

Healthcare through Community Participation

Role of ASHAs

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This study of the operation of the Accredited Social Health Activist programme of the National Rural Health Mission in one of the tribal blocks of Thane district in Maharashtra finds that incentives given to ASHAs generate a bias in their work activities and shift the attention of these community health workers from the community to the health services system. Moreover, the poor socio-economic background of ASHAs makes them depend on the incentives offered since this is their main source of income. Additionally, due to the excessive focus of ASHAs on curative care, the community considers them more an extended arm of the health service system, not as change agents as envisaged in the programme.

India has witnessed several phases of the community health worker (CHW) programme since Independence. The Accredited Social Health Activist (ASHA) – the flagship programme under the National Rural Health Mission (NRHM) – is the latest of its kind that is operational throughout the country. The Mitandin, one of the state-level initiatives, was scaled up as the ASHA programme similar to the earlier experiences of the government with CHW programmes that had its origin in the non-governmental organisation (NGO) sector. Despite the fact that the characteristics of CHWs were not uniform, certain commonalities were found in terms of its conceptualisation and its implementation. The two important characteristics of the CHW programme observed across various countries are its ability to generate community participation, thereby making health a priority which motivates the community to access healthcare. The present study was carried out in one of the tribal blocks of Thane district of Maharashtra. The programme was launched in 2007 in this tribal block and the data was collected in 2009. This article evaluates the performance of ASHAs in the community and examines whether or not they could generate community participation. This was accomplished by examining the current functioning of the ASHA programme in the block in terms of work activities of ASHAs, incentive structure and its relationship with motivation along with the general acceptance of ASHAs in the community.

CHW and Primary Health Care

The concept of CHW, according to Rifkin (2008), is a term used to refer to a person who lives and works closely with the community on health-related issues like

health education, providing healthcare, and so on. Though the term was used diversely during the initial stages of the programme, by the 1980s it had achieved a universal global concept (Walt 1988). Moreover, the success of the CHW inspired the Alma Ata conference of 1978, where primary health care was declared as the key to achieve health for all by 2000 AD. Thus, the idea of community participation, one of the principles of primary health care also became a characteristic of CHW programme across the world. The relationship between primary health care and the CHW scheme achieves significance in the Indian context not only due to the chronological coincidence, but also due to the accommodative space the CHW scheme could gain within the health services system. Scholars attribute the additional impetus that the CHW scheme gained within the Indian health services system to the success of the multipurpose worker (MPW) programme (Maru 1983), which for the first time was able to cover the larger population of the country with some form of healthcare.

Similar to the initial debates on operationalisation of primary health care, concerns were also raised on the actual implementation of the CHW scheme. This, according to Rifkin (2008: 773), revolves around two issues: first, those related to the technical aspects, namely, training, tasks, competencies, payment, support and supervision. The second aspect addresses the scope of CHWs becoming “agents of change” or whether their work activities get caught within the existing socio-economic and political structures. More important is the extent of community acceptance they could generate. The road blocks for the accomplishment of community participation through the CHW programme is further elaborated by Rifkin (2009) by identifying three factors. First, the dominance of the biomedical paradigm that conceptualises community participation as one of the interventions, thereby failing to capture the concept in its totality. Second is the fact that, in situations where the shortage of person power is tremendous, the chances of utilising the CHW for

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extending health services interventions become an easy option. The third is the capacity of participation to address the felt need of the community as well as address the issues of empowerment, leadership and compassion. Here the dynamics of the community that is embedded in the historical, social and cultural evolution of the community becomes pertinent and a challenging task to understand.

CHWs in India

The main feature of CHWs in India is that they are from the local community who serve their own community and are selected by the community. Despite the consideration that the role of CHWs are supplemental to the health services, a lot of questions were raised on the adequacy of the involvement of the community in selection, dispersal of honorarium as well as monitoring the work of the volunteers (Maru 1983). This is because the work of the CHWs falls between the realm of health services system and the community, skewing towards the former and not necessarily as a link between the two as it is ideally envisaged. It is precisely the inadequacy of the link that has led to the continued debate on whether the community health volunteers can be mere volunteers or paid employees, and if paid then by whom and with what level of administrative control (Walt 1988). This question was most relevant when it was found that CHWs largely act as extension of health services rather than as change agents for community development (Maru 1983).

