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Impact of Covid-19 Pandemic on the Accredited Social Health Activists: An Exploratory Study in Rangareddy District of Telangana, India

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Abstract

The whole world is immensely dealing with the COVID-19 which was originated from the Wuhan city in the end of 2019. All the countries have been in a devastating state by the sudden outbreak which led to many deaths from the deadly infection. Many low- and middle-income countries are being suffering due to the poor healthcare infrastructure and a smaller number of healthcare workers. India is one of them. Due to the insufficient number of healthcare workers, the workload on the existing numbers has increased to a double-fold, especially on the grass-root workers. Accredited Social Health Activist (ASHA), an initiative of the National Rural Health Mission in India is involved in the implementation of the primary health care facility at the grassroot level. The effective implementation of the health care policy depends on the performance of the ASHA workers. The present study aims to identify the challenges and barriers faced by the ASHA workers while delivering their services during the pandemic times and provide policy suggestions for strengthening of the grass-root level health care workers for facing any kind of future health emergencies.

Keywords: Accredited social health activist workers, COVID-19, Healthcare workers, Incentives, India, Pandemic

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Introduction

An Accredited Social Health Activist (ASHA) is a frontline community healthcare worker who works at the grassroot level as a part of the National Rural Health Mission (NRHM), 2005 under the Ministry of Health and Family Welfare (MoHFW).[1] An ASHA is supposed to act as an activist who will promote primary healthcare and mobilize the community towards using the services available by creating awareness as well as counseling them.[2] During the COVID-19 (coronavirus disease emerged in 2019), the ASHAs have to perform regular as well as additional tasks assigned to them within the limits of their regular incentives. This paper attempts to explore the challenges faced by the ASHAs during the pandemic while delivering services to the community areas of Chevella and Serilingampally under the Rangareddy district of Telangana.

Firstly, I argue that increase in workload of ASHAs during the pandemic has led to many ill-health consequences, both physically and mentally. Having to work whole day with the at-risk population need to have high level of motivation. There are many factors that influence the level of motivation at work. Hence, this study seeks to know whether there is any relation between the level of motivation and their recognition and remuneration.

ASHAs, whose role includes social activism, is the key cadre in India's Community Health Worker (CHW) program.[3] There are three key components which are essential to be selected as an ASHA worker. First, she must be a women resident of the village concerned either married/divorced/widowed in the age group of 25–45. Second, she must have completed her schooling till 8th grade. And finally, after her selection, she is given training for the period of 21 days educating them about the duties they have to perform along with the incentive scheme. In the pandemic, ASHA workers have a great role to reach to every individual in the community and screen them for the disease, i.e., COVID-19.

COVID-19 is an infectious disease caused by a newly discovered coronavirus which was named as "severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)" as the new name on 11th February 2020. The World Health Organization (WHO) declared the outbreak a Public Health emergency of International Concern on 30 January 2020, and a pandemic on 11 March 2020 (WHO). Most of the people who are exposed to this virus will suffer from mild to moderate respiratory illness and recover without requiring special treatment.[4] While those of older age and with underlying co-morbidities are likely to develop serious illness. But the condition from the March of 2021 is different as the country (India) got hit by the second wave of the pandemic. The rate of spreading the infection from one person to another increased drastically resulting in coming out of approximately 400,000 fresh cases and 3500 deaths everyday.[5] Also, the severity not only resists to the elderly people but also affecting the younger ones and those with good immunity.

The COVID-19 has resulted in many negative consequences mainly affecting the psychological well-being of an individual. It has led to the development of anxiety, stress, and depression among the people (affected/non-affected) due to various reasons like fear of losing the loved ones, wage loss, domestic violence, etc.,[6] Similarly, the workload on ASHAs has been increased in this pandemic as they have been assigned with different tasks in

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different states of India. Overall, they have to monitor and gather information about the migrant workers, students coming back to their states from their hostels, and also for the local needs of their respective communities.[7] She has to screen the workers for any symptoms, counsel the students and quarantine them.[7] before the pandemic, she has to work for 7–8 h/day to complete her tasks but now, she has to contribute more of her working hours without getting any improvement in her remuneration.[7] There are many questions that arise such as what are the consequences from the additional work on their physical and mental health? Are the ASHAs satisfied with their remuneration with respect to the amount of work they do?

