KERALA INSTITUTE OF LABOUR & EMPLOYMENT

Enhancing Healthcare Delivery:
A Comprehensive Investigation of ASHA Workers' Activities, Challenges and Welfare Measures in Kerala

കേരള ഇൻസ്റ്റിറ്റ്യൂട്ട് ഓഫ് ലേബർ & എംപ്ലോയ്മെന്റ്

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FOREWORD

It is my privilege to present this noteworthy study, "Enhancing Health Care Delivery: A Comprehensive Investigation of ASHA Workers' Activities, Challenges, and Welfare Measures in Kerala," conducted by Kerala Institute of Labour and Employment (KILE). This study is a testament to our commitment to address crucial healthcare issues and contribute to the well-being of the community. The comprehensive investigation into the activities, challenges, and welfare measures surrounding ASHA workers in Kerala is an attempt to understand and enhance their vital role in the healthcare system. By investigating ASHA workers' activities, pinpointing challenges, and evaluating existing welfare measures, the research sheds light on areas that require attention for the betterment of healthcare providers and recipients. The recommendations emerging from this research study poised to have a meaningful impact on policy decisions, healthcare practices, and the overall effectiveness of ASHA workers in delivering essential services. These insights will be a valuable resource for policymakers, healthcare practitioners, and organisations dedicated to advancing public health. As we navigate the ever-evolving challenges in labour and employment, KILE remains steadfast in its commitment to research that brings about positive change. A special note of gratitude goes to the Research Core Committee of KILE, the Research Team, and all those involved in this study. Their dedication and expertise have been instrumental in producing a study that contributes to academic knowledge and holds practical implications for Kerala's labour and employment landscape.

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EXECUTIVE SUMMARY

Kerala's healthcare success is attributed to Accredited Social Health Activists (ASHA's), bridging the healthcare gap in local communities. They are crucial as the first point of contact for healthcare, offering education and disease surveillance. Empowering ASHA's with resources and training can amplify their role. Despite their essential work, ASHA's face challenges like limited resources, inadequate pay, and insufficient recognition. Supporting and empowering them is vital for Kerala to strengthen its healthcare achievements. This study aims to investigate ASHA's working conditions and challenges in Kerala. It explores their living conditions, social status, security, and attitudes of healthcare professionals and the public towards them. ASHA's suggestions for improvement are also considered, including systematic performance evaluation and monitoring..

Structure of the Report:

The report is organized into several key sections, each focusing on specific aspects related to ASHA workers in Kerala. The sections include an introduction to the study, an overview of the methodology employed, major findings and insights gathered, and culminate with significant recommendations to address the challenges faced by ASHA workers.

Methodology:

The study utilized a mixed-method approach to gather comprehensive data on the duties and difficulties of ASHA workers. Quantitative data was obtained through questionnaires administered to ASHA's. Qualitative data was gathered through focus group discussions and case studies with ASHA's, which allowed for a deeper understanding of their experiences and perspectives.

Major Findings:

The study delved into the working conditions and challenges faced by Accredited Social Health Activists (ASHA's) in Kerala, India, with several key findings:

1. Integral Healthcare Role: ASHA's play a pivotal role in Kerala's healthcare system, acting as the first point of contact for many communities. They provide essential services like health education, disease surveillance, and maternal and child health.

2. Trust and Community Engagement: ASHA's grassroots presence fosters trust and community engagement. They are well-regarded by the local population, who often turn to them for healthcare information and support.
3. Empowerment Through Education: Education barriers initially hindered ASHA's, but their determination led to valuable healthcare knowledge. However, they expressed the need for more training to handle emergencies confidently.
4. Advocates for Change: ASHA's actively advocate for better working conditions, wages, and healthcare access for themselves and their communities. They leverage their positions to drive change.
5. Health Crisis Response: ASHA's step up during health crises, even at personal risk, highlighting their commitment to their communities' well-being.
6. Challenges Faced: ASHA's face various challenges, including limited resources, inadequate remuneration, and a lack of recognition for their contributions.

The study underscores the critical role of ASHA's in Kerala's healthcare success and the need to address their challenges. Empowering and supporting ASHAs can further solidify the state's healthcare achievements, ensuring a healthier and more prosperous future.

Major Recommendations:

The study has produced several important recommendations to enhance the role and well-being of Accredited Social Health Activists (ASHA's) in Kerala's healthcare system:

1. **Establishment of a Government Commission:** To comprehensively address the welfare of ASHAs, it is recommended that the state government establish a dedicated commission entrusted with the responsibility of overseeing ASHA's well-being, advocating for their rights. The commission should consist of experts in healthcare, social welfare, and community development, as well as ASHA representatives, to ensure a balanced and inclusive approach.
2. **Training and Skill Development**: ASHA's require comprehensive training programs to bolster their healthcare knowledge and emergency response skills. Continuous education can empower them to provide more effective care.
3. **Recognition and Appreciation**: To boost morale and motivation, healthcare authorities should acknowledge ASHA's contributions regularly. Recognition can come in the form of awards, certificates, or public appreciation.

4. **Fair Compensation**: ASHA's should receive adequate remuneration for their services. Their role is demanding, and fair pay is essential to motivate and retain them.

5. **Enhanced Resources and Travel Allowance:** To fulfill their duties effectively, ASHAs need essential resources such as gloves, masks, and umbrellas. Ensuring their safety and well-being should be a priority. Additionally, considering the diverse geographical locations they serve, providing a reasonable travel allowance can facilitate their mobility, especially in remote areas, ensuring timely access to healthcare services.

6. **Uniforms**: Providing ASHA's with uniforms can help community members easily identify them. This could foster trust and respect among the population.

7. **Performance Evaluation**: Implementing a systematic performance evaluation and grading system is crucial. This could include regular assessments of their healthcare knowledge and skills, as well as their community engagement.

