Impact of the Pandemic on Accredited Social Health Activists (ASHA) in India

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Introduction

Accredited Social Health Activists (ASHAs) are community health workers under the National Rural Health Mission of Government of India. Along with auxiliary nurse midwives (ANMs) and anganwadi (childcare) workers (AWWs), they are among India's frontline health workers. This note describes the situation of ASHAs during the Covid-19 pandemic.

The all-woman ASHA programme began in 2005. There are some one million ASHAs in India today, and the programme now covers all States except Goa (GoI 2020a). According to the National Health Mission (NHM) guidelines, any "woman resident of the village – married/widow/divorced, and preferably in the age group of 25 to 45 years . . . with formal education up to eighth class" can be selected as ASHA (GoI 2005, p. 3).[1] After selection, ASHAs undergo a brief period of training. Their task involve creating health awareness, conducting immunisation drives, facilitating reproductive and child healthcare, and promoting other healthcare initiatives in their respective States.

Along with the local bodies and other peripheral health workers (such as AWWs and ANMs), ASHAs play an essential role in strengthening the primary healthcare system in India. ASHAs are paid a small "honorarium" and some task-based incentive payments. The state does not recognise ASHAs as "workers," but as "volunteers/activists" and excludes them from the protection offered under various labour laws.

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[1] Women eligible and willing to serve their community are selected by the gram sabha in consultation with various community groups, anganwadi centres, nodal officers at block and district levels, and the village health committee; available at https://nhm.gov.in/images/pdf/communitisation/task-group-reports/guidelines-on-asha.pdf, viewed on June 9, 2020.

They do not receive social security benefits such as paid leave, insurance of any kind, or maternity leave.[2]

The precarious situation of ASHAs is a consequence of policies that advocate reduced public spending on social sectors, flexible and informal labour contracts and the use of volunteers with minimal training for a wide range of tasks. Widespread contract work is especially prevalent in works dominated by women workers, such as care work (Hemalata 2020).

We conducted in-depth telephonic interviews with 31 ASHAs from six States of India – Andhra Pradesh, Assam, Haryana, Tamil Nadu, Telangana, and West Bengal – between April 15 and May 4, 2020 (Table A1). The respondents belonged to different districts, rural and urban areas, castes, and classes (self-employed and manual wageworkers) (Table A2).

We used a semi-structured questionnaire with a focus on (a) demographic details (age, education, marital status, household size, etc.); (b) information on work (tasks performed during the Covid-19 pandemic, time spent on various tasks, transportation, and the population covered); (c) remuneration (payment structure, average earnings, last payment received, pending months of payment, health insurance, etc.); (d) safety at work (provision of safety gear, self-isolation possibilities, precautions taken to deal with infections, and conflicts during Covid-19 household surveys); and (e) household socio-economic conditions (intensification of housework, employment and earnings of other members, caste, land ownership, and access to the public distribution system and other welfare schemes).

Intensification of Work

Our first major finding is that work for an ASHA has intensified during the pandemic and lockdown. Before the pandemic, an ASHA worked an average of seven to eight hours per day to complete the tasks assigned to her, including, for example, immunisation drives, awareness camps, assisting pregnant women, and attending meetings with health officials. Most regular tasks, other than the care of pregnant women, were put in abeyance during the lockdown. Despite the suspension of usual tasks, the average number of hours of work per day increased by two to three hours for most respondents because new tasks related to containing the spread of the infection were assigned to them. A respondent from North Dinajpur, West Bengal, said,

> I have to survey 50 households every day to screen them for symptoms. My workload has gone up as more migrant workers return home, and I have to monitor their quarantine as

[2] In Assam, after several organised struggles led by ASHA workers' union regarding social security provisions, the State government rolled out schemes to cover all NHM employees including ASHAs under the Asha Kiran Scheme (provision of health insurance coverage of medical benefits up to Rs 25,000 per year and Rs 1 lakh in case of death) and Ayushman Bharat Health Assurance Scheme (family coverage of Rs 5 lakhs) (Kalita 2019).

> well. And, now that transport is not available, I have to walk to my health sub-centre, which is four km away from my home. These days, I go out at 8 in the morning and can only come back by 7 in the evening.

