over its tenure but essentially this was a CHW Scheme.

Box 1.8
Community Health Worker Schemes in the Indian
Rural Health Sector

1940:	CHWs recommended in rural areas for basic health care by Sokhey Committee but no implementation.
1943:	A citizens' health committee, increased number of nurses, health visitors and dais in rural schemes recommended by the Bhore Committee but no implementation.
1963:	The Chadha Committee set up for National Malaria Eradication recommended basic health workers one/10,000 population to work as multi-purpose workers to work for malaria eradication, family planning and collection of statistics.
1965:	The Mudalier Committee found the recommendations of the Chadha Committee impractical as basic health workers could not do justice to all the work.
1973:	The Kartar Singh Committee on Multi-Purpose Workers
1975:	The Shrivastava Committee Mention of existing ratio of one male health worker/7000 population and one female health worker/10,000 CHWs. Recommended to be changed to one male and female health worker/800. In addition, two other layers of health workers recommended: Health Assistants and Multi-Purpose Workers.
1977:	**A national CHW scheme for basic health care in rural areas called the Swasthya Rakshak Scheme was introduced. Around four lakh male CHWs were engaged. Women introduced with resistance from the male workers. The scheme dwindled to a halt.**
	The Declaration of the Alma Ata
1978:	Several state level CHW schemes but no national scheme
1995 onwards:	Madhya Pradesh Jan Swasthya Rakshak Scheme (male workers)
Madhya Pradesh:	Mitanin Scheme (women workers)
Chhattisgarh:	Pada Swayam Sevika Scheme for adivasis (male workers, replaced by
Maharashtra:	women)
	The Women Health Volunteers Scheme (women workers)
Andhra Pradesh:	Sahiyya Scheme
Jharkhand:	**A national CHW Scheme called the ASHA scheme is introduced under**
2005-6:	**the National Rural Health Mission (2005-12)**

Sources: This data is abstracted from CHC 2005, Chatterjee 1993, Frankel 1992 , NHSRC 2011 and http://nifw.org/NDC/Documentation Services/Committee_and_Commission.html

Progression of the Swasthya Rakshak Scheme

Within five years of the introduction of this CHW Scheme some 400,000 male CHWs were selected and trained – one for almost every Indian village - making it the largest health cadre in the world outside of China in the 'seventies (Chatterjee 1993). Box 1.9 presents an overview of the Swasthya Rakshak Scheme. There were several expectations from this CHW who was expected to provide basic curative, preventive, promotive and referral services. This CHW scheme ran into difficulties within a few years of its outset. The programme continued until 1985 though some states continued with it into the 'nineties (NHSRC 2011). There was no formal closure of the Scheme and then it dwindled to a halt. The entire progression of the Scheme was fraught with issues that might be of some consideration for the ASHA Scheme of the current times.

Box 1.9

The Swasthya Rakshak Scheme of 1977

Objectives: Maru (1983 in UNICEF 2004) summarized the following as the objectives of the scheme based on the various official pronouncements:

- To provide basic curative, preventive and promotive health care at the door-steps of the people,
- To involve rural people in the provision, monitoring and control of basic health services, to place "people's health in people's hand" and
- To create a resource person trusted by the local population who could provide a link between primary health center and the local community.

The scheme included training of one community health volunteer (CHV) for every village community comprising of 1000 population.

Maru (1980) gave the following details about the Scheme.

Activities:

- The CHV was expected to know the health needs of the community and to provide basic health services: minor treatments, preventive measures, including education and liaison with specialized health institutions.
- The CHV was expected to educate the village population about health problems, such as family planning or public sanitation and personal hygiene, which might not be perceived by the community members as their felt needs. A CHV was supposed to be a change agent as well as a representative of the community

Training: After the CHV was identified and approved by the selection committee, he/she used to undergo through a three-months training in simple and basic health care at the primary health center.

Honorarium: The government used to provide an honorarium of rupees 50 per month plus basic medicines worth rupees 50 and both of these were disbursed to CHVs through the primary health centers.

Analytical Studies on the Reasons for the Discontinuation of the 1977 CHW Scheme

Most of the literature available on the CHW Scheme of 1977 is in the form of analytical articles with little empirical research. There was one early empirical study which found that there were difficulties in procedures of selection, training, logistics and supervision of these CHWs (NIHW 1978). The health literature of the time presents several critical views on this CHW Scheme as well as of a **dai** (traditional birth attendant) scheme of the era. These articles by health activists indicated disillusionment with the transfer of the CHW concept to the public health sector.

An editorial article in the Medico Friends Circle Bulletin entitled '*The Rural Health Care Scheme-MFC View*" (MFC Collective, 1978) critiqued the draft plan of this scheme on ground of lack of planning for ongoing training, logistics and supplies. The study points out that the system of selection of the CHW ignores the rural stratification of caste and class and its intimate relationship with rural health problems. Maru (1980) notes how the bureaucracy was resisting the new Scheme with mutual distrust on both sides. Sadgopal (1977) discusses similar difficulties in the traditional birth attendant (**dai)** training programme of the time. She points the impracticability of expecting the **dais** to take over the government's maternal and child health activities given her limited social mobility as an untouchable called only for delivery. The findings of one early empirical study (NIFW 1978) of the 1977 CHW Scheme about the existence of difficulties in procedures of selection, training, logistics and supervision thus upheld the perspectives of these analytical articles.

As seen in other analytical studies the entire Rural Health Scheme came to be identified with the CHWs who were expected to facilitate the "provision of health services at the doorsteps of every villager" (UNICEF 2004). These could have been unrealistic expectations from the CHWs (Walt in Yesudian 1991).

Lack of political commitment was cited as one reason why the Swasthya Rakshak scheme was not effective. The Janata Government that brought in the Scheme only lasted for 30 months and the later Congress government was not impressed with the scheme (Ashtekar 2005). Gill Walt (in Yesudian 1991) further pointed to a lack of systemic commitment suggesting that CHWs were dropped in an administrative vacuum; and that resources got diverted and reforms delayed by the actions of the dominant political and bureaucratic groups.

The CHWs were said to have earned the resistance of sections of the medical community (UNICEF 2004) and the nursing community (Walt 1988). The reason for resistance as per experts was that the CHWs were reported to have focused on curative tasks which were termed as '*the medicalization of CHWs'* (Chatterjee 1993). There is an extremely negative analysis of how CHWs became 'quasi doctors.'

"The CHWs began to perceive themselves as village medical practitioners, often even demanding further training for this purpose. While village communities concurred because their perceived need was for curative services, they usually viewed the CHWs as 'third class doctors' and bypassed their services wherever possible." (Chatterjee 1993 in Rokhde et. al., page 360)

At the implementation level, essentially the Scheme appeared to be rejected by the health personnel (Chatterjee 1993, Walt 1988). This was then ascribed to the fact that the CHWs were largely giving curative services.

A Retrospective Analysis of the Discontinuation of the 1977 CHW Scheme

In retrospect, there was little analysis on the reasons for this concentration on curative tasks by CHWs. These CHWs received a fixed amount of rupees 50, therefore, payment could not have been the reason. Was their training responsible for this? As seen by experts these CHWs were oriented towards curative care through their training that was conducted by the Primary Health Center doctors and supervisors (Chatterjee 1993).

The community's 'perceived need' was curative care at that time (Chatterjee 1993). Were the CHWs then merely responding to what is now commonly acknowledged as the 'felt need' of the community for curative care? (NHSRC 2011) Lastly if the 'perceived need' which is now the 'felt need' continues to be curative care spanning a period of three decades then is it not time to reconsider the contribution of the CHW in rural areas?

In retrospect, gender was a major issue for the halt of the Scheme. At that time, as men were the targets of family planning programme in the 1970s and early 1980s, male CHWs were selected. Subsequent realization of the importance of maternal and child health services and fresh attention to women as the main targets of family planning, led to a change in policy. Following the conviction that women should be employed as CHWS, in the mid '80s, attempts were made to phase out male workers and recruit women in their place. But the organized male CHWs brought political pressure and legal procedures were initiated against their removal (Chatterjee 1993). The replacement of men with women as CHWs was done in 1977 for fulfilling the priorities of the policy makers. In retrospect it showed a gender bias by both the system as well as the male CHWs that protested against it. The considerations of the women CHWs did not even enter in the debate.

Questions were raised about the political and policy commitment to and management of the CHW Scheme at that time. Expert analysis showed that there was a lack of political commitment at the uppermost echelons of the administration. In retrospect, the policy-makers appeared to have looked upon the CHWs as vehicles for their own priorities first for showcasing '*democratization of health care'* by the Janata Government (Chatterjee 1993) and then for implementing Family Planning programmes that were the priority of the Congress government.

At one stage, the Union Ministry of Health and Welfare had decided to formally abandon the programme. However, instead of formally closing it down, in view of the sensitive social and political ramifications, the programme was simply allowed to wither away by denying it training, funds and supplies (Bannerjee 1985). The experts pointed that it was the unionization, political pressures and legal injunctions brought about by organized male CHWs that led to paralyzing the scheme in most states (Chatterjee 1993). However in retrospect, could this also be seen as the neglect of the aspirations of the CHWs by the health services and the political leadership of the day?

There was resistance from the male CHWs as recorded, but in retrospect, the legitimacy of the male CHW's demands for stability as manifested by their union and litigation activities was not a consideration at the macro level. Their protests at being replaced by women or for a change in working conditions were dealt with by simply bringing the scheme to an unofficial halt which translated into a real halt due to the withdrawal of training and resources. In retrospect, this suspension of the Scheme could not be countered by the CHWs who would have been interested in remaining in the post, because they were not formally a part of the system and the unionization could not be sustained. This could be the alternative view to the one that pointed to unionization as cause of the suspension of the scheme.

Thus India could not sustain a national CHW scheme within the rural public health system in the 'seventies. The community and the immediate colleagues of these CHWs from the health services were closest to the CHWs and hence the most affected by these shifts in policy. However their perspectives were not considered during the entry and exit of the Scheme. One early empirical study (NIHW 1978) did ask village level stakeholders about CHWs and found that when the Swasthya Rakshak Scheme was first introduced the community had initially welcomed it.

Effects of the Experiences of 1977 on the Subsequent CHW Schemes

There was a belief in the CHW historically in the country with established community health worker schemes in the voluntary sector before the Alma Ata Declaration. This concept was not imported from the West. Mahatma Gandhi had formulated the earliest primary health care effort by formulating a village (non- medical) doctor's course as early as in the nineteen forties before the advent of the China's barefoot doctors. A hundred candidates were to be trained as village doctors in Wardha but this effort could not fructify as he was assassinated (Ashtekar 2001).

The historical analysis shows that a national CHW Scheme was repeatedly proposed since the pre-independence era but was finally brought into the Indian health system a year before the country was a signatory of the Alma Ata Declaration, showing that it was an primarily

an internal decision. Yet the sustainability of the CHW concept was endangered when it first came as a national scheme.

Years later when CHW Schemes were re-introduced at the state level, the CHWs were women in most of the schemes like the Mitanin Scheme of Chattisgarh. The work of the CHWs in all the state schemes revolved around the mandates of the health system perhaps to retain better accountability and supervision. The selection, training and the terms of engagement were as volunteers not taking into account the aspirations of the CHWs of 1977. However where the 1977 Scheme collapsed these schemes like the Mitanin Scheme largely continued, indicating that there was a level of political and administrative commitment. In the case of some of the CHWs like the pada sevikas and dais of Maharashtra they were incorporated into the ASHA Scheme.

The Accredited Social Health Activist Programme (ASHA Scheme)

The second national CHW Scheme that this nation has seen is the Accredited Social Health Activist Programme (ASHA Scheme) under the National Rural Health Mission (2005-12). The terms of engagement for the CHW of the ASHA Scheme are almost the same as the previous Schemes. Box 1. 10 gives the guidelines issued by the Ministry of Health and Family Welfare.

Box 1.10

Accredited Social Health Activists Guidelines

- Every village/large habitat will have a female Accredited Social Health Activist (ASHA) - chosen by and accountable to the panchayat- to act as the interface between the community and the public health system. States to choose State specific models.
- ASHA would act as a bridge between the ANM and the village and be accountable to the Panchayat.
- She will be an honorary volunteer, receiving performance-based compensation for promoting universal immunization, referral and escort services for RCH, construction of household toilets, and other healthcare delivery programmes.
- She will be trained on a pedagogy of public health developed and mentored through a Standing Mentoring Group at National level incorporating best practices and implemented through active involvement of community health resource organizations.
- She will facilitate preparation and implementation of the Village Health Plan along with Anganwadi worker, ANM, functionaries of other Departments, and Self Help Group members, under the leadership of the Village Health Committee of the Panchayat.
- She will be promoted all over the country, with special emphasis on the 18 high focus States. The Government of India will bear the cost of training, incentives and medical kits. The remaining components will be funded under Financial Envelope given to the States under the programme.
- She will be given a Drug Kit containing generic AYUSH and allopathic formulations for common ailments. The drug kit would be replenished from time to time.
- Induction training of ASHA to be of 23 days in all, spread over 12 months. On the job training would continue throughout the year.
- Prototype training material to be developed at National level subject to State level modifications.
- Cascade model of training proposed through Training of Trainers including contract plus distance learning model
- Training would require partnership with NGOs/ICDS Training Centres and State Health Institutes.

Source: National Rural Health Mission, http://mofw.nic.in/NRHM.htm.

Progression of the ASHA Scheme

The ASHA Scheme currently has 8.5 lakh ASHAs across all states and union territories. The objective, mandates for ASHAs, functions, training, role and activities are presented in Box 1.11. This Scheme is very well documented and there is ample empirical research on this Scheme.

A recent national evaluation study of the ASHA Scheme was conducted by the National Rural Health Mission itself through its technical support institution the National Health Systems Resource Centre (NHSRC) and was published in 2011. According to this document, the ASHA Scheme was initially included in states that were identified as ‘high focus’ states. These were Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Uttar Pradesh, Uttarakhand, Rajasthan, Orissa, the North Eastern states, Himachal Pradesh and Jammu and Kashmir. The guidelines also enabled the rest of the states to implement the scheme in selected districts.

Later “*On January 2009 responding to a very positive political and administrative feedback from the states, a decision was taken to extend the programme within even in the non-focus states* (NHSRC 2011, executive summary page 1).”

There are mandated management and monitoring structures for the ASHA Scheme at the central, state district and block levels. However, the NHSRC study (2011) found that establishment of structures at the state level and the levels below were weak in the eight states covered by the study. This appears to indicate that the positive political and administrative feedback was not translated into ownership of the Scheme by the local administrators. Seen historically, this is a repetition of the previous national CHW Scheme of 1977.

Box 1.11

The ASHA Scheme (2005-12)

Objective: "*Every village/large habitat is to have a female Accredited Social Health Activist (ASHA) - chosen by and accountable to the panchayat- to act as the interface between the community and the public health system"* (NRHM Mission Document). States have been mandated to choose State specific models. Accredited Social Health Activist (ASHA): currently 8.5 lakhs in the villages of the country under the National Rural Health Mission (NRHM 2005-12).

Mandates of NRHM for ASHAs:

Women - 25 to 45 years in age

Educated up-to eighth standard (relaxed in case of non availability)

Local resident of village: One ASHA per 1000 population

Selected by the Village Health and Sanitation Committee

Functions:

Supervised by the public health system

Volunteer

No fixed hours of work

Will receive fixed incentive for fixed tasks for pre-decided tasks

Training: ASHAs to be trained by the health system/designated trainers in pre-decided modules.

Role: "*ASHA would act as a bridge between the ANM and the village and be accountable to the panchayat"* (NRHM Mission Document).

Activities: The job description of ASHA shows that she is supposed to only promote government public health programmes. *"She will be an honorary volunteer, receiving performance-based compensation for promoting universal immunization, referral and escort services for RCH, construction of household toilets, and other healthcare delivery programmes."* (http://mofw.nic.in/NRHM.htm)

Current status: There are 8.5 lakh ASHAs across all states and union territories.

Source: The National Rural Health Mission: Mission Statement; http://mofw.nic.in/NRHM.htm.

Roles of ASHA: Policy Statement

The second debate in common to the CHW Scheme of 1977 centers on the role of the CHW, in this case, the ASHA.

"*The role definition of ASHA evolved through serious advocacy efforts by concerned civil society activists. The programme design was by a multi-stakeholder force that laid out three roles for the ASHA: that of a facilitator of health services, of a service provider and that of an activist"* (NHSRC 2011, main report, page 12). The multi-stakeholders in this case were various health officials and civil society activists. In this there was a risk that the stakeholders' own requirements from the ASHA as a CHW would be in the forefront of the programme design with three roles.

The NHSRC (2011) study presents the findings on the functionality and effectiveness of the ASHA within the three roles mentioned above. The study found that *"the vast majority of ASHAs are functional (i.e. carry out a defined task) irrespective of context and other constraints. There is a wide variation in range, coverage and outcomes, and this makes generalization of any sort difficult."*(NHRC 2011, executive summary, page 15). Even within the constraints the report attempts to give an overview of the ASHA's performance in three roles.

ASHA as Facilitator-link Worker: NHSRC (2011)

As a 'Facilitator-link worker' the ASHA was found to be clearly successful in two services namely getting pregnant women to the institutions for delivery and getting pregnant women and young children to immunization sessions in the village as per NHSRC (2011).

Yet there were limitations in the manner in which this role was performed. The study has presented a question that promotion of these two services might be so narrowly linked to incentives by the ASHA that associated changes in maternal behavior required for child survival might not be pursued by her. There is a matching finding that women who opted for home delivery were not met by ASHAs or offered any other services. It has also urged for improvement in facility level care to match the increased demand creation of institutionalized deliveries by the ASHAs.

The study postulates that marginalized sections might respond better to institutionalized delivery and immunization services if their felt curative needs are addressed. While the concerns are visibly from the view of programme implementation, the study appeared to have ignored the compulsions of the ASHAs and the pregnant mothers in the offering and the taking of the two services which might have provided a different dimension.

ASHA as Service Provider: NHSRC (2011)

The success of the ASHA is found to be limited in the second mandated role of the ASHA as a person responding to health care needs of the community and effective in changing health behavior. This aspect is seen as less supported administratively yet ASHAs are reported to be functional in care provision of about 50% of illness episodes and in visiting newborns within three days activity (NHSRC 2011, executive summary page 26).

ASHAs could potentially have provided valuable interventions to prevent child mortality in terms of immediate home based first contact care, home based follow up and facilitation of prompt diagnosis with support. As noted, for many in the public health and civil society this was the main reason for supporting the ASHA programme. This study states that it is not the lack of incentives or motivation but the shortfalls of adequate skills and support that hinders a better performance by the ASHAs in this role (NHSRC 2011, executive summary page 26).

The study does not dwell upon the reasons for this limited support from administration for such functions that could have enhanced the participation of the ASHAs. Rather it addresses the issue in terms of shortfalls in official structures like the supervisory and training structures, drug supplies, and incentivisation.

Service Provision by ASHAs: Other Studies

There are two earlier studies of the NRHM that have included the aspect of service provision by the ASHA. They have a nation-wide scope. These studies are as follows. Bajpai, Sachs and Dholakia (2009) formed an international advisory panel on NRHM that undertook a mid-term evaluation of the NRHM on the request of the Ministry of Health and Family Welfare. This study covered five districts in Uttar Pradesh, Rajasthan and Madhya Pradesh Conducted after four years of the NRHM, it found that ASHAs had helped increase institutionalized deliveries and that there was a growing pressure on the public health services in context of referrals for delivery that needed to be addressed. They found that training and payment mechanisms for ASHAs were inadequate.

Another study (IIPS 2011) conducted almost as a parallel was the concurrent evaluation of the National Rural Health Mission in the year 2009 by the International Institute for Population Studies. This study differed from the others because it also included a household survey and a separate survey of currently married women between 15 and 45 years of age. The report was based on a sample of selected districts from 33 states/union territories. The data suggested that just about half of the women were aware of ASHAs in the village and knew that ASHAs provided free medicines but there were wide regional variations. Women who were aware, reported a wide range of health issues that were discussed with them by the ASHAs

including Janani Suraksha Yojana. The study reported that the ASHAs found their training, refill of drug kits and payment structures inadequate.

An evaluation study of service delivery under NRHM in Andhra Pradesh, Uttar Pradesh, Bihar and Rajasthan conducted for the Planning Commission (Gill 2009) states that significantly more women than men were found utilizing the public health services under the NRHM and in terms of age group the 21-40 years age group dominates across patients across states. On the other hand the Peoples' Health Watch Report (Jan Swasthya Abhiyan 2008) also asserts that the ASHAs are largely working for Reproductive and Child Health Services. However while Gill (2009) says this fits into the NRHM's focus, the Peoples' Report suggests that the ASHA programme needs to be changed and that the NRHM should be providing comprehensive Primary Health Care.

ASHA as 'Activist': NHSRC (2011)

The findings on the role of ASHA as 'activist' are that her contribution is limited. The study (NHSRC 2011) has tracked changes in ASHA interventions with the training modules and found that when the module 5 covered some aspects of activism, the formation and activation of Village Health Committees did pick up although some states did not introduce this module in the ASHA training. There is no attempt to conjecture on the reasons for some states' reluctance to introduce this module 5. The study does note that even in the states where the initial major thrust was given in this direction, it was not sustained in the nature of support provided to ASHAs. The study does not investigate the reasons for the lack of sustenance of support from the states to form Village Health Committees.

ASHA Scheme in the Long Term: NHSRC (2011)

The NHRSC (2011) study notes that one concern of many stakeholders is unionization of ASHAs and a demand from them for regularization of services. The study acknowledges formation of unions yet states that this is one of the ASHAs' many demands and by no means the first priority. However the study says that the monetary aspect is most associated with ASHAs when they are perceived as link workers without any element of activism. There is an assumption about the comprehension and acceptance of the ASHAs about the three roles and commensurate incentives here.

Further the study recommends that those ASHAs who want to be voluntary are supported and incentivized to be so and those who want regular employment are encouraged for entering training programmes to upgrade their skills particularly as nurses of para medical staff. A combination of fixed plus incentives pattern is also suggested for the ASHAs. Thus this study

clearly rules out any regularization of the ASHA services within the ASHA Scheme itself. This is similar to the 1977 CHW Scheme. However the study does mention the possibility of a 6 hour fixed responsibility in the future.

Progress and Points of Debate

To sum up the progression of the ASHA Scheme, 8.5 lakh village women have been selected and trained. This was done on the initiative of the government and the civil society and implemented by the administration. The ASHAs are found to give services to varied extents but their performance has been uniformly found satisfactory in two programmes: increasing the rate of institutional deliveries and immunization coverage. There are indications that they are able to give information on varied topics whenever they reach the women (IIPS 2009). The studies have all reported inadequacies in training and delays in incentives as mentioned by ASHAs and stakeholders, which have been described in some detail across the studies.

Historically, in the 1977 CHW Scheme, three important points of debate had emerged. Firstly, the administrative support at local levels was not satisfactory for the 1977 CHW Scheme (NIHW 1978). Secondly, the role of the CHWs of 1977 was debated (NIFW 1978, Chatterjee 1993) and there could have been unrealistic expectations (Walt in Yesudian 1991).Thirdly, the aspirations of the CHWs of 1977 about their incentives and service conditions but were not addressed. The same debate on role definition and payment structures had emerged years later in the Mitanin Scheme as well (CHC 2005). These debates were not resolved in 1977, and have emerged as crucial debates for the ASHA Scheme as well.

10. **Gaps in Available Knowledge and the Basic Conceptualization of this Study**

The current study does not look at the ASHA Scheme in isolation but as the latest entrant in a tradition of CHW Schemes that has continued over fifty years globally. The findings will have implications for the ASHA Scheme but also have some resonance for all CHW schemes. The preceding discussion shows that there are some factors that have not been explored previously for CHW Schemes as well as for the ASHA Scheme. The current study seeks to fill some of the gaps in knowledge that have been identified as presented below.

Gap One - The nature of the engagement of the ASHA with her work

A study on ANMs (Iyer and Jessani 1995) showed that although they were conscious of the fact that they were serving the community, there was no perception of increased self-esteem among the ANMs. Apart from the NHSRC (2011) which had asked the ASHAs their reasons to

join and the aspects that they found satisfying, none of the studies (IIPS 2011, Bajpai Sachs and Dholakia 2009) have consulted the ASHAs on their perspectives of their engagement with the scheme.

These aspects are under-researched for not only the ASHA but for CHW programmes as well. This is important to study because the 'communitisation' of the CHW/ASHA is a two-way process between the CHW/ASHA and the other stakeholders.

Gap Two – Research on the mutual engagement of the health services system and the ASHAs

There is some research work on the perspectives of the local stakeholders from the health services, about CHWs (CHC 2005). Their acceptance has not been universal as is seen in the history of CHW schemes in the public health system of the country. An analysis of the CHW Scheme of 1977 shows that resistance from the medical and nursing establishment was a key factor. Therefore this is an important factor to be studied.

Secondly, there is limited research work done on the definition of the CHW tasks. Unlike professionals whose tasks are universally defined by educational qualifications, the responsibilities of a CHW lends itself to different interpretations by the policy-makers, health activists and system stakeholders who are all instrumental for her involvement in health care. Even in policy documents, the CHW's responsibilities is often described rather than defined as exemplified in the ASHA Scheme. This aspect can yield valuable insights on role definition at various levels of the health services system. The findings are important for the ASHA and other CHW Schemes.

Gap Three – Research on the mutual engagement of the community and the ASHAs

Over expectations about what the CHWs could achieve in the community had been noted in the 1977 CHW Scheme. They also stemmed from the prevalent perspective of the CHW as a change agent in that time. David Werner had written an article entitled '*The Village Health Worker-Lackey or Liberator*?' in 1978 (Werner 1978) where he discussed the expectations that the CHW should help his people to liberate themselves from outside exploitation and their own short-sightedness as well. The feasibility of the change agent expectations was also endorsed in India at that time by the belief among some activists that work on social determinants can be the lever for social and economic changes (Patel 1978).

At the implementation levels of CHW Schemes, the basic requirement from the community is acceptance. The past experiences in India show that the CHW received a positive response from community particularly in the NGO sector. This aspect of engagement must be examined anew for a CHW Scheme of national scope like the ASHA Scheme. Except for the

IIPS study (2011) which basically looks at the community's knowledge levels about ASHA activities and extent to which ASHA services were received, the other studies (NHSRC 2011, Bajpai, Sachs and Dholakia 2009) have not involved the community at all.

On the other hand the CHW/ASHA's experiences with the community are a gap in the knowledge as well. Any CHW programme including the ASHA Scheme cannot be successful without encouraging the acceptance of CHWs/ASHA by the community and vice-versa, therefore, these aspects are important.

11. Basic Conceptualization of the Current Study

This study proposes to understand perspectives of ASHAs and local stakeholders from the community and the health services system. The aim is the generation of emergent linkages from the micro level that will have implications for the ASHA and other CHW Schemes. An understanding of the prevailing perceptions of the ASHA's role by those most closely concerned with her at the micro level can help to infer how far or near the expectations made of this functionary from the top are fulfilled at actual implementation.

Secondly the study seeks to trace the various 'pulls' and 'pushes' or the rewards and the pressures that the ASHA might be facing during the discharge of her duties. Thirdly the study seeks to understand the expectations of the community from health programmes and from health functionaries at the village level including the ASHA. It also seeks to explore the ASHA's experiences with the community.

Fourth, it seeks to identify the expectations of the local health system from the ASHA and vice-versa. Lastly, very little is known about the lives of the Community Health Workers and the manner in which they incorporate health responsibilities within their daily lives. Such data might be a 'bottom -top' guide to the changes that are required at policy and programme level for the CHW to be enabled to fulfill her best potential. If on the other hand, findings indicate that the ASHA has not had positive experiences or has not been a positive experience, it may be time to look inward and make changes in the way health care is structured in rural India.

The importance of these aspects has been reflected even in the topmost echelons of the ASHA Scheme as seen by the views of the National ASHA Advisory Committee of 2009.

"*multiple understandings of ASHA program …including the impact of being ASHA on the individual woman and the ASHA's involvement with the communization of NRHM … have implications for program mechanisms and achievements of outcomes in different contexts.* " (Report of discussion of NAMG Aug 2009, www.mohrw.nic.in/NRHM).

12. The Conceptual Framework of the Current Study

The Community Health Worker is placed within the broader context of Health and Development. Literature review showed that there are four ***Major Approaches to Health and Development.*** These approaches each have a distinct perception of the role of the Community Health Worker within health systems. An overview of the major approaches is presented first in the following section. This overview includes the approach to health and development chosen for this study. In addition the second theoretical perspective relevant to the conceptual framework namely the social ecological model is presented in this sub section.

Approach One: The Primary Health Care Approach of the Alma Ata Declaration

In 1978, WHO and UNICEF called a global conference of health ministers at Alma Ata located in the former Soviet Union. The conference was called *The International Conference on Primary Health Care.* This was the first time that the concept of holistic health was defined and a formal articulation was made internationally of the *Primary Health Care Paradigm* through the *Alma Ata Declaration***.** The Declaration of The Alma Ata's Primary Health Care Paradigm clearly saw Health and Development as interlinked as it called for major changes when it committed for signatory governments including India, to ensure "*the provision of adequate health and social measures*" by the year 2000 (Declaration of the Alma Ata 1978).

The Primary Health Care Paradigm of the Alma Ata Declaration asserted that the people have the right and duty to participate individually and collectively in the planning and implementation of their health care. The Declaration officially placed the Community Health Worker (CHW) as an invariable part of rural health care systems. In this approach to Health and Development the CHW was intended to be one among a team of health workers working within the context of far reaching social and health reforms.

Approach Two: The Economists' perspective on Health and Development

Broadly this perspective proposes that poor health status can impede the economic progress of society and that is the reason it must be addressed. This perception has been incorporated into the understanding of health in the international development echelons since long and still prevails in some sections. This understanding has been followed by some health researchers as well.

"*... few studies exist on the economic impact of illness at the national level…This vacuum is perhaps one reason why health investments are often considered by economists as entirely*

'consumption' and why economic planners often downgrade the significance of health investments…Health investments have yet to recognized as investment in human capital. "(Das Gupta and Chen 1998, page 10)

This Approach that sees Health and Development in economic terms has influenced health policy internationally. When the sweeping reforms of the Alma Ata Declaration were found to be politically and economically difficult to implement, international development and funding forums influenced the public health policy of developing countries to narrow the scope of the public health services. The role of the Community Health Worker within the health system was seen as the most convenient way to overcome the shortage of doctors and trained medical personnel in rural infrastructure. This is the contemporary understanding of the function of the CHW in many sections of the health sector in India even today.

Approach Three: The Moral and Ethical Approach on the linkages between Health and Development

The Moral and Ethical perspective to Health and Development essentially looks at health reforms as the means to overcome health inequalities. In this approach, equitable access to healthcare is a moral concern.

"*There is a resurgence of interest in the economic argument that improving the health of the poor helps them extract themselves from poverty. However, our view is that health inequalities and inequities are ultimately ethical issues…Working towards the elimination of absolute poverty and the adverse health consequences that accompany it, is essentially to be justified on moral grounds, not in terms of economic return. We believe that inequalities and inequities can be reduced through appropriate policies in public health, in the health system and in other areas. How far they may be eliminated altogether is debatable-but speculation about this ultimate objective should not distract from the many obvious steps that may be taken to improve the current situation.*" (Leon and Walt, 2004, page 2).

Such a perspective sees the Community Health Worker as an agent to health equity. The functions of the CHWs in their communities are then seen to be those that promote accessibility of the marginalized to the available health care.

Approach Four: The Rights Approach to Health and Development

This is the approach chosen for the conceptual framework of the current study.

In the past few decades, there has been a remarkable improvement in the health status of people in most countries across the world. However, despite the general improvements in the state of the health like the falling infant mortality rates and the rising life expectancy there are considerable inequalities in the health status between countries, regions, socio-economic groups, communities and individuals. This perspective sees Health as a subject of political and developmental change that is directed towards good health and equitable existence for all. The holistic approach to Health and Development initially professed in the Alma Ata recommended such change without taking the political and economic implications into consideration. The Right to Health perspective *demands* such change and advocacy is the strategy that is employed to put forth this demand to concerned agencies.

In India it was the Rights perspective, although not always articulated, that fueled much of the active voluntary movement in the 'seventies and 'eighties towards rural primary health work. The votaries of this Approach saw Comprehensive Health as the way forward that included not only health services but diverse issues like agriculture, self-help groups, potable water supply and panchayati-raj. Advocacy efforts were directed at the government provisions under related programmes for the rural and urban poor populations. This approach is followed in many voluntary health organizations to date.

The role of the Community Health Worker would perhaps have its broadest interpretation within this framework. At the ground level, these village level health workers are seen as capable of tackling multiple tasks with due training, supervision and infrastructural support. This model has been amply demonstrated in the Indian voluntary sector. In the Indian public health sector, however, the CHW of the 'seventies never did reach that potential.

The Right to Health Care

This approach is an offshoot of the Right to Health Perspective. The Right to Health Care perspective acknowledges the poor state of health and the national and international conditions that have led to it but it is issues of immediate concern that is of the inequality and inequity in the public health care systems that have been raised most often by it. (Sanjeevi 1988, Antia and Bhatia 1993, Antia, Dutta and Kasbekar 2001, Leon and Walt 2004, Gangolli, Duggal and Shukla 2005).

The major themes that concern the advocates of Right to Health Care are about ways in which commercialization of health services is manifested, in India and other developing countries. Three major themes are addressed within this Framework. Firstly, the way the private sector dominates health care in the nation and now comprises three quarters of the entire health system of our country, both in terms of numbers as well as the nation's overall health expenditure. Secondly how the pharmaceutical and instrumental industry has become a thriving commercial enterprise to the detriment of rational health care. Thirdly, the rapid corporatization

or ownership of health services by business houses that are based on the profit motivation. Closely related to these developments has been the perpetuation of a techno-managerial model of health care inspired by the West that has also been taken up as an issue by the Right to Health Care activists. (Antia, Dutta and Kasbekar, 2001).

The Right to Health Care approach has been particularly strong since the 'nineties. This was the time when the shadow of structural adjustment and the pressure to reduce government expenditure in health, and to reorganize the health sector to bring in private provision and payment for service, has been seen by many as a major threat to equity in developing countries. (Leon and Walt 2004). The major issues raised by the votaries of the Right to Health Care Framework for advocacy and research are to do with the deficits in the health human power, health infrastructure and spending in public health. This Approach highlights the plight of the poor due to the deficits of the public health system particularly of the rural poor.

In December 2000, the Peoples' Health Assembly was held at Bangladesh. At that time a Peoples' Charter for Health was released. This Charter put forward the *demand* for Health as a Human Right. It declared that governments have a fundamental responsibility to ensure universal access to quality health care and related social services. It also put forth a number of demands for changes towards this end.

The concerns of the Right to Health Care perspective have been articulated by Abhay Shukla in his paper called 'Reclaiming Public Health An unfolding struggle for health rights and social change' (Shukla 2005). Shukla has laid down policy objectives for the Right to Health Care activists to work towards. A strengthened and re-oriented public health system of comprehensive primary health care that includes Community Health Workers in every habitation is a goal of this Approach. Here the CHW is seen as an indispensable part of a strengthened public health system (Box 1.12). This study takes the Human Rights Perspective and places the ASHA functionary within the Right to Health Framework.

Box 1.12

Goals of the Right to Health Framework

Medium Term Goal:

Reclaiming public health and demanding a system for universal access to appropriate public health care in a Rights-based framework

Some policy objectives to work towards:

1. A strengthened, accountable and re-oriented public health system.
2. A constitutional framework to assure public health services as a Human Right.
3. Mechanisms for raising the public finances for the public health system.
4. Special health measures for various groups with special needs.
5. Social-ecological methods appropriate to major health problems.
6. Regulation of the private medical sector.
7. Effective public health support to indigenous healing systems.
8. Ensuring access to essential drugs in a rights-based framework.
9. Operationalizing accountability and redressal mechanisms for the public to reclaim the public health system.
10. The base of the strengthened public health system would need to be a framework of decentralized, comprehensive primary health care with a CHW in each habitation. The indispensability of CHWs is acknowledged within a vision of their contribution. CHW's contribution is of strong community anchoring, flexibility and local evolution of diverse models, emphasis on empowering women and demand generation by the CHW for improved utilization and accountability.

The Long term Goal and large vision: Linking the struggle for health rights to the struggle for larger social transformation to challenge the dominant social order. The Right to Health Care is seen as one arena of assertion of people's power and a platform for developing people's awareness and strength.

Source: Shukla 2005.

The Social Ecological Model

This is the second theoretical perspective chosen for the conceptual framework of the current study.

The Rights Approach sees the CHW as the foundation of a comprehensive public health system. The role of the CHW thus lends itself to a systems approach. In recent years diverse communities of researchers have endorsed health research that links trans-disciplinary models in biomedical sciences that use systems methodologies to understand multilevel effects on health outcomes (Lounsbury and Mitchell 2009). One such *Social Ecological Model* was developed by the European Health Promotion Indicator Development (EHPID) Project as a common frame of reference and a rational basis for the selection, organization and interpretation of *health promotion indicators* in the public health field (Bauer, Davis et.al 2003).

Box 1.13

The EHPID Social Ecological Model and its Conceptual

Inferences for the Current Study

THE EHPID SOCIAL **General type of systems**	**ECOLOGICAL MODEL** **Description of systems**	**INFERENCES OF THE MODEL FOR THE CURRENT STUDY**
Environment	Larger context into which the other systems are embedded	National and international conditions like the state of economy, politics and health culture that impact Health and Development.
Policies	Formal regulations	Health Policy: i. International ii. National
Organization	Association with formal rules, regulations and practices	Health Systems : i. National level ii. Local level
Person	Single person or groups of independent individuals with common Characteristics	All persons concerned with the implementation of the Community Health Worker Scheme at the village level: i. Primary stakeholder: CHW ii. Key stakeholders

Source: Adapted from the European Health Promotion Indicator Development Model

(Bauer, Davis et al 2003).

Health promotion in the EHPID Model is defined as "*the process of enabling/empowering individuals and communities to gain control over the determinants of health and thereby improve their health.*" This definition is in tandem with the Right to Health Care Approach that aims at various measures to reclaim the public health system and considers the non-medical CHW as the community anchor for the same. Box 1.13 presents the EHPID Social Ecological model and the conceptual inferences drawn from this model for the current study.

Taking the influence of the Social Ecological Model proposed by the EHPID, the current study takes a systems approach to understand the health system where the CHW as the primary stakeholder and the other stakeholders at the village level are seen as being at the micro system or at the Person Level of the larger multi layered health system.

To sum up, carrying forward the tradition of the CHW, the ASHA in this study represents several ideals as reflected in the Conceptual Framework:

- The ability of the vulnerable communities to take initiatives for their own health.
- The potential for an ordinary citizen and a non- medical person from the community to take back the responsibility for her own bodily functions from the health professionals through the know-how imparted through the CHW.
- The demystification of medical knowledge
- The human potential to learn and grow
- The decentralization of health and development services.

In the current study on the ASHAs thus, the ASHA is the primary stakeholder. The key stakeholders are her significant others at the village where she lives and works namely the members of the community and the local members of the public health services. The area of investigation is not the ASHA's performance but facets of the ASHA's engagement with her work, as an individual, with the community and with the health system. The aim is to explore the perspectives of these stakeholders about the ASHA because they are the most affected by her functions.

The findings will have implications for the planning and implementation of ASHA and other CHW Schemes. By understanding the ASHAs' and the key stakeholders' perspectives about the ASHA Functionary, an understanding about the relevance of the Community Health Worker to the CHWs, the community and the local members of the health services can be inferred.

This is a comparatively unknown area of knowledge as most available perspectives on the CHWs are from the gaze of policy and experts. This study takes the position that the perspectives

of the stakeholders most affected by the CHW Schemes must be incorporated within knowledge, policies and implementation.

The following Chapter Two describes the methodology adopted by this study in view of the conceptual framework of the study.

METHODOLOGY

This research study began with the researcher's concepts about Community Health Workers within Primary Health Care. A concept is defined as "*an abstract or generic idea generalized from particular instances*" (Merriam-Webster Dictionary). The particular understandings that influenced the primary conceptualisation of this study were gained from the researcher's education, readings, peer discussions and field experiences. A literature review carried out for this study confirmed that Community Health Workers had been involved in primary health care particularly for the rural, poor and distant communities across the world for over the past five decades. However, research studies emphasised their utility to the health system and the community and there were several gaps in the knowledge about the Community Health Workers themselves.

This study was based upon the understanding that generating the unknown perspectives of the Community Health Workers and the stakeholders from their immediate environment is necessary for the effective implementation and sustenance of any Community Health Worker (CHW) Scheme. This view is based upon the history of national CHW schemes in the public health system of the country. As discussed in Chapter One, in India a national CHW Scheme was that introduced in the public health system in 1977 was not sustained within the system. This 'failure' indicated the necessity to generate inclusive perspectives in order to strengthen any subsequent CHW Scheme within the public health system like the ASHA Scheme. Secondly, the need to engage with these perspectives at the policy level was also corroborated by expert opinions. With regard to the ASHA Scheme, the National ASHA Monitoring Group 2009 had recommended that the perspectives of the ASHAs and the key stakeholders from the villages where she worked, needed to be generated (Chapter One). This was the primary conceptualisation of this study that guided its Methodology.

This study aims at theory-building by the use of mixed methodology. Therefore it has delineated the theoretical framework in detail at the outset of the study.

1. Ontological and Epistemological Assumptions of the Study

Guba and Lincoln (1994) categorize inquiry paradigms according to their stance on the following three questions:

"The ontological question: What is the form and nature of reality and, therefore, what is there that can be known about it?;

The epistemological question: What is the nature of the relationship between the knower or would-be knower and what can be known?;

The methodological question: How can the inquirer go about finding out whatever he or she believes can be known?"

(Guba and Lincoln 1994 pages 105-117)

The answers to these three questions they contend, hold the assumptions upon which the selected research paradigm is based. Accordingly, the ontological and epistemological questions were addressed first in this discussion. The current study is based upon some underlying beliefs of the researcher regarding health and development. These beliefs could be called as the assumptions of the researcher. The assumptions are articulated as follows:

1. The health of individuals and the health care available to them are influenced by not only scientific advances but also by the social, political, economic and infrastructural conditions and the prevalent cultural and gender understandings.

2. Decentralisation of health care is one of the paths to equitable development and vice-versa.

3. Inclusion of the CHW in public health systems is a representation of the system's commitment to the health care of the poor and deprived populations.

4. There are multiple stakeholders in any setting. The stakeholders at implementation level should be identified and their voices should be heard for a holistic understanding of the setting (epistemological understanding).

It was important to identify the theoretical foundations of the study taking into consideration the primary conceptualisation and the assumptions.

2. Theoretical Foundations of the Study

This study was based upon three theoretical perspectives which are interlinked to provide the theoretical framework. This section presents the theoretical perspectives first and the next section gives the consolidated framework.

2.1 *Human Rights Perspective*

The overall approach of the study was drawn from the Human Rights Perspective. This Perspective was formally articulated as The Universal Declaration of Human Rights (Annexure 1), which was adopted by the UN General Assembly on 10 December 1948. The Preamble stated: "*…Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world."*

The Universal Declaration of Human Rights (1948) laid down various forms of Human Rights that were the entitlements of all people. Article 25 laid down the foundations of the Right to Health: *"Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services."*

Since 1948, The Right to Health perspective has been developed and interpreted in numerous ways in the subsequent decades. Based on the principles of epidemiology and social determinants of health, it has influenced the major global statements on public health ranging from the Alma Ata Declaration (1978) to the Social Determinants of Health Declaration (2008). It is the basis of research, advocacy and field implementation across global public health interventions. The Right to Health Perspective basically demands an understanding of the complexity and reality of health issues. It advocates for commitment from the public services for the fulfilment of health care and related developmental needs particularly for the poor and remote populations.

Health Care is seen as located within the larger Health Rights Perspective elaborated above. This Perspective contends that today in an atmosphere of commercialization of health services, Health Care is a Human Right to be fulfilled by the public or civic system particularly for the rural and the poor that are most affected by the commercialization (Shukla 2005). The CHW is important in the actualisation of Health Rights of the community:

"The base of strengthened public health would need to be a framework of Comprehensive Primary Health Care including Community Health Workers in every habitation…" (Shukla 2005 page 326).

This study took the Rights Approach for understanding Human Rights, Health, Health Care and the CHW within it (Figure 2.1). It recognised that there are inter-linkages between them and that the CHW under study namely the ASHA must be seen within this context. Such an understanding can be located as a Social Ecological Approach. Thus within the broad umbrella of the Rights Perspective, the Ecological Systems Theory influenced the theoretical framework of this study.

2.2 *The Ecological Systems Theory*

This theory is most associated with the work of Urie Bronfenbrenner who applied a contextual approach to study human development. Within a framework of child development, the child was seen as the individual under study and influences upon the child's development were seen in terms of increasingly expanding layers of interactions called systems. Five types of systems had been proposed in terms of layers that influence development of the child: the micro-system (e.g. the home/classroom of the child); the meso-system (two interacting micro-systems

e.g. the effect of the home on the child); the exo-system (external environment which indirectly influences the development e.g. the mother's place of work); and the macro-system (the larger socio-economic-cultural context). Contained within each of these systems is the individual (the child). The fifth system is the chromo-system or the environmental and socio-historic events over the life course(Paquette and Ryan, http://pt3.n/edu/paquetteryanwebquest.pdf, downloaded on 31st August 2010).

The Ecological Systems Theory treats individuals as active agents who constantly shape, and are shaped by, their environments (in terms of systems as seen above). It attends to the way that roles, norms and rules set by multiple systems shape behaviour. Perception played an important role in Bronfenbrenner's theory. He emphasises the importance of perceptual factors in understanding behaviour and human development (Bronfenbrenner 1979).

The current study saw the ASHA as the individual being studied within the public health structure. The perceptions and interactions of the ASHAs and other stakeholders from the system and the community at various levels were seen as influences affecting the development and functioning of the ASHAs. However, the ASHAs were also seen as dynamic participants that can change the way the ASHA Scheme functions. The inclusion of multiple stakeholders is a key part of this study because it studied the operational aspects of the ASHA Scheme. The theoretical paradigm of Constructivism applies to the study in this context.

2.3 *The Paradigm of Constructivism*

Constructivists essentially believe that reality is constructed in the mind of the individual, rather than it being an externally singular entity. The social world is understood ("interpreted") by different people in different situations in different ways. In order for a scientist to understand social behaviour, therefore, they have of necessity to understand how people (individually and collectively) experience and interpret their world. (Livesey Chris, http// www.sociology.org.uk, downloaded on 28 Aug 2010).

Thus the purpose of any research as seen through the lens of Constructivism, is to understand the nature of reality which is variously defined by individuals. Constructivism indicates that interactions create meanings of reality for individuals but they have the freedom to choose their own meanings. The epistemological understanding of Constructivism is based upon the acceptance of every individual's interpretation of reality. The individual interpretation is contextualized within the surroundings and all interpretations are valued (Denzin and Lincoln 2000, Hesse-Biber 2010).

One of the strongest proponents of Constructivist Epistemology was Jean Piaget, a French-speaking Swiss developmental psychologist and philosopher known for his epistemological studies with children. Piaget's interpretation of Constructivist Epidemiology is

that understanding develops exponentially in the learner through the process of equilibration, whereby the learner balances new knowledge with previous understanding. (Piaget 1964).

Constructivism applied to the current study in these ways: firstly it is proposed that the ASHA be seen within the immediate environment where various understandings of the ASHA are possible and all are valuable. Secondly, the ASHA's interpretations of her work are influenced by interactions within her immediate environment and the stakeholders' perceptions of her functioning. This is comparatively an unknown view and understanding this will generate a new understanding that has the potential to bring about changes in the ASHA Scheme at all levels of the public health system.

3. An Integrated Theoretical Framework for the Study

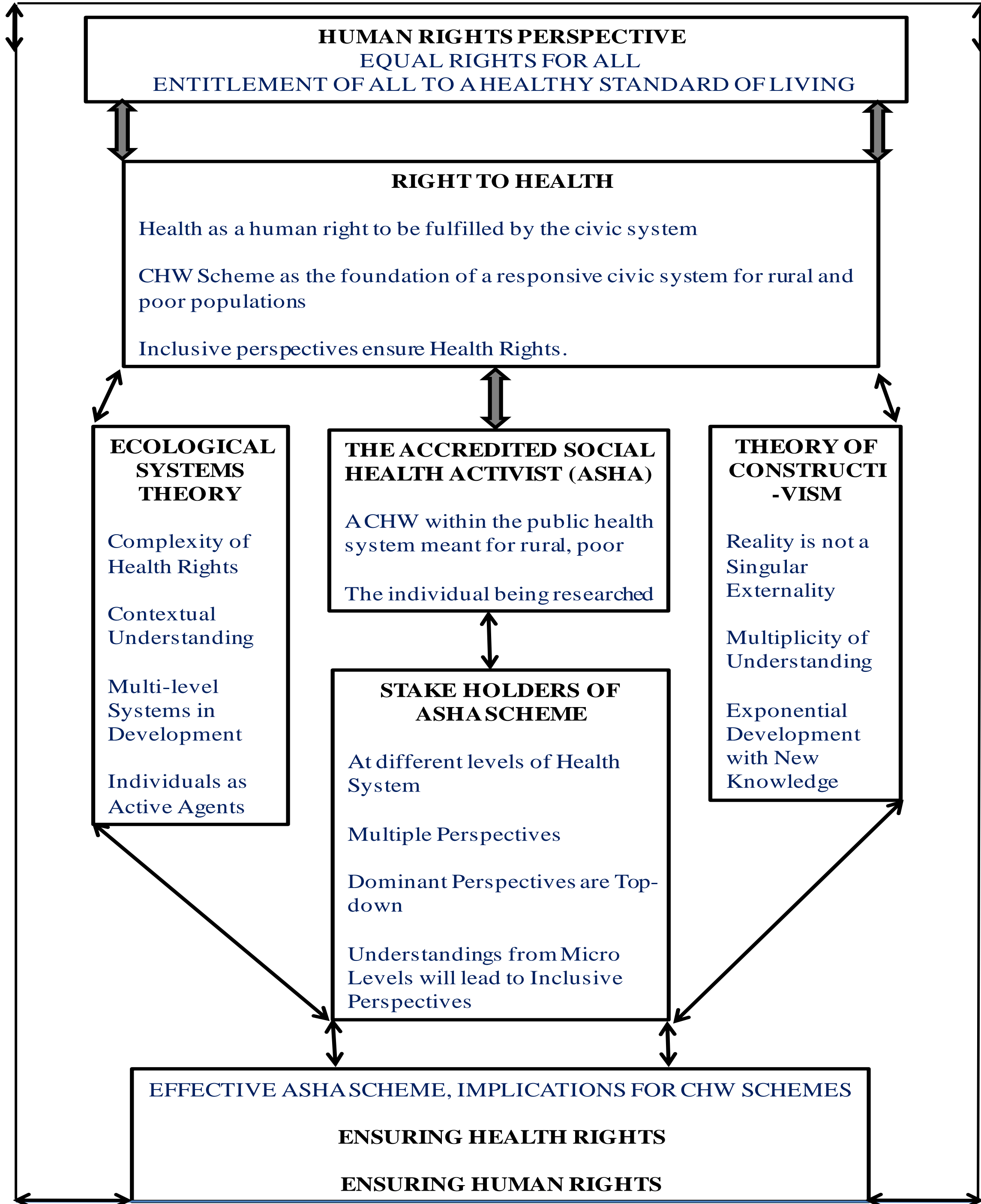
The primary conceptualization, assumptions and the theoretical underpinnings were all woven into an integrated theoretical framework for the study. While forming the theoretical framework, the theoretical linkages that were already prevailing in the existing knowledge of CHWs and the linkages that were proposed in this study at the outset were recognized separately in the framework (Figure 2.1).

The overall approach towards the study is based upon the Human Rights Perspective. The Health Rights Perspective within the Human Rights Perspective is the basis for taking the CHW named ASHA as the unit of analysis. Further, based upon the Ecological Systems Theory, the ASHA functionary is the individual under study within the context of the larger rural public health system. The study sees the Community as a micro system of the public health system. The daily interactions between the ASHA and stakeholders from the Community during the course of her work are considered as the closest influence upon her motivations and understandings as they form her daily experiences. The next layer of influence upon the ASHA is that of her immediate seniors in the public health structure with whom she interacts regularly and who are her guides to the larger health system. The inclusion of multiple stakeholders for the current study is from these micro-systems. This understanding was based not only on the ontology and epistemology of the study, but also upon previous studies on Community Health Workers (CHWs) that had included multiple stakeholders (Chapter One).

The macro system for this study would be the higher levels of the public health structure. The chromo system is the historical evolution of public health services in the country. This study postulated that currently the dominant perspectives that decide the position and functioning of the ASHA Scheme come from the chromo system and the macro system. Consequently the study aimed to generate new multi-dimensional understandings of the ASHA from the relatively unexplored micro levels of the ASHA Scheme.

Figure 2.1

The Theoretical Framework at the Outset of the Study



The stakeholders from the community and the system at implementation or village level were essentially anticipated to have multiple interpretations of the ASHA Scheme, a position that is drawn from the Constructivism Paradigm. As learning is seen as a dynamic process, the new knowledge can enhance the ASHA Scheme, the rural public health system and all CHW Schemes. It would be a step towards strengthening the Health Rights and thus the Human Rights of the community (Figure 2.1). The Research Questions of this study were based upon the conceptualisation and theoretical framework.

4. Location of the Study

This study was conducted in the Shahapur taluka of Thane district in the state of Maharashtra. Maharashtra is not one of the 18 priority states of the National Rural Health Mission, but has pockets of Adivasi areas that have very low health status. Thane district adjoins the city of Mumbai and has a mix of urban, rural and Adivasi populations. It is the most populated district of India.

Population

Thane district has 13 talukas of which 7 have a large Adivasi population. Shahapur has been designated as one of the Adivasi talukas of Thane. It is also the largest taluka of Thane. Shahapur has a small urbanised district headquarters and a total of 94 villages. The 2011 Census of India showed that Shahapur had a population of 1,10,489. Males constituted 51% of the population and females 49%. Shahapur had an average literacy rate of 87%, higher than the national average of 59.5%. Male literacy was 89%, and female literacy was 84%. In 2011, 12% of the population was under 6 years of age.

Regarding the social background of the residents, the predominant group in Thane district is of the OBC group named Kunbis and they are prominent in Shahapur as well. There are also a number of different Adivasi groups in the taluka.

Infrastructure

Shahapur was selected for this study because in many ways it is typical of our rural and tribal areas that are underdeveloped, despite the proximity to cities. The highly developed metro Mumbai is at a distance of 80kms and the Thane city where the district head quarters of the health services is located is at a distance of 45 kms. It is connected by road (Eastern Express Highway) and rail (Mumbai Suburban Railway) yet local inhabitants struggle to commute because the villages are far flung and the public transportation within Shahapur is inadequate.

The most common modes of local transport are walking, privately owned share seat jeeps and rickshaws.

The taluka has natural beauty, therefore, there is a demand for the upcoming residential constructions and second homes among the upwardly mobile outside Shahapur but some villages are so remote that it takes upto two hours and the use of more than one mode of transportation to reach them. There are private colleges located at the Taluka Headquarters attended by the students from the suburbs and city of Mumbai. The four dams located at Shahapur namely Tansa, Bhatsa, Vaitarna, and Modak Sagar, together supply drinking water to Mumbai. Yet a large part of Shahapur taluka face water shortage in the summer and the area is drought prone.

Employment Opportunities

Since Shahapur supplies almost all the drinking water to Mumbai, the government of Maharashtra has declared this area to be a No Chemical Zone; no one can start a chemical industry here. The area does have some industries like the Jindal steel plant and others in the area. However, despite the high literacy rate and industrial presence the local dominant economic activity is still agriculture. The poor have small land holdings or work as daily labour on others' land. When there is no work on land they work in brick kilns (**"veet bhatti"**).

Health Services

Regarding health services, Shahapur has a mix of government and private health services. There are many private practitioners at the taluka headquarters, which is the urbanized part of the taluka. However, this urbanized area is just a small section of the entire taluka. The availability of private alternatives is for villagers if they can reach it and afford it. Unlike other areas there are few visiting doctors in the villages because they are difficult to reach. Therefore it is the only public health services that are universal in the area.

The government health infrastructure in the taluka is functional; particularly post the National Rural Health Mission (2005-12). Shahapur has a sub divisional hospital located at the taluka headquarters, 9 Primary Health Centres (PHCs), and 69 Sub Centres. The ASHA Scheme is fully functional in the area. There were 340 ASHAs working on record in the 9 PHCs in Shahapur, offering good chances for a diverse sample of Community Health Workers. The area also has some voluntary organizations including the Integrated Rural Health Project, a Field Action Project of the Tata Institute of Social Sciences.

All the 9 Primary Health Centres in the taluka were covered in the sampling. The details are delineated in the section on Methodology. The following section presents the Research

Objectives. The unit of analysis is the ASHA but the unit of research differs depending upon the Objective in question.

5. Research Objectives of the Study

1. To explore the backgrounds of the ASHAs and the linkages with their perspectives about their work.

2. To understand the ASHAs' engagement with their work within their daily lives.

3. To explore the ASHAs' perspectives about their responsibilities vis-à-vis the perspectives of the stakeholders from the health system.

4. To understand the ASHAs' perspectives about their contributions to the health needs of the community vis-à-vis the community's perspectives on the same.

5. To delineate the role perceptions of the ASHAs by the ASHAs and the stakeholders at the implementation level.

6. The Methodological Framework of this Study

The Research Objectives of this study aimed primarily to "understand" aspects of the ASHA's work that were comparatively less known. This is the quality of an exploratory study which has been defined as one which *"seeks to investigate an under-researched aspect of social life"* (Hesse-Biber and Leavy 2010). This study has also taken a Constructivist approach as seen in the preceding section of the chapter. The Constructivist paradigm is primarily qualitatively oriented and so is this study. The Research Objectives, the analysis and the inferences of this study follow a qualitative approach. However, the Research Objectives of the study were found to require mixed sampling and data collection methods in order to be addressed effectively.

Traditionally social and behavioural research has had three Paradigms and each has an associated methodology. The Positivism paradigm is associated with quantitative research, Constructivism with qualitative research and Pragmatism with mixed research designs. Mixed Methodology has been seen as: "*…located within a pragmatist paradigm and interested in both narrative and numeric data and their analysis*" (Teddlie and Tashakkori 2009).

Further to this, rather than looking at the Quantitative, Qualitative and Mixed as three distinct Methodologies, researchers like the authors (Teddlie and Tashakkori 2009) have introduced the "QUAL-MIXED-QUAN continuum". Studies have been seen as having a "dominant design" with a few components from the opposite side. Taking the argument ahead, the authors propose that the use of methods is freed from the Methodology. Therefore, it is

entirely possible to use all methods within all paradigms provided they support the purpose of the study.

This is also sanctioned by Hesse-Biber, who has clarified that the deployment of a qualitative approach does not rule out the use of quantitative methods provided there is clarity on how the mixed methods design furthers the goals of a qualitative approach to understanding social reality (Hesse-Biber and Leavy 2010).