Along with the government level CHW programme, it is important to briefly look at three successful experiences of CHWs in the country, namely, the comprehensive rural health project (CRHP), Jamkhed, Maharashtra, comprehensive health and development project (CHDP), Pachod in Maharashtra and the Mitani programme, Chhattisgarh. The first two are successful NGO experiences that have tremendously influenced the CHW scheme in India during the 1970s and the third is a government level programme in Chhattisgarh that became the basis for the current programme on ASHA under the NRHM.

CRHP, Jamkhed

CRHP of Jamkhed started by Raj and Mabelle Arole in 1970 was planned with the objective of providing total healthcare to the community by integrating preventive, promotive and curative care with the participation of the community. Village health workers (VHWs) were selected from among middle-aged women who were active, well-motivated, respected members and interested in offering their services to solve simple health-related illnesses within the community. The incentive for the VHWs was not money, but the job satisfaction they received from their usual work of 3-4 hours in the morning and couple of hours in the evening. Each VHW was given an honorarium of Rs 30 a month. The VHWs covered the population effectively and provided continuous primary health care to the people whom the health professionals were not able to reach (Arole and Arole 1975).

The project approached the community by addressing their felt needs – food and water – by initiating a community kitchen and installed tube wells with the support and participation of the community (ibid). It was this support gained from the community that got translated into solving health problems through community health programmes. This was done by using the resources from within the community and activating people to identify and help solve their own health problems. CHWs and their activities became successful only within this larger context of community participation that was ensured by the NGO through several other developmental activities in the community. These developmental activities ranged from provision of tube wells, soil and water conservation, afforestation, loans for income-generation activities, and so on (Arole 1993).

CHDP, Pachod

CHDP of Pachod was started in 1977 and covered 72 villages and hamlets situated in the southern part of Paithan block of Aurangabad district, Maharashtra. As identified by scholars elsewhere (Rifkin 2009), here too health was only the 11th priority for the villagers when the project started. Within health services, the major

focus area was on maternal health as it was the only instance when immediate medical help was felt as a necessity by the villagers. The CHW programmes thus started equipping the workers by rendering special training for midwifery skills. The response was not good initially when it was found that villagers sought help from the village dais than from the CHWs during emergencies despite the training, skills and knowledge the latter had (Dyalchand and Soni 1983). Thus, before implementing the CHW project, training was provided to village dais who then worked in the villages. Their services were utilised by the villagers effectively. Subsequently, CHWs started complementing the work of dais by organising health education, immunisation camps and collecting natal information, thereby supporting the activities of traditional birth attendants (TBAs).

Consequently, CHWs became the key for implementing any health activity in villages where the strategy was to identify the felt needs of the community and work towards addressing them on a regular basis. The felt needs of the community addressed by the CHWs included problems due to malnutrition, the programme on safe water supply using hand pumps and the education of children in the project villages. The role of CHWs in accomplishing inter-sectoral development within the project villages became mutually enriching and empowering which would have led to the success and sustainability of the Pachod experience. It is obvious that the success of a programme is determined by its capacity to address the felt needs of the community through an inter-sectoral approach.

Mitanins of Chhattisgarh

Another landmark CHW programme in recent years has been the Mitani programme of Chhattisgarh which was started in 2002. Learning from the experiences of the earlier large-scale programmes, the Mitani programme was based on community selection, wherein the selected facilitators ensured that the community made an informed choice and that the voices of the weaker sections were also heard in this process. Further, to prevent any mitanins becoming

registered medical practitioners (RMPS) or illegal curative care providers, curative care was given only a supplemental position in the programme, thereby encouraging preventive and promotive role of the CHWs. However, no incentives or honorarium were paid to CHWs in the first three years of the programme, thus, bringing about participation only through motivation and support. More importance was given to the initiative to strengthen the public health system, alongside creating awareness about the health services system as this can lead to acknowledgement of one's entitlement, thus, ensuring the basic human right (PHRN 2007).

The two successful experiences of the NGO mentioned above reveal that the village health workers, by addressing the felt need of the community, were able to obtain a significant acceptance of the community. The sustainability of the programme was possible due to the comprehensive approach of development that was predominant.