8. **Community Engagement**: ASHA's should conduct regular community meetings to educate people about various health issues. Such interactions can strengthen their role and foster a sense of community ownership in healthcare.

9. **Health Insurance**: ASHA's should have access to health insurance that covers their medical expenses when they fall ill. This would alleviate their financial burdens during times of sickness.

10. **Supportive Infrastructure**: The government should ensure that ASHA's have the infrastructure they need, including reliable transportation in remote areas and access to medical supplies.

11. **Advocacy for Policy Change**: ASHA's should be encouraged and supported to advocate for policy changes that benefit both their profession and the communities they serve.

12. **Regular Feedback Mechanism**: Establishing a feedback mechanism for ASHA's to express their concerns, suggestions, and challenges can provide valuable insights for policy improvement.

13. **Mental Health Support**: ASHA's often face stressful situations. Offering mental health support services can help them cope with the emotional toll of their work.

Implementing these recommendations will not only enhance the effectiveness and well-being of ASHA's but also reinforce Kerala's healthcare achievements. It is vital to recognize ASHA's

as essential healthcare providers and provide them with the necessary tools and support to continue their critical work effectively.

In conclusion, this study sheds light on the significant duties and difficulties faced by ASHA workers in Kerala, emphasizing the need for comprehensive reforms and support to enhance their work and living conditions. Implementing the recommendations outlined in this report will not only empower ASHA workers but also contribute to the overall improvement of healthcare services in the state

CHAPTER 1
INTRODUCTION

1.1. INTRODUCTION

Community Health Workers (CHWs) are indispensable pillars of health and well-being worldwide. They serve as educators and advocates, empowering communities to take charge of their health. The roots of CHWs trace back to the 1800s when "midwives" were trained to provide healthcare to rural women and children. This concept evolved into the "health visitor" movement in the early 1900s, focusing on health education and care for families (WHO, 2010).

By the 1960s and 1970s, CHWs expanded their roles to include advocacy and addressing social determinants of health, such as poverty and housing (Kironde & Klaasen, 2002). The 1978 International Conference on Primary Health Care in Alma Ata, Russia, emphasized the vital role of CHWs in connecting marginalized individuals to healthcare (WHO, 2010). Over 50 years, CHW programs worldwide have prioritized services like immunizations, nutrition, family planning, maternal and child health, disease control, and basic care (Catalyst 2005, 2007; Brown 2006). Female health workers are frequently enrolled due to their focus on maternal and child health (Lehmann & Sanders, 2007).

CHWs are a diverse group, including nurse-midwives, caregivers, and volunteers, enhancing healthcare access and promoting healthy behaviors in underserved areas. They often work in underutilized service regions with unmet health needs (Lewin, et al., 2010). Their impact

on disease control, immunization, and family planning is well-documented (Shrestha, et al., 2003).

Job satisfaction significantly influences CHW performance, driven by intrinsic and extrinsic motivators (Glenton et al., 2010). CHWs are often volunteers, connecting communities with the formal healthcare system (GOI 2011). They benefit from peer support, cross-learning, and community-based organizations, which should complement their role rather than undermine it (Kironde & Klaasen, 2002).

Intrinsic motivation, including a desire for community interaction, often surpasses financial compensation. Cultural values like solidarity and social support reinforce CHWs' enthusiasm (Robinson & Larsen, 1990). Public recognition through events and involvement in public meetings can further boost their motivation.

CHWs' performance motivation hinges on the healthcare delivery system's status. Resource constraints, poor communication, and unclear responsibilities can undermine trust in CHWs (Baker, et al., 2007). They require regular supportive supervision, potentially involving experienced volunteers or NGOs (Kane, et al., 2010).

As CHW programs expand, overburdening becomes a concern. CHWs' low formal education level may complicate program orientation and monitoring (Abbatt, 2005; Henderson & Tulloch, 2008). India could consider experimenting with offering preferential treatment, such as social securities and public privileges, to CHWs and their households as demonstrated in Guatemala and Nepal (Bhattacharya, et al. 2001).

In essence, CHWs are the unsung heroes of global health, tirelessly working to bridge the gap between communities and healthcare systems, with intrinsic motivation, cultural values, and support systems driving their efforts. To fully leverage their potential, recognizing their contributions and addressing their unique challenges are paramount.

1.1.1. Inception of Asha

India's ASHA program, initiated in 2005 by the Ministry of Health and Family Welfare, has been a cornerstone in transforming rural healthcare. ASHAs, community-based health workers, are pivotal in providing health education, preventive measures, and referrals, especially in regions where the scarcity of trained healthcare personnel leaves communities underserved (Memo No. HFW /NRHM-20/2006/(Part-11)/163 1, 27/06/2012).

Economists have long underscored the significance of health in economic development. Poor health can impede societal progress, a view held by some health researchers, though it has been less explored (WHO, 2010). The economic impact of illness has primarily been studied at the national level, potentially contributing to the perception of health investments as consumptive rather than investments in human capital.

This perspective has shaped international health policy, directing focus towards public health services and the role of community health workers in addressing the dearth of medical personnel in rural areas. Nevertheless, a resurgence of interest posits that enhancing the health of the impoverished can alleviate poverty, a viewpoint emphasizing health equity and accessibility for marginalized populations (WHO, 2010).

Health disparities persist globally despite significant progress in global health. Health and development converge in a concept where health is seen as a political and developmental issue, aiming for health equity (WHO, 2010). The Right to Health perspective underscores the need for political and economic changes to champion health equity, employing advocacy to garner the attention of relevant authorities.