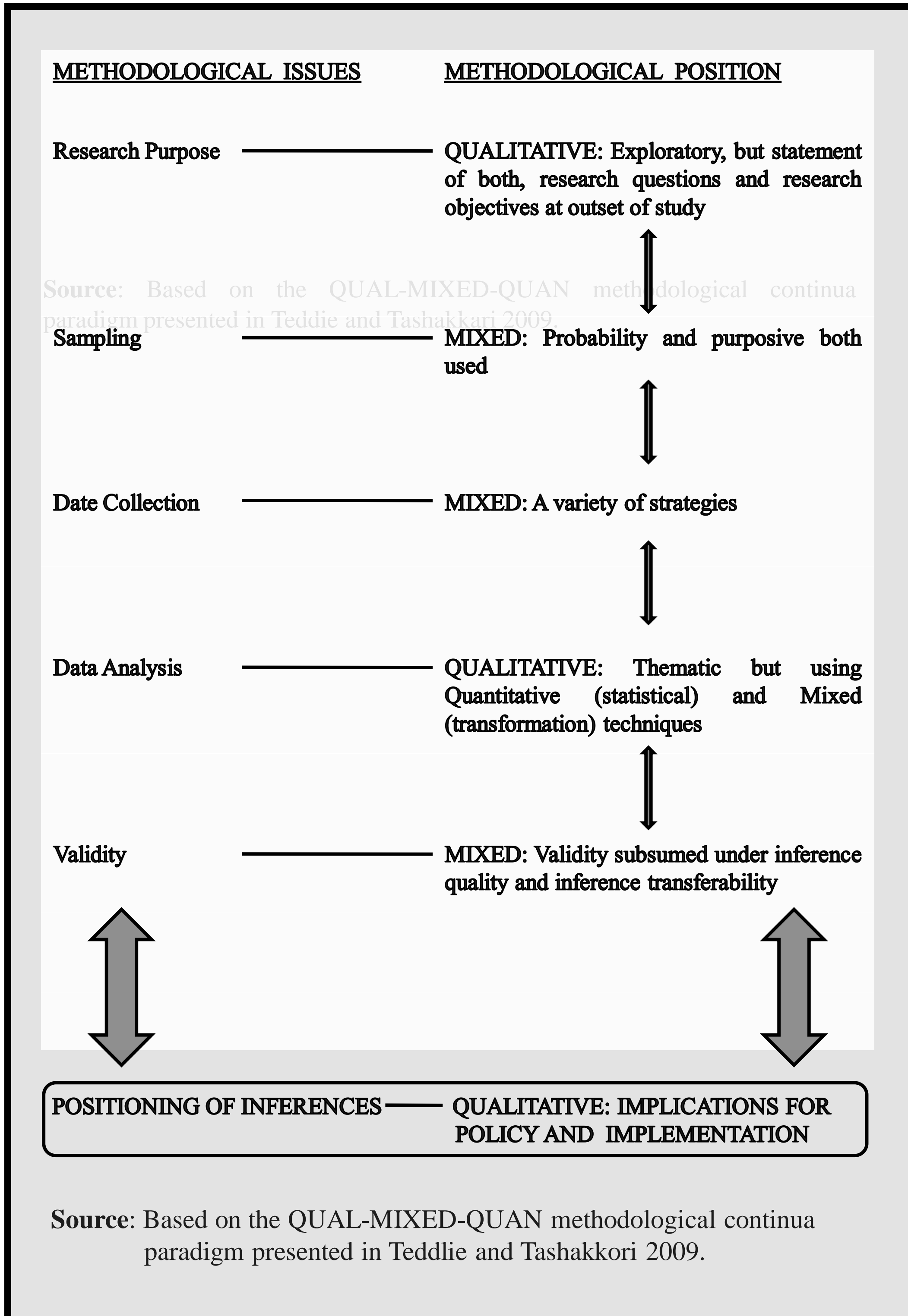
The purposes for applying mixed methods in a research design are stated to be Triangulation or convergence of results from different methods countering inherent method biases; Complementarity or elaboration and enhancement of results to increase meaningfulness; Development or use of results from one method to help develop or inform another method; Initiation or using the results of one method as the base for another method and Expansion or use of a second method to increase the scope of enquiry (Creene and Caracelli in Cresswell 2008).

Bryman (2006) has proposed that the purpose of using mixed methods in a research design could be for Instrument Development; when there is a diversity of views then perspectives can be identified by qualitative methods and relationships between variables can be uncovered by quantitative methods. Secondly, when there are unexpected results from one method then they can be understood by employing another method. Thirdly, one method can set the context for investigation by another method.

In this study different methods were used to serve several of these purposes at some point. These will be elaborated in the chapters on the findings of this study. Therefore, this

Figure 2.2

The Methodological Framework of the Study



Source: Based on the QUAL-MIXED-QUAN methodological continua paradigm presented in Teddlie and Tashakkori 2009.

study has used Mixed Methods where the qualitative approach is the dominant approach. In this study the quantitative methods were used to contextualise and to triangulate, not to testany hypothesis. The methodological framework of this study was set within a QUALITATIVE-MIXED-QUANTITATIVE methodological continua paradigm (Figure 2.2).

7. The Research Design

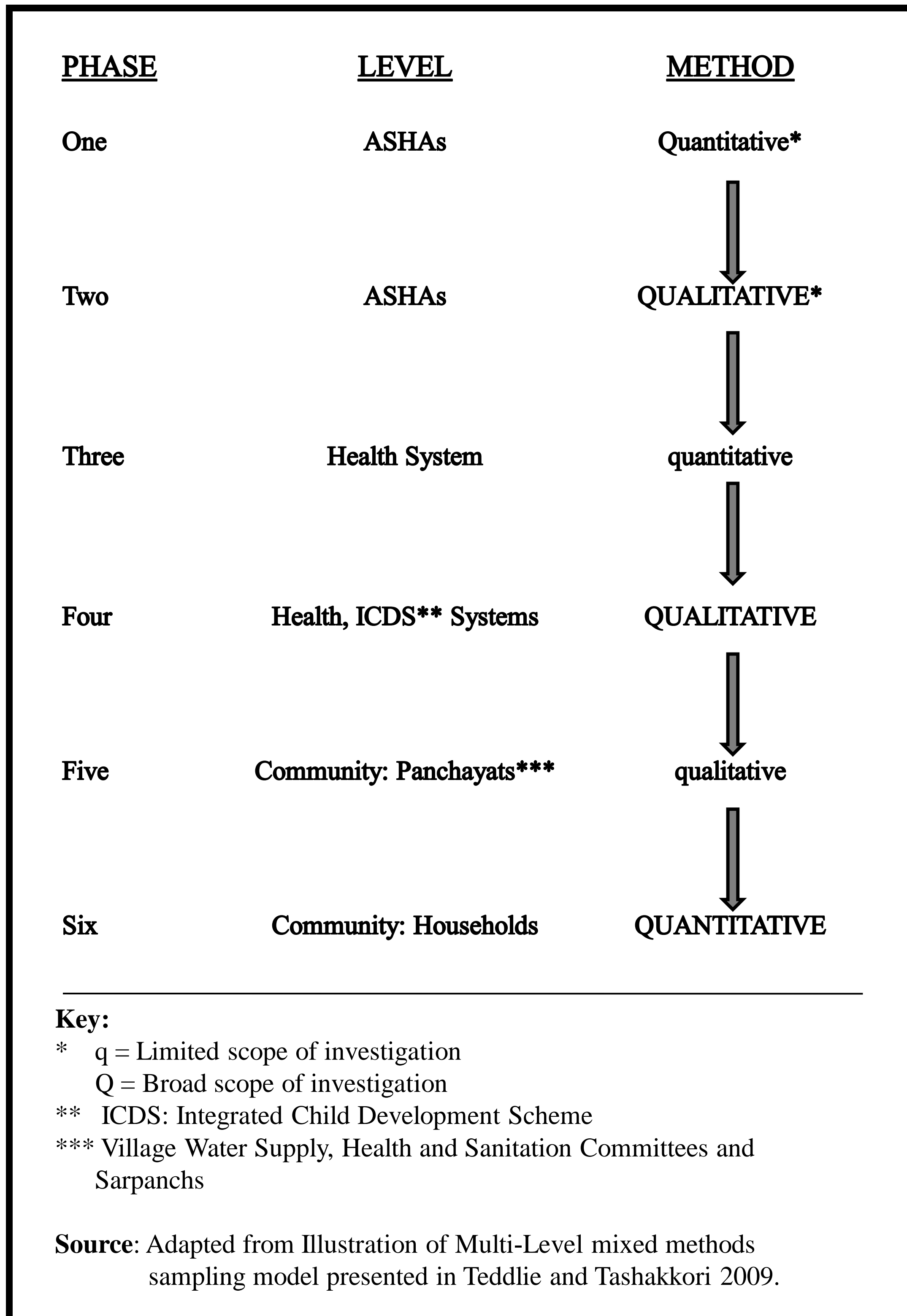
The Research Design of this study was formulated keeping the Research Objectives in mind. The Research Objectives were based on the different groups of stakeholders of the ASHA scheme and different methods are required for every group. The Research Design of this study, therefore, required a phased approach. The "*multi-level mixed design"* (Teddlie and Tashakkori 2009) was found to be the most suitable research design for this study. The unique characteristic of multi-level mixed design is its use in naturally occurring hierarchical structures within organisations. In these designs, choice of methods and sampling are made at each level of the structure and collected in a sequential or parallel manner. They are analysed accordingly. The results are used to make multiple inferences which are then integrated into meta inferences (Teddlie and Tashakkori 2009).

Within this overall multi-level mixed design, an additional design was nested. Some of the quantitative data after analysis is transformed to qualitative propositions through analytical conversion. The transformed qualitative propositions are then included as a point of enquiry within the qualitative enquiry. This is done for the purpose of Complementarity or to enhance the quantitative findings. This process of transformation has been called a *conversion mixed design* (Teddlie and Tashakkori 2009) and this design is nested within the overall research design of this study (Figure 2.3).

This study required six phases of the Data Collection corresponding to the six phases in the research design.

Figure 2.3

The Research Design of the Study: Sequential Multi-Level Mixed Design



8. Data Collection

The stakeholder groups were covered in six sequential phases of Data Collection (Figure 2.3). Two phases were required for each of the stakeholder groups namely the ASHAs; the stakeholders from the Health services system and the Integrated Child Development Scheme structure; and the stakeholders from the Community (households and members of the Village Water Supply, Health and Sanitation Committee). The six phases were developed in terms of feasibility and effective time planning. The study began with observation visits to the study location and the research design, sampling and methods were based on the observation of the field conditions.

For the data collection the visits to the study location by the researcher included the Block Medical Officer's Office, nine Primary Health Centres, six Sub-Centres and Anganwadis. Visits were made to several villages during data collection. In addition the six villages for the household survey were visited for the duration of the survey. These six villages were different from the others that were visited because they were identified through a sampling procedure (next section). Some of the data collection sites like the Block Medical Officer's Office and the PHCs were visited more than once to complete the data collection.

8.1 *Sampling Methods*

In this section the Sampling Methods used at each of the six phases of Data Collection will be discussed individually. Two methods were administered to the primary stakeholders of the study, the ASHAs. Firstly, a quantitative method, and secondly, a qualitative method (Figure 2.3) were administered immediately one after another.

8.1.1 ***Phase One: ASHAs (quantitative):*** The quantitative method used in Phase One was a survey (details in the next section of this chapter). A total of 340 ASHAs working in the nine PHCs were on the records of the Block Medical Officer. All the ASHAs in the block were planned to be covered in the survey (Census sampling). However, feasibility was a factor because all the ASHAs gathered centrally at the taluka level only annually. It was impossible to meet them individually because they were in a wide geographical area and it was also impossible to organise a special gathering centrally because of the expenditure. However, the ASHAs did meet in smaller groups at the monthly meetings in their respective PHCs. It was possible to access them in nine separate data collection sessions, one in each PHC, and this was done to complete the survey. The sample size of ASHAs covered in the survey was 244 ASHAs as the remaining ASHAs although on record were not present in the PHCs during data collection (details in the following section).

8.1.2 ***Phase Two: ASHAs (QUALITATIVE):*** The second method used for ASHAs was a qualitative enquiry through interviews. The sampling strategy was to select a divergent sample of

ASHAs on the basis of the findings from the preceding quantitative survey. Therefore, the data of the survey was analysed fully before beginning the sampling procedure for the qualitative interviews. The purposive sampling method was applied to get a divergent sample of ASHAs for the qualitative method. The criteria for selection were: firstly, are presentation of ASHAs from all nine PHCs; and secondly, a varied demographic profile on characteristics likes age, years of experience, caste and income. The third criterion of selection was the ASHAs' responses given to an open question in the survey on the reasons they had taken up this responsibility. Since it was a qualitative enquiry, saturation was also a criterion for sampling.

For the qualitative interviews, the ASHAs were met individually at PHCs, Sub-Centres (SCs) and in their own villages. The sample size of ASHAs for the qualitative enquiry was 24 ASHAs. A sample size of 30 or less is considered appropriate for a purposive sample (Teddlie and Tashakkori 2009). A sample size of 20-50 interviews is required for a grounded theory (Morse 1994, Mertens 2005 and Creswell 1998 in Teddlie and Tashakkori 2009). Therefore, this sample size was appropriate for the analysis.

The third and fourth phases were with stakeholders from the Health Services and Integrated Child Development Scheme (ICDS) systems. A quantitative survey of the ASHA Facilitators and secondly a qualitative enquiry of various stakeholders from the Health Services system and the ICDS (Figure 2.3) were administered respectively. The two methods were administered immediately one after another.

8.1.3 ***Phase Three: Health Services and ICDS Systems (quantitative):*** The ASHA Facilitators are the immediate supervisors of the ASHAs. Each woman ASHA Facilitator is mandated to supervise 10 ASHAs within her respective area. The records at the Office of the Block Medical Officer revealed that there were 34 ASHA Facilitators working in the Taluka.

The ASHA Facilitators would have been required to be accessed individually or during the monthly meetings of the ASHAs at the respective PHCs. However, the researcher was invited to observe a joint co-ordination meeting between the ASHA Facilitators and the Block Medical Officer and other officials. During this meeting, qualitative data was collected in the form of process documentation of the meeting by using Observation. At the end of the meeting, the questionnaire for the survey was also administered to the ASHA Facilitators. There were 29 ASHA Facilitators present in the meeting and all were administered the questionnaire. Attempts were made to meet the absent ASHA Facilitators later at their respective PHCs but were not successful. Therefore, the sample size of the ASHA Facilitators was 29.

The responses of the ASHA Facilitators to the survey were analysed immediately, before the qualitative method was applied in the next phase that is in Phase Four. Analysis of the open questions from both ASHA and ASHA Facilitators' surveys was used to shape the qualitative enquiry of the stakeholders from the Health and ICDS Systems in Phase Four.

8.1.4 ***Phase Four: Health Services and ICDS Systems (QUALITATIVE)*:** For the qualitative enquiry with the Health Services and ICDS Systems, interviews were conducted of the stakeholders other than the ASHA Facilitators. These were the LHVs (Lady Health Visitor – senior ANM located at the PHC), ANMs, Multi-Purpose Workers and Health Assistants. The Block Medical Officer, Block Facilitator, PHC Medical Officers and Anganwadi Workers were also interviewed individually as key informants.

The convenience sampling method was used and interviews were conducted as per the stakeholders' availability. In all, a total of 20 group plus individual interviews were completed at Phase 4. It was observed that saturation was reached very quickly as the views expressed were more or less uniform across the stakeholders. The interviews were conducted at the Anganwadis, Sub-Centres, Primary Health Centres and the Block Medical Officer's Office.

In the fifth and sixth phases the stakeholders from the Community were covered by both methods namely a qualitative enquiry and, secondly, a quantitative survey of households (Figure 2.3). A qualitative enquiry of the Sarpanchs and members of the Village Health Committee and a household survey were conducted at the fifth and sixth phases of data collection respectively. The analysis of data from the previous phases was factored into both the forms of enquiry from the community.

8.1.5 ***Phase Five: Community (qualitative):*** Convenience sampling was used for the qualitative enquiry in Phase Five, which was carried out simultaneously with other phases according to the availability of the stakeholders.

Unstructured interviews (using a discussion guide), were conducted with two woman Sarpanchs and one male Sarpanch only, because it was difficult to contact or meet the other Sarpanchs. Some were not present in the villages during data collection and others were living outside the villages. In addition, only two group interviews were conducted with the members of two separate Village Health Committees because members from other Village Health Committees were not present in the villages during data collection. These Committees were not from the same villages where the Sarpanchs were interviewed. This was done to get a more divergent sample at this phase.

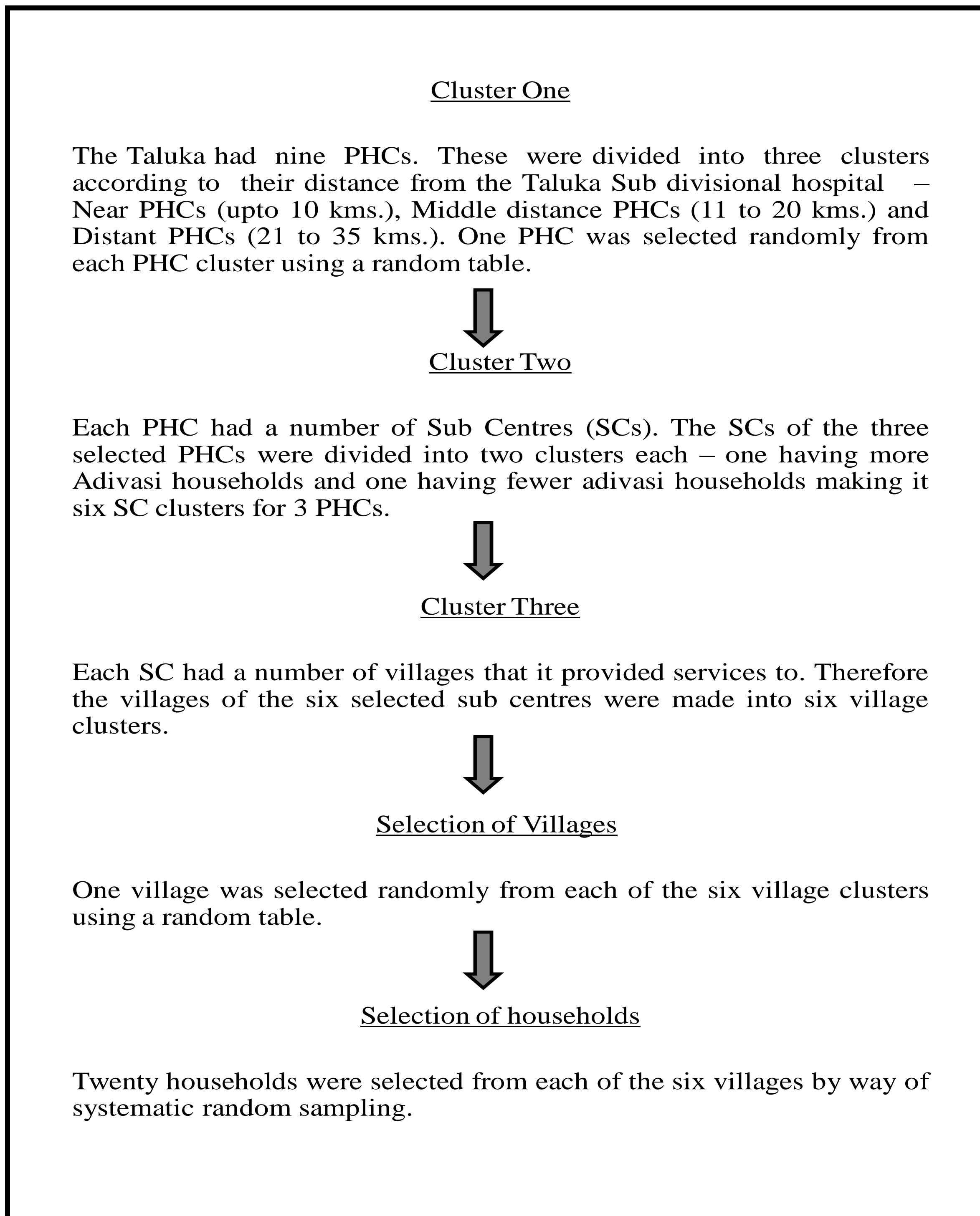
The stakeholders from the health structure like the ANMs expressed their inability to help to set up more appointments for interviews. The number of interviews could have been small at this phase however, since the general level of involvement of this group of stakeholders was analysed to be low with the ASHAs, saturation was achieved even with the limited interviews.

8.1.6 ***Phase Six: Community (QUANTITATIVE):***

The concurrent evaluation of the National Rural Health Mission (NRHM) for the Ministry of Health and Family Welfare (IIPS 2011) was a national study on comprehensive parameters of the NRHM.

Figure 2.4

Sampling Methods for The Household Survey



According to this study the percentage of gram panchayat villages that had a community health centre (rural public hospital) within 10 kms. was 33.4% of the sample of 1,962 villages. In Maharashtra, the comparable figure was 27.7% of 112 surveyed villages. Since just a third of the villages in the state had a hospital within 10 kms. in the national evaluation (IIPS 2011), the current study has used distance from the taluka level sub divisional hospital as a parameter for sampling of the villages for the survey. The previous readings, discussions and field observations of the researcher too had indicated that it was an appropriate manner of sampling.

A household survey was conducted in the community with a sample of 120 households selected from across 6 villages in the Taluka by using probability sampling methods. This was the last phase of the Data Collection. Multiple Cluster sampling was used at the PHC, SC and Village levels. A random selection table was used for the random selection at various stages of the Multiple Cluster sampling (Figure 2.4). In the last stage of sampling for this phase, systematic sampling was used at the village level to select 20 households each from six villages. The total number of households in the six villages was 661 households. The total sample size was 120 households.

For the systematic random sampling of households at village level, the sampling frame was all the households in the respective village. The Census of 2011 was recently undertaken in the area. Therefore, an updated list of households was available with the Sub-Centre/ASHA/Anganwadi worker at every village. The sample of 20 households was selected from the households list at every village by a mathematical calculation. For example if the total number of houses in the village were 100 then 100 was divided by 20 (number of households required in the sample from the village) which is five. Thus in the village with a hundred households, every fifth household was selected and thus 20 households would get selected as the sample for that particular village. This procedure was followed in each of the six villages. If the selected household was unavailable for some reason then the neighbouring household was taken in the sample. In one of the villages the list was not available, therefore, houses were counted manually and listed for the sampling procedure.

8.2 *Sample Size, Research Methods and Research Tools*

In the preceding section the sampling methods at each phase of data collection were discussed. In this section the sample size, research methods and research tools are discussed (Box 2.1) for each phase of the data collection.

Box 2.1

Phasewise Sampling, Sample Size and Research Methods

PHASE AND STAKEHOLDERS	METHODO-LOGY	SAMPLING	SAMPLE SIZE	METHODS AND TOOLS
One – ASHAs	Quantitative	Census	244 ASHAs	Survey, Self-Answered Questionnaire
Two – ASHAs	QUALITATIVE	Purposive	24 ASHAs	Qualitative Interviews, Semi-Structured
Three – System	Quantitative	Census	29 Facilitators	Survey, Self-Answered Questionnaire
Four – System	QUALITATIVE	Convenience	20 Group and Individual Interviews: Various Stakeholders	Qualitative Interviews, Unstructured
Five – Community	Qualitative	Convenience	5 Group and Individual Interviews	Qualitative Interviews, Unstructured
Six – Community	QUANTITATIVE	Multi-Clustered and Systematic	120 Households	Survey with Open Questions

KEY: q = Limited scope of intervention

Q= Broad scope of investigation

8.2.1 ***Phase One: ASHAs (quantitative):*** A survey of all the ASHAs in the study location was conducted to understand the backgrounds of the women that work as ASHAs including demographic details, family background, motivations and task priorities.

Sample Size

At the outset of the survey the researcher had collected the information on the number of ASHAs working at each PHC from the office of the Block Health Medical Officer which is the block headquarters of the public health services. The records showed that there were a total of 340 ASHAs from as many villages and **padas** (tribal hamlets) working in the block. However, during the ASHA meetings when the survey was administered, a total of 244 ASHAs only was present across all the nine PHCs. About 28.2% of the ASHAs were not present on the meeting days when the survey was conducted. This high rate of absenteeism across PHCs led the researcher to ask the health staff at the PHCs for the reasons (Table 2.1).The common answers were '*gone on leave', 'resigned'* and *'absent today'*. In some PHCs, there was no response to a query on the reason for the absenteeism of ASHAs.

A second round of data collection was done in the following month in two PHCs, one located near the block headquarters and the local railway station and one located at a distance from the block headquarters. In the second round too, only 3 out of 15 and 1 out of 8 of the originally absent ASHAs respectively, were present in the two PHCs. Otherwise, the same ASHAs were found absent again.

At this point a second round of data collection was abandoned for the remaining PHCs as being logistically difficult and the total sample size of ASHAs for the survey was accepted as 244.

Table 2.1

Number of Ashas on Records and Present during Data Collection

NAME OF THE PRIMARY HEALTH CENTRE (PHC)	TOTAL NO. OF ASHAS IN THE PHC (AS PER THE BLOCK HEADQUARTERS)	NO. OF ASHAS PRESENT AND COVERED DURING DATA COLLECTION	ASHAS NOT PRESENT DURING DATA COLLECTION		REASONS FOR ABSENCE GIVEN BY THEIR SUPERVISORS AT THE PHC
			No.	Percentage	
Shendrun	30	24	6	20	2 Resigned 4 Absent
Washind[1]	45	30	15	33	4 on Maternity Break 3 Resigned 8 Absent
Kasara	47	33	14	29.7	Reason not given
Kinawali	33	23	10	30.3	8 Resigned 2 Absent
Aghai	40	31	9	25.7	1 on Maternity Break 1 on Leave 4 Absent 3 Vacant positions
Khardi	35	20	15	42.8	3 Resigned 1 Pada Worker but has been counted as ASHA on Record 11 Absent
Takepathara	35	26	9	25.7	2 on Maternity Break 7 Absent
Dolkham	45	35	10	22.2	4 Resigned 2 Vacant Seats 4 Absent
Shenva[2]	30	22	8	26.6	Reason not given
Total	340	244	96	28.2	

(1) Two rounds of data collection were done in Vashind PHC. The second round after a month yielded only 3 more ASHAs than the first round.

(2) Two rounds of data collection were done in Shenva PHC. The second round after a month yielded only one more ASHA than the first round.

(3) In both PHCs , the same ASHAs were absent on both rounds.

Research Methods

Two methods were used in this phase of data collection namely survey and free listing.

Research Tools

Tool 1: The tool used was a self-administered questionnaire in the local language (Questionnaire translated into English in annexure 2A). Most of the questions were kept close ended where the ASHAs had to only tick the right option. This was done in order to maximise the participation of the ASHAs in view of their minimum educational qualifications (standard eighth).

Rationale for Use of Tool 1: A self-administered questionnaire was chosen because it was participatory. Going through this exercise would introduce the ASHAs to the research. Secondly, an open question on their reasons for joining required some reflection and writing the responses gave that space to the women. Most importantly the answers could provide the "language of the ASHAs" to the researcher and aid the qualitative enquiry that followed this phase.

Tool 2: All the 244 ASHAs also did a free listing exercise which was possible to combine with the self answered questionnaire as both the tools were participatory tools.

Rationale for Use of Tool 2: All the ASHAs were asked to write down their responsibilities in the order of their own priorities in Free Listing. This single tool could give insights into the nature of ASHAs' understanding about their responsibilities and their prioritisation of the same. Various linkages were found during the analysis of the data to the Free Listing.

8.2.2 ***Phase Two: ASHAs QUALITATIVE***: The data of the survey in the phase one was the base for the qualitative enquiry from the ASHAs in phase two.

Sample Size

ASHAs were selected on the basis of the sampling methods described in the preceding section. The ASHAs were interviewed at this phase until saturation was reached. The sample size was 24 ASHAs.

Research Method

The research method used in phase two was the Interview method.

Research Tool

A semi-structured interview was the tool consisting of a common set of open ended questions in a fixed order (Annexure 2B). Probing was done for in-depth insights.

Rationale for Use of Tool

This was an exploratory study but the topic of the study required that perceptions be generated on specific issues. Therefore, a list of open-ended questions in fixed order was found suitable rather than an in-depth open interview. Secondly, administering the same questions could also aid triangulation of findings.

8.2.3 ***Phase Three: Health System quantitative***: The immediate supervisors of the ASHA in the system were the ASHA Facilitators. A survey of all the Facilitators working in the taluka was conducted.

Sample Size: All the ASHA Facilitators that were present were administered the questionnaire (previous section). The sample size was 29 Facilitators.

Research Method: Two methods were used in this phase of data collection namely survey and free listing.

Research Tool 1: The same self–administered questionnaire with open questions and free listing that was given to the ASHAs (Annexure 2A) was also administered to their Facilitators.

*Rationale for Use of the Tool***:** It was observed that the ASHA Facilitators were also women, working in an impermanent position and hailing from the villages like the ASHAs. Administering the same tool could give data for perceiving the similarities and differences in the demographic details, family background, and motivations from the ASHAs.

*Tool 2***:** All the 29 ASHA Facilitators also did a free listing of the responsibilities of the ASHAs like the ASHAs in the previous phase.

Rationale for Use of Tool: The ASHA Facilitators' free listing of the ASHAs' tasks could be valuable for analytical inferences and triangulation.

8.2.4 ***Phase Four: System QUALITATIVE:*** The stakeholders from the health services system apart from the ASHA Facilitators were covered at phase four. As seen in the preceding section

these stakeholders including the ANMs, Health Assistants and Multi-Purpose Workers at the PHCs and Sub Centres. The Block Medical Officer, Block Facilitator, PHC Medical Officers, Lady Health Visitors (LHVs – senior ANMs located at PHCs) and Anganwadi workers were interviewed individually.

Sample Size: Interviews were conducted until saturation was reached. A total of 20 individual and group interviews were conducted.

Research Methods: At phase four, the Interview method was applied. In addition, structured observation (process documentation of staff meetings), unstructured observation (by observing the various staff at work and in meetings) and analysis of documents (task-incentive chart and staff records) were also used.

Research Tools: An interview guide (Annexure 2C) was used for all 20 interviews where questions were asked in no fixed order.

Rationale for Use of the Tool: Although aware that their inputs would be used for research in all confidentiality, the stakeholders from the health services system were observed to be reticent and reluctant to agree for any formal interview. The staff at the sub centres was not willing to talk individually therefore group interviews were conducted. The Medical Officers, LHVs and the Anganwadi workers on the other hand were more open however they preferred a conversational mode of interviewing.

The last two phases of data collection were with the community as seen in the previous section. Both qualitative and quantitative research methods were used.

8.2.5 ***Phase Five: Community qualitative:*** In this phase a qualitative enquiry was conducted with Sarpanchs and members of the Village Health Committees.

Sample Size: Five Interviews were conducted as seen in the previous section. These included three individual interviews with three village Sarpanchs (one male and two female Sarpanchs) and two group interviews with the members of two separate Village Committees.

Research Methods: Interview and observation were the two methods that were used at this phase of the data collection. The interviews were conducted simultaneously with other phases of data collection depending upon the availability of the respondents.

Research Tools: An interview guide (Annexure 2D) was used for all the 5 interviews where questions were asked in no fixed order.

Rationale for Use of the Tool: Although, the accessibility to stakeholders was limited, it was important to include this phase of data collection because it illuminated the nature of the

linkages of village panchayat systems with the ASHA Scheme. An interview guide could commonly be used in both the individual and group interviews.

8.2.6 ***Phase Six: Community QUANTITATIVE:*** At the final phase of the current study, a household survey was conducted at the villages where the heads of the households were interviewed by the researcher.

Sample Size: The decision to have a sample size of 120 households for the survey was based upon reasons of time and expenditure available for the research. Within the limitations, the priority was to have as divergent a sample as possible, therefore, the decision was taken to select households from across the study location and not from one village.

Regarding selection of the sample, as seen in Figure 2.4, the Primary Health Centres were first categorized in terms of distance from the public hospital that is the sub-divisional hospital in the taluka. Table 2.2 shows the distribution of the sample of PHCs, villages and finally the households selected for the survey. A sample of 120 households made up about 18% of the total households in the six villages which is a good representative sample size of the six villages. By factoring in the distance from hospital in the sampling procedure, an in-built filter against possible distance-related bias in the observations of the respondents was incorporated.

Table 2.2

Households: Sample Selected for Survey

SELECTED PRIMARY HEALTH CENTRES	DISTANCE FROM BLOCK LEVEL HOSPITAL	SELECTED SUB-CENTRES	SELECTED VILLAGE / PADA	TOTAL HOUSE-HOLDS	NO. OF SELECTED HOUSE-HOLDS
Dolkhamb	Far (more than 20 kms.)	Dehane	Chinchwada	85	20
		Gunde	Valshet	162	20
Khinawali	Medium (11 to 20 kms.)	Chikhalgaon	Chikhalgaon	89	20
		Mugaav	Patroli	16	20
Washind	Near (Upto 10 kms.)	Ambarje	Maasavne	109	20
		Vashind 2	Raikarpada (Station Area)	200	20

3	-	6	6	661	120

Research Method: The household survey was chosen as the preferred research method to be used in the community after all the previous phases of data collection had been completed. It was preferred because a preliminary analysis of the data collected in the previous phases showed that the section of the community that needed to be further investigated was the household level.

Research Tool: While the surveys conducted upon the ASHAs and the ASHA Facilitators were in the form of self-administered questionnaires, the survey for the community was in the form of an interview schedule administered by a researcher where apart from the demographic information, all the questions were open questions (Annexure 2E).

*Rationale for using the tool***:** The purpose of the research at this phase was to understand the perceptions of all members of the community about the ASHA working at their respective villages. The choice of the tool was left open until the preliminary analysis of the data from other phases was consulted. Towards the end of the data collection it was felt that participative strategies would delimit the choice of respondents from the community in terms of age, gender etc. Since the ASHA's services are meant for all, a household survey would be suitable. The head of the households were the persons interviewed as they would be the ones knowing about the health behaviour of the household members.

8.2.7 ***Methods Used in all the Phases:*** At the end of each day of data collection, memos and observations were written out daily. Observations were recorded in the form of notes.

After each phase of research, data was analysed, before proceeding to the next phase so that it could inform the construction of the questions for the next phase. Thus, the survey data completed at phase one was analysed before going to phase two of data collection.

The qualitative interviews were not tape-recorded as per the preferences of the researched persons. Rather interviews were written out by hand during and immediately after the interviews at the interview location itself. At the end of each day the interviews were read repeatedly and completed. Member checking was done at the venue with every interviewee to be ensured of the correct representation of their views. The interviews were written out in English but the Marathi phrases used by respondents were also written in order to retain the "language of the stakeholders".

Content analysis of several policy documents (cited in the chapters) was also used in addition to the methods discussed above.

9. Plan of Analysis and Presentation of Chapters

The hallmark of an authentic mixed method research design is when there is integration of approaches across the study (Teddlie and Tashakkori 2009). This study met the condition because mixed methods were used at all phases of sampling, research methods and data analysis. Analysis of the preceding phases informed the sampling and instrument development in the next phase.

9.1 Overview

Data collected from each method at every phase was analysed separately. In the in-depth interviews, trustworthiness and credibility of the data were established by member checking, and focusing on the words chosen by the participants to ensure their interpretations. The attempts were to retain thick descriptions and not to rationalise in any of the interpretations. Thematic analysis was used for the qualitative data.

The use of the quantitative methods was to set a base, contextualise and to expand the understandings of the qualitative methods. For the quantitative data, SPSS was used to generate statistics after the creation of categories and the coding. Tables created from the statistical output were seen as descriptive statistics forming trends that were incorporated into the analysis. Therefore, tests of validity were not included in the analysis. At some points, data transformation was used with the quantitative data, where the numbers were analysed quantitatively and also transformed into qualitative analysis and both were included in the findings to enhance the understandings. This study uses the technique of juxtaposition to highlight the distinct perspectives of the stakeholders.

All the findings of this study are presented in the form of thematic analysis using constant comparison across stakeholders and methods. Data displays in the form of tables, quotes, text boxes, matrices, vignettes and figurative representations are presented in the respective Chapters as found applicable for the themes.

Quotes are presented anonymously when they are from the open questions and observations of the ASHAs made in the self-answered questionnaire. Quotes from the in- depth interviews are used with pseudonyms and a brief background of the person being quoted.

9.2 Chapter-wise plan of Analysis and Presentation of Chapters

Chapter One gives the Introduction to the study and **Chapter Two** gives the Methodology of the study.

Chapter Three gives the background of the ASHAs and the linkages with their perspectives about their work. This Chapter has two sections. In the first section the personal backgrounds of the ASHAs and in the second section a profile of the ASHAs at work have been given. Statistical tables are used for thematic analysis in both the sections.

The data is drawn from the self-answered questionnaires administered upon 244 ASHAs. There were pre coded and open questions. The responses to each of the open questions were first listed, then translated into English, and then categorised by the researcher. Care was taken to retain the list of the original Marathi answers separately for quotes. Then, the entire data from the questionnaires including the pre-coded questions were processed through the SPSS. The output was checked and refined three times before the tables were made for this Chapter.

Apart from the discussion on the emergent themes, tables, quotes and text boxes are presented in the Chapter.

Chapter Four discusses the ASHA's experiences at home, the village and with the self as a woman and health worker. It begins with an analysis of the reasons to join and motivations to remain as ASHAs. The findings begin with the analysis of the reasons written by 244 ASHAs in the self-administered questionnaire. Since a self- answered questionnaire was applied, the ASHAs had given their answers in Marathi. Each response was translated into English, listed and categorised before it was processed through SPSS to create a table.

The motivations of the ASHAs are subsequently analysed through the emergent themes from the in depth interviews of ASHAs done in phase Two. The analysis shows the triangulation of themes from the self-administered questionnaire and the in-depth interviews. The rest of the Chapter Four, presents an analysis of the data from the in depth interviews of ASHAs in terms of analytical themes. There are linkages with the backgrounds of the ASHAs as presented in Chapter Three.

Chapter Five is about the ASHAs in their work space. The various perspectives from policy, levels of stakeholders from the health services and from the ASHAs are presented in the Chapter. The findings from all the stakeholder groups fell into two emergent themes. These were (a) the location of the ASHA functionary within the health services system and (b) the duties of the ASHA functionary. The theme of location emerged during the investigation on the duties of the ASHAs.

Besides the findings from interviews, the data used in this Chapter includes a qualitative content analysis of the related policy documents. In this Chapter, the analysis derived from the process documentation of various official meetings forms an important part of this Chapter as well. In addition, the data includes a participative tool of free listing of ASHA tasks by both the ASHAs and their supervisors the ASHA Facilitators. The findings of the free listings are presented as quantitative tables in this Chapter. The same data has been analyzed qualitatively later in Chapter Seven. Lastly, Observation was a method that could yield valuable analysis in this Chapter.

This Chapter uses the technique of juxtaposition to highlight the distinct perspectives of the stakeholders. All these methods are used in a synthesized manner to present the two emergent themes. This Chapter has quotes, matrices, text boxes and a figurative representation.

Chapter Six discusses the perspectives of the community about the ASHA functionary. This Chapter presents the data of the household survey of 120 households. Besides this the findings from five individual and group interviews of Sarpanchs and members of the village health and sanitation committees are included in this Chapter. As in the previous Chapters, this Chapter also uses the technique of juxtaposition to highlight the distinct perspectives of the stakeholders. Findings of the tables and the in depth interviews have been used in a synthesised manner to present the analytical themes. In this Chapter, apart from the tables, quotes and text boxes are given. The first theme that emerged from the data was about the location of the ASHA functionary within the community's understanding of the health services available in the village. Next, the theme of location was explored further in terms of location within the health seeking behaviour of the community. The understandings about the duties of the ASHA functionary are the third emergent theme. Lastly the rights of the ASHAs with regard to the Village Health Committee and vice versa are presented in this Chapter.

Chapter Seven is the final Chapter of the current study. A meta-analysis of the findings across methods and stakeholders is presented in this Chapter. The final aim of the analysis in this Chapter is to understand the implications of these findings for the women working as ASHAs, for the ASHA Scheme and for all CHW programmes.

Role perceptions about the ASHA functionary as seen by stakeholders form a significant part of the discussion. The ASHAs' understandings about their role were analysed by a process of data transformation from the quantitative table on reasons for joining presented in Chapter Three. These inferred perceptions were then triangulated during the in depth interviews of the ASHAs. The findings emergent from the ASHAs about their role perception are presented in this Chapter. In the backdrop of the ASHAs' role perceptions, the role perceptions of other stakeholders are tracked in the analysis.

This Chapter also relooks at the theoretical framework and presents the emergent theoretical framework at the end of the research study. In the final analysis, the discussion in this Chapter is about theory-building according to the emergent themes. It presents some points of

considerations for the ASHA and all CHW Schemes. Matrices, quotes and text boxes are used in this Chapter.

10. Ethical Considerations

The requisite permissions from the District Medical Officer, District NRHM Manager, Block Medical Officer and the respective Primary Health Centre's Medical Officers were taken before data collection. The area being far flung, it was necessary to ensure the presence of the persons to be researched before setting out for data collection. The participation of stakeholders from the system was taken for appointments but was consciously restricted to logistics like making initial contacts and planning the data collection dates. Otherwise all aspects of the research process from sampling to transportation were independent of the official health structure. The identity of the villages where the survey was conducted was not revealed as also the interviewees.

The privacy of all the researched was consciously guarded while collecting the data even on the premises of the PHC or other facilities. Before collecting any data from any participant they were briefed about the subject, purpose and potential uses of the research study for the thesis and publications. They were assured of confidentiality. Their verbal consent was obtained with the option for them to withdraw from the research at any time if they chose to do so.

During data analysis, the qualitative interviews were typed out and analysed by the researcher personally. Real names were retained in the original typed interviews, as well as the survey forms for ease of tracking the data. However, the identity of the researched was protected in the presentation of the findings for their safety.

11. Limitations of the Study

This study was located in one taluka of the country and therefore the findings are contextual within the conditions that are unique to the taluka. The findings yielded linkages for the consideration of further exploration.

The study used mixed methods for sampling and data collection. The analysis was primarily qualitative thematic analysis. Further research is thus required to confirm the emergent linkages.

Some limitations specific to some phases of this study are as follows. Although all care was taken to get a probability sample by the right sampling methods, for the household survey, the sample may not be completely representative because the sample size is small considering the sampling frame. Out of 94 villages in the taluka, six villages were covered in the survey. The

Census showed the population of Shahapur to be around 1, 10,000. If the average household size is taken as 5, the total number of households is projected to be 22,000. However, as the overall approach of the study is qualitative therefore the limitations of a small sample size are overcome to an extent. The survey also had a number of open questions therefore it was valuable for qualitative analysis. Lastly, the selected households are 120 households out of 661 households of six villages (about 18% of the total households in the six villages), therefore, they are representation of the six villages at least.

Secondly, there were just five qualitative interviews with the Sarpanchs and members of the Village Health Community. Although saturation was reached with this stakeholder group, further investigation with other members of the community could have added more dimensions to the findings regarding the Village Health Committees.

THE BACKGROUNDS OF THE ASHAS AND LINKAGES WITH THEIR OWN PERSPECTIVES

For the past five decades, the primary reason for the involvement of Community Health Workers like ASHAs within public health systems has been their membership of the community that the systems aim to reach. However there is another side of the equation as well. The economic, social, educational and cultural background of the women as members of the community in its turn also influences their perspectives about their work as Community Health Workers. The ASHAs' backgrounds also include their experiences at work and these influence them too. A successful and sustainable public health intervention involving CHWs like the ASHAs can only be designed when the influences of their backgrounds are explored, acknowledged and integrated into the system as well. Chapter Three takes this standpoint to explore the backgrounds of the ASHAs and the linkages with their perspectives about their work. The analysis is presented from the view of the primary stakeholders of the study namely the ASHAs.

This Chapter has two sections. The first section presents the personal background of the women who work as ASHAs. The linkages with the ASHAs' perspectives of their location within the health system are explored in this section. The second section presents a profile of the ASHAs as workers. The linkages of their education and experiences at work with their aspirations are explored in this section.

1. The Personal Backgrounds of the Women who Work as ASHAs

A profile of the women working as ASHAs in the study location is presented in Table 3.1.

Each of the parameters in table 3.1 is discussed separately below. The linkages of each of the parameters with the ASHAs' perspectives about their location within the health services system are also explored.

Table 3.1

Personal Backgrounds of the Women Working as ASHAs

PARAMETERS	**PROFILES**		
		NUMBER (N = 244)	**PERCEN-TAGE**
AGE DISTRIBUTION (AGE GROUP IN YEARS)	18 to 24	62	25.4
	25 to 30	120	49.2
	30 to 35	55	22.5
	35 to 40	6	2.5
	No Response	1	0.4
	Total	**244**	**100.0**
MARITAL STATUS	Unmarried	1	0.4
	Married	228	93.4
	Widowed	13	5.3
	No Response	2	0.8
	Total	**244**	**100.0**
NO. OF FAMILY MEMBERS	Up-to 5	117	48.0
	6 to 10	99	40.6
	More than 10	27	11.1
	No Response	1	0.4
	Total	**244**	**100.0**
MAIN SOURCE OF FAMILY INCOME	Labourer on other's land	57	19.8
	Own Farming	148	51.4
	Labourer in Industry	15	5.2
	Work in City	26	9.0
	Self-Employed	17	5.9
	Any Other	18	6.2
	No Response	7	2.4
	Total	**288***	**100.0**

Continued…

PARAMETER	**PROFILE**		
		NUMBER (N = 244)	**PERCEN-TAGE**
MONTHLY FAMILY INCOME (IN RS.)	Less than 500	39	16.0
	501 to 1000	42	17.2
	1001 to 1500	38	15.6
	1501 to 2000	24	9.8
	2001 to 2500	22	9.0
	2501 to 3000	37	15.2
	More than 3001	31	12.7
	No Response	11	4.5
	Total	**244**	**100.0**
CASTE BACKGROUND OF THE ASHAs			
Other Backward Castes	(a) Kunbi	117	48.0
	(b) Sonar	1	0.4
	Sub-Total	**118**	**48.4**
Adivasi	(a) Warli	10	4.1
	(b) Agri	15	6.1
	(c) Katkari	6	2.5
	(d) Bakur	1	0.4
	(e) Kokana	1	0.4
	(f) Adivasi (tribe not mentioned)	2	0.8
	(g) Mahadev Koli	7	2.9
	(h) M. Thakur	45	18.4
	Sub-Total	**87**	**35.6**
Hindu/Maratha	(a) Hindu (caste not mentioned)	16	6.6
	(b) Maratha	8	3.3
	Sub-Total	**24**	**9.9**
Minorities	(a) Baudh	3	1.2
	(b) Nav Baudh	4	1.6
	(c) Mahaar	3	1.2
	Sub-Total	**10**	**4.1**
	No Response	5	2.0
	Total	**244**	**100.0**

*Multiple Responses.

1.1 ***Age Distribution***

Most of the ASHAs in the sample were from the age group of 25 -35 years (Table 3.2) in keeping with the national trend (NHSRC 2011, IIPS 2009). The ASHA Scheme mandates the ASHAs to be a woman resident of the village, married/ widowed/ divorced, preferably in the age group of 25 to 45 years (National Rural Health Mission, Ministry of Health and Family Welfare 2006).

Table 3.2

Age Distribution of the ASHAs

AGE GROUP (IN YEARS)	NUMBER (N = 244)	PERCENTAGE
18 to 24	62	25.4
25 to 30	120	49.2
30 to 35	55	22.5
35 to 40	6	2.5
No Response	1	0.4
Total	244	100.0

In the sample of this study, except for six ASHAs out of 244, who were in the 35-40 years age group, the ASHAs were a young population. However about one fourth (25.4%) were the youngest being 18 to 24 years of age. As seen in a national study (NHSRC 2011) only the states of Rajasthan (24%) and Jharkhand (28.9%) had such a high number of women in this age group.

These were all women in their child-bearing years and included mothers with very young children. It was observed during the ASHA meetings that some ASHAs had come with their breastfeeding babies and toddlers. In some cases the ASHAs were accompanied by older women from the family who were holding the toddlers outside the hall. It was an indication of the fact that the position of ASHA was a coveted one among families as even new mothers had accepted the responsibility. The task-incentive arrangement was possibly attractive for the women but perhaps not in the manner envisaged by the policy. In fact all the women in the sample were in their productive years. These women had conceded to work as ASHAs or their families had

conceded despite their having domestic responsibilities as married women within rural families. It follows that the women and their families perceived the amounts being given in the light of payment for their work. This indicated the manner in which they located themselves within the health services system.

1.2 *Marital Status*

The experiences of earlier public health interventions in the voluntary sector in India had suggested that married women from 25-35 years of age were the preferred profile of CHWs for sustainability of a CHW Scheme (Antia and Bhatia 1993). The ASHAs in Shahapur followed the national trend where almost all the ASHAs were married (NHSRC 2011, IIPS 2011). Almost all the ASHAs in the sample (93.4%) said that they were married (Table 3.3).

Table 3.3

Marital Status of the ASHAs

MARITAL STATUS	**NUMBER (N =244)**	**PERCENTAGE**
Unmarried	1	0.4
Married	228	93.4
Widowed	13	5.3
No Response	2	0.8
Total	244	100.0

There were thirteen widowed women in the sample. Not a single ASHA in the sample had indicated that she was separated or divorced. This could be due to social stigma in the community. For example one of the ASHAs had indicated her marital status as 'married' but had also written against her response in the survey:

"*Married but living with my brother"*.

Most of the ASHAs were married (Table 3.3) and were therefore probably not the main earners of the family. An earlier national level study (NHSRC 2011) has also shown that about 65% to 89% of the ASHAs had said their husbands were the main family earners and 5% to 20 % said it was their fathers.

Following the national trend, in this study only the small percentage of women who said they were widows (5.3%) could be classified as main earners. However as reported above there could be women in the sample who had not declared that they were separated, divorced or otherwise not supported despite being married due to the social stigma. These women could also be uncounted main earners.

1.3 *Family Size*

The distribution of family size among the ASHAs of this study was almost equal between nuclear families (48.0%) and joint families (Table 3.4). About 40.5% of the ASHAs were from families having 6-10 members and as many as 11.1% had families with more than 10 members.

Table 3.4

Number of Family Members of the ASHAs

NO. OF FAMILY MEMBERS	**NUMBER N=244**	**PERCENTAGE**
Up-to 5	117	48.0
6 to 10	99	40.6
More than 10	27	11.1
No Response	1	0.4
Total	244	100.0

Women from large joint families were working as ASHAs and they had the consent of their families to do the work.

*"In my family 4 brothers live together and eat from the same field, all 4 families live together. I am also the member of the village's self-help group. The Anganwadi Worker got me selected as ASHA by telling sister (*ANM)*. I first asked the whole family and then only I joined. I asked everyone whether I should join*." (GS, ASHA, working for the past four years, lives in a joint family that cultivates vegetables and members also work as daily laborers)

The fact that the women gained consent to work outside the home even in joint families was itself a pointer to their perception of the post as being paid work.

The ASHAs were asked about all the sources of employment for their families apart from their own remuneration.

1.4 *Family Sources of Income*

The main source of employment in Shahapur is agriculture and the data reflects this. Many ASHAs gave multiple responses to the question because their families had more than one source of employment. However over 70% of the responses mentioned agriculture as a source of employment for their families, in the form of working on their own land (51.4%) or working as labourers on others' lands (19.8%). Both the avenues were not mutually exclusive because these were multiple responses (Table 3.5).

Table 3.5

Main Source of Family Income of the ASHAs

MAIN SOURCE OF INCOME	NUMBER* (N=244)	PERCENTAGE
Labourer on other's land	57	19.8
Own Farming	148	51.4
Labourer in Industry	15	5.2
Work in City	26	9.0
Self-Employed	17	5.9
Any Other	18	6.2
No Response	7	2.4
Total	288	100.0

* Multiple responses of 244 ASHAs

In fact the data on sources of employment revealed the struggles for survival. Agriculture was the mainstay of many of the ASHAs' families. It is a seasonal employment therefore, the families depended upon other sources of income also. However, employment opportunities outside of agriculture are few in Shahapur. Being the main supplier of potable water to Mumbai it is a Non Chemical Zone. There are some industries but the major commercial activity is by outsiders in the form of private educational institutions or private housing complexes being built as second homes. These developments had not provided as many avenues for employment.

Only about 9% of the responses were regarding some form of employment in the city (Thane/Nashik), 5.2% were labourers in industrial jobs and the rest were self-employed (5.9%) or had other sources of employment (6.2%). The latter group reported a variety of options taken up by the families to make the ends meet other than their land holdings (Table 3.6).

There were as many as 17 different occupations that had been mentioned under the categories of 'self-employed/any other.' However, collectively these non-agricultural occupations made up only about one fifth of the ASHAs' responses. Thus apart from the seven respondents who did not mention any occupation (Table 3.5), the family members of the ASHAs were largely dependent upon agriculture for employment. Given the family size

Table 3.6

Other Sources of Income of the Family Members of ASHAs*

OTHER SOURCES OF INCOME	NUMBER

Black Smith ***(Lohar)***	2
Temporary Labour in Industries ***(Temporary Kaam)***	4
Own Business	2
Furniture Making	2
Brick Layer ***(Veet Kaam)***	2
Hotel	1
Casual Labourer	4
Painting	1
Plumber	1
Printing Wedding Cards	1
Auto-Rickshaw Driver	2
Security Guard (***Watchman)***	2
Peon (***Chaprasi)***	1
Teacher in School (Probably Tribal School)	1
Working in Shop	2
Tailoring	3
Vegetable Vendor	4

* Occupations mentioned in the categories of family members "self-employed/any other" in Table 3.5

(with more than half the ASHAs coming from large joint families), the poverty of the families was apparent. Farmers and labourers in the area took up work in brick kilns in the off season and every adult member worked, reflecting the collective household efforts to remain solvent. Despite these efforts the total family income was low.

1.5 ***Monthly Family Income***

Most of the ASHAs said that the total monthly income earned by all working members of their families excluding their own remuneration was below rupees 3000 (Table 3.7). Only about 12.7% of the ASHAs said their monthly family income was above rupees 3000. The national trend of most ASHAs across states also revealed a family income between 1000-3000 per month ((NHSRC 2011). However this study further explores the implications in the face of such poverty.

It was observed that the produce of their land was mainly consumed by the families themselves particularly in larger households and little produce was available to be sold in the market. Therefore, the amount of disposable cash available to most families was limited.

Table 3.7

Total Family Income Per Month of the ASHAs (Self-Reported)

TOTAL FAMILY INCOME (IN RS.)	NUMBER (N = 244)	PERCENTAGE
Less than 500	39	16.0
501 to 1000	42	17.2
1001 to 1500	38	15.6
1501 to 2000	24	9.8
2001 to 2500	22	9.0
2501 to 3000	37	15.2
More than 3001	31	12.7
No Response	11	4.5
Total	244	100.0

Considering the inadequacy of cash flow in agro-based families and the fact that ASHAs were paid in rupees, this was a further reason for the families to expect gains from the ASHA post. Therefore regardless of the fact whether ASHAs were main earners or not, their earnings from the ASHA post were valuable for the family income.

1.6 *Marital Status by Family Income Per Month*

Linkages between the marital status and the level of income among the ASHAs were explored. Was there a possibility of single women having to face higher expectations than married women due to poverty? The data showed (Table 3.8) that poverty was seen in all families regardless of the marital status of the ASHAs. Within this overall finding the women who had reported themselves as widows were likely to have more economic pressure. It is significant that out of the total 13 widowed women, 5 widowed women had not responded to the question about the total family income. This was proportionately larger than the married women who had not responded.

A national study on the ASHA Scheme (NHSRC 2011) has discussed the concern whether voluntarism among ASHAs is possible or whether it is displacing her from her livelihood. The data showed that ASHAs in West Bengal (91%) and Rajasthan (80%) had cited

the ASHA work as their main individual source of income and these states provide a fixed monthly income. However in the states where no fixed income was given to ASHAs too, ASHAs from districts of Bihar and Assam and from the state of Kerala had indicated that ASHA work was their main individual income source. Where ASHA work was not the

Table 3.8

Marital Status by Total Family Income Per Month (Self-Reported)

MARITAL STATUS		TOTAL FAMILY INCOME PER MONTH (IN RS.)								TOTAL N=244
		Less than 500	501-1000	1001-1500	1501-2000	2001-2500	2501-3000	More than 3001	No Response	
Unmarried	Number (Percentage)	-	-	1 (100.0)	-	-	-	-	-	1 (100.0)
Married	Number (Percentage)	35 (15.4)	41 (18.0)	36 (15.8)	23 (10.1)	22 (9.6)	36 (15.8)	30 (13.2)	5 (2.2)	228 (100.0)
Widowed	Number (Percentage)	3 (23.1)	1 (7.7)	1 (7.7)	1 (7.7)	-	1 (7.7)	1 (7.7)	5 (38.5)	13 (100.0)
No Response	Number (Percentage)	1 (50.0)	-	-	-	-	-	-	1 (50.0)	2 (100.0)
Total	Number (Percentage)	39 (16.)	42 (17.2)	38 (15.6)	24 (9.8)	22 (9.0)	37 (15.2)	31 (12.7)	11 (4.5)	244 (100.0)

main source, the ASHAs reported work on land (own and others') as their main source of income.

These findings support the inference from the current study that the post was seen as paid work and not as honorarium. ASHAs and their families depended upon this income whether the ASHA was a main earner or otherwise because the family income was small.

One of the ASHAs had written her reasons for joining in the questionnaire as follows: "*Because I always had a liking for health as a subject… I have come to know about the overall status of my village. I have been able to be in contact with every person of my village. I have come to get full information about immunisation.*"

The reasons show that this ASHA values the non-monitory gains from the work. The same ASHA was selected in the purposive sample for in-depth interview. On being further asked about her experiences she said:

"My husband says 'I earn a salary and you are doing social service ***(janseva)****. You should work but you should also get something'... I did not know anything about ASHA. I am doing* ***seva*** *so I like it. Those who fall ill say ASHA* ***tai*** *come and see. Some say take us to the Primary Health Centre* ***(dawakhaana)****."*(NJ, ASHA for five years, husband has a job in a factory and earns rupees 3000 per month)

1.7 *Caste Background of the ASHAs*

Shahapur has been designated as a tribal taluka. The rich variety of tribal backgrounds in this taluka was reflected in the fact that ASHAs from seven different Adivasi groups made up a sizable representation of about 35.6% of the total sample (Table 3.9). While a national study (IIPS 2011) had found adequate representation of Scheduled Castes as well as Tribes, the current study found only 4% of all ASHAs said they were in the Minority group (Table 3.9). Nearly one tenth of the women reported their religion as Hindu, not writing their caste.

The OBC group of Kunbis is predominant in the district of Thane where Shahapur is located and this was also reflected in the fact that the largest percentage of ASHAs (48.4%) was of OBCs.