The greater acceptance by the community has ensured voluntarism, which is obvious from their self-motivation and job satisfaction and not through the honorarium provided to them. These are the successful examples where the community has used its own resources effectively and helped to solve its own problems. Even though CHWs worked as an extension of the primary health care services, they were self-motivated, enthusiastic, accountable and played a very important role in overall development of the community.

In the Mitanin programme, the major involvement of the community is during the selection process and subsequent activities like training, referral or monitoring, which, in turn, depend on the existing public health system. Regarding the affiliation of CHWs, one can see a departure from the community to the health services system, due to the fact that the process of formalisation becomes easier when attached to formal structures. This could be one factor that was

overlooked in the debates on honorarium and its relationship to motivation that finally resulted in the adoption of the "performance based payment system" as practised in the programme of ASHAs (PHRN 2007: 31-33). Policymakers generally refer to CHWs as "volunteers" or "activists"; which means self-motivated persons working willingly for the development of their own community and without any expectation in monetary terms. It is this concept that got significant support that culminated in the nationwide programme of ASHA under NRHM.

ASHAs under NRHM

In 2005, to provide effective healthcare to rural population, the United Progressive Alliance government launched the NRHM under which the ASHA programme was started. The programme was initiated as an independent initiative under NRHM which has many features similar to the earlier CHW programmes. The similarities are obvious from the key components of ASHAs like the presence

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of a female health worker from the community who is selected by the community and given multiple job responsibilities. She would be provided with performance-based incentives and would be the first port of call for any health demands, with a special focus on women and children (GOI 2005).

During the design of the ASHA programme, though many of the essential features of the CHW programmes were incorporated, some of the loopholes in the large-scale programme were checked and the strengths of small-scale NGO-based programmes were incorporated (PHRN 2007). Thus, the essential features that resulted in the success of the programme were CHWs being women, selection done by the community and provided continuous training and support. However, the essential curative care is considered an important component, but it is not the only element. It is part of the empowerment process accomplished through carefully selected and motivated leadership with good quality referral support that needs to be sustained (PHRN 2007: 22). Additionally, there is provision that, the ASHA guidelines can be modified at the state level in consultation with the mentoring groups and the central government. Thus, in totality, the programme of ASHAs under the NRHM is a modification of the earlier CHW scheme with the introduction of honorarium and incentives attached to various activities with the responsibility of disbursement given to the health services system. In this context, it is interesting to see how ASHAs differ in terms of their work and to what extent the ASHAs avoid the pitfalls of the earlier CHW scheme in India.

The Study

The data for the present paper is from a larger study on ASHAs carried out in one of the tribal blocks of Thane district of Maharashtra, where the ASHA scheme has been implemented since 2007. It covers various aspects in the process of selection, training, work responsibilities and job satisfaction within the context of the support systems that are provided. Information pertaining to work activities is used here. The study area is a tribal, hilly and one of the underdeveloped

blocks of the Thane district which has a majority tribal population. The villages of this block are scattered all over the hilly region. In many villages there are no roads developed by the government. The main occupation of the villagers is subsistence farming. The majority of the local tribal population falls in the below poverty line (BPL) category.

There were 219 ASHAs working in the tribal block under four primary health care centres (PHCs) at the time of our survey. Out of them, a sample of 40 ASHAs were selected by using probability proportionate to size (PPS) method (Table 1). This was possible because the lists of ASHAs were available with respect to the PHCs under which they worked. Here, it is important to note that though the selection of ASHAs is expected to happen within the community, in actual situations they are attached to the PHCs working in the area. This is obvious from the list of ASHAs maintained by the PHCs which thus becoming custodians of the names as well as the territory of their work. In other words, instead of ASHAs seen as a person working in the community, they are always seen as the lower level staff of the health services system. After finalising the exact number of the ASHAs to be selected under each PHC, the ASHAs were selected by simple random sampling method.

Table 1: Selection of ASHAs from Each PHC Area

PHC	No of ASHAs Working	No of ASHAs Selected for the Study
PHC 1	60	11
PHC 2	32	6
PHC 3	70	13
PHC 4	57	10
Total	219	40

The main information used for this study is collected from the ASHAs working in this block. A structured interview schedule was used to collect information from the ASHAs. All the respondents were interviewed by the face-to-face interview method. The data was collected on socio-economic background, common work activities of the ASHAs and problems faced while working in the community. Besides, incentives earned by ASHAs and its relationship with motivation for work and reasons for becoming an ASHA were also looked into. The information was

supplemented by informal discussions from various community members as well as healthcare professionals working in the same community.

