IFC | INSTITUTE for COMPETITIVENESS

NHSRC

GRASSROOT SOLDIERS

ROLE OF ASHAs IN THE COVID-19 PANDEMIC MANAGEMENT IN INDIA

Note: This is an effort toward documenting the efforts of ASHAs during the COVID-19 pandemic. It is not a comparative statement or an endorsement of efforts by any of the entities mentioned in the report. The report cannot be construed as a Harvard or Stanford study.

IFC | INSTITUTE for COMPETITIVENESS

NHSRC

Grassroot Soldiers

Role of ASHAs in the COVID-19 Pandemic Management in India

Authors

Dr Amit Kapoor
Honorary Chairman, Institute for Competitiveness
Visiting Scholar and Lecturer, Stanford University

Maj Gen (Prof) Atul Kotwal, SM, VSM
Executive Director, NHSRC

Dr (Flt Lt) M A Balasubramanya
Advisor, Community Processes and Comprehensive Primary Health Care

Contributors/Research team from the Institute for Competitiveness

Akshay Bhambri
Research Manager, Institute for Competitiveness
Doctoral Fellow, Harvard University

Shivani Kowadkar
Researcher, Institute for Competitiveness

Meenakshi Ajith
Researcher, Institute for Competitiveness

Contributors/Research team from NHSRC

Dr J N Srivastava
Advisor, Quality and Patient Safety

Dr Himanshu Bhushan
Advisor, Public Health Administration

Ms. Mona Gupta
Advisor, Human Resources for Health

Dr Neha Dumka
Lead Consultant, Knowledge Management Division

Dr Padam Khanna
Senior Consultant, Knowledge Management Division

Mr. Prasanth K.S.
Senior Consultant, Public Health Administration

Dr Neha Singhal
Senior Consultant, Community processes/ Comprehensive primary health care

Dr Suman
Senior Consultant, Community processes/ Comprehensive primary health care

Dr Abhay Dahiya
Consultant, Quality and Patient Safety

Dr Surabhi Sethi
Consultant, Human Resources for Health

Dr Palak Dhiman
Consultant, Public Health Administration

Dr Vijaya Shekhar Salkar
Junior Consultant, Community processes/ Comprehensive primary health care

Dr Mussarrat Siddiqui
Junior Consultant, Public Health Administration

Ms Ashu Ranga
Junior Consultant, Public Health Administration

Designed By

litmus.ink

Preface

In the shadows of COVID-19, there are incontrovertible stories of hope and humanity. Important steps and innovative partnerships have taken shape for strengthening India's response to the pandemic. The country's incrementally built public health care system was crucial in leading this effort. ASHAs have constantly worked at the community level and charted a path for India's response and recovery from the pandemic. The report "**Grassroot Soldiers: Role of ASHAs in the COVID-19 pandemic management in India**" is a reminder of how the country acted swiftly during the pandemic and how ASHAs have been the linchpin of India's primary health care system. It is a joint initiative by the **Institute for Competitiveness (IFC)** and **National Health Systems Resource Centre (NHSRC)**. This evidence-based and action-oriented report highlights the indispensable role of ASHAs in expanding the coverage of the primary health care system in India, tackling COVID-19 and improving the quality of health care services at the grassroots.

Through primary and secondary research, this report has captured the experience of ASHAs in both rural and urban areas. Interviews were set up with ASHAs, ANMs, medical officers, and beneficiaries for a holistic understanding of India's primary health care system. A diverse range of experiences came to light through interactions with ASHAs from numerous states including Kerala, Punjab, Chhattisgarh, Odisha, Manipur, Jammu and Kashmir, Gujarat, and Karnataka. Excerpts from telephonic conversations and video interactions with the ASHAs and beneficiaries have been incorporated into this report. India also launched one of the largest vaccination programs in the world, extending its reach to the innermost regions of the country. This was possible only due to the sheer courage and determination of frontline health workers who weathered difficult circumstances to protect communities from the pandemic. Detailed interviews with experienced officials from the World Health Organisation (WHO), Immunisation Technical Support Unit (ITSU) of the Ministry of Health and Family Welfare (MoHFW), Bill and Melinda Gates Foundation (BMGF), John Snow Inc (JSI) and the Clinton Health Access Initiative (CHAI) have shaped the narrative of this document. Hence the report is a compendium of both the situational assessment and recommendations for the primary health care services in India, focusing on the role of ASHAs.

It is designed as a comprehensive document to inform and sensitise its readers and practitioners concisely about the complex nature of public health care in the country. It is unique because it is a compilation of multilateral feedback from varied but principal stakeholders of the health sector in India. Public Health needs further attention and nourishment to face future challenges, and we are on track to strengthen health care initiatives in the country. Over the years, the government has keenly provided essential resources, policy, and personnel support to improve quality and access. This document complements these efforts by tapping into the field experience of ASHAs, drawing lessons for the future. It brings to you the voices of ASHAs with constructive suggestions and recommendations.

We hope the report will be of immense value to its readers for an evidence-based understanding of India's laudable response to COVID-19 and to streamline future strategies.

Table of Contents

List of Abbreviations

A&NI	Andaman & Nicobar Islands
AAA meetings	ANM ASHA AWW meetings
ABDM	Ayushman Bharat Digital Mission
ABHA	Ayushman Bharat Health Account
AB-HWC	Ayushman Bharat- Health and Wellness Centres
AF	ASHA Facilitator
AIIH & PH	All India Institute of Hygiene and Public Health
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ARI	Acute Respiratory Infection
ASHA	Accredited Social Health Activist
BLSA	Basic Life Support Ambulance
CCC	COVID Care Centre
CD	Communicable Disease
CHO	Community Health Officer
CHW	Community Health Workers
CPHC	Comprehensive Primary Health Care
DDK	Disposable Delivery Kits
DPT	Diptheria, Pertussis and Tetanus
ENT	Ear Nose and Throat
FRCH	Foundation for Research in Community Health
FRU CHC	First Referral Unit Community Health Centre
GDP	Gross Domestic Product
GRAP	Graded Response Action Plan
HBNC	Home Based Newborn Care
HIV	Human Immunodeficiency Virus
HSP	Health Service Provider
HWC-SHC	Health and Wellness Centre- Sub Health Centre
ICDS	Integrated Child Development Scheme
ICMR	Indian Council of Medical Research
IDSP	Integrated Disease Surveillance Programme
IFA	Iron Folic Acid Tablet
ILI	Influenza Like Illness
IPC	Infection Prevention and Control
IPHS	Indian Public Health Standards
MAS	Mahila Arogya Samiti
MCH	Maternal and Child Health
MO	Medical Officer

MoHFW	Ministry of Health and Family Welfare
MPW	Multi-Purpose Worker
NCD	Non-Communicable Disease
NCT of Delhi	National Capital Territory of Delhi
NGO	Non-Governmental Organisation
NFHS	National Family Health Survey
NHM	National Health Mission
NHSRC	National Health Systems Resource Centre
NRHM	National Rural Health Mission
NUHM	National Urban Health Mission
OPD	Outpatient Department
ORS	Oral Rehydration Therapy
PHC	Primary Health Centre
PHC-HWC	Primary Health Centre Health and Wellness Centre
PIB	Press Information Bureau
PLA	Participatory Learning Action
PM-ABHIM	Pradhan Mantri Ayushman Bharat Health Infrastructure Mission
PMJAY	Pradhan Mantri Jan Arogya Yojana
PMJJBY	Pradhan Mantri Jeevan Jyoti Bima Yojana
PMSBY	Pradhan Mantri Suraksha Bima Yojana
PMSYMDY	Pradhan Mantri Shram Yogi Maan Dhan Yojana
PNC	Postnatal Care
PPE	Personal Protective Equipment
PPTCT	Prevention of Parent-to-Child Transmission
PTCT	Parent-to-Child transmission
RMNCHA+N	Reproductive, Maternal, Newborn, Child, Adolescent Health Plus Nutrition
RRT	Rapid Response Teams
RTI	Reproductive Tract Infection
RTPCR	Reverse Transcription–Polymerase Chain Reaction
SARI	Severe Acute Respiratory Infection
SDG	Sustainable Development Goals
SHC	Sub Health Centre
SHC-HWC	Sub Health Centre Health and Wellness Centre
SOP	Standard Operating Procedures
STI	Sexually Transmitted Infections
TB	Tuberculosis
TT	Tetanus Toxoid
UHC	Universal Health Coverage
UHI	Unified Health Interface
UHWC	Urban Health and Wellness Centre
UPHC	Urban Primary Health Centre
UT	Union Territory
VHSNC	Village Health Sanitation and Nutrition Committee
WHO	World Health Organisation
WHV	Women Health Volunteer

Executive Summary

ASHAs have been pivotal in connecting households with health care facilities. These are women from the local community who choose to serve the community's health care needs. They form the bedrock of the primary health care delivery system in India. Having a strong footing in the community, they ensure the provision of a range of services – from being involved in national health programmes, door-to-door surveys, vaccination, providing information on hygiene practices, nutrition and sanitation, reproductive and child care services, communicable and non-communicable disease prevention and control etc.

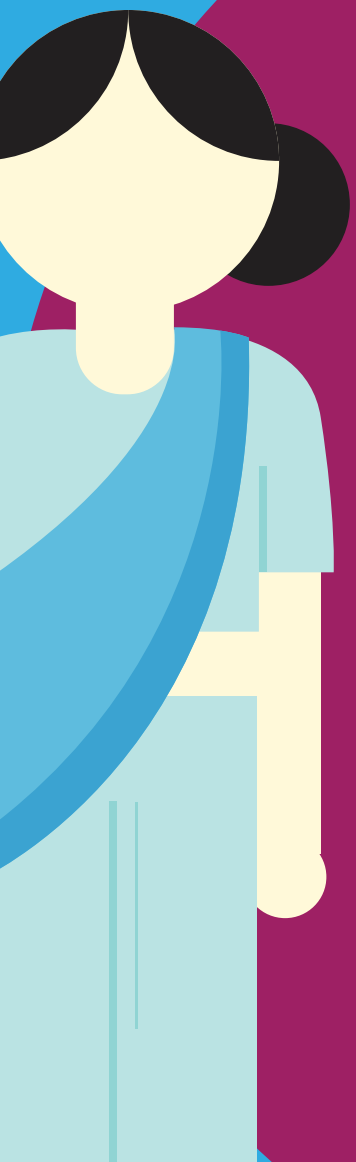
In a country as diverse as India, addressing public health challenges involves dealing with social and structural issues that prevent vulnerable and marginalised populations from accessing quality health care. Communities have unique health care needs. This understanding lies at the core of an equitable health care system. The disparities at the sub-national level need a bottom-up approach for promotion of health care. As per the World Bank, India has registered significant improvements in major health parameters such as life expectancy, infant mortality, and maternal mortality, but there is still huge scope for the country to elevate its health care system. Against this backdrop, having a solid and efficient interface between the community and the health care framework is crucial.

Community-based health care includes engaging a range of actors such as NGOs, women and youth groups, local authorities, and health care workers working in different capacities. ASHAs are the binding force of this ecosystem. ASHA exemplifies a successful community-led health care model. It shows the benefits of greater democratisation of the health care system and more community participation. Their work during COVID-19, being nothing short of a feat, further highlighted their importance in the system. The report discusses their role in managing COVID-19 at the ground level. The focal point of the report is to bring their experiences to the fore, in their own voice. Chapter 1 of the report introduces the idea and ecosystem of public health in India. The second chapter introduces the ASHA programme, how ASHAs were multi-purposed during the pandemic, the training they underwent for the same and the various roles and responsibilities they shouldered. The chapter also discusses the ASHA support system and the financial inputs offered by Government of India for the ASHAs during the pandemic. Chapter 3 puts forth experiences of frontline workers in managing COVID-19 at the grassroots level. It draws on primary research conducted for the report. Chapter 4 brings forth the role played by ASHAs in the COVID-19 Vaccination drive. Chapter 5 captures how the pandemic tested the mettle of ASHAs and how it led to their empowerment in times of crisis. The report concludes with a set of recommendations to further consolidate this.

The programme has given an opportunity for local women to develop into health care functionaries and community leaders. At a time when increasing female labour force participation and women empowerment are becoming subjects of extensive discussion, role of the ASHA programme in providing women with agency must be assessed. What must have motivated these women to transcend all kinds of barriers, from mental to physical, during the pandemic and work tirelessly protecting and enhancing the community's health? The report tries to provide an insight into this work and the underlying motivational force that drove them. COVID-19 was a mighty opponent to combat. Comparing the manner in which ASHAs strove against the pandemic with soldiers on a battlefield, is an apt parallel.

01

The Ecosystem of the **Indian Public Health System**



It was a usual day in the life of Parvati*(name changed) on 24th March 2020, who is an ASHA, a community health volunteer, working to strengthen the access and reach of health services for women and children in the hinterland of Chhattisgarh. After completing her household chores early morning, she prepared for the day ahead. She had planned household visits that day to a newborn child and a tuberculosis patient. She had heard about rumours of an impending lockdown, but that did not deter her from her duties. Post dinner, she gathered with her family to listen to the Hon'ble Prime Minister's address to nation, hopeful to get clarity in an anxious environment where she was worried about the unknown future. She shared:

> *We had started feeling that something was going to happen and hence we had stopped going outside since few days. Then we heard Modi Ji talk about lockdown on TV and I was anxious about how will we work now, considering we have to wear a mask and maintain "do gaj ki doori'. Next day, I didn't have a mask, so wore a gamcha and I started writing on the walls of the village on how to maintain 'do gaj ki doori,' wear a mask and keep washing hands properly. Slowly, we started working fully"*

On 24th March 2020, India announced a nationwide mobility restriction, and ever since, our country has been handling the pandemic. India quickly learned its lessons and immediately scaled up its health care infrastructure to deal with the pandemic. Every Indian state and UT ramped up the availability of hospital beds, testing facilities and supply of medical oxygen to gain resilience from the virus.

At the grassroots, ASHAs sprung into action for timely delivery of primary health care services.

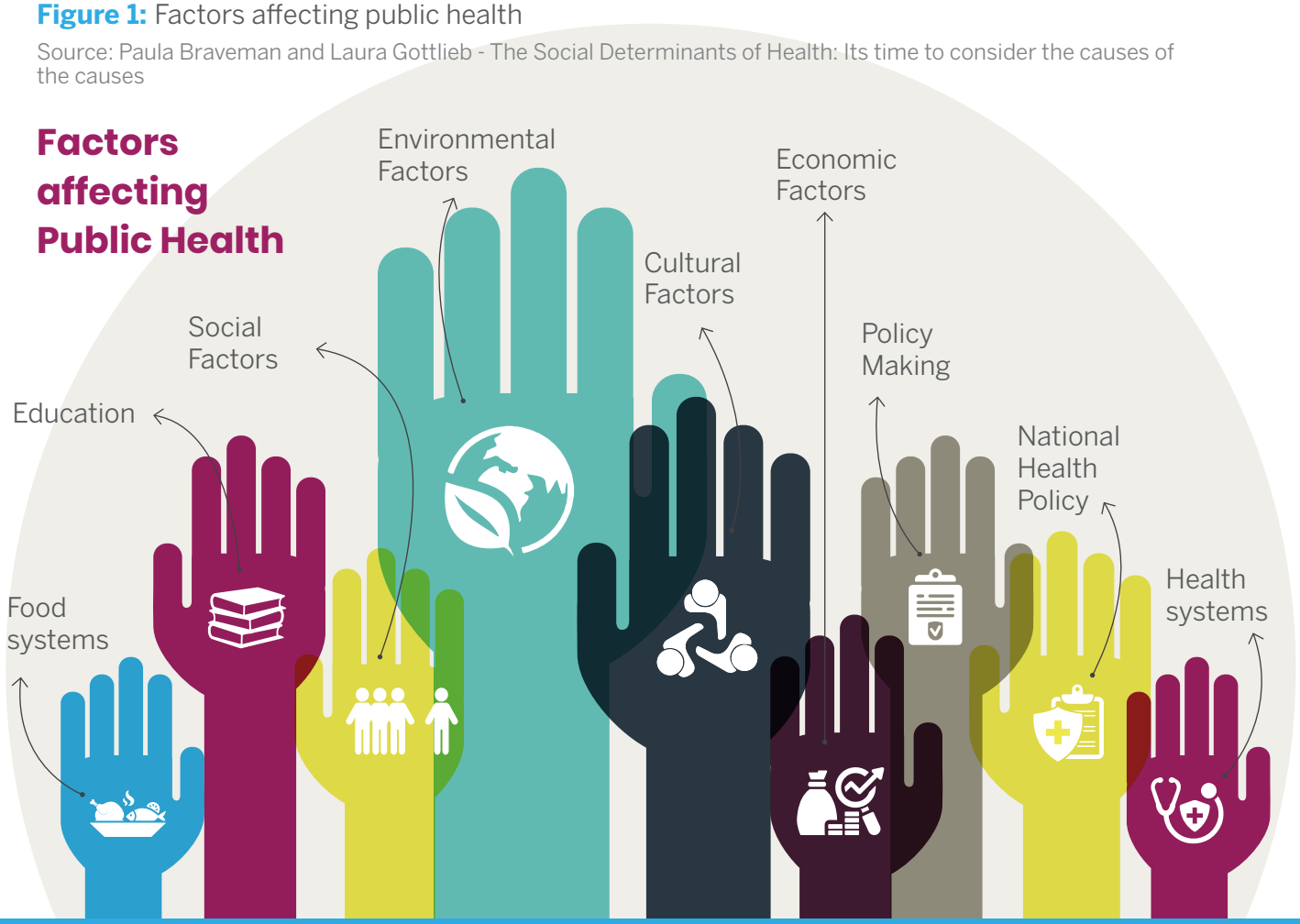
Controlling community spread is one of the key challenges in managing the pandemic and frontline workers in India put in relentless efforts to curb the spread of the virus at the community level. Through active surveillance of new cases, and delivery of medicines and essential commodities during lockdown, while ensuring continuation of non-COVID-19 care, frontline workers in rural and urban areas closely monitored the situation on the ground. When India rolled out one of the largest vaccination drives in the world, frontline workers also tackled a range of issues like vaccine hesitancy, and eagerness and helped organise one of the most successful vaccination programs in India. The pace, scale and efficiency of India's response were aided by its rapidly growing public health ecosystem. What do we mean by public health? Why is it important for India? What are the enabling factors for public health in India? This chapter will provide a comprehensive overview of public health, its meaning, and its relevance for India.

Public Health, in 1887 was defined by C.E.A Winslow as "the science and the art of preventing disease, prolonging life, and organised community efforts for (a) sanitation of the environment, (b) control of communicable infections, (c) education of individuals in personal hygiene, (d) organisation of medical and nursing services for early diagnosis and preventive treatment of disease, and (e) the development of social machinery to ensure everyone a standard of living adequate for the maintenance of health, so organizing these benefits as to enable every citizen to realise his birth right of health and longevity", which gave a broader dimension addressing the wider determinants of health. In simple terms, public health refers to the collective health of a community. It goes beyond medical sciences to include socio-economic aspects like equity, quality, inclusivity and accessibility. It is multi-sectoral and is influenced by diverse factors that confluence the creation of a healthy society. These factors are also called as social determinants of health. WHO cites that between 1990-2000, the dip in child mortality by almost half was aided by factors outside health care. Health service delivery was only one of the factors contributing to the reduction in under 5 mortality. Public health interventions such as immunisations followed by a decrease in fertility, improvements in per-capita GDP, Water & Sanitation, infrastructure, education, and gender equality are some of the significant factors that led to the decline of U5MR globally (Bishai, Cohen, Alfonso, Adam, Kuruvilla, Schweitzer,2016). As an interdisciplinary subject, policymaking accommodates various socio-economic and geo-political factors and plays a crucial role in shaping the public health ecosystem of a community.


KOJAK
SELINGE
Tho auto cisable syringe
0.5ml
100 UNITS

Figure 1: Factors affecting public health

Source: Paula Braveman and Laura Gottlieb - The Social Determinants of Health: Its time to consider the causes of the causes



Policymaking helps to streamline resources and may facilitate the prevention of the onset of certain diseases or assist in better management of certain diseases, while promoting healthy lifestyle. A policy that is adapted to local context can remove any cultural, social, or political constraint in developing community responses. For example, many Indian states and UTs came up with guidelines and Standard Operating Procedures (SOPs) to tackle increased cases during the pandemic. Delhi Government passed a colour coded Graded Response Action Plan (GRAP) to tighten restrictions based on the COVID-19 positivity rate to safeguard its public health and prevent administrative delays while responding to health care needs. States also started screening the inflow of migrants and travellers who may be potential carriers of the virus. Likewise, technology was used to strengthen surveillance during the pandemic. For example, Maharashtra launched the 'Mahakavach App', Karnataka launched 'Corona Watch' and Goa launched 'Test Yourself Goa'.

Accessibility is an essential measure of successful public health infrastructure. Spatial inequalities in health care are rampant throughout India, especially along hilly terrains and remote areas. In such situations, primary health care becomes a vital part of public health. The importance of primary health care was first realised in the Alma-Ata Declaration of 1978 which emerged as a major milestone of the twentieth century in the field of public health, and it identified primary health care as the key to the attainment of the goal of Health for All. India, being a signatory to the declaration has been practicing primary health care as a strategy to attain Universal Health Coverage.

Therefore, public health goes beyond the Ministry of Health and Family Welfare and demands involvement of every department, be it Women and child development, Rural and urban development, Education department, Food processing, Environment, Agriculture, or Social justice etc. All the ministries need to internalise community health outcomes while designing their policies, to holistically address community needs.

Structure of **Public Health in India**

While Western history of public health talks about Greek and Roman practices of sanitation as public health measures and dates to 500 BCE, it has largely ignored the Indian contribution. The history of public health in India can be divided into three parts – pre-Vedic era, Vedic era, and post Vedic era including colonial period and postcolonial period. In the pre-Vedic Era 2500 BC (Indus valley civilisation), well planned cities and houses with drainage suggesting practices of environmental sanitation by ancient people was evident. Vedic Era, 3000-1400 BC, Ayurvedic descriptions for healthy lifestyle including cleanliness and purity, good diet, proper behaviour, and mental and physical discipline. Post vedic Era, 600 BC – 600 AD, many hospitals were built along with medical education in Taxila and Nalanda. In the colonial period 19th to mid 20th Century, the Indian Medical Services was formed in 1896 and public health, sanitation and vital statistics were transferred to the provinces in 1919, public health education and research institutions like AIIH&PH were opened and the Bhore Committee report of 1946 is an important milestone in the evolution of public health infrastructure in the country. The report laid a long-term plan for strengthening the primary health care infrastructure in the country. Post independence, since 1947, public health interventions and medical sciences evolved while responding to the contextual needs within the country. Over the years, India has solidified its public health delivery at the grassroots in both rural and urban areas and the efforts provided a strong platform to carry out a dynamic response to the pandemic.

Globally, public health systems evolved in various communities through trial and error and by expanding medical knowledge at controversial times. Epidemic and endemic infectious disease stimulated thought and innovation in disease prevention on a pragmatic basis, often before the causation was established scientifically (Tulchinsky & Varavikova 2014).