Methodology

This study is qualitative and exploratory in nature. It used individual in-depth interviews using a semi-structured questionnaire followed by case studies. Purposive sampling technique was used to select the study locations namely Chevella and Serilingampally Mandals, Rangareddy district due to more availability of the ASHA workers in their respective Primary Health Centers (PHCs). Chevella Mandal is a rural area whereas Serilingampally is the urban area, which were also selected purposively for comparison purpose. The PHCs selected in Chevella and Serilingampally were Chevella PHC and the Gulmohar Park PHC respectively. From each of the PHC, five ASHA workers were selected and the interview was held in the PHCs itself. Hence, the sample unit for analysis was 10 ASHAs from Rangareddy district, Telangana.

The semi-structured questionnaire contained the following issues: (a) Demographic details (age, education, marital status, household size); (b) Working details (types of tasks performed during the pandemic, time spent on each task, population covered in a day); (c) Transportation (type of transport used to reach the surveillance site, wages spent on it, time consumed per travel); (d) Remuneration (payment structure during pandemic, pending payments, health insurance); (e) Safety at work (provision of safety gear, self-isolation, conflicts); (f) Household Socio-economic conditions. The responses of the ASHA workers are crucial in understanding the various challenges faced by them and help in providing policy suggestions. The responses also provide evidences for effective policymaking.

Data Collection

Data were collected through in-depth individual interviews as well as few case studies to gain deeper knowledge. Open-ended semi-structured questions were asked about the challenges and barriers faced by them while delivering the services amidst the pandemic along with the amount of workload increased after the pandemic and what is the compensation they are paid for. The individual interviews, as well as the case studies, were conducted between March 1st and April 30th, 2021. Each interview existed for 20–25 min, to adjust with the timings of the ASHAs due to their busy schedule. The exposure to the Chevella ASHAs was possible due to one of the friend's contacts as a resident of Chevella. Whereas, in Gulmohar Park PHC, the permission was granted for interview by the head of ASHAs after showing all the academic documents.

Oral, as well as written consent, was obtained from each of the participants before which they were explained about the purpose and procedure of the study in their comfortable language, Telugu. The procedure was explained by a translator who could speak fluent Telugu. Audio recordings and field notes were taken, and the interview was transcribed on the same day after returning from the field to prevent losing any information.

Profile of the Respondents

Out of the total sample of 10 ASHAs, half of them fall under the age group of 30–35 as they have been working in this field for a long time. All of them were married and had children. They all follow Hinduism and majority of them belong to the Scheduled Caste and Scheduled Tribes. The age group Appendix Figure 1 and the Caste profile Appendix Figure 2 of the participants are listed below. Nine out of ten respondents lived in a nuclear family. Although most of them lived in a nuclear family, the monthly family expenditure exceeded the total income Appendix Figure 3.

According to the selection criteria of the ASHAs, all of them passed the primary schooling. Six out of ten respondents completed their schooling till 10th grade. While only four respondents completed their higher secondary education Appendix Figure 4. Since the experience as an ASHA matters a lot in the field, they were also asked about their work experience. Eight respondents were having experience of more than 2 years in the field while the other two were the newcomers working since the pandemic began.

Double Burden on the ASHAs

Before the pandemic, the ASHAs were assigned with different tasks on a weekly basis. Everyday they have to visit the houses under their cover to enquire about signs and symptoms of any prevailing disease, distributing the essential drugs, and maintaining a register at the PHC of the pregnant women and the status of their newborn. The weekly tasks they perform are the Ante Natal Care (ANC) registration, Motivation to the parents for their child's vaccination, Vaccination Day in PHC, visiting schools to educate students about the National Health Programs (NHP), Taking pregnant ladies for ANC visits to the nearest PHC, Vaccination Day in Anganwadi Centre (AWC) and Deal with delivery cases respectively. If they have completed all the tasks in a week and maintained the register well, then they will get an incentive of rupees 7200 per month. If they fail to accomplish any task due to any of the reasons, the incentives will be deducted.