Table 3.9

Percentage Distribution of ASHAs by Caste

CASTE		NUMBER N=244	PERCENTAGE
Other Backward Castes			
(a)	Kunbi	117	48.0
(b)	Sonar	1	0.4
	Sub-Total	118	48.4
Adivasi			
(a)	Warli	10	4.1
(b)	Agri	15	6.1
(c)	Katkari	6	2.5
(d)	Bakur	1	0.4
(e)	Kokana	1	0.4
(f)	Adivasi (tribe not mentioned)	2	0.8
(g)	Mahadev Koli	7	2.9
(h)	M. Thakur	45	18.4
	Sub-Total	87	35.6
Hindu/Maratha			
(a)	Hindu (caste not mentioned)	16	6.6
(b)	Maratha	8	3.3
	Sub-Total	24	9.9
Minorities			
(a)	Baudh	3	1.2
(b)	Nav Baudh	4	1.6
(c)	Mahaar	3	1.2
	Sub-Total	10	4.1
No Response		5	2.0
Total		244	100.0

This study tried to explore the implications of caste upon the ASHAs. ASHAs were not directly forthcoming about the repercussions of caste upon their work. The in-depth interviews did show that there were differences in the way that the community responded to the ASHAs depending upon their caste. From the survey data however, the fact that the families of Adivasis were at the lower economic end of this basically poor community was apparent.

1.8 *Caste by Family Income Per Month*

In terms of household income, more Adivasi ASHAs reported a lower family income than the OBC ASHAs (Table 3.10). However, these were relative differences within an

Table 3.10

Caste (Self-Reported) by Family Income Per Month (Self-Reported)

CASTE		**TOTAL FAMILY INCOME PER MONTH (IN RS.)**								**TOTAL N=244**
		Less than 500	**501-1000**	**1001-1500**	**1501-2000**	**2001-2500**	**2501-3000**	**More than 3001**	**No Response**	
OBC	Number (Percentage)	11 (9.3)	16 (13.6)	21 (17.8)	15 (12.7)	11 (9.3)	25 (21.2)	13 (11.0)	6 (5.1)	118 (100.0)
Adivasi	Number (Percentage)	26 (29.9)	18 (20.7)	11 (12.6)	5 (5.7)	6 (6.9)	8 (9.2)	11 (12.6)	2 (2.3)	87 (100.0)
Hindu*/ Maratha	Number (Percentage)	1 (4.2)	5 (20.8)	5 (20.8)	4 (16.7)	3 (12.5)	1 (4.2)	4 (16.7)	1 (4.2)	24 (100.0)
Dalit	Number (Percentage)	1 (10.0)	1 (10.0)	1 (10.0)	-	2 (20.0)	2 (20.0)	-	1 (10.0)	10 (100.0)
No Response	Number (Percentage)	-	2 (40.0)	-	-	-	1 (20.0)	1 (20.0)	1 (20.0)	5 (100.0)
Total	Number (Percentage)	39 (16.0)	42 (17.2)	38 (15.6)	24 (9.8)	22 (9.0)	37 (15.2)	31 (12.7)	11 (4.5)	244 (100.0)

*Caste not given by ASHAs

overall background of poverty among all ASHAs regardless of caste. Overall the majority of the ASHAs regardless of their caste had reported a monthly family income of less than 3000 apart from their own remuneration (Table 3.7).

Thus the cash payments that all the ASHAs brought into the family were likely to be a source of sustenance for their families despite the differences in family size, sources of employment, family income and caste background.

To sum up the findings, the backgrounds of the ASHAS influenced expectations from their post even with full knowledge of it being a volunteer position. However this was not only a matter of the poverty which is the most predictable reason for expectations. It was also a matter of rural culture. ASHAs came from a culture where all kinds of work were done to earn remuneration. The gender factor was also apparent in the matter of potential expectations. The ASHAs were largely married women from a societal structure where their marital status gave them security and identity. As such they were accountable to their families and the expectations of their families for their participation as it meant hours spent away from the participation in the family's income generation or domestic activities. This did not diminish the fact that most ASHAs appreciated the learning, societal stature and service satisfaction that this engagement offered to them. While there was acceptance and even pride that they were trained to serve a good cause, ASHAs faced the pull of service with the push of earning a sum to contribute to the family income.

Secondly, the conditions at work for all the ASHAs in terms of tenure of service, hardship of effort and difficulties in the current remuneration system might have led them to have aspirations for a better opportunity at work.

These themes and the seeming contradictions were explored further in the subsequent phases of the current study.

2. A Profile of the ASHAs as Workers

While the preceding section explored the personal backgrounds of the ASHAs, the next section gives a profile of the ASHAs as workers. Table 3.11 is a profile of the ASHAs as workers.

Table 3.11

A Profile of the ASHAs As Workers

PARAMETER	PROFILE		
		NUMBER (N = 244)	PERCEN-TAGE
EDUCATIONAL QUALIFICATIONS	Upto 4th Std.	10	4.1
	5th to 7th Std.	78	32.0
	8th to 12th Std.	150	61.5
	Under-Graduate	3	1.2
	Graduate	3	1.2
	Total	244	100.0
NO. OF YEARS THE WOMEN HAVE WORKED	One	26	10.7
	Two	29	11.9
	Three	102	41.8
	Four	61	25.0
	Five	21	8.6
	No Response	5	2.0
	Total	244	100.0
HOURS OF TRAVELLED OUTSIDE VILLAGE	Up-to 4	36	14.8
	5 to 8	67	27.5
	9 to 12	49	20.1
	More than 12	89	36.5
	No Response	3	1.2
	Total	244	100.0
MODE OF TRAVEL (LAST WEEK)	Walking	150	36.6
	Bus	56	13.6
	Auto-Rickshaw	75	18.3
	Jeep	118	28.8
	Ambulance	8	1.9
	Did not travel last week	3	0.7
	Total	410	100.0
WHEN LAST PAYMENT WAS RECEIVED	This month	32	13.1
	Last month	114	46.7
	Two months before	47	19.3
	More than two months before	33	13.5
	No Response	18	7.4
	Total	244	100.0
AMOUNT OF LAST PAYMENT (IN RS.)	Less than 500	96	39.3
	501 to 1000	56	23.0
	1001 to 1500	28	11.5
	1501 to 2000	16	6.6
	2001 to 2500	10	4.1
	2501 to 3000	10	4.1
	More than 3001	19	7.8
	No Response	9	3.7
	Total	244	100.0

Each of the parameters in Table 3.11 is discussed separately above. The linkages of the ASHAs' education and experiences at work with their aspirations are explored.

"They must take us in ***(tyaane aamhaala ghetlech paahije)"*** (Observation written by a ASHA in her questionnaire)

An analysis of the statistical data on education, remuneration and working conditions of the ASHAs led towards one overarching theme. Not only did the families have expectations but the women also had aspirations from their engagement as ASHAs.

2.1 Educational Qualifications

The mandate of the ASHA Scheme is that the women working as ASHAs must have a minimum qualification of 8th standard pass (National Rural Health Mission, Ministry of Health and Family Welfare 2006) with relaxation in qualifications where this was not possible. The data revealed a wide range of qualifications starting from fourth standard to graduates and diploma holders reflecting the diversity of the women enrolled as ASHAs in the area. This finding was confirmed by a national study on ASHAs as well (NHSRC 2011).

Table 3.12

Educational Backgrounds of the ASHAs

EDUCATIONAL QUALIFICATIONS	**NUMBER N=244**	**PERCENTAGE**
Upto 4th Std.	10	4.1
5th to 7th Std.	78	32.0
8th to 12th Std.	150	61.5
Under-Graduate	3	1.2
Graduate	3	1.2
Total	244	100.0

As many as 61.5 % of the ASHAs were above the mandated qualification having 8th to 12th pass qualifications and there were also three undergraduates and graduates each in the sample (Table 3.12). Similarly over 50% of the sample of a national study except for ASHAs in Rajasthan was high school pass (NHSRC 2011).

In addition to the years of schooling, there were eighteen ASHAs in the sample who had additional qualifications in the form of vocational diplomas and courses including the

Anganwadi Course (Table 3.13). Such a high percentage of educated women in the ASHA post pointed to their aspirations from it. It highlighted the fact that there were many educated women in the area who were eager to work but there were not too many opportunities for them.

Table 3.13

Additional Qualifications Cited by the ASHAs

DIPLOMA/COURSE	NUMBER N=18
Anganwadi Course	1
Anganwadi Course, Machine Course, Krushi Vyapar Thanthra Gyan (Agricultural Technology)	1
Beautician Course	1
Computer Course	2
Computer Course and Tailoring	1
Family Planning Association of India (11 months course)	1
Nursing Course	1
Tailoring Course	8
Tailoring and Mehandi Course	1
Tailoring and Computer Course	1
Total	18

Yet a sizable 32% of the ASHAs had qualifications from 5th to 7th standard and 4% were educated upto 4th standard only (Table 3.11) as against the minimum qualifications. The experiences of voluntary organisations have shown that educational levels are not always a bar to effective functioning among CHWs. Whether this holds true for ASHAs is a matter of study beyond the scope of this research. However the strong work ethic of the ASHAs should hold them in good stead despite qualifications.

An important reason why there were many under qualified ASHAs in the area was revealed only in the second phase of the study. Many of the women that were already involved with the health services as Pada Workers (a state level scheme preceding the ASHA Scheme for tribal areas in Maharashtra) were also taken as ASHAs of their areas on the initiative of the local Primary Health Centres (PHCs). Educational qualifications were not the criteria for the Pada Workers and these less educated women simply continued within the system as ASHAs. As

discussed in the next chapter, for these women, accepting the ASHA position was seen as a step upward within the system.

A key finding was that all the ASHAs had aspirations from the post. Not only the educated ASHAs that were working for the first time but also the former pada workers expressed their expectations (Box 3.1). The ASHAs in this taluka could have been more aware of their rights or aspirations than in other areas due to two other influences. The ASHAs were members of a union. Secondly, there were voluntary organisations working with the ASHAs in the study location.

Box 3.1
ASHAs' Expectations from the Post

"I work as ASHA. I have a family. I should be paid regularly."

*"The work of the ASHA can be done while also taking care of the home. As we work we get the compensation (**mobaadlaa**) too that helps us to protect ourselves (**aamcha rakshan hoto**)...yet our compensation should be increased for us to protect our families too. This compensation for our work is what we are asking."*

"ASHA should be paid 3000."

*"All this service (**seva**) is for the village. Agreed it is social service but we need to run our families (**kutumb chaalavayche aahe**) and if we are compensated monthly amount of at least 3000 then we will also feel motivated."*

*"I am able to reach timely help to the ill in my village and I get some financial support for my family. More people in the village know me now but although these reasons are there for doing this work but the government (**sarkaar**) should increase our compensation this is my request".*

Note: These are voluntary observations written by ASHAs in their questionnaire.

An analysis of the educational qualifications by the caste of the ASHAs was done. In concurrence with the findings from a national study (NHSRC 2011), more ASHAs who were Adivasis were at the lower end of the educational qualifications (Table 3.14).

Regardless of caste, the ASHAs all hailed from similar marital, income and cultural backgrounds. It was also apparent that all the women had aspirations from the post, not only due to their educational qualifications but also due to perceived investments that had been made by the ASHAs in the work over the past years of experience.

Table 3.14

Educational Qualifications by Caste

CASTE		EDUCATIONAL QUALIFICATIONS					TOTAL N=244
		Upto 4th Std.	5th to 7th Std.	8th to 12th Std.	Graduate Drop-out	Graduate	
Other Backward Class	Number (Percentage)	-	25 (21.2)	90 (76.3)	1 (0.8)	2 (1.7)	118 (100.0)
Adivasi	Number (Percentage)	7 (8.0)	42 (48.3)	37 (42.5)	1 (1.2)	-	87 (100.0)
Hindu (Caste not given)	Number (Percentage)	-	5 (20.8)	19 (79.2)	-	-	24 (100.0)
Dalit	Number (Percentage)	-	4 (40.0)	4 (40.0)	1 (10.0)	1 (10.0)	10 (100.0)
No Response	Number (Percentage)	3 (60.0)	2 (40.0)	-	-	-	5 (100.0)
Total	Number (Percentage)	10 (4.1)	78 (40.0)	150 (61.5)	3 (1.2)	3 (1.2)	244 (100.0)

2.2 Number of Years of Involvement

The number of years put in by the ASHAs in the responsibility was in itself a basis for aspirations among the ASHAs. As seen in Table 3.15, the maximum number of ASHAs said they had worked for three years (41.8%), followed by a quarter of the ASHAs who had worked for four years (25.0%).

Table 3.15

Number of Years the Women have Worked as ASHAs

NO. OF YEARS THE WOMEN	NUMBER	PERCENTAGE

HAVE WORKED	N = 244	
One	26	10.7
Two	29	11.9
Three	102	41.8
Four	61	25.0
Five	21	8.6
No Response	5	2.0
Total	244	100.0

About 8.6% of ASHAs reported having worked for five years. These women included the former Pada Workers who were now also ASHAs. These women had simply added their years of work within the health services. It indicated their expectations.

The rest of the women had worked for up-to one year (10.7%) or between one to two years (11.9%). However having seen the Scheme running successfully for the preceding years they would have already built their aspirations from the position as well.

2.3 Hardships of Efforts: Travelling Outside the Village

This study looked at the ASHAs' perspectives and travel was a hardship of effort to them. ASHAs were, therefore, asked how many hours they had spent travelling for their work. Since recall for more than a week could be difficult, ASHAs were asked to count the estimated hours spent travelling in the past one week. Over 35% of ASHAs had spent more than 12 hours travelling in the previous week. As seen in Table 3.16, while about 20.1% said they had spent 9 to 12 hours, about 27.5% had spent 5 to 8 hours in the previous week outside their homes. About 14.8% also reporting just 4 hours outside their homes, thus it was evident that there was no pattern.

Table 3.16

Number of Hours Travelled for Work in the Previous Week of ASHAs

(Outside the Village)

NO. OF HOURS TRAVELLED FOR	NUMBER	PERCENTAGE

WORK IN THE PREVIOUS WEEK	N = 244	
Up-to 4	36	14.8
5 to 8	67	27.5
9 to 12	49	20.1
More than 12	89	36.5
No Response	3	1.2
Total	244	100.0

Hours spent travelling outside could be dependent on the sizes of their villages, the kind of medical requirements requiring referral from their villages in the past week, the distance from their villages to the PHC and whether there was a delivery case where the ASHA had to accompany the woman in the past week. The newly recruited ASHAs could also be relatively less active as their training had not been completed. The data on hours of travel highlighted a basic dilemma of tracking the work of CHWs like ASHAs in actual person hours.

The national ASHA evaluation study ((NHSRC 2011)) had recorded the number of hours the ASHAs had spent at their work and found that most ASHAs spent three to five hours daily. However the explorations during this study revealed that most of the ASHAs were unable to quantify their hours of work specifically because their tasks were interwoven within their daily routines. They were not accustomed to calculating hours but tracking tasks. What stood out most for them about their working conditions was the time spent outside their homes going around the village on foot and time spent travelling outside their villages for this work. Travel was difficult in the area and more so for women.

The hours spent travelling by the ASHAs did not equate their total hours of work in the week. Many of the responsibilities were carried out from home. There were additionally tasks being carried out regularly that were not accounted or paid for (Chapter Five). For example the ASHAs were taking daily rounds on foot of their villages and had not counted those hours in travel time because this was not a paid task. There were also perceived hardships of travel coming from being away from home which were a felt experience

(Chapter Four). The total experience of hardship at travel was not captured completely by the numbers but helped to identify a causative factor for their aspirations. Another quantitative parameter of hardship of effort was the mode of travel used during the course of their work in the past week.

2.4 Hardships of efforts: Modes of travel

The ASHAs were asked to indicate the modes of travel used by them in the past week. Multiple modes had been used just to reach the PHC in most cases. It was an indication of how far flung the villages in the taluka were and the difficulties of travel for the community also.

ASHAs had indicated more than one mode of travel in the week with only three ASHAs reporting that they had not travelled in the past week (Table 3.17). There were multiple responses where walking topped the list (36.6%) with other means being jeep (28.8%), rickshaw (18.3%), and bus (13.6%). Eight ASHAs reported travelling by ambulance indicating that they had escorted Caesarean delivery cases to Thane District hospital in the past week. This meant they had taken the woman from the village to the PHC by rickshaw or jeep depending on the location of the village, then to the block level hospital from where they were given an ambulance to go to Thane.

Table 3.17

Mode of Travel for Work in the Previous Week for ASHAs

MODE OF TRAVEL FOR WORK	NUMBER* (N=244)	PERCENTAGE
Walking	150	36.6
Bus	56	13.6
Auto-Rickshaw	75	18.3
Jeep	118	28.8
Ambulance	8	1.9
Did not travel last week	3	0.7
Total	410	100.0

*Multiple Responses of 244 ASHAS

Thus the seemingly simple task of escorting patients to the PHC or block level hospital or District hospital was seen in terms of hardships of efforts by the ASHAs.

2.5 Hardships of Efforts: Delay in Receiving Remuneration

The ASHA Scheme has mandated that ASHAs be paid a fixed amount for each task that they have completed. Therefore payments were calculated every month. This arrangement for remuneration which appears logistically sound was in practise one of the main difficulties with the system that the ASHAs had encountered. As reported in the in-depth interviews as well, payments had become a rallying point for the ASHAs' aspirations. The current study showed that the four concerns of ASHAs regarding remuneration were delays, small amounts, unpaid amounts and procedural difficulties. The last two concerns emerged during the in-depth interviews of the ASHAs. However, the aspects of delays in getting paid and the amounts received were included in the background information in order to get an overview of the situation at the block level.

Table 3.18

Time of Last Payment Received by ASHAs

PERIOD OF TIME	NUMBER N=244	PERCENTAGE
This month	32	13.1
Last month	114	46.7
Two months before	47	19.3
More than two months before	33	13.5
No Response	18	7.4
Total	244	100.0

When ASHAs reported the time of the last payment received, as seen in Table 3.18, few ASHAs selected the option of having received payments in the current month (13.1%). About half of the ASHAs reported they had received remuneration in the past month (46.7%). Some amount of delay in receiving payments was certainly indicated by these numbers. Delay in receiving remuneration was further confirmed by the fact that about 19.3% wrote that had got their latest remuneration two months before and about 13.5% wrote more than two months before. A figure that revealed the possible extent of the delay is that about 7.4% did not give any response at all to the question.

2.6 *Hardship of Efforts: Small Amounts of Remuneration*

Box 3.1 highlighted how expectations of ASHAs rallied around the amount of payment received by them. Table 3.19 shows that the agitation among the ASHAs about payments was partly explained by the numbers. The largest percentage of ASHAs (39.3%) reported having received less than rupees 500 as their latest remuneration. As seen in Table 3.18 this amount too had been received the previous month or even before. The next largest percentage of ASHAs (23.0%) received between rupees 500 to 1000. The rest of the ASHAs had last received higher amounts.

Table 3.19

Amount of Last Payment of the ASHAs

AMOUNT OF LAST PAYMENT (IN RS.)	NUMBER N = 244	PERCENTAGE
Less than 500	96	39.3

501 to 1000	56	23.0
1001 to 1500	28	11.5
1501 to 2000	16	6.6
2001 to 2500	10	4.1
2501 to 3000	10	4.1
More than 3001	19	7.8
No Response	9	3.7
Total	244	100.0

It is necessary to study the rate chart of ASHA tasks as designated by the system to understand this pattern of amounts (Box 3.2)

There were 20 paid tasks listed in the official rate chart for the ASHAs. The amount given for institutional delivery under the Janani Suraksha Yojana (JSY) for escorting women from Adivasi families or families below the poverty line for institutional delivery and accompanying them for 24 hours was the highest paid task of the ASHAs at rupees 600 per institutionalised delivery including travel. A closer examination of the rate chart showed the vast contrast between the rates of payments under JSY as against each other task. It was as if the ASHAs were being monetarily encouraged to prioritise getting eligible mothers under the Janani Suraksha Yojana to be escorted for hospital delivery. Annexure 3A shows that this pattern of rates was based on the compensation package suggested by the NRHM and it was the same in other states apart from Maharashtra.

Payments for equally important but comparatively more regular tasks like submission of malaria slides were very low paid. As shared by the ASHAs during the survey, payments under the Janani Suraksha Yojana (JSY) were delayed but the main source of regular payment for them. The only other regular payment made to the ASHAs was an amount not mentioned in the chart at all namely rupees 150 for attending the ASHA monthly meeting. At the time of the data collection the largest percentage of women in the sample had not attended to a delivery of a mother covered by the JSY recently therefore they had received less than rupees 500. However the rates being so low, the quantum of their efforts for varied tasks was not reflected in the payment according to the ASHAs.

Box 3.2

Rate Chart of Incentives for ASHAs Displayed at a PHC

1. Under JSY for encouraging pregnant women for institutionalized delivery: 600 for adivasi and 200 for non adivasi women for each patient taken for delivery to Primary Health Centre, Sub-Centre, district hospital or recognized hospital.
2. For encouraging Family Planning Operation: 150 for each woman and 200 for each man sterilized.
3. On completion of DOTs treatment: 250 for each TB patient.
4. Malaria blood slide: 5; for complete treatment: 50 for each PF (PHELSIFERA) and 20 for each PV case.
5. For referral service to the seriously ill (malaria and dengue): 50 for admitting to government facility (PHC/SC/rural hospital
6. Leprosy treatment: for finding new case: 100; for completing treatment of contagious case: 400; for completing treatment of non- contagious case: 200
7. Epidemic control: for first information to PHC MO: 100; for referring seriously dehydrated child to PHC/Rural Hospital: 25
8. Examination of pregnant HIV woman: 10
9. Delivery of HIV infected woman: 500 for accompanying woman
10. Check-up of pregnant HIV woman: 300 per HIV mother
11. Organizing village health and nutrition day with ANM and AWW: 150
12. Referral for seriously ill children from adivasi area: 50 per patient
13. For encouraging building of each latrine in the village: 75
14. Treatment of jaundice: 50 for admitting contagious patients to PHC/RH
15. For encouraging immunization at village level by AWWs and ANMs:150
16. Registration with gram panchayat: births-10
17. Registration of maternal death-500
18. Registration of new born death-50
19. Complete immunization in the village:750 for 100% coverage and 500 for 90% coverage.
20. Facilitating Cataract operation:175 per patient

2.6.1 Number of years worked by amount of latest payment received

Amounts received by ASHAs were in the same pattern regardless of the number of years of service put in by them (Table 3.20). In the view of the ASHAs, if most of them were receiving less than rupees 500 as their latest payment, regardless of the number of years they

Table 3.20

Number of Years Worked by Amount of Latest Payment Received (Self-Reported)

NO. OF YEARS WORKED AT ASHA		AMOUNT OF LATEST PAYMENT (IN RS.)								TOTAL
		Less than 500	501-1000	1001-1500	1501-2000	2001-2500	2501-3000	More than 3001	No Response	N=244
One	Number (Percentage)	11 (42.3)	6 (23.1)	3 (11.5)	1 (3.8)	3 (11.5)	2 (7.7)	-	-	26 (100.0)
Two	Number (Percentage)	10 (34.5)	9 (31.0)	-	3 (10.4)	-	2 (6.9)	4 (13.8)	1 (3.4)	29 (100.0)
Three	Number (Percentage)	46 (45.1)	25 (24.5)	13 (12.7)	3 (2.9)	4 (3.9)	3 (2.9)	6 (5.9)	2 (2.0)	102 (100.0)
Four	Number (Percentage)	21 (34.4)	8 (13.1)	8 (13.1)	7 (11.5)	2 (3.3)	2 (3.3)	8 (13.1)	5 (8.2)	61 (100.0)
Five	Number (Percentage)	6 (28.6)	7 (33.3)	3 (14.3)	2 (9.5)	1 (4.8)	-	1 (4.8)	1 (4.8)	21 (100.0)
No Response	Number (Percentage)	2 (40.0)	1 (20.0)	1 (20.0)	-	-	1 (20.0)	-	-	5 (100.0)
Total	Number (Percentage)	96 (39.3)	56 (23.0)	28 (11.5)	16 (6.6)	10 (4.1)	10 (4.1)	19 (7.8)	9 (3.7)	244 (100.0)

Table 3.21

Educational Qualification by Amount of Latest Payment Received (Self-Reported)

EDUCATION		AMOUNT OF LATEST PAYMENT (IN RS.)								TOTAL N=244
		Less than 500	501-1000	1001-1500	1501-2000	2001-2500	2501-3000	More than 3001	No Response	
Upto 4th Std.	Number (Percentage)	4 (40.0)	3 (30.0)	3 (30.0)	-	-	-	-	-	10 (100.0)
5th to 7th Std.	Number (Percentage)	29 (37.2)	17 (21.8)	8 (10.3)	4 (5.1)	5 (6.4)	3 (3.8)	7 (9.0)	5 (6.4)	78 (100.0)
8th to 12th Std.	Number (Percentage)	60 (40.0)	34 (22.7)	16 (10.7)	12 (8.0)	5 (3.3)	7 (4.7)	12 (8.0)	4 (2.7)	150 (100.0)
Under-Graduate	Number (Percentage)	2 (66.7)	1 (33.3)	-	-	-	-	-	-	3 (100.0)
Graduate	Number (Percentage)	1 (33.3)	1 (33.3)	1 (33.3)	-	-	-	-	-	3 (100.0)
Total	Number (Percentage)	96 (39.3)	56 (23.0)	28 (11.5)	16 (6.6)	10 (4.1)	10 (4.1)	19 (7.8)	9 (3.7)	244 (100.0)

Table 3.22

Primary Health Centre where ASHA Works by Amount of Latest Payment Received (Self-Reported)

PRIMARY HEALTH CENTRE	DISTANCE FROM BLOCK LEVEL HOSPITAL*		AMOUNT OF LATEST PAYMENT (IN RS.)								TOTAL
			Less than 500	501-1000	1001-1500	1501-2000	2001-2500	2501-3000	More than 3001	No Response	N=244
Shendrun	Near	Number	2	1	6	3	3	5	3	1	24
		(Percentage)	(8.3)	(4.2)	(25.0)	(12.5)	(12.5)	(20.8)	(12.5)	(4.2)	(100.0)
Vashind	Near	Number	14	7	6	3	-	-	-	-	30
		(Percentage)	(46.7)	(23.3)	(20.0)	(10.0)					(100.0)
Kasara	Far	Number	15	12	4	-	2	-	-	-	33
		(Percentage)	(45.5)	(36.4)	(12.1)		(6.1)				(100.0)
Khinawali	Medium	Number	18	4	1	-	-	-	-	-	23
		(Percentage)	(78.3)	(17.4)	(4.3)						(100.0)
Aghai	Far	Number	4	12	3	5	3	-	2	2	31
		(Percentage)	(12.9)	(38.7)	(9.7)	(16.1)	(9.7)		(6.5)	(6.5)	(100.0)
Khardi	Medium	Number	6	8	3	-	1	-	-	2	20
		(Percentage)	(30.0)	(40.0)	(15.0)		(5.0)			(10.0)	(100.0)
Takepathara	Far	Number	9	7	5	1	1	-	2	1	26
		(Percentage)	(34.6)	(26.9)	(19.2)	(3.8)	(3.8)		(7.7)	(3.8)	(100.0)
Dolkham	Far	Number	28	3	-	3	-	1	-	-	35
		(Percentage)	(80.0)	(8.6)		(8.6)		(2.9)			(100.0)
Shenva	Near	Number	-	2	-	1	-	4	12	3	22
		(Percentage)		(9.1)		(4.5)		(18.2)	(54.5)	(13.6)	(100.0)
Total	Total	Number	96	56	28	16	10	10	19	9	244
		(Percentage)	(39.3)	(23.0)	(11.5)	(6.6)	(4.1)	(4.1)	(7.8)	(3.7)	(100.0)

Box 3.3

ASHAs' Expression of Altruism/Service Motive

"*We should work for serving the community (**jan seva**) and we also like the work of ASHA. Doing ASHA work is like working for your own home."*

"I feel social service is service of God."

*"I like social service (**samaaj seva**) very much. We should tell others about health (**aarogya**), their wrong decisions should be changed (**chookiche nirnay badalle paahijet**) so that they will progress, their health will improve. This is what I feel. Whatever good things we learn during training, we should reach those to illiterate and ignorant people (**ashisheet ani adaani lok**). This is what I feel. I can do something for others, that is satisfying to me. When I give them referral services (**sandharb seva**), medication (**aushadh upchaar**) and advice (**salaah**) I don't get payment but I get inner satisfaction (**aatmasamaadhaan**) and that is the truth. (*the truth. (**she is a caste Hindu Maratha, last drawn payment self reported is 1500-2000**)

*"ASHA means she is a village volunteer (**gavanchi kaaryakarti**) therefore she should not count anyone as lowly (**tucch**) she should behave with love to all and these are the two words I have written if you find them wrong then I will accept my mistake."* (**she is a caste M. Thakur adivasi education 8th standard**)

*"After I have joined as ASHA there is awareness (**janjaagruti**) in the village and there are improvements (**sudhaarnaa**) in the village."*

"I do not do this work for myself but for welfare of families and in this I get happiness. I get happiness in the fact that I am ASHA. This itself makes me proud no other reason." (**last payment self reported was 500-1000 received two months back**)

"…because I feel a lot of respect for this work…"

*"ASHA voluntary work is my own wish. I am totally ready to do this work. (**ASHA swayamsevika kaam swataachi icchaani. Kaam karnyaas purna majhi tayaari aahe**)"*

*"…My village is becoming healthy (**aarogyamaye**)…Each child and mother and ill person experiences good health from my side that makes me very happy."*

"I have a lot of liking for this work. I feel that all the people in all the villages should be disease free and in my village infant deaths and maternal deaths should not occur. I try very hard for this." ((**ASHA since 3 years, last payment self reported, less than 500**).

*"To serve the world is what ASHA means (**jagaachi seva karne mahanje ASHA hoy**)."*

Note: These Voluntary Observations written by ASHAs in their questionnaire.

had worked; it was below the expectations of their families and their own aspirations. Dissatisfaction was higher because these were not even the amounts received every month as seen in Table 3.18.

2.6.2 Educational qualifications by amount of latest payment received

The largest number of ASHAs received less than rupees 1000 per month as their last payment across educational levels (Table 3.21).

2.6.3 Primary Health Centre where the ASHA worked by amount of latest payment received

The factor of distance was also examined to see whether the payments received varied according to the distance of the PHCs from the district sub divisional hospital. There could also have been differences due to the manner in which the ASHA programme was administered in every Primary Health Centre. However no such variations were seen in the payments received (Table 3.22).

The lengthy discussion on payments and the emphasis of the ASHAs upon it as expressed by ASHAs could also give a biased inference about their expectations and aspirations being primarily monitory. However the other side of the story was that there were several testimonials about the service aspect of their work that were also expressed by the same ASHAs throughout the survey. Box 3.3 presents the observations written voluntarily by ASHAs in their questionnaires not in response to any of the questions. Altruism or the service motive emerged as a strong motivation as seen by some of the observations volunteered by the ASHAs.

3. **Attrition/Absenteeism and Remuneration**

In Chapter Two there was a discussion on how the sample size of the first phase came to be 244 ASHAs although there were 340 ASHAs on record. About 28.2% of the ASHAs were not present on the meeting days when the survey was conducted. A second round in two primary health centers showed that the same ASHAs were absent in the next month as well. A recheck at the block headquarters showed up the same 340 ASHAs on roll.

There could have been instructions from the Block Level to maintain the required number of ASHAs proportionate to the population. This could have been the reason that the PHCs had kept all the names of even the regular absentees among ASHAs on the official records. The response of a Block level official (designation not mentioned to protect the confidentiality of the respondent) to the disparity in figures gave a hint of the kind of pressures for maintaining the numbers.

“*Can there be some way of showing 340 ASHAs in the study?”*(NP, Block level Official of Shahapur)

The researcher said that 340 ASHAs would have to be covered in the survey to be shown in the study. He did not suggest any way to get 340 ASHAs covered. However, he agreed that the study should mention absenteeism as a cause of lower figures covered in the survey. The response of other Block level officials to the figures showed that it was not an unexpected finding for them. In fact it was the response of another Block level official (designation not mentioned to protect the confidentiality of the respondent) that gave the first clue to the fact that this trend of absenteeism/attrition was related to expectations of better working conditions by the ASHAs. The officials were well aware of it and in their individual capacities, even agreed with the ASHAs’ aspirations.

“Some months down the line, more ASHAs will not be there from this list. There is nothing for them.” (DS, Block level official of Shahapur)

The ASHAs had expectations yet were motivated by altruism.

These themes and the seeming contradictions were explored further in the subsequent phases of the current study.

EXPERIENCES OF ASHAS: TRAVERSING TO NEW ROLES IN OLD ENVIRONMENTS

The placement of the Accredited Social Health Activist (ASHA) within the National Rural Health Mission is unique like all Community Health Workers within all health services systems. Other workers in the health services system leave their homes and go to a different location to work. They return back to the environments of their homes. This gives them the required division of time and orientation between their professional and personal identities. However the ASHA is selected and trained to introduce new activities and functions within the same environment where she has been earlier living only as a member. In her identity as a woman within the family and community, she has a set role and as ASHA she is now expected to introduce newer functions while still continuing with the older role. She slips in and out of her personal and professional identities with the same people every day. Chapter Four explored this daily journey of the ASHAs.

This Chapter has four sections. In the first section the reasons and motivations of the ASHAs for accepting this post are explored. Section Two presents the negotiations to create and retain spaces by the women for being ASHAs. Section Three explores the experiences of the ASHAs when they stepped out of their homes into the community as ASHAs. Finally in Section Four the ASHAs look inwards at the impacts of this journey upon their relationships with their families and their communities.

1. The Beginning: Reasons and Motivations of ASHAs

When the women became ASHAs the journey began with their reasons when they agreed to take up this post.

1.1 *Reasons for Taking up the Post*

The ASHAs wrote more than one reason in the self-answered questionnaire for taking up the post. There were varied reasons that fell into 12 different categories as seen in Table 4.1.

Table 4.1

Reasons why ASHAs Accepted this Responsibility

REASONS WHY ASHAS ACCEPTED THIS RESPONSIBILITY	**NUMBER OF ANSWERS* (N=244)**	**PERCENTAGE OF ASHAS****
An opportunity for doing social service	113	46.3
To get monetary support for one's own family	59	24.2
An opportunity for self-expression and exploration	30	12.3
An opportunity to learn new things	35	14.3
To gain social recognition and identity	14	5.7
To carry forward the family tradition of social service	2	0.8
Motivated by the health system to join as ASHA	7	2.9
Have a liking for the kind of work the ASHA does	100	41.0
An opportunity to utilize one's own education	12	4.9
To prevent the occurrence of home deliveries maternal deaths and infant deaths in one's own village	41	16.8
To facilitate timely health services in one's remote and deprived village	27	11.1
For one's own financial independence	9	3.7
Incomplete answer/ No answer	9	3.7

Note:

* Multiple responses of 244 ASHAs

** Percentage of ASHAs that gave this reason out of 244 ASHAs

When the categories of answers were analyzed further the reasons fell into five sub-groups.

1.1.1 Economic reasons

One fourth of the ASHAs (24.2%) reported that they joined 'to get monetary support for one's family' (Table 4.1). Some of the responses were as follows.

"Because there is no one to earn an income in my home therefore I accepted this work."

"I lost my family land in the Bhatsa project (local dam project). I have no land nor do I have a house. I have three children. My husband is a labourer that is why I felt I should do this work."

"Since I am solely responsible for my daughter I accepted this work."

The explanation of this 'lower' percentage of ASHAs citing financial need could lie in the fact that the amounts earned by the ASHAs currently were less and late according to them (Chapter Three). Therefore the women were not able to support their families to their satisfaction as of now. Better financial gain was rather an expectation for the future from the post. On the other hand although the post did not yield the expected income yet almost a quarter of the ASHAs did look for economic support from it.

Most of the ASHAs that had given reasons of financial need, wrote in terms of supporting their families but another economic reason was in contrast. A few ASHAs (3.7%) wrote that they had joined for their own financial independence.

"I should get two paise by my own hard work and not spread my hand in front of anyone therefore from my heart I am very very keen to work."

1.1.2 Reasons expressing a desire to serve the village

The desire to serve people was expressed in many ways as a reason by the ASHAs (Table 4.1).

The largest percentage of ASHAs (46.3%) had written that they took up the responsibility to serve the village. They expressed this in many forms. A common reason was

'*An opportunity to do social service*'. This was expressed in several ways.

I have a liking for social service. I had a wish to do something for people."

Some of the women also gave deeply personal reasons for social service as quoted below.

"When I was 8 to 10 years old I saw a man fall very ill. Since then I developed a liking for social service and that wish of mine was fulfilled in the work of ASHA that is why I accepted."

"My own daughter was malnourished. Other children in the village should not get malnourished. That is why I have accepted this work. I learnt how to take care of malnourished children."

Another form of expression of the service motive was that of "*a liking for the kind of work that the ASHA does*". This reason given by about 41.6% of the ASHAs was categorized separately than the reason of social service given above. This was because these ASHAs had mentioned a specific preference for the functions offered by the ASHA post vis-à-vis any other form of social service. Some of the responses expressing liking specifically for the work as ASHAs were as follows.

*"I already had a liking for health **(aarogya)** as a subject."*

*"I will be very happy to do as much of this work as I can and I do this work from my heart because I wish to do it (**Maazya kadun jewadha kaam hoyeel tevdhaa malaa khoop anand hoyeel ani he kaam me manaa pasoon karne hee mazi icchaaa aahe)."***

The service motive was expressed even more specifically by a significant number of ASHAs (16.8%) that said that the '*prevention of home delivery and maternal and infant deaths in own village*' was a reason for joining. Some of the responses given were as follows.

"The old customs were causing maternal deaths and infant deaths."

*"Our work is to prevent the deaths of mothers and children **(maata ani baal mrutyu**) that is why I have accepted this responsibility."*

Another specific function stated by the ASHAs (11.1%) as a reason for joining was *'to facilitate timely services in one's own village'*. A typical response falling under this category was as follows.

"In our village first of all there is no convenience of vehicles and also the ***dawakhaana*** (Primary Health Centre) *is not near. People have to walk for 4-5 kms. Because I accepted ASHA's work, people with minor illnesses (****kirkol aajaar****), fever, loose motions and pregnant women – these people have started getting medicines."*

One insight that emerged was that the specific functions of service mentioned by the ASHAs could be their reasons in retrospect. These could be the positive impacts realized by the women after they had started working. However the overall picture that emerged was that the reasons citing social service in several manners were mentioned by the highest number of ASHAs.

This finding is in keeping with the findings of the national survey conducted on ASHAs (NHSRC 2011). The NHSRC study had asked more than 1500 ASHAs across sixteen districts in eight states why they chose to become ASHA. They were asked to select from nine pre-decided options that had been based upon a previous qualitative study. The nine options offered in the national study (NHSRC 2011) on the basis of their qualitative study, were largely similar to the reasons given by the ASHAs in this study. In the NHSRC study too, 'The desire to serve the Community' had emerged as the foremost reason chosen with the percentage of ASHAs ranging from 63% to 85% in the states (NHRC 2011).

Discussion: The Desire to give Service (*seva*) as a Reason to Join as ASHA

The desire to serve was cited the most as a reason to join by the ASHAs in this as well as the larger NHSRC (2012) study on ASHAs. However a further analysis of the ASHAs' responses showed a sense of grandiosity in some of the expressions of the ASHAs.

*"I had a lot of liking (****ateeshay aavad****) for the work of ASHA. Helping the poor, solving their problems, helping them to get their rights was my wish therefore I accepted this work and in this work is my satisfaction (****hyaachaatach majhaa samaadhaan aahe).****"*

The words of some of the ASHAs indicated that the emphasis on service and social respect by the ASHAs could also be an aspect of the values that had been ascribed to them and ingrained by them as women. Their service to their family members as care givers gained them the acceptance and approval within their family and community. Therefore the service aspect of their work as ASHAs was the most acceptable reason to accept this post as it was an extension of their traditional nurturing work within their families.

Such values could also have been ingrained during their training and supervision which was done largely by ANMs. Jones (1994) and Iyer and Jessani (1995) had studied nurses in Britain and ANMs in India respectively. These studies had traced the history of nursing and found that it was initially allotted to women because their ‘natural work’ was taking care of children in any case. The association with motherhood imbued nursing with lofty principles of service and self- sacrifice. The reasons given by the ASHAs suggests that these principles could be attributed or imbibed by CHWs like ASHAs as well. The ASHAs’ immediate seniors were woman ANMs and male MPWs (Multi-Purpose Workers) who had imbibed and exhibited such values regarding their own work and would find it a ‘natural’ value for the ASHAs to follow as well (Box 4.1).

Box 4.1

Values of Service and Sacrifice Embodied in ANMs: A Vignette

An ANM illustrates the values of service and sacrifice imbibed by the nursing profession. ANM Shaaleen (name changed) had a notable personality due to her unbounded energy and warm smile. The researcher first met her at the Takipathara Primary Health Centre (PHC), the most remotely located PHC in the entire block located in a hilly area more than 20 kms. from the Shahapur headquarters. Early one morning, the researcher went inside the PHC to get directions as she was unable to locate the sub-centre she had to visit on that day. Shaleen was about to set out for Immunisation Day (**A monthly event for every village where all eligible immunisations are covered)** at a village about 10 kms. away. Like all ANMs she had no vehicle. She was to be taken to the village with her icebox containing the immunisation vaccines, by her male counterpart, the Multi-Purpose Worker (MPW). The MPW would use his own private two- wheeler for this task, this being a normal practise among the MPWs of Shahapur.

To make sure that she would reach in time Shaleen had spent the previous night at the PHC itself along with other colleagues. It was monsoon time and the PHC quarters were leaking so she had slept in the female ward in the PHC itself. The MPW too had slept in the male ward the previous night. The researcher asked the health staff what they had all had for their breakfast. They took the researcher to a nook in the PHC with a stove. Shaleen had prepared vegetables and rotis for dinner for about six colleagues including the medical officer the previous night. The ANM was appreciative that the doctor had 'eaten what was served to him without comments.' The rations for this dinner had to be brought beforehand at their own expense, because there is no shop near the PHC. This morning the milk had curdled so they had all taken just black tea of which they had a second round with the researcher.

And so everybody set out from the PHC, the ANM and the MPW on their two-wheeler, another set of health workers on foot and the researcher in a vehicle. The researcher could not offer a lift as she often did during data collection because all were going in different directions. Throughout, the ANM was cheerful and polite but her impatience to get going this morning was evident. The researcher asked her why the hurry. "*Because I have to come back and work madam*" she said.

This is not to suggest that the women did not derive joy from service. Rather the analysis showed that the ASHAs had written multiple reasons. Therefore reasons of social service and

growth aspirations were complementary and not contradictory drives among the ASHAs. This is illustrated by a response written by a ASHA.

"*I have done a course in nursing. But after marriage I remained at home. I had the desire to do social service. Social work gives a lot of joy and an opportunity to learn new things. I feel very happy doing this work of ASHA. Social work is the service of God. By working in this post we are able to serve God and also to do some work."*

1.1.3 Reasons Citing Non-tangible Gains like Learning and Gaining Social Recognition

In the current study, the reason stating that the work '*gave them opportunity to learn'* was cited by about 14.3% of ASHAs. Responses ranged from a blanket statement on the same lines to specific descriptions. Again for some ASHAs it could be a retrospective reflection.

*"I felt very different when I did the work of an ASHA (**ASHAcha kaam kartanaa malaa veglech vatle**). As ASHA I learnt about BCG, smallpox and other diseases."*

About 5.7% of the ASHAs had also given statements of '*gaining social recognition and identity'* in our study. Some of the older studies of CHWs in voluntary settings in India (Antia and Bhatia 2003, Arole and Arole 1994) had highlighted this aspect of the CHWs' work. However the struggles of the women to gain the response of the community over years had been described in these works, particularly by Arole and Arole (1994). Respect of the community was the end result of years of work by the CHWs if ever attained. Therefore, if the ASHAs had given such reasons for joining itself it could have been a retrospective reflection. Some of the responses were as follows.

***Gaavat chaar lok aaplyalaa vichaartaat**"* – a common Marathi expression freely translated as "Many people in the village ask after you."

*"People in the village came to know me as a community health worker (**saamajik aarogya sevika**) and I felt very happy. I also got co-operation from home."*

*"When we go to the **dawakhaana*** (Primary Health Centre) *the doctor asks has the ASHA come with this patient? At that time we ASHAs stand up with great self-pride (**mothyaa swaabhimaanane ubhe rahto**)."*

*"Due to this work you get respect (**maan**) in the village."*

The findings of the current study thus showed that the ASHAs valued the self-growth opportunities offered by the post. However fewer women directly mentioned their own self growth compared to the reasons of giving service. An earlier study (Bhattacharya, Winch et.al.

2001) had reviewed several findings on incentives and disincentives that motivate sustain and retain Community Health Workers (CHWs). This study had also found that monetary incentives and the possibility of future paid employment were incentives that motivated CHWs. However a much longer list of non-monetary incentives like social recognition and acquisition of valued skills were found to be motivating factors for CHWs. This study did not indicate which reasons were cited more often by CHWs.

1.1.4 Reasons of Personal Growth

The growth aspirations from the ASHA post were not limited to just professional growth but also extended to their personal growth. A finding of this study was that ASHAs had written purely individual reasons of *'self-expression and exploration'*. Statements falling into this reason were written by slightly more than a tenth of the women (12.3%). One statement commonly given by the ASHAs could be a 'learnt expression' or a free expression. It is quoted below.

"Chool ani Mool hyacha peksha baher padaayla midel" (a Marathi saying freely translated as "I will be able to step outside the routine of cooking and child-rearing.")

On the other hand some statements were fundamentally personal.

"I don't have children. I will spend the rest of my life in service and I like this work and I need this work."

"My family was opposed but I wanted to definitely do social service therefore I accepted. I feel very proud due to this work because ASHA ***sevika*** *has given a lot of service to this village."*

Such statements citing self-growth in the work were written even by women who had economic reasons to join. For instance the ASHA who written that she joined because of economic reasons after the family had been displaced by the Bhatsa Dam (sub section 1.1.1) also wrote:

*"You take in their strength and give them your strength ("**tyaanchee atma siddhi ghyayachi ani aapli atmasidhi tyaana dyaayachi**.")."*

1.1.5 Reasons of Professional Growth

There were direct expressions of professional growth aspirations although the number of ASHAs writing these reasons was much less than ASHAs citing reasons of giving service. About 12 (4.9%) of the ASHAs had directly written a reason that '*the post gave them an opportunity to utilize their education*'. Some of the other responses categorized under this reason were as follows.

"I am 12th pass and have done the Anganwadi course so I accepted this work."

"Although I am educated yet there was no use of my education. I had no other work except farming. Every day I had to work in the sun, wind and rain. So I accepted this work."

Thus professional aspirations were not freely expressed as the number (12 ASHAs) indicated but they could not be ignored as reflected in the educational qualifications of the respondents. The mandatory qualification for ASHAs is 8th standard. Chapter Three showed that more than 60% of the ASHAs were between 8th and 12th pass, and some had higher qualifications as well. The presence of a large number of educated women itself indicated that they had professional growth aspirations from the post.

Another reason relating to professional growth was that ASHAs were '*motivated by members of the health system*'. Only 7 ASHAs (2.9%) had given responses that fell within this reason. However observations showed that all the selections of ASHAs were initially made by the stakeholders from the health services system and in a manner that gave encouragement to aspirations. As expressed by an ASHA,

"*In the beginning I was a* ***pada worker****. I was told to do this work from the* ***dawakhaana*** (Primary Health Centre**)."**

(*****a community health worker in the state Pada Health Workers Scheme for adivasi areas that pre-dates the ASHA Scheme)

Two ASHAs gave yet another reason relating to professional growth namely '*carrying forward the family tradition of service*'. However observations showed that there were other ASHAs who were 'second generation' workers in the health system and therefore were likely to look at the post in terms of professional growth.

*"My mother-in-law is a trained dai and I too wanted to improve the community (**samaaj sudhaarna**). I wanted to do something for the village therefore I accepted this responsibility."*

Thus reasons of professional growth were cited by comparatively fewer ASHAs but the educational qualifications and the manner of selection of the ASHAs indicated that there was a larger number of ASHAs who did have professional growth in mind.

1.2 *Motivations and Concerns*

The in depth interviews triangulated the findings from the survey about the reasons for ASHAs to join the post and more importantly for staying in it. The data revealed that the ASHAs had joined for opportunities for social service and economic reasons. Making use of educational qualifications was also stated in the in depth interviews. Further, there were ASHAs who were formerly **pada** workers and had been motivated by the health system. The phenomena of ASHAs being second-generation health workers was seen too as in the case of MR whose mother-in-law was a **dai** and is now an attendant in the Sub Centre. In this case it was the mother-in-law who told MR to join as ASHA. To a large extent the findings of the qualitative and quantitative data on reasons and motivations of the ASHAs were identical.

However the major learning when the ASHAs were met individually for face to face interviews was how strongly the avenues of growth, self- expression and self- identity offered by the post motivated them. They sought personal strength through the ASHA work. The other important finding was that payment was mentioned by most of the ASHAs during the interviews as well. Matrix 4.1, illustrates how while their paths and reasons for joining were different and their life situations were different, the women all valued the intangible opportunities for growth offered by the post. However their common concern was their remuneration. Thus motivations and concerns were separate among the ASHAs.

Matrix 4.1

Co-Existence of the Intangible Motivations and the Remuneration

Concerns of ASHAs

ASHA	PRIMARY MOTIVATION	CONCERN
VS, 10th pass, working since 4 years, active in local NGO, Gram Sabha	Service, Growth *"If there are any opportunities please keep me in mind, keep my mobile number."*	Remuneration *"My mother-in-law questions me for the payment."*
NJ, also Pada worker, mother of two sons, one a heart patient. Husband in a full time job	Service, Societal support *"I do the ASHA work for my children, I want to blessings of people for my children."*	Remuneration *"People don't say it but there are expectations."*
DR, also does tailoring, husband irregular worker, 3 daughters	Gain in family status, self-esteem *"My Father-in-law taunts us that we have no son. Now I say my children will study because education is free for girls. And I am ASHA, it's a post for women."*	Remuneration – Respect *"It is not only the money…"*
MJ, former gram panchayat member, Adivasi, husband/self-active citizens	Service, Leadership *"We know what it is like to be poor."*	Remuneration *"I will do social service and be able to contribute to my family as well."*
BS, widow with graduate son who is working, has support of brother and wife	Independence, confidence *"For one year after my husband died, thoughts would not stop coming. I had never stepped out before he died, not even to the fields."*	Remuneration *"The work is hard. If nothing happens, I too will leave."*
WR, daughter-in-law of village Sarpanch, told to join because "*no one else was willing because there is less payment."*	Independence, identity *"I was glad to join, my childhood wish to work has come true."*	Remuneration *"I don't know how much longer I will be able to continue. Now even my family has started questioning."*

Discussion: An Analysis of the Financial Concerns of ASHAs

The preceding national CHW Scheme in India to the ASHA Scheme was called the Village Health Guides Scheme. It had started in 1977 but did not sustain. An analysis of this failure as seen by experts has been presented in Chapter One. One of the factors of failure as opined by expert analysis was the selection of males as CHWs because the men were looking for economic gains from the post, due to unemployment.

"Since the structural context was not considered in the development of the CHW programme in India, health planners failed to appreciate how great an impact the high rate of unemployment in Indian villages would have on the selection process (Agarwal 1979), resulting in males, rather than females, being selected as CHWs."

(Walt in Yesudian 1991 page 139).

Some states at that point had also attempted to replace the male CHWs with women. The male VHWs at the time, had unionized for better benefits thwarting attempts to replace them with women (Banerji 1985). The implication of the attempts by the state to replace men at that time might have been that women would not look for economic gains as CHWs. Women are also seen as naturally inclined towards service to others. In the current ASHA Scheme too these patriarchal values might have been operative in the selection of women rather than men as ASHAs.

Times have changed since 1977 and the ASHA Scheme has come three decades later than the VHW Scheme. The backgrounds of ASHAs showed that the men in their families worked in villages at various occupations but their efforts were not enough to keep the family solvent and most of the families were still in poverty. The data reveals that remuneration was an important concern for the ASHAs particularly because they were women. They were expected to contribute to the family income. This aspect is discussed at length further in the Chapter.

Bhattacharya and Winch (Bhattacharya, Winch et.al. 2001) had reported 'the possibility of future paid employment' as one of the motivations for individual CHWs. Walt (Walt in Yesudian 1991) had pointed out that the desire for future employment was seen in Sri Lanka among volunteers who had joined to give service but as young, educated women had few job opportunities. She had pointed to job seeking voluntarism in CHW

Schemes in Nigeria, Zambia and India but the gender of these CHWs was not specified by her. However the NHSRC survey on ASHAs (NHSRC 2011) had reported that only 3% of the ASHAs said they had joined because they wanted a government job.

The data of the current study revealed that the financial motivations of the ASHAs could not be compartmentalized only into their wanting a job or not wanting a job. Even if the ASHAs did not want a government job they uniformly had concerns about the remuneration (Matrix 4.1)

which could be overlooked. It was also necessary to understand why the ASHAs did not want jobs. The findings in the current study indicated gender-related factors discussed below.

Having started to work as ASHAs, the women went about the challenge of incorporating the work as ASHAs within their lives. The following Sections are about the adjustments and the exertions required by the women to work within the familiar environment of their own families and villages.

2. Creating and Retaining Spaces for Being ASHAs: Experiences of the Women

An important finding from the interviews was that the family of the ASHA emerged as a key stakeholder in the implementation of the ASHA Scheme. This was not reported by any previous study. It was also not factored into the original research design of this study (Chapter Two). The foremost challenge for the ASHAs after joining was to be able to step out of their homes for a purpose that was not related to their domestic requirements. ASHAs had to demonstrate their primary adherence to the social and familial norms to gain co-operation from their family.

2.1 Negotiations and 'coping mechanisms' to create space at the outset

ASHAs discussed how they prepared the environment at home to be able to work when they had just joined as ASHAs. There were vocal assertions of their will. Attempts were made to 'win over' some members of the family initially and then the rest of the members. The experiences of PS reflected such negotiations.

Case Study 1: Negotiations for Space (PS)

PS is an ASHA who has had done her 10th standard and a Diploma from the Family Planning Association of India. She was working as an attendant in a private hospital for three years before marriage. After marriage she moved to the village and joined as an '*ANM assistant'* at the Primary Health Centre. This is not a post that is commonly mentioned in the official administrative structure but she said that she was working and receiving a separate payment for this. When the ASHA Scheme came she joined additionally as the ASHA of her village as well. Women holding such 'dual positions' as health workers were observed in other villages as well. The most common combination was of the same woman being a pada worker and an ASHA.

*"The atmosphere at home was very peculiar when I married (**gharaacha vataavaran Vichitra hota).** She* (mother –in-law) *felt this woman has studied and worked she will go here and there. I have a hatred for such things.*

I told my husband if I behave wrongly, if I sit in somebody else's vehicle who is not a proper person; you chop me to pieces with your own hands. But if I am behaving properly then nobody should tell me anything, I will not tolerate it. I will not take it. I hate such behaviour. If I face a problem with her I speak only with my husband I don't discuss all this with my mother- in-law.*

Slowly (with the passage of time) *my mother-in- law understood and agreed and now she feels all the people visit our house first, we have importance. Now my in-laws tell visitors to wait for me if I am not there. She gets involved when a woman has to be convinced* (for institutionalised delivery). *She has started feeling she is **aadarsh*** (ideal mother-in-law)***."***

(*Distance is a major factor in the working lives of ASHAs)

The story of PS shows how intense the struggle to move into public spaces can get for a woman at the outset of accepting the ASHA post or any CHW post in rural India. Familial assent required time and the 'social service' aspect of the work could gain that for PS after some time. Thus gain in social recognition to the family of the ASHA due to the nature of her work could also help her get the space but the initial resistance from the family has to be overcome first. ASHAs shared that families were more accepting of their work with the passage of time but it was a grudging acceptance.

PS is educated and had work experience but other women too had to face such struggles for moving into the public domain and were not always successful in fully gaining familial assent to go out of the domestic routine even after years of being health workers otherwise.

Case Study 2: Negotiations for Space (BS)

BS is a 45 year old widow and had taken on the responsibility of being an ASHA after having been a member of the local self-help group that cooks meals for the children of the Village Anganwadi. Thus she had worked for the past five years in the system in total. She has support from her brother and his wife. Her adult son is a graduate holding a temporary job. He had not objecting to her work in the self-help group earlier but did oppose the odd working hours required from an ASHA. BS had put up her own resistance to her son.

"My son told me 'is it right that you go out at night. Once someone asked me that is your mother having a relationship?'

I told my son, will the people who comment come to see whether we have eaten or whether we are starving?"

2.2 *Pressures for Remuneration*

In Chapter Three the high absenteeism/attrition among the ASHAs was reported. Linkages of absenteeism/ attrition with the low remuneration were seen from the responses of the Block level officials (not medical officers). These linkages were seen from the interviews of the ASHAs as well. The findings from in depth interviews showed that even while the ASHAs themselves felt confident about handling their work at home and their responsibilities outside the home, the lower remuneration made it less worthwhile for their families to agree for the ASHAs to move about in public spaces. Members of the community too had similar perceptions.

Case Study 3: Pressures for Remuneration: (VS)

VS had been an ASHA for three years at the time of the interview. She said that she liked the work. Her husband is a daily labourer. Their family income per month is rupees 1000. She shared her experiences at home.

"*I have no problem in getting co-operation from my village.*

At home my mother-in-law says 'this one just gets up and goes. She goes out for work but there is no money to be seen. She gets a phone call and she goes. She just gets up and goes.'

My husband says 'you go here and there but get nothing'.

We are trained and are unable to ignore the village people's needs but we are in the same poverty as them. We too… our condition too is like theirs."

The story of DM reflects that the families of the ASHAs could be resistant to their work due to the advance payments made by the ASHAs for their work.

Case Study 4: Pressures for Remuneration (DM)

DM had been an ASHA for one year at the time of the interview. She lives in Karjat, a distant area and has to travel by the local train to reach the block sub –divisional hospital. Her joint family including her husband work and survive on a common land holding.

"*My husband does not say anything about my work. We have to ask my father- in -law. Even for my* ***tikli baangdee*** (bindis and bangles which are compulsory apparel for married women and must be replaced immediately). *Once when I asked for money to take the patient for delivery, my father- in- law said, you take money from home for delivery, for meetings, for training, what's the use of such work? I just left home without any money, I travelled '**without**' (ticket) and went to Asangaon."*

An ASHA could also have a divided house with some family members supporting her work and others placing stress on the remuneration. In such a situation the ASHAs would still feel the stress of being financially accountable particularly in the face of poverty and large family sizes. This is the story of CI.

Case Study 5: Pressure for Remuneration (CI)

CI works as ASHA, at home as well as on the family land. She has 23 members in the family. She said the family's land '*only yields enough to feed us'*.