The new tasks include (a) surveying 30–50 households per day to gather information on travel histories, the health profile of household members (for example, whether or not persons in the household suffer from hypertension or diabetes), and visitor details; (b) providing quarantine instructions, monitoring persons in quarantine, and checking their symptoms; (c) preparing and submitting reports to the medical officer at the primary health centre (PHC); (d) administering medicines for hypertensive or diabetic persons; and (e) advising people on precautions to be taken (for example, social distancing, wearing masks, washing hands, and keeping senior citizens safe).

There were variations in the tasks assigned to ASHAs across different States. For instance, in Haryana, they had to monitor and gather health-related information from migrant workers who had come for the harvesting season. In Andhra Pradesh, ASHAs were asked to screen lorry drivers and migrant workers at construction sites for Covid-19 symptoms. During the lockdown, many students returned to their villages, and ASHAs had to collect details of their travel and provide quarantine advice. District medical officials sometimes sought supplementary information based on local needs, which often meant ASHAs were required to revisit households. A respondent from Mulugu district, Telangana, said,

> Sometimes, the PHC facilitator calls up in the middle of the night to inform us that a few migrant workers have returned to the village; we are expected to go to the village at that hour to screen them for symptoms.

Moreover, the commute time for ASHAs increased because of the absence of public transport.[3] In West Bengal, ASHAs had to meet the medical officer at the PHC every Wednesday during lockdown. After completing the household surveys, they had to either walk or take a private vehicle to get to the PHCs, which could be as far as 10 km from the village. In Haryana, a respondent had the additional responsibility of collecting masks from the PHC and distributing them to the ASHAs assigned to her. This entailed substantial travel, for which she had to pay out of pocket. After frequent complaints in Andhra Pradesh, Haryana, and Telangana, the requirement of visiting PHC to submit details was deferred. In Haryana, ASHAs were asked to submit the survey details and other information online. This was not possible, since many ASHAs had neither Android smart phones nor digital literacy required for the task.

Earnings

Our second finding is that ASHAs have not been adequately compensated for the loss of usual earnings and additional Covid-19 related tasks. The remuneration of an ASHA

[3] The survey was conducted during the second phase of the lockdown when public transport was unavailable.

Table 1 *Details of payment, earnings, and pending months of payment*

State	Remuneration (in Rupees)	Earnings per month (in Rupees)	Number of months for which payment is pending
Andhra Pradesh	10,000	10,000	0
Assam	3,000 + incentives	4,000–4,500	1–2
Haryana	4,000 + incentives	7,000–7,500	2
Tamil Nadu	2,000 + incentives	3,000–3,500	4–5
Telangana	3,000 + incentives	5,000–6,000	1
West Bengal	3,500 + incentives	4,200–5,500	1–2

Source: Compiled from authors' survey.

comprises a fixed honorarium plus task-based incentives.[4] The fixed amount is paid by the State Government, and incentive payments are shared by State and Central Governments. Although the incentive amount for specific tasks does not vary, the fixed component varies across States, from Rs 2,000 in Tamil Nadu to Rs 10,000 in Andhra Pradesh.[5] Many respondents complained about irregularity in payments. In extreme cases, four to five months of payments were pending. Table 1 provides details of payments and irregularities.

During the pandemic, the suspension of many incentive-based tasks, such as working in immunisation drives and village health awareness campaigns, lowered the earnings of ASHAs. On average, they receive around Rs 3,500 as incentives for various tasks. For now, the Central Government announced an incentive of Rs 1,000 per month for Covid-19 duty, which is much less than the loss of incentive payments. Our respondents demanded double the usual payment to compensate for the loss of their earnings.

Safety at Work

Thirdly, ASHAs face unsafe working conditions because of inadequate protective gear, insufficient training, and lack of recognition as government health workers. ASHAs reported being provided insufficient protective gear while undertaking their Covid-19 duties. Most of them received disposable masks and were asked to wash and reuse them. A few received a 200-ml bottle of sanitiser, and none received gloves or personal protective equipment (PPE). The apathy shown by higher medical officials towards the safety of ASHAs is disturbing. A respondent from Krishna district, Andhra Pradesh, said,

> We are asked to monitor persons at quarantine shelters in the containment zone that exposes us to a high risk of contracting the infection. When we ask for PPE, the

[4] For example, they were paid Rs 250 for conducting a village health awareness campaign and Rs 600 for caring for pregnant women and assisting them during delivery.