Incentivising for What?

One of the most divisive issues of any CHW programme design is that of an honorarium. As the CHWs are seen as supplemental to government health services, they are not provided with any fixed monthly salary, and instead, provided an honorarium. One of the explanations for giving an honorarium is to compensate for the livelihood loss due to the time devoted for that specific work. Besides, there are arguments that without monetary support, it is impossible to ensure participation of women as well as sustain their participation, as a larger number of dropouts will hamper the spirit of the programme (PHRN 2007). On the other hand, there are arguments that the meagre amount that is paid is not sufficient for their livelihood. The final argument is that the very term “volunteer” or “activist” that is ingrained in the CHW programme or ASHA conveys the sense of belongingness to the community and when it becomes “paid”, the patronage will be shifted from the community to those who pay, usually the health services system (ibid).

To understand this relationship, in this study the ASHAs were asked questions pertaining to their daily work activities. On an average, ASHAs work 4.9 days a week and spent around one and half hours in a day for various activities. The various activities ASHAs carry out include providing drugs, counselling, referring patients, helping auxiliary nurse midwife/anganwadi worker (ANM/AWW), helping health assistant/lady health visitor (HA/LHV), maintaining patient records, conducting community meetings and so on. Further, based on the NRHM guideline, questions were asked to ASHAs to list their common activities. Here it is interesting to note that all the respondents included referral of the patients to the nearest health facility as their common work activity, with 95% including distribution of drugs in their common activity list, whereas 87.5% included maintaining records within their common activity.

Seventy-five per cent of the ASHAs said that helping health professionals is also one of their common activities. Only eight out of 40 respectively had included counselling and two listed conducting meetings as their common activity. Further, it has been found that out of those 40 ASHAs, who said referral to health facility was their common activity, 34 ASHAs (85%) have responded that the referral of the pregnancy case is their common type of referral. This when examined in the context of the incentive structure prevalent for various activities in the block reveals that the maximum incentive (Rs 600 per case of referral) given to ASHAs is for the referral of pregnant woman to a healthcare facility (GOM 2008a).

As the largest amount of incentives is for referral of pregnancy cases, ASHAs are predominantly referring such cases. When examined from the point of view of the ASHAs, it has been found that majority of the ASHAs consider pregnancy cases as their main source of earning. This was obvious from one of the ASHAs' comments that "if there is no case of delivery, in the community, there is no income". Also, some ASHAs were of the view that if the community is a small one, then it is not worthwhile to work as an ASHA. On further probing, the reason mentioned was that there could be very few pregnancy cases and so too other

diseases, and therefore they have very poor earnings. In one of the ASHAs words, "if the hamlet is small, and there are no pregnancy cases, then there is no income for an ASHA". Some of the ASHAs complained that there are no incentives provided for certain activities like providing drugs to the community and assisting PHC staff during their field visits.

The above findings establish a strong relationship between the incentives and the performance of ASHAs. Here, it has to be noted that the larger incentives in pregnancies motivates ASHAs to refer these cases compared to other referrals. ASHAs see incentives as their main source of income. This picture will become clearer if we take a look at their socio-economic background.

Incentives

Data was collected on the socio-economic profile of ASHAs selected for the study. "Subsistence farming" is the main family occupation for a majority of the ASHAs. The average annual household income was found to be Rs 12,800. When set against the Government of Maharashtra's BPL category of those with an annual household income of less than Rs 15,000, it was found that 32 out of 40 ASHAs fell in this category. When asked about the reasons for working as ASHAs, 37 ASHAs responded that they joined the scheme to support their families financially. As

these women do not have any source of income other than agricultural activities, they see the ASHA programme as a means of financial support to their families.

As the study reveals, ASHAs are seeing incentives as their major source of income, neither as a motivating factor for their loss of livelihood nor as a case for inner motivation and willingness to work as was conceptualised in the programme. The poor socio-economic background of rural women is an important factor that resulted in them opting for being ASHAs. Here, it is highly possible that the value attached to each activity by the ASHAs will be based on the kind of incentives offered. This could be the reason why the incentive structure for ASHAs has generated a kind of bias in the work activities. This bias in the work activities of the ASHAs due to the targeted incentive structure has defeated the whole purpose of bringing ASHAs as health workers to address the health needs of the community. Ideally, ASHAs are portrayed as the first port of call for any and every health-care need of the community, irrespective of the type of health problem.