In India, this rights-based approach has been instrumental in propelling voluntary movements in rural primary health. It envisions comprehensive health solutions that encompass health services, agriculture, self-help groups, water supply, and local governance. The Community Health Worker (CHW) assumes a crucial role, capable of multitasking with appropriate training and support, a model that has thrived in the Indian voluntary sector (Sanjeevi, 1988; Antia and Bhatia, 1993; Antia, Dutta and Kasbekar, 2001; Leon and Walt, 2004; Gangolli, Duggal and Shukla, 2005). However, the CHW in the public health sector is yet to reach its full potential.

The Right to Health Care perspective acknowledges the poor state of health and the national and international conditions that perpetuate it, with a keen focus on inequality and inequity in public health systems (Antia, Dutta and Kasbekar, 2001). The dominance of the private sector in India's healthcare system, responsible for three-quarters of healthcare services and expenditure, is a key concern. Profit-driven corporatization in healthcare, often at the expense of rational care, is unsettling. The rapid adoption of a Western techno-managerial healthcare model compounds the issues (Antia, Dutta and Kasbekar, 2001).

This approach gained prominence in the 1990s amid concerns about structural adjustment effects and reduced government health spending in developing countries (Leon and Walt, 2004). It spotlights the challenges faced by the poor, particularly in rural areas, due to public health system shortcomings.

In 2000, the Peoples' Charter for Health asserted that governments must ensure universal access to quality healthcare. Shukla (2005) advocated for a strengthened and reoriented public health system with CHWs at its core, echoing the Social-Ecological Approach. This perspective, exemplified by the European Health Promotion Indicator Development (EHPID) Project's Social Ecological Model, provides a framework for selecting and interpreting health promotion indicators in public health (Bauer, Davis et al, 2003).

The Social-Ecological Approach defines health promotion as "the process of enabling and empowering individuals and communities to gain control over the determinants of health and improve their health." This aligns with the Right to Health Care Approach, aspiring to enhance the public health system and positioning CHWs as its integral component.

Notably, the ASHA program emerged with its unique challenges, facing issues like administrative support, role clarity, and unmet expectations for incentives and working conditions, akin to earlier health initiatives (NRHM). Launched in 2005, the National Rural Health Mission (NRHM) aimed to enhance health indicators and infrastructure in 18 states, with the ASHA program playing a pivotal role. These female community health activists serve as liaisons between communities and public health systems, focusing on maternal and child health, promoting health education, and improving access to healthcare services (Memo No. HFW /NRHM-20/2006/(Part-11)/163 1, 27/06/2012).

ASHAs, armed with knowledge and drug-kits, act as the first contact point for health-related demands, catering to the deprived sections of the population, particularly women and children. They provide health information, counsel on birth preparedness, safe delivery, immunization, contraception, and promote healthy practices. ASHAs mobilize communities, facilitating access to health services and essential provisions.

The Accredited Social Health Activist (ASHA) program is an essential component of the healthcare system in India. The key components of the ASHA program include (Memo No. HFW /NRHM-20/2006/(Part-11)/163 1, 27/06/2012)

1. Selection of ASHA: An ASHA must be a resident of the village and be a woman, either married, widowed, or divorced, between the ages of 25 and 45. Preference is given to literate women who have completed at least 10th standard. If no suitable candidate with this qualification is available, the requirements may be relaxed.
2. Rigorous Selection Process: The selection of an ASHA involves a series of steps that involve community groups, self-help groups, Anganwadi Institutions, the Block Nodal officer, District Nodal officer, Village Health Committee, and the Gram Sabha.

3. Continuous Capacity Building: The training and development of ASHA's is an ongoing process. ASHA's undergo multiple training sessions to acquire the necessary knowledge, skills, and confidence to perform their roles effectively.

4. Performance-based Incentives: ASHA's receive performance-based incentives for promoting universal immunization, reproductive and child health services, and construction of household toilets.

5. First Point of Contact for Healthcare: Empowered with a drug-kit and knowledge, ASHA's are expected to be the first point of contact for health-related demands of deprived sections of the population, especially women and children.

6. Health Activist: ASHA's are health activists in their communities who raise awareness about health and its social determinants and mobilize the community towards local health planning and increased utilization and accountability of existing health services.

7. Health Information Provider: ASHA's provide information to the community on various health determinants such as nutrition, basic sanitation and hygiene practices, healthy living and working conditions, and the need for timely utilization of health and family welfare services.