"*We are 4 brothers and all live together but the kitchens are separate. None of the others* (other women of the household) *work but they don't say anything to me. They take care of my children when I am not there. I have 2 sons of 12 and 3 years old. When I became ASHA my younger boy was 7-8 months old but my mother- in- law took care of him. She says 'you do so much for expectant mothers so you should do this work.' But when I go out one of my sister -in -laws always says 'what is this you work for 150-200 rupees."*

The community's perception of the ASHA's tasks could also be as low paid work for the health services system. The fact that the ASHAs said they were doing social service was not appreciated by all around them according to BJ.

Case Study 6: Pressure for Remuneration (BJ)

BJ works as an ASHA. She has passed 4th standard and is an Adivasi. Her famly depends upon their own landholding and her husband also works as watchman. BJ faces no opposition from her family for doing the work but yet feels the pressure for remuneration.

"When I leave my home the neighbours say, look the lady is leaving for doing ***samaaj seva*** *(social work)."*

2.2.1 Linkages between uncertain remuneration and absenteeism/attrition

Earlier in this Chapter the data showed how ASHA BS had stood up-to adverse comments from her son for moving in public spaces. During her interview she had expressed her satisfaction that the ANM acknowledged her role in saving lives including six children in her village from a malaria epidemic. Her work ethic was apparent in her description of her routine. She related how the distances she had to walk to cover the village and the surrounding **padas** (tribal hamlets) took up-to six hours to cover if she took a round at one stretch. Yet she also said in the same interview:

"People in the village should understand that it is not that I work because I get money. My condition is such… (that I have to think of remuneration)**.** *If nothing happens, then I too will leave."* (Case Study 2 BS)

These linkages were confirmed by the ASHAs' immediate seniors within the health services system too.

"One of the ASHAs shared this with us. Her husband called her out to the front (front room of the house) *and introduced her to his friend, saying 'Ask my wife her salary – it is 150*.' Can he possibly be saying this with appreciation?"*

(Sister BK, LHV [Lady Health Visitor, the designation given to senior ANMs], ASHA trainer and supervisor working from the PHC Level).

(*The amount of rupees 150 is the only fixed part of the ASHAs' remuneration. This is the compensation for attending the ASHA monthly meeting. The rest of the remuneration shifts each month according to the incentives.)

Yet during the interviews the medical officers who represented the highest level of the local health system seemed unaware of any familial or community pressures upon the ASHAs or the associations of remuneration with absenteeism/attrition. Doctors simply attributed the low attendance and the dropouts to absenteeism.

2.3 *Coping Patterns to Face Expectations of Remuneration*

ASHAs negotiated for familial co-operation by highlighting the service aspect of their work and the promise of a better financial future. On the one hand the importance of their contribution to health care was reinforced by the system and on the other hand was the concern or humiliation faced for payment. This was a double bind faced by the ASHAs. In such a situation ASHAs often bought time from the family to continue by the promise of a better future. The expectations from the post were high among the ASHAs who expected their terms of work to change as seen in the case of SS.

Case Study 7: Coping with Familial Expectations of Remuneration (SS)

SS is an experienced ASHA. She works in a Primary Health Centre at a high distance from the block headquarters. Her family is dependent upon their land holding for survival. Her narration illustrates the double bind faced by the ASHAs, and their hopes for a better future.

"*I tell them (*family members) *about the hopes that they* (seniors in the health system) *give us in the training. They tell us during every training session that due to ASHA there is immediate treatment and free treatment so they value the ASHA's work. Then I too feel someone is getting help so I should carry on.*

We are living on hope that something good will happen as they tell us. Suppose we leave and then something happens then we will feel it is'nt it? We are here on basis of a hope. After all ASHA means hope."

Hope was also fostered by the fact that former pada workers were now ASHAs. There are now a number of women health workers at the village level, including the Pada Worker, Anganwadi Helper, the Self Help Group members, the ASHAs and the Anganwadi Worker. These posts were seen in terms of a gradual upward mobility within the system, by the ASHAs as well as their families (Box 4.2).

However the ASHAs were clear that even the empowerment of increased remuneration would not extend to any change within their domestic responsibilities. This was expressed clearly by ASHA WR who said that things would not change at home even with an increase in the remuneration. The only change she said would be that she would be able to continue to work.

Box 4.2
Familial Expectations of Upward Mobility

During data collection, the researcher visited a village and the newly recruited ASHA had gone to the Primary Health Centre with an expectant mother. The father-in-law, brother-in-law and husband were all eager to share details of the ASHA's work with me. The ASHA returned back in the course of the day. When the researcher revisited the house, the father-in-law said that the ASHA was educationally qualified. She had worked as an assistant at the PHC near her parental home before marriage. She had joined because she was told to do so by the local Primary Health Centre after she got married and moved into this village. With folded hands he asked the researcher if the researcher could put in a word with the authorities and make the ASHA an Anganwadi worker because that was a permanent and salaried position. The researcher could explain the limitations of her position to him and he agreed that the researcher could do nothing. He said he made the request to all the 'official' visitors to the village since a new Anganwadi was expected to come up in the village.

*"If the payment is increased then the only change is that I will be able to work. Nothing else will change. (**"Paise wadhawle tar phakta malaa kaam kartaa yeil. Doosra kaaheech naahee badalnaar")***

(Case study 8 WR).

2.4 *Concerns of Safety and Reputation Related to Moving in Public Places*

Concerns related to moving into public spaces for their work was a recurrent theme in the conversations with the ASHAs. This aspect was mentioned in terms of reputation. Secondly there were concerns about the transportation difficulties and the associated safety factor. These concerns were mentioned largely in the context of the Janani Suraksha Yojana. The time for delivery of expectant mothers can be at any hour of the night or day. Under the scheme, the ASHAs have to accompany the mother up-to the public health facility for institutionalized delivery and stay with her until she has safely delivered. This means moving out of the village alone with the expectant mother and her family. In Shahapur the means of transportation are generally the private jeep or the auto rickshaw. Travel with expectant mothers and their family members to the PHCs or the next levels of referral can take up hours (Box 4.3).

Box 4.3

The Travel Conditions in the Study Location: A Representation of Rural India

Shahapur is the largest Adivasi block in Thane district having nine primary health centres and the National Rural Health Mission is operational there. The research therefore mandated travel to all the nine primary health centres, some sub-centres and villages. If the period of preparation and data collection were put together the researcher has spent more than an year travelling within Shahapur. While collecting data, the researcher met up with many of the public health personnel and learnt, 'the other side of the story'. In the researcher career so far she had largely looked at policy and implementation from the view of the beneficiaries. She was now studying the same from the view of those health personnel that were implementing these public health programmes. Among the many learnings from data collection, there is one set of leaming that was not originally within the scope of the study. It came about because the researcher coincidentally met and conversed with many public health personnel while travelling in the taluka. The researcher found that many of these talks revolved around one theme, namely how the distances had affected their work that day. All the sharings illustrated one common theme: the impact of geographical distance upon the implemention of a public health service, as experienced by different public health personnel from different Primary Health Centres in Shahapur.

To truly acknowledge these experiences, it is necessary to understand the travelling conditions within the block of Shahapur. The common impression is that at 120 kms. distance from Mumbai, Shahapur is well connected by the local railway service to the cities of Thane and Mumbai. However having once reached the nearest railway station to Shahapur namely Asangaon, travel within the block becomes difficult. The distances between villages are large and the local terrain includes hilly areas and dirt tracks. The local citizens use various forms of transportation. Few of the citizens of Shahapur have their own two wheelers or four wheelers. Most people walk long distances and also use the public bus service. These buses work on fixed routes and timings. Dependency on private transportation is therefore very high. There is the private rickshaw service but that only functions for short routes. Therefore for moving from one village to another, the common form of transportation is the shared jeep – privately owned jeeps that go on fixed routes and charge on a per seat basis. Passengers have to catch a seat and wait until seats are fully occupied for the jeep to start. Jeeps are readily available at the centre-place of most villages. Indeed it is rumoured that the 'jeep owners' lobby' of Shahapur block is so strong that it effectively blocks all other modes of transportation from expanding in the area. A single outing outside the village for any chore can take up most of the day.

Safety was not threatened by the transportation drivers or the odd hours. It was from the men in the community. When ASHAs travelled with the expectant mothers for delivery, the

family members sometimes accompanied them. ASHAs shared how they felt vulnerable to sit close to the men in the shared jeep or rickshaw while going to the PHC. At times the men were drunk adding to their sense of discomfort. This was a difficulty also shared by an ANM during data collection. The same sense of sacrifice and service expressed as a reason for joining, kept these women going in such situation. ASHAs said they reminded themselves that they were helping the expectant mothers. They did not look for entitlements for safe journeys, did not question the behaviour of the men but ascribed the onus of keeping safe upon their own conduct.

"ASHA should earn that respect from the people. There is a saying when you deal with people you should have sugar-sweetness in your mouth and ice-coolness in the head."(VS, ASHA since four years, active in local NGO and gram sabha)

2.5 Retaining Spaces to Work and Maintaining Status Quo at Home: the Balancing Act of Responsibilities

The ASHAs reported that their responsibilities as ASHAs had become incorporated into their routine of the day. Their daily domestic responsibilities did not change and the work of the ASHAs was in addition to that. This had both positive and negative aspects. It was a positive aspect that the ASHAs had incorporated their daily responsibilities as a united whole consisting of both, their work as homemakers and as health workers. This indicated a synthesis and not a conflict of their responsibilities. The negative aspect was that this could lead to a physically demanding daily routine. To the naked eye, most of the ASHAs looked underweight and overworked. Walt (in Yesudian 1991 page 137) had noted in her analysis of voluntarism in Community Health Workers Schemes that in less developed countries that "*women are in general heavily burdened with daily tasks, with survival or subsistence, particularly poor urban and rural women. There is little time for voluntary work although there may be considerable reciprocity between neighbours or families at certain times."*

The current study found that the ASHAs were indeed burdened with daily tasks however not a single woman mentioned the ASHA tasks as an additional work load or burden. They only shared their ways of managing it with their domestic work. There is a strong rationale for the current flexible working hours of all CHW Schemes as also under the ASHA Scheme. The acceptability to work came from their family only provided the ASHA's commitment to the household and agricultural work remains constant. This was regardless of the background of the woman. While keeping the post with flexible hours was 'convenient' for the community, the system and the families, it meant that the ASHAs were working the entire day. Yet the ASHAs did not express the increased work load as their concern.

If the ASHA was able to gain some respite from her domestic duties while doing the ASHA tasks it was only when her domestic tasks were shared by the other woman members of the family. Some ASHAs said that their husbands had dropped or picked them up from the PHCs at times. However most ASHAs received only passive support from husbands and in-laws, typically they '*say nothing*.'

Case Study 8: The Balancing Act (WR)

WR is the daughter-in-law of the village Sarpanch. She is an Adivasi. She has worked as ASHA since the past two years. She joined due to her family but calls the work as 'her childhood wish come true.' However she balances her own wish fulfillment with her household responsibilities as there is no respite from the daily chores.

"My daily routine has included the ASHA work. First I fill water. I have to go two- three times to the well to fill enough water for the house – each trip takes half hour. Then my sister-in-law and myself, we both make breakfast, wash utensils, clothes and clean the house. I then do a round of the village… I go to see the delivery patients, ill patients and I tell about the immunisation. It takes one to one and a half hours. Then we make lunch. In the afternoon if there is some area left like the further ***padas*** *I visit them. If it is summer I have to fill the water again. Evenings we make dinner.*

My sister-in-law is at home but she does not say anything. She just got married. She helps with the housework.

At home my father- in -law and mother- in- law don't say anything about the ASHA work, My husband works outside so he is out for 15 days in a month, he does not say anything…

When I stay overnight for delivery with a mother I have to take my 8 months daughter with me."

Like WR, the strain on a largely unexposed rural woman barely in her twenties and spending the night in the unfamiliar surroundings of a Primary Health Centre or hospital can be tremendous for any ASHA. Why would an ASHA who had no support from home to look after her young child as in the case of WR take on this strain? Why would she take her child overnight with her, adding to her strain and also exposing the young child to hospital infections? Many ASHAs shared that after they had spent time accompanying the women for delivery, they came home and cooked for their families as well (Box 4.4).

Box 4.4

Travelling for Work and Maintaining Status Quo at Home: An ASHA's Experience in Implementing the Janani Suraksha Yojana

The researcher met an ASHA Sushma (name changed) while commuting together in a jeep **(at Shahapur privately owned jeeps function like rickshaws to move from one village to another)**to go towards the Shahapur headquarters. She has been working as an ASHA in the Khardi Primary Health Centre (PHC) since the past 3 years. The researcher had come to the PHC for data collection, and she had participated in my data collection along with the other ASHAs. We got talking in the jeep as we both headed to our respective homes, when Sushma told me that she was returning home after three days.

She said that three days back, she had brought a young woman accompanied by her family members from her village to the PHC for delivery. After reaching the Primary Health Centre the PHC doctor decided to refer her to the Thane Civil Hospital for specialised intervention. The expectant woman's family refused to take her to the Civil Hospital saying that Thane is too far. (**Thane is connected by train and is a two hours commute from Khardi. The Civil Hospital is further away from the Thane station).** Since the woman had already been sent outside the PHC the family then got her admitted in a private hospital in Khardi itself.

As it is mandated under the JSY that the ASHA has to be with the mother until she has delivered, and the woman took three days to be delivered, Sushma stayed with the woman in the hospital for three days. In a normal delivery, Sushma would be back home from the PHC after an overnight stay at the most. In this case, Sushma stayed alone because the woman's family had to get back to work. Ultimately the woman delivered a daughter. Sushma was in constantly in contact with her own and the woman's family on her mobile phone. The husband then came to the hospital.

Sushma had left her own home three days back but she had to stay back in the hospital in order to get the signature and seal of the doctor on the mandated form given to ASHAs, because that is a requirement. **(The signature of the sister or doctor in charge during a delivery in both private and public hospitals is necessary in order to get the remuneration for the ASHAs).** She then came

directly to the PHC from the hospital to submit the form.

(ASHAs have been instructed that the signed form has to be handed in to their supervisors to claim the JSY incentive. Her home being far from the PHC, she decided to hand over the form on the same day.) Since the researcher was meeting up with all the ASHAs at her PHC she too participated in my data collection. She then found that the Auxilliary Nurse Midwife (ANM) was on leave that day. The form had to be submitted on the same day. Therefore, after the data collection was over, Sushma contacted the ANM from her mobile. The ANM who lives nearby, called her home. Sushma then went to the ANM's home that was near the PHC, to hand over the form.

Form submitted, Sushma too boarded the same shared jeep as the researcher, and we were both headed towards our homes. Sushma was spending the jeep fare at her own expense to cover one part of the journey to her village (the ASHAS get rupees 600 for Janani Suraksha Yojana inclusive of expenses and travel). She would complete the rest of her journey by walking 2 kms. up to her home. Sushma has not changed her clothes in three days, as the expectant woman had developed problems suddenly and the referral to hospital from PHC was unexpected. Since she had not been home in three days, Sushma would be expected to cook the dinner for her family that evening after reaching home. During this entire sharing with me, Sushma's demeanour could be best described as matter of fact. She was happy that the mother and child were safe. The family of the young mother in this case was presented a bill by the hospital said Sushma. The woman's husband, a casual labourer, was with her but they had not yet taken discharge. Sushma was very worried about how the family would pay up. She had no clue whether the private hospital in question was empaneled under JSY and the provisions for patients in case it was so, but she did know for certain what the ASHA has to do if any family decides to go to a Primary Health Centre, Government hospital or a private hospital for a delivery.

The researcher appreciated the fact that Sushma was at the end of a three days duty. She had a walk to her home and her domestic responsibilities still awaiting. The articulate Sushma was at loss for words for the first time but smiled in an embarrassed manner and softly mutters "*thakwaa tar yeto*…"**(one does get tired).** She then said "*kaay karu shakto*" **(what can be done).**

When there was no other woman in the family, the members of the family remained unfed. Temporary arrangements to look after the children were made with the neighbours or by keeping the child at the village Anganwadi. Why would these women continue to work?

Certainly the determination to continue working in these women showed that the work was an avenue for some satisfaction or some aspiration which the women did not wish to relinquish.

Case Study 9: The Balancing Act (AA)

Some ASHAs felt they had managed the balance between their various activities well. AA is a 'second generation' health worker, her mother-in-law being a Dai. AA has passed the 8th standard. She lives in a joint family. Her last remuneration as ASHA was less than rupees 1000. A confident and smiling woman who preferred her home as venue for interview and also introduced her mother-in-law, she shared how she balanced her responsibilities with the ASHA tasks.

"The work of the ASHA is within the routine of my daily life except when I go to ***Dawakhaana*** (Primary Health Centre) *or with an expectant mother* (for delivery). *Patients come home I give medicines for the TB and Leprosy patients at my home- now they know me so they come by daily. I don't have to visit them. The expectant mothers too come and I make them take the tablets in front of myself. I do my daily round of the village after I finish my cooking."*

AA saw the work of the ASHA in terms of defined tasks to be managed by her. She was either overlooking the aspect of information-giving or was not 'counting' it because this was a non-paid activity. This manner of thinking could also be due to the task-incentive system of reporting and remuneration which had taught a task-oriented thinking about the work of the ASHAs.

AA's cheerful management of her day which she saw in terms of tasks to be done shows that indeed the ASHAs were burdened but they wanted to hold on to this post as they saw it like an opportunity. The strong work ethic of the women was also seen with the often expressed sentiment that "since we have taken on the work we must do it."

3. An Insider and An Outsider: Changing Spaces in the Community

As Community Health Workers, the ASHAs were now working in the same village where they were formerly just one of the residents like the others. The manner in which the ASHAs now defined their relationship with the community had different dimensions. The women were being viewed in a distinct manner by their former neighbours. This was an evolving relationship but the narrations of the ASHAs demonstrated that their relationship with the community was largely between themselves and the community. There was no involvement from the health services system in their relationship with the community. There was only compliance to the requirements of the system in terms of completion of tasks. ASHAs did not seem to expect any involvement from the system in completing their tasks in the community either, indicating

the extent of their isolation from the system. Their relationship with the village was related by them in terms of task completion as well.

3.1 *Crossing the Prevalent Limits of Mobility: the gains and the stresses for the ASHAs*

ASHAs crossed the prevalent limits of physical mobility for women in their villages in their quest to provide services in the community. In the process they gained confidence but also faced difficulties. This is highlighted by the experiences of VR.

Case Study 10: Mobility (VR)

VR is one of the older ASHAs in the sample. She was selected in the first batch of ASHAs in the taluka. Belonging to an OBC family, whose sole source of income is their land holding, she shared her experiences with the Adivasis in the area. The tone was almost of 'an outsider who is looking in' the village.

"*Adivasis are afraid to go to Primary Health Centre because they have never gone before. Once an Adivasi mother was having trouble and I took her to Civil Hospital in Thane* (district hospital). *I was afraid to travel alone as I had never gone out of the village, only up-to the sub divisional hospital* (Shahapur block headquarters). *But they gave me ambulance. There the doctor shouted at me, 'why has she low haemoglobin, did you not give her iron folic acid tablets?' I used to give, she used to show me the empty strip but maybe she did not eat them. The doctor called our sister* (ANM) *there. The woman and her child survived. Faith started building in the village with such cases. Now it is not as hard as before.*

Over time the women like VR had crossed other prevalent limits for women as well. The curative function of the ASHAs had them speaking with the men in their villages whom they would not normally have interacted with.

Men do come home and ask for medicines too. If they have a problem they come in the evening when everyone is at home."

One of the aspects of increased social mobility that was sought to be observed was the effects of caste dynamics upon the ASHAs. Their backgrounds highlighted that although the Adivasis and Dalit ASHAs were lower in educational status there was not much difference in the family incomes (Chapter Three). The daily routines of the women were also fairly similar, as seen in the qualitative interviews. The data showed that gender and not caste was the major factor of consideration to analyse the situation of the ASHAs. However a few indications of how caste affected mobility were discovered during the interviews.

Case Study 11: Mobility (DA)

Caste dynamics at the village were not readily discussed by the ASHAs. In Shahapur, the OBCs were widely perceived as the dominant caste. In the view of some of the ASHAs, there were positive changes in the functioning of the Primary Health Centres after the NRHM and the increased use of the services by the poor. Yet exploration also revealed that caste dynamics could direct the flow of entitlements. In Shahapur, the OBCs were widely perceived as the dominant caste but Adivasis were seen to be dominant over the Dalits in the village.

One ASHA from the Dalit section did discuss the situation in her village. DA works as a ASHA and also in the self-help group. Her husband sells boiled eggs in the city "*where nobody know who we are"*. Her home had a television and a DVD player that she said had been purchased because she and her two children had very little opportunities to socialize with the others in the village. DA invited the researcher home after the researcher shared food and water with her at the Primary Health Centre. DA is a plump and pretty woman and has two healthy school going children. Her home is a hut with several photographs of Baba Ambedkar on the wall. She narrated her experiences with her village.

"In my village the Katkaris (Adivasis) are the dominant group. There are all castes but these people are dominant in the gram sabha and fight to get all the services for themselves. They do not live peacefully together in my village. These people get everything."

DA had been taken on in two positions, namely as self-help group president that provided cooked food for the Anganwadis and later also as the ASHA for her village despite the caste factor. This could be due to her capabilities and also because of the unavailability of other women that were willing to join as health workers.

They come for medicines to my home because I have the kit. They ask reasons if the medicines are over. For anything else, they don't listen to me." "*I am the president of the self-help group and we give* ***paushtik aahar*** *(*nutritious meals*) for the Anganwadi. I am very talkative and help any visitors to our village. So they asked me to start the self-help group. I was given a bad time in the village for trying to get the other women to join in. Somebody's husband said no, somebody's mother- in- law said no, somebody's sister- in- law said no, to the extent that they even beat me. But I said I will do this, got the members and started cooking on my own. Now I alone cook for the village Anganwadi here in my kitchen. There are other members but they don't cook.*

(Do the children eat?)

Yes it comes from the government so no one says no to the food.

As ASHA I give attention to main points only. I give more services for women … I work for delivery and for information to adolescent girls.

I keep medicines that I give to all. Otherwise I do not move around much in the village. They (the ANMs and MPWs) *don't even ask me to go around because they know the atmosphere of my village.*

(Do the villagers allow you to enter their houses?)

Yes, for the women, only for delivery.

Although this was the story of one ASHA, a key informant, it can be indicative of the situation of ASHAs who are from a lower caste in their respective villages. DA's village has a mixed population of SC, ST and OBCs. As she saw it, the dominant caste group was an Adivasi group in the village and it limited the areas of intervention available to the ASHA. The discriminations were all at a subtle level. On the other hand, the post of ASHA had partially opened doors for her that were previously closed as she got a limited access to families that would not have entertained her ordinarily. As of now this had no real implications of social acceptance for her according to DA. The community felt entitled to the services provided by the ASHA due to her association with the public health system therefore they co-operated for limited services like ante-natal care, escort for institutionalised deliveries and primary curative care.

Like DA, on the other hand, ASHAs from the upper castes found that that the work granted them the mobility to go to the homes of people in the village with whom they normally did not socialize.

Case Study 12: Mobility (GR)

GR is an ASHA who belonged to the upper caste and had joined primarily because of her family background as an influential landed family. In her case, the ASHA position opened up opportunities to enhance her social mobility.

"I did not know how to talk, now I do.

I did not even know even how the peoples' houses looked from inside. Now I go everywhere not only in the houses of 'good' people. We go to Katkari and Warli (Adivasi) *houses also."*

An important caste-related finding of this study was that the ASHAs said that they faced a difficulty in encouraging the usage of public health services among the Adivasi women. Shahapur was classified as 'tribal block' because of the number of Adivasis living in the block. Ironically the ASHAs felt that the challenge of working among the Adivasis was the most difficult.

3.2 *Encouraging Institutionalized Deliveries: the struggles of ASHAs within their own villages*

ASHAs across the sample shared the misgivings of the Adivasis towards the public health services and the almost insurmountable obstacles to convince them for institutionalised delivery. The history of mistrust between the Adivasis and the public health system was apparent. It was difficult for the ASHAs but on the other hand the trauma faced by the expectant mothers at a very vulnerable time.

"*Among Adivasi families they feel they (public health services) don't take money, but they will cut us up and kill us. Once an Adivasi mother aged 31 was due with her sixth child. It was a breech baby. I took a jeep and took her to the PHC on my own expense. Then they sent her to the sub divisional hospital. I spent for that. She insisted on going back home. I told her I will spend 100 rupees again but please come at least to the PHC. She returned back home anyway and delivered at home."*

(NJ, ASHA and Pada Worker, mother of two children,husband has a factory job)

ASHAs also shared how they counseled the families about the benefits of institutionalised delivery.

"*I give my mobile number to mothers to give them confidence and to be able to contact me. Adivasis have to be explained ten times about what kind of services are offered to them. Earlier they were not going to the PHC for anything.* (Then what services were they using?)

Nothing, deliveries were at home. Except for serious illnesses they never took medicines, not even for serious illnesses sometimes."

(VM, ASHA and Pada Worker, husband daily labourer, OBC)

One of the tactics used by the ASHAs to convince the family for institutionalised delivery was to inform them about the financial incentives given under the Janani Suraksha Yojana.

"*My relationship with the village people is good but sometimes they do not co-operate for getting the expectant mother to the* ***dawakhaana*** (primary health centre) *for delivery. Mothers themselves are not ready, their families too object more than the mothers. Then the JSY* (Janani Suraksha Yojana) *helps-when they hear about the money they come."*

(Case Study 8 WR)

The ASHAs' side of the story was upheld by the middle ranks of the system like the ANMs and the LHVs.

"*I am working since the past 27 years but I will tell frankly that the success is not great as expected from NRHM. Home deliveries are still happening here regularly. Therefore the risks*

of high maternal and child mortality rates remain. The reason is the distance and the people. In this PHC there are more than 20 villages and more than 70 ***padas*** *(tribal hamlets) and the M Thakurs (one of the Adivasi groups) are the most dominant. Once a patient died, the entire road was full of people, they threw stones at us. Its a very difficult area. Second, the sub centers are in remote areas so the people are not able to reach. Even rickshaws are not available. The woman delivers before our people reach them too."*

(ST, LHV [Lady Health Visitor, the designation given to senior ANMs] in one of the most remote PHCs in the block)

3.3 *ASHAs as Frontline Workers*

ASHAs shared some of the situations where they had felt themselves to be vulnerable to the community in the course of their work. Some of the concerns shared by the ASHAs were of being held accountable for discontinued schemes by the community in the absence of any other official communication to the village. GY shared her perspectives on the matter,

"Whichever scheme the **sarkaar** (administration) *begins, they should implement it fully otherwise people ask us. For example hypothermic kits for new-borns were given to us for some time to be distributed. Then it was discontinued. People ask us."*

(GY, ASHA in a PHC near the block headquarters, last paid rupees 1000 more than two months back)

Though the ASHAs were held accountable by the community and felt themselves to be accountable there did not seem to be any avenues for the women to seek support or answers from the system. They were facing the community almost on their own. This was seen in the way that the ASHAs provided service in very crucial situations at times. The sense of achievement for their own conduct during such incidents was apparent in their conversations. However the lack of systemic support to them was underlined in their narrations. ASHAs were taking decisions which were beyond the powers entrusted to them by way of training or tasks. It was only natural that their expectations from the system grew as they were representing the system to the community in emergency situations. The experiences of RW showed that the ASHAs were taking several decisions alone.

"Once there was a second time Caesar (Caesarian delivery) *case. Because she had a Caesar* earlier I thought it is better to take her in time to the sub-divisional hospital. There the doctor was not there who could do a Caesar. They are never there for Caesar. The mother said "**maami*** (aunty) *it is not paining a lot, let us go by train." So we all went by train at 9 in the night to Thane Civil. Her Caesar happened there. Another Caeser case I had earlier had a better*

financial position so I told her relatives, let us put in money and put her in private in Shahapur. They had to spend 10,000. I also gave some money."

(RW, ASHA in one of the distant PHCs but the PHC is connected by the local railway line)

(*The ASHA takes all women due for delivery to the PHC. Then if the woman cannot be delivered in the PHC there she has to organise private transport for the woman to the next level that is the sub-divisional hospital.)

On the one hand were the numerous concerns of being in the frontline , and on the other, ASHAs felt that they had succeeded in winning the trust of the people of their villages due to their representation of the health services in their villages. DR and PS described experiences that were shared by other ASHAs also.

"Once a woman was on the verge of delivery and the family refused to take her. She was in trouble I could see that. I almost forced the husband to take her to the PHC. We both carried her and put her in rickshaw. Now they always say I saved both the lives."

(DR, ASHA since 4 years, passed middle school, joint family)

"Patients do tell good things. I took the decision to refer a seriously ill child to Civil Hospital. They did not have to pay anything. The Multi-Purpose Worker wanted to send her to the PHC. The child's Father now tells all visitors to their home that "She saved me."

(PS, ASHA , 10th pass and Diploma Holder, experience in hospital, husband is a farmer, mother of one)

4. The Changes within the Community and the Family

As seen in the Sections above, the act of accepting and sustaining the work of being an ASHA brought about changes in the relationships of these women with their families and their communities. These were evolving relationships but some shifts were clearly articulated by the ASHAs.

4.1 *The shifts in the Relationship with the Community*

The ASHAs' association with the health services led to positive gains with the community too. Their work in the frontline of the health services increased their status in the community to an extent. The work of the ASHAs in the community gave them a sense of confidence in dealing with the community due to their knowledge and association with the

system. A sense of 'guiding' the community was apparent in their conversations. In the face of humiliations about the monetary aspects of their engagement, the ASHAs drew their sense of personal worth from the 'knowledge-sharing' aspect of their work. The high potential of independent functioning among these women from the village was apparent. However the lack of support from the system in terms of guidance and knowledge could be risky for the community and the ASHAs.

"Women call us, take us to the side and confide in us. Earlier we used to tell only each other and if women don't know themselves, what will they tell each other? We are able to guide them."

(VR, ASHA passed 10th standard, last earned remuneration was below rupees 1000)

"*The people are more secure now and don't tell sister* (ANM) *now but me. They don't go to private... So much trust they send me to ask at the PHC if they have a problem. ASHA is preferred over private."*

(RB, ASHA since three years, her PHC is the closest to the block headquarters but her own village is located in a comparatively inaccessible area)

The post of ASHA simultaneously also created a distancing from the community of the system. A sense of 'us' and 'them' was observed at all levels of workers within the health system. It was observed that the ASHAs too had imbibed this perception to some extent. They referred to the Adivasis almost as if they themselves were only service providers and not members of the community. It was as if their work had made them outsiders looking inside their own village. This factor was brought out by IC. Being an ASHA from an Adivasi background she was commenting on the difficulties of working with the 'Adivasi mothers'. IC shared how 'the Adivasi women were afraid to go for institutionalised delivery because they thought they would get stitches'. When asked whether it was easier for her to explain things as she too was an Adivasi, she replied:

"*No it is not any different for me. I still have to explain to them."*

(IC, ASHA with experience, lives in a village with amenities of drinking water and a government school)

On the other hand the ASHAs were also distanced from the system. An indication of this distance in their personal lives was seen when the ASHAs talked about where they or their family members went in case they required curative care. The reported usage of public health services was low among their family members due to factors like long queues outside the OPD.

The ASHAs themselves largely did not admit to requiring any medical care at all. Younger ASHAs were reluctant to discuss where they would go for their own deliveries in the future.

The ASHAs and their families thus did not appear to think of the PHCs as approachable places for personal treatment. They maintained a distance from it as one would from a place of work.

4.2 *Empowerment for the Family but not Within the Family*

As seen above, the ASHAs' relationships with their families were basically related to creating spaces for themselves. As time went by, the non – monetary gains to the families from their work in terms of enhanced social position and interaction did help the ASHAs to gain the passive acceptance but the empowerment was for the family.

Case Study 13: Empowerment for the Family not the ASHA (BN)

BN is an ASHA who is born, brought up and married in the same area as she works. She went to school up-to class 10th yet she first began moving out of the home only after becoming an ASHA. BN had shared how her family had become more outgoing after she became an ASHA. She had noticed how she too had become more confident. However her position in the family had not changed very much. Every adult in the family worked in the fields and so did she. She cooked and served the family members as before. Her family felt comfortable to take an objection to her work. Her 'coping technique' was to continue her work as ASHA but not retaliate or react to the family's objections. The 'service' aspect of the ASHA work kept her motivated to carry on but her inner growth and confidence did not help her to negotiate openly to continue the work.

*"Earlier I used to feel afraid to talk to other people… especially to talk in front of big people. I can talk anywhere now. Due to this work I came to know what happens in the village. Earlier no one used to participate in anything from our family, they would not go for gram sabha (*meetings*), not even for* ***haldi kumkum*** *(*a local socio-religious function for women*).Now my father –in-law goes for gram sabha and at home there are conversations about what is happening in the village.*

*When I am tired from the field and have to attend to someone who needs medicine at home I feel reluctant. But then I remember that this is helping them and I feel ready to carry on the work. Patients come home at any time and they (*family) *also object. When I am serving food and patients come, they say things…I listen, I don't reply back."*

In some cases the ASHAs could gain the approval of only some members of their families due to the perceived gain in status.

Case Study 14: Empowerment for the Family (CS)

CS had been an ASHA for the past two years. She is from the Lamani tribe. She has passed her 10th standard and also holds a diploma in 'computer' and tailoring. Her husband works in a factory. Being educated she looks upon the post as an avenue for professional and personal growth but in the absence of 'satisfactory remuneration' could not gain her husband's approval. The ASHA post became an accomplishment to share with the other family members and to thereby negotiate for her spouse's approval.

"My husband leaves early for work. My mother –in-law looks after the kids so I am able to go to the village. Sometimes my husband says there is no payment then why do you give your time, leaving your kids?

My mother- in- law and father –in-law feel good about my work, they say to people, 'my daughter –in-law works.' I guided my sister –in-law for ante- natal care during her pregnancy. When I visit relatives from my in-laws' side, I carry my tablets. When there is dysentery among the children they 'phone and ask how to make ORS. They ask for my advice. I share my experiences. I say to my husband better than sitting at home I am serving the people. Also I get information. Come to know so much."

The exploration also showed that ASHAs had contributed to changes at home but said there was no change in the extent of their personal liberty after joining as ASHAs. They had as much liberty as the other women in the village except when they went out for work.

Case Study 15: Lack of Empowerment within the Family :(GS)

GS comes from an Adivasi family. All the family members are engaged in farming but she is from a relatively better off background. Therefore women in the family do not engage in casual labour. She has been an ASHA since four years and is a recent mother.

"My day is from 5 am to 9 pm. I spend the most time on farming only during sowing and harvesting. Otherwise I am at home. The ASHA work that requires me to go out is delivery and immunisation – that is the main work. I take rounds of the village, otherwise I am at home."

Campbell and Gibbs (2008) had conducted a longitudinal study on participation of women lay workers in care of AIDS patients in a rural community in South Africa over a period of five years. The study showed that while participation enhanced the women's knowledge, skills and confidence, the project had limited impact upon the women's empowerment in personal

interactions with male project leaders, their husband (about use of condoms) and in community leadership and decision-making. The data in this study suggested the same.

Case Study 16: Lack of Empowerment in the Community (MJ)

ASHAs shared how they did not gain familial approval to participate in public forums like the gram sabha. This was true even of women like MJ who had earlier been a gram panchayat member. MJ is an ASHA who has 4th standard pass and is remarkably self-assured in her behavior. An Adivasi, her husband and she herself are active in the village. She receives support from her husband for the ASHA work to the extent that he participated in escorting the women of the village for institutionalised delivery. However, he did not think it necessary for her to attend the panchayat meeting.

"When I discuss attending the gram sabha meeting my husband says 'I am attending, I will tell you what happens."

To sum up the findings of the Chapter, the ASHAs had to undertake various negotiations for space and mobility within their families and communities in order to carry out their engagement. Further in time, the struggles were to retain the spaces by maintaining the status quo between their domestic and ASHA tasks. Despite the passage of time the acceptance of the family for their engagement was largely passive ("*they say nothing").* Yet the pressures of remuneration and the high rate of absenteeism/attrition in the study location showed that ASHAs were accountable to their families.

When the satisfaction from the work and the concern or humiliation for payment were both co-existent it was a precarious and stressful situation where the balance was not tilted in favour of the women, compelling even otherwise motivated ASHAs to consider leaving. However even with an increased remuneration ASHAs did not feel that it would bring about any changes in their status within the family, it would only retain their space to work. Their keenness to retain the space was apparent.

As with their families, the initial struggles of the ASHAs with the community were to do with creating spaces to work including their own physical and social mobility. Safety and reputation within the community were factors that weighed heavily on the women. While their engagement with the community gave them personal confidence due to their knowledge and contact with the health system, they were exposed to potentially risky situations. They were held accountable for health services and were taking on key decisions as frontline workers in the face of absence of support from the system. Their lack of expectations on this front was a manifestation of their distance from the system.

The key finding was the simultaneous feeling of personal empowerment and distancing from the community experienced by the ASHAs after joining this post. However the personal empowerment from the work did not translate to changes at home and was not enough to sustain the women in the face of the unequal power balances in their families. The emergence of the family as a stakeholder was another key finding. The next Chapter explores the life of the ASHA within the work spaces. The influences of her personal background are apparent in the perspectives of all the stakeholders.

THE ASHAS WITHIN THE PUBLIC HEALTH SERVICES SYSTEM: MANIFOLD PERSPECTIVES IN A SHARED SETTING

The women who had joined the post of ASHAs had stepped out of the familiar environments of their family and community independently only after becoming ASHAs. However this was not the first time that the women had started working. All of the women were already working at their homes. They were involved in income-generating activities like labour in agricultural fields. The women's reasons for joining the ASHA post in addition, showed that they saw the post as an avenue towards personal space and growth. There were also some aspirations and the expectations of their families associated with this post. This Chapter takes the analysis further and explores the legitimacy of such aspirations from the ASHA post.

The focus of this Chapter is on the understandings about the responsibilities of the ASHA Functionary. The stakeholders from the health services at various levels were found to function in a different context than the ASHAs within the same work setting. Their understandings of the responsibilities of the ASHA Functionary therefore were not always the same as the ASHAs' understandings. The data revealed that there were two emergent dimensions of responsibilities across all the stakeholders. The first dimension of responsibility emergent from the perspectives was '***the location of the ASHA Functionary within the health services system***'. Section One presents this dimension. The second dimension of responsibility was '***the duties of the ASHA Functionary***.' Section Two presents this dimension. In this Chapter each perspective of the responsibilities of the ASHA Functionary is presented separately and within its own context.

A. THE LOCATION OF THE ASHA FUNCTIONARY WITHIN THE HEALTH SERVICES SYSTEM

This Section presents multiple perspectives of the location and the implications for the ASHA Scheme. The analysis moves from inside out that is starting from the ASHAs and going on to the different levels of the stakeholders from the health services. Data from various methods is presented in this analysis.

1. The Location of the ASHA Functionary according to the ASHAs' Perspectives

There were two facets of the ASHAs' perspectives which are discussed below.

1.1 ***Location according to ASHAs (facet one) :'ASHA Functionaries are a Part of the Public Health Infrastructure'***

An exploration of the ASHAs' lives showed that they identified themselves as a part of the public health infrastructure. Such identification could be a way of creating space for

themselves within the pre-defined roles played by them within their families and communities. Secondly, the manner in which the ASHA Scheme was implemented in the study location strengthened this perspective of the ASHAs although they were all well aware of the voluntary nature of the post.

"I will select the role of ASHA as a representative of the health services system. Because she works for health department, has a uniform and identity card and they respond to ASHA at the PHC and the Thane Civil Hospital. They give our patients precedence, talk to us as if we are mini sisters when they see our uniform. Once a patient needed blood and at the Civil Hospital the doctor and sister took me to the side and said, 'ASHA we have to give her blood.' I felt so proud. We too are highly trained by the health services system like the sisters."

((BS, 45, widow with graduate son who is working, has support of brother and wife)

A detailed analysis of the points of identification mentioned by the ASHAs as seen by the statement of ASHA BS was made. The analysis is from the ASHAs' perspectives.

1.1.1 *Points of Identification: Manner of Recruiting ASHAs*

Data in the preceding chapter revealed that the ASHAs were selected by the local stakeholders from the health services in the initial years of the Scheme and not by the Village Committees as mandated by policy (Box 5.1). The ASHAs related that the latest batches were selected by involving the Village Committees in some villages. However the local stakeholders from the health services like the ANMs, LHVs (Lady Health Visitors [senior ANMs]) and MPWs (Multi-Purpose Workers) continued to take an active interest in the selection of ASHAs in the block, perhaps due to a lack of suitable candidates, or pressures to fill the required numbers of ASHA positions. The ASHAs therefore essentially saw themselves as being recruited by the health services system.

Box 5.1

National and State Guidelines for the Selection of ASHA Functionary

NATIONAL NRHM GUIDELINES

"ASHA will be chosen through a rigorous process of selection involving various community groups, self-help groups, Anganwadi Institutions, the Block Nodal officer, District Nodal officer, the village Health Committee and the Gram Sabha."

Source: National Rural Health Mission, Maharashtra
http://www.mohfw.nic.in/NRHM/Documents/perf

MAHARASHTRA STATE NRHM GUIDELINES

"Village Health, Nutrition and Sanitation Committee will recommend three names of suitable candidates to Gramsabha.
Gramsabha will select one lady as ASHA amongst these shortlisted candidates.
Appointment letter of ASHA will be issued by Taluka Health Officer. "

Source: National Rural Health Mission, Maharashtra,
http://www.healthasha.maharashtra.gov.in

Case Study 1: Manner of Recruiting (SM)

SM is an ASHA who hails from a family of 13 members dependent upon a single land holding. She said her mother-in-law encouraged her to become a pada worker and agreed when she became an ASHA as well. The reason was the manner in which her appointment as ASHA was conveyed to her by the full time and experienced Multi- Purpose Worker (MPW) who had recruited her. Expectations from the ASHA post were clearly fostered by the stakeholders from the health services in terms of upward mobility.

"…I was already a Pada Worker, for that I am getting 300…The doctor (MPWs are locally called doctor) *enrolled me* (as ASHA)*, he told me I will get a few rupees more."*

It was also seen that the ASHAs had been recruited on grounds of their acquaintance with the local members of the public health services system, leading to a sense of identification.

Case Study 2: Manner of Recruiting ASHAs (CS)

CS is an ASHA who hails from the pre-dominant Kunbi (OBC) group. She has passed her 12th and has two diplomas. She said she wished 'to join' somewhere for work. She also said she really liked it when she was able to ensure that the women she escorted for delivery were able to receive the services of the doctor.

"*I did not know about this ASHA, my mother came here* (to the Primary Health Centre) *for treatment. Then RA sir* (Health Assistant, a full time and experienced worker stationed at the Primary Health Centre) *who is from our caste told her about this post and I joined. I got educated because I should get some position. There are reservations for our caste yet although I have applied earlier for other positions I have not managed to get a job."*

For the women who were fresh recruits also, the ASHA post was presented as a means to bettering their existing financial situation during recruitment. Such expressions came from the stakeholders from the health services who recruited them, encouraging the ASHAs to see themselves as doing 'paid work' of the health services system. It was seen that these were actually the beliefs of some of the full time personnel and they conveyed these beliefs to the ASHAs during recruitment.

"*At least they* (ASHAs) *get four paise for the house. Like this one…she used to be ill all the time. Now she is working regularly and she doesn't fall ill. We selected her because she is needy."*

(DC, Multi-Purpose Worker introducing an ASHA to the researcher in a Sub Centre)

1.1.2 Points of Identification: Association of the Health services system with the Entire Work Experience of the ASHAs

The selection, training, ongoing supervision and payments of the ASHAs were all completed by the members of the health services system.

The ASHAs reported to people from the health services system like the ASHA Facilitators and ANMs / LHVs in monthly meetings. Their duties were all related to the health services system.They got paid by cheque from the health services system after the ASHA Facilitator and ANM checked and signed their records.

The ASHAs who saw the various procedures of their post being handled by these stakeholders from the health services had a sense of identification with the health services system.

1.1.3 Points of Identification: The Common Use of Terminology with the Stakeholders from the Health Services

Some common terminology was used across all stakeholders like some technical terms. As a result of the training, ASHAs used terms like "***kuposhan*** (malnutrition)", "***BS*** (blood sample)", "***Caesarean delivery***" etc. with the ease of daily habit like the stakeholders from the health services. Every ASHA was well versed with these terms. Use of such formal terms gave a sense of technical expertise to the ASHA. The programme terminology was also identical at all levels of the health services system. For example the members of the community were referred to as "***laabhaarthi*** (beneficiaries)" by all including the ASHAs who were basically members of the same community. Other terms like "***maata***" for the expectant mother were the same across the line from the doctor to the ANMs to the ASHAs.

Some short terms were used uniformly among the ASHAs themselves – for example the Caesarean delivery was called "***Caesar***" in short by all ASHAs even when talking to the . stakeholders from the health services.The use of a common terminology with the stakeholders from the health services had given the ASHAs a sense of pride and identification with the the health services system.

1.1.4 *Points of Identification: The Symbols of Identification and Recognition Provided by the Health Services System*

The ASHAs were given sarees as uniform just like the full time Anganwadi Workers. The other cadre of health providers who were given uniforms were their supervisors namely the ASHA Facilitators and the ANMs. They had been given appointment letters. The post also granted precedence of service to the patients escorted by ASHAs at the government centres. The preferred treatment to 'their' patients increased their pride in their villages as the patients witnessed this treatment.

"*When they give blood to the women brought in by me I feel good. We go to the Hospital or Primary Health Centre and they see us in our uniforms they immediately let us come in and therefore the patients also benefit.*"

(MJ, ASHA, former gram panchayat member, Adivasi, husband/self-active citizens)

However such a response was restricted only to the delivery patients or the seriously ill patients referred through the ASHAs. As seen in the following Section, the central ASHA Scheme policy document has focused on the ASHA Functionary's responsibilities in terms of awareness-building and 'activism'. At implementation level however, no such comparable backing was provided for tasks like health education or advocacy for the rights of the community

to the ASHAs. ASHAs were thus reinforced to remain within the circle of public health functions with a firm focus on facilitating institutionalized deliveries.

1.1.5 Points of Identification: Being Sole Decision Makers In Their Own Villages

"Once a woman was still in jeep (on the way to the primary health centre for delivery) *and she delivered. I had somehow convinced them to take her to the PHC but even in that condition her family did not agree to take her to the hospital. So I persuaded them somehow to go to the Sub Centre at least. There I phoned the sister* (ANM) *and the doctor of the PHC came to the Sub Centre with everything and helped her. She needed stitches. Now she is alright."*

(MJ, ASHA, former gram panchayat member, Adivasi, husband/self-active citizens)

As frontline workers, a responsibility that had also been entrusted by the central NRHM policy, the ASHAs were often in a situation of being sole decision makers in critical conditions for their community. This decision-making responsibility that fell upon them due to their presence as the sole representative of the health services system in the village, also added to their feeling of alignment with the health services system as they made decisions for the health services system (often by default).

1.1.6 Points of Identification: ASHA as the First Point of Contact for other Health Functionaries

For the stakeholders from the health services visiting the village the ASHAs' residence was the first point of contact. Another point of contact was the home of the Anganwadi Workers. All those related to the public services depended upon these functionaries to show them around the village, and their homes were the transit points. This built the sense of identification of the ASHAs with the health services system.

With so many points of identification with the health services system it was logical for the ASHAs to have expectations from the system as well. A sense of entitlement was a governing theme in the ASHAs' expressions.

*1.2 **Location according to ASHAs (facet two) : 'Awaiting Changes: A Sense of Entitlement from the Health Services System'***

Seeing themselves as a part of the public health infrastructure, the ASHAs expressed a sense of entitlement from the health services system for their post.

1.2.1 Sense of Entitlement: Dissatisfaction with the Physical Setting among ASHAs

The first indication of the sense of entitlement was derived from the ASHAs' observations about the physical setting of their ASHA monthly meetings.

The ASHA monthly meetings were held at their respective Primary Health Centres (PHCs). ASHA meetings were the only avenue for the ASHAs to regularly meet their peers and the other stakeholders from the health services. The ASHAs typically met in a hall within their respective PHCs in the morning hours during a fixed day in the month. The halls had a fan and mats were spread out on the floor where the ASHAs sat for the better part of the day.

Despite the provisions under NRHM for up-gradation of infrastructure, many of the PHCs had retained their older structures. The quality of the meeting halls differed among the PHCs ranging from separate constructions to a semi-pucca room outside the PHC with a tinned roof and leakage during the rains. There were no other amenities in the halls and ASHAs were expected to go to the main PHC building for water and toilets. Typically in all PHCs, tea or food needed to be ordered from a distance and the ASHAs carried their own food.

As seen earlier, the ASHAs had identified themselves as a part of the health services system's infrastructure. However ASHAs spoke in terms of '*us*' and '*them*' when talking about the amenities in the meeting hall. Seeing themselves as working for the health services system just like the other stakeholders, they were not resigned or disappointed but indignant because they were not getting the expected treatment. Their expressions indicated a sense of entitlement from the health services system.

"Do you see there is not even a toilet for us? They tell us to use the women's ward toilet. Suppose we get an infection? There is always a risk…" (ASHA)

"They call us for the whole day and do not even offer us a glass of water. The ASHAs are continuing to work but they are upset (***naaraaj***)**."** (ASHA)

1.2.1 Sense of Entitlement: ASHAs' Perspectives about their Incentives and Tasks

The ASHAs' sense of entitlement from the health services system was made most visible in the ASHAs' expressions about their remuneration. Remuneration was a topic on which the ASHAs expressed themselves the most, probably because it was the most visible manifestation of their location within the health services system. They expressed several difficulties with the current remuneration system (Box 5.2). These difficulties gave them a sense of entitlement.

The prevalent understandings among the ASHAs about the task-incentive balance also enhanced a sense of entitlement because the ASHAs had little information or control over the remuneration system.

A) View of the task-incentive balance as a one-on-one arrangement

“Women feel better because I go with them for delivery and stay until it is done. We have no objection to more work because we get to learn something new. But the load on ASHA increases every month and the payment is not there.”

(MS, ASHA, 30, OBC, widow, family occupation daily labourers, wrote that she likes the work, needs the work and wishes to spend this life in social service)

An important aspect regarding the performance – based incentive arrangement was that it had brought a perspective of seeing the work as broken into tasks. Secondly it brought in the perspective that every task should be accounted and paid for. The ASHAs and other stakeholders were aware of their voluntary status but did not see their work as partly incentivised voluntary work. This was a failure of communication/training/understanding. Among the ASHAs, the altruistic nature of

Box 5.2

Difficulties in the Current Remuneration

System: Perspectives of ASHAs

Non Paid Tasks

ASHAs said there were many tasks for which they received no payment.

One major activity under this head mentioned by ASHAs was of escorting those women for institutionalised delivery that were not covered under the Janani Suraksha Yojana (JSY). ASHAs paid for their own travel and that of the mothers in advance which was not always reimbursed. They also paid for their own food during hospital stay.Claiming this amount had its attendant difficulties like non-cooperation of the sanctioning authorities.

The view that the ASHAs were not paid for some tasks was also triangulated by system stakeholders.

"*ASHAs work even if they get nothing*."

(MPW from a sub centre in the presence of ASHAs)

"*Many of the ASHA tasks are without payment. Earlier they were not bringing in women not covered under the JSY for delivery because they are not paid. Then we told them that it is a service to women .If the women or children die they will get curses for being a part of wrong doings (***shraap). *Now they bring all the women even if they get nothing.*"

(ANMs of a PHC, ASHAs were not present during the conversation)

Low Paid Tasks

Payment of some tasks was very low like submission of one malaria slide at rupees ten. There were sub-tasks that required time and money at the ASHAs' expenses.

"For one malaria slide it is 10 rupees but if we bring the slide or the patient to ***dawakhaana*** (for diagnosis after initial detection by ASHA) *we are not paid for transportation."* (ASHA)

Advance Payments

The ASHAs said they were making advance payments for travel fares for escorting mothers for institutionalised deliveries which was difficult for them. A previous study on ASHAs has also mentioned this difficulty (NHSRC 2011).

Although the administration claimed that they had arranged for fixed rickshaw vendors who would wait for the payment it was not always the case. The jeep owners too did not wait for the payments so the ASHAs were making payments. Similarly advance payments were made for travel for trainings and meetings which were reimbursed later. ASHAs complained that there were hitches in getting reimbursed in terms of delays, non-cooperation from the signing authorities to release the money and getting part reimbursement of the money spent.

their responsibility was seen as a source of non-tangible gains but this was disassociated with the tangible gains. An improvement in the tangible gains from tasks was awaited.

B) Lack of clarity among ASHAs/administrative mishandling of the entitled incentives

When asked about what were the amounts they received, the ASHAs could recall just a few of the incentives from the rate chart of ASHA incentives (Box 3.3). The incentives they could recall were rupees 600 for escorting women for institutionalised deliveries under the Janani Suraksha Yojana (JSY) and rupees 100 each for attending the ASHA meeting and as travel allowance for escorting a pregnant mother not covered under the Janani Suraksha Yojana for institutionalised delivery. Of these the correct amount was only mentioned for the JSY. The amounts of the other tasks as mentioned by these ASHAs were less than the rate chart (the rate chart had mentioned rupees 150 for the ASHA meeting and rupees 200 for travel). This could be a case of poor recall by the ASHAs or administrative mishandling of incentives.

C) Lack of access to the rate chart of incentives

ASHAs had been given a chart with the amounts of incentives offered for each task during the training but many ASHAs had long misplaced it. The rate chart were meant to be displayed at all Primary Health Centres and Sub-Centres. However, just one Primary Health Centre out of the nine in the block had displayed it. None of the Sub Centres that were visited had displayed the chart. ASHAs thus had no reminders of the amounts to be claimed except from their own records and memory.

> *"For Leprosy treatment of 1 year we get 400* (rupees)*, half year we get 250* (rupees)*. For Malaria ... 5 rupees for detection of suspected case. If found positive then for 14 days treatment we get 25-50* (rupees)*. I have never got anything for getting DOTs treatment completed, is it to be done free? For JSY* (Janani Suraksha Yojana) *we get after months. For meeting we get regularly. Other payments I don't remember. We were given a printed form* (rate card of incentives) *but I don't have it. "*

(JS, ASHA, 40 years, former pada worker, last payment received less than rupees 1000, cited reasons of social service and economic need for accepting the ASHA responsibility)

Besides the pressures from the family, the findings showed that there was also a basic sense of insecurity because the understanding about the incentive amounts for various tasks was not clear among all ASHAs. The task-incentive health services system left some ASHAs feeling unsure of their claims for the work they had completed. ASHAs also reported that there were varied time frames for different tasks and that too increased the sense of insecurity among the ASHAs.

D) Lack of channels to address the difficulties regarding incentives

The ASHAs also felt that there were no avenues within the health services system for them to express their difficulties.

"*We should get all our incentives regularly. Recently I got 3 years arrears' all at once for JSY* (Janani Suraksha Yojana). *For all the other tasks, the doctor* (MPW) *told me*

to forget the past years and start fresh records. How can we just forget? We are aware of what we should get but if we protest…(gestures towards her neck). "

(DA, ASHA, a dalit woman from an economically stable family, [mobility case study 2 in chapter four])

The stakeholders from the health services saw the situation differently. An ANM admitted to not displaying the chart outside her Sub Centre in order to protect the ASHAs from the constant questioning about their payments from the families and the community.

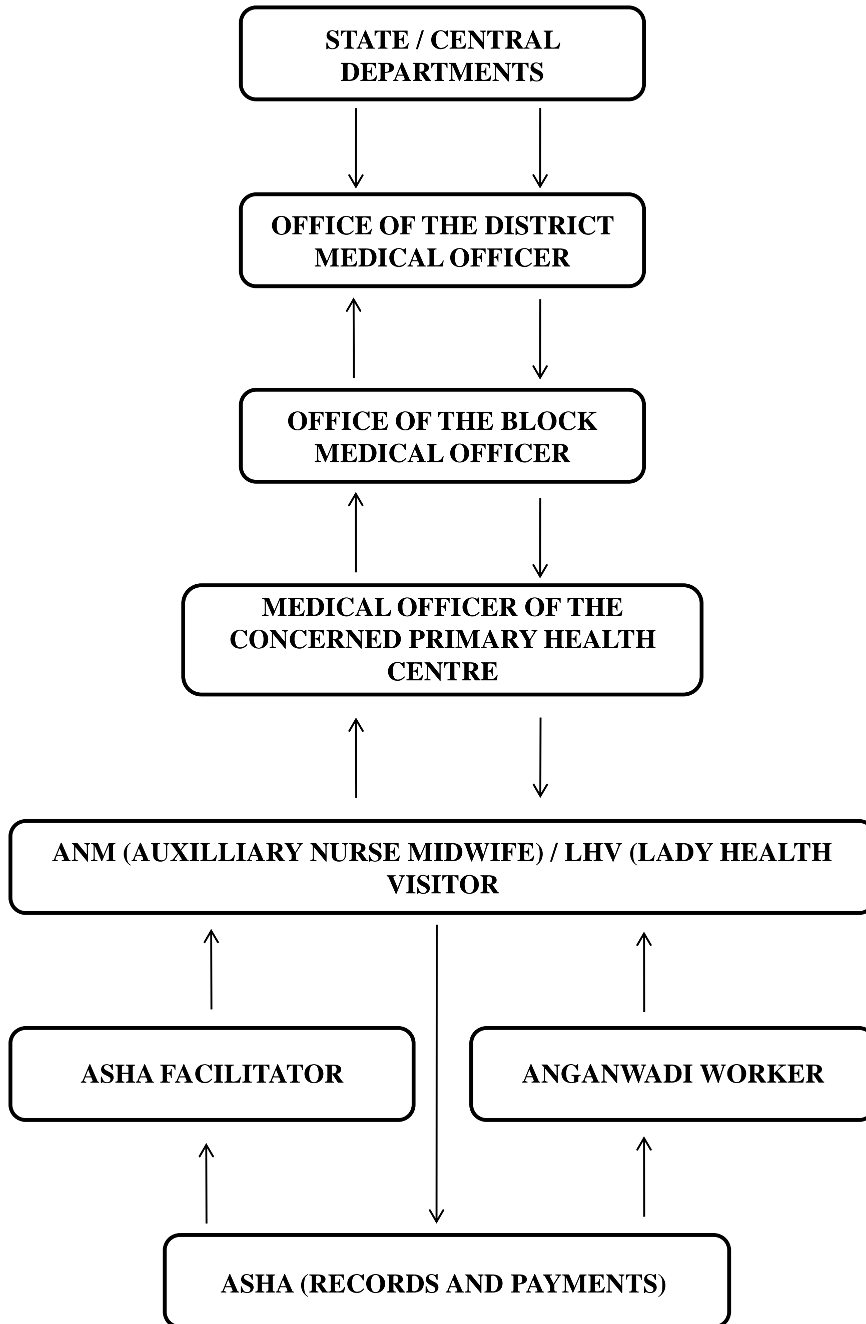
"*I have the chart and we are supposed to display it. I don't because they* (ASHAs) *will be questioned all the time…they suffer from both ends* ***(teela doonhee baajuni maran)****."* (ANM in a Sub-Centre)

The chasm between the perspectives on this one aspect of payments illustrates how the location of the ASHA Functionary was viewed so differently. According to the ASHAs, and their sympathisers from the health services system, the delays in receiving incentives were a serious enough matter to trigger absenteeism/attrition and needed to be addressed by the health services system (Chapters Three and Four).