Here it has to be noted that on the one hand, the whole concept of the "volunteer" or "activist" emphasises working for the community without any expectations in terms of monetary benefits. It is from this perspective that CHWs and their work need to be analysed. Successful

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CHWs always have a community orientation and belongingness and are not necessarily driven by the incentives/honorarium that is paid. Even the honorarium paid is not influencing their work activities or their performance as an incentive does. While designing the ASHA programme, this “activist” concept has been adopted by the policymakers; which is also partially adopted from mitanin programme of Chhattisgarh, where initially no honorarium was provided (PHRN 2007). Here the money that is paid as incentive to ASHAs is an indication of the administrative locus of control lying within the health services system. In short, there is a contradiction between being an activist and working in a “performance based incentive system”. One of the arguments against regularising ASHAs by providing salaries and other employee benefits similar to other health professionals is that if they are given the benefits and assurance then they will not perform. Instead of strengthening the existing monitoring system of health services system, it is unfair to attribute the “security” of a permanent employee as a reason for non-performance. The activities ASHAs do as part of their roles and responsibilities focus predominantly on health services-related activities. This will gradually nullify the “communitisation” activities of ASHAs, thereby becoming one more extended arm of the health services. The process has already begun which is obvious from the other important activities of ASHAs.

Predominance of ‘Curative’ Role

ASHA workers are given multiple job responsibilities like creating awareness about the determinants of health, counselling the community, referring patients to the nearest health facility, and providing drugs to cure primary illnesses (Goi 2005). As mentioned earlier, when asked about their common work activity, 38 out of the 40 ASHAs included providing drugs for minor primary illnesses as one of their activities. In addition to that, assisting ANM/MPW was included by 30 of them as their common work activities. It is significant here to note that the other work activities like counselling and arranging community meetings were

identified by only 8% and 2%, of the respondents, respectively. Through these findings, it can be clearly seen that ASHAs identify dispensing drugs to the community and helping health professionals as important activities, next to referral to health services. The importance of the work of distribution of drugs could also be due to the fact that there is a great demand for the drugs in the community. This trend shows that, ASHAs are becoming the drug providers to the community, an extension of the primary health care services. It warns us about the possibility of ASHAs turning into RMPs in the future as many of the health workers of the earlier programmes became RMPs or informal curative care provider; e.g. *jana swasthya rakshak* (PHRN 2007).

The ASHA’s role in the community is more important compared to ANMs as they belong to the community and work to address the health needs of the community on various fronts. But ASHAs tend to copy or substitute the work of ANMs. They see their role limited to being health service provider like an ANM and do not see their larger role in the community as a change agent. This could be also due to the fact that some of the “performance based incentive system” that the ASHAs receive is based on the ANM’s report, which indirectly can result in a control on the former by the latter.

The second indication of the above finding is that there is a clear shift in the type of work that is interesting and acceptable to the ASHAs in their overall work pattern. Activities like arranging community meetings and rendering counselling in the community have got less priority when compared to others like referral, drug distribution and assisting health professionals. The former require community participation and need sustained effort, whereas the latter is more of an extension of the health services. In other words, there is a domination of health service-related activities which questions the capability of ASHAs to “communitise” and become a worker who can address the needs of the community. Here it is interesting to understand the cautionary note by some of the successful

CHW programmes like the Mitanin of Chhattisgarh, where curative care was only introduced as supplemental and later in the programme, which was not central to the programme resulting in almost no mitanin becoming RMPs (PHRN 2007).

Acceptance of ASHAs

As mentioned earlier, the NRHM views the ASHA worker as an interface between the community and the health system. For the success of this ambitious large-scale CHW scheme, acceptance of these new band of CHWs from the members of various caste-class-groups of the community is essential. A good warm welcome or acceptance from the community would work as a kind of support and motivation for the ASHAs. To examine the support and acceptance of ASHAs by the community, the former were asked questions regarding the problems faced by them while working in the community. Thirty of the 40 ASHAs said they faced problems while working in the community.