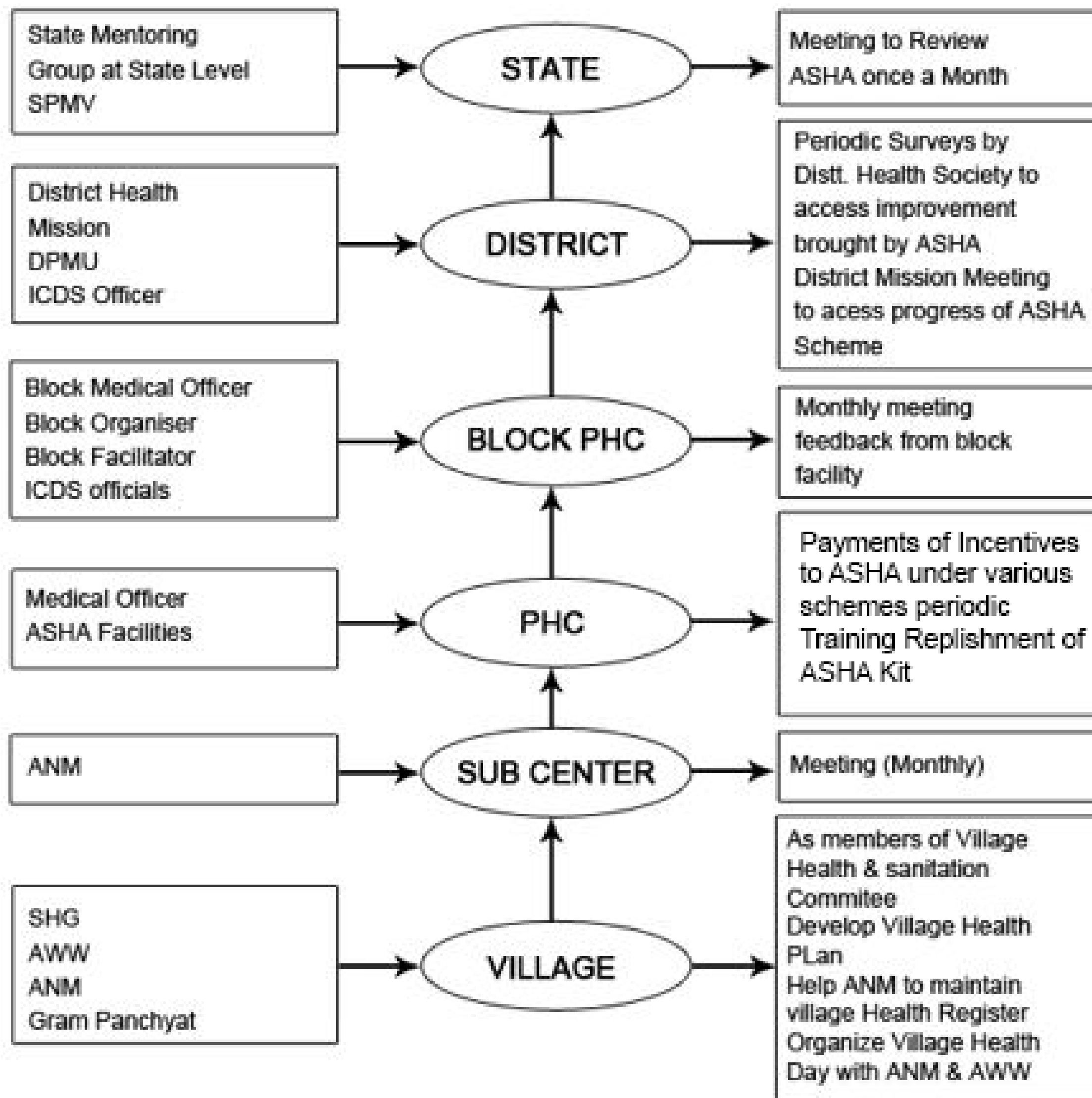
8. Health Counselor: ASHA's counsel women on birth preparedness, safe delivery, breast-feeding, immunization, contraception, and the prevention of common infections such as Reproductive Tract Infections and Sexually Transmitted Infections.

Facilitator of Health Services: ASHA's mobilize the community and facilitate access to health and health-related services available at Anganwadi centers, sub-centers, and primary health centers, such as immunization, ante-natal check-ups, post-natal check-ups, supplementary nutrition, and sanitation. ASHA's also act as a depot holder for essential provisions such as Oral Rehydration Therapy, Iron-Folic Acid and pain killer Tablets, chloroquine, Disposable Delivery Kits, oral pills, and condoms.

1.1.2 Support Mechanism for ASHA

The ASHA program, a community-based healthcare initiative launched in 2005 by the Ministry of Health and Family Welfare in India, relies on robust institutional support at the village level to maximize its impact (Memo No. HFW /NRHM-20/2006/(Part-11)/163 1, 27/06/2012). This support network encompasses a diverse range of stakeholders, including women's committees (such as self-help groups or women's health committees), the village Health & Sanitation Committee of the Gram Panchayat, peripheral health workers (notably ANMs and Anganwadi workers), and the trainers responsible for ASHA's initial and ongoing in-service training.

Figure 1: Support Mechanism for ASHA Workers



https://nhsrcindia.org/sites/default/files/2021-06/ASHA%20Update%20Jan%202019.pdf

ASHA's, at the forefront of this initiative, shoulder multifaceted responsibilities that complement the efforts of other healthcare providers. They serve as educators and mobilizers within communities, with a particular focus on marginalized groups, fostering health-promoting behaviors, and raising awareness about the social determinants of health. Moreover, ASHA's play a pivotal role in boosting the utilization of healthcare services, actively engage in health campaigns, and assist individuals in asserting their health entitlements.

The ASHA program hinges on the voluntary participation of local women, carefully selected and rigorously trained to champion various health objectives, including universal immunization, safe childbirth, newborn care, disease prevention (both communicable and

non-communicable), improved nutrition, elderly care, and the promotion of household and community sanitation.

ASHA's are not just messengers; they are selected from their own communities, ensuring a deep understanding of local needs and dynamics. They function as a crucial support system for community health interventions, extending their services to those facing barriers in accessing healthcare services due to diverse factors, including social, occupational, and financial challenges.

To maintain the program's effectiveness, ASHA's require continuous support and training. ASHA facilitators, often ANMs, are designated to provide this vital support, offering mentoring, guidance, and supervision to ASHAs within their allocated areas.

The National Rural Health Mission (NRHM) recognized systemic shortcomings in the healthcare system, including the lack of holistic approaches, infrastructure, human resources, and community ownership and accountability. To address these issues, the NRHM introduced communitization, flexible financing, capacity building, progress monitoring, and innovations in human resource management (Memo No. HFW /NRHM-20/2006/(Part-11)/163 1, 27/06/2012). Decentralization and convergence became ongoing processes to facilitate healthcare communitization, with village health plans integrated into the district plan, forming the cornerstone for planning, implementation, and monitoring.

PRIs, self-help groups, health, nutrition, and sanitation committees were actively engaged to ensure local accountability in program delivery. The NRHM emphasized resource utilization and micro-level leadership by PRIs, providing guidelines for effective utilization. The mission adopted a synergistic approach, aligning health with determinants like nutrition, sanitation, hygiene, and safe drinking water. A key component was the creation of Accredited Social Health Activists (ASHA's) in every village, serving as the bridge between rural communities and healthcare services. ASHA's were entrusted with providing primary medical care, disease control, maternal and child services, family planning counseling, health determinant awareness, and community mobilization for local health planning.