On the other hand interviews with the stakeholders from the health services revealed that they were aware of the delays but attributed it to the lengthy administrative procedures (Figure 5.1) not due to paucity of funds or any other resistance from the health services system. According to their seniors, the LHVs and the Medical Officer, lack of advance planning at the Sub Centre level by the ANMS who were in charge of the accounts for (continued ...)

Figure 5.1

Procedure of Procuring ASHA Incentives



ASHAs was also a factor for the delays. The ANMs on the other hand pleaded a lack of time in an overburdened schedule for the task of accounting for the ASHA incentives.

"*I have 5 ASHAs and 5 Village Water Supply Health and Sanitation Committees in our Sub Centre. The load of accounting has come upon us ANMs. I wish it could be transferred to Multi-Purpose Workers. We are not able to manage it in time."*

(ANM in the most remote Sub Centre visited during data collection)

The two perspectives on the current incentives reflected the two views of the location of the ASHA Functionaries: for the ASHAs, it was a denial of their rights and for the stakeholders from the health services it was an additional responsibility; where the needs of the ASHAs were acknowledged but not seen as something that could be addressed by them. However on the individual level there was a tacit acceptance among their seniors that the ASHAs should get a secure position and payment. This was a source of encouragement for the ASHAs to see their remuneration as their right. There were many expressions for a change particularly for remuneration of ASHAs, some within their hearing as well.

"*I don't know what is the future of the ASHA Scheme but they are useful. They are working for all the national health programmes. They should be given some security – for position and income."*

(ST, LHV [Lady Health Visitor, a senior ANM located at a PHC] and supervisor of ASHAs)

Thus the task-incentive arrangement was the most visible symbol of their present location to the ASHAs and they looked for changes in it. Their emotions were tied into the aspect of remuneration. In this they were also encouraged by the expressions of the stakeholders from the health services who were their seniors and expressed hope for change in their individual capacities but not in their official positions where ASHA incentives were a matter of set procedures and one of the tasks in a busy day.

The immediate supervisors namely the ASHA Facilitators were the most articulate in their expressions for entitlements for the ASHAs and the one level of stakeholders from the health services that even expressed this in their official capacity.

"The ASHA should get a monthly payment that is what I say from my heart."

(ASHA Facilitator's written observation)

2. The Location of The ASHA Functionary according to the ASHA Facilitators' Perspectives

This Sub-Section presents the perspectives of the immediate seniors of the ASHAs namely the ASHA Facilitators, about the location of the ASHAs.

The ASHA Facilitators were appointed to supervise the work of the ASHAs. This level of stakeholders was the closest to the ASHAs in terms of hierarchy and proximity. Several points of similarities had been observed with the ASHAs in their working conditions as well. For instance, unlike the other full time workers of the health services system, the ASHA Facilitators were comparatively newly recruited under the NRHM like the ASHAs. The Facilitators were also contractual workers like the ASHAs and most were in their first paid position. They had the same post related privileges of uniform and identity. They were paid a sum of rupees 3000 per month but it was not a salary as it was calculated as a daily incentive over 20 working days. In their personal lives too, these women were all from the local areas like the ASHAs.

2.1 The Location of ASHAs according to the ASHA Facilitators' (Facet One): ASHA Functionary As 'A Partner In Their Own Struggle For Rights'

A survey was conducted on the ASHA Facilitators where all the 29 ASHA Facilitators in the taluka had been administered the same self- answered questionnaire as the ASHAs. Box 5.3 presents the profile of the ASHA Facilitators with the similarities and differences as compared to the ASHAs.

The data from the survey showed that the Facilitators were likely to have expectations of better job security from their own post because they were well educated and already full time workers of sorts in the health services system. The altruistic expectations from them in this 'job' might have also been learnt by them after joining, because they had little direct contact with the community in the course of their work. Hailing from comparatively more financially and socially powerful families, the Facilitators were also better placed to take up the cause of their own security. There were variations in family income levels but homogeneity of gender and working conditions amongst the Facilitators. A similar homogeneity of the Facilitators was also existent with the ASHAs. Therefore it was logical that there was a high degree of affinity towards the rights of the ASHAs among the Facilitators.

Box 5.3

Similarities and Differences between ASHAs and ASHA Facilitators

SIMILARITIES	DIFFERENCES
(A) The Demographic Profile I. **Gender**: All the 29 ASHA Facilitators were women as were the ASHAs. II. **Age Group**: There were 24 ASHA Facilitators between 25-30 years of age, four were between 30-35 years old and one was more than 35 of age. The highest numbers of ASHAs were also in the same age group of 25-30 years. III. **Marital Status**: All the ASHA Facilitators except one woman were married like the majority of the ASHAs. IV. **Family Size**: Like the ASHAs there were almost a proportionate number of small and large family sizes among the Facilitators. The largest number of Facilitators (14), were from smaller families with 1-5 members. There were 11 Facilitators having 6-10 family members while four Facilitators had more than ten family members.	**(A) The Demographic Profile** I. **Caste**: ASHA Facilitators predominantly came from the dominant caste group of the district namely the OBC group of Kunbis. There were 26 OBCs, two Adivasis and one Neo-Buddhist among the Facilitators. However the ASHAs came from a mix of caste backgrounds with a wide representation of Adivasi groups. II. **Family Occupations**: Like the ASHAs the major source of income for their families was agriculture but the data indicated larger family land holdings. Only two of the Facilitators reported to their family members doing casual labour on others' lands, while 16 Facilitators reported working only on their own land. The difference also lay in the nature of self-employment avenues among family members. There were 13 Facilitators who said their family members also had their own enterprises. These were income generating occupations like milk-retail, photography, tuitions, sand supply, tailoring etc. Seven of the

Continued...

SIMILARITIES	DIFFERENCES
(B) The Working Conditions I. **Number of years in service**: Most of the women had spent two to three years in the post (25 Facilitators). The rest had spent up-to two years while one Facilitator did not respond to this question. This profile was similar to that of the ASHAs. II. **Payment**: ASHA Facilitators were also paid incentives like the ASHAs. All the Facilitators had received the same amount of rupees 3000 as their last payment because they had fixed incentives (rupees 150 per day for 20 days/month). However like the ASHAs their payments too were delayed. Just six Facilitators said they had been paid that month. Five Facilitators got paid in the previous month, and as many as 18 of the 29 Facilitators wrote that they had not been paid for more than two months. These were Facilitators from across five Primary Health Centres. III. **Travel**: The Facilitators travelled like the ASHAs as they had to follow up with the ASHAs in their villages as well as to attend the respective ASHA meetings. All of the Facilitators had travelled in the previous week, with 21 Facilitators writing that they had spent more than 12 hours travelling in the past week. The figures ranged from 25 to 40 hours. Four Facilitators each had travelled from 9 to 12 hours and from 5 to 8 hours respectively.	Facilitators had a family member in a job like teacher, peon, security person etc. These were multiple responses indicating a higher standard of living than the ASHAs. III. **Family Income**: There were wide differences regarding monthly family incomes among the ASHA Facilitators. Almost half of them (14 Facilitators) reported family incomes above rupees 3000 but the range was wide from rupees 5000 to rupees 30,000 per month. The rest of the Facilitators reported family incomes lower than rupees 3000. Among the ASHAs there were few differences regarding monthly family incomes among the ASHAs as the women all hailed from poor families having incomes less than rupees 3000 across the caste groups as seen from their backgrounds. IV. **Educational Qualifications**: The educational qualifications of the ASHA Facilitators were higher than those of the ASHAs but there were wide variations within that. There were 11 Facilitators who had passed 12th standard, 14 graduates (Largely BA), one undergraduate, and one BA Bed. and MA Bed. each. Additionally between these 29 women, 20 held diplomas or had done courses in a variety of subjects like nursing, beautician, typing, MS Office etc.

Continued...

SIMILARITIES	DIFFERENCES

IV. **Mode of Travel**: Like the ASHAs, the ASHA Facilitators had walked (28 Facilitators), used the public bus (19 Facilitators), used a jeep (25Facilitators) and a rickshaw (16 Facilitators). These were multiple modes of travel therefore these were multiple responses. The ASHAs too had reported travelling in the previous week and using these multiple modes of travel but unlike the ASHAs their Facilitators did not travel by ambulance. This is because the ASHAs were required to escort women for institutionalized delivery but not the Facilitators.

IV. **Reasons for Joining**: There were multiple reasons like the ASHAs and the reason of doing social service was cited by the highest number of Facilitators as in the case of the ASHAs as well with 17 Facilitators citing this reason out of 29.

It was surprising that 7 Facilitators mentioned a reason 'reaching timely service to the village' as they were not direct service providers.

(B) The Working Conditions

Reasons for Joining: Economic gains were indicated as a reason by more Facilitators than ASHAs. Unlike the ASHAs where about a quarter of the total ASHAs had cited reasons of economic gain, here a third of the Facilitators that is 9 women cited economic gain for their family and 5 women cited financial independence for themselves. Use of educational qualifications was cited by more respondents (10 Facilitators).

Unlike the ASHAs, where more than 10% had given reasons of self-expression just four Facilitators had cited this reason. In fact this was the main difference that although the altruistic reasons were mentioned by many, reasons of professional growth stood out more among the Facilitators than the ASHAs.

The ASHA Facilitators saw the ASHAs as co-workers in a struggle for their rights along with the Facilitators themselves.One major and lasting impact of the Facilitators upon the ASHAs was that the Facilitators often brought up the difficulties of the ASHAs in meetings but to scant attention by the senior stakeholders. The voluntary aspect of the ASHA post was not acknowledged by the Facilitators. They saw the ASHAs as '***partners in a struggle for rights within the health services system***' rather than as volunteers receiving an incentive. In the process a greater focus on the remuneration aspect was created although the Facilitators too were aware of the altruistic aspect of the work of the ASHA functionaries. The ASHAs strengthened their identification as workers of the health services system and their sense of entitlement to better working conditions.

2.2 Location according to ASHA Facilitators (Facet Two): The ASHA Functionary as a Junior Partner

The Facilitators demonstrated a protective nurturing approach, calling the ASHAs they supervised as "*my ASHAs* (**maajhi ASHA**)" in the ASHA meetings. They took up the cause of ASHAs' difficulties with the local stakeholders from the health services. In one of the Primary Health Centres, the Facilitators actually joined hands to get the delayed dues of the ASHAs released by threatening the PHC medical officer with mass resignation and were successful in getting the incentives released. There was another aspect of such "protectiveness" as it was a benevolent manifestation of dominance (ASHAs' work aided their own too).

There was a joint union of the ASHAs and the Facilitators in the study location. The office bearers were from outside the health services system. It was observed that the Facilitators took the lead to organise the attendance of ASHAs in the joint protest marches including escorting them to distant venues. The ASHAs were observed to be aware of the union activities but not involved as office bearers. There was widespread involvement in joining protests but the ASHAs' knowledge was limited and participation was passive. It appeared that the participation was activated by the Facilitators. For the ASHAs, it was the financial lose in terms of membership fees and travel expenses to venues for protests that had made an impact. To some ASHAS the union "*gave hope*". The kind of awakening that the unions might have aimed for was expressed by one ASHA who said that the union had made her aware of the fact that the ASHAs had rights.

Box 5.4

Voices of ASHA Facilitators about the ASHA Scheme

Advocacy for increased Incentives: *"The ASHA will become a mini sister in her village…The NRHM administration should not give her incentives but a salary."*

"I come to know in the villages that the ASHA appointed by the NRHM is getting a lot of response. But the payment they are getting breaks the heart."

"I sincerely feel that the ASHA should be involved but attempts should be made to get her suitable payment."

Advocacy of ASHA's contributions: *"There was no consideration for the woman at all and it was said that she is meant only for doing work but today attention is paid to all. My ASHAs and me are firm that we will reach where the sister (ANM) has not reached and therefore we try to get all the knowledge we can."*

"ASHA is rated higher than any ANM, MPW or doctor."

Advocacy for acknowledgement of ASHAs by system: *"I have a good communication with the MPW and ANM. But the ANM feels that the ASHA is not co-operating with us…It is important that the ASHA, ANM, MPW and NRHM should be united."*

ASHAs' Rights within the system: *"The administration has allotted so much money for NRHM but it is not reaching the beneficiaries because the associated employees are fulfilling their own needs. The scheme and the compensation offered to ASHA should be strictly complied with. My ASHAs work but do not get paid and that is a serious matter."*

"ASHA is identified as a social worker but she too has needs therefore the administration should think about her. ASHAs are economically weak that is why they go walking through the villages and padas and do this work."

3. The Location of the ASHA Functionary according to the Health Services Stakeholders' Perspectives

The local stakeholders from the health services did empathise at their individual levels with the concerns of the ASHAs yet were also participants in the processes that aided the alienation of the ASHAs. To understand this dichotomy it is necessary to first look at the general nature of interactions and communications within the public health services system. This will contextualize the gaze of the stakeholders from the health services towards the ASHAs.

3.1 The Hierarchical Nature of Interactions and Communications within the Health Services System

The hierarchical in nature of the Indian public health services system is manifested in all aspects of its functions like job allocation and reporting health services systems. Observations carried out during data collection showed that a culture of deference towards the seniors was built into the daily interactions. The same deference was seen also from the women towards the men in the health services system. This is related to the patriarchal nature of the medical profession (Jones 1994, Iyer and Jessani 1995).

3.1.1 Deference To Seniors And Men As Manifested In The Daily Interactions

The hierarchy in the public health services system was manifested daily by the simplest of matters like the seating arrangement. It was observed that an ANM would never sit in the presence of the medical officers in the Primary Health Centres even when the morning OPD clinic ran into six hours or more. When the ANMs in their turn entered the Sub Centres, the ASHAs would then remain standing. When a MPW entered the sub centre, the ASHAs would remain standing and the same behavior was seen by the Anganwadi helpers in the village Anganwadi as well. When asked, the ANMs, ASHAs and Anganwadi workers gave the same reply: "*It is not fitting to sit in front of seniors*".

At times the ANMs and LHVs who were women, had more years of experience as compared to the Medical Officers, still the deference was seen in behavior. However the male Multi-Purpose Workers (MPWs) and Health Assistants (HAs) that also had more years of experience would use that power to negotiate with the Medical Officers about the work allotted to them. These were the middle rung within the block health administration but with the maximum years of experience in the health services system.

3.1.2 The Hierarchical Pattern of Supervision

A hierarchical orientation was most visibly demonstrated in the processes of supervision. The stakeholders of the health services system were seen to encourage complete compliance of terms of service. Iyer and Jessani (1995) had mentioned how the hierarchical nature of relationships between the Medical Officers and the ANMs reduced whatever bargaining powers that the ANMs might otherwise muster. The current study also showed the same.

*"Just yesterday some NRHM (*National Rural Health Mission*) senior officials had come. They fired me* (rebuked me) *so badly for the home deliveries* (the health services system has set a target of 100% institutionalised deliveries from all villages). *They were scolding for so long because ANMs* (Auxiliary Nurse Midwives*) don't stay in the Sub Centres. There is no light and water in Sub Centres, how can they stay? Then I decided… one of the Sub Centres has light but no water. Now we have decided that ANMs can stay there in shifts."*

(A LHV [a senior ANM located at a Primary Health Centre] with 27 years of experience)

This study reveals a top-down approach of supervision across all levels of the stakeholders in the health services. There were no formal avenues to redress grievances in the health services system and the hierarchical approach discouraged any form of dialogue with the superiors. This pattern came from the top level of the stakeholders from the health services consisting of largely male doctors towards the middle order of the stakeholders from the health services like the LHVs (Lady Health Visitors), ANMs, male MPWs(Multi-Purpose Workers) and male Health Assistants (HA). Even as the middle order of stakeholders from the health services suffered this approach, they still replicated it down the line to their juniors in the health services system as a matter of course.

Coming from such a strict hierarchical orientation themselves, it was logical that it would be extended to the ASHAs by their seniors as well. This was the overall context within which the middle order and senior block level stakeholders from the health services had located the ASHA Functionary.

3.2 The Location of the ASHA Functionary according to stakeholders from the health services

Investigating stakeholders' views on a sensitive subject like the location of any worker within the health services system is difficult. It was observed that the ANMs and MPWs were particularly reticent about giving their opinions. The other stakeholders from the health services spoke more but tried to be 'politically correct.'

3.2.1 Location (Facet One): 'As the lowest level within the health services system's structure' in terms of supervision

The researcher attended a meeting of ASHA Facilitators that was chaired by the highest authority in the Block, the Block Medical Officer. The agenda of the meeting was to guide the ASHA Facilitators for effective supervision of ASHAs. In the meeting, the ASHA Facilitators were conveyed the manner of supervision of ASHAs that was required by the health services system by their seniors. The hierarchical nature of supervision required by the health services system was made clear by the Block Facilitator who repeatedly used the word 'controlling' for supervision. In the context of the ASHAs he repeatedly said to the ASHA Facilitators that:

"*We are here for controlling you and you are here for controlling the ASHAs."*

This hierarchical approach was reinforced by the fact that the ASHA Facilitators were commonly referred as '*Block Supervisors'* by their seniors in the health services system. A formal manner of supervision was expected as manifested in the Supervisor's assertion that ASHAs need not be treated in a personal manner. The Facilitators were being encouraged by the senior supervisors to treat ASHAs in a formal way thus subverting any empathy towards them.

*"The ASHA's responsibility is an official responsibility so treat them in an official way not as a personal interaction (**gharghuti vyavahaar karu nakaa)."***

A) Approach towards the Difficulties of the ASHAs according to stakeholders from the health services

The prevalent norm of 'compliance without complaints' of the middle order towards their seniors was applied by them in turn to the difficulties of the ASHAs as well. This was seen in the meeting when the ASHA Facilitators attempted to share the difficulties of the ASHAs. Many ASHA Facilitators brought up the issue of the delayed payments of the ASHAs but these were repeatedly ignored in the meeting. The expectation was conveyed that the ASHAs should accommodate their difficulties.

For example, in the meeting an ASHA Facilitator brought up a point that the Anganwadi worker was asking an ASHA under her area for a portion of her incentive. The medical officer at the PHC was not responding to this ASHA's complaints. The response of the Block Facilitator was, "*If your seniors are not paying attention why do you want to take it up?"* The Block Medical Officer did not participate in this discussion at all.

B) Replication of hierarchical processes and approaches at the PHC Level

The processes of the ASHA monthly meetings at the PHCs showed an almost perfect replica of the hierarchical patterns at the Facilitators' meeting (Matrix 5.1).

The monthly meetings of the ASHAs at the PHCs were conducted by the middle order namely the LHVs, MPWs and Health Assistants (Has) at the PHC level. These stakeholders were also the ASHAs' trainers and supervisors, therefore there was a strong sense of their being in charge of the meeting. As seniors they maintained a distance and dignity from the ASHAs and focussed on task compliance. 'Softer' elements of team building or strengthening the communications were conspicuously absent in ASHA meetings.

The ASHA Facilitators also attended the ASHA meetings as a part of their work.The agendas of the ASHA meetings were generally limited and covered reporting from the ASHAs to their seniors. The agenda was restricted only to co-ordination and information-giving activities from the seniors to the ASHAs. The ASHAs largely listened and expressed no difficulties except in the logistics. Record keeping was emphasized heavily.

The ASHAs were wary of conversations even among themselves and only spoke when spoken to. They were more communicative when they were not in the presence of the seniors. In some PHCs when there were joint meetings for the ASHAs and the Anganwadi workers, both sides kept to themselves and their reporting authorities were separate as well. The direction of communication in the meetings was in the top- down manner.

Matrix 5.1

Hierarchical Approach of the Health Services System: Observations of Meetings

STAKEHOLDER	SEATING	PARTICIPATING IN MEETING	INTERACTION WITH OTHER PARTICIPANTS	VIEW OF ASHA SUPERVISION (Manifested)	APPROACH TO ASHAs (Manifested)
Medical Officers	Chair	Soft spoken, doing most of the talking , focus on task completion by ASHAs	Formal e.g., unsmiling, no food/drink	Overall In-charge.	No engagement with ASHAs' issues, sharing NRHM goals.
Block Facilitator	Chair	Loud, communicative, confident	Competing with BMO: e.g, interrupting, at ease: called for special beverage	Regimentation, Trainer, big brother	No engagement with ASHAs' rights, focus on tasks completion by ASHAs
Block Supervisor	Chair	Less talk but confident	"Hardware provider" e.g., facts, figures	Trainer big brother	Realistic but not willing to engage on ASHA's rights
LHVs, MPWs	Chair	Less talk in front of seniors. In-charge at ASHA meeting	All deferential to seniors, women to men. With ASHAs, facilitators: kind but formal.	Official Trainer, big brother/sister	Sympathetic but non-commital
ASHA Facilitators	Floor Chair	Largely listening with seniors. With ASHAs: Sharing of difficulties	Respectful, Cooperative e.g., had the refreshments	"How to manage": concrete issues representing rights of ASHAs	Senior to junior, nurturing, big sister
ASHAs	Floor/Standing	Largely listening	Respectful	Clear about needs, difficulties	Sense of entitlement from system

The seating arrangement also revealed the hierarchical positioning. ASHAs sat on the floor while all the others sat on chairs. The ASHA Facilitators, who had sat on the floor in the Facilitators meeting with their seniors, sat on chairs in the ASHA meetings.

3.2.2 Location (Facet Two): A lack of Ownership in terms of acceptance

There was a deep chasm between the supervision pattern of the ASHAs and the acceptance of the other mandates of the ASHA Scheme. On the one hand the style of supervision of ASHAs was hierarchical thus putting the ASHA Scheme in line with all the other functions of the health services system. On the other hand the manner in which the other mandatory requirements of the ASHA Scheme were handled by the stakeholders from the health services reflected a lack ownership. One of difficulties mentioned by ASHAs was non-reimbursement of advance travel expenses (Box 5.2). The interface on this one issue revealed the lack of ownership (Box 5.5).

Box 5.5

Ownership: The Interface between the ASHAs

and the Stakeholders

Issue: Non reimbursement of travel expenses made by ASHAs in advance

When the village achieves 100% immunisation the ASHA is supposed to receive a one- time incentive from the Village Health and Sanitation Committee. The travel expense of ASHAs for escorting women who were not eligible under the Janani Suraksha Yojana and for escorting seriously ill patients is also supposed to come from the untied funds of rupees 10,000 allotted to every Village Health and Sanitation Committee. The ASHAs pay for the travel in advance and are supposed to claim for it later. The claim is supposed to be processed by the Village Committee. In practise however, it was two system stakeholders – either the Anganwadi Workers or the ANMs - that sanctioned the amount. The Sarpanch then signed for it. The Village Committee was largely not involved as mandated.

ASHAs' Perspective:

ASHAs reported that many times the Anganwadi Workers or ANMs did not agree to sanction the travel amount that they had already spent in advance, making it an out-of-pocket expense. They had to face humiliation at home on this count. Several ASHAs felt there was non-cooperation due to a sense of rivalry coming from "that side". This rivalry was extended to snatching credit for referrals of cases where they were entitled an incentive so that their incentives were denied to them. "*The record of ASHAs in this PHC is zero because they say they brought all the cases not us".* (ASHAs of one PHC)

Continued...

The vulnerability is underlined by the fact that in one of the villages, the members of the Village Water Supply, Health and Sanitation Committee said that the ASHA of their village was on the verge of resigning against their wishes because the Anganwadi worker had held back the ASHA's 2400 rupees. They were not aware of their own powers in the situation. One of the members had begun to supply his own vehicle for travel to prevent an escalation of the situation. The ASHA said *"I am unable to bear the insulting words… every time I ask she says you are a nuisance imposed on me* (**dokyaawar basawlee aahe)** *".*

System's Perspective:

Block Medical Officer: *"An amount of 10,000 rupees is annually given to each village through the Village Water, Health and Sanitation Committee.*

The process of routing the money is from the District Health Office to the Block Health Office. From here we sent it to the joint account of the Anganwadi Worker and the Sarpanch in each village. The entire amount is paid in one lot into the account.

We have received directions from the Head Office for the formation of Village Committee in each village on basis of NRHM norms. The spending pattern is told to the Anganwadi Worker during the training period. There are written guidelines with the Anganwadi Workers. The directions for spending as given to the workers are to give 100% for transportation of the critically ill and mothers not covered by the Janani Suraksha Yojana. They are also to be given a fixed amount for toilet –building from this amount. The Anganwadi Workers are unable to spend – either there is lack of confidence or lack of knowledge. We are thinking of handing over the signature power to the ANM."

Medical Officer at PHC: *"We cannot directly control the spending of gram poshan (Village Health Committee) because the Anganwadi Worker reports to the ICDS structure."*

LHV: *"During the monthly meetings there are so many arguments between the Anganwadi Workers and the ASHAs that it becomes difficult. Some say the meetings should be held separately but that will lead to more differences among them. The older Anganwadi Workers are a bit upset* (**thode naaraaj***) that ASHAs get an incentive for tasks that they never got. Once one came with a case (patient for Family planning operation) and said give me the incentive. I said why have you done the ASHA's work, don't you have your own work to do? Then there are the Rs.10,000 that the Anganwadi Worker gets for the Anganwadi and other expenses. They will not give to ASHAs and it comes out in the meetings. The ANMs are newly appointed under NRHM but they have Rs.10,000 allotted. There are some ANMs also who will not give* (to ASHAs).

The Sarpanchs also can be arrogant with the ASHAs. Before this, women never went to the gram sabha meeting so Sarpanchs feel what will women do there. The Village Committee members don't take much interest. We tried to call for training but only 5 Sarpanchs came. The Anganwadi Workers do feel it. Earlier any visitor who came to the village went to their house, now they go only to the ASHA's house. All visitors gothere. As a result the Anganwadi Workers too make demands – on Village Immunisation and Health

Continued...

Day (a monthly day set aside for every village for covering the children and mothers eligible for immunisation. Follow up of other matters might also be taken up) we expect the ASHA to only make the MPW,ANM and Anganwadi worker sit and offer water at her home. Some Anganwadi Workers say give tea and snacks otherwise what are you getting incentive for 100% immunisation for? I won't sign. Such things are not good for the ASHAs."

(Sister BK, LHV [Lady Health Visitor]and ASHA supervisor and trainer)

ANMs: *"The Anganwadi Workers do not pay for transportation and 100% immunisation because there are no instructions. We do not give for the same reason. In the beginning I gave 600 under JSY and the Medical Officer said why are you sticking your neck out? I thought I will repay the 600 and then I did not pay anything further until I got written a letter from the Block Medical Officer for JSY."*

(JN,ANM, nearly 25 years' experience)

"*It is different now for them (ASHAs). Look at my feet - they are swollen. It was difficult there were no toilets in the Sub Centre. I have come from a village I could do this work. When I had to stay overnight the MO used to call up my family and speak to my daughter – we are keeping back your mother today for work. What you see now is different from the earlier days."*

(NT, ANM, due to retire in two years)

Anganwadi Worker: *"It was better earlier. We were getting awards for good performance. Now they give to only two Anganwadi Workers in the block. I have walked 20 kilometers to reach a village on immunisation day. I still walk. Now it is just not like before .Nobody asks after us* (**aamhaala konni vichaarat naahi)"**

(SP, Anganwadi Worker since over two decades)

The words of the stakeholders from the health services triangulated the ASHAs' difficulties. They faced pressure from home over this issue.

Some manifestations of the lack of ownership were further seen in the manner of conducting the mandatory requirements for the ASHA Scheme. The behaviour was in sharp contrast to the supervision of ASHA tasks.

A) Lack of Ownership: Chairing the ASHA Meetings

The ASHA monthly meetings were held rigorously every month as mandated officially. However they were largely conducted by the local health staff namely the LHV, Health Assistant or the Multi-Purpose Worker. The Medical Officers (doctors) of the PHCs were observed to come only for training sessions. This could be because the timings of the OPD in the PHC were also in the morning. In some clinics the OPD was seen to extend from the morning to the afternoon. (The reported daily OPD attendance of the PHCs in Shahapur was between 100-200 patients. Although there are two medical officers allocated to a PHC, there was just one attending to the OPD in the PHCs.) However even after OPD hours the MOs were largely not seen in the ASHA meetings except to give some training inputs.

There was no specific participation by the ASHA Facilitators in the ASHA meetings. However they would be expected to take charge before the other staff came in to conduct the meeting much in the manner of 'class monitors'. In one of the PHCs an experienced ASHA Facilitator was found to be conducting the ASHA meeting.

B) Lack of Ownership: Condescending Attitude

The ASHAs were tolerated or accommodated at best, by the senior stakeholders from the health services who had several years of experience, despite their empathy towards the incentive factor.

"*Earlier there were limited tasks of the Community Health Workers* (a reference to the lapsed Village Health Guide Scheme of the 'seventies and 'eighties) *and they had a fixed payment. Now the ASHAs have to do many tasks and the payments are per incentives. I have seen at least a 100 such schemes in my service tenure. It succeeds in the NGO sector and they bring it here. It fails here …there is constant attention paid to the CHWs in NGOs… we don't get that kind of time here, we have so many things to handle."*

(Block Facilitator and Block Coordinator, both with more than 25 years of experience)

There was weariness among the senior stakeholders from the health services in discussing the ASHA Functionary. The implementation of the ASHA Scheme was seen as an additional responsibility. There was no inclination towards the ASHAs' integration into the health services system. This could have also originated from the stakeholders' own job fatigue.

"*ANMs are overburdened as it is. They have 10-15 villages. They cannot take the responsibility to improve the performance of ASHAs. All of us have enough to do at PHC level, we need outside support to help us with this. The solution is not to*

discontinue the scheme but to improve it. They see this as a government job and if it is discontinued they will feel we have been removed. Villagers will feel our people have been removed. It will be difficult to get a response for our services."

(SS, Medical Officer of a PHC at the end of the day's OPD which extended from 11 am to 3 pm. The time spent with each patient was 2- 5 minutes.)

Those staff of the Primary Health Centre that had limited direct contact with the ASHAs also displayed a condescending approach in their dealings with the ASHAs.

"Their payments do get delayed…amount? Whatever they get is enough for them."

(TP, woman administrative clerk at a primary health centre)

"You know once an ASHA said that she had submitted four slides. I made her confess that there were three slides. The MPW told me to let it go but I did not. She would not agree so I questioned her for two hours until she cried and finally she agreed. No, ASHAs never make false claims but in this case it was her mistake, not mine. "

(JG, woman pathologist at a PHC discussing her interactions with ASHAs as they submit malaria slides to her. ASHAs get an amount of rupees five per slide. The MPWs normally collect the slides from the villages but if they do not, the ASHAs bring the slides to the PHC as slides have to be given to pathologist within 24 hours of collecting them. The travel cost for this is not covered in the ASHA's incentives.)

C) Lack of Ownership: Transgression of 'porous' boundaries by seniors

Some important documents in the past have clubbed the roles for different village level health functionaries. For example the ICSSR/ICMR report 'Health for All: An Alternative Strategy (ICSSR 1981, 2nd edition page 136) gives a list of directives for "*village level activities to be carried out by the **dai** and/ or CHV*." These directives of past Schemes did not factor in the dynamics that could occur between various community level health functionaries at the local level while implementing the directives. The NRHM directives on the other hand are only for the ASHA Functionary which is a positive aspect. However there are 'porous boundaries' of the location of ASHAs. There are functions that are open to interpretation at the implementation level. The data showed that there was exploitative behaviour by the seniors that basically showed a transgression of 'porous boundaries'.

There are three women village level health workers namely the ANMs, Anganwadi Workers and ASHAs apart from the male Multi-Purpose Workers (MPWs) and Health Assistants (HAs).

C.1 Allotment of non – mandated additional tasks

The current study also found that the ASHAs were facing power play in the form of added responsibilities. The ASHAs said that home visits were being made by them to visit pregnant women, new mothers, the chronically and critically ill, and also to oversee the consumption of doses that were meant to be taken in the ASHAs' presence. The visits were valued by the community.

In addition to these the local stakeholders of the health services had asked the ASHAs to do several additional visits. They were asked to take daily rounds of the entire village and the surrounding hamlets, ask after the health of families, and also visit Anganwadis daily. This issue had first come up in Chapter Four.

The NHSRC (2011) study states that the main task of the ANM that is 'handed over' to the ASHAs is home visits. Further it states that the task is on the list of ANMs but it is not being done anyway by them hence there is no conflict (2011 main report, page 113). However cognizance has not been taken of the ASHA and her family members' gaze towards home visits. Meeting the directives for several kinds of visits took up working hours and energy and this labor is currently unaccounted for. There is no clarity of the nature of visits required and it is left open for interpretation by the ANMs and others at the village level.

The ASHAs had also reported the insistence for each delivery to be an institutional delivery for which the ASHAs were not paid for escort and overnight stay if the mothers were not eligible under the Janani Suraksha Yojana.

In addition the male MPW and the Health Assistants who also works at the village level are not factored into the Central policy but the ASHAs worked with them too. There is a need for further research on the precise tasks that are 'handed over' to the ASHAs. Several testimonials of non-mandated 'hand over' of tasks by all the village level functionaries are presented further in this Chapter.

C.2 Competiveness from the salaried seniors over incentives

Both the ANMs and the Anganwadi Workers in some villages were reported to ask ASHAs to host them with tea and snacks on Village Health and Immunisation Day because it is the ASHAs who get this incentive. This was reported by a LHV. There were instances of these functionaries also asking for a share of the ASHAs' incentive as reported by ASHA Facilitators,

members of a Village Health Committee and LHVs. There were instances of these workers competing for credit over family planning cases (Box 5.5).

The current study interprets the 'handing over' as seen in the villages as a reflection of the hierarchical orientation of the health services. There are gaps in defining boundaries of the ASHA's involvement within the policy itself which leave the ASHAs vulnerable.

B. THE DUTIES OF THE ASHA FUNCTIONARY

This Chapter discusses the responsibilities of the ASHA according to stakeholders. The first emergent dimension was '**The location of the ASHA Functionary within the health services system**. It was discussed above. The current section explores the second emergent dimension of responsibilities, namely '**the duties of the ASHA Functionary**.' While the first dimension of location was presented from inside outwards, that is starting from the ASHAs and moving outward towards the different levels of stakeholders from the health services, the dimension of duties is presented in the reverse fashion. The findings are presented from the outermost level namely the national policy and the discussion moves inward through different levels of stakeholders to the ASHAs' understandings of their own duties. The analysis focuses on the shifts in perspectives about duties at seven levels. The first three levels are of policy and the following four levels are of stakeholders. The exploration starts from the Central NRHM Scheme.

1. The ASHA Functionary's duties as per the Central National Rural Health Mission policy

In Chapter One there was a discussion of the ASHA Scheme within the National Rural Health Mission (NRHM). This sub-section provides an analysis of the roles and responsibilities of the ASHA Functionary as described in the Central NRHM policy.

The Central NRHM directives (Box 5.6) articulate a ten point list of the roles and responsibilities of a Community Health Worker namely the ASHA. In several past CHW schemes as well as landmark documents like the Alma Ata Declaration of 1978, the role of the CHW is described but the actual responsibilities are not well-defined. This articulation of Roles and Responsibilities is in itself a step forward towards strengthening CHW Schemes like the ASHA Scheme within health services systems.

This is the first level of the seven levels of stakeholders that have interpreted the duties of the ASHAs. An analysis of the Central ASHA Scheme shows:

1.1 The perspective of ASHA as 'activist'

The largest ASHA responsibilities at the central NRHM policy level are to do with a number of directives for ASHAs to take ownership for awareness, participation and good health practices in the village and also the higher usage and accountability of public health services.These women are expected to be "*activists*" but towards the end of the increased usage of public health services only. This subversion of the term 'activists' (synonyms: advocates/protestors/campaigners) is only indicative of the deeper contradictions within the ASHA and other CHW Schemes.

Secondly location is also related to the NRHM directives of performance-linked incentives. The NRHM directives have taken into consideration the potential of the CHW for fulfilling these duties from the legacy of CHWs in time. However they have not factored in the location of the CHWs, in this case the ASHAs, within the public health services system. A CHW within a supportive health programme that takes ownership might not have the concerns of the ASHA within the public health services system. It is a fact that the issue of incentives has come up strongly only in the previous 1977 CHW Scheme which was also a public health services scheme.

The terms of the directives in the Central ASHA Scheme are so broad that they could lend themselves to varied interpretations at the state level. In the following section there is an analytical discussion on how the ASHA Scheme is seen by the State of Maharashtra.

Box 5.6
Roles and Responsibilities of the Accredited Social Health Activist (ASHA): Central NRHM Policy

ASHA will be a health activist in the community who will create awareness on health and its social determinants and mobilize the community towards local health planning and increased utilization and accountability of the existing health services. She would be a promoter of good health practices.
She will also provide a minimum package of curative care as appropriate and feasible for that level andmake timely referrals. Her roles and responsibilities would be as follows:

- ASHA will take steps to **create awareness** and provide information to the community on determinants of health such as nutrition, basic sanitation & hygienic practices, healthy living and working conditions, information on existing health services and the need for timely utilization of health & family welfare services.
- She will **counsel** women on birth preparedness, importance of safe delivery, breast feeding and complementary feeding, immunization, contraception and prevention of common infections including Reproductive Tract Infection/Sexually Transmitted Infection (RTIs/STIs) and care of the young child.
- ASHA will **mobilize the community and facilitate them in accessing** health and health related services available at the village/sub-center/primary health centers, such as Immunization, Ante Natal Check-up (ANC), Post Natal Check-up (PNC), ICDS, sanitation and other services being provided by the government.
- She will **work with the Village Health & Sanitation Committee of the Gram Panchayat** to develop a comprehensive village health plan.
- She will arrange **escort/accompany** pregnant women & children requiring treatment/ admission to the nearest pre- identified health facility i.e. Primary Health Centre/ Community Health Centre/ First Referral Unit (PHC/CHC /FRU).
- ASHA will **provide primary medical care** for minor ailments such as diarrhoea, fevers, and first aid for minor injuries. She will be a provider of Directly Observed Treatment Short-course (DOTS) under Revised National Tuberculosis Control Programme.
- She will also act as a **depot holder for essential provisions** being made available to every habitation like Oral Rehydration Therapy (ORS), Iron Folic Acid Tablet (IFA), chloroquine, Disposable Delivery Kits (DDK), Oral Pills & Condoms, etc. A Drug Kit will be provided to each ASHA. Contents of the kit will be based on the recommendations of the expert/technical advisory group set up by the Government of India.
- Her role as a provider can be enhanced subsequently. States can explore the possibility of graded training to her for providing newborn care and management of a range of common ailments particularly childhood illnesses.
- She will **inform** about the births and deaths in her village and any unusual health problems/disease outbreaks in the community to the Sub-Centres/Primary Health Centre.
- She will **promote** construction of household toilets under Total Sanitation Campaign.
- Fulfilment of all these roles by ASHA is envisaged through continuous training and up-gradation of her skills, spread over two years or more.

(**Source**: Guidelines on Accredited Social Health Activist (ASHA) Annexure 1,pages 1-2)

2. Duties according to the State National Rural Health Mission policy

This study was conducted in the Thane district of the state of Maharashtra. The State NRHM policy is presented in Box 5.7. The following discussion tracks the changes in the guidelines of the roles and responsibilities of ASHA from the Central to the State level. The analysis is based upon the findings of the current study and highlights the implications for the ASHAs at the villages.

An analysis of the State ASHA policy shows:

2.1 Increase in the level of involvement for national health programmes

In accordance with the Central scheme the ASHAs' primary duty in the state scheme is also to promote good health practices. However the broad view of the central scheme notably the role of 'activist' for encouraging the usage of public health services is increased as she is expected to be not only an 'activist' but also a "*link worker*" as seen in Box 5.7.

The duties of the ASHAs as spelt out in the Central and State policies look alike however there are subtle differences.

The first difference between the central and the state policy is that the ASHA is overtly connected with the Village Committee in the state policy. This connection is both empowering and also increases the ASHA's accountability to the Village Committee. While the guideline is good in intent the data showed that this connection did not happen at implementation. Several ASHAs in the study location were not even members, thus an opportunity for their empowerment was lost at the implementation level.

The second notable change is the 'bureaucratisation' of ASHA functionaries. Unlike the central policy, in the state policy the ASHAs were expected to extend coordination with other village level health functionaries and also to keep records. In the villages, unlike the experiences regarding the Village Committee, this part of the State policy mandates was being implemented fully. ASHAs were accountable to other functionaries and were keeping records. There were thus new procedural demands over the ASHA functionaries starting from the state level policy.

Box 5.7

The ASHA Scheme Maharashtra State: Increase in Involvement

DESCRIPTION

- "Accredited Social Health Activist (ASHA) is a community based Functionary.
- ASHA is trained **community based link worker** and acts as bridge between the Government functionaries and Tribal & Non-tribal population who find it difficult to access the health services.
- ASHA is a first port of call for any health related demands of the community.
- ASHA is a health activist and she creates Health Awareness in community.
- ASHA is promoter of good health practices."

(**Source**: The Maharashtra state ASHA Scheme, Introduction, (http://www.healthasha.maharashtra.gov.in)

THE DUTIES OF THE ASHA WORKER

- **Preparing the Village Health Plan** as a member of the Village Health, Nutrition, Water Supply and Sanitation Committee. She will **report to the Committee** whether the Plan is being implemented and work according to the directives of the Committee. This is an important part of her work.
- She is expected to provide curative care for minor illnesses and when needed also refer expectant mothers and children etc. to public health facilities.
- She must communicate with the community to encourage positive changes in their health behaviour.
- **To coordinate with the Anganwadi Worker, Dai, ANM, MPW.**
- Health awareness
- Help ill patients to reach public health facilities.
- First Aid
- Depot holder
- **Record Keeping.**

Source: 'The official guidelines of NRHM for state officials, issued by the Public Health Department, Government of Maharashtra' (**Sarvajanik Arogya Wibhaag, Maharashtra Shaasanan**), pages 25-26, translated from the original Marathi.

The policy had not considered the possibility of increased working hours. The Maharashtra State guidelines on NRHM (Sarvajanik Arogya Wibhaag, Maharashtra Shaasanan, page 25 translated from the original Marathi document) also states that *"The ASHA is expected to give 2-3 hours for this work for four days a week."*

At the implementation level, the duties delineated above (Box 5.7) would not allow the ASHAs to keep limited days and working hours. Illnesses and deliveries can happen at any hour.

2.2 Resistance to increased ownership by ASHAs

The ASHAs had taken critical decisions for their community and been held accountable by the community as well (Chapter Four). They saw an inherent contradiction and countered it in their own expectations from the health services system. The ASHAs also demonstrated their own resistance to their "bureaucratisation" sans commitment from the establishment. An ANM shared the following incident.

"There is now a condition that women selected as ASHAs have to sign on bond paper. I took two ASHAs to the block headquarters but they refused to sign and I had to bring them back."

(ANM)

There was a further refinement in the duties down the chain of administration at the District level.

3. Duties according to the District and the Taluka Administration: further involvement

At the District level, the administration of the NRHM Scheme had a dedicated administrative and infrastructural set up working under the District Medical Officer and a separate NRHM administrative structure. In the Thane District where the current study was located, the NRHM Manager was a woman with an MBA degree. While talking about the ASHAs in Thane district she said, "*I have visited the remotest villages where vehicles don't reach and the last leg of the journey is on foot. When I went to a village recently the ASHA was out for her work. She returned and I saw a woman in front of me in uniform who had been found working totally on her own although I went without prior notice. I felt proud of my own staff that day."*

3.1 ***Progressive increase in expected ownership at the District Level***

The good work ethics of the ASHA in question and the 'patriachal / matriachal' ownership by the manager who called the ASHA her staff member were both evident at their own individual levels. When asked to share her viewpoint on the ASHA Functionary, the

manager shared a slide of her presentation to the medical officers. She had entitled the slide as "*ASHA volunteer*".

The "*duties and responsibilities*" of this "*volunteer*" were listed as follows:

1. **Home visits.**
2. Registration of births and deaths.
3. First Aid.
4. Awareness building
5. **Maternal and Child Health**
6. **Increasing the rate of institutionalized deliveries**

In this NRHM Manager's official diktats, the location of the ASHA Functionary remained constant as a volunteer but additionally there was now an expectation that she would also do home visits. This was a gratis service that was actually being provided in the study location according to the community and was appreciated by the community (Chapter Six).

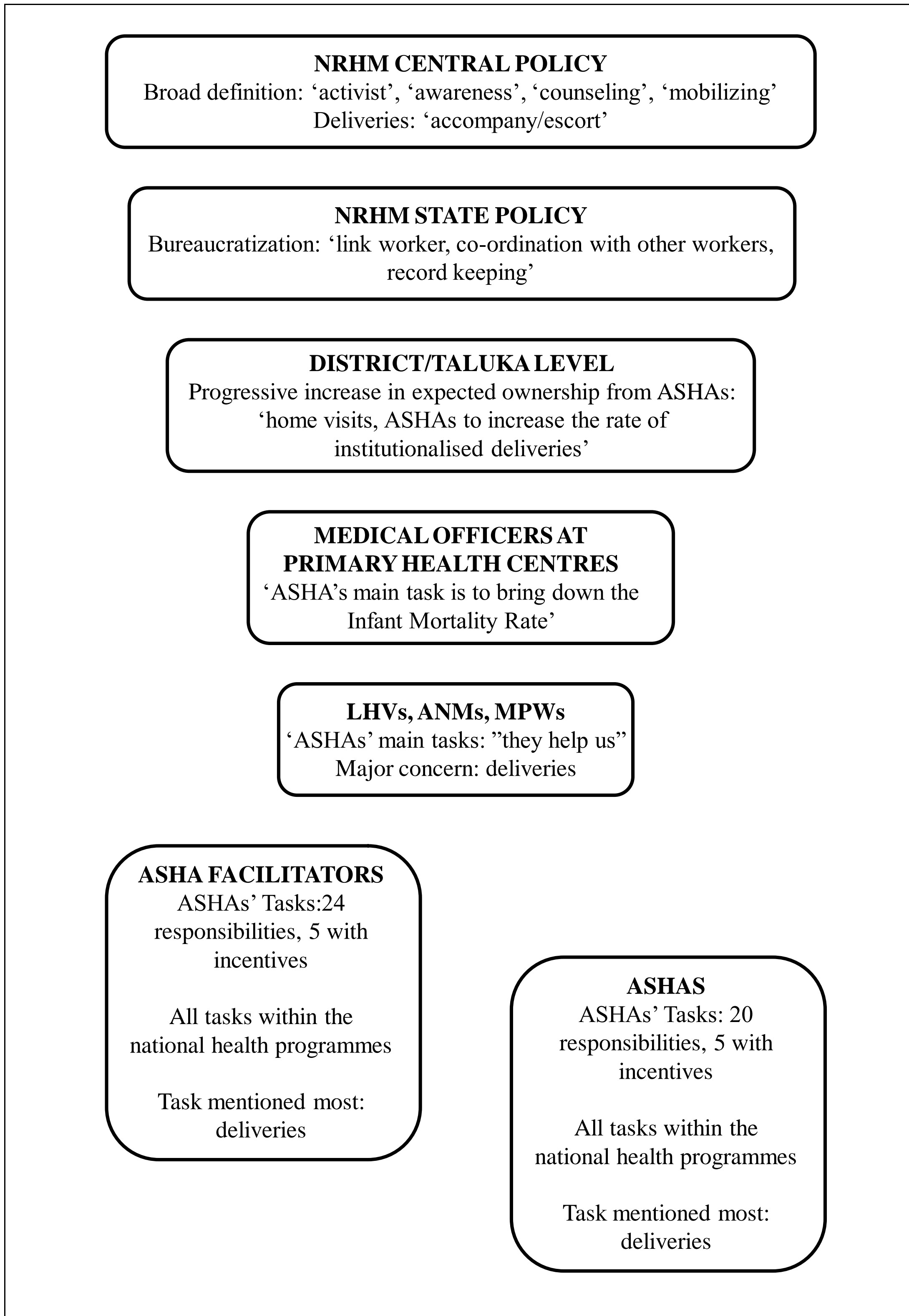
3.2 Increase impetus towards delivaries

However the biggest change that happened at the district level in terms of ASHA duties was the increased impetus of the ASHA functionaries towards institutionalised deliveries from the side of the administration. Up until the central and state level NRHM Schemes, the role of the ASHA Functionary was restricted to '*facilitating institutionalised delivery*'. According to the district NRHM manager the ASHAs had to "*increase the rate of institutionalized deliveries*."

There was a transition from merely facilitating to actually ensuring that each of the potential beneficiaries of the Janani Suraksha Yojana (JSY) in the village underwent institutionalised delivery. This was not even a requirement in the original Maharashtra State JSY policy (Annexure 5.1) which had provided for cash payments even for beneficiaries

Figure 5.2

Perspectives of ASHA Duties: Multilevel Analysis



delivering at home. In fact the Maharashtra state JSY policy (Annexure 5.1) does not mention the ASHA Functionary at all. The question then arises as to how the ASHA Functionary had become so closely associated with JSY in the common understanding among the health professionals.

Data from the study location also showed that the ASHA duty in institutionalised deliveries, was further extended at block level, to persuading each and every expectant mother and her family for institutionalized delivery, even if not covered under JSY. In the process the ASHAs faced resistance from some mothers particularly the Adivasis, and resistance from their own families because they were paid only for travel (Chapter Four).

The study location was in the Thane District where the infant mortality rate was high. The Medical Officers and ANMs expressed that there would be an improvement if all deliveries were institutionalised. The reason becomes clear on an examination of the Maharashtra State JSY policy (Annexure 5.1). "*The aim of the Scheme is to facilitate deliveries under the care of trained medical and paramedical professionals so that maternal mortality and infant mortality rates are lowered.*"

From this level onwards, the analysis moves from the policy to the stakeholders at the local public health services system. Figure 5.1 illustrates the progression of the duties of the ASHA Functionary.

4. Duties according to the Medical Officers: 'to bring down the infant mortality rate'

The one group of stakeholders from the health services that were the least satisfied with the ASHA functionaries in the block were the medical officers. Their perspectives are encapsulated in the words of the Block Medical Officer:

"ASHAs have helped to increase institutional deliveries however the IMR (Infant Mortality Rate) *remains high. They have not helped to bring it down."*

This was a widespread perspective among the doctors. In three Primary Health Centres (PHCs) the doctors showed their annual graphs tracking unchanging mortality rates to prove the ineffectuality of the ASHA Functionary. The medical fraternity's perspective about the duty of the ASHA Functionary is reflected in the words of one of the medical officers at one of the PHCs in the study area.

Case Study 3: The medical officers' perceptions of ASHA duties (Dr. LN)

Dr. LN is a young Medical Officer posted at one of the most remote PHCs of the taluka. The villages under the PHC's jurisdiction largely have an Adivasi population. He held this conversation after the day's OPD was over.

"I take each subject in each meeting (ASHA meeting) *for example importance of breast feeding but implementation does not happen. Despite telling repeatedly that first meal for mother should be given within two hours, meal does not come for hours* (this is a hilly area with just two services of the public bus in a day.*)*

Main issue is to lower MMR (Maternal Mortality Rate) *and IMR (*Infant Mortality Rate*) and it does not happen because of poor ante-natal and post-natal care by ASHAs and poor supervision by ASHA Supervisors. I see such low levels of HG (*haemoglobin*). If they are taking all tablets*(iron and folic acid tablets) *how is it so low?*

*The explanation that Adivasis do not listen holds no importance. That is what they (*ASHAs) *are there for. It is in their job chart. They are supposed to do it. Today if I tell them to repeat the information they would give to an ANC mother* (pregnant woman requiring ante-natal care) *they are unable to tell. I am aware of Abhay and Rani Bang's work but it is not happening here. Why? I am not able to understand.*

I am saying openly that in my area the IMR (Infant Mortality Rate) *has not reduced. Once a child is gone what am I there for, an autopsy? I want the child I examine to live not die. This is the main work you have been kept for if this is not improved, what is the use?*

(When the role of the social determinants of health and the failures of the related social sector schemes was brought up, he had a response for these factors too.)

There are other reasons, I am fully aware of the bigger picture but that is not in my control. The health services system at the PHC is in my control and I want to try to improve that."

5. Duties according to the middle order: 'they help us in our work'

The middle order of the stakeholders from the health services namely the LHVs, MPWs and ANMs in contrast to the doctors, professed their satisfaction with the ASHAs.

"No ASHA refuses to work even if it is in the night. In my sub- centre we have organized fixed jeeps. They phone me if needed and I send the jeep."(MPW)

The reason for this satisfaction is self-evident within their words. Across all the stakeholders at this level, the common expression was "*ASHAs help us in our work."* Presented

below are the words of different stakeholders in different posts and how they saw the ASHA Functionary's duties. The common theme was that the ASHAs had taken over some the functions of these paid employees of the health services system and it was appreciated by them. However these were the same stakeholders that had demonstrated a lack of ownership for the mandates of the ASHA Scheme (Section One).

"In our area, the ASHAs detect suspicious TB cases. The ASHAs send suspicious cases to the PHC and after tests the patient is declared by the Health Assistant (HA) at the PHC.ASHAs are already trained for giving the doses so when they come for the monthly meeting, they are handed over the doses and the regimen to be followed is explained to them. The Multi-Purpose Worker (MPW) at the sub- centre and the HA at the PHC/Block are in charge of overseeing the treatment and keeping the records.

Before the ASHAs the technicians used to do the detection and follow up, now they have been absorbed as MPW or HA. Earlier the ANM or MPW used to personally give the doses now the ASHA does that.

*There are plenty of patients, earlier there used to one or two per village. One reason is that we had orders not to detect too many cases - not officially but that was told. Now the order (**aadesh**) is the opposite – find them all. The ASHAs do that. We also oversee when we make monthly trips to the villages."*

(IP, Health Assistant with more than 20 years of service)

"*Now they are told that once a day you must go to the Anganwadi. Earlier Anganwadi workers used to distribute the food now if the ASHA is there she does that. And every day if possible, they have been told to spend two hours in the village. If you are going to fix all the hours, then fix their payment."*(Sister BK, LHV and trainer)

"*Now the ASHAs have to bring blood samples (Blood slides of suspected malaria cases in the village are now taken by the ASHAs, earlier they were taken by the MPWs). At this time of the year the load is very high. I go during meetings and teach them. Its only rupees five per slide that they get. If the MPW collects it from the village it is okay otherwise their bus fare is more than that. They have to bring it within 24 hours you know. I have to record the positive cases and share it with the concerned ANM and MPW. Then the treatment begins (where she gives the doses to the patient in the village daily). Only on successful completion of treatment they will get something. The main thing is I must train ASHAs regularly tell them the importance of what they are doing."*(NM, Pathologist in a PHC)

"*We have targets for every national program and we work together to meet the targets. Now the targets are not numbers because we do not get so many patients – for example, Leprosy*

patients. Now the target is 100% coverage for all. There is still Leprosy but people hide it. These people (ASHAs) are better at finding. People tell them more easily. After the patient has started treatment at the PHC we also tell phone them (ASHAs) to see the spot. We keep a watch."(MPW at Sub Centre)

"We phone them and tell them about the dates(for immunization)…they call everyone and it is so much easier because of them. We do not have to go from door to door and also everyone gets immunized. They help us."(ANM)

Thus the doctors found the ASHA Functionary ineffectual due to the inability to do ante natal and post natal care and there was practically no mention of the other duties that the ASHAs might be doing. The middle order on the other hand, saw the ASHAs as 'helpers' doing several tasks within the national health programmes. However these ASHA duties were the same as their own. Therefore the credit or discredit for the performance of the national health programmes were shared by the middle rung of the health services stakeholders, namely the LHVs, ANMs, MPWs and others. It is no coincidence that these stakeholders from the health services were also the supervisors and immediate contact sources of the ASHAs from the health services system.

The research on the duties of the ASHAs also included the perspectives at the lowest rungs of the health services. All the 244 ASHAs in the taluka and all the 29 ASHA Facilitators were given a free listing exercise. They listed the responsibilities of the ASHA Functionary in the order that they thought was appropriate. This tool was used to gain an insight into their perspectives and priorities of the ASHA duties. Both the groups of stakeholders were administered the same tool for the sake of comparability.

6. The Responsibilities as per the ASHA Facilitators: 'to support the functions of the health services system'

All the 29 ASHA Facilitators who had participated in the survey were given an exercise in free listing. They were asked to list the responsibilities of the ASHA Functionary in the order of the priorities as seen by them.The written responses of all the ASHA Facilitators were compiled into a table showing total duties by ranking order. Care was taken to make the list according to the ASHAs' expressions and only some categorisation was done when necessary for clarity (Table 5.1). The following findings had emerged from the collated free listing of all the ASHA Facilitators.

6.1 Number of ASHA responsibilities listed by the ASHA Facilitators

The Facilitators' list had a total of 24 ASHA duties by all Facilitators compared to the ten directives in the central government's NRHM policy. There was no overwhelming pattern of choices that was discernable in the individual free listings of Facilitators which included between 5 to 10 ASHA duties.

6.2 Nature of ASHA responsibilities listed by the ASHA Facilitators

The perspectives of ASHAs Facilitators about the duties of the ASHAs reflected the expectations of the middle order of stakeholders from the health services. The ASHAs were expected to work for all the national health programmes by the ANMS, MPWs, LHVs and HAs.The free listing from the Facilitators triangulated these expectations as all the tasks listed were within this expectation.

There were some responsibilities that clearly put the ownership on the ASHAs for the goals of the health services system like task 21which expected ASHAs to ensure that every person in the village receives public health services. Even the primary duty of the ASHA

Table 5.1

Free Listing of the Responsibilities of the ASHA Functionary by the ASHA Facilitators

R. NO.	RESPONSIBILITIES OF THE ASHAS ACCORDING TO THE ASHA FACILITATORS	RANKING AND NUMBER OF MENTIONS										TOTAL* (N=29)
											0	
	MATERNAL HEALTH CARE											
	To keep regular contact of all ANC/PNC cases in the village and facilitate all services to them.											28
	To ensure that all expectant mothers go for delivery to the hospital and accompany them to the hospital											26
	CURATIVE HEALTH CARE											
	To accompany the seriously ill persons in the village to the PHC and follow up until recover											8
	Detection and referral to PHC of TB, Malaria, Leprosy and Cataract cases											7
	To personally gives the patients of TB, Leprosy and Malaria in the village their medication regularly											14
	To maintain the medical kit for the village											4
	To give medications for minor illnesses and provide first aid											9
CO-ORDINATION WITH THE LOCAL HEALTH SERVICES SYSTEM AND PANCHAYAT												
	To work with various public functionaries for health planning and co-ordination											18
	To visit the Anganwadi and help the AWW											3
0	To identify eligible patients and to be present during all public health activities in the village											6
	HEALTH EDUCATION											
1	Health education on various topics											14

Continued...