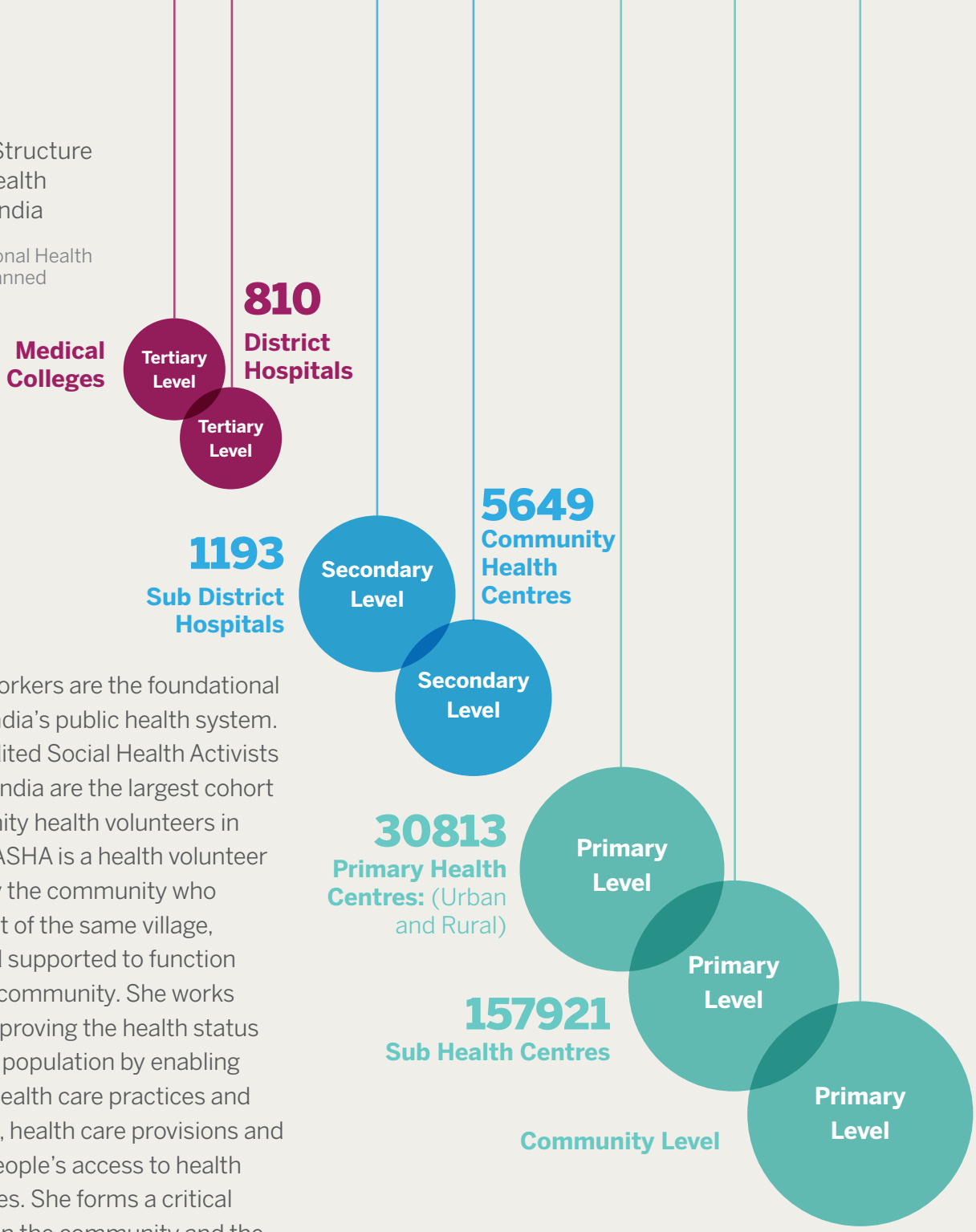
Public Health always starts with the community. Raising awareness is a critical component of health promotion and disease prevention. India achieved public health milestones through practical and locally appropriate community outreach for eradicating smallpox, yaws, and polio. Even today, Sub health centres and primary health centres in rural and urban areas raise awareness about vaccination for infants and provide care for pregnant women.

The structure of Public Health Ecosystem in India

Primary Level	**Rural Areas:** • Sub Health Centre- Health and Wellness Centre • & Primary Health Centre- Health and Wellness Centre. **Urban areas:** • Urban. Primary Health Centre – Health and Wellness Centre • Urban Health and Wellness Centre
Secondary Level	• Community Health Centre in both rural and urban. Areas • Sub District Hospitals, • District Hospitals
Tertiary Level	Medical Colleges

Figure 2: Structure of public health system in India

Source: National Health Mission; * planned



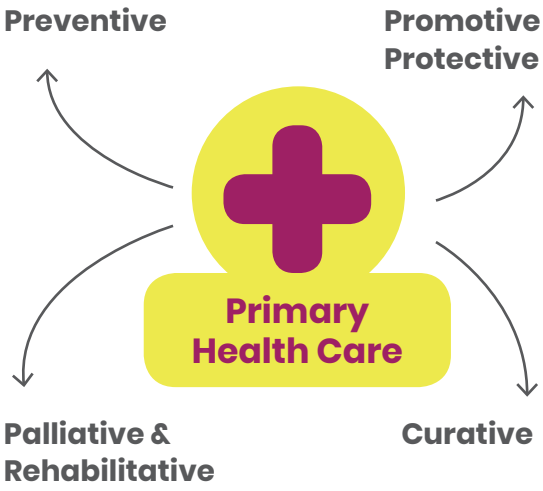
Frontline workers are the foundational blocks of India's public health system. The Accredited Social Health Activists (ASHA) in India are the largest cohort of community health volunteers in the world. ASHA is a health volunteer selected by the community who is a resident of the same village, trained and supported to function in her own community. She works towards improving the health status of the local population by enabling improved health care practices and behaviours, health care provisions and securing people's access to health care services. She forms a critical link between the community and the public health system. The ASHA is appointed by, and accountable to the village Panchayat. She works for the community and is supported by the community for services rendered, apart from performance-based support from public health programs (Reference- Cabinet Note, No. 1/ CM/2005 dated 4th January 2005).

ASHAs are not just the backbone of the Indian Public Health Care Systems but are also instrumental in bringing about a social change in the community she serves. Public Health facilities are further set up based on population norms, to cater to the needs of the community.

Relevance of **Primary Health Care**

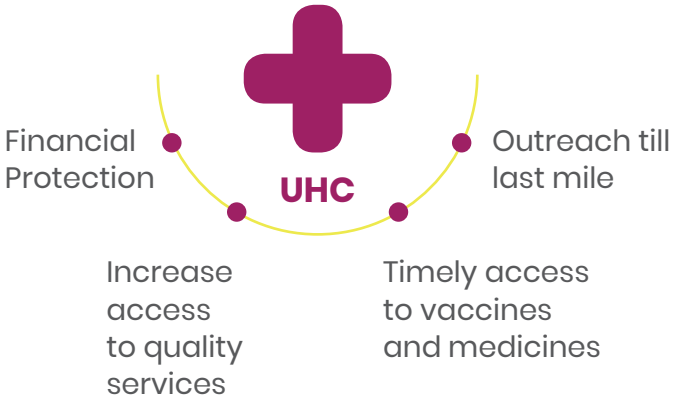
Primary Health Care is a whole-of-society approach to health that aims to ensure the highest possible level of health and wellbeing and their equitable distribution by focusing on people´s needs and preferences (as individuals, families, and communities) as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation, and palliative care, and as close as feasible to people's everyday environment (WHO,2018). In simple terms, Primary Health Care refers to high priority essential services like ambulatory or first contact personal health care with a specific focus on low-income populations.

Figure 3: Functions of Primary Health Care.
Source: World Health Organisation



AB-HWCs have the potential to bring down household expenditure on health. In India, most rural. Providing good health facilities at the primary level is a cost-effective way of delivering services and the best way forward for larger countries like India to move towards universal access. Also, by addressing the underlying behavioural determinants of ill health, improved primary health can reduce the burden of disease in a community and free up resources to invest in the quality and safety of health care delivery. AB-HWCs also reflect a commitment to democratic values like social justice and participation.
It elevates public health to the status of a fundamental right; every individual has the right to attain the highest possible standard of living.

Figure 4: Objective of Universal Health.
Source: World Health Organisation



Every country globally strives to achieve universal health coverage (UHC), and access to primary health care is the critical component of this effort. Providing effective primary health care can raise awareness and will help prevent the escalation of health issues. By focusing more on essential population-related services,

Primary care is also the first building block for SDG 3 on Good Health and Well Being. Achieving the targets while leaving no one behind in Agenda 2030 can be made possible only through primary health care.

Primary Health Care in India

In 2014, the Ministry of Health and Family Welfare constituted a task force for the rollout of Comprehensive Primary Health care. It identified the challenges, components of service delivery and institutional structures for setting up primary health care in India. The report outlines 10 framework factors contributing to the poor primary health care system in the country including: lack of responsiveness, limited attention to social determinants, human resource shortages, marginalisation and exclusion of specific population groups, supply side deficiencies, Mismatch between provider training and services to be delivered etc. Based on this framework, 9 recommendations were evolved to strengthen primary health care infrastructure in the country.

Figure 5: MoHFW task force recommendations to strengthen primary health care in India.

Source: Report of Task Force on Comprehensive primary health care rollout.

Post-2014, India's primary health care system was mostly built around these lines and has made considerable progress in terms of achieving access, quality and equity. It adopts the whole of society approach prescribed by the World Health Organisation by focusing on factors beyond health care delivery such as social and institutional determinants, placing community processes at the centre.

Ayushman Bharat- Health and Wellness Centres (AB-HWCs)

In February 2018, Government of India translating the National Health Policy 2017's aim of progressively achieving universal health coverage into a budgetary commitment launched Ayushman Bharat program.

The two main pillars of Ayushman Bharat are 1: Ayushman Bharat- Health and Wellness Centres (AB-HWC) and 2: Pradhan Mantri Jan Arogya Yojana (PM-JAY). To provide comprehensive primary health care services, the program aims to transform existing Sub Health Centres and Primary Health Centres in rural and urban areas into Ayushman Bharat - Health and Wellness Centres. These centres provide Comprehensive Primary Health care with focus on promotive, preventive, curative, rehabilitative and palliative care services, universally free and closer to home. These Ayushman Bharat Health and Wellness Centres are for rendering 12 package of services from emergency care to palliative care, ensuring continuity of care by appropriate referrals, optimal home and community follow-up irrespective of their age and gender. They provide expanded range of diagnostics and drugs and also leverage the platform of teleconsultation (eSanjeevani HWC) for specialist consultation. Pradhan Mantri Jan Arogya Yojana (PM-JAY) - The second interrelated component provides health insurance cover of Rs. 5 lakhs per year to over 10 crore poor and vulnerable families for seeking secondary and tertiary care. The aim is to mitigate catastrophic expenditure on medical treatment which pushes a sizeable section of the population into poverty every year in India. It covers up to 3 days of pre-hospitalisation and 15 days of post-hospitalisation expenses such as diagnostics and medicines without any restriction on the family size, age or gender. The benefits of the scheme are portable across the country i.e. a beneficiary can visit any empanelled public or private hospital in India to avail of cashless treatment (National Health Authority, 2021).

The Ayushman Bharat programme has evolved over the years, in both urban as well as rural areas, to a point now where India is committed and hopeful of operationalising

1.5 Lakh

Ayushman Bharat – Health and Wellness centres by December 2022.

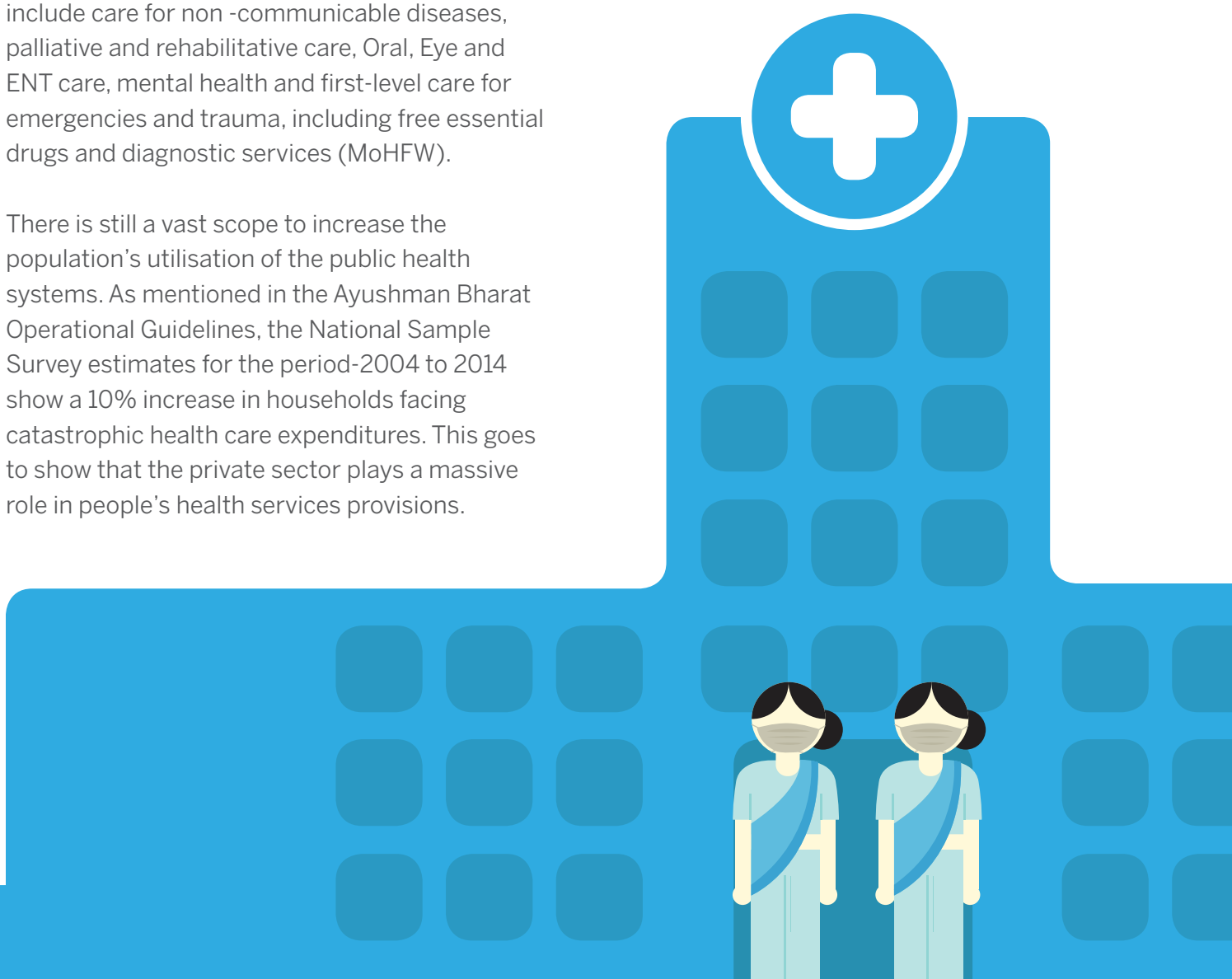
Considering that the first AB-HWC and the CPHC (Comprehensive Primary Health Care) Application was inaugurated at Bijapur in April 2018, the increase in the number of AB-HWCs over the last few years has been commendable. AB-HWCs aim to deliver a holistic and people-centred response to health care needs of people across different geographies. They symbolise a comprehensive bottom-up approach to

strengthening the health care ecosystem. People's participation and regular involvement in the community is yet another main feature that AB-HWCs incorporate into the system. Another important goal they aim to achieve is using appropriate technology for improving access to health care consultation and treatment initiation, enabling reporting and recording. It aims to build electronic records for smoothening health care processes in the country, at a granular level. To transform SHCs/PHCs to AB- HWC, they would be properly equipped and staffed by a trained Primary Health Care team. This able group of health care functionaries ensure the delivery of the expanded package of services (NHM, 2018). AB-HWCs are envisaged to deliver an expanded range of services that go beyond maternal and child health care services to include care for non -communicable diseases, palliative and rehabilitative care, Oral, Eye and ENT care, mental health and first-level care for emergencies and trauma, including free essential drugs and diagnostic services (MoHFW).

There is still a vast scope to increase the population's utilisation of the public health systems. As mentioned in the Ayushman Bharat Operational Guidelines, the National Sample Survey estimates for the period-2004 to 2014 show a 10% increase in households facing catastrophic health care expenditures. This goes to show that the private sector plays a massive role in people's health services provisions.

(NHM, 2018). the AB-HWCs services affordable and increasing the utilisation of public health systems in India. They have played a significant role in combating COVID-19 at the grassroots level in rural and urban areas.

The AB-HWC team comprising of Medical Officers, Staff Nurses, Community Health Officers, ANM/MPWs and ASHAs have worked tirelessly during the pandemic to ensure access to essential health services in the community. Their closeness to the community helps them cater to their requirements better. The AB-HWC teams have played a key role in ensuring that non-COVID-19 essential services do not get hindered during the pandemic.



The revised Indian Public Health Standards (IPHS) guidelines 2022 classify Health and Wellness centres in the following manner:

- ## Sub- Health Centre

Health and Wellness Centre-Sub Health Centre (HWC-SHC) in Rural areas – As per the latest guidelines, there will be one subcentre per 5000 population in plain areas and 1 per 3000 population in difficult tribal/hilly areas. The centre is led by a Community Health Officer (CHO). The other team members are Auxiliary Nurse Midwife (ANM) and a Multi-Purpose Worker (MPW) (Male) or two ANMs, and support staff.

Urban Health and Wellness Centre (UHWC) in Urban areas – There will be one Urban-HWC per 15,000-20,000 population catering predominantly to poor and vulnerable populations, residing in slums or other such pockets. The Urban-HWC is to be staffed with a Medical Officer, a Staff Nurse/Pharmacist, Male-MPW and one support staff. Staff Nurses will also be supporting the doctors while examining the patients, particularly the female patients to ensure their privacy and dignity. Ideally, the ANM and ASHA are responsible for the catchment area of a UPHC.

- ## Primary Health Centre (PHC)

HWC-PHC in Rural areas – There will be one HWC-PHC for every 30000 population in plain areas and 20000 in hilly and tribal areas. The states should make PHCs functional as 24/7 facilities and will prioritise these 24/7 PHCs for conducting child deliveries.

UPHC-HWC in Urban areas – There will be one UPHC-HWC for every 50000-population established in close proximity to urban areas. An Urban PHC-HWC provides round-the-clock emergency and secondary care services and higher-level health care facilities. They provide routine OPD care along with preventive and promotive health interventions and function as UPHCs-HWCs. However, the UPHCs with indoor beds already conducting deliveries can continue to function as 24x7 UPHCs-HWCs.

The Medical Officer at the PHC-HWC mentor and monitor the primary health care team at SHC-HWC linked to his/her PHC-HWC. Similarly, the UPHC-HWC Medical Officer mentors and monitors the teams at UHWCs linked to his/her UPHC-HWC.

Specialist UPHC/Polyclinic (Urban) – There will be one UPHC polyclinic for every 2.5 -3 lakh population. "Multispecialty UPHC/Polyclinics" in urban areas are established with the aim to further reduce morbidity and mortality by providing specialist services on ambulatory/daycare basis, closer to the urban community. Such polyclinic services would be limited to outpatient care.

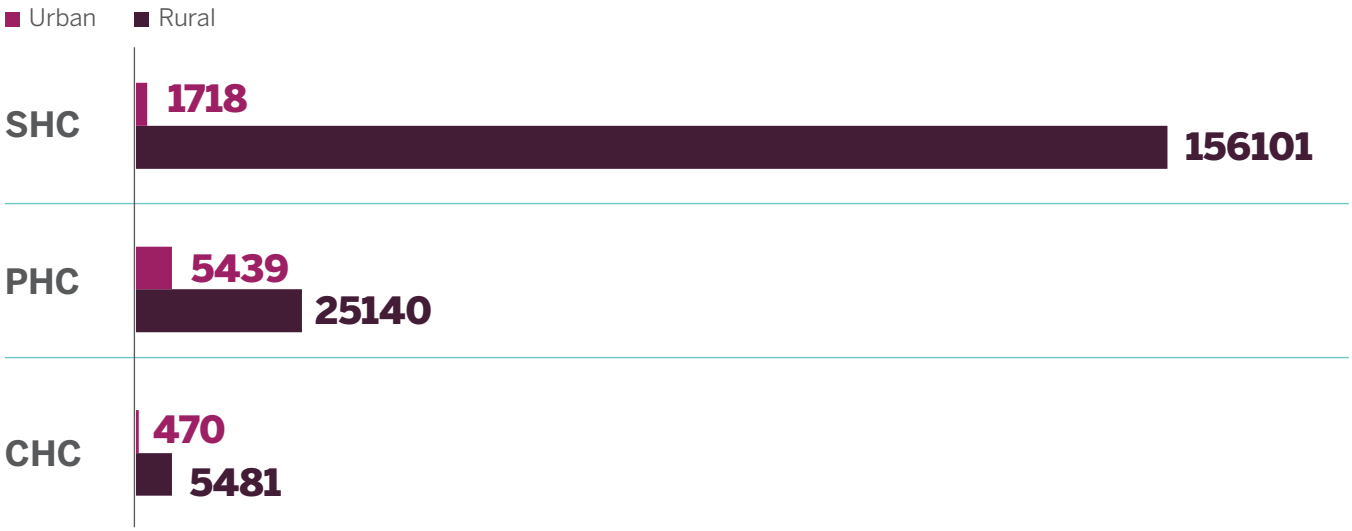
COMMUNITY HEALTH CENTRE

Non-FRU CHCs in rural areas – FRU CHCs provide essential services including preventive, promotive, curative, palliative, and rehabilitative services etc. Curative services include normal delivery, stabilisation of common emergencies, etc. Non-FRU CHCs in rural areas will have 30 essential beds.

FRU CHCs in both rural and urban areas – Along with the normal services, CHCs provide specialised care which can be rendered through specialists (physicians, surgeons, obstetricians, paediatricians, and anaesthesiologists) and the accompanying infrastructure (functional operation theatre and blood storage unit). Both elective and emergency surgical services of secondary level care is also provided. FRU-CHCs provides surgical services and go beyond obstetric services.

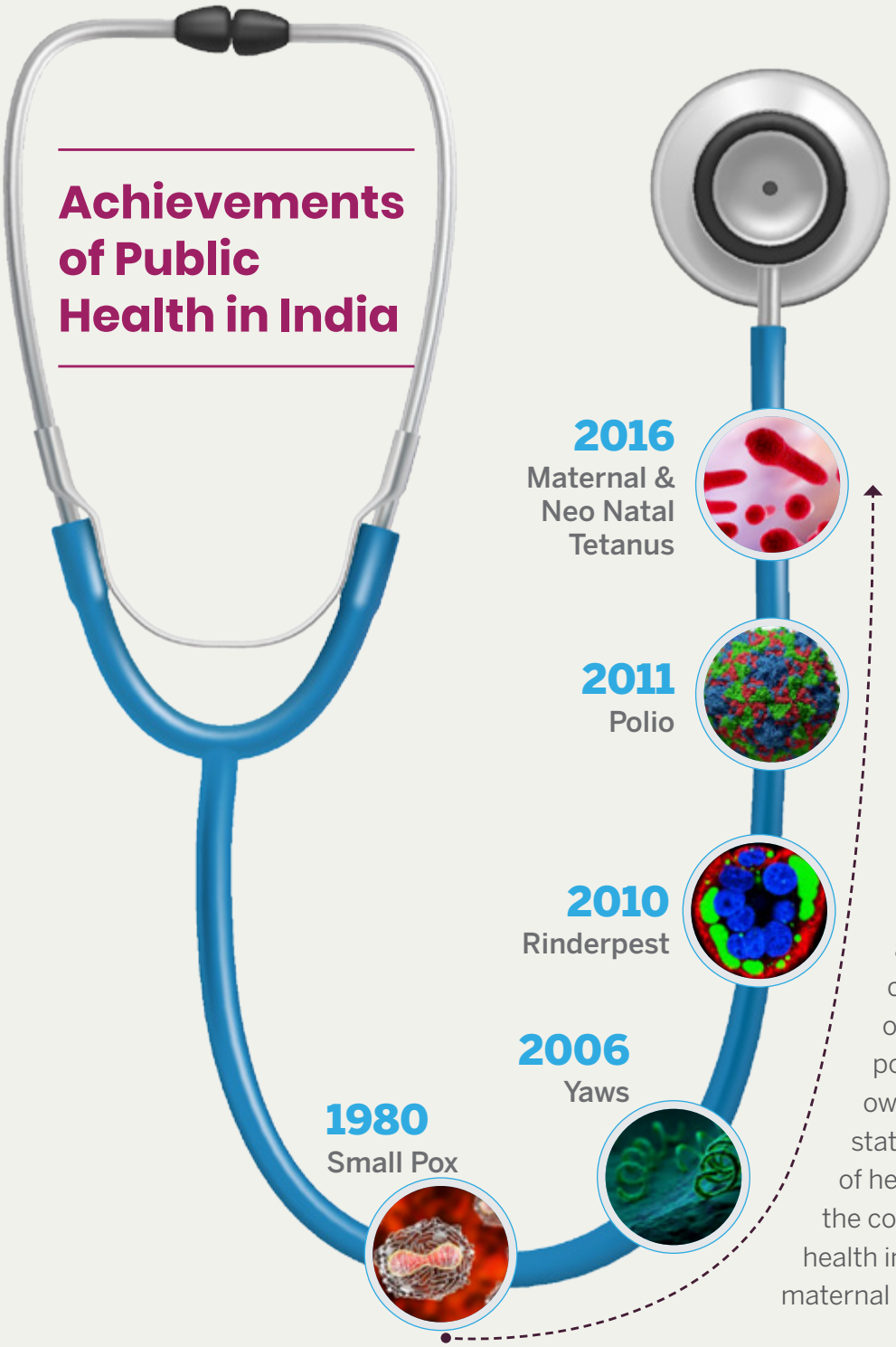
Figure 6: No: of functional Health Centres in India as on 31st March 2020.

