# Problems and Challenges Faced by ASHA Workers in special reference to JSY (Janani Suraksha Yojana)



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## Abstract

All people, regardless of caste, race, religion, creed, age, or gender, have a right to education and health care, according to human rights laws around the world. Even the Indian Constitution has emphasised human rights through many advantages and rights, particularly in matters like healthcare and education. It has been noted that a large portion of the population in India suffers from a variety of health issues due to a lack of adequate healthcare services. In the healthcare system, there is a lot of emphasis on the health of women and children. In India, both the infant mortality rate (IMR) and the maternal mortality rate (MMR) are higher than they are in any other nations. Since independence, the Ministry of Health and Family Welfare has taken numerous actions after realising this. It has been discovered that there is an increase in disease and mortality in rural areas when compared to metropolitan ones. The cause is that there aren't enough medical facilities and inadequate transportation options to get to urban areas in times of health emergencies like pregnancy, childbirth, severe wounds, etc. The Department of Health and Family Welfare established Primary Health Centers (PHCs) in the majority of the communities after realising this.

**Keywords:** Health Care, NRHM, ASHA, Health Centre, Janani Suraksha Yojana

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## Introduction

A fundamental component of the healthcare system is the Primary Health Center (PHC). In developing nations, the primary health centre is the fundamental structural and operational unit of public health care. In India right now, there are over 23,109 PHCs. PHCs were created to offer patients primary healthcare that is available, accessible, and inexpensive. However, due to ignorance, the majority of rural residents, particularly women and children, no longer have access to healthcare facilities. Furthermore, infections spread among kids and babies as a result of the unsanitary environment. Children in rural areas are malnourished and lack access to nutritious food, which contributes to their malnutrition. As a result, the government has placed an emphasis on nutrition, hygiene, and healthcare for rural residents, particularly for mothers, children, and babies. Thus, India was used to recruit Community Health Workers (CHWs). Community health workers (CHWs) gained notoriety after the Alma Ata Declaration, which acknowledged primary healthcare as the essential component for enhancing community health, was released in 1978. CHWs are described as members of the community by the World Health Organization, chosen by and accountable to the community they serve, supported by the health system, but with less training than professional health workers. Despite the fact that these traits highlight the underlying connections that shape a CHW's position, they vary both within and between countries in terms of their tasks and responsibilities, recruitment, training, and incentives, depending on the programme goal.

Later, in September 2004, the UPA government proposed the idea of the National Rural Health Mission (NRHM) in an effort to make access to health care services universal. The primary goal of the NRHM was to make "Primary Health Care," or the fundamental medical care, accessible to everyone. The Government of India's National

Rural Health Mission (2005–12) was introduced on April 12th, 2005. Through inter-sectoral convergence, the National Rural Health Mission aims to offer quality healthcare to the rural population, especially the most disadvantaged members of society. Numerous innovations have been implemented in the states under the National Rural Health Mission (NRHM) to efficiently deliver healthcare services. One of the main ideas in this mission was to select an ASHA (a village-level social activist) who would work to raise knowledge of health and its determinants, engage the local population in local health planning, and encourage the use of the existing health services. The functional effectiveness of the ASHA as the grassroots health activist greatly influences the achievement of the NRHM goal.

One of the key tactics outlined in this mission was the appointment of an ASHA in each village, or a village-level social activist. The functional effectiveness of the ASHA as the grassroots health activist will greatly influence if the NRHM's goal is actually realised. One of the key tactics outlined in this mission was the appointment of an ASHA at the village level in each community with 1,000 residents or more. Primary medical treatment, guidance on cleanliness and hygiene, prenatal and postnatal care, accompanying pregnant mothers to the hospital for a safe delivery, and other services were intended to be provided. The NRHM has planned for the ASHA's capacity to be built through training and motivation through performance-based compensation in order for her to carry out her duties appropriately. It was proposed that the Panchayat would select ASHA and be responsible to it. She would serve as a liaison between the neighbourhood and the public health programme. For promoting a range of primary healthcare services in general and reproductive and child health services in particular, such as universal immunisation, referral and escort services for institutional deliveries, construction of household toilets, and other healthcare interventions, ASHA would be compensated based on performance.

The National Rural Health Mission (NRHM) introduced the Accredited Social Health Activist (ASHA) in 2005, as was already mentioned. They are women who work in the community health worker programme in India. In cooperation with facility-based auxiliary nurse midwives (ANMs) and the Anganwadi worker, the main objective of the ASHA programme is to encourage the adoption of skilled birth attendance.

The foundation of the NRHM is made up of ASHA employees, who are chosen by and answerable to the village. In the rural community, they must offer preventive, promotional, and curative health facilities. In the early stages of NRHM implementation, a lot of attention was placed on enrolling and training ASHA personnel. The performance of the ASHA employee in terms of her duties and job must now be thoroughly examined. Concerns about the function and effectiveness of ASHA employees have been raised in each and every midterm evaluation of NRHM in India. Despite the various benefits and performance-based incentives, some people believe that the ASHA employees still require some type of job security. Her knowledge and practical skills related to her job obligations will be improved by the initial training and ongoing orientation sessions.