The ASHA, an integral figure in this initiative, is a female village resident with a minimum of 8 years of formal education. In tribal areas, she serves a population of 700, while in rural villages, this extends to 1,000 individuals. The ultimate goal is to have an ASHA in every village in India, with a target of 250,000 ASHA's in 10 states, under the National Rural Health Mission (Memo No. HFW /NRHM-20/2006/(Part-11)/163 1, 27/06/2012). ASHAs have played a remarkable role in mobilizing women from valuable communities, resulting in tangible reductions in infant and maternal mortality rates.

1.1.3 National Overview

Table 1: State-wise Distribution of Total ASHA Workers

State/UT	Total ASHAs
Andaman & Nicobar	412
Andhra Pradesh	41383
Arunachal Pradesh	4082
Assam	32546
Bihar	85822
Chhattisgarh	72048
Dadra and Nagar Haveli and Daman and Diu	426
Delhi	5982
Gujarat	42672
Haryana	20292
Himachal Pradesh	7914
Jammu and Kashmir	12373
Jharkhand	41129
Karnataka	41577
Kerala	26475
Ladakh	549
Lakshadweep	104
Madhya Pradesh	67547
Maharashtra	66863
Manipur	4048
Meghalaya	6784
Mizoram	1091
Nagaland	2007
Odisha	47465
Puducherry	312
Punjab	19676
Rajasthan	52222
Sikkim	676
Tamil Nadu	2520
Telangana	27040
Tripura	7662
Uttar Pradesh	162913
Uttarakhand	11599
West Bengal	58640

Source: Total ASHAs | National Health Systems Resource Centre (nhsrcindia.org)

The ASHA initiative stands as the cornerstone of community healthcare processes, extending its coverage to all States and Union Territories, with the exception of Goa and Chandigarh, encompassing both urban and rural populations. Notably, since the inaugural ASHA update in October 2009, remarkable and unwavering progress has been achieved concerning ASHA selection, training, and service delivery across the majority of states and Union Territories.

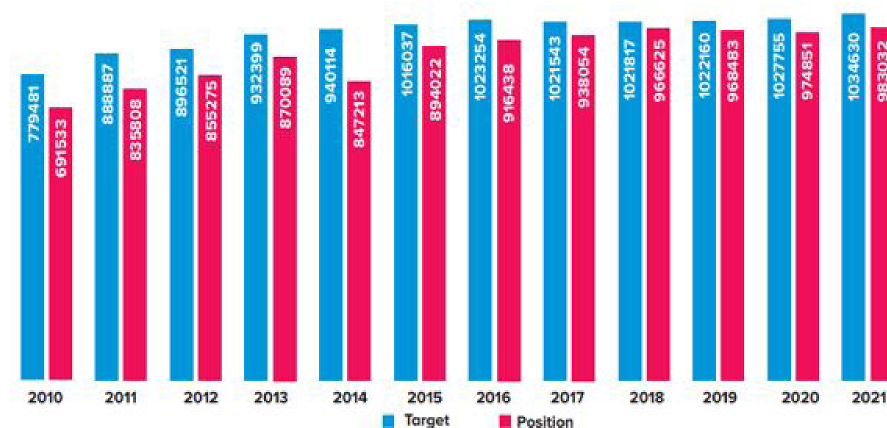
Presently, the nation boasts an impressive count of 9,83,032 active ASHAs, closely approaching 95% of the ambitious target set under the aegis of the National Health Mission (NRHM and NUHM). This target envisions one ASHA for every 1000 individuals in rural areas and a ratio of one ASHA for every 2500 individuals in urban regions. This resounding achievement signifies a monumental step towards enhancing healthcare accessibility, particularly in underprivileged communities.

The journey from the inaugural update in 2010 to the latest statistics for FY 2020-21, spanning a significant eleven-year period, reveals an astounding growth trajectory. The total ASHA target has surged by approximately 33%, surmounting from 7,79,481 to the present 10,34,630. Simultaneously, the number of dedicated ASHA's diligently fulfilling their roles has surged by an impressive 42%, catapulting from 6,91,533 to the current 9,83,032.

The graph below, encapsulated in Figure-1, paints a compelling visual narrative of this decade-long ascent, depicting the remarkable surge in ASHA numbers. This notable expansion in the target can be attributed, in part, to the strategic rollout of the ASHA program in urban areas, effectively implemented under the National Urban Health Mission (NUHM) in the year 2013.

The Trend in Asha Program from Year 2010 to 2020 (Target & In Position)

Figure 2: Number of ASHA's in Position against Target



Source: Annual ASHA report 2020-2021

At present, there are approximately 9,14,101 ASHAs working under NRHM, which is almost 96% of the set target of 9,56,672 ASHAs.

- Except for Bihar, Rajasthan, Kerala, Telangana, West Bengal, DD&DNH, and Lakshadweep, all other states/UTs have around 95% or more ASHA's in place against the set targets of ASHA selection.
- The states with high focus such as Jharkhand, Uttarakhand, and Odisha have selected 100%, 98%, and 99% ASHA's respectively, while the rest of the states in the group have around 95% ASHA's in position against the targets.
- In the northeastern states, all states except Nagaland (96%) and Tripura (99%) have selected 100% ASHA's.
- In non-high focus states, except for Kerala, Telangana, and West Bengal, the rest of the states have reported selection of above 90% ASHA's against the target.
- The Union Territories, except for Daman, Diu & Dadar Nagar-Haveli and Lakshadweep where 92% ASHA's are in position against their respective targets, have reported more than 96% ASHA's in position.