During the pandemic, the ASHA workers played a major role in preventing and controlling the spread of infection by screening every individual at risk. At the same time, they faced many rivalries as they were expected to carry out the daily tasks along with the additional tasks which were assigned due to the pandemic. They must visit 30 houses in a day for screening of the community members, checking if they had any signs and symptoms related to COVID-19 along with noting down the traveling history if anyone has recently immigrated. Those who are found with mild symptoms were taken to the nearest PHC for testing by the ASHA. Next to which if the test comes out to be positive, the person has to be quarantined for a period of 14 days and a continuous watch to be kept by an ASHA.

They have to maintain a special register keeping track of the 'at-risk' population such as children <5 years of age, pregnant women, and the older adults. One of the ASHAs said,

From the last one year we are doing the same work of screening the people from morning to evening. Along with this, we have to trace the primary contacts of those who tested positive in the PHC. After

asking the patients about their recent contacts we have to call them and advise them to take the immunity boosting foods and come to PHC if they feel any mild symptoms. (Personal interview 2021)

Apart from suggestions, they will work hard to maintain all the guidelines in the community and look that all the members of the community are following the same. Keeping up with all the additional as well as the daily tasks was itself a challenge for them. Another ASHA added,

We have to walk to the signal first from the PHC to get any vehicle. During complete lockdown, there were no single vehicles available. We used to wait for one or two hours long. Sometimes the policemen standing on the signals will help us by arranging some vehicles carrying fruits and vegetables to reach our site. We are very thankful to them. (Personal interview 2021)

Travelling remained a major problem for them. It took a much longer time for them to reach the sites even if they get the vehicles because of longer waiting time and sometimes they have to change two vehicles if the location is far away. Many of them have covered a longer distance on their foot, no doubt they have been tagged as "bare-foot workers."

Social and Financial Exclusion

Though it has been 15 years since the ASHAs were introduced under the NRHM, still there are little success stories about the inclusion of ASHAs by providing them equal rights and participation. The way the community members, staffs, and colleagues behaved with them varied from place to place. For instance, the ASHAs working in the urban PHCs were very much satisfied how they were treated by the people and staff while on the other hand, ASHAs working in the rural PHC were disappointed equally. To support, one of the ASHAs working in the Chevella PHC said,

If we get to know that some outsider has come to our village, then we will go and insist them politely to go back to their places where they came from. But most of the time people will ignore us and pretend to not listen. Even when they us coming from a distance, they will close the doors on our face. We do not get any respect wherever we go. The villagers will sometimes pass on bad comments and never allowed us to stand in front of their houses. They even used to tear the red posters which were stuck for the quarantine purpose. Whenever we take any pregnant lady to any PHC for delivery, they will not allow us to enter inside the main gate. We have to wait outside the gate until the delivery is done. Whenever we questioned them, we were told that they neither recognize nor trust us. (Personal interview 2021)

The structure of pay depends on the number of tasks carried out by the ASHAs on a timely basis. If they fail to accomplish any task due to some reason, the pay will be deducted for the particular task from their incentives. They receive a total of 7200 rupees for doing all the tasks. However, all the additional tasks they carry out during the pandemic were worth rupees 1000 per month which continued only for the duration of 3 months. One of the Ashas added,

At the time of training, we are taught that the meaning of ASHA as "Keeping No ASHA (Expectation)" for any kind of facilities or permanent salary. This month, 300 rupees were deducted from our incentives because we failed to update the NCD (Non-Communicable Disease) reports on the website and couldn't deliver the IFA (Iron-Folic Acid) supplements to the adolescent girls of our village. It was not our fault because the doses were not available at the PHC due to lack of supply. Still, we were counted at the fault. (Personal interview 2021)

The kind of behavior and the unequal treatment of the ASHAs by the community and the officials may lead to many deprivations according to the Capability approach (Amartya Sen, 1979). According to the approach, improper and unequal treatment also leads to many deprivations such as lack of opportunity, confidence, motivation, and poverty.