ASHA also makes prompt recommendations and offers a minimal package of curative care that is appropriate and practical for that level. The ASHAs would be compensated based on their performance in promoting household toilet building, universal immunisation, referral and escort services for reproductive and child health (RCH), and other healthcare delivery initiatives. Although the Central Government establishes broad standards for the appointment of ASHAs, each States are allowed to adopt their own models in accordance with the State's needs. The effectiveness of this initiative has a significant impact on the government's rural health programmes. The success of the government's health programmes in rural regions, especially the Janani Suraksha Yojana, is heavily reliant on ASHAs because they are the initial point of contact between the health care facility and society. The three typologies of the ASHA—as an activist, a link worker or facilitator, and a community-based health care provider—are at the centre of the discussion of the organization's role. She will give advice to expectant mothers on topics including birth preparation, the value of a safe delivery, breastfeeding and complementary feeding, immunisation, contraception, and the prevention of common infections like RTIs and STIs as well as how to take care of a small kid. ASHA will be the initial point of contact for any health-related needs of underprivileged populations,

particularly women and children who have trouble accessing health services.

The NRHM's framework highlights ASHA's role as a community health activist. She is expected to provide primary medical care with her kit, control diseases through information, education, sanitation, and surveillance, antenatal, natal, and postnatal services to women, counselling on family planning, safe abortion, child immunisation, and vitamin A supplementations, change in behaviour regarding breastfeeding, birth spacing, sex discrimination, child marriage, girls' education, care of the child in particular, household survey, and working with health organisations. According to the ASHA programme rules, ASHAs can play three different functions. First, ASHAs must act as a "link worker," a link between the health service centres and the vulnerable and rural populations. Second, ASHAs are expected to perform the role of a "service extension worker," for which they receive training and a package including supplies like condoms, oral contraceptive pills, delivery kits, and simple life-saving medications like cotrimoxazole and chloroquine. Thirdly, they are described as "community health advocates who will raise knowledge of health and its social determinants, organise the community into local health planning, and promote utilisation and accountability of the existing health services."

**Role of ASHA Workers in JSY (Janani Suraksha Yojana):**

Regardless of the location or length of the pregnancy, maternal death is defined as the death of a woman during pregnancy, delivery, or within 42 days of giving birth. According to studies, 75% of deaths are avoidable, and measures taken to address maternal mortality can also lower the number of baby deaths. The Indian Prime Minister introduced Janani Suraksha Yojana (JSY) on April 12, 2005, as a safe motherhood initiative to lower India's Maternal Mortality Rate (MMR) and Infant Mortality Rate (IMR), which is a crucial part of NRHM. With a special focus on low performing states that require proper counselling of pregnant women for the antenatal check-up, birth preparation, immunisation, and postnatal care, JSY seeks to encourage institutional deliveries among poor pregnant women in all of the states and union territories. Additionally, it aims to educate and inform them about the government of India's health-related services. The effectiveness of the government's health programmes in rural areas rests greatly on this functionary, especially the Janani Suraksha Yojana, as they serve as the first link between the health care institution and society.



The function of ASHA or another linked health professional connected to the Janani Suraksha Yojana (JSY) is to:

- Identifying pregnant women as programme beneficiaries and reporting or assisting with ANC registration.
- Where necessary, help the expectant mother obtain the required licences.
- Provide the women with and/or assist them in having at least three ANC examinations, including TT injections and IFA tablets.
- Choose a functioning government health facility or a licenced private health facility for referral and treatment.
- Legal counsel for institutional birth.
- escort the recipient ladies to the chosen medical facility and remain by her side till she is let go.
- Plan to immunise the newborn up until 14 weeks of age.
- Inform the ANM/MO about the mother's or child's birth or death.
- A post-natal visit within 7 days of birth to monitor the mother's health following delivery and to assist in arranging care, as needed.
- Encourage family planning and advocate for starting the newborn's breastfeeding within an hour of delivery and continuing it for up to three months.

**Problems and Challenges Faced:**

The ASHA employees encounter numerous issues as they carry out their duties regarding healthcare in their areas. Lack of collaboration from a variety of persons, including family members—especially the husband—who refuse to cooperate because of their higher working hours, irregular schedules, and smaller wages or honoraria. When ASHA employees were carrying out their duties to conduct surveys of Corona patients in villages and underdeveloped areas and to raise awareness about the corona virus in towns and villages during the Covid19 period, many television reports revealed that there had been widespread attacks, attempts at attacks, and abuse against them. As a result, many ASHA

employees experience various forms of threats from others while carrying out their tasks.