SR. NO.	RESPONSIBILITIES OF THE ASHAS ACCORDING TO THE ASHA FACILITATORS	RANKING AND NUMBER OF MENTIONS										TOTAL* (N=29)
											0	
	CHILD HEALTH CARE											
2	**Facilitating complete immunization of under 5 age group of the village**											13
	PREVENTIVE HEALTH CARE											
3	To make efforts towards reducing the incidence of mortality in the village											8
4	To demonstrate hygienic practices in her own lifestyle and educate the community											9
BUILD RAPPORT WITH THE COMMUNITY:												
5	To maintain good communication with all the villager community / take a leadership role to hold meetings in the village											11
	RECORD KEEPING TASKS:											
6	Maintaining records of eligible cases for all health services											5
7	*Maintaining records of births and deaths in the village*											7
	REPRODUCTIVE HEALTH CARE:											
8	**To advice and facilitate use of Family Planning methods and accompany eligible cases to PHC for monthly camps**											10
	EMERGENCY SERVICES:											
9	To alert the PHC as soon as possible if there is any epidemic in the village											5
0	To refer the seriously ill and accompany to PHC even at night if necessary											3

Continued...

SR. NO.	RESPONSIBILITIES OF THE ASHAS ACCORDING TO THE ASHA FACILITATORS	RANKING AND NUMBER OF MENTIONS										TOTAL* (N=29)
		1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	
LINK BETWEEN THE HEALTH SERVICES SYSTEM AND THE COMMUNITY:												
21	To ensure that every person in the village receives public health services	4	-	1	1	1	2	-	2	1	-	12
ADMINISTRATIVE TASKS:												
22	To remain present for monthly meetings	-	-	-	-	-	-	-	1	-	-	1
23	To submit report on time to the Block Supervisors	-	-	-	-	-	-	-	1	-	-	1
24	To ensure the recording and payment of her own incentives for the tasks completed in the month	-	-	-	-	1	1	-	2	-	-	4
	TOTAL	29	29	29	29	29	26	22	16	14	1	226

Note: 1-Ante-natal Care (ANC); 2-Post-natal Care (PNC); 3-Primary Health Centre (PHC); 4-Auxilliary Nurse Midwive (ANM); 5-Sub-centre (SC);6-Rural Hospital (RH); 7-Anganwadi Worker (SWW).

The responsibilities in bold letters have incentives and in italic letters have incentives but ASHAs reported not getting them.

*Multiple responses of 29 ASHA Facilitators.

Facilitators was put onto the ASHAs by four Facilitators as seen in task 24 which expected the ASHAs to ensure their own incentives as well.

6.3 The prioritisation of responsibilities according to the ASHA Facilitators

The prioritisation of responsibilities was inferred on the basis of the total number of times any task was mentioned by all the Facilitators. The highest priority was to Maternal Health Care which was mentioned the highest number of times. This is a triangulation of the emphasis

coming from the Medical Officers, LHVs and ANMs for institutionalised deliveries and care of pregnant women as seen in the preceding section.

6.4 The task-incentive balance as reflected by ASHA Facilitators

The widespread perception among the ASHAs, their families and some stakeholders from the health services that the ASHA's work was not adequately reimbursed was analysed by exploring the task-incentive balance. Just five of the 24 duties of ASHAs listed by the ASHA Facilitators were giving her incentives namely escorting women for delivery (task 2), detection and referral (task 4), completing the treatment regimen of the TB, Leprosy and Malaria cases (task 5), complete immunization of under 5 age group in the village (task 12) and facilitating Family Planning (task18). The remaining 24 listed responsibilities were gratis.

The linkages with the location of the ASHA Functionary were clear – the Facilitators saw the ASHAs' responsibilities as supportive to the functions of the health system. Therefore the ASHAs were seen as partners in the Facilitators' own struggle for a position within the health services system with commensurate benefits.

At the final stage of the analysis of the duties of the ASHA Functionary by multiple levels of stakeholders, the ASHAs themselves were asked to list down their responsibilities in the order of their own understanding.

7. **The Responsibilities of the ASHA Functionary according to the ASHAs: 'to do what we are told in meetings'**

A similar exercise of free listing was carried out by all the 244 ASHAs who participated in the survey where they were told to write out their own responsibilities in the order of importance they gave to each. The written responses of all the ASHAs were

Table 5.2

Listing of Responsibilities of ASHAs

SR NO.	RESPONSIBILITIES OF THE ASHAFUNCTIONARY AS LISTED BY ASHAs	RANKING AND NO. OF MENTIONS													TOTAL* (N=244)
			1	2	3	4	5	6	7	8	9	10	11	12	
MATERNAL HEALTH CARE:															
1	To keep regular contact of all ANC_1/PNC_2 cases in the village and facilitate all services to them.	No.	46	46	18	13	11	11	5	5	1	1	-	-	157
		%	18.9	19.0	7.5	5.4	5.0	5.8	3.9	5.7	2.0	6.2			
2	**To ensure that all expectant mothers go to the hospital for delivery**	No.	41	37	39	30	10	10	8	4	3	-	1	1	184
		%	16.8	15.2	16.0	13.0	4.6	5.3	6.3	4.6	6.1		16.7	16.7	
CURATIVE HEALTH CARE:															
3	To refer/accompany, if necessary those who are very ill to the PHC_3	No.	5	8	30	13	5	9	9	4	3	-	-	-	86
		%	2.0	3.3	12.0	5.4	2.3	4.8	7.0	5.0	6.1				
4	**Detection and referral to PHC of suspected cases of various diseases**	No.	1	1	8	20	22	17	17	8	2	-	-	-	96
		%	0.4	0.41	3.3	8.4	10.0	9.0	13.0	12.0	4.1				
5	**Follow up treatment of all patients for chronic disease – TB, Malaria and Leprosy**	No.	-	5	8	17	25	16	1	12	3	2	-	-	89
		%		2.1	3.3	7.0	11.0	4.6	8.9	3.9	6.1	12.5			
6	To give medications for minor illnesses and be depot holder for kit	No.	6	5	14	31	10	16	5	6	4	-	-	-	97
		%	2.5	2.1	5.8	13.0	4.6	8.5	3.9	6.9	8.2				
SUPPORTING/HELPING THE PUBLIC HEALTH FUNCTIONARIES:															
7	To participate in all the public health activities at the village level	No.	61	25	14	15	9	8	10	4	1	1	-	-	148
		%	25.0	3.0	5.8	6.3	4.1	4.2	7.8	4.6	2.0	6.25			

Continued...

SR. NO.	RESPONSIBILITIES OF THE ASHAFUNCTIONARY AS LISTED BY ASHAs	RANKING AND NO. OF MENTIONS													TOTAL* (N=244)
			1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	
EDUCATION, INFORMATION, REFERRAL:															
8	To give information	No.	13	37	18	20	19	9	8	6	2	2	2	13	149
		%	5.3	15.23	7.5	8.4	8.7	4.8	6.3	7.0	4.1	12.5	33.3	5.3	
CHILD HEALTH CARE:															
9	**To facilitate the immunization of all eligible children in the village**	No.	13	17	29	13	17	10	4	5	3	3	-	-	114
		%	5.3	7.0	12.0	5.4	7.8	5.3	3.1	5.75	6.1	18.75			
PREVENTIVE HEALTH CARE:															
10	To not allow infant and maternal mortality cases to happen in the village	No.	6	11	18	11	9	6	8	6	2	-	1	-	78
		%	2.5	4.5	7.5	4.6	4.1	3.2	6.3	6.9	4.1		16.7		
11	To ensure that drinking water sources are clean and to redirect stagnant water sources	No.	-	1	4	6	9	5	10	6	6	-	1	-	48
		%		0.4	1.7	2.5	4.1	2.6	7.8	7.0	12.0		16.7		
RAPPORT BUILDING WITH THE COMMUNITY:															
12	To have communication with all in the village and undertake various communication tasks	No.	14	9	2	6	7	16	5	6	4	1	-	-	61
		%	5.7	3.7	0.8	2.5	3.2	8.4	3.9	7.0	8.2	2.5			
RECORD KEEPING:															
13	To facilitate registration of pregnant women by ANM	No.	21	15	5	5	7	1	4	-	1	1	-	-	60
		%	8.6	6.2	2.1	2.1	3.2	0.5	3.1		2.0	2.5			
14	To get all births and deaths recorded with Gram Panchayat	No.	6	10	5	3	2	8	8	-	3	1	-	-	46
		%	2.5	4.1	2.1	1.3	0.9	4.2	6.3		6.1	6.25			

Continued...

SR. NO	RESPONSIBILITIES OF THE ASHAFUNCTIONARY AS LISTED BY ASHAs	RANKING AND NO. OF MENTIONS													TOT* (N=244)
			1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	
REPRODUCTIVE HEALTH CARE:															
15	**To advise and facilitate eligible couples for adopting Family Planning Methods**	No.	-	10	16	23	28	25	12	7	5	2	-	-	128
		%		4.12	6.6	9.6	13.0	13.0	9.4	8.1	10.0	12.5			
EMERGENCY SERVICES:															
16	*To tell the SC$_5$/PHC as soon as possible of any epidemic in the village*	No.	-	-	9	7	12	9	3	1	1	-	-	-	42
		%			3.7	2.9	5.5	4.8	2.3	1.0	2.0				
17	*To refer and accompany if necessary, the seriously ill to the PHC/RH$_6$ at night*	No.	3	-	1	-	1	-	2	2	-	-	-	-	9
		%	1.2		0.4		0.5		1.6	2.0					
LINK WORKER BETWEEN THE HEALTH SERVICES AND THE COMMUNITY:															
18	To ensure that all are availing of public health services	No.	6	5	2	1	2	3	1	-	1	-	-	-	21
		%	2.5												
ADMINISTRATIVE TASK:															
19	To compile various statistics	No.	2	1	1	1	12	10	3	2	-	1	-	-	33
		%	0.8	0.4	0.4	0.4	5.5	5.3	2.3	2.3		6.25			
20	To attend ASHA monthly meetings	No.	-	-	-	4	2	-	5	2	4	1	1	-	19
		%				1.7	0.9		3.9	2.3	8.2	6.25	16.67		
TOTAL RESPONSES BY ASHAs		No.	244	243	241	239	219	189	128	87	49	16	6	1	1665
		%	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	

Note: 1-Ante-natal Care (ANC); 2-Post-natal Care (PNC); 3-Primary Health Centre (PHC); 4-Auxilliary Nurse Midwive (ANM); 5-Sub-centre (SC); 6-Rural Hospital (RH); 7-Anganwadi Worker (SWW).

The responsibilities in bold letters have incentives and in italic letters have incentives but ASHAs reported not getting them.

*Multiple responses of 244 ASHAs.

compiled into a table showing total responsibilities/tasks by the ranking order given by the ASHAs. Care was taken to make the list according to the ASHAs' expressions and only some categorisation was done when necessary for clarity. The following findings had emerged from the collated free listing of all the ASHAs. (Table 5.2)

7.1 Number of responsibilities listed by the ASHAs

The ASHAs collectively listed 20 duties of the ASHA Functionary (Table 5.2). However individual lists ranked from 1 to 12 responsibilities/tasks, indicating the uneven writing abilities, recall abilities or knowledge levels of the ASHAs.

7.2 Nature of responsibilities listed by the ASHAs

Analysis showed that all the 20 duties mentioned by ASHAs were completely aligned with the requirements of the national health programmes. The lists of the ASHAs and the ASHA Facilitators were almost the same although they were made by these respondents at different times and in different locations. Box5.8 shows the sub tasks that were mentioned under each duty, collectively by all the ASHAs. The mention of sub tasks was uneven across ASHAs. However there were several non-incentivised tasks and several sub tasks were required to get one incentive in the paid tasks. The free listing thus gave an insight as to why the performance-based incentives were not seen as commensurate to the duty.

Box 5.8

Sub Tasks that were Mentioned by the ASHAs under each Duty

1. **To Keep regular touch with all ANC/PNC cases includes**: Facilitate the early registration of all expectant and post-delivery mothers in the village with the ANM; facilitate all blood, urine, and HIV tests; ensure all the immunization is done for expectant mothers; refer undernourished mothers for supplementary nutrition to the Anganwadi and follow up their food intake; visit all mothers once in every two days; keep track of undernourished children; ensure Anganwadi services of weight taking and nutrition for them and counsel mothers and their mother-in-laws on nutrition for mothers and children. Facilitation of testing, care and institutional delivery by HIV+ mothers has also been mentioned.

2. **To ensure that all expectant mothers deliver in hospital includes**: Keeping track of the due date of delivery by the expectant mothers; convincing the mother and family member for the institutionalized delivery; accompanying mothers for delivery to the PHC/RH and staying there until the delivery is done; informing about Janani Suraksha Yojana to eligible mothers and ensuring that she gets the

Continued...

benefits; accompanying complicated delivery cases to the relevant hospital facility as recommended by the doctor and staying there with the mother until delivery is over; follow up after mother and child return home.

3. **Detection and referral to PHC of suspected cases of various diseases includes**: Identification by symptoms of suspected cases of Leprosy, tuberculosis, Malaria, jaundice, HIV+ and malnutrition among mothers and children in the village. All of these have to be referred and followed up for testing and their treatment regimen.

4. **Follow up services for chronic diseases include**: storing at home and personally giving medications to detected patients of various diseases in the village. Ensuring that DOTs regime for Tuberculosis is completed was mentioned.

5. **To give treatment for minor illness includes**: Illnesses mentioned were loose motions, fever, cold, and headache. If the patient does not get better then he should be referred to PHC. Being a depot holder for medical kit was mentioned.

6. **To participate in all public health activities at village level includes**: Participation in Village Health and Nutrition Day, Immunization Day and Women's meets. These activities take place on monthly basis in the village conducted by Auxillary Nurse Midwife, Anganwadi Worker and Multi Purpose Worker together. The ASHAs inform them about eligible beneficiaries, and gather up eligible beneficiaries for receiving the services, their attendance on meeting days is mandatory. Besides, identifying and referring eligible beneficiaries for Cataract camps was mentioned. Assisting the Anganwadi Worker and ANM and visiting the Anganwadi has been mentioned. Specifically checking the preparation and distribution of nutritional food was emphasized. Lastly, whenever any of these public health functionaries come to the village or when Block Facilitators come, the ASHAs must accompany them as they go through the village and receive them at her home as that is the base for ASHAs activities. Maintaining equally cordial communication with all the public health functionaries has been mentioned separately several times as has preparing village plan.

7. **Health Education includes**: The topic mentioned were nutrition for expectant mothers; informing about supplementary nutrition at Anganwadi for Poor mothers; adolescent family life education; cleanliness in surroundings; personal hygiene; care of new born; advocating breast feeding; care of the ill; encouraging villagers to build toilets in their homes; removing the people's misbelief about health system and informing about the public health services available.

8. **To not allow infant and maternal deaths to happen**: This was mentioned in these words as a separate task by ASHAs. Other ways of expression were- to ensure there are no home deliveries, to take complete care of the mothers and newborns, to take care of malnourished children.

Continued...

9. **Rapport – building with the community includes**: Attendance at self help groups and Gram Panchayat meetings; remaining present for public functions like Independence Day and Republic Day. Leadership was mentioned in terms of solving health problems of the people. A ASHA said that if there is difficulty in the village, the Police Patil and Sarpanch should be involved by the ASHA. The ASHA should keep a watch on the village and the health of the village. Many ASHAs have mentioned it as a task to move around in the village daily/ regularly and to regularly visit villagers. There were many mentions of having good communication and playing a counseling role among all the people. To serve the people of the village has been mentioned by many as the role of ASHA.

10. **To advice and Facilitate eligible couples for adopting Family Planning Methods include**: Largely the ASHAs have mentioned convincing and accompanying women with two children for sterilization. Only 15 ASHAs have mentioned the encouragement of spacing methods and only 6 have specifically mentioned facilitating men for FP methods.

11. **Link Worker between the health system and the community includes**: Mention of the necessity for all in the village to know of the health services and to benefit from them is included. Facilitating poor people and Adivasis to get the Public health services has been mentioned separately.

12**. Administrative Tasks includes**: Different aspects like conducting survey; keeping note of different age groups; keeping note of number of families; knowing the statistics of the village; knowing the population of the village have been mentioned. The ASHA is also seen to be responsible for keeping note of her own work, sharing it with the Block Facilitator and ensuring that she receives her own payment.

7.*3* *The prioritisation of tasks according number of mentions*

If the total number of mentions of tasks was seen, then in common with the ASHA Facilitators the two components of Maternal Health Care received the highest number of mentions. In this the unpaid service of keeping in touch with the ante-natal and post-natal cases and facilitating services to them (task 1) received a total of 159 mentions across the rankings. The partly paid service of escorting all women (only women covered under the Janani Suraksha Yojana get incentive) for delivery (task 2) received 182 mentions across the rankings. This is a triangulation of the expectations from the preceding levels of stakeholders from the ASHAs.

7.4 *The prioritisation of tasks according ranking*

The free listing was also analysed in terms of the choices made for first rank. Of the total 20 responsibilities listed by ASHAs, totally 15 different responsibilities were included in the first rank by various ASHAs. The responsibilities included sub tasks (Box 5.8). This indicated the

diffuse understanding of their priorities by ASHAs, perhaps not originally intended by the policy makers. The top five tasks mentioned by the ASHAs were as follows:

I. About 25% of the total responses in the first rank: "To participate in all the public health activities at the village level". This is not a paid responsibility.

"Participation in Village Health and Nutrition Day, Immunisation Day and Women's' Meets" **(ASHA)**

"To participate in the national disease control programmes." **(ASHA)**

"*ASHA works under the directions of the ANM and the Anganwadi Worker."* **(ASHA)**

II. About 18.9% of the total responses in the first rank: "To keep regular contact of all ANC/PNC cases in the village and facilitate all services to them". This is not a paid responsibility.

"To register the expectant mother and take care of her until her delivery." **(ASHA)**

III. About 16.8% of total responses in the first rank: "To ensure that all expectant mothers go to the hospital for delivery." This is a partly paid task as ASHAs received payment under the Janani Suraksha Yojana for facilitating institutionalised deliveries of woman from Below Poverty Line families. For other deliveries they get only travel fares.

"*To avoid infant deaths and maternal deaths, (there should be) hospital delivery."* **(ASHA)**

"Home delivery must not happen." **(ASHA)**

"We have to take a lot of effort because if a delivery does not happen in the Primary Health Centre then we have to take her to the next hospital (sub-divisional Hospital at taluka level or civil hospital at Thane district) and we do that." **(ASHA)**

IV. About 8.6% of the responses in the first rank: "To facilitate registration of pregnant women by ANM" The ASHAs reported not receiving any payment for this task although it is mandated in the incentives.

V. Two tasks namely, "To give information on various topics" and "To facilitate immunization of eligible children" were about 5.3% each of the responses in first rank. Both are not paid tasks.

Thus assistance or the "helper" role was ranked First in priorities by ASHAs, triangulating the hierarchical approach.

In addition to the top five responsibilities/tasks discussed below, there were nine others also collectively mentioned by ASHAs as first rank (Table 5.2).

The task-incentive balance and task prioritisation by the ASHAs: a discussion

Of the 20 duties, the same five tasks were receiving incentives according to the ASHA Facilitators and the ASHAs as well. The question of whether the ASHAs were concentrating only on the paid tasks was examined from the free listing.

Seen across tasks, the task that had the highest number of mentions overall among the 20 tasks was institutionalised delivery. Thus the numbers seemed to uphold the assertions of the doctors that the number of institutionalised deliveries had gone up in the area and their indications that the ASHAs were prioritising this task.

However there was a separate sub text to the high number of mentions. Firstly this was the task that was emphasised at all the preceding six levels of stakeholders. Secondly the ASHAs felt obligated to participate in all the public health services. This was the responsibility that was ranked first by the largest number of ASHAs. It followed that the ASHAs would prioritise delivering as a reflection of the expectations from them and reiterated in the training.

The dependency on Janani Suraksha Yojana vis-a-vis task prioritisation: a discussion

The question was whether the ASHAs prioritised the task of institutionalised deliveries because of the incentives under the Janani Suraksha Yojana.

The ASHAs in the sample of this study had expressed their dependency on Janani Suraksha Yojana (JSY) for remuneration. JD, an ASHA working in a village at a distance from the PHC, said she had been escorting delivery patients but they were not eligible for JSY incentive therefore she had few earnings.

"*In my village there are no BPL families* (no poor family has a BPL card) *therefore I do not get benefit of JSY and there are only general patients. Please give a thought to the ASHAs in this situation."* **(ASHA)**

However this dependency on JSY to get a decent remuneration did not necessarily imply that non paid tasks were not being carried out by all ASHAs (Table 5.2 and Box 5.8). It did imply that the ASHAs aspired for a better remuneration for their work. This finding is in confirmation with other studies too. Janani Suraksha Yojana (JSY) was found to be the main source of incentives for the ASHAs in two national evaluation studies (NHSRC 2011, IIPS 2011); however ASHAs were seen to be doing a total of 13 and 15 tasks respectively in these studies as well.

Another example from the tasks mentioned by the ASHAs also strengthens this argument that tasks were done despite the dependency on JSY for remuneration.

Curative Health Care was mentioned as a responsibility that had four different components (Table 5.2). Under Curative Health Care, the unpaid escort service to ill patients (task 3) received 86 mentions across the rankings. There were almost the same number of mentions that is 89 mentions across the rankings of the paid service of follow up of TB, Malaria and Leprosy (task 5). This indicated that incentives were not the motivating factor for the responsibility.

To sum up, the ASHAs were selected, trained and supervised by stakeholders from the health services like the LHVs, ANMs, MPWs who had spent two decades or more working in an inherently hierarchical health services system. These personnel had undergone a fresh training and briefing before undertaking the responsibility of the ASHA Scheme in the area. Yet the hierarchical orientation aided to place the ASHA Functionary at the lowest rung of the existing hierarchy in terms of supervision.

There was a difference in the individual views of the same stakeholders and the formal line of approach towards the ASHAs. The middle order of the health services system consisting of the LHVs, ANMs and MPWs who also dealt directly with the daily functioning of the ASHA Scheme, individually expressed their expectations for a better working arrangement for the ASHAs. While there was a pervasive 'big brother/sister' attitude the ASHAs were largely seen as aides by these full time personnel. Hence the ASHAs were the recipients of a benevolent attitude from all the levels of the health services that they engaged with namely: the ASHA Facilitators, the ANMs/LHVs/MPWs/Health Assistants and the Block level Officials. This was ascribed to the progressive bureaucratisation of ASHAs sees safeguards, in a hierarchical and gandarised system.

As far as the duties of the ASHA Functionary are concerned, the definition from the Central NRHM Policy was broad and open to interpretation in the extent to which the ASHAs could take initiatives for their villages. This approach itself was questionable in terms of an idealistic view of the ASHA as a Community Health Worker. In the Central NRHM policy the actual duties were restricted. There was an expectation of 'activism'. However at each level of policy down the line towards the ASHA Functionary, the duties were increased but not all were incentivised.

At the State, district and block level, there was an expansion in the number of duties which benefitted the National Health Programmes which is a state responsibility. However this was not acknowledged by the doctors in the health services system who felt that the main purpose of the ASHA's involvement was not met as the mortality rates were high. The CHWs that have demonstrated a success in containing infant morbidity have been provided full infrastructural backing, constant training, close supervision and moral support as seen in Chapter One. The absence of these factors but the expectation of such performance without it by the doctors was another indication of the kind of unrealistic expectations that were made from the ASHA Functionary.

In the journey from policy to implementation, the duties had increased but the original mandate of the ASHA Scheme where she was envisioned more as a facilitator than an implementer of public health programs was lost.

While the duties had increased and were tailored to the requirements of the health services system, the location of the ASHAs had remained as in the original policy. The status of 'volunteer' granted in the original scheme was pulled out of context and became exploitative because the ASHA Functionary was put in a double bind of being accountable for increasing duties for the health services system without the health services system's ownership for the mandates that were provided for her protection. This was the dichotomy that the ASHAs sought to resolve by seeking their entitlements that they felt were denied to them. Remuneration was the visible symbol of this dichotomy and the ASHAs were the most vocal about this aspect of their engagement vis-à-vis the health services system. However this did not imply that the ASHAs did not acknowledge the inherent altruism and benefits of their work. ASHAs demonstrated a high degree of confidence in their ownership of their own work as benefits to their community.

Chapter Six presents the perspectives of the ASHAs and the community regarding the extent to which the ASHAs were able to meet the health needs of their community.

THE ASHAS AND THE COMMUNITY: PERCEPTIONS OF RELEVANCE

The findings presented in this study so far were primarily about the perspectives of two stakeholders of the study namely the Accredited Social Health Activists (ASHAs) themselves and the stakeholders from the health services. The community is the third but the most important participant in the ASHA Scheme as the end goal of the other stakeholders is to reach the community effectively.

Recent studies of the National Rural Health Mission (NRHM) and the ASHA Scheme have explored the work of the ASHA Functionary in the community. The studies have explored the availability of services and the effectiveness of services within the provisions of the ASHA Scheme (NHSRC 2011, IIPS 2011 and Bajpai, Sachs and Dholakia 2010). This Chapter explores the relevance of the ASHA Functionary according to the community.

Section One of this chapter presents the social determinants of health available to the community in order to contextualize the subsequent findings on their perspectives. The contextualization also helps to bring out the validity of some of the understandings of the other stakeholders.

In Section Two, the location of the ASHA Functionary as seen by the community is presented. The analysis in this Section explores how the ASHA Functionary has been located within the community's understanding of the services available to the village.

In Section Three, the theme of the ASHA Functionary's location is explored further in terms of location of the ASHA's services within the health seeking behavior of the community.

In Section Four of this Chapter, the duties of the ASHA Functionary according to the perspectives of the community is presented. Five dimensions within this theme are presented as emergent from the data.

In Section Five of this Chapter, the rights of the ASHA Functionary within the community are presented in terms of participation in the Village Health Committee which is a mandatory provision at the village level under the NRHM, is presented. These five sections together present the perspectives of the community upon the location, duties and rights of the ASHA Functionary vis-à-vis their own health needs.

1. Social Determinants of Health available for the Households

According to the Alma Ata Declaration, along with several reforms in other aspects of national and community development, some of the essential provisions for good health were: a decentralized health services system that included CHWs; nutrition; safe water; sanitation and

education for all (Declaration of Alma Ata 1978). These provisions have been acknowledged as the social determinants of health subsequently by several authorities (Chapter One).This Section sets the context for the community's perspectives by exploring the status of the social determinants available to the households in the sample. In Shahapur the literacy levels are high as seen in Chapter Two, therefore access to formal education was not explored in the current study.

1.1 Accessibility to a Public Health Facility

Distance from the Sub-divisional Hospital and the Primary Health Centre had emerged as a key concern of the community. Distance was an issue even for villages considered to be comparatively 'near' a facility because of the lacunae in other services like public transportation facilities.

Case Study 1: Accessibility (Distance from a public health facility) AP

AP is a member of the gram panchayat, and former pada worker of the public health services. When asked to express his expectations, he said:

"*Distance is the main thing. The* ***dawakhaana*** *(PHC) is 5 kms away. If we don't reach in time the OPD closes down. We have to go to private doctors. Our lives are in danger at that time. We need a dispensary nearby. The ASHA has only the tablets for fever and loose motions. If anyone gets seriously ill we have to put them in a bedsheet and carry them to the PHC. Only recently a rickshaw has come to the village.*

Apart from distance, another difficulty that was mentioned was of transportation to be able to reach the public health facilities.

Case Study 2: Accessibility (Lack of public transportation) PM

PM, is an Anganwadi Helper since 6 years. She lives in a tribal village connected by a lengthy and stony dirt track to the main road. The distance of the village from the Primary Health Centre is within 10 kms. She said:

"*We don't want anything as much as transport. In the summer people go to work in brick kilns, Kalyan, Nashik. They come back in the monsoons. That is when they have problems of health. We find it very difficult to reach the PHC and it is difficult for delivery and seriously ill throughout the year."*

This finding of the current study is ratified by previous studies as well. In a recent national study of the NRHM (IIPS 2011, page 150), '*Health facility far off*' was mentioned by about 50.5% and '*transport not available*' was mentioned by about 49.6% of sampled gram panchayats across India. In Maharashtra about 37.2% and 42.6% of sampled gram panchayats respectively mentioned the same.

The difficulties with transportation had been expressed in the in-depth interviews by the ASHAs as well.

Case Study 3: Accessibility (Lack of public transportation) ASHA PS

PS is an ASHA, who has passed10th and is a Diploma Holder. Her husband is a farmer, and she is the mother of one child. Her first expectation was transportation.

"A bus is necessary to reach the PHC. Although the PHC vehicle is there, there is only one. Mini bus at least should be arranged so that we come for delivery and treatment to the PHC. Doctors and medicines are available, but we should reach there."

Difficulties of accessibility were compounded by the poor state of roads in the area.

Case Study 4: Accessibility (Poor infrastructure) ASHA BR

BR is an ASHA since the past 3 years. Her village falls under a PHC located near the railway tracks and is close to the block headquarters. According to her:

"Roads are bad during the rains. There is no direct road to the PHC and no transportation is possible. We have to walk to reach."

1.2 Sources of Drinking Water for the Community

The sampled households were located in six villages across the taluka. Their accessibility to safe water sources was explored in the survey.

Table 6.1

Households: Main Source of Drinking Water for the Family

MAIN SOURCE OF DRINKING WATER FOR THE FAMILY	**NO. OF HOUSEHOLDS (N=120)**	**PERCEN-TAGE**
Uncovered Well	25	20.8
Hand Pump	34	28.3
Tube Well / Borehole	15	12.5
River / Canal*	21	17.5
Uncovered Well + Other Sources (Hand Pump)*	4	3.3
Covered Well + Other Sources (River/Canal/Hand Pump)	11	9.1
Hand Pump + Other Sources (Tube Well / Borehole)	8	6.6
No Response	2	1.6
Total	**120**	**100.0**

Only about 28.3% of households in the sample had access to piped water which they accessed from common hand pumps. The other sources of covered water cited were tube well/bore well (12.5%) and covered well (9.1%). However a total of almost 40% of the households were using uncovered water from uncovered well (20.8%) and river/canal (17.5%) as seen in Table 6.1. This is a serious health hazard.

According to a national study (IIPS 2011, page 16) 70.0% of the sampled households in Maharashtra and 77.8% in India had access to piped water. The proportion of households using uncovered water in the current study is thus higher than the national and state averages.

Some ASHAs had discussed the situation of water supply in their own villages during the in-depth interviews. The uneven coverage in the taluka was confirmed by them. The changing face of rural India is indicated by the fact that it was the Adivasi ASHAs who were the most satisfied with the drinking water as their areas had tap water. These ASHAs were not in the sampled villages. The entitlements of the Adivasi Rahiwasi Yojana and other public schemes for Adivasis seemed to have reached the community as seen from the next case study.

Case Study 5: Access to Potable Water (ASHA MJ)

MJ works as an ASHA. She is an Adivasi and former gram panchayat member. Her husband and she are active citizens.

MJ is an ASHA with interest and experience in public life. She said that although she herself had studied only upto standard fourth, her husband was educated. She was happy with the sanitation and environment in the tribal hamlet that she lived in and felt it was cleaner and had better amenities than the adjoining village. She called the non Adivasi population as '*general*'.

"We Adivasis are clean, not like general. You see our houses. Our utensils. Our village have houses with toilets, there is water."

To sum up, the access to piped water to the households in the sample was reported by them to be much lower than the national figures, highlighting how the averages can overwhelm the particulars. Shahapur is the taluka that supplies potable water to most of Mumbai city. However it faces drought regularly in the summer. As seen in the in-depth interviews, the women spent time and energy fetching water for the entire family daily and the task was doubly arduous in the summer.

1.3 Nutritional Intake

Measuring nutritional intake is a specialized topic of research in itself. In this study the heads of the households were asked to recall the last three meals taken by the family in order to gain a broad view of the nutritional value of their regular meals (Table 6.2). Quantities of food were not asked as they would have differed for each family member.

Table 6.2

Households: Recall of Last Three Meals taken by the Family

FOOD ITEMS	LAST NIGHT DINNER		TODAY MORNING		TODAY LUNCH	
	No. (N=120)	Percentage	No. (N=120)	Percentage	No. (N=120)	Percentage
Rice / Bhakri*	2	1.6	14	11.7	7	5.8
Bhakri / Rice and Veg.	75	62.5	72	60.0	102	85.0
Bhakri/Rice, Veg and Pulses	2	1.6	3	2.5	1	0.8
Bhakri/Rice and Gravy	20	16.7	-	-	5	4.2
Bhakri/Rice, Egg/Mutton/Fish	21	17.5	4	3.3	2	1.6
Tea/Biscuits/Poha	-	-	24	20.0	-	-
Nothing	-	-	3	2.5	2	1.6
No Response	-	-	-	-	1	0.8
Total	**120**	**100.0**	**120**	**100.0**	**120**	**100.0**

***Bhakri = flat bread made out of rice flour**

The compiled data showed that protein intake was poor in all meals. Within the protein sources, households might have used groundnuts for some preparations according to the local practices which were not reported, but very few families reported any pulses.

Among protein sources there were some mention of meat, fish and egg. Largely the contents of meals were rice and vegetables.

1.4 Source of Employment of the Main Earner

The household survey asked the occupation of the main earners of the family (Table 6.3).

The ASHAs had reported that their family members were doing different income-earning activities but cultivation was the major activity as seen in Chapter Three. In common

Table 6.3

Households: Occupation of the Main Earner of the Family

OCCUPATION OF MAIN EARNER OF THE FAMILY	NO. OF FAMILIES (N=120)	PERCENTAGE
Cultivator (own land)	36	30.0
Cultivator + Other work*	12	10.0
Labourer (on other's land)	41	34.0
Labourer + Other work*	3	2.5
Sub-Total	*92*	*76.6*
Industrial Worker	*5*	*4.2*
Self Employed*	*13*	*10.0*
Job (Govt./Private)**	*6*	*5.0*
Looking for Work	*4*	*3.3*
Total	**120**	**100.0**

Note:

* Preparing leaf plates, Painting walls, Cowherd, Collecting and Selling Dry Twigs/Wood, Carpenter, Working in Brick Kilns (*Veetbhatti)*, Plumber, Vegetable Vendor, etc.

** Peon, Postman, Working in Railways, Working in BMC

with the families of the ASHAs, the main earners were doing different activities. The major income-generating activity of the main earner was cultivation (76.5%). Among the non-agricultural occupations, only about 5% of the main earners were job holders. The rest of the non-agricultural self-employed were doing petty and low income activities like preparing leaf plates. Though about 30.0% worked on their own land, it did not necessarily indicate wealth as most of the land was in small holdings. Agriculture in any case is a seasonal employment therefore the majority of main earners were only partially employed during the year.

Eating off the land, there would be little in terms of cash for the households except through other sources of employment. This finding matched with the family backgrounds of the ASHAs as well (Chapter Three), thus triangulating the possibility of income expectations from their families.

To sum up, the community was largely poor and dependent on agriculture for sustenance and nutrition. This was the reason why the families largely ate locally produced rice/ or flat bread (**bhakri)** made of local rice with locally grown vegetables cooked in oil. While this was wholesome food it was deficient in terms of nutritional intake by the lack of protein sources. The current study did not explore the quantity of food taken at each meal therefore the caloric value could not be deduced from the data which could have given further insights into the nutritional status. It is likely that the entire community is under nourished. It is important to conduct further research on this aspect.

1.5 Family Size

To get a full picture of the poor nutritional intake of the community, the number of family members who survived on the small land holdings of these households was explored.

Table 6.4

Households: Family Size

FAMILY SIZE (No. of Family Member)	NO. OF HOUSEHOLDS (N=120)	PERCENTAGE
Upto Five Members	73	60.8
Six to Ten Members	47	39.2
Total	**120**	**100.0**

As in the case of the ASHAs, the family size of the households covered in this survey (Table 6.4) was divided between small families having up-to five members (60.8%) and large families having six to ten members (39.2%).

To track the linkages between nutritional intake, occupation and family size, a sizable number of households were large and all the families had limited sources of income. Their nutritional intake was therefore likely to be unsatisfactory. The data generated by the current study about the meal recall also showed that the quality of nutrients were likely to be insufficient. This was likely to be the status of most of the households in the community.

The high levels of malnutrition in this district were currently only reflected in data on children. The Thane district regularly tops the areas having high child mortality rates in the country. However the findings from this study indicated that there was hidden hunger among the adults as well. The ASHAs were serving a poverty ridden and nutritionally deprived adult and child population. There were few opportunities for employment and accessibility of health and social infrastructure is poor as seen below. The perspectives of the community about the ASHAs must be viewed from this background.

1.6 Sanitation Facilities

Many ASHAs felt that they had not made much headway in the matter of promoting sanitation and building toilets in their villages and the data reflected the same (Table 6.5).

Table 6.5

Households: Arrangement for Latrine

ARRANGEMENT OF THE HOUSEHOLD FOR LATRINE	NO. OF FAMILIES (N=120)	PERCENTAGE
Flush/Pour Latrine connected to Piped Sewer Health services	9	7.5
Flush/Pour Latrine connected to Septic Tank	8	6.7
Public Latrine	3	2.5
Open	94	78.3
Flush/Pour Latrine + Open	5	4.2
No Response	1	0.8
Total	**120**	**100.0**

About 78.3% of the households reported using open spaces. The common experience of ASHAs was that people were not willing to build toilets because houses in the villages were close to each other and neighbors objected to toilets of the families. This was pointed out by some members of the gram panchayat as well. According to a national study of the NRHM (IIPS 2011, page 16), about 39.0% of the households in the sample in Maharashtra and 42.6% in India had toilet facility.

On comparing the data of a national evaluation study (IIPS 2011) and the current study, the trends were in the same direction with reference to the distance, potable water and sanitation facilities, with some differences. The households in the current study and the national study (IIPS 2011) as well, found distance and transportation with regards to the public health facilities difficult. The households in the sample of the current study fared worse than the state average in terms of safe drinking water and sanitation facilities.

Caste was also taken as an analytical indicator in our study. Presented below is the distribution of the households in the sample in terms of caste.

1.7 Caste Break- up of the Households

As seen in Chapter Three, nearly half of all the ASHAs in the taluka were Adivasis themselves. In the sample of the households, the Adivasis made up 40% of the total sample, with the dominant OBC social group of Kunbis at 45% of the sample. The Minority group was about 14% of the sample that had one Christian household also (Table 6.6). Caste had its own effects on other parameters as seen in the findings below.

Table 6.6

Households: Caste Backgrounds of the Families

CASTE BACKGROUNDS OF THE FAMILIES	NO. OF FAMILIES (N=120)	PERCENTAGE
ADIVASIS:		
Katkari	27	22.5
MahadevKoli	5	4.2
M. Thakur	15	12.5
Adivasi (Adivasi group not mentioned)	1	0.8
Sub-Total	**48**	**40.0**
OTHER BACKWARD CASTES:		
Kunbi	53	44.2
Agri	1	0.8
Sub-Total	**54**	**45.0**
MINORITY		
Baudh	5	4.2
Mahaar	4	3.3
Thakral	7	5.8
BhatkiGosavi	1	0.8
Sub-Total	**17**	**14.1**
CHRISTIAN (Religion)	1	0.8
Total	**120**	**100.0**

The following sections present the findings on the location, duties and rights of the ASHA functionaries according to the community. The analysis contextualizes the findings on the basis of the status of the social determinants of health in the community. The data was collected by interviewing the heads of 120 households. They were largely male respondents.

2. Location of the ASHA Functionary within available Services: 'A conduit to free Services from the Government'

The general perception among the health researchers and academicians about the usage of the public health services is that it is low, and the majority of the health needs are being taken to the private sector. The current study first looked at the respondents' understandings of the health services available to their village including the ASHA Functionary. At the outset it must be noted that all the six villages had ASHAs.

2.1 Availability of Health Services to the Village: Community's Understandings

"We have to go to the **dawakhaana** *(*PHC*), there is nothing available in the villages."*

(Head of a household)

Table 6.7

Households: Description of Health Services Available to the Village

DESCRIPTION OF HEALTH SERVICES TO THE VILLAGE BY THE HEAD OF THE HOUSEHOLD	**NO. OF RESPONSES* (N=120)**	**PERCEN-TAGE**
We go to Private Doctors for minor illness and to Primary Health Centre for others	3	2.4
We go to the *Sarkaari Dawakhaana* (Primary Health Centre)	46	36.2
We go to the *Sarkaari hospital* (Sub-Divisional Hospital at Block)	3	2.4
We go to the *Sarkaari Dawakhaana* (Primary Health Centre) normally and for serious illnesses to Private facilities	13	10.2
For minor illness the ASHA gives tablets	9	7.1
We get free tablets, tonics, immunization and information in the village (ASHA not mentioned by name)	35	27.6
We have nothing in the village we have to go to the city (Private/Public facilities)	2	1.6
We only go to Private facilities in the city	12	9.4
We go to Sarkaari Dawakhaana (Primary Health Centre) and if there is no improvement we go to Bhagat (Traditional Healer)	1	0.8
We do nothing / gharguti (Home Remedies) / Bhagat (Traditional Healer) and if there is no improvement we go to *Sarkaari Dawakhaana* (Primary Health Centre)	3	2.4
Total	**127**	**100.0**

Note: Responses in bold are about the services of the ASHAs

*Multiple Responses of 120 households.

The heads of households were asked to describe the health services available to the village. The proportion of responses mentioning any service was taken as an indication of its location within the priorities of the households.

When asked about the health services available to the village, most of the services mentioned were public health services. About 36.2% of the responses from the heads of the

households mentioned the Primary Health Centre (PHC), about 10.2% mentioned the PHC plus private for serious illnesses. In addition there was mention of the sub-divisional hospital (2.4%), PHC plus **bhagat** (0.8%) and PHC plus household remedies/**bhagat** (2.4%). Thus about half of the responses mentioned the public health services particularly the PHC as a service that was available to the village.

The services of the ASHA Functionary were mentioned much less than the PHCs. Only about a tenth of the responses (10.1%) directly mentioned the ASHA. However the indirect mention of ASHAs was higher as about 27.6% of the responses were that 'free tablets/tonics/immunisation/information' were available to the village. These services are currently provided largely by the ASHAs with participation from the Anganwadi Workers and the ANMs. It indicated that the ASHAs were largely associated with what they could provide and that these provisions included information also. However the 'free services' were not mentioned by two thirds of the respondents. This could mean that the 'free services' provided were either not reaching all the people or that they were not considered as important enough to be mentioned as health services according to the community. The presence of a medical doctor might be considered as mandatory by the community in a health service.

Thus largely most of the responses about the services available to the village were about the public health sector. Few of the households had prioritized private services in the sample as seen by the number of mentions. This could be because most of the villages were located at a distance from the private facilities; or due to poverty and inability to pay for private services; or due to the success of NRHM interventions.

2.1.1 Caste by description of health services available to the village

If the reported available health services to the village were seen according to the caste of the respondents (Table 6.8), then the mention of the PHC was the highest among the OBC respondents (37.3%). The mention of free services' was comparatively lower (17.0%). There is a possibility that the OBC population depended more upon the services from the PHC than upon the ASHAs.

Table 6.8

Households: Caste by Description of Health Services Available to the Village

CASTE / RELIGION OF THE FAMILY	NO. OF RESPONSES FOR EACH SERVICE AVAILABLE TO THE VILLAGE* (N=120)											
		We go to Private Doctors for minor illness and to Primary Health Centre for others	**We go to Sarkaari Dawakhaana (PHC)**	**We go to Sarkaari Hospital (Government Hospital)**	**We go to Primary Health Centre and for serious illnesses we go to Private Facilities**	**For minor illness the ASHA gives Tablets**	**We get free tablets, tonics, immunization and information in the village (ASHA not mentioned)**	**We have nothing in the village we have to go to the city (Private / Public Facilities)**	**We go to Primate Facilities in the City**	**Primary Health Centre and if there is no improvement we go to Bhagat (Traditional Healer)**	**We do nothing / home remedies / Bhagat and if there is no improvement we go to Primary Health Centre**	**Total**
Adivasis	No.	-	17 (34.7)	-	3 (6.1)	3 (6.1)	21 (42.9)	-	2 (4.1)	1 (2.0)	2 (4.1)	49 (100.0)
Other Backward Castes	No.	2 (3.4)	22 (37.3)	2 (3.4)	8 (13.6)	6 (10.2)	10 (17.0)	1 (1.7)	7 (11.9)	-	1 (1.7)	59
Minorities	No.	1 (5.6)	6 (33.3)	1 (5.6)	2 (11.1)	-	4 (22.2)	1 (5.6)	3 (16.7)	-	-	18 (100.0)
Christian (Religion)	No.	-	1 (100.0)	-	-	-	-	-	-	-	-	1 (100.0)
Total Responses	**-**	**3**	**46**	**3**	**13**	**9**	**35**	**2**	**12**	**1**	**3**	**127**

*Multiple Responses of 120 households

Among the Adivasis about 42.9% of their responses mentioned the free services, the highest among all the caste groups. Adivasis also mentioned the PHC but the proportion of responses was lower (34.7%) than the OBCs. This could be interpreted in terms of higher awareness and access to the free services by the Adivasis.

Among the Minority group the number of responses that mentioned PHCs (33.3%) was less than Adivasis and the OBCs. They also mentioned the free services (22.2%) but less than the Adivasis. The data indicated that this caste group was being served by the public health services but access needs to be improved.

The analysis then turns towards the direct mention of the ASHA Functionary. The responses of OBCs that mentioned the services of the ASHAs were about 10.2%. However the ASHAs were mentioned directly in a lower proportion among the Adivasis (6.3%). This triangulated the findings from in depth interviews of the ASHAs that there was resistance from them for institutionalised delivery.

Not a single Minority respondent mentioned the ASHA's service as being an available service. This could be related to discrimination by ASHAs. Alternatively the location of the homes of the Minorities in the villages could have been responsible for them to be neglected – the homes were generally on the outskirts of the villages and difficult to reach by foot. However the Adivasi hamlets too were on the outskirts of some villages yet they had mentioned 'free services' the most. These Adivasi households could be receiving more 'free services' as a conscious planning strategy. Perhaps a large number of ASHAs were Adivasis themselves therefore they were living in Adivasi hamlets, making accessibility easier. In this case, increasing the proportion of ASHAs from Minority communities might ensure that ASHA services and 'free' benefits reach more households from Minority caste groups.

We go to the ***dawakhaana*** (PHC) *or the sub-divisional hospital. If I tell her* (ASHA) *my problems or ask for tablets she does not give. She behaves as if she has not heard me. I had gone to call her when my daughter-in-law's delivery was due but she did not come."*

(Lalita D, Buddhist, widow, lives with her 2 sons and their minor children, and a daughter, both the sons work outside the village)

To sum up the highest priority was given to the Primary Health Centres (PHCs) among the households. Next was the mention of 'free services' including referral and information which are provided largely by ASHAs. The direct mention of ASHAs was lower than the mention of 'free services' indicating that the ASHAs were located by the community as a conduit of the 'free services'. Since the mention of PHCs was much higher, the ASHAs might either not be reaching the households or her services were not as valued by the households.

Thus the households' understandings of health services at the village and the location of the ASHAs within them was established and the exploration moved towards the health seeking behavior of the households.

3. Location of the ASHA Functionary within health seeking behaviour: 'ASHAs as a Conduit'

After analyzing the community's description of the health services available to the village, the choices the community made when availing health services were analyzed. These were not absolute choices but within the needs, means and available services.

To begin understanding health seeking behavior, the heads of the households were asked to recount the household's requirement for health services in the past.

3.1 Recall of the Family Members who had required Health Services

The head of the households were asked which family members had required health services in the past three years (Table 6.9).These are the numbers as recalled by the largely male heads of the households about their family members. This is not a systematic study of morbidity since that was not the aim of this study. The aim was to explore understandings.

The male heads of 120 households could collectively recall 265 episodes over the past three years. As recalled, the wives had required health services in slightly lesser number of episodes (20.8%) than the male respondents themselves (23.8%). The daughters and daughter-in-laws were recalled as requiring health services (9.8% each) lesser than the sons (17.7%) and the granddaughters (3.8%) lesser than the grandsons (6.8%). The recall could be reflecting the priorities in the health seeking behavior of the households in terms of gender.

Table 6.9

Households: Recall of which Household Member Needed Health Services

FAMILY MEMBER	**NO. OF RESPONSES* (N=120)**	**PERCENTAGE**
Self (Male)	63	23.8
Self (Female)	6	2.3
Wife	55	20.8
Son	47	17.7
Daughter	26	9.8
Daughter-in-Law	26	9.8
Grand-Son	18	6.8
Grand-Daughter	10	3.8
Mother (Senior Citizen)	9	3.4
Father (Senior Citizen)	1	0.4
Sister	3	1.1
No one needed services	1	0.4
Total	**265**	**100.0**

*Multiple Responses of 120 households.

3.2 Recall of the Health Needs of Family Members

The heads of the household were also asked to recall the health need for which services were needed for the family members (Table 6.10). Health needs were largely defined in terms of illnesses by the respondents.

Table 6.10

Households Recall of the Health Needs of Family Members

HEALTH NEEDS OF FAMILY MEMBERS	NO. OF RESPONSES* (N=120)	PERCEN-TAGE
Fever / Body Pain / Cold / Loose Motions	148	55.8
TB / Malaria / Leprosy / Other Chronic Diseases	38	14.3
Epidemic of any kind	13	4.9
Immunization Child	11	4.2
Immunization Mother	4	1.5
Delivery	13	4.9
Snake Bite / Scorpion Bite	5	1.9
Others**	32	12.0
Not Applicable	1	0.4
Total	**265**	**100.0**

*Multiple responses of 120 households.

****Others**: Swelling of Hands and Feet, **Vayaa Mule** (Due to Old Age), **Ang Baher Yene** (Prolapsed Womb), **Vaat** (Ayurvedic Term as in Vaat-Pitta-Kapha), **Devi Aali** (Possessed), Orthopedic Operation, Breathing Problems, Liver Operation, Eye Problems, Jaundice, Weakness, Malnourished, Hysterectomy, Hole in the Heart and Arthritis.

A large part of the ASHAs' services are free services meant for the women and children. However immunization and delivery were mentioned as health needs of the family in very small numbers. This indicated that these were not seen as health needs by the male heads of households. Maternal and child health were the services which were of such a high priority for the health services. However the highest need of the community according to the largely male heads of households was for curative services.

More than half responded that family members had suffered from fever/body pain/cold/loose motions. The next highest numbers of mentions were of chronic diseases. Both these conditions are ones that can be addressed at the PHC level with the support of the ASHAs.

However it was the list of ailments mentioned as 'others' that showed that the health needs of the community were very varied and there were serious illnesses that could only be handled by specialists. In the absence of resources, the patients of such illnesses could be suffering needlessly (Table 6.10).

"Since the past two years I have been taking medicine for weakness and breathlessness from the ***dawakhaana*** *(*PHC). *I get breathless when I walk. I am not feeling better. They don't give good medicines and then the symptoms increase. I am forced to go to private. I have exhausted my money for this."* (Head of a household)

3.3 Recall of the Health Services taken for meeting the Health Needs of Family Members

The head of the households were asked what services their family members had availed for their health problems.

As many as 14.3 % of the responses were: 'no treatment was taken for the needs' (Table 6.11). The previous Table 6.10 showed that the majority of the health needs of the community were such that they could be handled at the PHC level with the support of the ASHAs. Table 6.9 showed that the public health services particularly the PHC were mentioned frequently as health services available for the village. Therefore these 14.3% (Table 6.11) ailments that received no treatment were those that the health services and the ASHAs had not reached. Further study is required to explore this gap.

The responses of Table 6.11 show that the PHC and the public hospitals had been consulted in various combinations for the health needs. The total percentage of needs that had been met by the public health services was 50.2%. This triangulates the findings of Table 6.9 where the PHC was mentioned in the same proportions as an available service. This also triangulated the responses of the medical officers that indicated a large OPD load. It is a matter for further study whether the OPD (Out Patients Department) load has increased post NRHM; and the implications of the increased OPD load for improving the response and infrastructural facilities of the public health services.

Table 6.11

Households: Recall of the Health Services

taken for Meeting the Health Needs

HEALTH SERVICES TAKEN FOR THE HEALTH NEEDS OF THE FAMILY MEMBERS	NO. OF RESPONSES*	PERCEN-TAGE

	(N=120)	
NO SERVICE TAKEN:		
No Treatment	38	14.3
Home Remedies	2	0.8
Vaidu / Buwa (Traditional Healer)	1	0.4
Sub-Total	**41**	**15.5**
PRIVATE SERVICES:		
Private Doctor	35	13.2
Private Hospital	36	13.6
Sub-Total	**71**	**26.8**
PRIVATE + PUBLIC SERVICES:		
PHC + Private Hospital	10	3.8
PHC + Private Doctor	1	0.4
Govt. Hospital + Private Doctor	3	1.1
Sub-Total	**14**	**5.3**
PUBLIC HEALTH SERVICES:		
Primary Health Centre	89	33.6
Govt. Sub-Divisional Hospital at Block Level	18	6.8
Sub-Centre	5	1.9
ASHA only	10	3.7
ASHA + PHC / Govt. Hospital	2	0.8
Anganwadi Worker / Dai	4	1.5
Civil Hospital outside the Block (Thane, Murbad, Mumbai)	4	1.5
PHC and Govt. Hospital	1	0.4
Sub-Total	**133**	**50.2**
OTHERS:		
Vaidu/Home Treatment + Private / Public Services	5	1.8
No Response	1	0.4
Sub-Total	**6**	**2.2**
GRAND TOTAL	**265**	**100.0**

*Multiple responses of 120 households.

The direct services of ASHAS were mentioned only in 3.7% of the responses for curative functions only. Since it was mandated, the ASHAs might have played the “activist” role for guiding the ill to the public services. However the community mentioned only that the treatment was done at the PHC or the hospital. It was apparent that the role of the ASHAs was not seen as important for direct curative care which was the highest need. It was likely that her role as a referral and information provider could have been ‘masked’ as well. This aspect must be explored further in another study. Further there was a need to explore whether the services provided by the ASHAs as a referral and information provider were ‘masked’ as well.

3.4 An exploration of the role of the ASHA Functionary as 'Activist' for referrals

A) Perspectives from the top of the health services hierarchy about health seeking behaviour

The NRHM policy had envisaged the ASHA as an '*activist*' for increasing usage of public health services. According to the ASHAs this role was being fulfilled as they indicated in the in-depth interviews. An acknowledgement of this increased usage of public services due to their efforts had been conveyed to the ASHAs by some senior members of the health service.

"Once we had gone for a meeting and ASHAs were given awards. Then the District Medical Officer said that ASHAs are doing so well. Patients have started using the government services much more and illnesses are becoming less now."

(BN is an ASHA. She has passed the 10th standard. Her husband is self-employed and their monthly family income is more than rupees 3000.)

However, apart from the efforts of the ASHAs, the improved curative facilities post NRHM and the proximity of the villages to the PHCs might also have been factors for increased usage of some PHCs.

Case Study 6: ASHA as '*activist*': (ASHA CS)

CS is an ASHA since 2 years, She is an Adivasi, and she is supported by her family for the work.

*"People are now aware of health services so they all come to the PHC (*Primary Health Centre*) regularly. Our villages are near the PHC. Poor people mostly use the PHC, Vashind* (area near the railway tracks and the taluka headquarters) *has many private hospitals but only some rich people go. Then too for Malaria, TB, Leprosy they come here. Earlier it was not so, earlier if we said come to PHC, people would say no. But now there are medicines and doctors, all come here. Deliveries too are mostly at PHCs or hospital except for the rich. For the poor, even emergency, breech deliveries don't go to private hospitals but the Thane Civil."*

B) Perspectives of the local health services stakeholders about health seeking behaviour

i) There was not a single acknowledgement of an increase in PHC usage among the Medical Officers in the study sample. There was no mention of any referrals made by the ASHA Functionaries. The doctors reported that the OPD load was always high even before the advent of the NRHM.

Interviews revealed that some Medical Officers felt over burdened by the OPD load. They expressed difficulties in adhering to the norm of 24/7 accessibility in some PHCs. Despite

being given a hardship allowance they felt the financial returns and the infrastructural amenities were inadequate for their families. However there was an indirect acknowledgement from the Medical Officers that there was higher awareness in the community. The Medical Officers reported pressure from the community to attend to the PHC and to continue the ASHA Scheme.

Case Study 7: Demand for ASHA and OPD Services from the Community

(Medical Officer)

This is the narration of a Medical Officer who was visiting the remotest village of the sample, nested among mountains. He was speaking about a distant PHC.

*"If the ASHA Scheme stops then we will get the maximum pressure from the people. NRHM benefits should be continued and regularized. Our community is stubborn and demanding. (**Naaman jhenaade manjhede**). If there is no MO* (Medical Officer) *in the PHC the community members phone up the Block Medical Officer. Once in one of the PHCs* (name of the PHC withheld) *there was no doctor for two days. The third day the community created such a racket outside the PHC that I was requested by the BMO* (Block Medical Officer) *to go to the PHC and remain there until the doctor rejoined."*

ii) Some Medical Officers expressed difficulties in handling deliveries at PHCs. One Medical Officer shared that even normal deliveries were routinely referred to the sub-divisional hospital from some PHCs. Caesarian deliveries were routinely referred to the District hospital because there was no specialist at the sub-divisional hospital. This triangulates the experiences of the ASHAs. Thus on the one hand the ASHAs were trained to bring all deliveries to the PHC and on the other hand the MOs/PHCs were referring them to the hospitals. This put immense strain on the ASHAs and affected the credibility of the ASHAs among the community where they had pro-actively pursued women and families for institutionalised deliveries.

iii) The Medical Officers in the PHCs had universally conveyed that the ASHA Functionaries had failed in their 'main purpose' as their efforts in ante-natal and post –natal care did not lead to a reduction of the Infant Mortality Rate (Chapter Five). In this community as in most of the rural communities, the solutions to child survival went well beyond the provisions of the health services as even the basic needs of the communities were unmet (Section One). The health beliefs of the community and the position of women within it were also factors for low child survival. These factors were acknowledged by the health services stakeholders but only in their personal capacities.

Case Study 8: Acknowledgement of Social Determinants

(Block level officials)

Block Level Official I (position and other details withheld)

"If I can only get pregnant women to eat a meal and sleep for a while in the afternoon it will really help …".

Block Level Official II (position and other details withheld)

"*There is a new drive against IMR* (Infant Mortality Rate) *that has been announced – zero IMR in six months. We have to identify all children in grade 1 and 11, we don't get grade 111 nowadays.* (Grades I, II and III are progressive grades of malnutrition among children). *We have to see that they eat and bring all weights to normal in six months. You know about health – tell me is it possible? It starts with the mother and does she have any choice for herself?"*

Such was the pressure to reduce infant mortality rates that it did not even give space to the full time functionaries to appreciate any progress in the community. As seen in the case study given above, the mention of improvement ("*we don't get grade III nowadays")* was a passing comment. The demand to contain the child mortality through the health services came from the top to the PHCs. Their inability to do so despite efforts was then transferred by the full time health functionaries to the ASHA Functionaries despite their understanding of the complexities. The ASHAs were implementing the pre-natal and ante-natal services therefore they were held responsible for lowering infant mortality rates.