[5] In Andhra Pradesh, they did not receive any incentives in addition to the Rs 10,000.

medical officers say PPE supply is inadequate and cannot be provided to all. Aren't our lives of any importance to the Government?

On March 29, 2020, the finance minister announced health insurance coverage of Rs 50 lakhs for all frontline health workers, including ASHAs, under the Pradhan Mantri Garib Kalyan Yojana (PMGKY) (GoI 2020b).[6] Very few respondents in our survey were aware of this announcement, and some were sceptical about its effective implementation.[7]

Given the nature of their work, ASHAs are at high risk of contracting the infection. Respondents were worried about their safety as well as the potential risks to their families. Some also shared instances of family members' apprehensions about ASHAs performing these Covid-19 duties. Even neighbours viewed them as potential spreaders when they returned from work. Self-isolation or home quarantine was not possible for them in their cramped homes. The only measure ASHAs took to ensure the safety of household members was to wash their hands, bathe, and wash their uniforms immediately after returning from work. A few respondents avoided cooking or childcare activities if there was another adult woman at home.

On March 27, 2020, the Ministry of Health and Family Welfare (MoHFW) released a notification stating the responsibilities of frontline health workers in containing the Covid-19 outbreak (GoI 2020c). These frontline workers were required to be trained by medical officers, according to the MoHFW guidelines. However, during our survey, we found that except for a few respondents in Assam and Haryana, none had received any Covid-19-specific training; they were only instructed by the block medical officer or ANM to conduct various tasks.[8]

Covid-19 duties further endanger these women as they have not formally been classified as government health workers. They were treated disrespectfully by men who refused to be counselled by women. Four of the seven Scheduled Caste ASHAs we spoke to said that they had had to face caste-based discrimination while carrying out their duties. For example, when conducting Covid-19 surveys, a respondent from West Godavari district, Andhra Pradesh reported facing casteist slurs from upper-caste men in the village who objected to receiving health advice from a Dalit woman. A few workers reported conflicts with people in the village who were reluctant to share information on their health profile and travel history. In one case, the police were called, and they instructed the respondents to cease threatening the ASHAs and cooperate with their survey.

[6] https://pib.gov.in/PressReleasePage.aspx?PRID=1609041, viewed on June 9, 2020.

[7] A CITU leader from Andhra Pradesh reported deaths of six ASHA workers on duty between mid-March and mid-April because of heavy stress from work pressure. Because testing was inadequate in the early phase of the lockdown, one cannot confirm if they died of Covid-19. It was unclear if the families of these workers would receive the Rs 50 lakhs compensation as announced by the finance minister.

[8] Refer to GoI (2020c).

Social Reproduction Crisis

During the lockdown, almost all the respondents reported that the other earning members of their household lost their jobs and did not receive wages for March and April. In such a situation, many ASHAs have become the sole earners in their households. A worried respondent from Karnal district, Haryana, said,

> My husband is a daily wage worker. Last year, he received only 30 days of work under MNGREGS. Even agricultural opportunities are few in the village in this season. He has been unemployed for the last two months. No dues have been paid till now.

Because of the meagre honorarium they receive, ASHAs generally depend on additional income-generating activities to meet the financial needs of their households. Because of the lockdown and intensive workload, they were unable to perform these activities. A respondent from Tirunelveli district, Tamil Nadu said,

> I used to roll and pack beedis, and I made Rs 1,200 per month. I have not received the honorarium for the last five months, and I am unable to do beedi work as well because of the lockdown.

Irregular payments, coupled with the loss of employment of other household members, have pushed many to take informal personal loans at exorbitant interest rates.

All these women also reported more intensive domestic work like cooking, cleaning, and childcare during the lockdown. They were worried about food for the family because now, meals previously received at the worksites for other earning members and midday meals for children were not available. Respondents with children did not receive cooked meals or the ration equivalent of midday meals. Therefore, these women, along with an intensified work burden, also suffered from the burden of domestic care work. They were shouldering an intensified double burden of work outside the home and household responsibilities.