1.1.4 Population Density per Asha

The ASHA initiative stands as the cornerstone of community healthcare processes, extending its coverage to all States and Union Territories, with the exception of Goa and Chandigarh, encompassing both urban and rural populations. Notably, since the inaugural ASHA update in October 2009, remarkable and unwavering progress has been achieved concerning ASHA selection, training, and service delivery across the majority of states and Union Territories.

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Figure 3: Population Per Asha in Rural Areas – The Trend

Source: Annual ASHA report 2020-2021

1.1.5 Training of ASHAs

The training of ASHAs has displayed notable progress across the four successive modules, denoted as Module 6 and 7 within the NRHM framework. These training endeavors have witnessed commendable achievements, with the highest completion rate recorded in Round 1, reaching an impressive 96%. The training momentum remained robust in subsequent rounds, with a still commendable low point of 83% in Round 4.

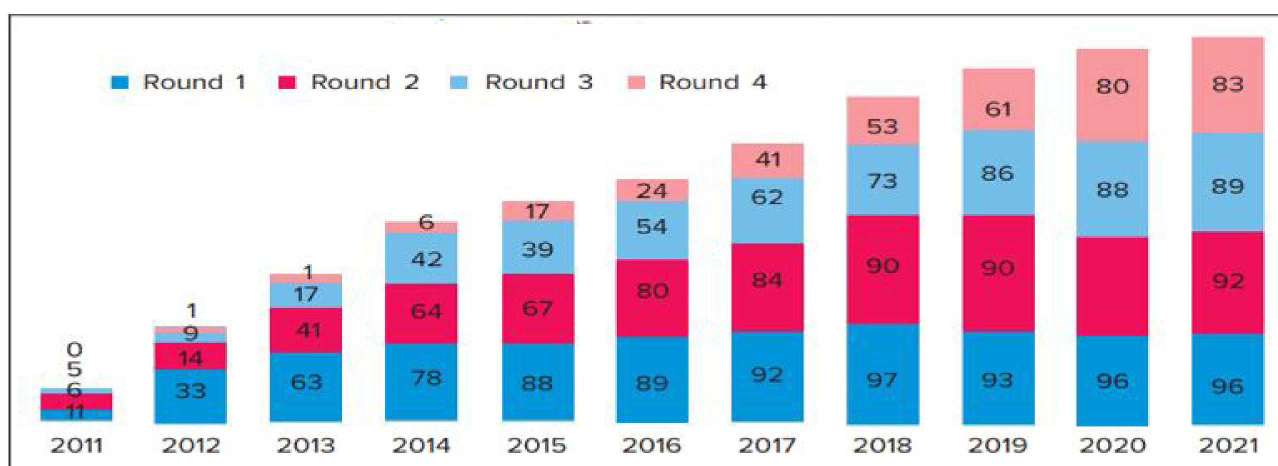
In the High Focus states group, including Chhattisgarh, Jharkhand, Odisha, and Uttarakhand, the dedication to ASHA training shone prominently, with each state consistently reporting progress rates exceeding 97% throughout all training rounds. However, it's noteworthy that Bihar, while showing commendable commitment, reported the lowest training achievement within this group at 47% during Round 4.

Venturing into the North-Eastern states, a similar pattern of unwavering commitment to ASHA training emerged. Most of these states reported completion rates surpassing 95% in all training rounds, with Arunachal Pradesh exhibiting the lowest training achievement at 75% in Round 4.

Meanwhile, in the Non-High Focus states, the training landscape exhibited variable progress. Among these states, Telangana recorded the lowest training completion status at 48% during Round 4.

Within the Union Territories, exemplary dedication was observed in Andaman & Nicobar Islands and Lakshadweep, where 100% training completion was achieved across all four rounds. In contrast, Ladakh and Jammu & Kashmir, while displaying strong commitment, reported training completion rates of 83% and 87%, respectively.

Figure 4: Cumulative training achievement of States and Union Territories on ASHA Module 6 & 7 up to 31st March 2021.



Source: Annual ASHA report 2020-2021

1.1.6 Kerala State Overview

In Kerala, the ASHA program, an integral part of India's National Rural Health Mission (NRHM), has been diligently working towards connecting marginalized communities with the healthcare system since its inception in 2005. The mission, initially slated for full implementation by 2012, aimed to ensure the presence of an "ASHA in every village" across India.

Kerala embarked on this journey by recruiting its first batch of ASHAs in 2006. As of the year 2022-23, approximately 26,448 ASHAs are actively serving the healthcare needs of the state's rural population.

These dedicated ASHAs in Kerala shoulder a multifaceted role, which encompasses the following responsibilities:

- **Promotion of Universal Immunization:** ASHAs actively promote and facilitate universal immunization within their communities.
- **Referral and Escort Services:** They provide vital referral and escort services, particularly in matters concerning Reproductive & Child Health (RCH) and other healthcare programs.
- **Construction of Household Toilets:** ASHAs play a pivotal role in promoting sanitation and hygiene by aiding in the construction of household toilets.
- **First-Contact Healthcare:** They act as the first point of contact for healthcare needs, offering initial medical assistance and guidance.
- **Facilitating Community Participation:** ASHAs are instrumental in mobilizing community engagement in various public health programs.

1.1.7 Role of ASHA Workers in Kerala

ASHA workers are the cornerstone of Kerala's healthcare system, extending a helping hand to every rural household. Their scope of activities is diverse and includes:

- **Home Visits:** ASHA workers conduct essential home visits, particularly to pregnant women and mothers with young children, providing crucial healthcare support.
- **Health and Hygiene Promotion:** They deliver valuable information on health and hygiene practices, empowering communities to lead healthier lives.
- **Healthcare Advocacy:** Motivating community members to utilize available health services effectively is another key aspect of their role.
- **Community Health Events:** ASHAs actively organize and facilitate community health events to raise awareness and promote health-seeking behaviors.
- **Health Status Monitoring:** They vigilantly monitor the health status of the community, aiding in early intervention and prevention efforts.