Given the location of the ASHAs as the lowest in the hierarchy, the 'scapegoating' of ASHAs was almost inevitable for the 'unsatisfactory' performance of the PHCs as regards the infant mortality rate. In the process, the increase in the usage of public health facilities due to the ASHAs' referrals was also not found to be laudable. None of the health services functionaries however questioned whether the demand made upon the health services to reduce infant mortality was justified in their official capacities. This was another indication of the essentially hierarchical nature of the health services.

Thus Section Three showed that the ASHA Functionary was not located as being directly useful by the male heads of the households for their highest need of curative services. The stakeholders from the health services also did not mention the ASHAs' role in the referral for OPD services. Recent studies and reports also mention just the increase in institutionalized deliveries as an achievement of the ASHA Scheme. There is a need to explore the role of ASHAs in referrals for curative services.

Another community-related activity also mentioned by the stakeholders from the health services was the ASHAs' efforts in prevention of epidemics in the villages through early warning and follow up activities. A larger quantitative study is needed to further examine the veracity of the contribution of ASHAs as '*activists*' to increase usage of public services.

It was necessary to understand the community's perspectives about the duties of the ASHA.

4. The Community's Perspectives about the Duties of the ASHA Functionary: 'a conduit of entitlements from the government'

The exploration of the community's perspectives about the duties of the ASHA Functionary was initiated by exploring whether the respondents were aware of the ASHA in their village.

4.1 Community's Awareness about the ASHA in their Village

ASHAs had been appointed and were active in all the six villages. However when asked whether there was a woman Functionary ASHA in their village though most of the respondents replied in the affirmative, around one tenth of the respondents were unaware that there was an ASHA in their village (Table 6.12).

Table 6.12

Households: Awareness about the ASHA in the Village

AWARENESS ABOUT THE ASHA IN THE VILLAGE	NO. OF FAMILIES (N = 120)	PERCENTAGE
Yes	106	88.3
No	14	11.7
Total	**120**	**100.0**

There could be a difficulty in placing the woman who provided services by her nomenclature as an ASHA Functionary in some cases as indicated by some responses in the household survey.

"*I don't know ASHA. There is a woman called Sharda who gives tablets and takes women for delivery."*

"There are two women in the village at whose homes we get tablets. If we have problems at night they come home."

4.1.1 Distance of the PHC by Awareness of the ASHA Functionary in the Village

Distance did not have any effect on awareness of the ASHA Functionary among those who were aware. All the respondents from villages falling under the most distant PHC were aware of there being an ASHA Functionary in their villages except for one respondent (Table 6.13). On the other hand, the maximum number of respondents who were not aware of ASHAs were from villages located under the PHC at a medium distance.

Table 6.13

Households: Distance from Block Hospital by Awareness about the ASHA in the Village

LOCATION OF RESPON-DENTS	DISTANCE FROM BLOCK LEVELS HOSPITAL	AWARENESS ABOUT THE ASHA IN THE VILLAGE				TOTAL (N = 120)	
		YES (No.)	Percen-tage	NO (No.)	Percen-tage	No	Percen-tage
Dolkhamb	Far (more than 20 kms.)	39	97.5	1	2.5	40	100.0
Washind	Medium (11 to 20 kms.)	36	90.0	4	10.0	40	100.0
Kinawali	Near (Upto 10 kms.)	31	77.5	9	22.5	40	100.0
Total		**106**	**88.3**	**14**	**11.7**	**120**	**100.0**

The quality of administration of the ASHA Scheme at local levels and the quality of the ASHAs rather than the distance of the villages was likely to affect the awareness of the ASHA Functionary in the village. The other factor could be the availability or lack of alternative health care facilities in the area.

4.1.2 Caste by awareness of the ASHA Functionary in the village

Caste was explored as a factor in awareness of the services of the ASHAs.

Most of the heads of households were aware of ASHAs. Therefore it was just the spontaneous mention of ASHAs and 'free services' that was lower (Table 6.7). This triangulated the analysis presented earlier that either the ASHA services were not reaching all households or were not valued enough as a health service to be 'counted' separately by the respondents.

Table 6.14

Households: Caste by Awareness about the ASHA

in the Village

CASTE OF THE FAMILY	AWARENESS ABOUT THE ASHA IN THE VILLAGE				TOTAL (N=120)	
	YES (No.)	Percen-Tage	NO (No.)	Percen-tage	No.	Percen-tage
Adivasi	40	83.3	8	16.7	48	100.0
Other Backward Class	51	94.4	3	5.6	54	100.0
Minority	14	82.4	3	17.6	17	100.0
Christian (Religion)	1	100	-		1	100.0
Total	**106**	**88.3**	**14**	**11.7**	**120**	**100.0**

If the proportion of respondents not aware of ASHAs was seen among their caste groups then the highest proportion of respondents not aware of ASHAs were among the Minority respondents at about 17.6% followed closely by the Adivasi respondents at about 16.7% and the OBCs at about 5.6% (Table 6.14).

4.2 Community's Perceptions of the Duties of the ASHA Functionary

The achievement that was often expressed by the ASHAs was in terms of providing curative care for the villagers. ASHAs had also shared their success in tackling chronic illnesses at their village. They had successfully detected diseases and facilitated their treatment.

"Fever, loose motions are controlled by ASHA at the village level. Patients with diseases like TB too have benefitted. A woman who has survived TB has told many others that 'she has saved my life'. So, more people come now. That woman had lost all hope I had to convince her so much for taking DOTS."

(BS, ASHA, widow with graduate son who is working, has support of brother and wife)

Such changes had not happened overnight but after a few years of work said the ASHAs. There was an element of trust that had built up between the ASHAs and the community.

"Most of the small ailments in the village, I treat them. They ask if I don't come for rounds on one day. There is more sanitation in the form of latrine construction. Now they trust me."

(CI, ASHA, Adivasi, lives in a family of 23 members, did not respond to the question on amount of last payment received).

These assertions of the ASHAs run counter to the findings in the preceding Section that showed that few respondents mentioned the ASHAs directly as a source of curative services. The community itself had a different perspective.

When the heads of households were asked about the duties of the ASHAs, they mentioned nine duties. There was awareness about not only the existence but also the functions. This triangulated the analysis that the ASHA services were known but not 'counted' by the community.

The duties of the ASHA as mentioned by the heads of households were matched with the duties mentioned by the other stakeholders (Chapter Five). The community's description of ASHA duties essentially matched the policy documents and the stakeholders. However the number of duties was different at each of the seven levels of stakeholders and was different at the level of the community as well.

The component of curative services had the highest number of responses from the households but a closer analysis showed that direct treatment by ASHAs was not the highest figure (Table 6.15). Four separate duties were mentioned in curative care where responses saying ASHAs gave tablets and tonics from their medical kit was lower (14.3%) than the follow up of chronic illnesses and dosages (20.8%). In absolute terms the ASHA's kit was not as valued by the community as her follow up of illnesses diagnosed at the PHCs.

If the curative services were intended to be the entry points into the community for the ASHAs, then the ASHAs were ascribing greater value than intended by policy or acknowledged by the community to their curative functions. This could be because these functions were 'tangible', or gave recognition. They had no other value for the ASHAs as most were gratis services.

The second highest component of ASHA services mentioned by the community was of Maternal and Child Health Services. Within this component a total of four tasks were

Table 6.15

Households: Understanding of the Responsibilities

of the ASHA Functionary

RESPONSIBILITIES OF THE ASHA FUNCTIONARY (AS MENTIONED BY THE HEADS OF HOUSEHOLDS)	**NO. OF RESPONSES* (N=106)**	**PERCEN-TAGE**
MATERNAL AND CHILD HEALTH		
ASHA facilitates immunization of expectant mothers at the PHC	17	6.9
ASHA takes delivery patients to the PHC	**46**	**18.8**
ASHA facilitates Family Planning Operations	**7**	**2.9**
ASHA comes with the AnganwadiBai. She goes from house to house to call children for immunization	13	5.3
Sub-Total	***83***	***33.3***
CURATIVE SERVICES		
ASHA gives tablets and tonics from her home (medical kit)	35	14.3
ASHA distributes tablets to the homes of patients (patients of chronic illnesses)	**51**	**20.8**
ASHA takes seriously ill people to PHC and facilitates their treatment and tests	20	8.2
During illness she visits, calls Doctor (MPW)/Nurse (ANM) to our house	3	1.2
Sub-Total	***109***	***44.4***
HEALTH EDUCATION/GUIDANCE		
ASHA gives free information/guidance on health services	22	9.0
Sub-Total	***22***	***9.0***
OTHERS:		
ASHA takes care of health matters in the village	2	0.8
ASHA attends monthly meetings (ASHA meetings at PHC)	1	0.4
ASHA puts medicine in water	6	2.4
I Don't Know	6	2.4
ASHA helps to acquire certificates like Death Certificate	1	0.4
Sub-Total	***16***	***6.4***
GRAND TOTAL	***245***	***100.0***

Note: *Multiple responses of 106 households that have said there is a Functionary ASHA in the village.

The duties in bold receive incentives for ASHAs.

mentioned by the community. It was notable that the task of escorting women for community when they narrated the ASHA's functions. Ante-natal care made up about 6.9% of the responses, immunization was about 5.3% and facilitation of Family Planning services was mentioned as just about 2.9% of the responses. In this the last figure showed how low it was in the priorities of the community (Table 6.15).

The 'activist' function of referrals and follow up was mentioned in various ways by the community in terms of ASHAs directly escorting the ill patients (8.2%) and giving guidance (9.0%).

Out of the nine duties of ASHAs mentioned by the community, three were getting incentives and the rest were gratis. Thus data from the community triangulated the view of the ASHAs and some of the other stakeholders that the ASHAs were providing many gratis services. On the other hand that there could be a higher focus by the ASHAs on the incentivized tasks as indicated by the medical officers. Data showed that the highest number of mentions by the community among the nine ASHA tasks were of the two paid tasks of escorting women (18.8%) and completing the treatment regimen of the chronically ill (20.8%). The current study has shown that apart from the incentive the emphasis from all levels of stakeholders except the community on escorting women was also responsible for the ASHA's focus (Chapter Five).

4.3 Community's Understanding about the Payments of the ASHA Functionary

When the respondents from the community were asked about the ASHAs' payment, the majority did not know anything at all (Table 6.16).

Table 6.16

Households: Understanding about the Payment of the ASHA Functionary

UNDERSTANDING ABOUT THE PAYMENT OF THE ASHA FUNCTIONARY ACCORDING TO THE HEAD OF THE HOUSEHOLD	**NO. OF RESPONSES* (N=106)**	**PERCENTAGE**
When ASHA goes for meeting she gets payment for travel	2	1.9
ASHA gets paid per delivery	3	2.8
ASHA gets paid for immunization	2	1.9
ASHA gets ***Maan Dhan*** (Token amount)	18	17.0
ASHA gets very little	28	26.4
I don't know	51	48.1
Very little, sometimes nothing	2	1.9
Total	**106**	**100.0**

Note: *Responses of 106 households that have said there is a Functionary called ASHA in their village.

Just 1.9% of the responses said she got paid for attending meetings, 2.8% that she got paid per delivery and 1.9% that she was paid for immunization showing some understanding of the performance-based incentive system.

In one of the villages a woman Sarpanch thought that the ASHA was getting a salary. This wide spread ignorance in the community led to misunderstandings, negative perceptions and therefore could lower the acceptance of the ASHAs. This lack of information then could also affect the location of the ASHA within the community as seen by the narrations of the ASHAs.

According to the ASHAs there was mistrust regarding the position and payments received by them and this observation was upheld by some health services stakeholders as well. At a meeting in a sub-centre the following experiences were shared by stakeholders:

"People in the village feel as if the ASHAs have been appointed for us"

(Multi Purpose Worker (MPW) in a Sub Centre)

*"They feel we get a salary like the MPW and ANM. They say 'Why do you do so much if you are getting only incentive (**mobadalla)'?** The **dai** says you have kicked my stomach**."***

(ASHA in a Sub Centre)

Due to the general lack of information about the payments received, the ASHAs said that they received demands from the community. With regard to the Janani Suraksha Yojana, ASHAs said that paying fares just for reaching the health facility for delivery was not enough according to some villagers. One of the ASHAs at a sub-centre said:

"Patients tell us you must pay for our return fare also. I say you have only been given a one-way fare that too a fixed amount. If a lot of relatives come, we tell them to pay for themselves."

According to the ASHAs, even those who had an understanding that the ASHA was paid per task felt that she was being paid even for the tasks that she was doing for no payment or nominal payment. The ASHA receives no payment for motivating children to get immunized, a task that she does in conjunction with the ANM and the Anganwadi worker. She receives a one-time payment when the village achieves 100% immunization. Yet the villagers felt she was being paid per every child. One ASHA shared:

"In the village some feel 'you must be getting a lot, therefore you go from door to door.' This happens when we motivate for immunization. There may not be any payment yet they feel…"

This feeling of the ASHA making gains at their cost, extended to the registration of expectant mothers where the ASHA is supposed to get rupees 10 per registration. As narrated by an ASHA:

"Like for registration they say 'I will not give my name and get registered for you to get money".

4.4 Utility of the ASHA Functionary in the View of the Community

The community members were asked how useful they found the ASHAs for the family and the village. (Table 6.17)

Table 6.17

Households: Utility of the ASHA Functionary for the Family and the Village

UTILITY OF THE ASHA TO THE FAMILY AND THE VILLAGE ACCORDING TO THE HEAD OF THE HOUSEHOLD	NO. OF RESPONSES* (N=106)	PERCEN-TAGE
ASHA is useful for curative services (giving tablets/taking ill people to PHC/guiding about treatment even at night)	52	30.4
ASHA is useful for facilitating institutional deliveries/maternal health	24	14.0
ASHA is useful for facilitating immunization / weighing children	15	8.8
ASHA is useful because she visits our homes and inquires about the family	38	22.2
ASHA facilitates Family Planning	4	2.3
ASHA is useful for guidance and information	21	12.3
We are in regular contact with the ASHA she does good work	3	1.8
ASHA is not useful	1	0.6
My family has not received any services from the ASHA so can't say	2	1.2
Total	**171**	**100.0**

*Multiple responses of 106 households that have said there is a Functionary called ASHA in their village.

The largest number of responses was that ASHAs were useful for curative services (30.4%) including tasks like giving tablets, escorting patients and giving referrals. This reiterated the importance given to curative health needs by the community. However the ASHA's efforts might be seen as useful but not be considered important for the curative needs since the highest usage was of the PHC services not the ASHAs (Table 6.11). Maternal services received a low mention (14.0%) triangulating the findings of Table 6.15.

The 'activist' role of giving information was mentioned in about 12.3% of the responses. The ASHAs were either not reaching out with information in a wider way or the community did not give information-giving a high priority as a useful service although information was being received. The following observations were made by stakeholders:

"*She gives good information. She tells us about immunisation, about giving nutritious food to our children.*"

(Head of household)

"In the village the personal hygiene has increased. Nutrition information has changed food habits in households. Drinking water is boiled by most families."

(VS, ASHA, remuneration not received since three months)

The second largest number of responses was that ASHAs were useful because they made home visits (22.2%). This task of the ASHAs was unpaid but valued by the community perhaps as it was seen as a representation of the public services' intervention for their curative health needs. Home visits thus did not necessarily increase the ASHA's respect in the community.

"They tell me you must be getting paid that is why you go from home to home."

(UK, ASHA who wants to be paid a regular amount)

The paid task of escorting women for delivery was mentioned as useful in just 14.6% of the responses perhaps also because most of the heads of the households who were the respondents of this survey were men. The findings also showed that there was an element of coercion involved in facilitating institutionalized deliveries and an element of resistance from the community particularly the Adivasis. This was related to the entire operationalization of the Janani Suraksha Scheme and the incentive to the ASHAs. Coercion is indicated by the following words of ASHAs:

"The number of institutionalized deliveries has gone up except for absolutely illiterate and stubborn mothers."

(GY, ASHA since 4 years, last received payment was above rupees 1000 and was for JSY incentive)

*"Last week one Adivasi woman would not agree for delivery (institutionalized delivery).She and her family were so stubborn (**hathhi),** I was in tears. My mother in law went separately to her house and convinced her family to come. I did not leave her she then came to the sub divisional hospital."*

(PS, ASHA, 10th plus diploma, last received payment was rupees 1500 received last month).

To sum up, the community's perspectives about the duties of the ASHAs were linked to her location. She was seen as a conduct to government services in location as well as duties. The ASHAs however emphasized the importance of giving direct curative care. This could be because they gained respectability through this 'tangible' task which also addressed the

community's highest need. They felt empowered when they escorted seriously ill to the PHC for the same reason.

The ASHA Functionary fulfilled the 'activist' role assigned by the NRHM by giving information and paying home visits but this was not a high priority for the health services stakeholders as seen in Chapter Five. The ASHA themselves also did not gain in terms of location in doing these gratis tasks as the community placed her as a representative from the health services who was paid for the visits. The ignorance of the community regarding the voluntary status of the ASHA and the incentive system led to distrust and lack of appreciation.

5. The Understanding of the Community about the role of the Village Health and Sanitation Committee vis-a-vis the ASHA Functionary

The 73rd Amendment of the Indian Constitution envisages the Gram Panchayat as the foundation of a three tier Panchayati system at the village, intermediate and district levels. This is an elected body at the village level. The state of Maharashtra where this study is located has held Panchayat elections regularly and has also reported formation of a Village Health and Sanitation Committee in most of the Gram Panchayats (IIPS 2011).

The Village Health and Sanitation Committee is called the Village Water Supply, Nutrition, Sanitation and Health Committee in Maharashtra (Village Health Committee for short in this study). This Village Health Committee is formed by at the village level and the members are the Sarpanch, gram panchayat members, ANM, Anganwadi Worker and the ASHA. They are supposed to make a Village Health Plan together. The Village Health Committee also releases the travel expenses of the ASHA Functionary for escorting the ill and the mothers who are not eligible under the Janani Suraksha Yojana. This Committee receives rupees 10,000 annually per village and it is an untied fund. The money goes into a joint account of the Sarpanch and the Anganwadi Worker. In some villages, the ANM was also observed to be controlling the sanction of the travel expenses for the ASHAs. Officially the ASHA is supposed to receive support from the Village Health Committee for her activities in the village.

5.1 Awareness about the Village Health Committee and Implications for the ASHA Functionary

Among the 120 heads of households that were administered this survey, about 62.5% were aware of the existence of the Village Health Committee. In face of the fact that all the six

villages had functional Gram Panchayats, it was notable that more than a third of the respondents were unaware of such a Committee in their village (Table 6.18).

Table 6.18

Households: Awareness about the Village Health Committee in their Village

AWARENESS ABOUT THE VILLAGE HEALTH COMMITTEE IN THEIR VILLAGE ACCORDING TO THE HEAD OF THE HOUSEHOLD	NO. OF HOUSEHOLDS (N=120)	PERCENTAGE
Yes	75	62.5
No	42	35.0
No Response	3	2.5
Total	**120**	**100.0**

Discussions with the Sarpanchs and gram panchayat members from across villages in the study area, revealed that awareness was uneven about the existence of the Committee even among those dignitaries who were supposed to be members of the Village Health Committee. Given below are some observations:

"There is a Water Supply and Health Committee in our village. Meeting is held one a month. The persons who have to be present are the Sarpanch, gram sevak, and 9 members.

(no mention of Anganwadi Worker or ASHA who are mandated members)

There is a separate budget for the committee. We use it if we require labour for minor repair works. I don't know the total budget of this village because we have a group panchayat. (no mention of health functions) "

(AP, Age 39 estimated, gram panchayat member in Adivasi village and former pada worker)

In another village that was close to the Taluka Headquarters and had largely pucca homes, the Sarpanch was completely unaware of the existence of the Village Health Committee and its provisions. This Sarpanch was 26 years old, a college graduate and an active member of

a political party. There was confusion about the sanction of the funds and the signatories in the village. The ASHA said she had received one incentive in three years, for the task of complete immunization, but through the ANM (Box 6.1).

Box 6.1

Correct Nomenclatures of the Village Health Committee

"Gram Poshan Pani Puravdha Samiti"
"Pani Poshan Puravdha Samiti"
"Arogya Poshan Aahaar Samiti"
"Grameen Pani Puravdha Swatchataa Samiti"

***(According to the Anganwadi Workers)**

On the other hand there were villages that showed a good understanding and implementation. A passbook and diary was maintained by an Anganwadi Worker in a remote village that showed regular incoming amount over the past three years from the health services for the Village Health Committee. There were also regular withdrawals for health-related items like the ASHA's incentives and extra nutrition like eggs for the children of the Anganwadi. The ANM overlooking this village took personal interest in the Village Committees under her Sub Centre. She also complained of the difficulties faced by the Anganwadi Workers in dealing with the co-signatories who were the Sarpanchs. They were difficult to track, rude and sometimes were drunk.

Thus there was an uneven awareness about the Village Health Committee among the households and even among the Gram Panchayat members. The ignorance extended to the Anganwadi Workers, also mandated as a part of the Village Health Scheme along with the ASHAs.

5.1.1 ***Engagements of ASHAs with Village Committees***

Awareness about the Village Health Committees was the lowest among the ASHAs from among all the stakeholder groups. Not a single ASHA said she was a member as seen during the qualitative interviews. Some ASHAs were aware that funding was available at the village level with the Anganwadi Workers but did not know the details. One ASHA said:

"We do not know about the Village Health and Sanitation Committee – what it does. The Anganwadi Worker gives only for 100% immunization. That also they don't give."

The inadequate representation of women in the gram panchayat resulted in an unequal equation with the members of the gram panchayat by the women functionaries like ASHAs. In one village the Sarpanch was a woman who knew about the provisions under the Village Health Committee but felt under confident about presenting her views because "*we are all women – the Anganwadi Worker, Helper, ASHA and me. The whole room is full of men during meetings. I keep my views to myself."*

The perspectives of an ASHA showed the extent to which the ASHAs were disengaged with the Village Health Committee even though they were otherwise more mobile and engaged with the village than the other women of the village.

"When there is a gram panchayat meeting they send us the information but they only talk about their matters. They hardly listen to us and we don't say also. Yes there was a separate committee of the gram sevak, Anganwadi Worker, teacher and ASHA but now it is not there. I did not have any work with them."

(MS, ASHA, travelled for more than 12 hours last week for her work using multiple means of transportation)

Thus awareness of the Village Health Committee was uneven among the households and qualitative data indicated that this trend was extended to the other stakeholders as well. Gender was a factor that hindered adequate participation of the women in various positions including the ASHAs. The implications for the ASHA Functionary were that she was deprived of a platform for participation as well as support from the community.

Box 6. 2

Experiences of an Anganwadi Worker with

the Village Health Committee

"Yes there is an amount given under the Village Water Supply, Health and Sanitation Committee (VWHSC) but it has not been spent. Last time we got 5000 now another 5000 has come. It is in the account. The Sarpanch is never in the village. He has a

shop in the main area. I am a woman and he is a man. I am a widow and he is the Sarpanch.

How can I wander around with him? For three days, I went every day to his shop when I wanted to repair the roof for the Anganwadi. He said come tomorrow, come later. Then he said give me the passbook. I will take out the money. Out of 5000 you spend 2500. How will I show receipt of 5000, if I spend only 2500? So I put up these plastic sheets for leakage from my own money.

For two years, I have refused to let him take out the money .Instead I don't spend the money at all. I have not told my supervisor but many others have this problem. Maybe the new Sarpanch after election will be better.

I have thought about this. I think the Sarpanch should not be there. We Anganwadi Workers are there, the second person could be elected or selected by the panchayat members but it should be someone who wants to work and not the Sarpanch."

(RY, widow with grown children, Anganwadi Worker for more than 20 years)

5.2 Understanding about the Functions of the Village Health Committee

The heads of households that were aware of the presence of a Village Health Committee in their own villages were asked about the functions of the Village Health Committee (Table 6.19).

Table 6.19

Households: Understanding about the Functions of the Village Health Committee

FUNCTIONS OF THE VILLAGE HEALTH COMMITTEE ACCORDING TO THE HEAD OF THE HOUSEHOLD	NO. OF RESPONSES* (N=75)	PERCEN-TAGE
Works for facilitating water supply in the village	42	35.0

Works for waste disposal/sanitation in the village	40	33.3
Works for sewage/drainage facilities in the village	11	9.2
Works for ***Phavaarne*** (malaria preventive spraying operations)	10	8.3
It is formed but does not do much	2	1.7
I don't know	5	4.2
Gives ASHA travel money for delivery patients	1	0.8
Gives ***Anganwadi*** money for toys	1	0.8
I think they give information on sanitation to Self Help Group	1	0.8
They encourage villagers to follow good practices (sanitation/health)	6	5.0
A very important arrangement between villagers and the government	1	0.8
Total	**120**	**100.0**

*Multiple responses from the 75 households that were aware of the Village Health Committee.

The largest proportion of answers mentioned that the Committee worked for facilitating water supply to the village (35.0%). Interviews with the gram sabha members had confirmed that money was being spent for laying pipelines within the village premises and cleaning the wells.

This was followed closely by responses that mentioned facilitation of waste disposal (33.3%). ASHAs had also pointed that waste disposal was a serious difficulty. Facilitating sewage and drainage facilities for the village was mentioned in almost a tenth of the responses (9.2%).

There was just one mention each of giving incentive to ASHAs and support to the Anganwadis. The findings from the study location thus revealed that the agendas of the Village Health Committees were predominantly about water and sanitation. Their agency to support the ASHA Functionary's work was not being utilised by the Village Health Committees. The non - involvement of ASHAs in meetings and agendas deprived the ASHA Functionary of her rightful position as a trained health worker in the village. The association of the Anganwadi Workers with the Village Health Committees too appeared to be restricted to the incentive aspect of the ASHAs.

None of the gram panchayat members mentioned the Village Health Plan at all, indicating that this participative function had been taken over by the health services stakeholders. Even the function of granting incentives was held up as a source of wielding power over the ASHAs in some villages, either by the Committee members or the others like the Anganwadi Workers or ANMs.

Case Study 9: Village Health Committee and ASHAs: (DB)

DB is a gram panchayat member and the former Sarpanch. He shared:

"*There is a Village Health Committee. We have used the money to repair the Anganwadi and for cleaning wells. The Anganwadi Worker gave me application for a large amount spent on travel of the patients spent by the ASHA. I told her if it is for vehicle (transportation) then show me the signatures. In many cases I have given my own vehicle to transport the patients. I have checked, people do not ask for money* (from the ASHA for travel)."

Thus the awareness and implementation of Village Health Committees was uneven across villages therefore a common interpretation for the six villages was not possible. The ignorance of the community about the mandates of the ASHA Scheme deprived the ASHA of an opportunity to gain their respect as a volunteer. The gender factor came up prominently in the implementation of the mandates of the Village Health Committees in several ways across the villages. This included the experiences of the ASHAs, Anganwadi Workers and woman Sarpanchs.

In conclusion the Chapter Six marks the third perspective on the ASHA Scheme which is from the community. Several points of triangulation were seen with the perceptions of the ASHAs and the stakeholders from the health services on the location and duties. The ASHA was perceived as a conduct of government services. The data from the community also reflected the denial of the rights of the ASHAs in the community. Data showed that an important source of empowerment for the ASHAs in the community, through the Village Health Committees, was not available to them, thus depriving them of valuable support and community acknowledgement. This affected her location within the community. The gender factor that was seen in the earlier findings came up strongly in the data from the community as well. In the following and concluding Chapter Seven, a meta- analysis of the findings has been presented with policy implications.

META INFERENCES AND THEORY BUILDING

The centrality of Community Health Workers in health care services for poor, distant, rural and marginalized communities has been acknowledged globally over the past five decades. The Community Health Workers (CHWs) have largely been discussed in terms of their effectiveness in several curative, preventive and promotive health functions for the community within a functional health system. The difficulties of the CHWs and stakeholders have also been explored and acknowledged in studies but suggested recommendations have been towards the sustenance of the CHW programmes. For instance, attrition among these functionaries has been studied with the view of retention (Bhattacharya and Winch 2001).

The common factor in most of the CHW programmes is that the CHWs are women. Gender however, has not been recognized as a factor in many studies. There are a few studies that have presented a gendered analysis of health workers particularly in context of the nursing profession (Jones 1994, Iyer and Jessani 1995, Sunderaraman, 1996). These studies say that power is wielded in a hierarchical fashion in health services and nursing and nurses are subordinated. Narayan (2002) has asserted that the patterns of discrimination remain even when women become doctors.

While the success of small-scale CHW programmes is indubitable, there is less clarity on the effectiveness of large-scale national CHW programmes (UNICEF 2004). There are several studies in India (NIFW 1978, Medico Friends Circle Collective 1978, Sanjivi 1988, Jessani and Ganguli 1990, Walt 1991, Chaterji 1993, Community Health Cell 2005, Ashtekar 2005) and in other countries (Prasad and Murleedharan 2007, Lehmann and Sanders 2007) about the involvement of Community Health Workers in the public health services. According to these studies the contentious issues that have persisted in large scale public CHW programmes are processes of selection and training; systemic support; nature of employment including payments; extent of curative services offered and the CHW's relationships with the local stakeholders from the health services and the community (CHC 2005, Lehmann and Sanders 2007).

National Community Health Worker Schemes in India

There have been two major national Community Health Worker (CHW) Schemes in India: namely the CHW Scheme of 1977 and the Accredited Social Health Activist (ASHA) Programme of 2005. The CHW Scheme of 1977 had suffered the same contentious issues discussed above (NIFW 1977, Chatterjee 1993) and it dwindled to a halt within some years.

There are several studies about the performance of the subsequent ASHA Scheme which began in 2005 in high focus states and in 2008 in the other states of India.The ASHAs have so far been found successful in varying degrees for ensuring institutionalized deliveries, universal immunization and creating awareness about health, hygiene and nutrition (Gill 2009, Bajpai,

Sachs and Dholakia 2010, IIPS 2011, NRHM 2012). Thus now the debate is not whether the ASHA Scheme has worked, rather it is on what has worked and what has not worked (NRHM 2012).

Cognizance has been taken of the difficulties of the ASHAs in existing studies. The main difficulties of the ASHAs that have been identified are delay in incentives and gaps in training and filling drug kits (NRHM 2012, IIPS 2011). These have also been acknowledged in the 12th Five Year Plan. Like the previous CHW Schemes, procedural recommendations have been given towards addressing these difficulties. There is no exploration about the underlying reasons for these issues.

Rationale for the Current Study

Frankel (Frankel 1992) had separated the success of the CHW concept from the outcomes of individual CHW programmes. Extending this analysis further the current study asserts that the success of a CHW programme does not reflect the situation of the Community Health Workers working within it. The gaze of the Community Health Worker (CHW) and the stakeholders can be interpreted very differently if the aim is just exploration and not sustenance of the programme.

Taking this argument forward the current study addressed the gaps in knowledge about the ASHAs which were also seen in the case of previous CHW Schemes. These are: the nature of the engagement of the ASHA with her work; the mutual engagement of the local stakeholders from the health services system and the ASHAs; and the mutual engagement of the stakeholders from the community and the ASHAs. The findings have addressed the underlying factors of the contentious issues that have dogged CHW Schemes globally and are also acknowledged in the ASHA Scheme.

Methodology

The conceptual framework at the outset of this study was based upon the Human Rights Approach and the ASHA was named as the unit of research. Under this overarching approach, the integrated theoretical framework of this study at the outset of the study was based upon two other theoretical perspectives as well. Firstly the Ecological Systems Theory where the ASHA functionary was seen within the context of the larger rural public health services system and the community. The stakeholders were seen to be located from the implementation or village level. Secondly, the ASHAs and stakeholders were anticipated to have multiple interpretations of the ASHAs with implications for the ASHA Scheme. This position was drawn from the Constructivism paradigm (Figure 2.1).

The methodological framework of this study was based upon the QUAL-MIXED-QUAN methodological continua paradigm (Teddlie and Tashakkori 2009) where the research purpose and data analysis are qualitative. However the sampling and data collection methods had mixed methods. The validity was according to the method used but the positioning of inferences was qualitative (Figure 2.2). The research design was a sequential multi-level mixed design of six phases, two for each stakeholder group namely ASHAs, the Health services system (four levels) and the Community (households and Village Health Committees) as seen in Figure 2.3.

The study was conducted in one taluka of Thane district in the state of Maharashtra. This is an Adivasi dominated area with poor infrastructural facilities. The ASHA Scheme is fully operational in the area.

At the completion of this study the emergent analysis had broadened the original theoretical framework presented in Figure 2.2. The emergent theoretical framework is presented in this Chapter as Figure 7.1. In this Chapter, the themes are presented first followed by a representation of the emergent theoretical framework at the end of this exploratory study.

Emergent Themes across Stakeholders and Methods

1. **The Genesis of the ASHA Scheme: A Glimpse into Changing Realities**

1.1 Gender as a Criterion of Selection

Women are selected as CHWs because there is a collective impression that female health workers are able to deliver care more effectively than males (Antia and Bhatia 1993, Prasad and Murleedharan 2007). The ASHA Scheme also has selected only women.

In the case of the ASHAs they were selected in the backdrop of the discontinued 1977 CHW Scheme where the organized male CHWs had unionized and litigated against the health services system which ultimately chose not to continue the Scheme. However despite their gender, ASHAs have been joining unions across the country (NHSRC 2011). In the study location too there was a joint union of the ASHAs and ASHA Facilitators.

1.2 Location

CHWs are selected from the communities that they serve because they are culturally close to the community for effective interventions (Werner 1970). Following this practice the ASHAs are local women. CHWs by definition work for poor and underprivileged communities. Hailing from the same communities that they serve the ASHAs too are poor and underprivileged. However the current study showed the women to be aware of their conditions and aspiring for change.

1.3 Educational Qualifications

The preferred educational profile of CHWs has been school educated as effective performance is not related to age, sex and education. However more educated CHWs are likely to look for better opportunities and migrate to other jobs (Prasad and Murleedharan). In addition in countries with lower literacy levels no educational qualifications have been insisted upon due to the assumption that availability will be poor.

In the ASHA Scheme the qualification of eighth standard is kept as relaxable (Box 1.11). However the data of the current study showed that over 60% of the ASHAs in the taluka were educated up-to 8th standard or above.

The ideal profile of CHWs is thus of a less educated local woman and the vulnerability due to the other factors in her background is apparent. Yet CHWs with this background have historically been successful across countries and interventions, upholding the faith placed upon human capabilities and the ideals of accessibility to health for all that they are seen to represent. Their background has thus proved to be a source of strength for their work.

The CHW's own empowerment was never the primary goal of the CHW Programmes in any case. Nevertheless women from these backgrounds have succeeded in small-scale interventions because they have been consistently supported. Systemic support has been in terms of training and infrastructure. Most importantly they have been encouraged at every step and their valued position has been demonstrated by stakeholders within the health care systems. Such support, even if it was towards the goal of effective interventions, had sustained the women in difficult working conditions (Arole and Arole1994). The stakeholders can thus either empower or disempower the CHWs despite their vulnerability.

The ASHA Scheme holds out the promise of the success of CHWs even within large-scale national programmes. It holds out the promise that CHWs can be the base of a strengthened public health system as envisaged within the Right to Health framework (Shukla 2005). However although the performance appears to show the successful scaling up of the CHW strategy, in the paucity of institutionalized safeguards the vulnerability of the ASHAs due to her background stands completely exposed. The CHW Scheme of 1977 had suffered the same contentious issues discussed above (NIFW 1977, Chatterjee 1993) and it dwindled to a halt within some years. The ASHAs are motivated and willing to work, but are being held back from fulfilling their potential by the same contentious issues.

2. Gender as a Factor for Vulnerability of ASHAs

2.1 ASHAs and the Janani Suraksha Yojana

The most overt expression of over-expectations or even scapegoating was seen in the current study in the perceived relationship of ASHAs with child survival. While doctors conceded that institutionalised deliveries were increased, they said the infant mortality rate in the area was not getting satisfactorily lowered. This was attributed to the ASHAs' neglect and failure to do ante-natal and post-natal care. The ASHAs were seen as failing to meet their main purpose by the medical doctors, LHVs and others. On the other hand they were also perceived as only concentrating on the Janani Suraksha Yojana (a programme for encouraging institutional deliveries among pregnant women).

On the other hand above all other programmes, it was the emphasis on'institutionalized delivery as the sole manner of safe delivery' that had resulted in pressure upon the LHVs, ANMs and ASHAs. The local ***dais*** were dysfunctional or had been absorbed as attendants in the study area. In the study location the entire focus was on escorting pregnant women for delivery to PHCs or the sub-divisional hospital. Home deliveries were a taboo and no ASHA was even aware that a successful home delivery also has been allotted incentives for mothers under the Janani Suraksha Yojana.

Deliveries were generally not happening in sub-centres visited in the course of data collection with the notable exception of one where the attendant was a trained and experienced former ***dai***. In some cases, deliveries were not taking place even at the PHCs. There was an additional dimension of the non- availability of a specialist at the sub-divisional hospital located at taluka headquarters, which resulted in all C-Section cases having to be taken to the Civil hospital.

The ASHAs on the other hand had reported stiff resistance for not only ante-natal and post-natal care but even institutionalized deliveries from the community (Chapter Six) particularly the Adivasis. This was known to the local health personnel but there was an expectation that it should be handled by the ASHAs at their own level. Gupte (1998) had reported how the state's emphasis on women targets and women motivators is a cause of concern among feminists because of distortions in human relations brought about by coercive campaigns.

Such an approach incurred the risk of alienating the ASHAs from the community on one hand and the health services on the other hand.

The gender of the ASHAs that was the main advantage for the health programme for women, is the most overlooked factor when it comes to the ASHAs themselves. The most overt expression of this imbalance was seen during the ASHAs' experiences of the implementation of the Janani Suraksha Yojana (Box 7.1).

The underlying power imbalance within the health services system which has led to such dynamics must be recognised. The CHW or ASHA can provide very essential and life-saving interventions as demonstrated by field projects provided she is given systemic support. However the onus of child survival cannot be put upon the ASHAs or even the health system alone.

Box 7.1

Narrations of ASHAs on Claiming Incentives under the Janani Suraksha Yojana

"Once I took the woman to the Shahapur sub divisional hospital and got her admitted and settled down. Then I went home by train (a half hour commute) to breastfeed my child. I went back to the hospital, by then the delivery had happened, so they did not sign. I got nothing."

"Once I had taken the woman to the Shahapur sub-divisional hospital. Her husband told me 'I want to withdraw money will you come with mw to show me where the ATM is.' I went down to the ATM and madam went into delivery. The sister refused to sign for my payment. She said you were not there. I just sat with my head in my hands on the bench outside. The doctor was passing by, he told me, don't pay attention to her, don't worry I will sign for you. And so I managed to get paid because the doctor understood my problem."

"I brought the woman to the PHC, from there they told me to take her to the Shahapur sub divisional hospital. I had limited money on me so I went without ticket to Asangaon by train and then paid the rickshaw upto Shahapur. There they told me it's a Caesarean, take her to the Civil hospital at Thane. I had no money with me. I also got my period. So I put the mother and her relatives in the ambulance and went home. The next day I was able to go to Thane but when I went to get the sign, they did not allow me, they told me I cannot be paid because I was not there for the delivery. .. for those few hours. I gave service to the woman for 9 months and did not get paid because I was not there for delivery."

"Once the woman is admitted, I do not move from her side. If I have to go to the bathroom I tell the sister and then I come straight back."

Child survival and health for all, are basically a function of social determinants and the health services can only be effective within them. The responsibility of the health services is to provide vital information, simple interventions, and essential medical care. However these cannot be considered as the full measure of requirements for child survival or the health of the population.In the ASHA training modules there is a focus on home-based care of mothers

and infants to be done by ASHAs. This is a good initiative for child survival. The question is how to delink the ASHA's performance on these tasks from the expectations of the LHVs, ANMs and medical officers to bring down the infant mortality rates because this is not a direct equation.

2.2 ASHAs and the Village Health Committee

The findings of the current study showed that the Village Health Committees that were visited were not addressing the work of the ASHAs in the course of their activities. The ASHAs reported that they were not aware they were even members in most cases. They were side-tracked during discussions when they went to the gram panchayat meetings. Gender oppression was seen in the case of the ANMs while discharging the requirements of the ASHA Scheme in the study location.

Case Study 1: Gender Oppression in the Village Health Committee

(Sub-centre Zen)

In one sub centre, there were five villages and five Village Health Committees that were all functional. The ANM and Medical Officer were actively involved with the Village Committees. Under the provisions of the Village Committee the Sarpanchs are required to be the co-signatories with the Anganwadi Workers for any expenses including the travel expenses of the ASHAs. In this case the ANM had taken upon herself the task of getting the signatures of the Sarpanchs because the Anganwadi Workers themselves were 'scared'.

The area was so remote that the ANM was escorted by her husband, also a public servant.

"I have a problem dealing with the Panchayat members because some of them are constantly drunk. So I accompany the Anganwadi Workers and my husband comes with us."(ANM)

The ASHAs simply expressed their gratitude that the ANM was safeguarding their interests by ensuring their travel expenses. They dismissed their attendance of the Village Health Committees out of hand.

The requirement of involving Sarpanch for incentives was reported to translate into a gender issue by the Anganwadi Workers as well. A change in the procedure must be considered. ASHAs had asked for control over the money in other studies (IIPS 2011). However the findings of this study indicated that this is not likely to be considered.

"There was a discussion on keeping the money with the ASHAs but it was dropped. Now we have given guidelines as to where it should be spent."

(LHV and trainer)

2.3 Vulnerability to Sexual Harassment

Sexual harassment is the extreme manifestation of the ASHAs' vulnerability. In this study a medical officer from one of the nine PHCs in the taluka was reported to sexually harass ASHAs and ANMs. This was shared collectively by the ASHAs, ASHA Facilitators and ANMs. They said it was related to the sanctioning of the ASHAs' incentives (Box 7.2).

The roots of this situation lie in the tradition of seeing the medical officers as the 'heads' of the primary health centres and therefore invested with unchallenged powers. There are many avenues for the abuse of such unchallenged power. This 'leadership' also puts a burden on the conscientious medical officers and frustration mounts due to the demands from such a location. The other side of the story is the essential vulnerability of the location of women personnel in the health services as illustrated in the case of the ASHAs.

Box 7.2

Sexual Harassment as an Extreme Manifestation of

Gender-Hierarchy Power Play

The ASHAs reported sexual harassment by a medical officer in one primary health centre out of the nine PHCs of the taluka. The doctor in question was delaying incentives of ASHAs and also making sexual advances upon them. The ASHAs were linking the two because he was holding back the incentives of newly recruited ASHAs and insisting for them to come alone to his office for computer training.

The ASHAs and Facilitators had jointly devised strategies like never visiting his office alone, moving around the PHC in groups and threatening mass resignation to get the ASHA incentives released. The ASHAs said that they avoided escorting for delivery to the PHC overnight. If it was inevitable, then they insisted for the woman's relatives to be there also and stayed in lighted areas throughout the night, not risking a visit to the toilet.

The kind of power play that can happen is indicated by the fact that the ANMs complained that the LHV was a 'supplier and agent' to the medical officer in question. The LHV advanced the concept of 'shame' and said it was better to keep the matter hidden as she was helpless. The senior taluka level officials said that they were aware of the misbehavior but that "*the women were used to it. They went on their own to him.*" The proposal to set up a committee was rejected because "*no one will come forward to complain.*"

The ASHAs themselves were not aware of any channels of complain but wanted the taluka officials to take it up. They did not want to risk their reputations and did not want any other action to be taken as they had not informed at their homes. There was extreme anger and frustration:

"*Why does the Block Medical Officer not punish him?*"

"He will not even die of AIDS…village women are pure."

3. The Presence of 'Unaccounted' Stakeholders

An exploration of the backgrounds of the ASHAs showed that there were several stakeholders other than the ones defined by the NRHM and this made her vulnerable to their expectations (Box 7.3).

Box 7.3

Stakeholders of the ASHA Scheme: Findings from the Field

SYSTEM	**STAKEHOLDERS (STUDY)**	**STAKEHOLDERS (NRHM)***	**STAKEHOLDERS (UNCOVERED)**
ASHA	ASHA	-	-
Health	Block: BMO, Facilitator PHC: MO, LHV, HA Sub-Centre: ANM, MPW Village: ASHA Facilitator	ANMs	-
ICDS	Anganwadi Worker	Anganwadi Worker	-
Community	Gram Panchayat, Village Health Committees, Households.	Gram Panchayat, Self-Help Groups	Separate Perspectives of men and women of the Village, Families of ASHAs
Others	-	District Health Mission, Zilla Health Mission, Officials from other Departments	Other Non-formal providers like Dais, Vaidus. Private Practitioners, NGOs, Unions

Note: BMO – Block Medical officer, MPW – Multi Purpose Worker, LHV – Lady Health Visitor (Senior ANM at PHC), HA – health Assistant.

*NRHM Mission Document.

3.1 Levels of stakeholders

During data collection, stakeholders from the health services system that were not mentioned in the NRHM Mission statement were included in an inductive manner. The findings showed that there were four levels of stakeholders from the health services system alone and each level interacted with the ASHA in their own manner (Box 7.4).

The presence of so many stakeholders from the health services system meant that there was a visible association of the ASHAs with the health services system. This had its own consequences:

a) The ASHA located herself as a part of the health services and developed a sense of entitlement from the system.

Box 7.4

ASHA: Levels of Stakeholders from the Public Health Services

i. At the village level the female ASHA Facilitators who were the immediate supervisors of the ASHAs.

ii. At the village level, the female Anganwadi Worker who was involved in immunization and other maternal and child health services, and was co-signatory with the Sarpanch for releasing the travel expenses spent in advance by the ASHAs from the untied funds given to each Village Health Committee.

iii. At the sub-centre level not only the female ANMs (Auxiliary Nurse Midwives) but also the male MPWs (Multi-purpose Workers) who visited and worked in the village for immunization and facilitation of other services were stakeholders. The ANM was responsible for recording the work and facilitating the payment of incentives to ASHAs. In some cases the travel expenses were facilitated by the ANM from the untied funds given to the Sub Centres, or through the Anganwadi workers.

iv. At the PHC Level, the LHVs (Lady Health Visitor, a senior ANM) who took the monthly ASHA meetings, ongoing training and were responsible for facilitating ASHA incentives, were stakeholders. The Medical Officer (MO) of the PHC was also involved in training, facilitation of ASHA functions and incentives.

v. There were stakeholders at the taluka level too. Although not interacting directly with the ASHAs, the BMO (Block Medical Officer) was the overall-in-charge. The Health Assistant and Block Facilitator stationed at the BMO's office, were involved in co-ordination, facilitation and reporting to the District Medical Officer's Office.

b) Secondly the community also associated her with the health services, therefore, their expectations from the ASHA were as a worker of the health system.

c) Thirdly, the health services system stakeholders associated the ASHA with the system's own functions. However this translated into crossing the 'porous borders' of the ASHA duties as defined by the central NRHM policy to the detriment of the ASHAs.

3.1.2 The Hierarchy-Gender Power Play and the reverse gaze

Stakeholders can successfully strengthen the CHWs despite the inherent vulnerability of their situation by their acceptance and support. In the case of the ASHAs this did not happen. This was related by the current study to the interplay of gender and hierarchy within the health services system and the community. A meta-analysis of the themes of '**location**' and '**duty**' of ASHAs across stakeholders highlighted this interplay (Matrix 7.1). The following repercussions were seen:

a) The ASHA could have been ideally valued by the stakeholders from the health services as both the representative of the community to the health services and to the community from the health services. Instead the gaze was completely reversed.

b) There was a lack of ownership of the mandates of the ASHA Scheme as demonstrated by the disrespect in the attitudes of the stakeholders. The ASHA became vulnerable to exploitation being a young woman having her first exposure to a formal working system in most cases. Her status as a volunteer only increased her vulnerability.

c) The ASHAs lost the opportunity to gain respect from the community as there was no association with the Village Health Committees. She was seen as a conduit of the free services from the health services. This happened due to the perceived close association of the ASHA functionary with the health services in terms of the number of stakeholders and the nature of her duties which were all to do with the National Health Programmes.

d) The ASHAs and the ASHA Facilitators saw the ASHAs as being deprived of her rights due to the manner in which the stakeholders from the health services implemented the Scheme. The expectations from the family also enhanced this perception.

Matrix 7.1

Perceptions of Duties and Location: Perspectives Mapping

Policy/ Stakeholder	**Understanding of the Duties of ASHAs**	**Linkages with Location of the ASHA Functionary**	**Perspective**
NRHM Central Policy	Designated Directions: 3 incentivized areas: promotion of immunization; referral and escort for RCH* and others; facilitation of household toilets Non incentivized areas: treatment of minor illnesses, referrals 7 directives to be 'health activist' - information, counseling, facilitation	Designated Roles: Facilitator-Link Worker Service Provider "Activist" for only the public health services	Ideal CHW Concept Performance-based incentives takes acceptance of CHW concept by all stakeholders for granted Hierarchy neutral ideology: Open to interpretation /Fuzzy? Contribution due to gender of ASHA taken for granted but no gender-based considerations in her working conditions
NRHM State policy	Straightforward Directives : "Preparing village health plan as member of Village Health Committee" "Link worker" "To co-ordinate with anganwadi worker, dai, ANM, MPW" "referral, record-keeping" "expected to give 2-3 hours for 4 days/week" "to be paid incentives within various national health programmes"	Increased ownership expected from ASHAs but no commensurate benefits: Bureaucratization – hours, record-keeping. Moved from "activist" to "link worker" "Co-ordination" (not defined –overlooks the possibility of exploitation)	Hierarchy-Gender issues: Directives sans facilitation Village Committee was not facilitated. Due to: Lack of engagement? Power play?

Continued...

Policy/ Stakeholder	**Understanding of the Duties of ASHAs**	**Linkages with Location of the ASHA Functionary**	**Perspective**
District Level	Addition of home visits and registration of births and deaths to existing duties Directive for ASHAs: “To increase the rate of institutional deliveries”: Change from “escorting” to taking ownership for deliveries	Bureaucratization Expectation of ownership by ASHAs increased Commensurate ownership of ASHAs not arrayed: ASHA is still called ‘volunteer”	Hierarchy-Gender issues: Ownership over deliveries increased due to gender but status remained fluid due to hierarchy and gender
Taluka Level	Straightforward Directives 20 paid tasks –incentives ranging from rupees 5 to 600. All tasks within national health programmes No mention of “activist” role	Bureaucratization One-on-one equation of tasks with incentives in the chart – linkages with ASHAs’ perceptions Incorporation of the ASHAs’ work within the public health functions	Hierarchy –rights issues: Directives for tasks but incentives range is arbitrary Vulnerability of ASHAs due to lack of control and knowledge about task boundaries and entitlements
Medical Officers at taluka, primary health centres	Unrealistic expectation: “*ASHAs’ main work is to decrease the Infant Mortality Rate (IMR)”*	Lack of ownership Therefore scapegoating?	Hierarchy-Gender Gender as the central consideration for the work of ASHA, also central to her vulnerability.
LHVs	Conceded with the doctors Agreed that ASHAs worked in all national programmes Saw ASHAs as doing ‘gratis’ tasks	ASHAs as lowest level in the health services system Perception of one-on-one task-incentive equation Empathy but no ownership	Hierarchy-Gender

Continued...

Policy/ Stakeholder	Understanding of the Duties of ASHAs	Linkages with Location of the ASHA Functionary	Perspective
ANMs, MPWs, Anganwadi Workers	*"The duty of the ASHA is to help us with our work"* Agreed that ASHAs worked in all national programmes Saw ASHAs as doing 'gratis' tasks	ASHAs as lowest level in the health services system Perception of one-on-one task-incentive equation Empathy but no ownership	Hierarchy- GenderIssues: - ASHAs alleged power play over tasks and incentives - Commensurate empower-ment through Village Committee was not facilitated. Due to: disengagement? No time, no skills? Poor response from the community?
ASHA Facilitators	Listed 24 ASHA tasks/responsibilities with various sub-tasks, all within the national health programmes Largely 'gratis' tasks/responsibilities with no designated incentives	List triangulated the ASHA as 'helper' ASHA duties seen as "supporting the functions of the public health services" ASHA as junior partner in the struggle for rights	Rights based framework: Endorsement of the sense of entitlement among ASHAs Complete rejection of the 'voluntarism' or 'activism' roles of ASHAs
ASHAs/ASHA's Families	Listed 20 tasks/responsibilities with various sub-tasks, all within the national health programmes : almost a duplicate of the ASHA Facilitators' list Largely 'gratis' tasks	ASHAs are a part of the health services system: - Aspirations - Several points of identification with the health services system Perception of one-on-one task-incentive equation, sense of entitlement Hardships of efforts therefore sense of entitlement	Rights –based but within the limitations of the existing hierarchy-gender framework: Major concern payment. Altruism and Growth seen as complementary and not contrary motivations

Continued....

Policy/ Stakeholder	**Understanding of the Duties of ASHAs**	**Linkages with Location of the ASHA Functionary**	**Perspective**
Households	Listed 9 ASHA tasks/responsibilities Triangulated paid and 'gratis' tasks. Low priority given to institutionalised delivery, resistance offered ASHAs' utility highest for referral and curative services – contextualised with social determinants Valued home visits but seen as service from the government	ASHA as conduit to free services from the system. Perception of task-incentives as a one-on-one equation	Gender- Hierarchy ASHAs seen as 'low paid' workers of the health services 'Demanded' services from ASHAs Social norms: rejection of 'voluntarism'
Sarpanch, members of panchayat/Village Committees	Did not have any engagement and vice-versa with payment or duties of ASHAs	ASHA as conduit to free services from the system. Perception of Task-incentives as a one-on-one equation. No information about payment patterns ASHA was not associated with their functions	Hierarchy/Gender Issues: ASHAs seen as 'low paid' workers Harassment over payments according to the ASHAs, ANMs Distanced from ASHA's functions

3.2 Gender: The ASHA's Family as a Key Emergent Stakeholder

There were other stakeholders outside the health services who also influenced the ASHAs' perspectives. One important finding regarding stakeholders was the emergence of the family of the ASHA as a stakeholder having strong influence upon the ASHA's perspectives. This aspect is discussed from the gaze of the ASHAs in the study. Their families' occupation, income and expectations from the ASHAs' post for remuneration influenced the ASHAs' perspectives about her work. An important finding of this study was that beyond the poverty factor, the gender factor was emergent with regard to the family. There was humiliation over 'small and delayed returns' and resistance from the family members for giving the ASHAs travel expenses in advance. Resistance from the family got escalated according to the ASHAs when all their travel expenses were not reimbursed as the Anganwadi Worker or ANMs were not co-operating in processing these incentives. This was a major influence upon the ASHAs' expectations.

3.3 Other Emergent Stakeholders in the ASHA Scheme

The data from this study showed that the community also showed a lack of acceptance of the concept of voluntarism along with the family. These interactions also affected the manner in which the ASHAs saw their post.

The men and the women of the village were likely to have separate perspectives about the ASHAs' work which was not factored into this study where the heads of households were interviewed who were largely male. In the current study, the decision to take households as a unit of research had to do with getting the perspectives of the family. A previous study (IIPS 2011) had included both heads of households and married women from 15 to 45 but the parameters that were studied were different for both stakeholder groups. It is therefore not possible to infer the differences in perceptions of heads of households and women.

Lastly, there was a list of other possible stakeholders that have not been included in this or other studies. These were other local health providers like dais; the workers of the voluntary projects that worked for ASHA training and the leaders and activists of a local union of ASHAs and ASHA Facilitators.

In this study the stakeholders were delimited to ASHA, Community (households and Panchayat members) and local members of the Health Services System due to lack of time and resources. This study had delimitated the stakeholders to sharpen the focus of the study on policy implications of findings. However further research must be conducted on the stakeholders of the ASHA Scheme.

4. ‘Performance based Incentives’ : a ‘power-neutral’ concept subverted at implementation

The central dilemma of all CHW Schemes is the broad and undefined nature of the CHW’s contributions to the health of the community which also have several ‘non tangible’ factors like giving information, providing referrals and influencing changes in behaviour. Therefore performance-based incentives will invariably not factor in some contributions even with the best of policy interventions. In the ASHA Scheme some tasks were incentivised and others were not, right from the Central policy. The system of performance-based incentives was perhaps set in a hierarchy and gender neutral framework, therefore, it was subverted during implementation.

4.1 The ASHAs’ Perspectives

The task-incentive equation emerged as the priority concern of the ASHAs due to her perception of being deprived of her rights. While the ASHAs were well aware of the power imbalances they looked for changes in the task-incentive balance, as the one-point solution to tilt the balance somewhat in their favour.

The ASHAs had cited several loopholes where the incentives were mismatched with the tasks according to the ASHAs. The major difficulty cited was that several tasks were being ‘handed over’ to them but they were not being paid for them.

MS is a second generation health worker. Her mother-in-law is a **dai.** She shared this perspective:

“Every few months our work gets increased.

First we only had to accompany women for delivery under JSY. Then they told us we have to visit the houses and keep the children ready for the ANM to do immunisation when she comes to the village. Ask the sister, she will tell how much easier it is for her now. We collect the children from house to house as she used to before. Even from the distant padas.

Then they told us to also do the blood slides for suspected Malaria cases which the MPW used to do. Now he does not have to find the cases as he used to earlier, he only comes and collects the slides from us.

Women feel better because I go with them for delivery and stay until it is done. We do not mind the work because we get to learn something new. But the load on ASHA increases every month and the payment is not there.”

4.2 The Responses of the Stakeholders from the Health Services

The health services system stakeholders at the middle level showed empathy in their individual capacities to the perceptions of the ASHAs. The ANMs expressed their helplessness about the delays in incentives due to the lengthy procedures and the lack of time to process the incentives. The medical officers on the other hand commonly perceived the ASHAs as concentrating more on deliveries under the Janani Suraksha Yojana (JSY).

The findings of the current study, and other studies showed that although the institutionalised deliveries (both under JSY and otherwise) were the most mentioned by the ASHAs (Table 5.2), other duties were also being done. Secondly, coming from hamlets with less than 1000 population in many cases, the number of women eligible for deliveries every year might not encourage any such concentration. There is a need to research the patterns of task preferences by the ASHAs.

The data of this study also showed that the directions to concentrate on certain tasks also came from the ASHA Facilitators (Table 5.1), ANMs and LHVs. There was a concept of '*the main work of ASHAs'* as maternal and child health among the ANMs. This finding has opened up a fresh research question: There is a need to probe into the manner in which the ASHAs prioritised their tasks and their reasons for doing so.

4.3 The Responses of the Community to the Task-Incentive Balance

For the third stakeholder group that is the community, the duties of the ASHA were so completely associated with the public health services that the ASHA in their village was located as a conduit for the free services provided by the public health services for them. The households as well as the members of the Village Health Committees largely saw the ASHAs as 'low paid workers' of the health services. There was almost total ignorance about the incentives system (Table 6.16).