Case Studies

Hemlata,[1] an ASHA worker working in the PHC of Serilingampally, Gulmohar Park Rangareddy district, Telangana lives in a nuclear family with her husband and two children. Her husband works for a real estate agency. Both of the children are attending a government school, one being in 8th grade and the other in 5th. The total expenditure for the house and children's education are being handled by both of the parents equally. Hemlata's house is nearby the PHC where she has been working for the past 6 years. After the pandemic, their family has been facing many issues related to the job and education. Her husband's job was on a halt and also the schools were closed. She was the only earning member in the family. After the start of online classes, there was a need of android phones for each of the children but they could only afford one phone due to their poor financial conditions.

She had a lot of responsibilities on her shoulders as the children and husband were at home and she has to go outside for working. She would wake up at 5:00 A.M every morning to finish her work at home and reach the PHC on time. She has to stay isolated from her family as she was working with the at-risk population the whole day. They were also not provided with any of the safety gear such as masks, and sanitizers. They have to buy it on their own expenses.

Goribee is also an ASHA worker in the PHC of Chevella Mandal, Rangareddy district, Telangana. She lives in a joint family with her husband, two children, and in-laws. From the two children, one is a toddler and the other child is attending a govt school in Chevella studying in 4th grade. Her husband is a heavy drinker and spends all his earned money on alcohol. He works at a construction site and is a daily wage earner. She said,

My husband will beat me whenever he comes home drunk. He forces me to leave my job as an ASHA and join with him on a construction site to get more money. My in-laws also agree with him and insist me to leave my job. There is no support from my home to me, especially during the pandemic. After returning from the field, they will not allow me to sit with them or my children. I was told to stay isolated till the day I work as an ASHA. (Personal interview 2021)

The financial crisis during the pandemic has brought about a new normal where people strive to work and earn for their livelihood. The ASHAs worked day and night without the facilities and support to overcome the situation. The recognition and remuneration still remain a major challenge for them to be addressed.

Psychological Distress

From the above case studies, it is clear that how the pandemic has affected the individual lives of the ASHAs. The way they are treated at home by their family members matters a lot as family is considered as a pillar of any individual. The second case study about domestic violence is responsible for the cause of several distress mainly being the anxiety and depression. Moreover, there were many cases where the ASHAs complained of not providing any safety gears such as

1 A proper consent was prepared and delivered to the participants Hemlata and Goribee for a personal interview used for case studies.

masks, sanitizers, and PPE kits which were at the utmost need. They used to cover the faces with their sarees and washing hands with hot water. On asking about their rights, they were forced to shut their mouths and threatened about losing their jobs. The acute pressure from the department for accomplishing the tasks on a timely basis was the major factor as it was related to their incentives.

The discrimination and the maltreatment with them by the officials as well as the community members also affect the level of motivation to continue their work.[8] They were not only expected to complete the door-to-door surveys but also work restlessly for the success of the inoculation drive in the rural areas. The hesitancy and myths about the vaccine led to the bad behavior by the community. Even their work-life balance got struck. Sometimes they will be called for work on a short notice to a distant place from their home which takes them 2 days to return home. Leaving the family and going for work, a woman faces a bulk of criticism in a patriarchal society, dominating in rural belts.[9] Hence, the mentioned situations support the hypothesis that the increase in workload has affected their physical as well as the mental health.

Any of the psychological distresses could result in a disturbance in the mental health of an individual. And we know that mental health is one of the important components for the quality of life and healthy aging. Though they have gone through a lot of psychological issues, the ASHAs have continued to work, some due to interest and others due to lack of money.