Source: Rural Health Statistics 2019-2020



The National Health Policy 2017 envisages as its goal the attainment of the highest possible level of health and wellbeing for all at all ages, through a preventive and promotive health care orientation in all developmental policies, and universal access to good quality health care services without anyone having to face financial hardship as a consequence. in rural areas. With the advent of AB-HWCs, every effort is being made to make available all the essential services including Oral, Eye, ENT, Emergency care, Mental health, Elderly and Palliative care closer to the community, thereby decongesting secondary and tertiary level facilities.

Figure 7: Diseases eliminated in India

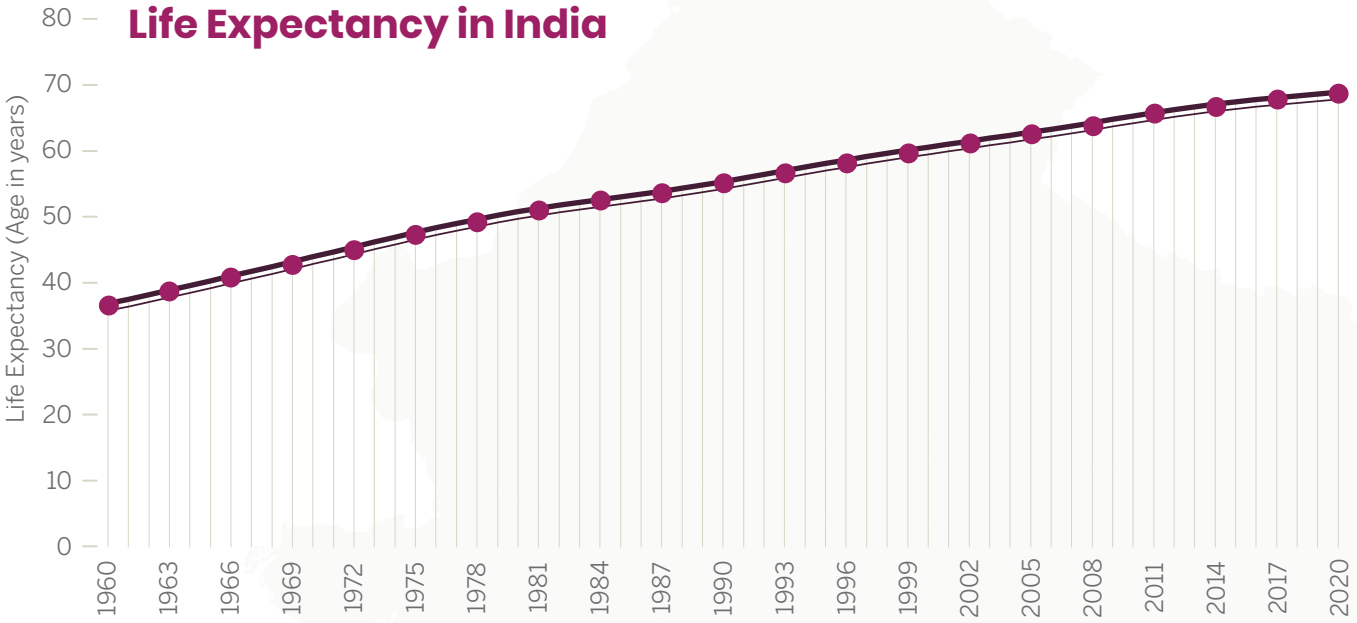


India has seen successful eradication programs for various diseases like polio, yaws, and smallpox. Community mobilisation has had a significant role in prevention campaigns in the country. India was one year ahead of the rest of the world while eradicating smallpox in 1979. In 2009, India reported the highest number of polio cases globally, and in 2011 the last case of polio was reported in West Bengal. Within two years, through extensive community mobilisation, India eradicated polio. This dramatic turnaround was made possible through a concerted effort at the community level, focusing on marginalised and migrant populations who are vulnerable owing to their socio-economic status. Increasing penetration of health care services across the country has improved public health indicators like life expectancy, maternal mortality, infant mortality.

A study published in the Lancet Journal in 2020 revealed that India gained a decade of life expectancy since 1990. From 59.6 in 1990, life expectancy in India has currently risen to a range between 77.3 – 66.9.

Figure 8: Rise in life expectancy in India

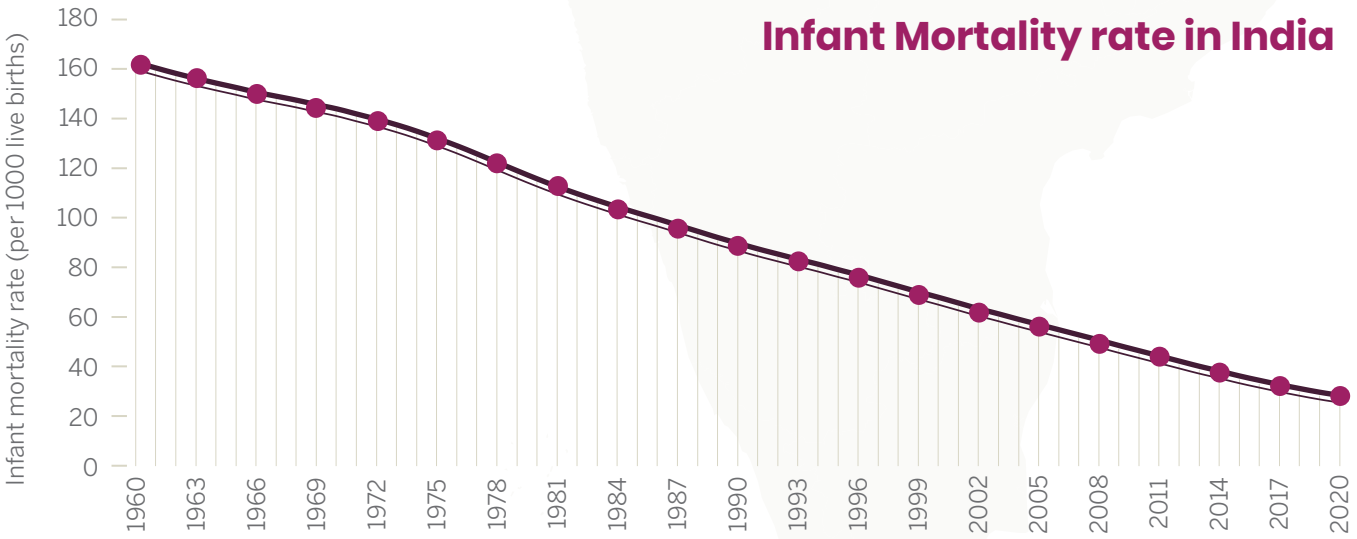
Source: World Bank



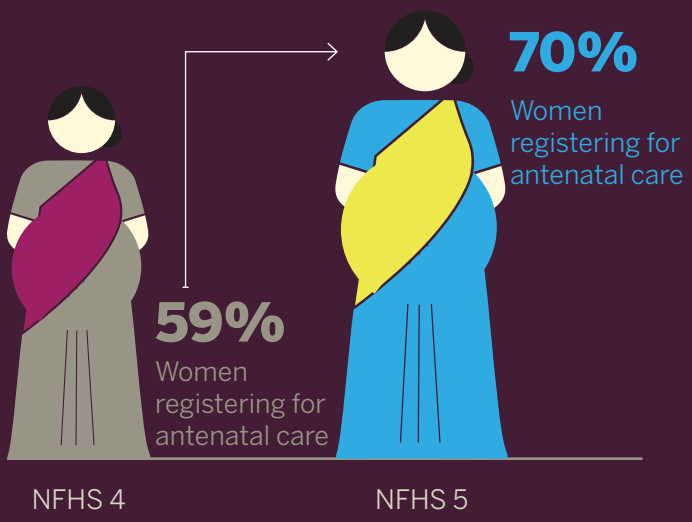
Over the years, there has also been a consistent decline in the country's Maternal Mortality Ratio and Infant Mortality Rate, which signals improvement in women's reproductive health in India.

Figure 9: Drop in India's Infant mortality rate

Source: World Bank, 2020



States like Kerala, Maharashtra, Andhra Pradesh, Tamil Nadu, and Telangana have already met the targets set by UN SDGs and at a national level, India has managed to bring down infant mortality rate to below 100 deaths per lakh live births in a year. **More women are now registering for antenatal care during the first trimester of pregnancy. Between NFHS 4 and NFHS 5, the figures have improved from 59% to 70%.**



The various milestones in India's public health delivery are a testament to the strengthening of primary health care. There is a strong correlation between primary health care and public health. Primary Health Care nudges the governments to focus on well-resourced frontline health care services acting as a gateway for more specialised care. Public Health also give administrative and policy momentum to the idea that primary care should be the driving principle influencing the overall health policy.


Uttarmisok Hospital

During the pandemic, the central government in additional to the existing two Ayushman Bharat service delivery pillars, launched two supporting/ enabling pillars. They are - PM Ayushman Bharat Health Infrastructure Mission (PM-ABHIM) and Ayushman Bharat Digital Health Mission.

PM-ABHIM – *With a prior financial allocation of 64,180 Cr across 6 years, the scheme was launched in October 2021 in addition to the existing National Health Mission in the country.* The scheme will focus on developing the capacities of health systems and institutions in India across all levels of health care delivery. Increased investments are also targeted in the mission to support research on COVID-19 and other infectious diseases, including biomedical research to generate evidence to inform the short-term and medium-term response to COVID-19 like pandemics (Operational Guidelines for PM-ABHIM, MoHFW, 2021). Apart from this, the government will also support the setting up of Health and Wellness Centres in rural and urban areas and Integrated Public Health Labs with special attention to the high focus states in India. Critical Care Hospital blocks will also be established in districts with a population of more than 5 lakhs. As per the recommendations of the fifteenth Financial Commission, local governments will be allocated a seizable sum to plug critical gaps in their health care system. FC XV allocated Rs 70,051 Cr for interventions that will directly lead to the strengthening of primary health infrastructure facilities in both rural and urban areas. In rural areas, the health grants will be allocated for developing diagnostic infrastructure, block level public health units and for the conversion of rural PHCs and SHCs into AB-HWCs. In Urban areas, health grants are mainly allocated for upgrading diagnostic infrastrcuture in PHC facilities and for setting up more UHWCs.

Ayushman Bharat Digital Mission (ABDM) – Facilitates the creation of an integrated digital health infrastructure in the country. It will bridge gaps amongst stakeholders of the health care ecosystem using digital technology. The scheme envisages the creation of the Ayushman Bharat Health Account (ABHA) number for the purpose of authentication and threading health records. A health care professionals registry will also be created as a comprehensive repository of all health care professionals involved in the delivery of modern and traditional medical services. A similar registry will also be made for health care facilities in the country, both public and private to connect with the digital health ecosystem. Finally, a Unified Health Interface (UHI) is launched as an open protocol for various digital health services. UHI will enable a wide variety of digital health services between patients and Health Service Providers (HSPs) including appointment booking, teleconsultation, service discovery and other services.

National Health Mission – From the information above, we can infer that health care has always been a priority for India. Over the years, central schemes have focused on accelerating progress towards Universal Health Coverage. In India, there is also the issue of the rural-urban divide in access to health care. Most multi-speciality hospitals are concentrated in urban cities and are financially and geographically inaccessible to the rural population. This is mainly applicable to tribal and hilly regions or areas with poor public transport. There are also disparities within the city. Despite the proximity of the urban poor and other marginalised sections to urban health facilities, they are often crowded due to the limited resources like infrastructure, human resources etc. of the urban public health system. All cities have a significant population from villages

who migrate for various reasons. This section, of population in particular, lacks information and assistance at tertiary hospitals and finds it difficult to adjust to the modern ecosystem of city super speciality hospitals. The central government launched the National Health Mission to tackle spatial disparities in health (NHM). NHM has two sub-missions under its fold- National Rural Health Mission (NRHM) and National Urban Health Mission (NUHM). Historically, the NHM sought to tackle a wide range of issues like maternal mortality, infant mortality, total fertility rate, and incidence of diseases like TB, Leprosy and Malaria. However, with the epidemiological transition that the country is facing, the priority at the national level is changing with a significant shift in focus to non-communicable diseases like hypertension, diabetes, cancers etc.

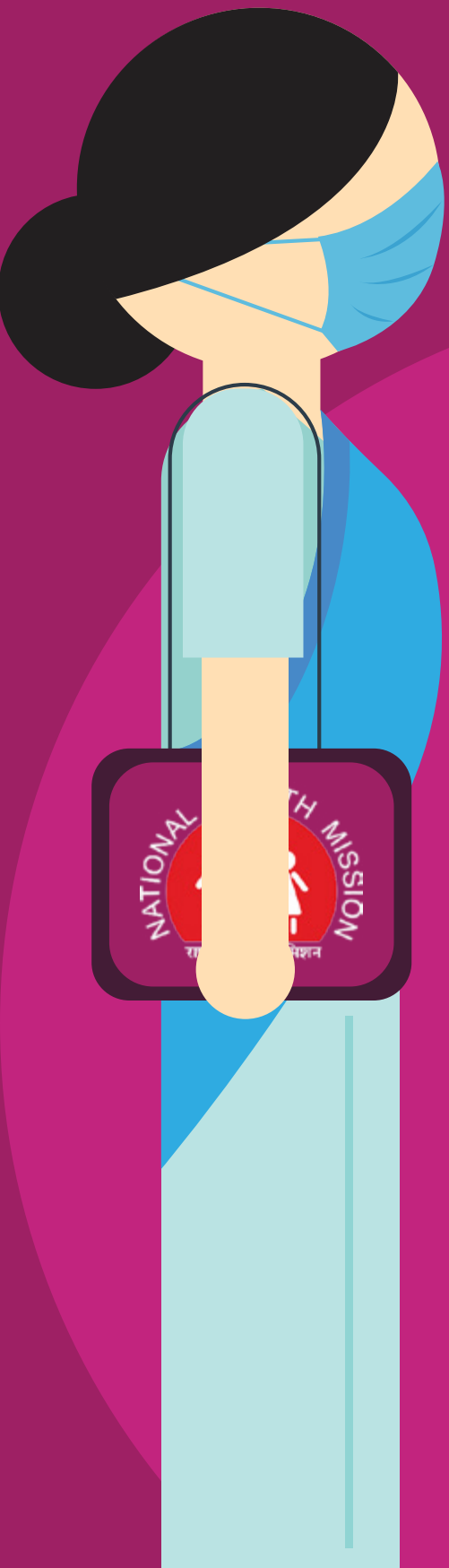
NRHM – Launched in 2005, NRHM aimed at architectural correction in India's Health System and to provide accessible, affordable, effective, accountable and reliable health care to all rural citizens and in particular to the poorer and vulnerable section of the population. The ultimate objective of NRHM is to develop a functional, community-owned decentralised health system in rural areas with convergence at various levels. NRHM is comprised of wide -ranging programs such as drinking water and sanitation. Therefore to incorporate these diverse yet interdependent programs, the District Health Action Plan would be the instrument driving the implementation of NRHM. The mission also aims to revitalise local health traditions and gives a thrust to AYUSH.

NUHM – NUHM was launched in 2013 to provide health care access to the urban poor. The scheme gives special attention to people living in slums and marginalised populations like street vendors, rickshaw pullers, coolies, and the homeless population. NUHM converges various plans under sanitation, drinking water, education and infrastructure maintenance. NUHM covers district headquarters, state capitals and cities and towns with a population above 50000.

India has made rapid strides to improve its health care services under the National Health Mission. NHM was also crucial in improving physical health infrastructure during COVID-19. Strengthening community processes has been the core of India's National Health Mission and the Accredited Social Health Activists (ASHAs) are an integral component of this mission. ASHAs are visibly the public health guardians at the grassroots level. An ASHA is a health care facilitator, a service provider, and a health activist. She provides preventive, promotive, and basic curative care complementing other health functionaries. An ASHA is involved in the education and mobilisation of communities, particularly those belonging to marginalised communities for adopting behaviours related to better health and creating awareness of social determinants, enhancing better utilisation of health services; participation in health campaigns and enabling people to claim health entitlements (Guidelines for Community Processes, 2014).

This report aims to bring out the role of ASHAs in building a robust health care delivery system at the grassroots, especially their endearing role in the management of COVID-19. The following chapter will delve into the transformational work of ASHAs in India.

02



ASHAs as the Backbone of

India's Public Health System

Introduction to ASHAs: **Grassroot Army of Indian Public Health care System**

One of the key features of a robust health care system is a pool of actively engaged and capable community health workers. Countries worldwide are increasingly realizing the significant role community health workers play, in bringing health care provision to the most remote and underserved sections of society. This trend has been particularly significant in low and middle-income countries. The World Health Organisation (WHO), defines Community health workers (CHWs) as *"health care providers who live in the community they serve and receive lower levels of formal education and training than professional health care workers such as nurses and doctors"* (WHO, 2021). The pandemic offered multiple lessons to the world, especially in areas of human development **and health**

care systems. It re-invigorated discussions on building more resilient health care ecosystems which reach out to broader segments of the population. A lion's share in reaching out to underserved sections of society goes to the efforts of the community health workers.

While a lot of literature elaborates on the role they play as facilitators between the formal health system and the vulnerable populations, the importance of this facilitation is as important as life itself for developing nations such as India. Given the heterogeneity in class, culture, geography, and other factors, expanding health system coverage becomes an enormous task. Recognizing the peculiar challenges of India, the government emphasised on strengthening the community health workers segment in the country.

Community participation and ownership of the health delivery system was one of the key pillars of reforms under NRHM. For sustainable and holistic development of the system, engaging people right up to the most remote areas of the country was essential. The mission focused on "establishing a fully functional, community-owned, decentralised health delivery system with inter-sectoral convergence at all levels, to ensure simultaneous action on a wide range of determinants of health such as water, sanitation, education, nutrition, social and gender equality" (NHM).

With this overarching objective, the NRHM provided a crucial component that has become an indispensable part of India's health care system – the ASHA programme. The programme has been a vital factor in the decentralisation of health planning and management. Subcentres were catering to a much larger population than they were originally intended to, and hence NRHM's thrust was on offering improved access to health care at a household level through the ASHAs. Named ASHA (Accredited

Social Health Activist), which in Hindi means ‘hope’, is a community health volunteer from the community, engaged in a range of roles and responsibilities.

Acting as a bridge between health care facility and the communities, ASHAs are one of the most essential components of the Indian health care system. ASHA, is a community health volunteer, who hails from the community she serves, chosen by the community she serves and lives amongst the community she serves. She is trained by the Government and incentivised for the task she performs. She is also accountable to the community. These community-based functionaries are the first port of call for the community they serve across all age groups. The Community processes Guidelines, 2014 describes her as a woman who is primarily a resident of the area, preferably ‘Married/ Widow/Divorced/ Separated’ and preferably in the age group of 25 to 45 years, with some basic educational qualifications as a requirement. She is tasked with multiple responsibilities, but the overall goal is for her to be able to mobilise the community towards local health planning, increase awareness and utilisation of existing health care measures and programs, promote good health practices, provide information on hygienic practices, nutrition, basic sanitation and a range of other health parameters. One of the main factors as to why ASHAs constitute the grassroots workforce for health care services is their belongingness to the community. The familiarity and their knowledge of the local landscape make them an able grassroots workforce who can be accessed with ease and confidence. Due to their belongingness to the area they serve, they often go beyond the call of duty, to help people in need.

ASHAs receive task-based incentives for a varied set of activities (nearly 40 tasks approved at the national level) related to maternal and child health (MCH), communicable diseases, and NCDs for community-level health interventions. Their usual work involves counselling women on a range of health-care parameters such as birth preparedness, breastfeeding, and complementary feeding, immunisation, creating awareness around the importance of safe delivery and contraception. She also is tasked with communicating the importance of preventing common infections such as Reproductive Tract Infection/Sexually Transmitted Infections (RTIs/STIs) which can be sensitive subjects, especially in rural areas. This is why the role of ASHAs become even more crucial. After the introduction of Ayushman-Bharat Health and Wellness centres in 2018, their roles have expanded beyond Reproductive and Child Health care and Communicable diseases to include Non-Communicable diseases, oral, Eye, ENT, Emergency, Elderly, Palliative and Mental health care services.

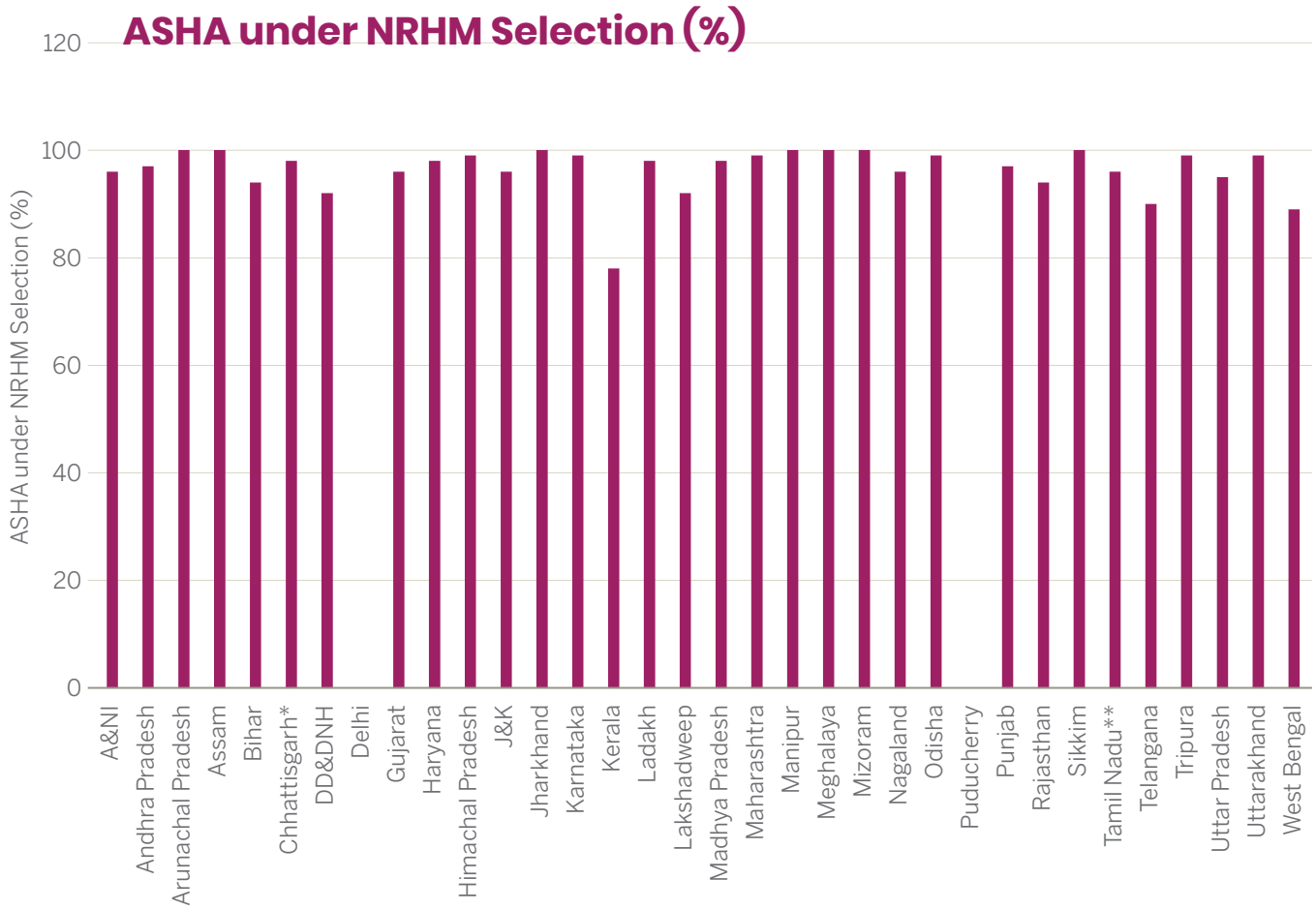
According to the National Health Mission, she also provides easier access to health-related services at the Anganwadi/sub-centre/primary health centres, and utilises this platform to spread key messages and awareness around government health programs. Being a member of the community, she is also involved in community-related interventions such as the Village Health Sanitation and Nutrition Committee's work and the Mahila Arogya Samiti (MAS). These community platforms are critical means to disseminate information on the social determinants of health and getting communities involved in local health planning (NHM). Additionally, an ASHA ensures the provision at household level, of supplies like Oral Rehydration Therapy (ORS), Iron Folic Acid Tablet (IFA), chloroquine, Disposable Delivery Kits (DDK), Oral Pills & Condoms, etc. to people in need.