The only way to ease this burden is by Government providing food grain, cooked meals, and care services (Rao 2020). In Andhra Pradesh, Assam, Haryana, and West Bengal, respondents received rations of five kilograms of foodgrains per person and one kilogram of pulses per household under PMGKY. In Tamil Nadu and Telangana, they received the State Governments' provision of foodgrain and cash transfers of Rs 1,000 and Rs 1,500, respectively. A respondent from Haryana reported having not received the ration because of problems related to establishing digital links with the Aadhaar identity card.

Summary and Recommendations

The note describes the challenges faced by ASHAs during the Covid-19 pandemic. Based on telephone interviews of ASHAs in six States, the main findings are the following. Firstly, their work has intensified because of the additional tasks and

longer commutes. Secondly, their remuneration was low and irregular, and they have also lost earnings because of the suspension of their usual incentive-based payments. Thirdly, their health was endangered because they were provided inadequate safety gear and insufficient training. Despite their essential role in delivering primary healthcare services, they had no social security benefits and were not recognised officially as health workers. A few of our respondents reported caste- and gender-based discrimination while performing Covid-19-related duties in the village. Finally, the loss of employment and earnings of their household members caused severe economic distress for ASHAs. Along with an increased work burden, they also shoulder an increased burden in domestic care work.

The main trade union of ASHAs in India, the ASHA Workers' Union, which has 80,000 members, has put forward a set of demands to meet ASHAs' needs in the time of the pandemic. This list of demands is an important articulation of the ways to improve the living and working conditions of ASHAs today. The demands are for (1) the provision of adequate safety gear; (2) frequent testing free of cost for all ASHAs; (3) health insurance and treatment coverage for ASHAs and members of their families; (4) payment of remuneration arrears, of a cash transfer of Rs 7,500 for ASHAs with a family income below the taxable limit, and of an incentive of Rs 25,000 a month for ASHAs on Covid-19 duty; (5) a payment of Rs 500,000 for ASHAs infected by the virus while on duty; and (6) free food rations.

Finally, it would be a fitting tribute to these "corona warriors" to recognise them formally as government health workers.

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Appendix

Table A1 provides details of the ASHAs interviewed. Among the 31 respondents, 21 were from rural areas and 10 from urban areas. In rural areas, the average population per ASHA was 1,000, whereas in urban areas, it was around 2,500. This difference in the ratio was because (a) more ASHAs were recruited in rural areas and, (b) in urban areas, there were alternative healthcare options such as private

Table A1 *Details of the respondents, by State, district, and area*

State	Districts covered	Number of ASHAs	Rural	Urban
Andhra Pradesh	Krishna, Prakasam, Visakhapatnam, West Godavari (4)	4	2	2
Assam	Dibrugarh, KamrupMetro, Lakhimpur, Nagaon, Sonitpur (5)	5	4	1
Haryana	Ambala, Faridabad, Jhajjar, Kaithal, Karnal, Sonipat (6)	6	4	2
Tamil Nadu	Krishnagiri, Tirunelveli, Tiruvannamalai (3)	6	4	2
Telangana	Adilabad, Mulugu, Nizamabad, Rangareddy, Wanaparthy (5)	5	3	2
West Bengal	Murshidabad, Jalpaiguri, Nadia, North Dinajpur, North 24 Parganas (5)	5	4	1
Total	28	31	21	10

Table A2 *Details of the respondents, by education, marital status, caste, and class*

Description		Number of respondents
Education	Less than class 10	4
	Class 10	14
	Class 12	10
	Above class 12	3
	Total	31
Marital Status	Married	26
	Divorced/separated	3
	Widow	2
	Total	31
Caste	Scheduled Tribe	1
	Scheduled Caste	7
	Other Backward Classes	18
	Others	5
	Total	31
Class	Self-employed	21
	Manual worker	10
	Total	31

nursing homes. In the latter case, even if ASHAs covered a larger population, the effective workload between the areas would be similar.

Table A2 provides information on the demographic and socio-economic characteristics of the respondents. All were between 30 and 45 years old, and the average household size was five, including dependent children and elderly persons. Only four of the respondents reported to have landholdings less than or equal to half an acre (one of whom reported cultivating banana), whereas the rest were landless. Except for three, all respondents were eligible for ration from the public distribution system (PDS).[9]

[9] These three respondent households were above poverty line and thus excluded from the targeted PDS.