The most common problems faced by the ASHAs are that the people from the community do not pay attention to the ASHAs about their health problems. Some common examples are not taking drugs regularly, women not divulging information regarding their pregnancy, women from the community not accessing the family planning operations and that dais still advise for home deliveries. If we try to look at the reasons, the majority of the ASHAs are young, newly appointed, recently married and working for a short period. So the community is not very familiar and friendly with them. The elderly women and dais find it difficult to accept their advice related to health problems. In other words, those mechanisms by which CHWs get acceptance in the community are either absent or not adequately focused in the ASHA programme. Moreover, it is not possible to consider community participation outside the class-caste-power politics of the community. Hence, it is clearly seen that various group members find it difficult to accept the advice, position and role of the ASHA in the community. Elderly women and dais have an upper hand, command and monopoly in the

community with respect to health issues like pregnancy and delivery practices and are not ready to give up this monopoly.

When asked about the meetings conducted by them in their communities, only two ASHAs had conducted meetings in the community. Moreover, those two ASHAs conducted meetings with pregnant women in the anganwadi with the help of the anganwadi workers. No community meetings involving various groups in the community were conducted by the ASHAs independently. Thus, one of the most important activities of ASHA – to create awareness about health issues and mobilising the community for health action plan – was absent. Here it is interesting to note that as nowhere do the NRHM guidelines for the ASHAs list out how ASHAs should conduct or arrange or initiate these meetings in the community. The NRHM documents and training modules talk about what is to be done for mobilising the community like conducting meetings, but do not say anything about how ASHA should approach or initiate these talks and mobilise the community (GOM 2008b and c).

The other reason behind the poor acceptance of the community is that, the ASHAs are focusing mainly on the health activities and not adequately on the overall development of the village. Due to this they have fewer stakes in the community. It is important to note at this juncture that successful CHW examples have shown how important it is to address the felt needs of the community by getting them involved and ensure long-term acceptance for the CHW within the community. In other words, scholars have identified that CHWs have a positive mandate to intervene effectively in health-related programmes by taking important initiatives in implementing other development activities in a community (Prasad and Muraleedharan 2008). “Health” should be one of the factors in the overall development of the village. ASHAs should involve themselves in the development activities other than health like in watershed development, education, food scarcity or as per the “need” of the community they are working in. This

will enable them to really “communitise” as expected in NRHM.

Conclusions

Community participation, one of the major principles of primary health care, can be accomplished in varied ways. The ASHA programme under the NRHM, based on the experiences of various CHW schemes in the country, is considered to have the potential to generate community participation through its implementation. This article examines this potential of ASHAs, based on their day-to-day work activities and acceptance within the community. It has been found that the role of incentives in the overall work activity of ASHAs has significance. This is for two reasons. First, the genesis of ASHAs in the CHW programmes and the activist embedded in the expansion of ASHA clearly gives the message of her as a worker for the community, by the community and of the community. When the idea of incentives is introduced, it is the performance-based payment system, that calls for a formal setting, whose administrative control lies within the health services system and the performance of ASHAs is then amended for achieving health-related targets. Here there is a contradiction between treating ASHAs as employees who need to achieve targets for getting their payment, but paying only a honorarium as ASHAs are viewed as volunteers from the community. This form of performance-based payment system has not only generated bias in their work activities, but also shifted the patronage of ASHAs from the community to the health services system. Moreover, the poor socio-economic background of ASHAs creates dependence on the incentives offered to them, thereby leading to bias in the work activities of ASHAs as they see incentives as their main source of income.

Due to the excessive focus of ASHAs on curative care, the community considers ASHAs more as an extended arm of the health services system and not as a change agent as envisaged in the programme. This is also because the priorities set by the ASHAs are more those of the health services system and not necessarily that of the community. In other words, there

is a failure of any specific mechanism through which ASHAs can understand the felt need of the community, thereby addressing their health needs in the given context. This has resulted in the sparse response of the community to the activities of ASHAs as they could not transcend the power dynamics in the community even after working therein. Thus, it is important to note that the ASHA programme in its current form has failed to generate community participation which raises a serious concern about the future of this CHW programme as the key for sustainability of any CHW schemes is its ability to communitise. CHWs do have tremendous potential and capacities which could strengthen the primary health care system, not by positioning its base only in the health service system but also within the community.

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