ASHA Benefit Schemes

The cabinet committee of Economic Affairs, chaired by Shri Narendra Modi, Prime Minister of India, approved an ASHA benefit package in the year 2018 for all the ASHAs to be enrolled in a social security scheme named Pradhan Mantri Jeevan Jyoti Bima Yojana and Pradhan Mantri Suraksha Bima Yojana for a duration of 1 year.[10] The beneficiaries were to get rupees 1000/- to 2000/- per month after the enrollment. On asking about the scheme to the participants of the study, none of them got enrolled in the scheme due to the lack of information and knowledge about the scheme.

Due to the inappropriate safety measures and resources, the states were asked to pay an additional incentive of rupees 1000/- to the ASHAs starting from January 2020. According to the ASHAs participated in the study, they received the additional incentive for the first 3 months only, i.e., from January to March 2020. Also, a token was raised for the introduction of the ASHA workers (Regularization of Services and other Benefits) Bill in 2018. Similarly, a recommendation to identify all the scheme workers as "workers" was also proposed in the 45th session of the Indian Labour Conference so that all the workers get the minimum wages and other statutory benefits.[11] Despite the poor response of the governing bodies towards recognizing the ground workers with mere equality, the bills are yet to be passed by either house.

The pandemic has, however, added responsibilities on both sides of the scale. The low expenditure on healthcare is another factor striking <1.5% of the nation's GDP. In the 2020–2021 budget allocation, the amount was reduced to 390 crores as compared to that of the last year which simply direct towards the poor allotment of the resources to the ground-level workers.

Conclusion

The ASHAs as a part of CHWs are known to be the links between healthcare and the community. They have the responsibility to visit door-to-door to keep up their everyday report about certain non-communicable diseases, Maternal and Child Health, Counselling for family planning, and infections if any. Though they were filled up with the daily tasks, the pandemic proved as a burden as well as a challenge for them. The additional tasks like screening of the community members for COVID-19 and isolating them if anyone turns out positive along with the continuation of the daily tasks was laborious. Many of them had to struggle to reach the surveillance site due to the lack of commuting facilities. Though, some of them carried out all the tasks smoothly as they have been working in the field for the past 10 years, traveling remained a major challenge for them too. Similarly, less attention was provided in the rural PHC in terms of assuring the safety measures like masks and gloves.

In spite of absolute work, the ASHAs had to hit the bricks demanding for their recognition besides remuneration. They called for equal rights and pay alike the Auxiliary Nurse Midwifes and other CHWs.[12] Following the constant demands, the government came up with a scheme of providing the supplementary incentive of rupees 1000 per month along with the persisting one. Nonetheless, participants of the study mentioned that they received the monetary benefit only for the duration of 3 months, which shows the misguidance and the ill-consideration of the ASHAs rights.

As learnt from the above case studies, the psychological distress concurs with the physical exhaustion. Type of behavior with the ASHAs keeps them motivated towards their work which was merely satisfied with the ASHAs working in the rural areas. The unwillingness and rude attitude of the people towards the ASHAs made their job tough. In light of the situation, proper education of ASHA's role in the society has to be disseminated. Likewise, complete support from the family especially the husbands made them reach to a greater number of households and vice versa. Letting to choose between the family and work manifested very strenuous for them.

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Appendix

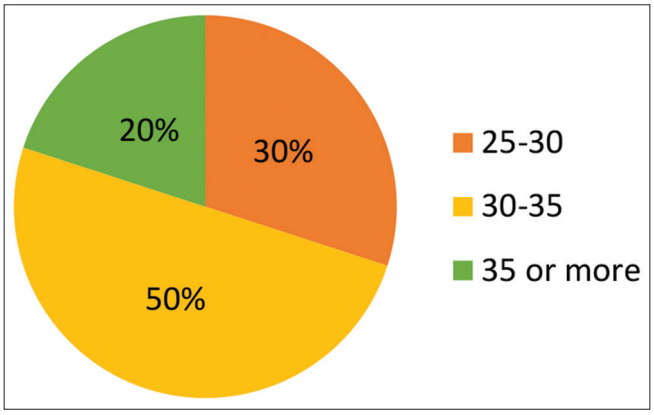

Figure 1: Age group of the ASHAs

The figure provides information about the age group of the ASHAs participated in the study. Ten ASHAs were selected purposively for the study among which five were in the age group of 30–35, since they have been working in the field for a longer time.