Despite Kerala's commendable progress in critical health indicators compared to other Indian states, it faces unique challenges. These challenges include high morbidity rates due to the resurgence of communicable diseases, second-generation issues like aging populations and non-communicable diseases, and sustaining high health indicators. The state recognizes the importance of improving healthcare quality to match the population's already high health-seeking behavior.

The National Rural Health Mission has been instrumental in providing much-needed resources to Kerala, helping address these challenges effectively. Over the past three years, Kerala has initiated several programs tailored to its specific healthcare needs and concerns. These initiatives align closely with the NRHM's Key Performance Areas, focusing on institutional strengthening, improving healthcare accessibility, enhancing service quality, and ensuring healthcare equity for marginalized groups.

As of the NHSRC's 19th edition of the semi-annual ASHA Update in January 2019, covering the period from July 2018 to December 2018, Kerala had 27,984 ASHAs in place, slightly below the target of 32,854 ASHAs. In rural areas, the percentage of ASHAs in position compared to the objective stood at 84%, slightly below the national average of 95%. Conversely, in urban areas, Kerala achieved a 100% placement of ASHAs, surpassing the national average of 88%. Kerala's population density per ASHA under the NRHM was 670, while the national average was 881.

Figure 5: Status of ASHA selection under NRHM and NUHM

	NRHM					NUHM		
	Rural ASHAs (Target)	Rural ASHAs (in Position)	Percentage of ASHAs in position against the target	Rural Population 2011 Census	Current Density- January 2019	Urban ASHAs (Target)	Urban ASHAs (In Position)	Percentage of ASHAs in position against the target
Kerala	30927	26057	84%	17471135	670	1927	1927	100%
India	948266	905047	95%	794838894	881	74395	65629	88%

Source: 19th issue of the semi-annual ASHA Update January 2019, released by the NHSRC

ASHA workers confront a multitude of challenges in their vital role, including:

1. **Low Remuneration:** ASHA workers do not receive regular salaries and depend on incentive-based earnings. This financial instability not only makes it challenging for them to sustain their livelihoods but may also deter their commitment to the job.
2. **Lack of Training and Support:** Many ASHA workers lack adequate training and support necessary for effective job performance. This deficiency can lead to frustration and potentially impact the quality of care they provide.

3. **Heavy Workload:** ASHA workers are often burdened with a substantial workload, responsible for a considerable number of households. This can hinder their ability to deliver the level of care and attention each household requires.

4. **Inadequate Infrastructure:** ASHA workers frequently operate in areas with deficient infrastructure, including poor road networks and unreliable access to electricity. Such challenges hinder their mobility, making it difficult to reach households and access healthcare facilities promptly.

5. **Social Stigma:** ASHA workers often face social stigma associated with their profession, which is sometimes perceived as having low status. This societal bias can adversely affect their morale and working conditions.

Despite these formidable challenges, ASHA workers in Kerala have made remarkable contributions to the health and well-being of rural communities. Their efforts have significantly enhanced immunization coverage, reduced maternal and child mortality rates, and promoted healthier lifestyles..

1.2 REVIEW OF LITERATURE

The 2011 evaluation conducted by the NHSRC (National Health Systems Resource Centre) underscored a crucial aspect in addressing India's complex healthcare challenges. It emphasized that the burden of healthcare cannot be solely carried by doctors and specialists. Instead, it advocated for a holistic approach that integrates disease prevention and awareness activities into the healthcare fabric. In this context, ASHA workers have emerged as pivotal agents in promoting health awareness and disease prevention within families and communities (NHSRC, 2011).

Turning our attention specifically to Kerala, ASHA workers have played a transformative role in the state's healthcare landscape. Their contributions, particularly in maternal and child health, have been profound. A study by Gopalan et al. (2019) illustrates this impact. It reveals that ASHA workers were instrumental in elevating Kerala's institutional delivery rate from a modest 42.5% in 2006 to an impressive 97.7% in 2016. This remarkable achievement can be attributed to the tireless efforts of ASHA workers, encompassing community mobilization initiatives, maternal and child health services, and effective referrals for antenatal and postnatal care.

Furthermore, another study conducted by Raveendran et al. (2021) underscores the significant role of ASHA workers in promoting health-seeking behavior among Kerala's rural population.

These dedicated workers have effectively created health awareness and advocated for vital healthcare interventions such as vaccination and family planning.

The positive influence of ASHA workers extends to child nutrition as well. A study led by Nair et al. (2021) reveals that ASHA workers have made a tangible difference by providing crucial nutritional counseling and support to mothers. This intervention has, in turn, had a positive impact on the nutritional status of children. This complements an earlier study conducted by Nair (2017), which highlighted the role of ASHA workers in enhancing knowledge and awareness related to maternal and child health.

Tissy Eruthichal's research, focusing on the 'Role of ASHA workers in rural development with reference to Kottayam district,' underscores the tangible improvements in the health of rural populations following the introduction of ASHA workers. They have effectively ensured adherence to newborn vaccination schedules, promoted cleanliness, and facilitated various healthcare programs. ASHA's presence has been pivotal in raising awareness about critical health issues like nutrition, basic sanitation, and hygienic practices within rural communities.

In the context of the COVID-19 pandemic, ASHA workers in Kerala played an indispensable role in managing the crisis. Their responsibilities encompassed contact tracing, monitoring individuals in home quarantine, providing health education, and distributing essential supplies during lockdowns (Nair et al., 2020). Moreover, they actively identified and referred individuals with suspected COVID-19 symptoms for further evaluation (Soman et al., 2020).

However, it's essential to acknowledge that the pandemic also exposed ASHA workers to significant challenges. These included an increased workload and concerns regarding insufficient compensation (Vayalil, K., 2021, March). Several studies conducted nationwide illuminated common hurdles faced by ASHA workers during the pandemic, including the lack of personal protective equipment, inadequate training, and heightened fears of contracting the virus (Kapoor et al., 2020; Kumar et al., 2021; Prasanna et al., 2020).