To understand their role as grassroots functionaries better, we must analyze their contribution to various health measure successes in India. Wagner et. al., (2016) found significant linkages between the increased presence of ASHAs and increased Diphtheria, Pertussis, and Tetanus vaccine (DPT) and measles vaccination coverage at the district level in India. Similarly, there are various studies investigating the impact of ASHA's contributions in different social and health indicators. Khandekar & Mane (2014) found a positive correlation between the number of institutional deliveries in India and the total number of ASHAs. This shows their significant impact on improving maternal and child care. The lack of adequate health care for maternal welfare in rural areas is a subject that has been oft-discussed. With a greater selection of ASHAs, the situation has improved for many rural areas. ASHAs have also played a major role in advising parents of malnourished children on measures to be taken for the children's betterment (Khandekar & Mane, 2014). There are other studies that highlight the positive role played by ASHAs in utilizing eye care services and creating awareness on the same (Shukla et. al., 2020).

Over the years, the number of ASHAs has risen significantly. The graphs below shows state/UT-wise variation in the percentage of selection of ASHAs under NRHM and NUHM (Selected ASHAs against the targeted figures). For ASHAs under NRHM, the selection percentage is better across states.

Figure 10: State/UT-wise selection of ASHAs under NRHM

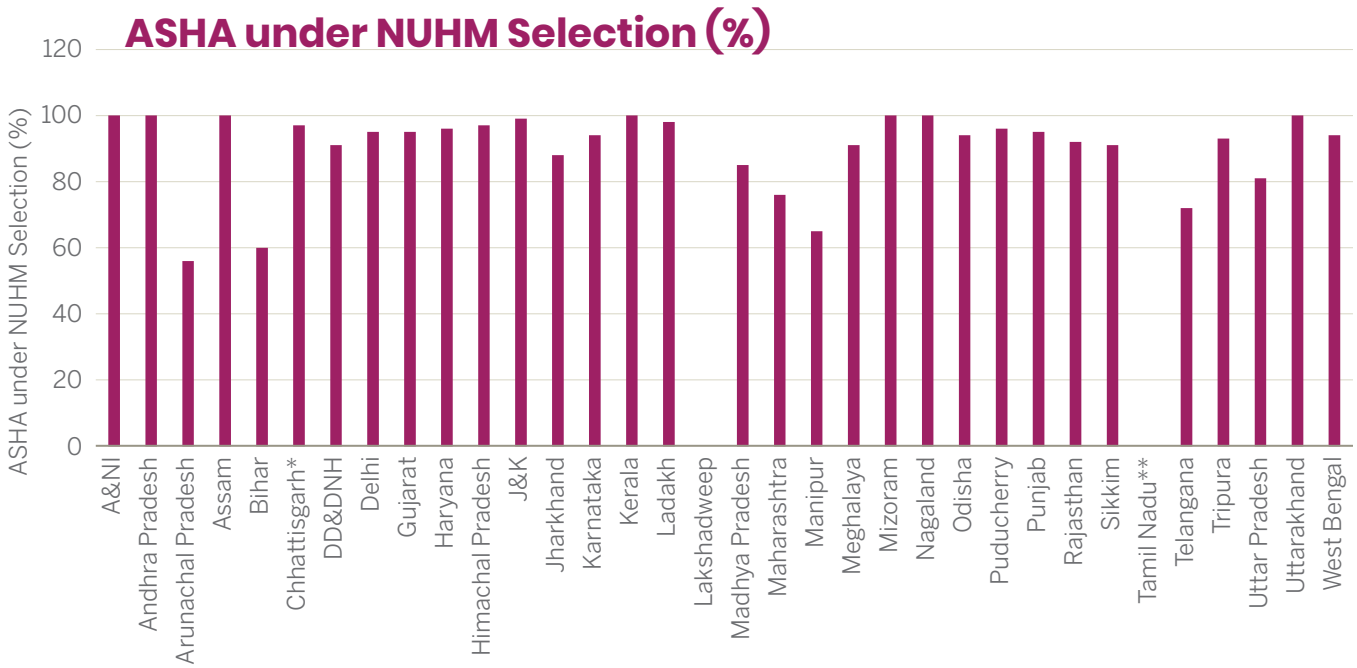
Source: ASHA Annual Update (2020-21)



*Chhattisgarh has selected ASHAs at the habitation level. ** Tamil Nadu-ASHAs have been selected only in tribal areas

Figure 11: State/UT-wise selection of ASHAs under NUHM (in percentage)

Source: ASHA Annual Update (2020-21)



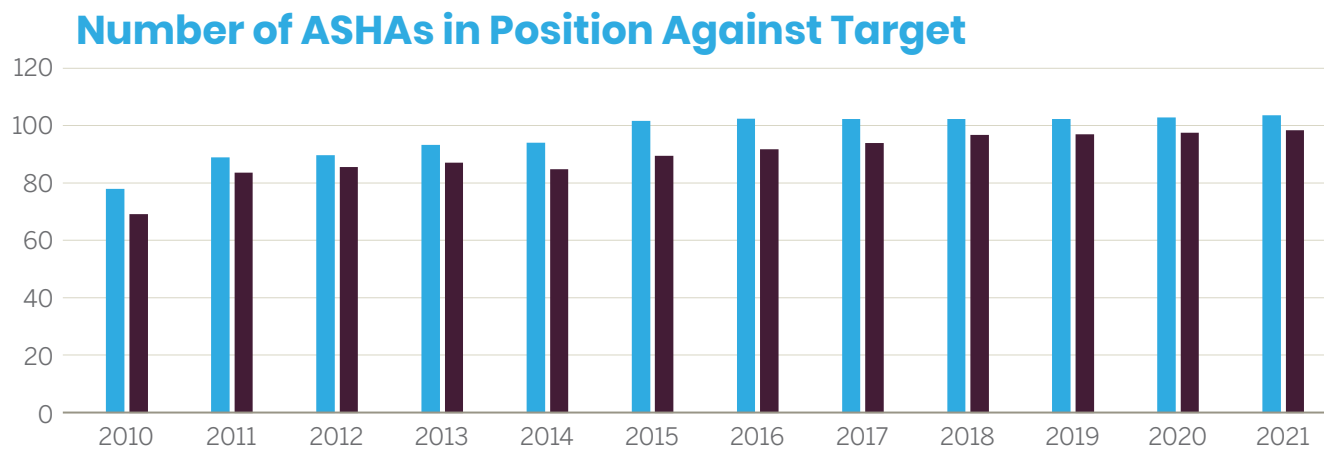
*Chhattisgarh has selected ASHAs at the habitation level. ** Tamil Nadu-ASHAs have been selected only in tribal areas

The strong presence and familiarity at the grassroots level, was perhaps one of the reasons why the government recognised ASHAs as important in tackling the pandemic from the bottom-up. The report will delve into this further in the subsequent sections. Studying their trajectory will offer insights for a better future plan pertaining to their development and capacity building.

Evolution of ASHAs: **Scaling of the program**

Figure 12: Number of ASHAs in position against targets from 2010 to 2021

Source: Annual ASHA Update (2020-21) ■ Target ■ Position

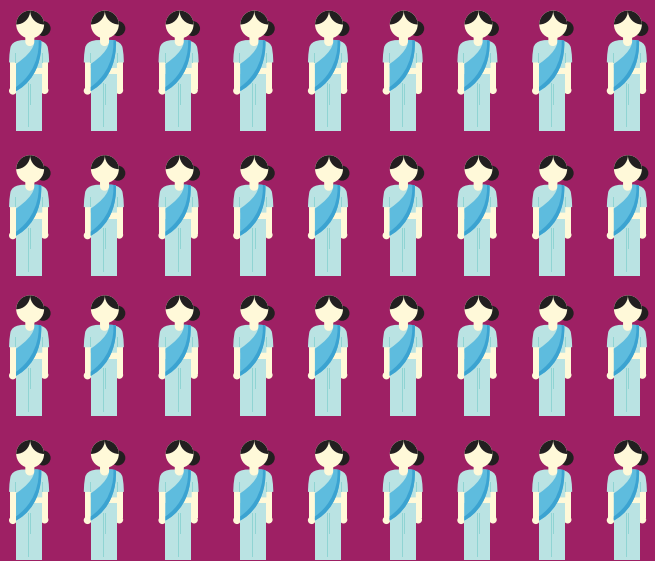


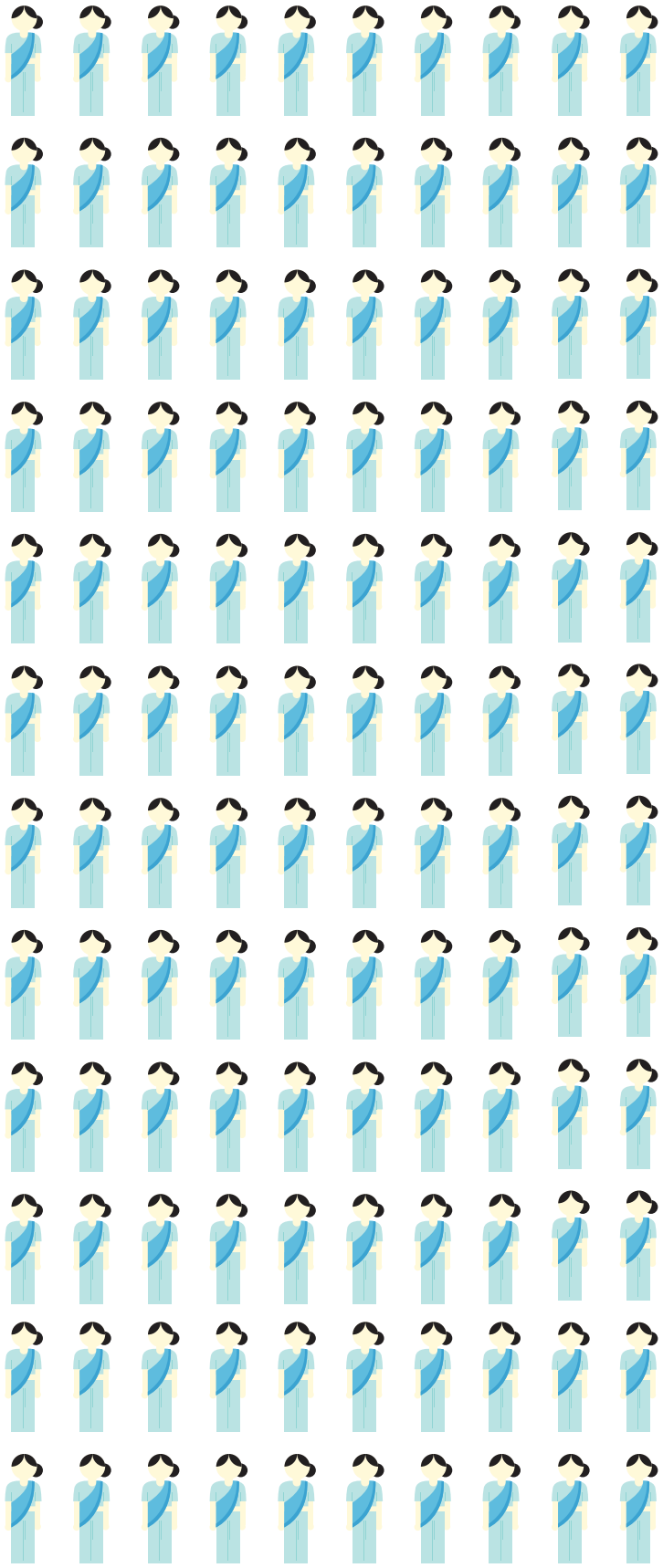
The evolution of ASHAs is a noteworthy development over the years. Since the programme's launch in 2005, it has transformed significantly. The transformations have mainly been brought forth due to local contextual needs and changing national priorities. They receive modular trainings. Over the years, their role and responsibilities, task-based incentives, honorariums, and non-monetary incentives have evolved in multiple ways. ASHAs are supported by formal support structures at different levels viz., State, district, block and sub-block levels. At the sub-block level it is the ASHA Facilitator who supports and mentors a group of 20 ASHAs. She is chosen from amongst the ASHAs and hence has complete understanding of ASHAs role and skills.

From the first ASHA update in 2009 to 2021, India has witnessed a steady progress in the number of ASHAs selected and trained, and in their efficiency in service delivery. According to the Annual ASHA update for 2020-21 a total of

9,83,032 ASHAs

are in position in the country,





against the target of

10,34,630

(95% in position)

under the National Health Mission (NRHM and NUHM). The target is decided as per the set norms of one ASHA for every 1000 population in rural areas and one ASHA for 2500 population in urban areas. From 2010 to 2020-21, the total ASHA target has registered an increase of about 33% and around 42% for ASHAs in position (ASHA Update, 2020). The programme's span across states has grown substantially. In 2006, a year after the programme's launch, it was focused on 18 high-focus states. It was in 2009 that the programme saw an expansion into all states and UTs (except Goa and Chandigarh) in India.

An overview of the annual reports on the ASHA program put out by the National Health System Resource Centre (NHSRC) shows the inclusion of states apart from the initially considered high focus states. The program included non-high focus states, Union territories, and north-eastern states in the subsequent years. This shows the efforts taken to expand universal health coverage across the length and breadth of the nation. In 2010, with the launch of Home Based Newborn Care(HBNC), skill-based training came to be emphasised in a major way. The National Health Mission's evaluation of the ASHA programme stressed on the skill-based training aspect. It noted that the training programme should be strengthened and made skill-based, as ASHAs should themselves be clear about what the measurable outcomes of their efficiency are so that they can function accordingly (NHM, 2010).

It is not just the number of ASHAs or their presence in different states that saw an increase over the years, but their role also expanded drastically. Since 2005, their journey has been challenging on many fronts. The government has provided support in all forms to ensure their adequate functioning and efficiency. In order to align the skill sets of frontline health functionaries with their expanded role, all frontline functionaries ASHA and MPW/ANM), were trained accordingly. The training modules on universal screening of NCDs for ASHA, MPW (F)/ANM,) were launched in 2017 (ASHA Update, 2017). This expansion of tasks for the ASHAs constitute a major development in their trajectory. It is important to note that the expansion of responsibilities is an addition to her core tasks of community mobilizing and service provision (ASHA Update, 2019).

The COVID-19 pandemic posed a completely different set of obstacles before the ASHAs. The year 2020 brought about a drastic shift in the way the frontline functionaries carried out their tasks. Their story of evolution is incomplete without accounts of their pandemic management experiences. Apart from their routine work which they continued even during the pandemic, their role further expanded to encompass creating awareness around COVID-19, early detection and timely referral of suspected cases, line listing of individuals with travel history within the last 14 days, individuals in contact with suspected/positive cases and following up with individuals on home quarantine (MoFHW, 2020). The capability of ASHAs that has enhanced over the years, due to their own work experiences, on-the-job training, and government support, shone through in their pandemic management efforts at the community level.

Multiskilling and Repurposing of **ASHAs for Pandemic Management**

Proximity to the community has always been ASHA's forte. The fact that their contribution would be required to battle the pandemic was evident. However, their effectiveness and utility depended on how they were going to be trained to work as the frontline defence against the pandemic. Various initiatives have been taken by the government to tap into these community health functionaries base to address pandemic-related challenges. Multiskilling and repurposing the ASHAs with the dissemination of new information and multiple trainings were undertaken. Additional incentive were introduced by the government for ASHAs. The incentives were also extended to the ASHA facilitators who provide the much needed handholding support to the ASHAs. A handy brochure titled "Role of Frontline Workers in Prevention and Management of Corona Virus" came to be developed by NHSRC in English and Hindi languages and was shared with all states/UTs for translation into regional languages. The idea behind the brochure was to disseminate factual information on ways to stop the spread of the virus, combat myths around COVID-19, clarify the role of ASHAs, and measures to be followed by ASHAs for their self-protection and effectiveness (ASHA Update, 2020-21).

Capacity building of ASHAs **for Response and Containment Measures**

Training of ASHAs for response and containment measures in the pandemic was undertaken on a huge scale. As the graphs above portray, rural areas, saw about 80% of the total ASHAs being trained to address COVID-19 challenges at the community level, whereas this number increased to a significant 95% in the second wave.

As is evident from table 1., there are wide variations in the trainings conducted across states and UTs. The health system which had hitherto conducted trainings in-person, had to quickly adapt to undertake online trainings of the functionaries. Frontline functionaries at the PHC level used individual mobile phones to attend virtual training sessions. A cascade model of training was utilised in areas where internet connectivity was patchy. It involved ASHAs being trained by block MO/LHV in small groups at the PHC. Within two months of the dissemination of guidelines to the states, about 90% of the ASHAs and ASHA facilitators received training in the prevention and management of COVID-19. Moreover, to equip health care workers at all levels in COVID-19 management, training materials like PPTs, video clips explaining proper usage of PPEs, usage of N-95 masks for HCWs, etc. were shared with States and Union Territories (MoHFW, 2020). By 22nd May 2020, around 8,92,446 ASHAs and 42,988 AFs were trained in pandemic management (MoHFW, 2020).

The training was not just limited to COVID-19. This training was put to use during the pandemic while going door-to-door and dealing with household-level issues that the pandemic brought forth. These may have had a positive impact on Community Health Workers' outlook towards training in general. Previous updates on the programme highlight the importance of regular continuous training that helps fill the skill gap. From our discussions with ASHAs from certain states, the increase in their confidence level and preparedness was evident. Quality training and experience has enabled ASHAs to perform better.

Table 1: State/UT-wise status of ASHA training in prevention and management of COVID-19

Source: Annual ASHA Update (2020-21)

Status of ASHA training in prevention and management of COVID-19

State/ UT	Rural ASHAs						Urban ASHAs					
	First Wave			Second Wave			First Wave			Second Wave		
	In Position	Trained	%	Target	Trained	%	In Position	Trained	%	Target	Trained	%
Bihar	87655	25000	29	85272	85272	100	582	0	0	550	550	100
Chhattisgarh	68277	67512	99	68277	67805	99	3771	3729	99	3771	3721	99
Jharkhand	39931	39807	100	39931	39964	100	1475	1475	100	1677	0	0
Madhya Pradesh	64094	62350	97	63183	62511	99	4525	4235	94	4525	0	0
Odisha	46134	45934	100	45941	45941	100	1700	0	0	1614	1522	94
Rajasthan	48207	48207	100	47924	47886	100	4269	4269	100	4298	4298	100
UP	155070	139592	90	156632	132811	85	6968	5666	81	6968	0	0
Uttarakhand	10700	10700	100	10418	0	0	1205	1205	100	1205	0	0
Sub-Total	**520068**	**439102**	**84**	**517578**	**482190**	**93**	**24495**	**20579**	**84**	**24608**	**10091**	**41**

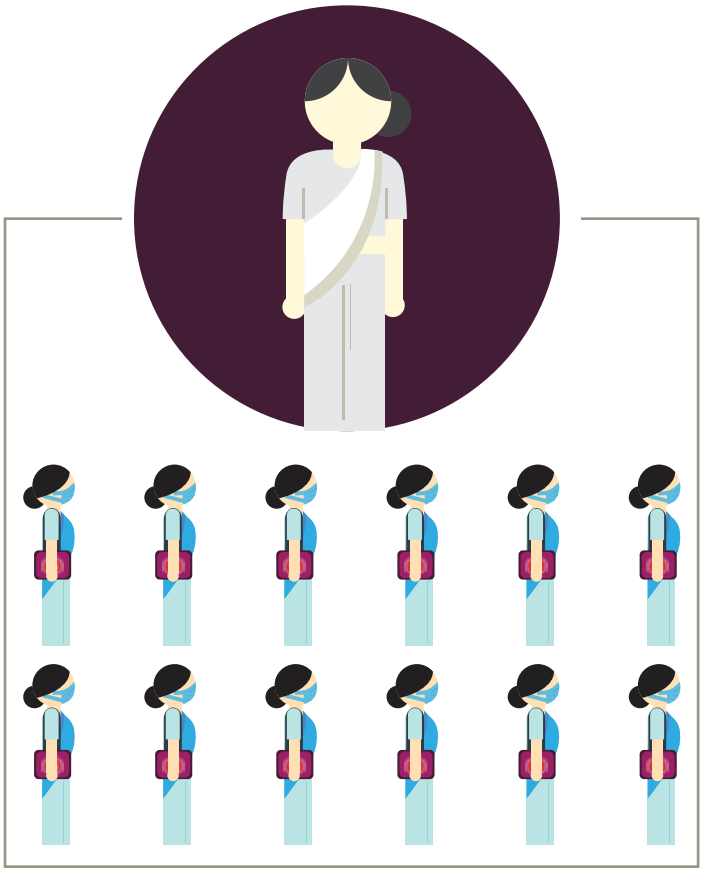
State/ UT	Rural ASHAs						Urban ASHAs					
	First Wave			Second Wave			First Wave			Second Wave		
	In Position	Trained	%	Target	Trained	%	In Position	Trained	%	Target	Trained	%
North-Eastern States												
Assam	31334	25000	80	31334	31334	100	1212	1212	100	1212	1212	100
Arunachal Pradesh	4040	2753	68	2753	2753	100	42	40	95	42	40	95
Manipur	3928	0	0	3928	3819	97	120	120	100	120	81	68
Meghalaya	6589	0	0	6589	6426	98	195	184	94	195	0	0
Mizoram	1012	1012	100	1012	1012	100	79	79	100	79	15	19
Nagaland	1917	1845	96	1917	1845	96	90	0	0	90	90	100
Sikkim	641	0	0	641	641	100	32	0	0	35	35	100
Tripura	7147	7147	100	7158	7158	100	504	398	79	504	427	85
Sub-Total	**56608**	**37757**	**67**	**55332**	**54988**	**99**	**2274**	**2033**	**89**	**2277**	**1900**	**83**
Non-High Focus States												
Andhra Pradesh	38216	38216	100	38216	35015	92	3200	3200	100	2609	2509	96
Delhi	NA						6036	5926	98	5982	5982	100
Gujarat	38853	38853	100	38391	38391	100	4478	4478	100	4281	4281	100
Haryana	17557	17557	100	18000	17699	98	2571	2571	100	2676	2593	97
HP	7881	2116	27	7881	7881	100	33	33	100	33	33	100
Karnataka	38674	38674	100	38407	37790	98	3125	3125	100	3091	2900	94
Kerala	24079	24079	100	24079	24079	100	2396	2396	100	2396	2396	100
Maharashtra	60816	60816	100	60862	60862	100	7522	7522	100	6001	6001	100
Punjab	17223	0	0	17144	17111	100	2569	0	0	2532	2479	98
Tamil Nadu	2555	2555	100	2650	2520	95	NA					
Telangana	23443	23443	100	23111	23111	100	3597	3597	100	3929	3929	100
West Bengal	54109	0	0	53077	52252	98	5701	5337	94	5487	0	0
Sub-Total	323406	246309	76	321818	316711	98	41228	38185	93	39017	33103	85
Union Territories												
A&NI	394	0	0	412	412	100	10	0	0	10	0	0
DD&DNH	340	282	83	351	0	0	98	98	100	98	0	0
J&K	12539	4791	38	11640	11640	100	136	136	100	136	0	0
Lakshad-weep	101	0	0	104	104	100	NA					
Ladakh	612	513	84	534	534	100	364	0	0	0	0	0
Puducherry	NA						326	326	100	341	304	89
Sub-Total	13986	5586	40	13041	12690	97	934	560	60	585	304	52
Grand Total	914068	728754	80	907769	866579	95	68931	61357	89	66487	45398	68
Punjab	17223	0	0	17144	17111	100	2569	0	0	2532	2479	98
Tamil Nadu	2555	2555	100	2650	2520	95	NA					
Telangana	23443	23443	100	23111	23111	100	3597	3597	100	3929	3929	100
West Bengal	54109	0	0	53077	52252	98	5701	5337	94	5487	0	0
Sub-Total	323406	246309	76	321818	316711	98	41228	38185	93	39017	33103	85

The Annual ASHA update (2020-21) highlights the way in which training sessions were conducted despite all odds. The number of travel restrictions and distancing norms made the situation a complicated one, wherein a major training initiative had to be conducted at the grassroots level while observing COVID-19 norms. Most training sessions were conducted in small batches at the local level. The use of digital platforms like Zoom, Webex by Cisco, and ECHO made it easier to conduct live sessions for ASHAs. The Kilkari platform under Ministry's RCH division was also leveraged to reach out to ASHAs via pre-recorded messages on their mobiles.