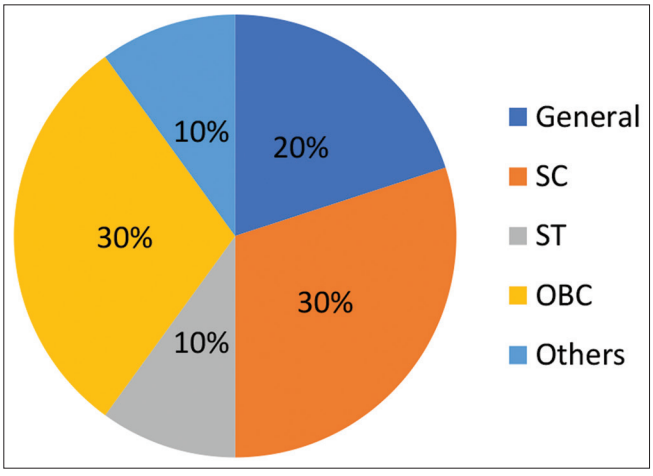

Figure 2: Reservation categories of the Asha workers

The figure depicts the Reservation categories the participants belong to. Majority of them belong to the Scheduled Caste (SC) and Other Backward Classes (OBC) categories. Very few were from the Scheduled Tribe (ST) category.

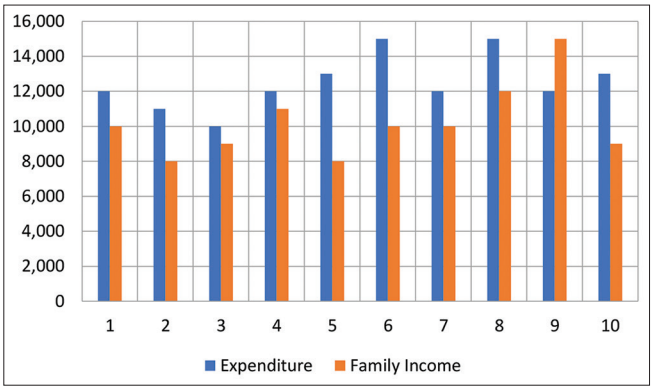

Figure 3: Income versus expenditure chart

The figure demonstrates the monthly family income and the expenditure of the participants. The income and expenditure include both the amounts of the ASHA workers as well as their husband's. It is clearly visible that the expenditure is higher for the families than their income

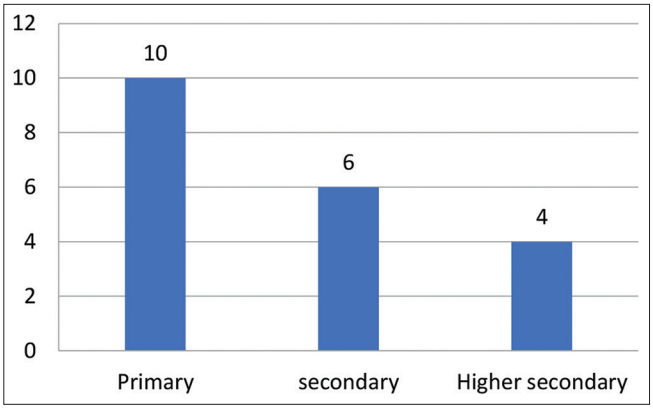

Figure 4: Education status of the ASHAs

The figure explains the level of education the participants attained for. All of them completed their primary education till 8th grade which is a necessity for the eligibility as an ASHA. Six of them attained the secondary education till 10th grade and four of them till 12th grade. Higher the level of education, lesser the number of attendants due to several reasons like dropouts, religious constructs, etc.