4.4 The Responses from the Policy Levels to the Task-Incentive Balance

Several policy studies have also taken note of the task-incentive balance and suggested suitable actions (Box 7.5). However these recommendations are made in a power-gender neutral framework which can get subverted within the current ASHA scheme. For instance, a suggestion has been made to limit the tasks of the ASHAs while preserving the voluntary nature of her engagement and incentive system (Report of the Working Group on Health GOI 2012). Considering the fact that the ASHAs have been doing several tasks so far, to now limit their tasks will leave them vulnerable to pressure from the community.

Box 7.5

The Task – Incentive Balance: Policy Perspectives

- **NHSRC, 2011**: ASHAs dependent on JSY for income, did a total of 13 tasks, Limit ASHAs' activities to four, Advocacy of potential gains to program managers, improved monitoring and supervision, change in payment: fixed plus performance based incentives.
- **IIPS 2011**: ASHAs dependent on JSY for income, total tasks done is 15, said they needed fixed and timely incentives
- **Bajpai, Sachs, Dholakia, 2010**: ASHAs said 33% were happy with incentives, 88% wanted regular salary, 95% would like to work as ANM, 33% wanted control on funds
- **Government of India Planning Commission, 2011, Draft Twelfth Year Plan (2012- 17):** Gaps are in training and payment of timely incentives
- **Report of the Working Group on Health GOI (2012-2017)**:The voluntary nature of the ASHA to be preserved, limit the tasks, performance based incentives to be given.

(**Analysis**: Recommendations are in a power-neutral and gender-neutral framework. Feasibility? Sustainability?)

This was indicated by an ASHA who said she would continue to give information and referrals even if the Scheme was discontinued because the community had expectations. Besides, although she is the sole representative of the health services and a frontline worker the ASHA would have to turn away needy people, a difficult task. Lastly, whatever the official diktats to limit the tasks, since the ASHA was located as the lowest level of the health services and had no recourse for grievances, there is no guarantee of compliance from the full time personnel for limiting ASHA tasks.

A strict definition of ASHA tasks which is commonly followed at all levels can be attempted but there is no assurance of compliance by the ASHA's seniors like ANMs and MPWs, given the ASHA's location within the health services system.

5. The Primacy to Curative Services among the Community: Location of ASHAs

For long the basic requirement of the community for curative care has been taken as their 'felt need' by experts. There is a need to acknowledge that given the poor socio-economic conditions and the urgency to work for food daily the poor populations for which the ASHAs work will give first priority to curative care. The data in the current study also shows this (Table 6.10). Some earlier studies have shown that communities prefer medical centres to trained para-medics for curative care (Bang 1986, Jaju 1986). This was indicated by the data of the current study as well. Therefore, the ASHA kit does provide immediate care and was mentioned the most (Table 6.15). However, the ASHA's role in curative care is for minor illnesses in the view of the community. It was components of referral and home visits that had emerged as the most valued part of the ASHAs' work (Table 6.17). This 'non-tangible' contribution should be recognized and factored into the ASHAs' duties as her 'main task'.

6. The Impetus among the ASHAs to remain Engaged with the Post

"We are living in hope…our name itself (ASHA) is hope."

(Case Study 4.7 SS)

This study found that growth was the defining impetus for the ASHAs. There is a need to recognise that not some but all ASHAs looked for growth from the post. More than 60% of the ASHAs in the sample had studied up-to 8th standard and above and some had diplomas. '*Making use of my education'* was mentioned as a reason for joining by ASHAs who had 10th standard or above qualifications – an indication of their difficulties to have reached that far. Among the ASHAs that were qualified below the mandated level of 8th standard in this Adivasi-populated study location, were former pada workers and second-generation health workers whose mothers-in-law were dais. They saw the post as 'upward mobility.'

6.1 Co-existence of Altruism and Self-Development with Growth Aspirations

However among the same ASHAs, the joy of altruism was not inimical to their expectations of growth, rather it co-existed. Specific functions that gave joy that were mentioned were: providing treatment for minor illnesses; ability to guide the ill to the PHC and to support women that were pregnant by their knowledge and presence during delivery. ASHAs reported feeling a sense of pride when the patients escorted by them were given precedence, received attention and when the doctors and nurses spoke with them about '*their patients*.' This made them feel '*like mini sister'*, a growth aspiration.

The ASHAs had noted changes in the participation of women in their families and even in the village, in conversations and activities after they had accepted the post. ASHAs also reported changes in their own selves. There were several expressions of the work as "an opportunity to learn". ASHAs said they felt more confident, outgoing, and energised by the work. The work provided an avenue of personal growth that the women valued in several ways.

6.2 *Personal Growth not Empowerment as the Impetus*

The ASHAs were fuelled by the promise of personal growth, however it did not translate into empowerment or a change in equations at home. In this study, the data showed that while families were dissatisfied with incentives, they did enjoy the enhancement in social status after the daughter-in-law became an ASHA. An ASHA said her mother-in-law expressed satisfaction with the fact that her daughter-in-law was supporting women. It was a good deed or "***punya"***. Another ASHA reported that delivery was not considered as 'impure' any more in the village.

However the enhanced status did not translate into active support ASHAs for their household or income-generation activities. Most women were doing the ASHA work in addition to the existing activities. In all investigated cases the daily routine itself was demanding because they were carrying out several activities like fetching water, cooking, taking care of children etc. ASHAs reported carrying their child to PHCs during escort duties. ASHAs that were assistants or pada workers were doing both the responsibilities in addition to housework. This finding is upheld by other studies as well. (Campbell, Gibbs et.al 2009 and George 2008)

6.3 The Investments made by the ASHAs: an Indication of their Quest to retain the Agency gained by the Work

During the interviews none of the ASHAs mentioned the increase in the working hours in a day after becoming an ASHA. They had simply adapted their routines to fit in the extra activity. If seen as isolated tasks it did not amount to much but the ancillary sub tasks that were added locally were arduous.

Case Study 2: The Quest to Retain Agency (NK)

NK is born and brought up in the same area as she works but first began moving out of the home only after becoming an ASHA.

"First I do housework then I come for work. If I have to go out for work then I finish house work earlier. In the morning there is cooking. Then one round of the village ...home visits... I can do one village round daily. Then we go to the field.

"Due to this work I came to know what happens in the village. Earlier no one used to participate in anything from our house, they would not go for gram sabha, not even for haldi-kumkum. Now my father –in-law goes for gram sabha and we talk about what is happening in the village at home.

Earlier I used to feel afraid to talk to other people. Especially to talk in front of big people. I can talk anywhere now.

When I am tired from the field and have to attend to someone who needs medicine at home I feel fed up. Patients come home at any time and they (family) also object. When I am serving food and patients come, they say things...I listen I don't reply back."

NK shared how the family is becoming more outgoing as she is too after becoming an ASHA. Yet her position in the family in terms of her responsibilities had not changed very much. Her family also feels comfortable to take an objection to her irregular hours at work while she does not retaliate.

The ASHAs' words showed that their primary urge in taking up this post in addition to the other work that they were doing was towards space and growth for themselves. Their financial contribution to the family was as a part of this quest. They were willing to invest time and energy for this. It indicated that there was a pool of women in rural areas looking for opportunities.

"Before doing this work I was somebody's daughter-in-law, somebody's wife, somebody's mother, now I am..."

(VS, ASHA with a diploma in nursing)

7. Role Perceptions of the ASHAs

This study had arrived at the role perceptions about the ASHA Functionary by a process of inference. Three role perceptions were structured from the quantitative table about the reasons given by the ASHAs for joining (Table 4.1) by the process of data transformation as seen in Box 7.6.

Each of these constructed role perceptions was presented to ASHAs in the in-depth interviews for triangulation.

a) The first role perception namely “ASHA is a worker of the health system” was triangulated but the ASHAs qualified their own meaning of the term ‘worker’. Most of the ASHAs said they were not “***karmacharis”*** or employees but were ***“karyakartis”*** or workers. This was also the description handed to them during their training.

b) The second role perception namely the “ASHA is a social worker” was triangulated but the ASHAs qualified the statement as they still saw themselves as associated with the health services.

c) Some ASHAs saw themselves in both the above roles. However concerns over remuneration were expressed uniformly.

d) The findings showed that while there were several expressions for personal growth not a single ASHA directly chose the role perception that “ASHA works for her own progress and satisfaction”. It indicated that the power of choice and the inclination to grow must be camouflaged by women in the ASHAs’ living and working conditions.

Box 7.6

Emergent Role Perceptions of ASHAs from Reasons by Data Transformation

REASONS FOR JOINING GIVEN BY ASHAs (MULTIPLE)	THEME	EMERGENT ROLE PERCEPTION	ASHAs' CONCERNS
"To get monetary support for one's own family".(24.2%) "For one's own financial independence" (3.7%)	ECONOMIC NEEDS	ASHA IS A WORKER OF THE HEALTH SYSTEM	"I work as an ASHA, I have a family. I should be paid regularly."
"To carry forward the family tradition of social service." (0.8%) "Motivated by the health system to join as ASHA." (2.9%) "An opportunity to utilize one's own education." (4.9%	PROFESSIONAL GROWTH	ASHA IS A WORKER OF THE HEALTH SYSTEM	"ASHA should be paid rupees 3000."
"An opportunity for doing social service." (46.3%) "Have a liking for the kind of work the ASHA does."(41.0%) "To prevent the occurrences of home deliveries, maternal deaths and infant deaths in one's own village." (16.8%) "To facilitate timely health services in one's remote and deprived village." (11.1%)	ALTRUISM	ASHA IS A SOCIAL WORKER (ALTRUISM BUT ENGAGE MENT THROUGH THE SYSTEM)	"All this service (**seva**) is for the village. Agreed it is social service but we need to run our families."
"An opportunity for self- expression and exploration." (12.3%) "An opportunity to learn new things." (14.3%) "Gain of social recognition and identity" (5.7%)	PERSONAL GROWTH AND SELF ACTUALISATION	ASHA WORKS FOR HER OWN PROGRESS AND SATISFACTION SELF GROWTH BUT ENGAGEMENT THROUGH THE SYSTEM	"I get to learn new things and also get some money."

Box 7.7

The Expressions of the ASHAs Reflecting their Role Perceptions

ASHA is a worker of the health system

"I will select the role of ASHA as a representative of the health system. Because she works for health department, has a uniform and identity card and they respond to ASHA at the PHC, the sub divisional hospital and the Thane Civil Hospital. They give our patients precedence, talk to us as if we are mini sisters when they see our uniform. We too are highly trained by the system like the sisters."
(Caste Study 4.2, BS, widow, former Anganwadi helper, son recently graduated and working)

"*ASHA is a representative of the health services because she is working for government schemes."*
(Caste Study 4.8, WR, daughter-in-law of village Sarpanch, likes the altruistic aspect of ASHA work, concerned about remuneration)

ASHA is a social worker

"I like to think of my work as that of social service. I like the way I can do everything at home and also do this work."
(DR, 3 daughters, also does tailoring, motivated by status, concerned about remuneration)

"*ASHA is recognised as social worker by all because she has no fixed income. When she gets that then only she can be considered as a* ***karyakarti****."*
(Caste Study 7.2, WR, second generation worker mother-in-law a dai)

ASHA is equally a social worker and a representative of the health services

"*I think I am equally a representative of the health system and a social worker. But I am more in agreement with ASHA being from the system because patients are brought by us to the PHC and ASHAs only work with government services."*
(NJ, also a pada worker, mother of 2 minor sons, one a heart patient, husband in a full time job)

"*I see ASHA as both a representative of the health system as well as a social worker. But the financial part is important."*
(VS, joint family, active in the local NGO and Gram Sabha)

8. The Future of the ASHA Scheme as Preferred by the ASHAs

The ASHAs' gaze towards the future reflected their limitations as women within their families and communities. Their views also showed their determination to continue the work.

8.1 Voices for Stability

Although associated passively with union activities, many ASHAs expressed a desire for a post and payment of a fixed nature. This aspiration appeared to be associated with the aspiration for permanency. However there was no mention of wanting a full time job.

"*ASHA scheme should continue. We should get recognition and a position officially. If we only get an incentive then we can get dismissed any time. But if there is official recognition then it is a position that is created so that even if we leave it will be filled by someone else."* (Case study 5.2 CS)

ASHAs felt their obligation was towards the community even in case of the scheme being discontinued.

"If you discontinue the scheme, the people will still come, and ASHA will not be able to refuse them. The life of the patient is important to them, they (community) will want the support, and we will work because we cannot send them back." (Case Study 4.3 VS)

ASHAs showed a willingness to upgrade their skills and their contributions in the future.

"If I am taught to do deliveries I will. I will do as much as I am able to do well."

(Voluntary observation written by a ASHA)

The manner in which the incentive system was implemented was the reason for some ASHAs to aspire for a regular fixed income.

"The only reason I will like to have a salary is because we do not get our incentives regularly. We also do not get all the incentives although we have a printed list and we write everything we do." (ASHAMS, quoted in previous section)

Above all the ASHAs wished for stability in order to gain the co-operation to continue working.

"*If the payment is increased I will be able to work."* (Case Study 4.8 WR)

8.2 Wish for Context-Specific Incentives

The ASHAs suggested that incentives should be context-specific. They also suggested that non-financial incentives should have practical value.

"*The amount of incentive should be increased. I do not want to be paid for those tasks that do not have incentives now but would like more from the ones that do give incentives. If the government gives us transportation, or a better travel allowance, we can do more."*

(Case Study 4.7 SS)

"I would like to continue with the incentive system not salary because we should be paid as we work but would like government to give us something for our future when we are not working any more."

(Case Study 4.1 PS)

"There are no BPL families in my village. The non BPL families should also get JSY and the ASHAs should also get JSY for non BPL families."

(Voluntary observation of an ASHA)

These findings about the wish of CHWs for context-specific incentives were upheld in a study of CHWs in Nepal as well (Glentonet, al. 2010).

*8.3 **Karyaakarti*** or ***Karmachaari***

Two terms were used by ASHAs with regard to their post. The first was *Karyaakarti* (worker) and second was *Karmachaari* (employee). Very few of the ASHAs talked about becoming full time employees. This is reiterated by a national study by NRHM (2011) that said about 3% of ASHAs looked for a government job.

"*I am not educated so do not expect to be a* ***karmachaari,*** *but we should get a fixed income."*

(MV, pada worker since the past five years, attendant at subcentre since three years and ASHA since one year.)

The ASHAs who did ask for jobs also clearly said it was in reaction to the lack of respect that they currently felt by their own community while working as outreach workers.

"*ASHA is a worker (**karyakarti**) but she should be employee (**karmachaari**) with eight hours duty and fixed income. People should come to us we should not be roaming around from house to house."* (Case Study 4.5 CI)

"We are ***karmacharis*** *even now because we work for the government. Let it remain as it is only give us a fixed amount. People must understand. It is not that we are working only to get the incentives."* (Case Study 4.2 BS)

Some ASHAs drew a straight comparison between their situation and the Anganwadi Worker's situation in the system and aspired for a similar arrangement. The ASHA wanted a better defined association within the system in order to gain respectability in her own community.

"*In training they say we are the government recognized social health workers. I would like to remain there. But if ASHAs get a fixed income then people will not suspect our intentions when we provide a service. Part time employee will be okay like Anganwadi Worker. People will respect us and use the services. Then people will come to us for their needs we will not have to go to request from door to door.*"

(GY,works as ASHA, pada worker and helps at the subcentre)

"I don't know what is in the future… it took 30 years for the Anganwadi workers…"

(Case Study 4.4 DM)

8.4 The Wish for Stability and Improvement within Status Quo

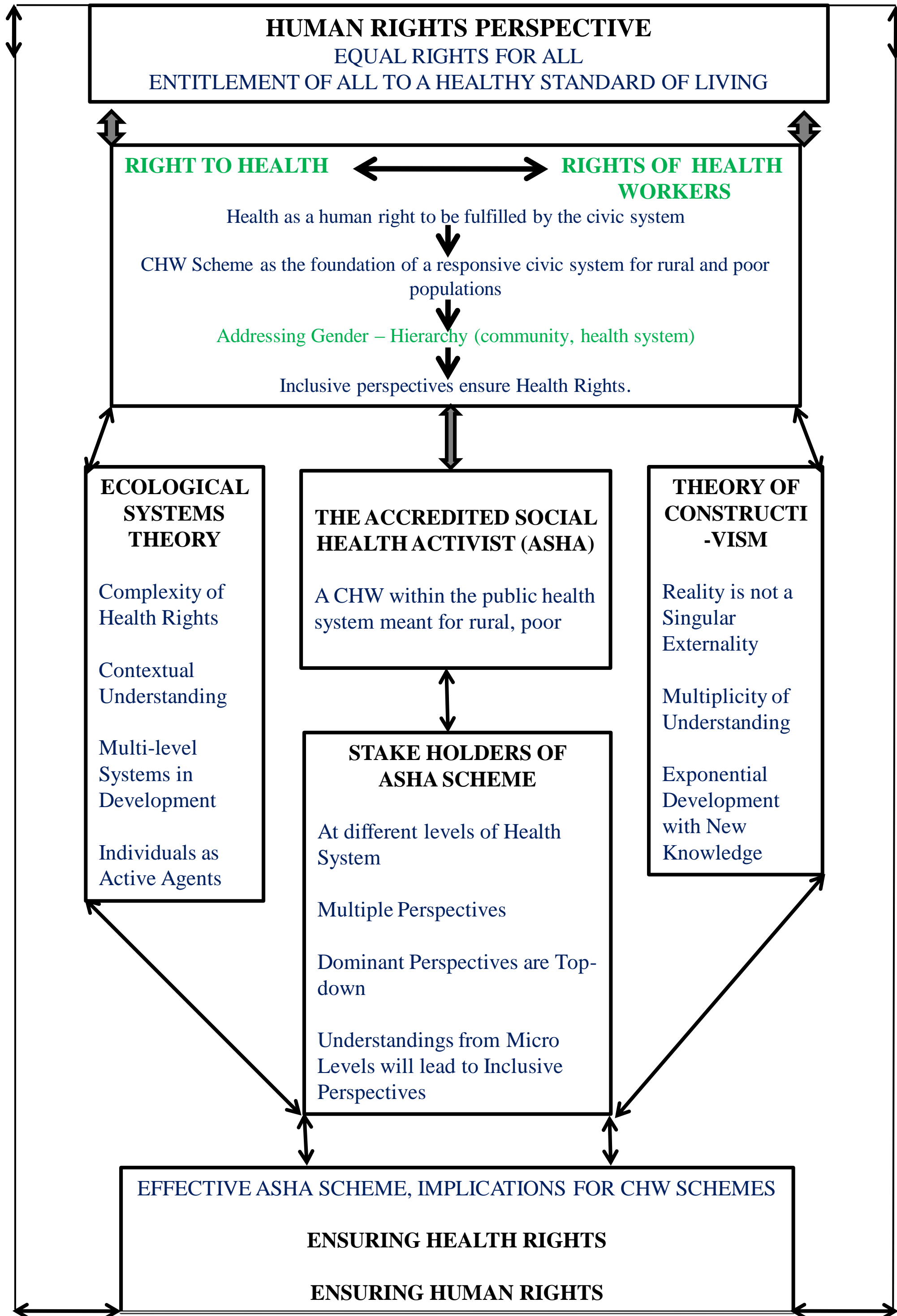
The ASHAs' overwhelming preference was to continue the work but to remain volunteers with improvements in status quo. It is 'convenient' for the health services and their families for ASHAs to be volunteers and it also represents the traditional family ideology. As at work so too at home the CHW is basically seen as a selfless caregiver. The current study indicated that such values were now were being passed on from the nurses to the ASHAs.

However the ASHAs indicated that they relished the sense of accomplishment and contribution to the family while not relinquishing their pre-existent roles which they were currently powerless to give up. This perspective is captured in a Canadian study on part-time women workers (not CHWs).

"*Our respondents see part-time work, not as a capitulation to the traditional, limited role of women in the family, but as an improvement on that role, an expression of autonomy and growth.*" (*Pupo 1989)*

Figure 7.1

Emergent Theoretical Framework to Address the Community Health Worker



9. The Emergent Framework to Address the CHW ASHA

At the beginning of this study (Chapter Two) the theoretical Framework saw the Community Health Worker as the foundation of a responsive civic system for rural and poor populations. The ASHA was placed within the Rights Perspective as a CHW within the public health system meant for the rural and poor populations. It was theorized that an effective ASHA Scheme would contribute towards health for all therefore understandings must be generated from the micro levels.

The emergent framework to address the CHW ASHA from the current study remains within the Rights Perspective. However within the Rights Perspective the rights of the CHW herself as a woman had emerged as a key factor of the framework. A gender, hierarchy and gender-hierarchy perspective must be factored into any analysis concerning CHWs. Both gender and hierarchy are seen as separate and also co-related factors in wielding power within the public health system. The Right to Health for the community can only be achieved if the Rights of Health Workers are preserved within health services (Figure 7.1).

10. Directions for Changes as seen within the Emergent Theoretical Framework

If the ASHA Scheme is implemented within the emergent framework then the following changes would be required. The direction for all future research, advocacy and interventions should be directed towards these changes.

10.1 Reform the Hierarchical Health Services System

The ASHA can only be as strong as the system is. The long term goal of the health services system should be to look within and reform the 'military style' health operations which are a legacy of the past. The successes of the ASHA scheme must not lead the decision-makers to ignore the potential exploitation from hierarchical wielding of power. Some amount of regimentation is needed considering the scale of services needed in the country. However given the sophistication of reporting systems, the culture of punitive and derogatory supervision in the health services, needs to be replaced by effective management and supervisory practices.

The onus of making changes in management and supervisory practices with the necessary training investments lies upon the policy-makers and not upon the stakeholders within the services who are already enmeshed within this culture. Re-orientation is needed from the top downwards because simply holding orientation sessions for local health personnel will be ineffective.

The lack of acceptance of CHWs by the hierarchical health services is a long standing issue and was found in the ASHA scheme as well by this study. It has been recommended in evaluation studies (NHSRC 2011) that there should be advocacy of potential gains through ASHAs to programme managers. This is a worthy suggestion that can be operationalized by considering other experiences in this direction. The experiences of other programmes (Lehmann and Sanders 2007) show that improving attitudes involves a complex process of educational and institutional reform. This should be the long term goal of medical education and the public health services.

Not just advocacy but re-orientation which should include 'appropriate management and supervisory practices' and 'CHW/ASHA sensitisation' is needed. However as a short-term goal a shift in the operationalization of current activities could be considered. The experiences of other countries showed that giving medical students specific experience of working collaboratively can assist in developing positive attitudes towards CHWs (Lehmann and Saunders 2007). Therefore collaboration between the medical officers, LHVs, ANMs, ASHA Facilitators and the ASHAs could be considered for community-based interventions.

Currently even the community interactions of the ANMs have reduced due to the presence of the ASHAs. These should be renewed and the participation of other functionaries can be planned. For example the doctors and ANMs are more likely to get attention if they participate in health education although the primary responsibility can be that of the ASHAs. Facilitators can also accompany ASHAs for hospital referrals. ASHAs could be also be briefed about the responsibilities of the others or even deputed for assistance. This will sensitise each about the other functionaries, reduce the sharp divide between curative and community functions and reduce the pressure of performance of all community related activities from only the ASHAs.

10.2 Introduce Institutional Reforms to Support Participation of System Stakeholders in the Community

This study endorses a strengthened public health system and not outsourcing of public health services. This is placed within the framework of Universal Health Care as proposed by the Peoples' Health Movement (Annexure 7.1).

The discussion above pointed to the need for health services personnel to engage with the community. If the local full time personnel are to step into the community more often, then their difficulties particularly in the face of increased demands for medical services need to be investigated and addressed. The suggestion given by the local medical officers in this study was that the curative load was too high for the health personnel to do any community-based activity outside of it. Data of this study also showed that there could be an increase in OPD usage and

other curative services and not only in institutionalised deliveries after the introduction of ASHAs.

Previous studies have put forth the demands to make PHCs more responsive in order for the ASHAs to be more effective (Jan Swasthya Abhiyan 2009). The data shows that apart from changes in approaches, commensurate changes in human power at the PHC level must be made in order to support the local health officials.

There is a need to recognise the social and managerial components of public health services. The full time health personnel like the doctors need to be supported in three specific areas: provision of health education and information about the public health services to the community, better administrative and reporting functions, and strengthened ties with the panchayat systems. The appointment of qualified social workers in PHCs can be considered for these tasks. They could be mandated to carry out training programmes for all levels of the health personnel as well. Avoiding the 'bureaucratisation' of the medical social worker will however be a challenge.

10.3 Improve Awareness about ASHAs in Communities

The need for orienting not only the Village Health Committee but also holding 'ASHA sensitization' sessions within the community is emergent from the data. However given the strong association of ASHAs with the health services in the community, such sessions need to be taken by senior levels of the taluka health services to enhance her social status. It calls for a level of commitment towards the ASHA Scheme within the services which is not apparent at present. Therefore, the efforts for sensitization must first begin within the health services.

10.4 Acknowledge and Act upon the Risk of Gender Oppression

A 'gender sensitive gaze' should be directed towards the women beneficiaries from the community. Efforts in the study area to provide information to families of women and conduct health education programmes for adolescents through ASHAs are the way forward. The same gaze should be also directed at the personnel who conduct the health programmes. There is a need for gender sensitisation of men and women in the health services for their own colleagues.

Redress systems for the community are being mooted within the NRHM (Update on the ASHA Scheme 2012). It is recommended that redress committees be set up for the ASHAs and other women personnel as well. There is a mandatory requirement for Complain Committee to be set up at all work places with more than 50 people under the Vishaka Judgement of 2006. This should be implemented with immediate effect at the taluka level. Given the hierarchy and social norms it is possible that the women might not come forward with

complains, so sensitization of all personnel should go hand in hand with the setting up of such a Committee.

10.5 Acknowledge the Primacy given by the Community for 'Curative Care by Medical Centres'

Currently the only two functionaries in the health services that provide curative care to the community are the ASHAs for minor curative needs/ detection/ follow up and medical doctors . The health services system should therefore consider activating the ANMs for some parts of curative care. They are better educated than the ASHAs and could be the next level of much needed curative services after the ASHAs from the sub-centres. However sub- centres have not been safe locations for the stay of ANMs, whether one ANM or two are placed there. Therefore the health system should consider placing the male MPWs at subcentres for night stay. Both the Anganwadi workers and the ASHAs could be authorized to use his support to reach patients to health facilities at odd hours.

The primary role of the ASHA should be information-giving, referrals and home visits. Further action-research studies are required to test the way forward.

10.6 Reform the Janani Suraksha Yojana

Escort services for pregnant women are a source of immense strain upon the ASHAs in several ways. This study endorses the recommendation of the NHSRC (2011) to remove the necessity of overnight stay by ASHAs under the Janani Suraksha Yojana.

10.7 Redefine the Post of the ASHAs

ASHAs cannot have fixed hours due to the nature of their responsibilities (delivery and emergency patients will not come at fixed hours) and are comfortable with not having a government job. However they could be called part time workers or given some further recognition. Their post should be redefined in terms of their proximity to the health services which is already recognized by all stakeholders. It will help them to strengthen their position in the system and the community.

Within these parameters, trust must be put upon them by working out a remuneration arrangement with a larger 'fixed' component and a smaller 'performance-based' component to avoid exploitation. Performance guidelines and monitoring systems can be worked out in concurrence. 'Non monitory' incentives can be considered for the performance-based incentives and tenure of services. Growth avenues (NHSRC 2011) in the form of posts as Anganwadi

Workers or ANMs with appropriate training can be provided for those who are keen but there must be provisions are in place to address the basic growth aspirations of all the ASHAs.

The equation with all the other health workers at the village level dais, needs to be addressed by relooking at their posts as well. Reduction of performance-based incentive is recommended also as a way of reducing tensions. Growth opportunities for Anganwadi Workers and ANMs will be required to be operationalized along with those of ASHAs. The work description of the full time male health workers like the MPWs and Health Assistants needs to be relooked at to create a better balance of tasks, travel and administrative responsibilities.

The administration will be opening itself up to the possibility of further demands by strengthened ASHA Functionaries, but that 'risk' must be weighed against the 'risk' of repeating the history of the 1977 CHW Scheme.

10.8 Recognise and Address the Social Determinants

The Village Health Committees had limited powers as expressed by the Sarpanchs. They had received no training or information on the possibilities of entitlements in the areas of development allotted to them. Enabling the Village Committees to make village health plans is only one half of the effort that is required to address the social determinants. It needs to be matched by political and administrative commitment for resource mobilization in the same manner as has been demonstrated for the ASHA Scheme.

For too long have the achievement of satisfactory social determinants been payed just lip service within the realms of health plans due to the apparently insurmountable difficulties like the lack of commitment, paucity of resources and the difficulties of co-ordinated efforts between government departments. The NRHM can take a bold stand to expand its scope to improve public transportation and roads – the bane of all efforts to improve health facilities and functions. Measures can be taken to improve sanitation and water supply within the NRHM by allocating better resources.

The question of malnutrition is not restricted to infants – there are indications of chronic hunger among adults as seen by the data of this study. This deficit will not be fulfilled by feeding programs for mothers and infants through Anganwadis. The economic system needs to be overhauled for active mobilization of educational and employment resources for the tribal and rural areas where ASHAs live and work.

An administration that can locate and train 8.5 lakh village women who have demonstrated efficiency can take their commitment to the logical path of holistic health.

11. Implications of the Study for Social Work

Social Work is directed towards advancing the interests of the vulnerable and the marginalized in any society. In the current study, therefore the Human Rights Approach was the overarching conceptual framework of the study.

The stakeholders of this study were all identified within a Rights understanding. The ASHA was the primary stakeholder of this study because the Community Health Worker was seen as the foundation of a responsive public health system. The other stakeholders namely the community and the local stakeholders from the public health system were selected because they were at the implementation level of the ASHA Scheme. The study thus explored the relatively unexplored perspectives of stakeholders at 'the bottom' of the ASHA Scheme in order to generate linkages towards inclusive perspectives. This understanding was drawn from the Ecological Systems Theory.

The methodological framework of the study was based upon a QUAL-MIXED-QUAN methodological continua (Teddlie and Tashakkori 2009) because mixed methods including transformation techniques were required in order to generate the perspectives of all the stakeholders.

A holistic approach was taken towards the ASHA as a Community Health Worker therefore her personal life and her working life were both explored in this study. This approach helped to generate unknown linkages. For instance several 'uncounted' stakeholders were identified in this study that were influencing the ASHA's functioning including her family. This finding had implications for social work interventions.

This study aimed to gain qualitative inferences towards strengthening the ASHAs, the ASHA Scheme and the public health services system within the goal of Universal Health Rights for All. The meta analysis of this study included eleven levels of stakeholders starting from the NRHM Central Policy to the village (Matrix 7.1). The study suggested directions for change across all the levels of the stakeholders (section 7.10). These directions open up several areas for future research, advocacy and field interventions by social workers for all the levels of stakeholders. Further, this study had indicated other 'uncovered' stakeholders (Box 7.3) for future exploration .

The emergent theoretical framework identified Gender, Hierarchy, Gender-Hierarchy as the critical frameworks within the over-arching Rights Framework when women within the health services are addressed. This emergent framework can be useful for the analysis of health services systems across social work and related disciplines. It has implications for the manner in which all Community Health Worker Schemes and public health services can be designed and implemented. The social worker is envisaged to play a critical role in this mission.

12. A Glimpse of the Future

To submerge the ASHAs' natural urge towards space and growth under their equally natural joy of altruism is to perpetuate exploitative values based on discrimination. As the year 2012 came to a close a few states in the country had announced a fixed payment for the ASHAs apart from the incentives. This can be the beginning of a major change towards equity for the ASHAs. This is only fitting since the ASHAs represent the highest values of equity in health care. In the future the Community Health Worker should be considered an equal to the health care professionals. That should be an integral part of the quest for 'Health for All'.

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ANNEXURES

ANNEXURE 1.1
COMMUNITY BASED HEALTH PROGRAMMES IN THE VOLUNTARY HEALTH SECTOR OF INDIA

CASE STUDY 1

Action for Welfare and Awakening in Rural Environment (AWARE)

Time frame of this narrative: 1975-1992

Area: Andhra Pradesh, with outreach in UP, TN, Kerala and Karnataka

Strategy: Integrated rural development with awareness, economic development, employment creation, legal assistance and health through people's organizations.

Health strategy: AWARE began with primary and curative care which was the felt need of the community. Slowly, it expanded its activities to preventive aspects as well. For example, linking waterborne diseases to safe drinking water led to awareness and activities for environmental cleanliness, hygiene and clean water, simultaneously agitating for government tube wells.

CHWs: AWARE Health workers consist of a team of men and women including dais, village health workers and paramedical workers.

Support for CHWs: Four Community Health Centres (distinct from government CHCs) equipped with 20 beds that function as base hospitals and training centres. By 1992, one of them was completely taken over by the local people's committee with their own income and management.

Performance: Active in 1500 villages every village got tube wells in two years. Twelve hundred villages were alcohol free. AWARE counted health knowledge and attitudinal changes of

community members as successes. Linkages between health and development were fostered as a strategy in many ways like raising income generation projects to fund medical centres.

(**Source:** Antia and Bhatia 1993).

CASE STUDY 2

Banwasi Sewa Ashram

Time frame: 1968-1992

Area: Four tribal blocks in District Sonabhadra in Utter Pradesh

Strategy: Activities are guided by the Gandhian view of Gram Swarajya.

Health Strategy: Four Level Linked Primary Health Care Infrastructure

CHWs: The First Link is the voluntary village health worker called the Village Health Friend at a village level.The Second Link is the more trained full time worker for 20-30 villages called Village Doctor.

Training: Ten days, then ongoing.

Support to CHWs: Systemic Support in the form of the Third Link that is a Training cum Health and Medical Care Centre.

The Fourth Link is through the Neighboring Specialized Institutions for referral of complex cases.

Approach: The use of indigenous and household remedies after scientific trials was encouraged to counter non availability and expenses of market drugs. This know how has helped equip the Village Health Guides with better knowledge than government's Health Guides.

Performance: In the year 1991-92, a survey was conducted of 46 Village Health Friends that showed that they were able to treat 15 common ailments with medicines and household remedies and had spread health awareness to their communities. The points of dissatisfaction were the slow pace of the spread of health knowledge, the high attrition of trained personnel and the constant need to study and analyze contemporary health situations.

(**Source:** Antia and Bhatia 1993)

CASE STUDY 3

The Comprehensive Rural Health Project

Time frame: 1971 to 1989

Area: Jamkhed in Ahmednagar district of Maharashtra

Strategy: This is a drought–prone area and the strongest felt need expressed was for curative care. Some of the villages agreed to give space for curative clinics that were used as a base to introduce preventive health activities.

CHWs: Called Village Health Workers in the project, most were illiterate.

Training: One week orientation then ongoing throughout the tenure. The entire training of the VHWs was looked after by the hospital doctors and nurses. This prevents compartmentalization and linkages at all levels of the staff.

Activities of CHW: The Village Health Worker, as she was called, was considered the first tier of health services, who was supported by health volunteers in her village. Her responsibilities were antenatal, intra and post parturition care of mothers, conducting deliveries, monitoring growth of infants, encouraging FP coverage, treatment of minor illnesses, identification of TB and Leprosy cases, facilitation of sanitation and water supply, referrals and record keeping.

Health education was imparted by her to the community through each and every activity rather than conducting health education as a separate activity.

Support to the CHWs: A mobile health team visited each village regularly, consisting of a paramedical team that trained and followed up the activities of the Village Health Worker and handled those health issues that the Village Health Worker could not.

Due to constant monitoring and early detection, there were practically no emergencies except for Caesarian deliveries and accidents.

For referral from the village for cases requiring further care, there was a 30 bedded fully staffed and equipped hospital and a 6 bedded sub centre. At this level, complete OPD and indoor treatment including surgery was offered.

For the few cases requiring highly specialized care, referrals were made to hospitals at the district level.

Performance: Quantifiable health results in the project area from 1971 to 1989 included drop in the birth rate (per 1000) from 40 to 24, Infant Mortality Rate (per 1000) from 180 to 25, immunization coverage from 2% to 91%, and eligible couples practicing Family Planning from 1% to 60% among others.

The project counted the acceptance of the CHW as a catalyst by her village as one of its achievements. The factors that have been attributed for this success of the CHWs were frequent meetings, encouragement and supervision by the project staff, keeping the village community involved at all stages and the ability of the CHW and the project staff to deliver at all times in terms of medical care and medication.

(**Source:** Antia and Bhatia, 1993)

ANNEXURE 2.1

SELF-ADMINISTERED QUESTIONNAIRE

1.	Date	:	
2.	Name	:	
3.	Your responsibility (tick)	:	ASHA ANGANWADI WORKER ANM (NRHM) ANM (PERMANENT) ASHA FACILITATOR
4.	Name of the primary health centre where you work (write)	:	
5.	Name of the village where you live (write)	:	
6.	Number of years you have worked (write):	:	
7.	Number of hours that you travelled for work last week (tick)	:	Up to 4 hours 5 to 8 hours 9 to 12 hours More hours
8.	How did you travel for work last week (tick)	:	Walking Bus Auto-Rickshaw Jeep Ambulance
9.	When did you get your last payment from the primary health centre (tick)	:	This month Last month Before
10.	How much was your last monthly payment (tick)	:	Less than Rs.500 Rs.500-1000 Rs.1001-1500 Rs.1501-2000 Rs.2001-2500 Rs.2501-3000 Above Rs.3000

11.	Your age in years (tick)	:	Below 25 yrs. 25-30 yrs. 30-35 yrs. 35-40 yrs. Above 40 yrs.
12.	Your education (tick)	:	Up-to 4th std. 5th to 7th std. 8th to 12th std. Diploma Graduate drop-out Graduate
13.	Your marital status (tick)	:	Unmarried Married Widowed Separated Divorced
14.	Number of family members (children and adults) living in your home (tick)	:	Up-to 5members 5-10 members More than 10 members
15.	What is the main source of income for your family (tick)	:	Labourer on other's land Own farming Labourer in industry Work in city Self- employed Any other (write)
16.	What is the total income of your family per month (tick)	:	Less than Rs.500 Rs.500-1000 Rs.1001-1500 Rs.1501-2000 Rs.2001-2500 Rs.2501-3000 Above Rs.3000
17.	Your Caste (write)	:	
18.	Why did you accept this responsibility? (write)	:	

Free Listing

Please write a list of all the responsibilities an ASHA handles in a village.
Please write as you understand their responsibilities.

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

ANNEXURE 2.2

SEMI-STRUCTURED INTERVIEWS OF ASHAS

No.		Questions
1	:	Please tell me about yourself and your work as ASHA.
2.	:	What are your expectations from the government for the health of your village?
3.	:	What has been the contribution of the ASHAs at the village level?
4.	:	After taking on the responsibilities of becoming ASHA what have been the experiences of the ASHAs? (*At work/At the community/At home/with the self*)
5.	:	I present before you the three possible roles of ASHA that have emerged from the ASHA survey that was conducted in this study. Please choose roles in the order of your preference with reasons. If you do not agree with the proposed roles of ASHA that are presented then please feel free to tell your own views about the role of ASHA. The three possible roles of ASHA are: (a) ASHA is a social worker. (b) ASHA is a worker of the health department at the village level. (c) ASHA is a woman who works for job satisfaction.
6.	:	In your opinion how do you see the future of the ASHA scheme?

ANNEXURE 2.3

INTERVIEW GUIDE FOR STAKEHOLDERS FROM THE HEALTH SYSTEM

1 : Tell me about your background and position in the public health system.

2. : Since the year 2005, the National Rural Health Mission (NRHM) has come within the health services. Have there been any changes in the health department's functioning?

3. : Have there been any changes in your own work from the earlier times to the present times?

4. : There is an ASHA Scheme in NRHM. Has the ASHA contributed at the village level?

5. : What are your expectations from the ASHA at the village level?

6. : What is the relationship between ASHA and the health department?

7. : In your opinion what is the future of the ASHA Scheme?

ANNEXURE 2.4

INTERVIEW GUIDE FOR MEMBERS/OFFICE BEARERS OF THE VILLAGE WATER SUPPLY, HEALTH AND SANITATION COMMITTEE

1 : Tell me something about yourself and your association with the Village Committee.

2. : Are the meetings of the Village Committee held in your village? If yes, then how many times in a year are they held and who are the people that should be present for it?

3. : Is there a separate budget for the Village Committee? If so how much is it and what is the money to be used for?

4. : What kinds of topics are generally discussed in the Village Committee meeting?

5. : Are there any discussions on health in the Village Committee meetings?

6. : There is an ASHA scheme in your village. What are your views regarding the contribution of the ASHA towards the health of the village?

7. : Is there any relationship between the Village Committee and the ASHA functionary? If so then how is the ASHA connected to the Committee?

8. : What are the facilities that should be made available for the better health of the village in your view?

ANNEXURE 2.5

HOUSEHOLD SURVEY

1. Date :

2. Primary Health Centre :

3. Sub Centre :

4. Village :

5. Name of the Respondent :

6. Main source of Drinking Water for the family (tick) :
   - 6.1 Tap water from treated source
   - 6.2 Tap water from untreated source
   - 6.3 Covered well
   - 6.4 Uncovered well
   - 6.5 Hand Pump
   - 6.6 Tube well/Borehole
   - 6.7 Spring
   - 6.8 River/Canal
   - 6.9 Tank/Pond/Lake
   - 6.10 Other sources (please specify)

7. What did the family have for dinner last night? What did you have today?

Food intake recall of the family over last three meals

Last night:	
Today morning:	
Today lunch:	

8. What kind of arrangement does this family have for taking a bath? (specify)

For men:	
For women:	

9. What kind of arrangement does this family have for disposing the household waste? (tick) :
   - 9.1 Throw it in the open near the house
   - 9.2 Throw it in the open way from the house
     Burn it
   - 9.3 Compost pit
   - 9.4 Other (specify)

10. What kind of arrangement does this family have for latrine? (tick) :

- 10.1 Flush/pour latrine connected to piped sewer system
- 10.2 Flush/pour latrine connected to septic tank
- 10.3 Flush/pour latrine connected to other system
- 10.4 Pit latrine
- 10.5 Night soil disposed into open drain
- 10.6 Night soil removed by human
- 10.7 Night soil serviced by animal
- 10.8 Public latrine
- 10.9 Open

11. Please tell us some details about your family:
(see next page – **Household Demographic Information**)

12. Please tell your religion and caste (write answer)

13. Please tell us about the kind of health services that you have in this village.

INVESTIGATORS' OBSERVATIONS OF SERVICES

Household Demographic Information

11.1 Serial No. & Name (Start with the Head of the Family)	**11.2 Relationship to the Head of the Family** (Write the Actual Response)	**11.3 Sex**	**11.4 Age** (Estimated or Actual)	**11.5 Education (Higher Level)**	**11.6 Occupation**	**11.7 Period of Employment**
		1. Male 2. Female 3. Other		0 Not Literate 1 Literate 2 Upto 4th Std. 3 5-10th Std. 4 10-12th Std. 5 Under-graduate 6 Diploma 7 Graduate 8 Other (specify)	1 Cultivator 2 Agricultural labourer 3Industrial labourer outside Village 4 Self-employed in village 5 Self-employed outside 6 Household duties 7 Student 8 Senior citizen 9 Looking for work 10 Other (specify)	1 Upto 3 month in a year 2 3 to 6 months in a year 3 6 to 12 months 4 Throughout the year

14. Please try to remember when your family members have needed any health services in the past 3 years, up-to today. How have you been handling it?

Health Needs and Services Received: Three Years' History of the Household (Self-Reported)

14.1 **Time Period** (Write as Reported)	**14.2** **Family Member** (Refer to Table 11)	**14.3** **Health Need** (1) Fever, cough, body pain, loose motions (specify) (2) TB, Malaria, Leprosy (3) Epidemic of any kind (4) Immunisation child (5) Immunisation mother (6) Delivery (7) Other (specify)	**14.4** **Service Taken** (8) No treatment (9) Home remedies (10) Vaidu/Buwa (11) Dai (12) Asha (13) Sub centre (14) Primary Health Centre (15) Govt. Hospital (16) Private doctor (17) Private Hospital (18) Others (specify)

15. Do you have a worker called ASHA in your village? (tick) :
15.1 Yes (if yes, please answer Q.No.16-20)
15.2 No
15.3 I don't know

16. Have you ever been in contact with the ASHA and how?

17. What are the responsibilities of the ASHA?

18. How is the ASHA related to the Government and to the village?

19. What kind of payments does the ASHA get?

20. In your opinion, how useful is the ASHA to take care of your family and your village?

21.	Do you have a Village Water Supply, Health and Sanitation Committee in your village? (tick)	:	21.1 Yes (if yes, please answer Q.No.22) 21.2 No

22. What does the village Health and Sanitation Committee do?

Note: The questions 6, 9, 10 and 11 are based on the Census of India, 2011.

ANNEXURE 3.1

COMPENSATION PACKAGE FOR ACCREDITED SOCIAL HEALTH ACTIVIST (ASHA)

HEAD OF COMPENSATION	ESTIMATED CASE/WORKLOAD PER ASHA (PER ANNUM)	COMPENSATION PACKAGE (In Rs.)	
		Suggested Compensation Per Case	Estimated Maximum Out-Go for Compensation Per ASHA (Per Annum)
JSY-Institutional Delivery (Rural) LPS	13	350 for ASHA & 250 for Transport	7800
JSY-Institutional Delivery (Urban) LPS	9	200	1800
Motivation for Tubectomy / Vasectomy / NSV	8/4	150/200	1200/800
Immunization Session	12	150	1800
Pulse Polio Day, if it is full day work it should be Rs.75/-	6	75	150
Organizing Village Health Nutrition Day	12	150	1800
DOTS	1	250	250
Household Toilet Promotion	12	75	1200
Detection, referral, confirmation and registration of Leprosy case/after complete treatment for PB & MB Leprosy cases	1/1/1	100/200/400	100/300/500

Continued…

Sample Activities and Performance based Payments to ASHAs in Some States

1. Madhya Pradesh

- Non-residential trainings @ Rs. 100/- per day
- Making Malaria slides @ Rs. 5/- per case subject to a maximum of Ra. 50/- p.m.

2. Rajasthan

- Social mobilization on VHND (Village Health & Nutrition Day) @ Rs. 150/- per session
- Cataract surgery @ Rs. 175/- per case
- Non-residential trainings @ Rs. 100/- per day
- Attending monthly meeting @ Rs. 100/- per day
- Motivating families for sanitary toilets @ Rs. 30/- per toilet for APL and Rs.20/- for BPL families & Rs. 10/- for regular usage for six months only

3. Uttarakhand

- Social mobilization on VHND days @ Rs. 25/- per session
- Cataract surgery @ Rs. 175/- per case
- Non-residential trainings @ Rs. 100/- per day
- Attending monthly meeting @ Rs. 100/- per day
- Motivating families for sanitary toilets @ Rs. 50/- per family

4. Jharkhand

- Social mobilization on VHND @ Rs. 150/- per session
- Cataract surgery @ Rs. 175/- per case

5. Orissa

- Pulse Polio Day Rs. 25/- per day
- Non-residential trainings @ Rs. 100/- per day
- Motivating families for sanitary toilets @ Rs. 50/- per families

Source: http://www.mohfw.nic.in/NRHM/Documents/perf**; downloaded on 16 Nov 2012**

ANNEXURE 5.1

JANANI SURAKSHA YOJANA

The Janani Suraksha Yojana is a Central Government Scheme under the National Rural Health Mission. It is funded 100% by the Centre and introduced in the States in the year 2005-2006.
*
The aim of the Scheme is to facilitate deliveries under the care of trained medical and paramedical professionals so that maternal mortality and infant mortality rates are lowered.

Eligible Beneficiaries and Benefits:

1. Pregnant women from Scheduled Castes/Scheduled Tribes/Below the Poverty Line and living in rural areas are eligible. Women below the poverty line are expected to submit official notification given to the family, ration card or a letter from the concerned tahsilsar, talati or gram panchayat.
2. The woman's age should be 19 years or more.
3. The benefits are for the first two issues.
4. The pregnant woman should get registered within 12 weeks at the Sub Centre.
5. The pregnant mother must get a medical examination three times in the duration of her pregnancy.
6. The woman will be paid rupees 500 in cash if she delivers at home within seven days of her delivery.
7. The woman whose delivery is conducted in a public health facility will be paid rupees 600 if the facility is in an urban area and rupees 700 if the facility is in a rural area in cash.
8. Women whose delivery is conducted in a private facility or non-government organization that is nominated by the government will receive the benefit from the nearest public health facility.
9. Women who deliver in their maternal homes or another location will be given the benefit immediately on producing the Janani Suraksha Yojana card given after the registration.
10. For Caesarian deliveries if a specialist is not available in the rural areas and a private specialist is invited he will be paid rupees 1500.The same amount will be paid to specialist if the delivery is conducted in a private facility. The nominated private facility will also receive the same amount.

After delivery the woman will remain in the public health facility for at least 48 hours when the woman can be motivated for the medical examinations of the mother and child and all medical care can be taken by health professionals.

Source: The official guidelines of NRHM for state officials, issued by the Public Health Department, Government of Maharashtra (SarvajanikArogyaVibhaag, Maharashtra Shaasan; undated). Translated from the original Marathi document.

ANNEXURE 7.1

SYSTEM FOR 'UNIVERSAL HEALTH CARE' BY PEOPLE'S HEALTH MOVEMENT - INDIA

(Released on the occasion of World Health Day - April 7/2012

and in preparation for Peoples' Health Assembly 3)

OUR VISION

We believe and reiterate that Health is a fundamental human right - that the government is responsible for the provision of health care, as well as an enabling environment for the realization of the right to health, which includes the right to having control over the social determinants of health. As noted by the Special Rapporteur for the Right to Health, the Right to health includes the Right of people to participate in all decisions related to health, the implementation of these policies, as well as their monitoring and evaluation.

Our starting principles continue to be the Right to Health and the Social Determinants of Health, and equally, i.e., the principles of Comprehensive Primary Health Care as enunciated in Alma Ata.

We believe and reiterate that Health Care is only one of the many determinants of health. Mere access to health care, even if universal, will have no meaning unless the larger social determinants of health are squarely addressed and issues of ethnicity, caste, class and gender are engaged-with as a society. We believe that the goal of Health for ALL! will definitely be furthered significantly with the introduction of Universal Health Care. However, we believe that <u>what</u> needs to be universalized needs to be reflected upon. We do not believe that a mere extension of access to the present technology and industry-driven, commodified, irrational and impersonal form of medicine that is dominant in today's world is the answer. In fact, we fear that a superficial and hurried attempt at universalizing an "essential health package" in the present un-regulated situation in which there is absolutely no accountability of the system to the people would be beset with two problems: First, it will be an inefficient, wasteful way of spending the taxpayers' money. Second, it will create new problems for the people and increase inequity. We believe that Health is a fundamental Right of the people and health care needs to be available based on people's needs rather than as part of a "purchased package". With regards to health, we also believe that the private sector should play only a supplementary and never a complementary or competitive role.

- PHM India emphasizes the concept of "universal" over the earlier dominant "selective" or "cost- effective" packages concept.
- It emphasizes tax-based financing of the health system.
- It completely rejects user fees in the health system.
- It is committed to "Free Medicines for ALL" in the Public Health System.
- It calls for the enforcement of price regulation and the application of price controls on all formulations in the Essential Drug List.
- It calls for the strengthening of public sector vaccine production capacity and the protection of the indigenous capacity even in the private sector.
- It calls for the protection of safeguards provided by the national patent laws and the TRIPs Agreement to protect the country's ability to produce essential drugs.
- It brings the critical issue of human resources to the center of the table.
- It specially welcomes the focus on strengthening the village level resources with the suggestion of additional community health workers, strengthening the very local level, giving priority to the CHWs and the nursing cadres; it suggests HRH management systems that establish clear career paths.
- It suggests strengthening and expanding the public sector and the earmarking of the necessary budget, and especially the establishment of a reliable urban health care system.
- It clearly states it is against the use of private insurance in the financing of health care.
- It highlights the need and urgency of private sector regulation, as well as outlining a potential regulatory structure.
- It brings community-based accountability mechanisms to the center stage.
- It insists any government report must undertake some consultation with a wide range of groups including civil society, international experts, academics and industry.
- It thinks that clear recommendations for regulation of the private sector need to have a substantive critique of the rapidly growing, unregulated private health system, especially the emergence of the corporate health care as a dominant entity in the last two decades.
- It objects health care needs being something that can be packaged, and the flaws of the current health system as something that can be rectified by tax based purchasing of services.

- It insists recommendations include a) the size and scale of health care financing required for universal health care expressed as % of GDP, and b) an estimation of the funds required for a 'Medicines for All' program.
- It welcomes the fact that government takes up the issue of the social determinants of health. But recommendations to address this challenge need to be made in concrete.
- It believes that a new way of looking at health and the health system is needed. This means making the current set of institutions more people centered rather than developing another slew of "expert" driven bodies with complicated lines of accountability to the people.
- It worries that top-down reports have many faulty interpretations of the reality concerning issues that are likely to completely defeat the purpose and spirit behind any evolving process for Universal Health Care.
- It believes that any Minimalist Essential Health Package will nothing but show the very contracted nature of the vision of health planners. This in no way can be considered as a universal health package.
- It believes the operational autonomy of public health facilities concept for any health facility (accountability frameworks, financial autonomy) actually means leaving the public sector to "fend for themselves". In the present environment, it will merely mean the death knell of this system and jeopardizing any hopes for a Universal System.
- In the present situation of a historically neglected and dilapidated public health system and a private sector that has received encouragement (and has an unregulated growth enabling it to reap huge and obscene levels of profit) inequity has vastly increased. Under these circumstances, the concept of "provider choice" is highly problematic.
- It believes that the private sector should never play a competing/complementary role, but only a supplementary role under a strengthened public health system accountable to the people.
- It rejects the failure to focus on strengthening the district health level that does not have the capacity or the robustness of governance needed for the task.
- It believes that cost escalation being contained by sticking to standard treatment guidelines, without questioning the basic commodification of health care, again questions the vision of access to universal health care.
- It suggests that piloting district health models should be initiated only after full discussion and public debate.

PHM INDIA's VISION FOR A UNIVERSAL HEALTH CARE SYSTEM

Health Care provision:

We firmly believe that the public health system has to be the back bone of any universal health system. In its present state it definitely cannot be so. The public health system has suffered years of neglect due to lack of funding, poor governance and active encouragement of the private sector.

It is also true that in order to cover the complete population with all the services the involvement of the private providers in some form may be necessary. However we hasten to add that the degree, form and content of the engagement can not be at the expense of the three critical steps:

- Strengthening of the Public Health system and especially the primary level of care with more health workers and encouraging and building up the capacity of self-care, and especially preventive and promotive care.
- Bringing the public sector up to its full functional capacity and expanding it to the level at which it is supposed to be including population coverage and infrastructure norms.
- A detailed mapping and assessment be done for each district of the actual needs for curative health care at each of primary, secondary and tertiary care level after taking into account a fully strengthened primary level (including curative, preventive and promotive). This, to decide on the need for contracting in the private sector the needs they can bring in respecting the terms of health as a public good. The integration of the public and private sector is not seen only in terms of provision and financing, but most crucially in terms of an integration of the "logic" of the health system, with corporate profit not being allowed to lead or define health provision. The health system has to be strictly and transparently regulated with its primary goal being the people's welfare rather than private profit. It is only under such conditions that we can develop a system that will truly serve the needs of the people equitably.

Health Care Financing:

There is little doubt that the most widely successful way is through, tax-based financing. The key challenge to financing then becomes the problem of resource allocation - to districts, and within districts, such that it reflects the needs of equity, access and quality of care. This needs to be in an environment of good governance and transparent financing systems so that there are no leakages and quality of care and efficient use of resources is ensured whether it is by public providers or in the form of contracting private providers. While a number of countries have provided models worth studying, each country needs to chart out its own course. For sure, one thing is that what one should be aiming for is health security and universal coverage and NOT the currently fashionable and politically convenient "insurance schemes for tertiary illnesses" or limited hospital based coverage. Using a single capitation fee to be paid to an integrated care provider as part of a "managed care" model is untested and potentially fraught with problems of denial of care, which would be particularly difficult to monitor when it is a private provider. We

point out that in the current social and economic context, the only possible integrated care provider other than the government is corporate entities, and given international and national experience with these, this is totally not desirable.

We would limit private sector participation to essentially roles that are supplementary to the public system, where costs and quality of care are subject to monitoring and equity considerations are respected.

The concept of "choice of provider "is also problematic as the public sector has many functions to perform, is very busy and it would be wrong for it to turn away patients who have chosen it. In such a circumstance, users would register with a private sector provider as an alternative to the free or low cost care in principle available in the public sector. In a situation where the private sector has historically grown using unjustified public subsidies and encouragement; it is ridden with conflicts of interests in referrals and in ownership; it is not competing on fair terms thus risking to undermine the public sector. We believe that the private sector should never play a competing, but only a complementary / supplementary role thus strengthening the public health system that is accountable to the people.

Governance:

Whatever the provisioning and the financing mechanisms, unless the governance of the whole health system is firmly people-centered and rights-based, these arrangements are likely to be exploited by the dominant and corporate private sector. We envisage a community-led and focused process. We further visualize institutionalizing a process of community-based monitoring, planning and action for health. This process needs to evolve from the learnings from the ongoing experiences in a number of countries where PHM has partners.

In addition to this, we believe that there needs to be greater internal democracy. The public health system is ridden with hierarchies and power centralization. The private sector is driven by the need of extracting profit from people in their weakest moment; it is further characterized by irrational and unnecessary interventions (both diagnostic and therapeutic). These issues need to be addressed comprehensively as well.

A regulatory framework for private health facilities needs to be strengthened. The system should be developed to give sufficient power to regulatory bodies.

IN CONCLUSION

We welcome any national attention and emerging policy level commitment to health care by government authorities. Always call for the following:

- A national public debate on the contours of any proposed universal health care system. Such an important issue cannot be rushed through and its various strands need to be understood, discussed and commented upon widely by the people.

- Definition of a clear, transparent and time-bound road map for strengthening and expanding the public health system is a must while improving its functioning and accountability; this must include allocation of adequate, increased budgets.

- Enactment of adequate laws guaranteeing the right to health, including National and State Health acts that lay down the framework for regulation of the health system particularly relevant for private medical providers. Providing entitlements must be accompanied by a clear framework for accountability and grievance redressal.

- While developing and operationalizing the universal health care system, highest priority must be given to significant expansion and improvement of public health services. Regulated private providers should not be competing with public providers for common resources, rather they may be in-sourced to provide services, but never as a substitute to the public sector.

- -Ensuring fora are provided for participation of community members, community based groups and civil society organizations along with elected representatives and public health officers at various levels for planning, monitoring and reviewing the functioning of the universal health care system.

- Organizing a process of mapping and estimating the pattern of health care services required in each district and within each district in areas with special needs. This process must be transparent and widely discussed by people in each district.

- We must be aware that the direction of developing universal health care anywhere must be towards strengthening the public health system and the socialization of health care, rather than promoting further expansion of unregulated, profit-oriented private medical care. Hence a national debate is essential and there should be no haste in rolling out these concepts; even the looming of the general elections should not become an excuse for the government to short circuit and distort the concept of Universal Health Care for narrow political gains.

Source: http://www.phmovement.org/en/India