While the pandemic called for efforts of a different kind, ASHAs continued to play an important role in enabling access to essential non-COVID-19 health care services such as immunisation, ANC, safe delivery, and availability of medicines for non-communicable and communicable diseases.

ASHA Support System **During the COVID-19 Management**

ASHAs shoulder a massive responsibility for functioning as a link between the formal health system and the masses. People's lives are dependent on their functioning. ASHAs have induced greater involvement of people in the formal health system and care facilities in India. Given the importance and the expanse of the work ASHAs do, it is imperative to offer them a robust support structure. While they receive help from ANMs and AWWs as well as other local authorities, tailor-made help catering specifically to ASHAs is a necessity for the program to be effective. **ASHA facilitators mentor ASHAs and guide them in their activities.**



There are other models of ASHA supervisors as well. At times, ANMs themselves perform the role of ASHA facilitators. Further, state specific support system is also present. For instance, the state of Rajasthan engages the

cadre of PHC supervisors as ASHA facilitators. ASHA facilitators function as a vital link in the health ecosystem at the community level. In recent years, states and UTs are devoting focused efforts in reinforcing support structures for ASHAs. They have realised the significance of offering strong support structures to ASHAs for their successful functioning (PIB, 2018).

Apart from the support mechanism that ASHA facilitators provide, they are also an exemplary career opportunity for ASHAs. Generally, ASHA facilitators are selected from the pool of ASHAs themselves. This makes for a good career progression for ASHAs and serves as an incentive to perform well. The presence of ASHA facilitators and their selection criteria varies across different states. Undertaking around 20 supervisory visits every month, the role of facilitators is very significant. They guide and provide handholding support to ASHAs with the village household visits, help conduct VHSNC meetings, and attend Village Health and Nutrition Days.

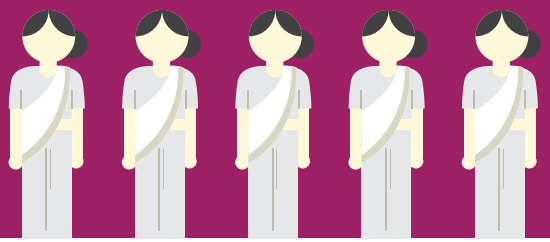
Yet another crucial factor in making the program effective is discussion and coordination among ASHAs working in a village. The program becomes all the more successful when ASHAs working in a certain area come face to face, share experiences, and express difficulties and stories of overcoming challenges. Cross-learning is important for community health functionaries. For this, the cluster meetings and AAA meetings (ASHA, ANM and Anganwadi workers) for all ASHAs in the area once a month are of huge importance. Considering that the nature of the job is voluntary, it takes immense effort to work. Inculcating a sense of affiliation among the group of ASHAs helps make it easier for them to work. The presence of ASHA facilitators helps ASHAs reach the most remote and marginalised homes. Additionally, they contribute to the training of ASHAs, enable selection procedures of new ASHAs and ease grievance redressal mechanisms. The government is increasingly recognizing ASHA facilitators as a critical component of the grassroots health ecosystem and has rolled out initiatives to support them. It brought about an increase in the supervisory visit incentives for ASHA facilitators and expanded coverage of Pradhan Mantri Jeevan Jyoti Bima Yojana and Pradhan Mantri Suraksha Bima Yojana to ASHA facilitators. Providing facilitators with the right incentives will help improve their performance and go a long way in strengthening the ASHA support system. A study conducted in Assam in 2013, wherein about 291 ASHA Facilitators were interviewed, notes the importance of strong supervisory or support structures for the sustainability of community health care functionary models. The ASHA Facilitator model of India is highlighted as an example of the need for such structures to make CHW programmes successful (Prasad, 2013).

According to the Annual ASHA update for the year 2020-21, there are about

39,546

ASHA facilitators

across 20 states and UTs in India.



There has been an increased awareness among the states and UTs about the importance of providing support structures for ASHAs as is evident from the fact that states such as Uttar Pradesh, Himachal Pradesh, West Bengal, Arunachal Pradesh, Andhra Pradesh, Telangana, and the UT of Andaman & Nicobar Islands have seen the creation of new positions of ASHA facilitators in the last few years. High focus states, with the exception of Odisha, harbor support structures at all four levels (State/ District/ Block & Sub-block). The update also highlights that most of the North-Eastern states have 3 to 4 levels of support structure. Amongst Non-High Focus states, states like Haryana, Karnataka, and Maharashtra have support structures at all four levels, whereas states like Andhra Pradesh, Gujarat, Telangana, Kerala, the NCT of Delhi, Himachal Pradesh, Punjab, and West Bengal have a mix of support structures set up to support the ASHA programme. While the needs of every state/UT differ, understanding the effectiveness of support structures for ASHAs is immensely important, as this will offer insights to other states to learn from and devise support systems accordingly. Striving to continuously build stronger support mechanisms is essential, so that in times of crisis, they can be relied upon.

Financial Inputs by the Government of India for **ASHAs During COVID-19 Pandemic**

In addition to providing quality and regular training, another significant aspect of building motivation of ASHAs is offering the right incentives. In view of the additional efforts taken by ASHAs during the COVID-19 pandemic, an additional incentive of Rs. 1000 per month per ASHA was provided for undertaking COVID-19-related activities from 2020 to March 2022.

Apart from monetary incentives, other benefits were also provided to them. Social security benefits like life insurance, accident insurance, and pension were extended to all eligible ASHAs and ASHA Facilitators through the Pradhan Mantri Jeevan Jyoti Bima Yojana (PMJJBY), Pradhan Mantri Suraksha Bima Yojana (PMSBY) and Pradhan Mantri Shram Yogi Maan Dhan Yojana (PMSYMDY) respectively (MOHFW, 2020-21). In case of loss of life due to COVID-19 or on account of COVID-19 related duty, the Pradhan Mantri Garib Kalyan Package extends the insurance scheme coverage of Rs. 50 lakh to ASHAs.

Additionally, to support them during COVID-19, states and UTs were requested to ensure that incentive for routine and recurrent activities (Rs. 2000 per month) was paid in full for all the ASHAs (MoHFW, 2020). Over 3,90,000 ASHAs and ASHA facilitators enrolled in PMSBY, 2,90,000 enrolled under PMJJBY and 2,80,000 enrolled under PMSYMDY. ASHA facilitators were also provided with an incentive of Rs 500 for her work during the pandemic.

Through the previous sections, the importance of community platforms have well been

established. Budgetary allocations to these platforms like Village Health Sanitation and Nutrition Committees and Mahila Arogya Samiti are also equally necessary. They form an important part of the health ecosystem of of the country. They provide scope to improve the representation of women and weaker sections of society. Having received an untied fund of Rs 10,000 on an annual basis which is topped up based on the expenditure of the previous year, more than 5.53 lakh VHSNCs had been set up as of 2020 (MoHFW Annual Report, 2021).

In addition to the central support, many states/ UTs also gave additional incentives to ASHAs for their involvement in COVID-19 management from the state funds. For example Uttar Pradesh granted Rs.500 per month per ASHA, Arunachal Pradesh Rs 1000 per month, Sikkim Rs. 5000 per month, Himachal Pradesh Rs. 2000 per month, Maharashtra Rs.500/- per month etc To intervene and safeguard the protection of frontline workers during the pandemic, MoHFW issued guidance for states/UTs to provide adequate PPE to ASHAs and ensure her safety vide DO Lr No.V- l80l 5/4/2020-NHM-ll dated 20.4.2020. States were suggested to provide ASHAs with Identity card to facilitate her movement in teams. On 22nd April 2020, an ordinance to the Epidemic Disease Act, 1897 was promulgated to protect health care personnel and property including their living/working premises against violence during epidemics.

In January 2021, the country launched its COVID-19 vaccination and the first dose was received by involved health workers and frontline workers, including police, paramilitary forces, sanitation workers, and disaster management volunteers. ASHAs received 1st, 2nd and booster doses as the vaccination program advanced in the country.

NHSRC in collaboration with NIMHANS and UNICEF, organised online National webinars in June 2021 on psychosocial support for ASHAs to enable them to cope up with stress and maintain their mental wellbeing. Locally and individually appropriate relaxation techniques, stories of valour with respect to work done during COVID-19, success stories of functionaries etc were shared through this webinar.

ASHAs as the foot soldiers of battle against COVID-19 pandemic: **Roles and Responsibilities**

Ground-level work done by the ASHAs during the pandemic is noteworthy. Armed with quality training and embeddedness in the community, they went above and beyond in managing the pandemic at the community level. The primary task executed by them is conducting community-level surveillance. During the first wave, ASHAs were tasked with the responsibility of listing all houses with recent travel history. Additionally, contact tracing was a major aspect of their work during the pandemic which was important for early detection and prevention. At a time when it was considered crucial to not overburden the health care infrastructure, contact tracing was the key. While disseminating information and awareness around COVID-19 was important throughout the pandemic, and still continues to be, creating awareness around it in the initial phase was particularly challenging. Communicating the gravity of the pandemic and encouraging behaviour change were major tasks handled well by ASHAs. Over the subsequent two years, constantly reinforcing the importance of COVID-19 appropriate behaviour for prevention and services for testing, quarantine, home isolation and treatment made available by the government, was also a part of the responsibility of ASHAs. As was evident in the discussions conducted with ASHAs across different states and UTs, as part of the primary research conducted for the study, constant following-up with patients and their families was also a major responsibility of the ASHAs. Home visits were undertaken, and isolations and quarantine

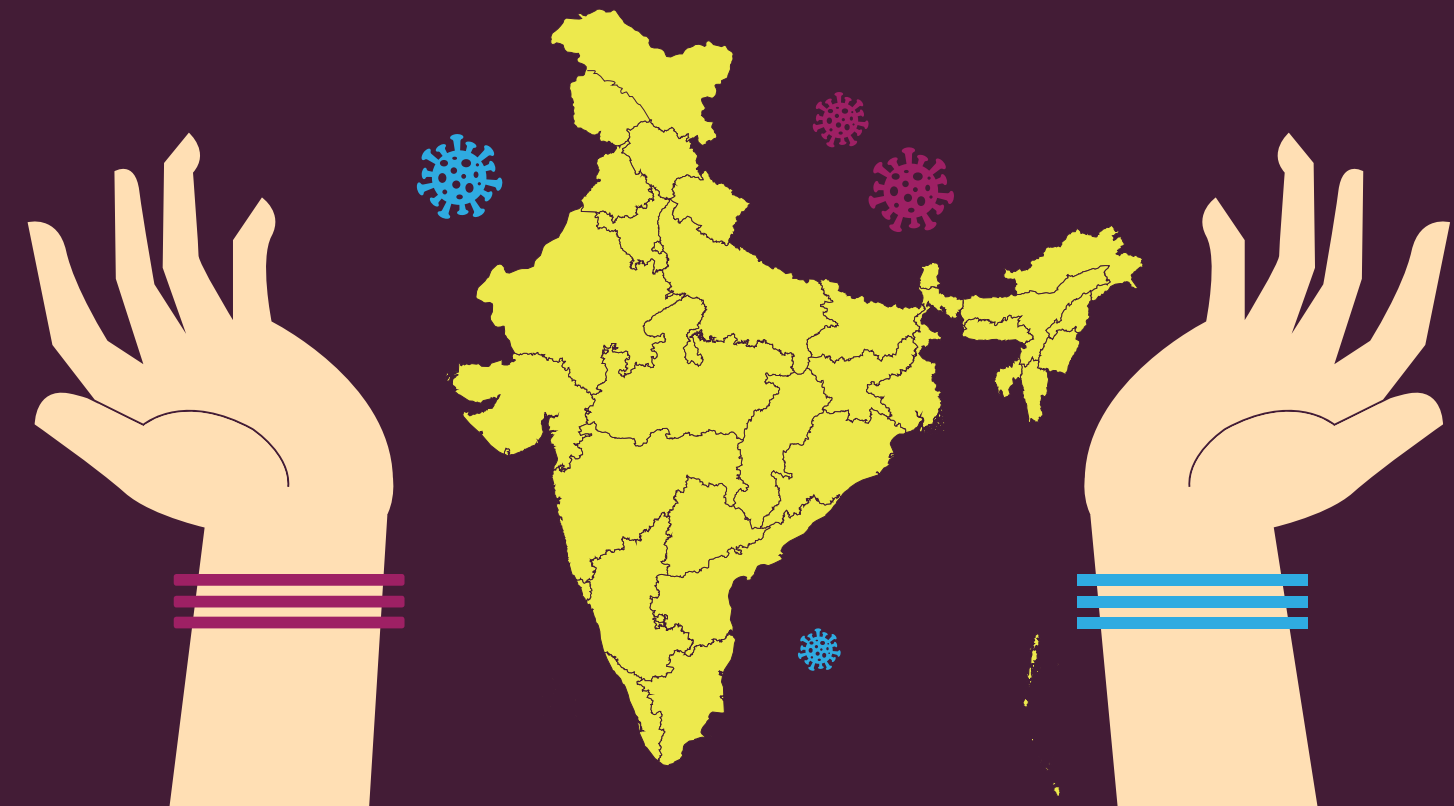
norms were monitored regularly by ASHAs. Their surveys helped in identifying high-risk patients as well. This included the elderly, as well as patients with diabetes, hypertension, heart disease, and /or respiratory illness who were more prone to develop severe complications due to COVID-19. At a time when the pandemic disrupted even the most basic services in society, ASHAs worked towards ensuring their provision. They acted as agents enabling access to institutional delivery, immunisation, and continued treatment for chronic illnesses.

There are many examples of ASHAs coming across as foot soldiers during the pandemic. Jharkhand's ASHAs, known as 'Sahiyas', shone through in their work around COVID-19-related challenges.

Large parts of the state are hard to access. Delivering health care services, especially in a pandemic, to the most remote areas, is a challenging task. In the face of this enormous task, Jharkhand's Sahiyas worked extensively with the local and state authorities to ensure the smooth functioning of the health care system and proper pandemic management. When Jharkhand launched the week-long Intensive Public Health Survey in 2020 to identify the high-risk population for COVID-19, house-to-house surveys were conducted. Around 42,000 Sahiyas were actively engaged in the survey. They played a crucial role in identifying local high-risk individuals more vulnerable to the virus. During the survey, the Sahiyas carried out multiple tasks (such as counseling for ANC/ PNC, home-based new-born care, home-based care of the young child, and follow-up of those on treatment with chronic diseases). Their efficient functioning was evident in their attempt to conduct multiple activities in the same visit so as to make each visit as useful as possible. In the conversations with ASHAs from Manipur, their work on the ground in the face of adversity became even more glaring. We spoke to ASHAs who were working in urban areas in Manipur, who highlighted the challenges of working in an urban area during the pandemic. Among a range of services they were enabling, serving migrant workers during the pandemic was one of their biggest tasks. Many migrant workers had to stay back in the cities once the lockdown was initiated.

On being asked how they helped the migrant workers, one of the ASHAs said,

> *In the area where we worked, migrants were mostly from Bihar and Punjab. We arranged separate vehicles for people who wanted to go back to their hometowns to make sure they travelled safely. Most of them did not even have access to proper food and water supply. We used to speak with the government and local leaders to ensure basic provisions for them. Our work involved sending medicines to the migrant workers on a regular basis. Most of them did not even pick calls out of fear that they will be asked to leave or that they would test positive if put through a COVID-19 test. In such cases, we would call and speak with some of their neighbours who would then go and inform the migrant workers that we were there to help and there was no cause for concern. After that, we were able to build some trust among these communities and they started calling us for help*



ASHAs were also equipped with IT across states and UTs. The Annual ASHA update 2020-21 highlights state-specific IT applications that were designed for ASHAs by a few states and UTs. They were adopted to track cases, formulate plans and ensure follow-up. Some of the examples include – the launch of the Corona Access app in Delhi, updating of the IDSP module in the TECHO+ app in Gujarat, updating of PLA application in Jharkhand, Corona Watch in Karnataka, and development of an application for ASHAs surveillance in Punjab.

Conducting door-to-door surveys, and coming up with ground reports to deliver a real-time assessment of the pandemic gave a granular picture to health authorities for taking appropriate steps. This would not have been captured had the ASHAs been absent in the health care system. ASHAs play a vital role not just in the health ecosystem but in the overall development trajectory of India. Increasingly, studies are emphasizing the need to take a bottom-up approach to assess various economic and social parameters in the country, given the inter-state and intra-state diversity on multiple fronts. The ASHAs have truly lived upto their names and have inculcated *'asha'* in each one of us.


राष्ट्रीय स्वास्थ्य मिशन
आयुष्मान भारत
हेल्थ वेलनेस सेंटर
SC SINGHANA, DISTRICT JIND
WELLNESS CENTER SC SINGHANA (JIND)

03

Experiences of ASHAs in COVID-19

Management Learnings from the States

Why does the experience of **ASHAs matter?**

The pandemic overwhelmed health systems across the world and penetrated through every nook and corner, challenging the resilience of communities. The interconnectedness of life became imminent, as individuals realised how their health was closely associated with the collective health of their society, neighbourhood, and community. An important way of tunnelling through this precarity cast on the world and India is to understand the dynamics of a particular society, its functioning and specific needs. ASHAs work in a distinct capacity as trusted community members with extensive knowledge of their panchayat or municipality. During interviews conducted for this report across Indian states and UTs, the one thing that stood out was how communities contacted ASHAs with the same ease and comfort of informing a family member of one's needs or illness. Since

the ASHAs conduct **door-to-door surveys and population enumeration in their designated locality, they are well-versed in their community's demographics, socioeconomic profile and special needs.**

Ponamma Rajan is an ASHA from Kumily Panchayat, Kerala. She was a resident of the Panchayat for 37 years and when the call for ASHAs came to their Panchayat, Ponamma was unanimously nominated by the people and her ward member. This is a testament to how ASHAs are repositories of trust in a community.

“ I used to work in Sindhu pharmacy, delivering Ayurvedic medicines, collecting them from the city and supplying them to a nearby pharmacy. When I bring in medicines for 100 rupees, I used to get 20 rupees for myself. This is how I started working and moving around the community. Within a few months, I was well acquainted with everyone in the ward and eventually the Panchayat. People started knowing me well. So, when the notification came for the recruitment of ASHAs in our panchayat, my ward member nominated me. At first, I was worried that my educational qualification would not be sufficient, but the ward member assured me that this job is about being there for the people and that I am perfect for this job. ”

Before the pandemic, we did do door to door surveys in our village. We advise newlywed couples in the village about the importance of using contraception to prevent STIs. Whenever a woman is pregnant in the village, they come to the nearest Health and Wellness Centre and speak with the ASHAs. At the AB-HWC, we collect basic information and note when the TT injections need to be taken and advise the mother on eating good food. We also support the delivery of newborns at the hospital. Since we keep a list of newborn children in the village, we know if someone missed their round of vaccination. Then we go to their homes and speak to the family and urge them to get their children vaccinated on time.

Ranjana, ASHA from UT of Jammu and Kashmir

With COVID-19 came fear, lack of clarity on how to manage due to different set of information being circulated through various sources. People needed a reliable source of information. ASHAs were provided training on how to deal with the conditions and help manage cases with proper information and contacts with right facilities. ASHAs played a pivotal role in improving the health-seeking behaviours of the community and home care practices had to be closely studied and monitored to manage the virus.

ASHAs had to work on reducing fears, building trust, and strengthening collaboration among stakeholders.

Multiple beneficiaries expressed how they had seen ASHAs working in their neighbourhoods for years, even before the pandemic. One beneficiary from Gujarat mentioned, *"We have seen ASHAs work in our area for the last 10 to 12 years. They visit our households and address our health concerns."*

I first heard of ASHAs (Mitanin) in our village back in 2003. Before the pandemic, ASHA Didis (Mitanins) used to come and check on us if we had any fever or illness and specifically took care of our nutritional intake as women. When I contacted COVID-19, I was isolated from my family for 21 days and every day the ASHAs from the nearby community centre used to come in the morning and evening to check on my health. They also bought me food and ensured that I was taking care of myself.

Beneficiary, Korba, Chhattisgarh

COVID-19 posed a unique challenge, which was evident from the interaction with ASHAs. It required heightened resilience, sensitivity, and special training. At the same time, they themselves had to look out for themselves and their own families, as many of them had elderly persons and children at home. Working in the field had become more challenging than before. The pandemic unfurled in different stages, requiring modified, locally appropriate roles for management of the situation.

This chapter will explore the challenges faced by ASHAs in different states and UTs of India. How did they delivery essential health care services during mobility restrictions? The pandemic brought with it, a plethora of incomplete information and panic which carried a risk for the grassroots workers getting stigmatised, and facing gender issues within the community, which resurfaced during the pandemic, like domestic violence. How were these issues tackled? To what extent did they help in rolling out vaccination drives? What was the procedure behind contact tracing and other measures taken to control the virus? How did they deal with their own mental and psychosocial well-being? By incorporating insights from interviews conducted with ASHAs, Medical Officers and beneficiaries from different states and UTs in India, this chapter attempts to capture their experiences and the exemplary courage in COVID-19 management.

COVID-19 Prevention and safe practices in the community

Several factors influence the extent of COVID-19 spread in countries ranging from population-level immunity and capacity to respond and adjust measures to changing circumstances. In any case, Infection Prevention and Control (IPC) is an integral part of containing and ultimately eliminating the spread of COVID-19. ASHAs were given special training to pursue fieldwork during the pandemic in the backdrop of emerging responsibilities, with newer communication strategies. In order to help the community, the frontline functionaries had to start with themselves. The first step towards ensuring safety is communicating the right kind of information, especially at a time when varied information circulated throughout social media, creating a web of unreliable sources of information. The initial months of the pandemic were rife with misconceptions, miscommunications and misunderstandings. From the beginning of restricted mobility to the rolling out of vaccines, ASHAs have been engaged at every step of the process. This began with first gaining authentic information about the virus themselves, creating awareness in the communities about the virus, knowing the cause, symptoms, and treatment for the disease. A whole new body of research was emerging alongside the spread and mutation of the virus. Constant updating of information was necessary for proper response to the virus.