ASHAs are expected to handle delicate and challenging situations in the community but they are at the bottom of the hierarchy, with the fewest educational qualifications and frequently with severe class disadvantages. They must convince the populace to accept and utilise contraceptives, transport expectant mothers to hospitals during labour, immunise kids and expectant mothers, and reform many other social norms. They are meant to offer advice to women, speak to their families, and occasionally even the husband, within the community. Additionally, the public must be aware of their phone number. They are expected to show up at any hour of the day or night to assist a pregnant woman in getting to the hospital. Once the delivery has occurred, they are required to leave the medical institution on their own at any time of day or night (since hospitals have no place designated for them to rest in). It has been noted that a small number of Primary Health Centers (PHCs) lack seating or rest areas for ASHA employees, making it challenging for them to fulfil their jobs in these settings.

Although the NRHM is frequently stated as the government's flagship programme and the hundreds of thousands of women who have been mobilised and trained as ASHAs are acknowledged with a sense of great accomplishment, the government has failed in its fundamental duty as an ethical employer. The NRHM has not promised the ASHAs regular salary, suitable working conditions, workplace security, or easy access to forums where they can voice their concerns. This is unethical on the side of their employer because ASHAs are at the bottom of the national health system's hierarchy and also have complex job descriptions that are out of proportion to their pay.

The ASHA, who is regarded as a "activist," receives minor rewards occasionally for completing particular "volunteer" tasks. The Auxiliary Nurse Midwife (ANM), who was formerly the employee of the health department to provide primary healthcare to pregnant women, has had her duties transferred to the ASHA. It is now the responsibility of the ASHA to locate pregnant women, encourage them to use available services, and transport them to medical facilities when they go into labour. ASHAs receive a meagre incentive payment for their efforts. Because of this meagre compensation, the health department is unable to properly recognise the ASHA as a "employee" who is subject to its obligations, including providing fair working conditions and pay. Their needs must be respected even though they are "informal labourers" for the health department. However, the current trend is to do all it takes to stop them from demanding complete labour rights, including official employment. They receive no particular advantages for being "volunteers," and the lack of social security also extends to maternity leave, health insurance, and life insurance. Frequent strikes and protests are held as a result of these employment issues, but the government has not yet found a solution to their issues with job security, post-retirement benefits, fair compensation or honoraria, etc.



Despite the delicate nature of their duties, ASHAs are still lacking an institutional framework that takes their safety and worries into account. This illustrates the government, the employerlack ,'s of responsibility and unethical behaviour. This raises the question of whether the health department initially perceives itself as responsible for safeguarding the mobility and safety of ASHAs. Between considering them to be employees and considering them to be volunteers or activists who are largely a member of the community, there is a fine line.

Lack of support from PHC staff, lack of compensation for services other than institutional delivery, an unclear reimbursement policy that results in delayed payments, a lack of confidence in one's ability to perform the desired work, which is a reflection of inadequate training, and a lack of understanding of how to collaborate with ANMs and Anganwadi workers were challenges that the majority of ASHA workers had to deal with. Medical Officer (MO) and ANM treated ASHA as a subordinate and failed to provide them with the required supervision, mutual respect, and affection. They also failed to grasp the issues that ASHA was facing. The ASHA expressed dissatisfaction about the cases they reported to MO/ANM receiving neither acknowledgement nor priority treatment.

As was said above, it is the responsibility of ASHAs to offer advice on women's and children's healthcare. They must travel to various homes in rural, hilly, and village settings for this reason, and in an emergency, they must provide care for

women and children. It is their duty to give pregnant women and young children medicine and nutrition. ASHA staff members are required to make transportation arrangements for sick women and children from rural and distant locations to the nearest medical facilities, even in the case of medical emergencies. However, it is made clear that they only receive a meagre pay. They don't even have maternity leaves or other forms of leave. In addition to these problems, they don't have any retirement benefits. Hence, ASHAs reside in low-income households. There are undoubtedly ongoing protests and strikes to demand higher ASHA salaries and other service benefits around the nation. But up until this point, their working circumstances have not improved. Many family members, especially husbands, express their displeasure with ASHA personnel as a result of lower and irregular salary or honoraria, insufficient and irregular incentives. As a result, there are disputes, arguments, and disagreements in the families of a small number of ASHA employees.

## Conclusion

By addressing both supply-side and demand-side challenges, the NRHM envisioned the ASHA as a female community member with some medical knowledge who could connect the community to the public health care system. By educating people about the advantages of preventative healthcare and facilitating referrals and transportation to public health facilities, ASHAs were designed to increase demand for the public health system. ASHAs provided more human resources on the supply side and could deliver fundamental healthcare directly to villagers' homes. Finally, ASHAs were entrusted with organising the community to provide bottom-up accountability and monitoring to public health provision as part of their position as "activists."

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