In general, the guidelines issued by the ministry of Health and Family Welfare outlined the certain practices to promote safety through community health care. These include handwashing, social

distancing and wearing of masks. The measures formed an integral part of the response towards COVID-19.

ASHAs were the local repository of knowledge, and they disseminated information on safe and appropriate behaviour to control the spread of the virus. ASHAs were engaged in ensuring that communities practice physical distancing when they are out, telling people the right way to let out a cough or sneeze in public and the appropriate methods to maintain good hygiene. In the post lockdown phase, ASHAs also closely monitored communities to ensure they do not take for granted the lifting of mobility restrictions and continue practicing COVID-19 appropriate behaviour. Finally, the most crucial part of preventing the disease was the vaccination drive. ASHAs worked relentlessly to communicate how immunisation can help prevent COVID-19 in the future.

Community Surveillance: **survey, contact tracing and referrals**

Public health surveillance is the continuous, systematic collection, analysis, and interpretation of health-related data (WHO, 2022). ASHAs had begun public health surveillance long before the pandemic. They conducted extensive door to door surveys in the locality to record information like age, health concerns and pregnancy-related information of households. This enabled ASHAs to track progress towards community health goals while serving as an early warning system for disease outbreaks.

The prevalence of COVID-19 and its high reproducibility necessitated continuous surveillance at the community level. The foremost role of ASHAs was to assist in contact tracing and house monitoring of symptomatic or suspected individuals within a community. Initially, positive patients were isolated at COVID-19 facilities but once home isolation started, surveillance was done through home visits and telephonic conversations. Initially, the surveillance period of a positive patient was 28 days which inlcudes 14 days at home or hospital and 14 days of self-reporting in case of any unabating symptoms. Tracking travel history was also a key element of disease surveillance during the first wave. Before community transmission was established, the movement of national and international travellers and the inflow or outflow of migrant workers were closely tracked by ASHAs. Several states had portals where travellers registered themselves along with their destination address and their period of stay. Most states like Maharashtra, Gujarat, Kerala and Karnataka started an online e-pass system to track the flow of travellers in and out of the state. ASHAs also supported this exercise by diligently calling families to guide them on quarantine protocols if the individual has a national or international travel history.

Surveys are essential to understand population immunity, the number of cases, and the emergence of new short-term or long-term symptoms. Monitoring the spread of the virus in the primary health care settings was needed to detect cases and clusters in the community. Testing facilities need to be available at the

primary level. If not, community testing facilities like drive-through sites or community buildings were essential to managing the pandemic at the community level. All Indian states and UTs worked to provide testing facilities at nearby institutions, and the facilities were run with the support of ASHAs. In line with the ICMR guidelines to check the surge of COVID-19, the Kerala government set up drive-in and drive-out rapid antigen testing facilities across the state, with a particular focus on underserved areas. Similar initiatives were also undertaken in major cities like Ahmedabad and Gurgaon wherein drive through RTPCR facilities were set up at sites like GMDC ground and Leisure Valley respectively. The testing booths were attached to health facilities accessed by the public, like primary and community health centres.

Once a person is tested positive for COVID-19, ASHAs called them regularly to understand the symptoms, intake of medicines, and if any other family members are infected or facing COVID-19 like symptoms. They also checked if the households have access to pulse oximeters, thermometers, and other essential commodities. If an infected individual is living alone, ASHAs also arranged food and medicines while visiting the household with words of encouragement. The community health workers faced problems on various fronts while responding to the community's needs.

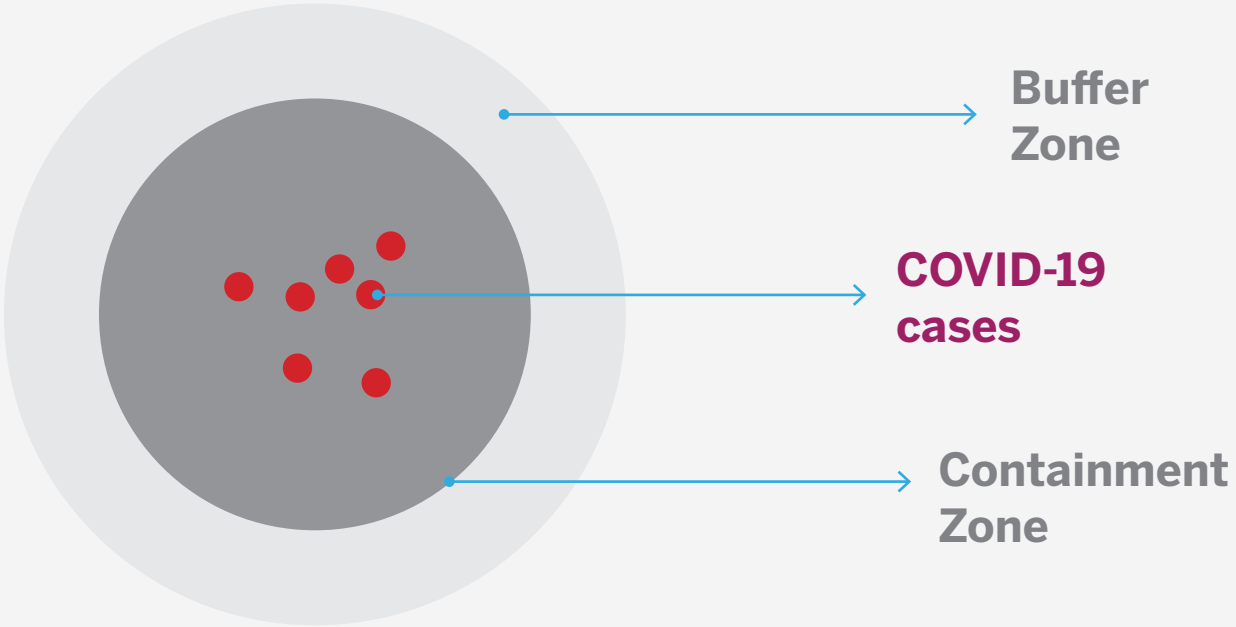
Active house-house surveillance

The ASHAs carried out active surveillance within the containment area in defined sectors of 50 households each in rural areas and 100 households in urban areas. A supervisory MO was kept on duty over the sectors in the ratio of 1:4. The Supervisory officers were drawn from the nearest PHC/CHC not falling within the buffer zone. They worked under the MO- in-charge of the PHC concerned. Active surveillance included enlisting of all houses; regular visit to each household to verify and search for persons with COVID-19 symptoms and Influenza Like Illness (ILI) in each sector. If such persons are identified, they were handed over to the RRT for transportation to sample collection centres and further management as per need.

ASHAs are trained in understanding the presenting symptoms and the potential contacts. Contacts are also listed based on the risk level as primary and secondary contacts. ASHAs provided information on symptomatic and asymptomatic cases while monitoring the community. Once the cases are identified, ASHAs stayed in touch with the community health centres about prescribed medicines and their administration. They regularly inform and follow up with individuals on the correct dosage and frequency of medication to ensure compliance. Apart from the household level, surveillance of ASHAs is also tailored as per the intensity of the outbreak within a community.

Figure 13: Perimeter control in the containment zone is primarily an administrative measure. There will be enhanced surveillance within the containment zone. The buffer zone is the area around containment where new cases are likely to appear. There is no perimeter control in the buffer zone.

Source: National Health Portal of India



Influenza-like illness (ILI), Acute Respiratory Infection (ARI) and Severe Acute Respiratory Infection (SARI) are the various types of diseases monitored by ASHAs. Within a containment zone, there will be enhanced ILI, ARI and SARI monitoring and self-reporting is encouraged. A control room is established at the nearest health facility, and people's movement is closely monitored. There is enhanced passive ARI/ILI surveillance, media surveillance, and training on case definitions and contacts in a buffer zone. ASHAs participate actively in the overall surveillance of a locality. As a referral, the ASHAs inform the Medical Officer at the primary health centre of individuals showing symptoms and update higher authorities about newly detected positive cases.

Continued Delivery of **Health Services during Pandemic**

Delivery of essential services directly and indirectly related to COVID-19 helps to significantly bring down overall morbidity and mortality during a pandemic. Health seeking may be deferred by people because of physical distancing compulsions or a general fear that health facilities are infected with the virus. Access to hospitals was also restricted since most of the facilities were converted to COVID-19 hospitals during the peak time of the pandemic. Essential health care services in an area may include reproductive, maternal, and newborn child health, treatment of chronic ailments and prevention of other communicable and non-communicable diseases to avoid further complications. The strength of these pre-existing essential services has played a major role in controlling the intensity of any pandemic. For example, during the 2014-16 Ebola outbreak in Western Africa, the overall mortality breached acceptable limits due to the general failure of the health system. This failure also spiked deaths from malaria, HIV and TB to the extent that the combined mortality from these diseases exceeded the total deaths due to Ebola.

The Ministry of Health and Family Welfare issued guidelines on adopting a Health Systems Approach to Essential Service delivery during the pandemic. This involved mapping of facilities in the public, private or non-governmental sectors. Several states like Andhra Pradesh also tied up with the NGO sector to expand hospital and ambulance networks for smooth delivery of services. Several organisations across the country like the Aurobindo Foundation, Menmunnam Seva Foundation and other important civil society organisations actively helped maintain a smooth supply of services Telehealth was also prioritised to prevent overcrowding in hospital facilities. ASHAs played a critical role in delivering telehealth services. As early as April 2020, States like Karnataka rolled out 'Apthamitra' mobile app to provide online medical consultation to people at home seeking assistance in 'dealing with' COVID-19. Till March 2022, more than 94,000 AB-HWCs were providing online consultations between AB-HWCs as spokes and doctor/specialist at hubs. The telemedicine service contributed considerably during COVID-19 and it decreased load on hospitals and helped patients to digitally/remotely consult medical professionals.

To ensure smooth delivery of services, ASHAs work together in close coordination with other networks in the village or municipality. They coordinate with existing groups like self-help groups, residents' welfare associations, or youth networks to continue delivering services. Part of the continued delivery of health services also involved the provision of groceries, especially to senior citizens who had restricted mobility. In cities like Delhi, Bangalore and Mumbai, youth networks were active in providing groceries to the elderly population. ASHAs and other health functionaries also ensured that each household had access to an emergency contact list for family, friends, essential services, medicines, and food.

Providing non-COVID-19 essential health services by giving doorstep delivery of **TB, HIV, and NCD medicines and ensuring sub-national Polio rounds**

Since March, 2020 the pandemic assumed centre stage and eclipsed all other illnesses. In India, numerous other communicable and non – communicable diseases also exist, which had to be addressed during COVID-19. As per the guidelines released by the MoHFW, primary health workers were to ensure that patients suffering from chronic diseases, both communicable and non-communicable, have access to regular medical supplies. A significant challenge was conducting polio rounds during the pandemic. Polio elimination largely depends on field surveillance, large scale community mobilisation and house to house supplementary immunisation activities. This exercise was obstructed due to COVID-19 induced morbidity and because states had to divert logistical, human, and other resources to fight the spread of COVID-19. ASHAs have a significant role in organising the pulse polio drive in the community centres. For instance, in Karnataka, 41000 ASHAs participated in organising the polio rounds in the state.

Despite the Pandemic, India recorded 5.8 million new cases of TB in 2020. A number lesser then 7.1 million of 2019 but still quite large.

India was one of the countries that significantly contributed to Global TB reduction by 41%.

India also reported the maximum drop in new cases. Supporting the patients and health system in the fight against TB is one of the responsibilities of an ASHA. Though the mode of transmission differs slightly, both TB and COVID-19 are spread by close contact between people. Drop in the diagnosis of new cases of active TB, outpatient setting challenges and diffiiculty in organising immunisation program during COVID-19 was noted. Despite these challenges, ASHAs worked relentlessly to monitor TB in the era of the pandemic (Jain et. al., 2020).

HIV control programs also faced significant threats during the pandemic. The primary mode of HIV acquisition in children is through parent-to-child transmission (PTCT) during pregnancy, childbirth, or breastfeeding. Most infant HIV infections can be averted by the provision of prevention of parent-to-child transmission (PPTCT) services. ASHAs are generally trained on the basics of HIV, the adherence with Anti-Retroviral Therapy and most importantly, eliminating any stereotypes existing

community against HIV positive patients. ASHAs across the country worked to prevent vertical transmission of HIV. Pregnant women who were HIV positive were counselled and encouraged to register for antenatal care to ensure that the virus is not transmitted from parent to child. Patients with non-communicable diseases and chronic health problems like cancer, heart conditions, or diabetes were also supported by the ASHAs. It also came to light that individuals with comorbidities were at a higher risk of not surviving the virus attack. Under such circumstances, ASHAs worked to allay the fears of the community. Therefore, the scope of work during the pandemic increased drastically.

Managing stigma and **discrimination**

A public health emergency like COVID-19 can be stressful for families and society in general. Stress is heightened not merely due to the disease but also from other socio-economic vulnerabilities. Economic slowdown, migration and resource constraints widened inequalities. Also, COVID-19 was a new disease with many unknown aspects, and the fear of the unknown often ran deep. Sharing the correct information, individual experiences, practising kindness and speaking up against negative stereotypes are essential for cooperation and smooth functioning of a society under stress. ASHAs were trained in soft skills like being polite, kind and patient while dealing with patients and households infected with the virus.

Social stigma in health occurs when there is a negative association between a person or a group of people who share certain characteristics and a specific disease. In COVID-19, functionaries were often stigmatised due to the nature of their work which put them at higher risk of exposure to the virus. In several cities and villages, landlords asked their tenants who worked as nurses and doctors in COVID-19 hospitals to vacate immediately. This propagated a sense of fear within the community. Discriminating against frontline workers who keep the system running smoothly is unfortunate and so is ostracising those individuals or households infected with the virus. Dealing with stigma is essential to prevent people from hiding the illness, fearing isolation. It also discourages people from seeking immediate health care and adopting healthy quarantine measures. Stigma worsens when there is insufficient knowledge of how the disease is transmitted, treated, and prevented. To pick a quote from our discussion with an ASHA from Manipur, *"People used to be wary of us thinking they would contract COVID-19 from us. They saw us as though we were the virus".*

COVID-19 pandemic propagated a wave of stigma, discrimination and aggression against the health functionaries including ASHAs in the country. The discussions conducted with ASHAs highlight their struggle and coping mechanisms. They mention that the discriminatory behaviour stopped bothering them after a point, because they realised that those hurling abuses were ignorant, and no matter how much it hurt them, one doesn't abandon their kin in times of crisis. Despite the challenges, this gave them the courage and resolve to continue their work. An ASHA shared

> *We endured a lot. I was hurt at first since the villagers would keep saying that we are doing this because we are being paid to do this. We tried to make them understand but did not really help. This went on from the very beginning uptil the vaccination. Later it stopped hurting. I started feeling that these are our own people, they are scared, uneducated and uninformed and this is my job to address this. That's why I would hear their words and simply let go of it, immediately. The Sarpanch helped a lot too. Now all is well*

Figure 14

Source: Ministry of Health and Family Welfare, Government of India

ASHAs play an essential role in reducing the stigma and discrimination associated with COVID-19. As trusted and accessible community functionaries, they work with a certain degree of familiarity in the neighbourhood, showing empathy and amplifying the circulation of good news to help overcome the tide of fears in people's minds. ASHAs also reached out to high-risk groups like senior citizens and younger children to ensure their needs are met. Once a person recovers from COVID-19, it is also essential to induct them back into everyday life.

Furthermore, to safeguard frontline functionaries during the pandemic, the Ministry of Health and Family Welfare passed issued guidelines to States/UTs to provide adequate PPE kits and other protection gear. States were also suggested to provide ASHAs with identity cards to facilitate her movement in teams. On 22nd April 2020 the ministry passed an ordinance to the Epidemic Disease Act 1897 to protect health care personnel and property (both living and working premises) against violence during epidemics. It ruled against any obstruction or hindrance for health care service personnel in dischargiing their duties. This too enabled ASHAs to perform her duties amid pandemic.

Augmenting **existing facilities**

COVID-19 Care Centres (CCC) to manage mild/asymptomatic cases

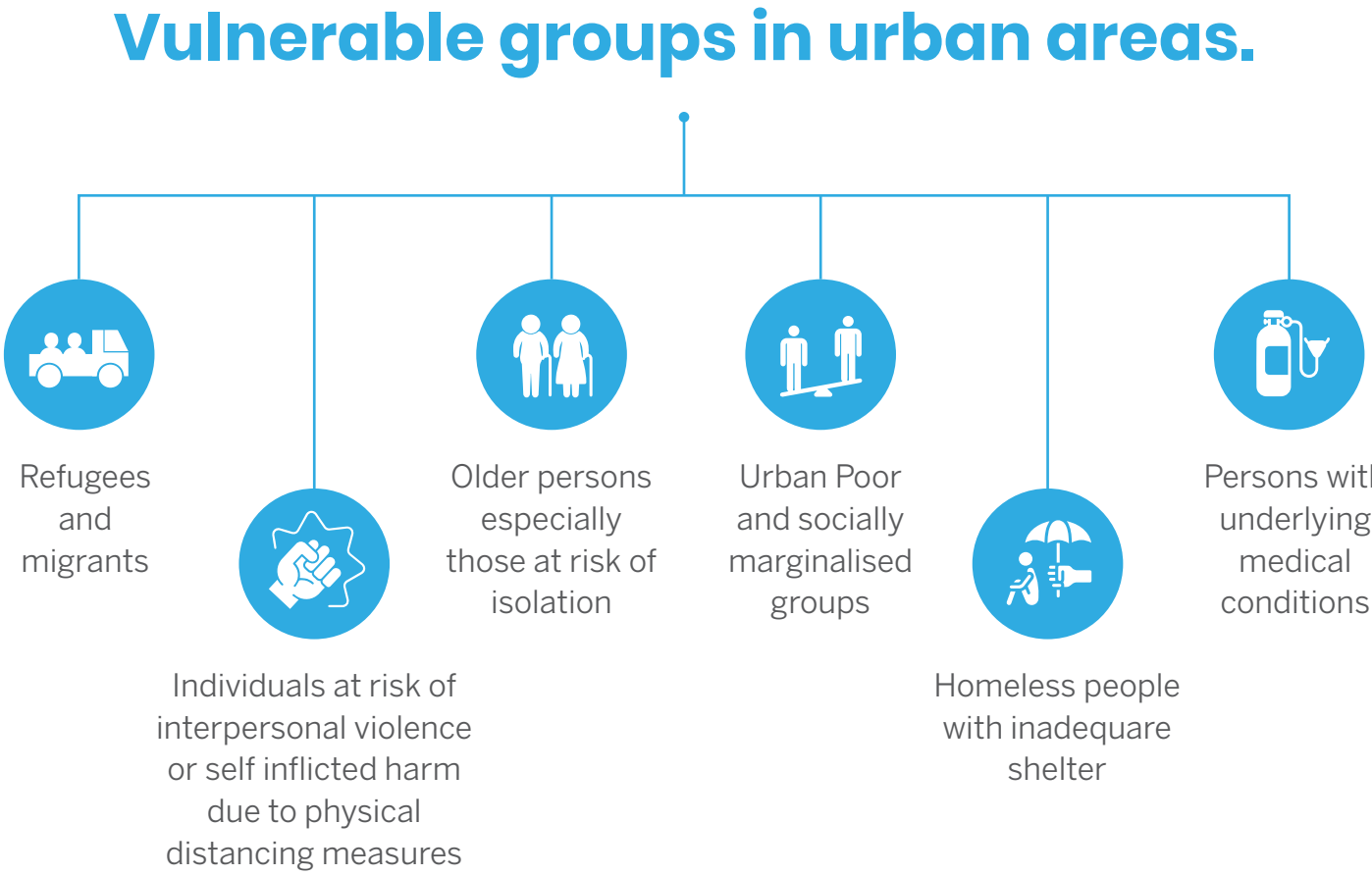
As per Govt. of India guidelines, rural areas planned a minimum of 30-bedded CCCs. The CCCs offered to care for asymptomatic cases with comorbidities or mild cases where home isolation was not feasible. These CCCs had a Basic Life Support Ambulance (BLSA) networked among themselves. These were equipped with sufficient oxygen support on a 24x7 basis to ensure safe transport of patients to dedicated higher facilities if the symptoms progressed from mild to moderate or severe. The Community Health Officer (CHO) of the nearby SHC-HWC or ANMs/Multipurpose Health Worker (Male) was the nodal person for the CCC from the Health sector and ASHA/Anganwadi Worker was supporting them. The Gram Panchayat supported by Village Health, Nutrition and Sanitation Committee (VHNSC) in rural areas was responsible for the implementation and upkeep of such facilities. The facilities worked under the overall guidance of the Medical Officer of the local PHC Health and Wellness Centre, supported by CHO of the SHC-HWC.

Special Needs in **Urban Areas**

The outbreak of COVID-19 in cities demonstrated the ability to address resource distribution, health care needs and issues of equity. Urban centres in India like Delhi, Kochi, Mumbai, Chennai, Kolkata, Bengaluru and other major cities or towns faced unique dynamics that challenged their preparedness. Being hubs of travel and employment, they have more migrants and diverse populations with different socio-cultural needs resulting in higher population density, and increasing chance for community transmission. Most of these cities have a sizeable section of urban poor in India and people living in slums. Such settlements often lack access to safe water and sanitation facilities and depend on the informal sector for employment.

Figure 15

Source: Strengthening Preparedness for COVID-19 in Cities and Urban Settings Interim Guidance for Local Authorities,2020, World Health Organisation



Therefore, a coordinated and multi-sectoral approach is the key in dealing with the pandemic in urban areas. A troubling crisis during the period of mobility restrictions in urban centres was the plight of migrant labourers. Most of them worked in cities as street vendors, construction labourers, and menial workers. The virus sparked an economic and employment crisis. With mobility restrictions measures in place, vendors were barred from selling on the streets and had no means to sustain themselves in cities. ASHAs across the country played a critical role in tracking the movement and return of migrant workers. ASHAs coordinated with the Rapid Response Teams (RRTs), and counselled family members while explaining the steps to be taken during home quarantine.

In Odisha, ASHAs leveraged Mahila Arogya Samitis in Urban areas to take care of women and newborns at the time of the pandemic. Mahila Arogya Samitis are women's collective groups formed in urban areas to take action on issues related to health, nutrition, sanitation and its social determinants at the slum or ward level. ASHA is its Member Secretary. They were specially envisaged as being central to 'local community action', which would gradually develop into the process of decentralised health planning. Thus, MASs are expected to act as a leading platform for women and local community groups in each slum area to improve awareness and access to the community for health services, to develop health plans specific to the local needs and serves as a mechanism to promote community action for health.

Unlike rural areas, urban cities have good tertiary health infrastructure. But due to population density and income inequities, they are often inaccessible to the urban poor. Under such circumstances, primary health care centres and community health functionaries are a beacon of hope in building resilience in cities. Given the expanse of urban areas, ASHAs collaborated with NGO partners too to address the unique needs in urban areas during the pandemic. Thus, the role of ASHAs in metropolitan cities was multi-faceted and called for dynamic responses to address the needs of different sections of the population.

04

Role of ASHAs in the COVID-19 Vaccination

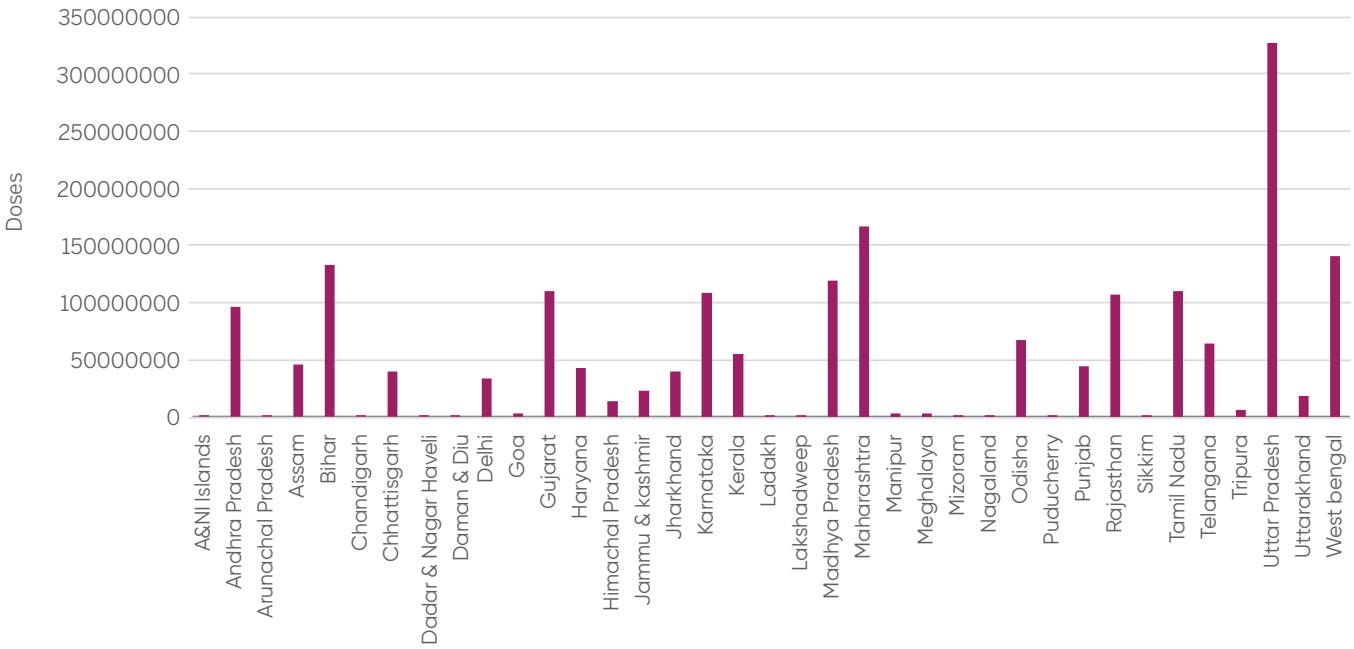
To combat the COVID-19 pandemic, the Government of India to combat the pandemic launched the largest vaccine drive in the world on 16th January 2021. Rolling out a vaccination drive in a country that harbours one of the largest and diverse populations in the world was a challenging task. Initially, the drive covered health care workers, frontline workers, and adults over 60 years of age. Gradually, those over 45 years with co-morbidities, adults 18 years and older, and recently, teenagers in the 15-18 years age category were included (WHO, 2022). Adding to the size of the population, the heterogeneity in terms of geographies, communities, level of urbanisation, infrastructure, and accessibility, makes it all the more daunting.

However, the country has achieved a significant feat by reaching a total of 1,91,96,32,518 doses as of 20 th May 2022 (MoHFW).

Since the beginning of the drive, the country has achieved remarkable milestones. It registered the highest number of vaccinations in a day – a total of 25 million doses on 17th September 2021. Recently, in January 2022, India crossed the one-year mark since the vaccine drive launch. The pace and the reach of the vaccination drive are both commendable. India has progressed gradually expanding its vaccine coverage to different age group brackets. The graph below shows a state-wise distribution of total doses reached. Across states, we see an average of 5,05,16,645 doses so far.

Figure 16: State/UT wise Total COVID-19 vaccination doses in India

Source: MOHFW, As of 2 June'22 at 7 AM



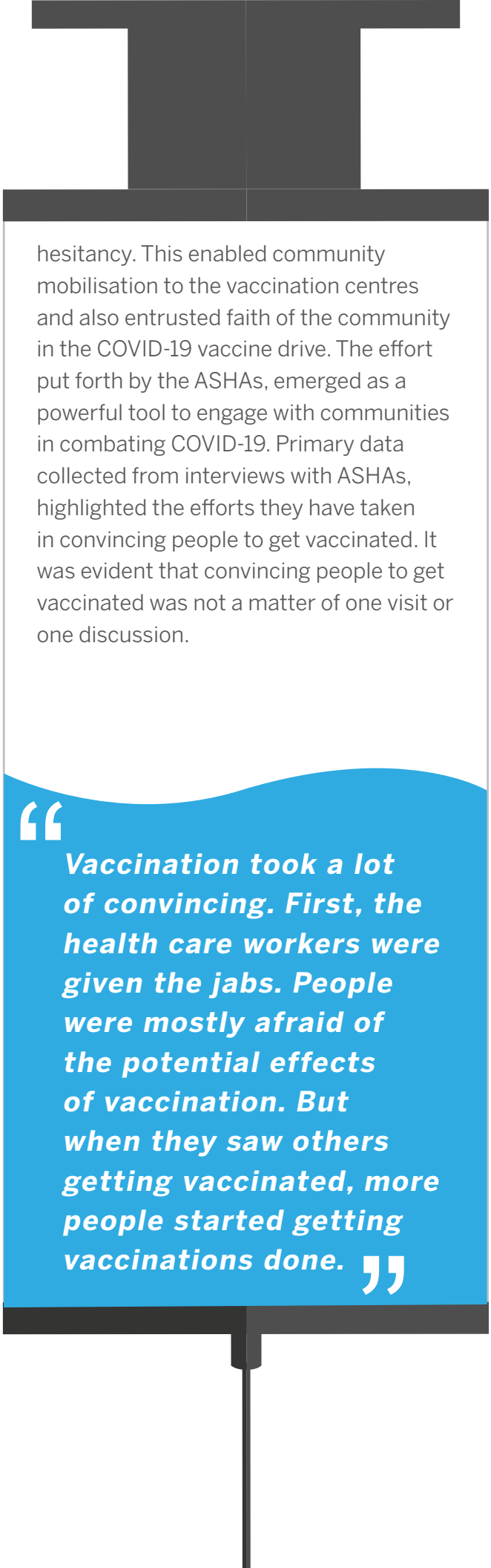
India has come a long way since the beginning of the vaccination drive. Conducting the drive successfully in a country like India requires the exercise to be one of immense coordination among different government tiers, bureaucratic levels and the people. Workers from all sectors involved in conducting the exercise undertook huge efforts to make the drive a success. An important aspect of rolling out the vaccination, from start to end, is the team of community health functionaries including ASHAs, ANMs and AWWs who took it upon themselves to ensure that everyone was covered across all sections of the society. It was not an easy task as deep-rooted hesitancy had to be overcome and rampant myths about vaccination had to be countered. The Community Health care functionaries covered miles and miles across hills and rivers, to reach remote communities and ensuring that no one was left behind in the vaccination drive. Even with the vaccination drive set up by the top levels of the government and local authorities, working from the bottom-up, and bringing people to the vaccine was a herculean task. This task was taken up by ASHAs working determinedly and diligently to ensure that beneficiaries were vaccinated.

The ASHA's role in the vaccination drive extended right from spreading awareness about vaccinations to getting eligible beneficiaries vaccinated with second and even precautionary doses. These frontline workers have traversed the length and breadth of India. They have been to places where other, more conventional medical service, either is not immediately available or would take too long to muster up. They ensure that information about the need for vaccinations, information about other methods to fight COVID-19, and critically the vaccines themselves are provided at every doorstep, no matter where the services have to be delivered, be it in a dense jungle or a distant mountain.

Initially, spreading awareness about the vaccine was the primary task. In this stage, the ASHAs encountered a major difficulty which was vaccine hesitancy among people. Before they could explain the logistics of getting registered and going for the vaccination, hesitancy among people due to various misconceptions and biases around the vaccine had to be countered. ASHAs faced tremendous challenges at this point. As part of this study, the discussions conducted with ASHAs from 7 States namely Odisha, Kerala, Jammu & Kashmir, Punjab, Manipur, Madhya Pradesh and Chhattisgarh bring out the obstacles they faced while facilitating vaccination. Even when they were a part of the community they worked in, it was challenging for the workers to combat vaccine hesitancy among the locals.

A common theme that stood out across various interviews with the functionaries was their method of countering fears of vaccination.

ASHAs demonstrated that any concerns around vaccination are unfounded, by getting themselves vaccinated, to showcase the community that there is no adverse impact of the vaccine on the health of the beneficiary in any manner, which helped instilling faith among the community for the vaccine. Their proximity to the community gave the health care system a close insight into community sentiment. They acted as a crucial link and first port of call between the system and the people, without which it would have been impossible to counter vaccine hesitancy at the local level. Their work is conducted on a door-to-door basis, going from household to household for surveys, awareness on vaccination and tackling the vaccination hesitancy. This enabled community mobilisation to the vaccination centres and also entrusted faith of the community in the COVID-19 vaccine drive. The effort put forth by the ASHAs, emerged as a powerful tool to engage with communities in combating COVID-19. Primary data collected from interviews with ASHAs, highlighted the efforts they have taken in convincing people to get vaccinated. It was evident that convincing people to get vaccinated was not a matter of one visit or one discussion.



> ***"Vaccination took a lot of convincing. First, the health care workers were given the jabs. People were mostly afraid of the potential effects of vaccination. But when they saw others getting vaccinated, more people started getting vaccinations done."***

It seemed to have taken the workers a lot of time and effort to counter vaccine hesitancy. An ASHA from Madhya Pradesh talked to us about her experience and approach to countering vaccine hesitancy. She said-

> *We used to dispel their fears around vaccination by emphasizing the fact that first, it is the health workers and local health authorities who have gotten the vaccine. We are absolutely fine and healthy, and we would encourage people to take the vaccine for their own well-being.*
>
> **ASHA from Madhya Pradesh**

Vaccine hesitancy was not just observed in rural areas but also in urban areas, where ASHAs had similar struggles countering hesitancy. In our discussions with ASHAs from Langol Tarung in Manipur, the problems faced by ASHAs in urban areas became evident. Facilitating vaccination was particularly difficult in these areas. The ASHAs from Manipur elaborated on the issues and pointed out that going from door to door was even more difficult in urban areas as they had to travel extensively within the urban spaces to reach people. While they used bicycles at times, they had to walk for kilometres to provide care and facilitate vaccination. Additionally, urban localities have gated societies that restrict entry at times. The mere fact that ASHAs working in urban spaces also have to reach households located on upper storeys in a building complex, shows the difficulty in accessing communities that ASHAs faced during the pandemic. This is yet another issue that the ASHAs from Langol Tarung highlighted *"Many times, the gates would also not open for us. We had to shout out from outside the gates at times, to communicate with people".* In such circumstances of difficulty in access, facilitating vaccination emerged as a bigger challenge.

Many studies and experiences shared by ASHAs highlighted the difficulties encountered in conducting vaccination campaigns in remote areas particularly the hilly regions with limited access and facilities (Agarwala, et.al., 2022). Health care workers had to rely on the ASHAs of the particular area, in arranging vaccination camps in the inaccessible areas where vaccination teams were not able to reach out to the people for vaccination.

The work undertaken by community health workers becomes even more visible while talking to a beneficiary who received help from ASHAs during COVID-19. Of the numerous beneficiaries that the ASHAs helped, some were interviewed for the report. The insights received from these discussions reinforce the importance of these grassroots soldiers. A beneficiary from Madhya Pradesh went on to speak about ASHAs in getting vaccination to the people. She said,

> *"There was a general fear among people around the vaccine. Many thought that the vaccine would impact their health adversely. ASHAs pursued us to go ahead and get vaccinated. By the time people under 18 had started to be vaccinated, fears and myths around vaccination had been dispelled to a large extent. This is why the drive was easier in the subsequent stages."*

ASHAs have a lion's share in breaking the wall between COVID-19 vaccination and the community members. If the initial work in countering hesitancy at the grassroots level was not done as efficiently as the ASHAs did, the drive would not have been smooth for the subsequent age groups. While there was a social stigma attached to health functionaries like the ASHAs working during the pandemic, initial suspicion soon turned into faith, as people started realizing the huge help that ASHAs were offering during such challenging times.

At a time when physical proximity was causing concerns in regard to the transmission of COVID-19 and stringent lockdown was implemented in the country and people were advised to limit travel movement, ASHAs continued to serve the community. They sometimes also encountered discrimination and rude behavior from people when they would want to visit households during the pandemic. It impacted workers' morale and affected them emotionally.

ASHAs also played a key role in tackling vaccine hesitancy among the pregnant women once the COVID-19 vaccine was approved for such beneficiaries. Pregnant women from lower income households and rural areas who did not have awareness and adequate information on the vaccine were reluctant to be part of the vaccination drive conducted in the country. Major concerns were regarding the health of the babies and other stigmas related to vaccine adverse effects. ASHAs in their areas organised awareness sessions specifically for such beneficiaries which played a major role in vaccine acceptance among the pregnant women. They presented live examples of the beneficiaries who got vaccinated during pregnancy and created motivation in the community against any uncertainty related to adverse effect on the pregnant women or baby.

After countering vaccine hesitancy, the real logistical effort began for the health workers. ASHAs played a major role in helping people register for the drive. They were of particular help to the elderly, adults with co-morbidities, and vulnerable households. When the government first rolled out vaccination for certain age groups and people over 45 years with co-morbidities, ASHAs working on the ground, shouldered the responsibility of identifying the target population and getting them vaccinated. They also had a regular follow-up with the beneficiaries for any adverse effect following immunisation. Psychological counseling was also provided by the ASHA to the beneficiaries.

After the vaccination drive has covered a substantial part of the population in rural as well as urban areas, people are gradually realizing the importance of ASHAs.

Watching ASHAs work tirelessly in the community during the pandemic has instilled among people greater faith in ASHAs. Yet another ASHA from Gujarat described the change in people's attitude towards vaccination,

> *Initially there was a fear of vaccination, and we had to call people to convince and mobilise them for the campaign. However, over time, they started calling us by themselves inquiring about vaccine registration and centres.*

They were also readily available for people experiencing any adverse symptoms after the vaccination. Throughout the pandemic, health workers ensured continuum in care. This factor was crucial in allaying fears of vaccination. Knowing that health workers are accessible in case of any health concerns is a significant component in countering vaccine hesitancy and generating trust among the community.

Another beneficiary from Madhya Pradesh added, *"We didn't want to take the vaccine initially, but because ASHAs persuaded us, we had to take the vaccine. But now we realise that it was actually beneficial to us. ASHAs tried every means to communicate with us about the importance of getting vaccinated. They would speak over the phone, but when people would not get convinced, they would come to our doorstep to talk to us".* Being the community's trusted aide, they have always interacted with the community first-hand. Health functionary's closeness to the community and familiarity with the locals has been instrumental in making India's COVID-19 vaccination a success.

India's massive vaccination programme is, therefore, unique not only because of its scale and efficiency. One of its less commented upon aspects is the role frontline functionaries have played in ensuring its reach and success. In breaking taboos and hesitations, in reaching places which seemed impossible to access, in countering misinformation, gossip and malicious propaganda, these functionaries have played an exemplary role in delivering COVID-19 vaccines in the world's largest democracy.

COVID-19: A Story of **Women's Mettle and Empowerment**

> ***Women empowerment - the process by which women gain power and control over their own lives and acquire the ability to make strategic choices.***
>
> European Institute for Gender Equality

"WHO has honoured our ASHAs with Director General's 'Global health leader' award. From maternal care to vaccinations, from nutrition to cleanliness, millions of ASHAs that too in villages and remote corners are campaigning for health with zeal. From the land of Japan, I extend my heartfelt gratitude to all the ASHAs and wholeheartedly salute them"

Shri Narendra Modi,
Prime Minister of India

The Sustainable Development Goal (SDG) 5 aims to achieve gender equality and empower all women and girls by 2030. As stated in the National Policy for the Empowerment of Women (2001), the principle of gender equality is enshrined in the Indian Constitution and is a Fundamental Right. The Constitution not only grants equality to women, but also empowers the State to adopt measures of positive discrimination in favour of women. Several measures have been adopted by the Central and State governments over the past few decades to alleviate the vulnerability of women holistically, such as 'Beti padhao, beti bachao', 'Poshan Abhiyan', 'Ujjwala scheme', women's helpline, etc., and India has indeed made remarkable progress in this regard.

The introduction of the ASHAs in 2005 under the National Rural Health Mission was a milestone, not only as a boon for the health sector, but also paved the way for gender empowerment in ways never seen before. Serving as an ASHA gave women with limited educational background, particularly from rural areas, an opportunity to break the shackles of their expected norms, and build a life contributing to wellbeing of their communities.

After their appointment, the ASHAs are trained and empowered with knowledge and skills necessary for interacting with the community, promoting their health and delivering correct key information. This knowledge enables them to lead healthier lives, and contribute to societal change, while also receiving incentives for their work which further aids their financial independence. The role of ASHAs relies strongly on communication and mobility. Their duties entailed moving out of the traditionally confining spaces of their homes, working alongside male peers, contributing to the health and benefit of their communities, and in turn, receiving their respect and acceptance. Their families have also accepted the nature of their work which involves interacting with the community, local government institutions and other organisations.

The ASHA is positioned uniquely as the guardian of her community's health. She dons the role of a leader, forging collaborations, and serving as an interface between her community and the public health system. Transcending the traditional role of a woman as a caregiver for her home, the ASHAs have grown to serve as efficient and resourceful pillars of the community, familiar with the needs of every household in her neighbourhood.

As described in Chapter 2, the ASHAs play multiple roles and are involved in delivering services linked to almost every health program which is a national priority. Soon after their induction training, ASHAs are engaged in the field, and carry out extensive door to door surveys to understand the demographics of their community. Her initial role as a mobiliser for maternal and child health services such as antenatal care, immunisation and family welfare, has grown to encompass supporting patients with communicable and non-communicable diseases as well. With the changing epidemiology of disease burden in the country, the ASHAs are now helping in prevention, screening and enabling follow-up of patients with NCDs such as Diabetes, hypertension and common cancers.

Pre-pandemic, the synchronisation between the ASHA and the ANM- women supporting women, and women empowering women, was a critical factor setting the rhythm for health service delivery in the community. The pandemic has further cemented this bond between them. Together, the ASHAs have taken centre stage during the COVID-19 pandemic, and set an outstanding example of how women can work for one's community actively.

The COVID-19 pandemic came as an unprecedented crisis and rattled the systems and processes worldwide. While it adversely impacted many lives and livelihoods, there is a story of empowerment that emerges from the experiences of numerous ASHAs tackling the pandemic at the ground level. COVID-19 provided an opportunity for ASHAs to prove their mettle.

Figure 17: Empowered roles of the ASHAs

When the pandemic struck, the ASHAs were concerned about the risks posed as a result of contracting the virus. They feared for the wellbeing of their families first, and second, themselves. At the same time, their call to duty motivated them to rise to the occasion when a pandemic threatened their society. Despite the limitations of travel during the periods of restricted mobility, the ASHAs were moving around fulfilling their duties. In Manipur, unlike in villages, cities are more congested and sprawled over a larger area. ASHAs walked several kilometres in the heat to check up on people, deliver medicines and kits etc. In interviews conducted for the report, no beneficiary failed to mention the repeated visits that ASHAs made to enquire about every family member's health in each household in the area. Their selfless contribution during the pandemic gradually turned into a source of pride for their families and they started supporting her activities as well.

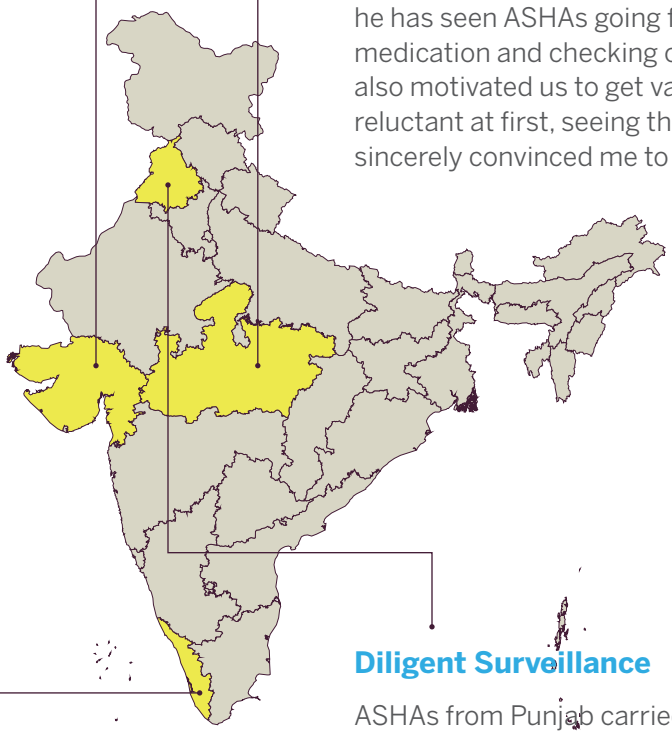
The boxes below capture an example of how the movement and presence of ASHAs.

The empowered "Bahu"

In a Village of Gujarat, newly married women who come into the village as "bahus" are enrolled in the ASHA program. She starts moving around the village, meeting people and gaining trust and acceptance from her peers in the public space. Jyotsna and Shilpa have been ASHAs since 2009 and 2011, respectively, and they have actively worked during COVID-19, ensuring that their village stays healthy.

Inspiring Presence

Dinesh, a citizen from Madhya Pradesh, recounts how he has seen ASHAs going from house to house giving medication and checking on people's health. "ASHAs also motivated us to get vaccinated. Though I was reluctant at first, seeing them out in the field working sincerely convinced me to go and get vaccinated."



Supportive Family

Ponamma Rajan's entire family contracted COVID-19, including her 65-year-old husband and grandchildren, who were 2 and 10 years old, but her family still supported her work as an ASHA. Ponamma's son used to take her around to deliver essential medicines and commodities to people in the Panchayat.

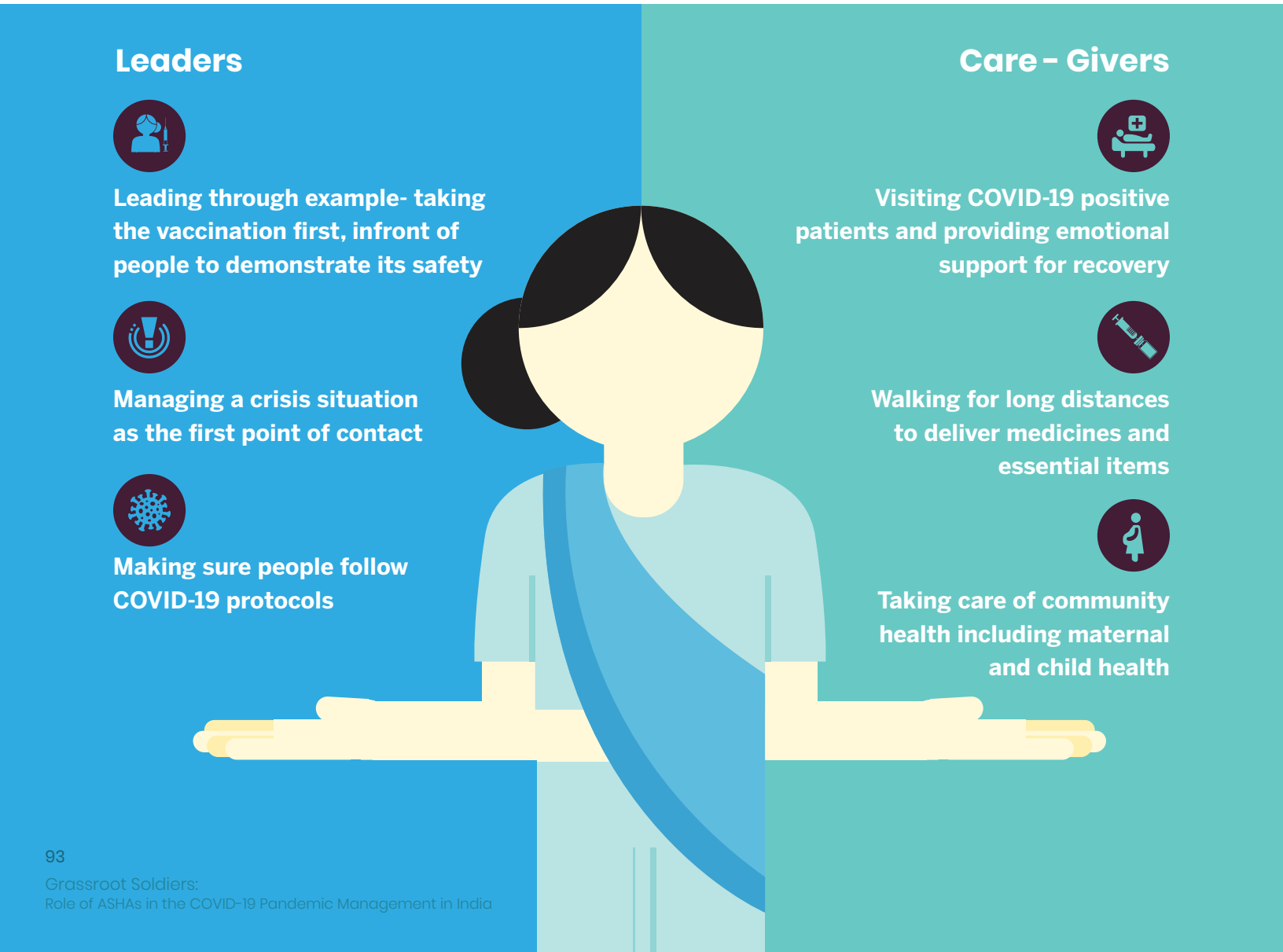
Diligent Surveillance

ASHAs from Punjab carried out careful surveillance in the community. They recall that in initial days people were annoyed and hesitant to take social distancing and wearing of masks on a serious note. "We had a hard time convincing people about the grievous nature of the pandemic. But we did not take their annoyance personally because as ASHAs we are responsible for their health and we were strictly doing our duty to the community.

Dual role of **caregiver and leader**

ASHAs are the first to receive a call if someone in the community is unwell, if someone in the village spiked a fever or needs to get an RTPCR test. ASHAs are accessible and approachable leaders in the community, and when the community called upon them to help, they responded without a regard for the time of the day. As trusted leaders and community representatives, the instructions of ASHAs are taken as final. They diligently surveyed the community to ensure everyone followed COVID-19 protocols like wearing masks, washing hands and social distancing. Families contact their designated ASHAs just like calling a family member and trust their word for health care and treatment. This was evident when we interviewed a beneficiary from Baramulla, UT of Jammu and Kashmir, and he told us how for the first time, he started sweeping his room and sanitising his space on the instructions of ASHA Ranjana.

Figure 18: ASHAs are both leaders and caregivers, present and accessible to the people, thereby reinventing the image of a leader.



As empathetic caregivers, ASHAs have redefined the meaning and image of a leader. An ASHA is caring and embedded in her community while also assertively guarding the health care system. In all the interviews conducted for the report, ASHAs were emotional and rooted in their experience. There was a sense of total commitment to their work and communities, without any biases. The ASHAs are aware of the social relationships, their dynamics and how it shapes them as leaders. This familiarity and empathy are precisely what sets the leadership style of ASHAs apart from the rest. This is a strength and a superior moral virtue which needs to be recognised. It is a leadership infused with care ethics to efficiently manage perhaps one of humanity's biggest challenges. This is undoubtedly a tale of women's empowerment manifesting as exemplary leadership.

Empowerment through partnership: An ASHA does not work in isolation. She receives support from the primary health care team at SHC-HWC comprising of CHOs and ANMs, ASHA Facilitators as well as from the community. She is resourceful and works in close collaboration with institutions like Panchayat, police, civil society organisations and citizens in the performance of her daily activities. Civil society organisations approach ASHAs to tap into the connections and trust of an ASHA to improve their reach. At the same time, ASHAs are also aware of various actors in the community and their role in the system. For example, Ponamma Rajan from Kumily immediately called The Red Cross to help provide supplies to a household that urgently needed groceries and food. In turn, when the Red Cross distributed COVID-19 kits for eligible people, the police directly approached ASHAs to identify which households required the kit. Therefore, ASHAs are critical pillars in the local governance system. ASHAs also leverage other institutions like Self Help Groups, Village Health Sanitation and Nutrition Committees, Mahila Arogya Samitis, and other peripheral health workers like ANMs and Anganwadi workers.

Repository of Trust: ASHAs are also empowered through the trust they receive from the community.

ASHAs are empowered communicators because they are women whose voices are heard and respected. Everyone in the community equally abides by the guidelines given by their ASHA and trusts their leadership for a full recovery. Therefore, making of an ASHA is a tale of leadership and empowerment suited for the changing times. During COVID-19, the frontline workers did not distinguish between "us" and "them". The Medical Officer from UT of Jammu and Kashmir Dr Rajat recalls that even during periods of mobility restrictions, all the ASHAs used to show up for work on time and do their duties diligently. They were selfless in serving the community while being cautious, wearing protective gear and taking care of themselves. ASHAs are empowered leaders empowering their community by guarding the overall health of everyone in their designated area of work.

Passion driving **motivation & efficiency**

Women from different walks of life felt a shift in their roles and responsibilities during the pandemic. Frontline health workers were no exception. In fact, their role widened substantially, covering both their routine work and COVID-19-related responsibilities. Their struggles were not just limited to the work front, many faced pressure on the family front as well. Overcoming challenges from multiple quarters was nothing short of a feat. Female frontline workers had to shoulder the added responsibility of domestic work along with extra hours at work. The motivation among ASHAs is evident from the discussions and makes for many inspiring stories. Multiple ASHAs mentioned the immense stress they underwent during the lockdown. Despite the pressure and fears, they kept on persevering and tapped into their inner strength to be able to work under duress. An ASHA from Manipur voiced her opinion when asked about how she coped with stress during COVID-19.

"How could we leave the field especially after seeing all the difficulties? We were chosen to serve the society and now when the society needs us, where will we go and run away? Even if we have to die or live, we cannot leave our work. Even if that meant isolating ourselves from family".

Leading by example:

After the introduction of the COVID-19 vaccination program, countering vaccine hesitancy was a substantial hurdle that health care workers faced. As elaborated in the previous section, despite the heavy work pressure, frontline workers left no stone unturned to motivate people. Convincing people, dispelling myths around vaccination, and helping with the logistics of vaccination, was not a minor task. It required immense motivation on part of the grassroot workers as it took relentless persuasion to make the vaccination campaign a success. They led by example, by getting vaccinated first so people with vaccine hesitancy could see and believe the benefits of vaccination.

Each ASHA is an inspiration in herself. There are some stories, like that of ASHA Annapurna from Karnataka, which stands out as a transformational story. She has been working in Shivamogga, Karnataka since 2017, covering a population of 3000. Her story in her own words is one of immense courage and inspiration. Annapurna has cleared her 12th grade examination. She is also a Bharatnatyam dancer. When asked what motivated her to join the ASHA programme despite her educational qualification and her skills as a Bharatnatyam dancer, she said,

"My mother is bed-ridden and I have a baby to take care of as well. I couldn't take care of them in any other job. When I am doing my field work as an ASHA, I can visit my house every now and then to visit them. I joined the programme for this reason".

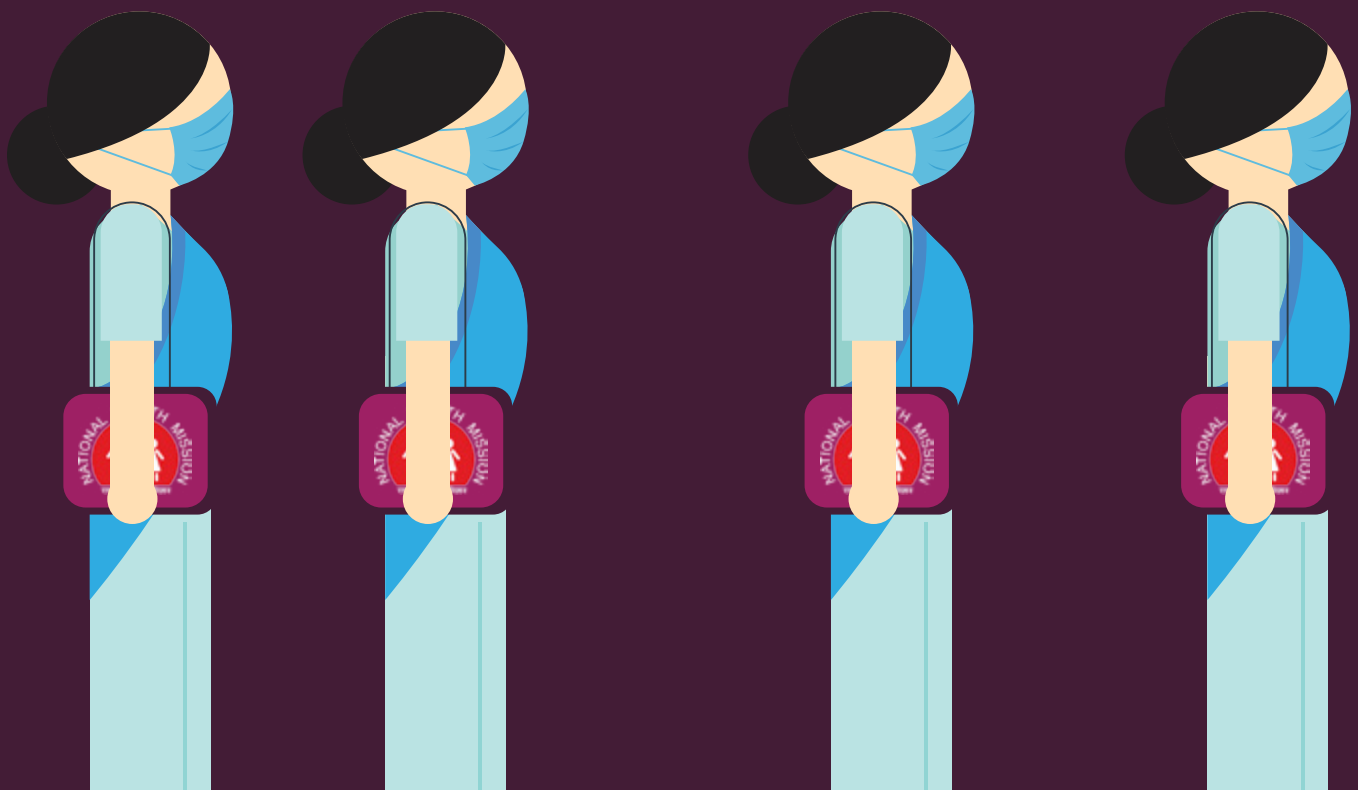
She goes on to recount her days working during the pandemic.

"During COVID-19, we faced issues when people would not be honest about their travel history. We had to find out who has travelled, locate them, and alert neighbouring households. People in containment zones faced challenges availing ration. We helped them in such situations".

Annapurna also played a role in assuaging discrimination against recovered COVID-19 patients. ***"Recovered COVID-19 patients would be avoided by others which made them feel ostracised. We urged others to not discriminate against them. Additionally, migrant workers were also going through a hard time during COVID-19. We helped them get in touch with social workers. We would arrange food for them".***

When asked about how she managed to deal with the pressure during such tough times, she said,

"Whenever I was tensed, I just smiled. I made sure I smiled and talked politely with people. I would make myself calm and composed. That is how I handled most situations!".



Transforming the crisis into an opportunity for growth:

An insight into one's own potential

The lessons from this pandemic have helped functionaries on the ground and reinforced their belief in their own capability. Most ASHAs said they have gained confidence now to deal with any crisis or situation in life. Their experience during the pandemic gave them an insight into their own potential. The confidence in their tone in conversations with us spoke volumes. To quote ASHA Anju from the UT of Jammu and Kashmir, *"We are prepared to do frontline work anytime, any day. Like we tackled COVID-19, we are also ready to tackle any other disease that might come in the future though we hope it does not happen".*

Strengthening relationships

Working closely with women at the grassroots, ASHAs have created safe spaces for women to converse with each other on health-related matters. A beneficiary from Madhya Pradesh, mentioned that she calls ASHAs whenever they face any health concern, reaffirming the trust and easy accessibility of the ASHAs.

Additionally, the bond between ASHAs and ANMs is also one of mutual respect and support. ANM Ranjana from the UT of Jammu and Kashmir explained how an ANM's work eased to a great extent because of ASHAs.

United in purpose

ASHAs helping other ASHAs, and seeking help from Medical Officers and ASHA facilitators stands out as a remarkable feature of the health care ecosystem at the grassroots. It is one of the primary reasons behind the efficient functioning of the community health worker system. They understand each other's problems and work with each other accordingly. A Medical Officer from Manipur stated that she allots work to ASHAs and ANMs that she knows can be done. She said that the ask is never unreasonable. One noteworthy feature that stood out strong in the discussions with the ASHAs is how they always responded to questions by referring to themselves as *'we,'* as a collective. This reflects the strength of their collaborative spirit.

India's cadre of

1 million ASHAs

was honoured by the World Health Organisation (WHO) for their outstanding contribution to advancing global health, demonstrated leadership and commitment to regional health issues. ASHAs are now Global Leaders in the public health care system of the country. Together, the resilience of the ASHAs, ANMs and all female frontline health workers has set the benchmark for altruistic dedication in the face of a crisis, and is a source of immense pride for the nation.

06

The Way Forward

The report is an attempt to assess the role of ASHAs as frontline functionaries in COVID-19 management and their contribution as the first point of contact for the people for availing health care services in many regions. In addition to being an attempt at understanding this, the report tries to bring forth ASHAs' experiences in their own words. COVID-19 crisis has revealed the unexplored and untapped potential of frontline functionaries. This has led to a stronger and more buoyant network of ASHAs. This opportunity could be leveraged for building a strong foundation of community health functionaries for a resilient health system in the country.

Enhance opportunities: Universalisation of ASHAs

The urban areas saw an unprecedented load of COVID-19 cases which utilised the services of ASHAs for awareness generation, mobilisation for COVID-19 vaccination, and monitoring of COVID-19 cases. As per the NUHM framework of 2014, ASHA are selected in the slum/slum-like areas, pockets of vulnerable population only. ASHAs played a critical role even in other areas of the town and cities. In fact, COVID-19 prevalence was high in non-slum areas including apartment complexes. The newfound respect for ASHAs amongst all people and the obvious need for public health action in all areas irrespective of the socio-economic status provides an opportunity for ASHAs to be selected and positioned in all urban areas instead of limiting ASHA selection to slum and slum like areas. This would enhance opportunities for more women to get engaged as ASHAs and would universalise positioning ASHAs amongst urban populations.

Leverage capacity to strengthen existing initiatives

The ASHAs have assuredly emerged as the grassroots soldiers, leading from the front. The learnings from the pandemic have helped understand the true potential of ASHAs. Leveraging capacities of ASHAs to comprehensively address a plethora of health issues grappling the country is undoubtedly the way forward.

Building on the already empowered ASHAs, she is now better prepared to undertake decisions at the local level. Many states and UTs still do not have ASHAs as the member secretary of the VHSNCs. Now the time is ripe to mandate all States/UT to recognise ASHAs as the member secretary of Village Health Nutrition and Sanitation Committee (VHNSC) in rural areas and member secretary of the ward level health committees in urban areas. This provides her an opportunity to focus on social and environmental determinants of health.

Easing of her job by leveraging technology

Technology can be a powerful enabling tool for ASHAs. Currently, her boosted self-confidence provides an opportunity to educate and empower her with technology tools which lightens her tasks while enhancing quality and timeliness of her outputs. A significant number of ASHAs have been provided smartphones and they have used smartphone technology for disseminating information during the pandemic. Upskilling ASHAs with technology can improve efficiency, transparency, and coverage of primary health care services in the country.

Consolidate ASHA as a voice of the community

ASHAs are to be a representative of the community in the health system voicing the communities needs and aspirations. The misconception amongst many that ASHA is the last rung of health care provider is to be eliminated. ASHAs heightened self-esteem following pandemic work should revive her role as social health activist. This would truly help ASHAs to be the voice of the community in the health system, raised trust of people in the public health system and fostering accountability of the system to the people.

Enhance security

The pandemic highlighted the importance of personal safety of community health functionaries in responding to a crisis. As recommended by WHO (Health System Resilience Toolkit), institutionalizing mechanisms for occupational health, safety, and well-being of health functionaries in all contexts is important. Relevant infection prevention and control measures (including personal

protective equipment), manageable workload, and mental health support, should be a priority in the country. The Personal Protective Equipment (PPE) is to be an integral component of ASHA kit. Enhanced tasks per household will augment task incentives for ASHA's. Further, the expanded range of services as envisaged under the AB-HWC program can now be expeditiously rolled out enabling both comprehensiveness in home-and community level care and enhancement of opportunities for task incentive for ASHA. Additionally, institutionalised mechanisms are required for supporting capacity development of ASHAs to seek career progression to other cadres like ANM, Nurse, etc.

Whole of Government approach

Frontline functionaries have demonstrated through example as to how they are the linchpin of India's public health in the good times and the bad times. To sustain the various efforts across India's public health care system, coordination between primary, secondary, and tertiary health care is important. However, it is equally essential to facilitate a whole of government approach by improving the community's literacy, physical infrastructure and access to basic services at the grassroots level. Harmonising policies through inter-departmental coordination is the way forward for India to achieve its health targets and overall development.

Though the pandemic stretched India's health system to the limit, it also manifested untapped potential of the 1 million ASHAs in the country and created both hope and aspiration. The onus is now on all of us to further strengthen the ASHA program while evolving a resilient health system in the country.

References

Ahmad (2016). For female health workers in India, a new digital tool puts data at their fingertips. UNICEF.

Annual ASHA Update (2020-21).

Annual ASHA Update (2017).

Baavanthappu BT. Essentials of Community Health Nursing. 1st ed. New Delhi: Jaypee Brothers Publishers; 1998. p. 684-93.

Background of ASHA Concept, Role & Responsibilities of ASHA, Selection Criteria for ASHA, Removal Criteria for ASHA and Institutional Arrangements for ASHA.

Ballard, M. et al. (2020), "Prioritising the role of community health workers in the COVID-19 response", BMJ Global Health, Vol. 5/e002550, http://dx.doi.org/10.1136/bmjgh-2020-002550.

Behan Box (2021). Female Frontline Community Health care Workforce in India during COVID-19.

Bhatia, K. (2014). Community health worker programs in India: a rights-based review. Perspectives in Public Health, 134(5), 276–282. doi:10.1177/1757913914543446.

Bishai DM, Cohen R, Alfonso YN, Adam T, Kuruvilla S, Schweitzer J (2016) Factors Contributing to Maternal and Child Mortality Reductions in 146 Low- and Middle-Income Countries between 1990 and 2010. PLoS ONE 11(1): e0144908. https://doi.org/10.1371/journal.pone.0144908.

Chokshi, M., Patil, B., Khanna, R., Neogi, S. B., Sharma, J., Paul, V. K., & Zodpey, S. (2016). Health systems in India. Journal of perinatology : official journal of the California Perinatal Association, 36(s3), S9–S12. https://doi.org/10.1038/jp.2016.184.

Cumulative COVID-19 Vaccination Report, MOHFW.

Development of Community Health. Available from: https://www.egyankosh.ac.in/bitstream/123456789/34288/1/Unit 1.pdf.

Directorate General of Health Services Ministry of Health and Family Welfare Government of India. (2012). Indian Public Health Standards (IPHS): Guidelines for Sub Centres. NRHM.

Elston, J. W. T., Cartwright, C., Ndumbi, P., & Wright, J. (2017). The health impact of the 2014–15 Ebola outbreak. Public Health, 143, 60-70.

Guidelines for enhancing performance of Multipupose worker (female). NHM. MoHFW.

Iyer Kavitha. (2021). Remote Tribal Village Shows How to Fight Vaccine Hesitancy. Indiaspend. https://www.indiaspend.com/covid-19/remote-tribal-village-shows-how-to-fight-vaccine-hesitancy-753840.

Jain, V., Iyengar, K., Samy, D., Vaishya, R. (2020). Tuberculosis in the era of COVID-19 in India. Diabetes & Metabolic Syndrome: Clinical Research & Reviews.

Khandekar & Mane (2014). Strengthening Primary Health Care Through Asha Workers: A Novel Approach in India.

Kumari, A., Mahey, R., Kachhawa, G., Kumari, R., Bhatla, N. (2022) Knowledge, attitude, perceptions, and concerns of pregnant and lactating women regarding COVID-19 vaccination: A cross-sectional survey of 313 participants from a tertiary care centre of North India. Diabetes & Metabolic Syndrome: Clinical Research & ReviewsWHO. (2022). India marks one year of COVID-19 vaccination.

Ministry of Health and Family Welfare Statistics Division (2018-19). Rural Health Statistics. NRHM.

Ministry of Health and Family Welfare Statistics Division (2019-20). Rural Health Statistics. NRHM.

MoHFW (2020) Chasing the Virus: A Public Health Response to the COVID-19 Pandemic.

NHM (2010-11). ASHA – Which way forward? Evaluation of ASHA Programme.

NHM Guidelines. Guidelines: Accredited Social Health Activist (ASHA).

NHM Portal, Ministry of Health and Family Welfare, Government of India.

Niyati S and Mandela Nelson. (2020). Impact of the Pandemic on Accredited Social Health Activists (ASHA) in India. Review of Agrarian Studies Vol 10.

OECD. (2021). Strengthening the frontline: How primary health care helps health systems adapt during the COVID-19 pandemic.

Sarwal Rakesh., Kumar Anurag (2020). The Long Road to Universal Health Coverage. The Indian Express.

Tulchinsky, T. H., & Varavikova, E. A. (2014). A History of Public Health. The New Public Health, 1–42. https://doi.org/10.1016/B978-0-12-415766-8.00001-X

Note: All images used in the report are for representation purposes only

Institute for Competitiveness, India (IFC) is the Indian knot in the global network of the Institute for Strategy and Competitiveness at Harvard Business School. IFC India is an international initiative dedicated to the enlarging and purposeful dissemination of the body of research and knowledge on competition and strategy, as pioneered over the last 25 years by Professor Michael Porter of the Institute for Strategy and Competitiveness at Harvard Business School. Institute for Competitiveness, India conducts and supports indigenous research, offers academic and executive courses, provides advisory services to the corporate and government sectors, and organises events. The institute studies competition and its implications for company strategy; the competitiveness of nations, regions, and cities and thus, generates guidelines for businesses and those in governance and suggests and provides solutions to socio-economic problems.

• • •

www.competitiveness.in

The Institute for Competitiveness

U24/8, U-24 Road, U Block, DLF Phase 3, Sector 24, Gurugram, Haryana 122022 info@competitiveness.in | www.competitiveness.in

National Health Systems Resource Centre (NHSRC) established in 2007 serves as an apex body for technical assistance to the Ministry of Health and Family Welfare (MoHFW), Government of India. Its mandate is to provide policy advice to MoHFW and State Governments, assist in strategy development to improve health outcomes, by facilitating governance reform, health systems innovations and improved information sharing among all stakeholders at the national, state, district and sub-district. It is actively involved in capacity development of States, monitoring and evaluation of health programs to realise National Health Mission goals.

The organisation has been the focal point for the ASHA program in the ministry and has been instrumental in rolling it out successfully in the States and UTs. NHSRC has been instrumental in conceptualizing and defining Ayushman Bharat – Health and Wellness Centres (AB – HWCs), National Quality Assurance programme, Indian Public Health Standards, guidance on Management of Human Resource for Health, Biomedical Equipment Management and Maintenance Program (BMMP), National Health Accounts etc and in supporting MoHFW in annual activities like Common Review Mission and Innovation summits.

NHSRC is the premier institution for all aspects of Health Systems Strengthening, evidence generation and has partnerships with several stakeholders in this field.

• • •

National Health Systems Resource Centre

Baba Gangnath Marg, Munirka,
New Delhi 110067
Email: nhsrc.india@gmail.com | www.nhsrcindia.org