To bolster the effectiveness of ASHA workers, it is imperative to address these challenges comprehensively. This entails continuous training, ensuring timely compensation, recognizing their vital contributions, and offering unwavering support. Training programs should cover both theoretical and practical aspects of healthcare, encompassing disease prevention, health promotion, and community mobilization (Nair et al., 2014). Additionally, ASHA workers should receive training in utilizing digital tools and mobile applications, which can significantly enhance healthcare service delivery (Kannan et al., 2019).

Supervision and support mechanisms are equally vital. Regular visits by supervisors, performance appraisals, and constructive feedback are crucial components of effective support (Chandrasekhar et al., 2019). ASHA workers also require substantial support from the healthcare system itself, including the provision of essential medicines, equipment, supplies, financial incentives, and formal recognition for their relentless work (Prasad et al., 2016; Kumar et al., 2021).

ASHA workers confront not only healthcare-related challenges but also social and cultural barriers in accessing and delivering healthcare services in their communities. These barriers include gender-based discrimination, caste-related biases, and language barriers (Nair et al., 2014). The workload issue among ASHA workers, as highlighted in a study by Prasad et al. (2016), further underscores the multifaceted challenges they grapple with.

A study by Kumar and Banerjee (2019) revealed that many ASHA workers expressed concerns about inadequate training in critical areas like communication skills, record-keeping, and basic clinical care. This dearth of essential training can lead to a lack of confidence, reduced effectiveness in their roles, and heightened stress and burnout.

Compensation is another crucial aspect. Many ASHA workers do not receive their incentives on time, which can be severely demotivating. Joseph (2015) found that the majority of ASHA workers in tribal districts are dissatisfied with their compensation. They often face higher expenditures and delayed incentives, particularly among tribal ASHA workers in Wayanad (Joseph, 2015).

An illuminating paper titled “Problems faced by Accredited Social Health Activists (ASHAs) in the delivery of primary health services in the community” offers a cross-sectional study focusing on ASHA workers in three districts of Kerala. The study unveils a spectrum of challenges encountered by ASHA workers in delivering primary healthcare services. It underscores that ASHA’s effectiveness in providing healthcare services depends significantly on the support and training they receive, both from the healthcare system and the community. The study identifies various challenges, including an overwhelming workload, payment delays, inadequate follow-up after initial training, lack of recognition, lack of priority treatment for patients referred by ASHA, absence of a fixed salary, dissatisfaction with honorarium, health insecurity, insufficient transport allowances, increased drop-out rates among ASHA workers, a substantial population to serve, and irregular maintenance of drug kits.

This comprehensive study unveils critical insights into the challenges faced by ASHA workers in delivering primary healthcare services. It underscores the need for continuous training and support to enhance their effectiveness in serving communities. Additionally, the

paper emphasizes the importance of prioritizing and recognizing patients referred by ASHA workers to boost motivation and job satisfaction.

Throughout the COVID-19 pandemic, ASHA workers demonstrated unparalleled dedication and resilience, significantly contributing to the resilience of the healthcare system. Their full potential, as suggested by various research studies, is still unfolding. However, these studies have illuminated several issues that require attention to strengthen ASHA workers, particularly in Kerala. There is an urgent need to bolster their training, ensure fair compensation, and offer unwavering support to these frontline healthcare warriors.

In conclusion, the literature review highlights the vital role of Accredited Social Health Activists (ASHAs) in addressing healthcare challenges in Kerala. They have significantly improved maternal and child health, raised awareness, and played a crucial role during the COVID-19 pandemic. However, ASHA workers face various challenges, including overburden, inadequate compensation, and lack of resources. To unlock their full potential, it is imperative to provide comprehensive training, supervision, and support. Addressing social and cultural barriers and ensuring fair compensation are also crucial. Recognizing and appreciating ASHA workers' dedication is essential. By addressing these challenges and enhancing their training and compensation systems, Kerala can harness their untapped potential, ultimately strengthening the healthcare system.

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CHAPTER 2
APPROACH TO THE STUDY

2.1 INTRODUCTION

The activities and problems of ASHA workers in Kerala are a topic of growing interest. However, apart from their crucial role in the health front, they often face challenges, such as low salaries, lack of proper training, and inadequate support from the government have been broadly understood through the existing studies on the topic. But it is essential to find out further issues related to their work front to formulate policies to enhance their livelihood. That has been probed in this study.

2.2 OBJECTIVES OF THE STUDY

The overarching objective of this study is to comprehensively assess the role and impact of ASHA workers in Kerala's healthcare system. By exploring their activities, challenges, and contributions, this research aims to provide valuable insights that can inform policy recommendations and interventions to strengthen and optimize the effectiveness of ASHA workers in delivering primary healthcare services to rural communities.

Its specific objectives include:

1. To find out if the ASHA workers are being paid commensurate with the work.
2. To understand the duties and responsibilities of ASHA workers and make changes in accordance with the need of the hour.

3. To find out what health and welfare schemes / benefits are available to ASHA workers.
4. To make suggestions to improve the living and working conditions of ASHA workers.
5. To explore opportunities to provide better training/services in the health sector through ASHA workers.
6. To propose and evaluate an appropriate grading system for ASHA workers based on assessment criteria and years of experience to provide a clear career advancement pathway.
7. To suggest Make ASHA workers a part of health policy and create conditions for mainstreaming their activities.

By accomplishing these objectives, our study aims to provide valuable insights and actionable recommendations to uplift and empower ASHA workers, ultimately contributing to the advancement of community health and well-being in Kerala.

2.3 RESEARCH DESIGN

This study adopts a mixed-methods research design to comprehensively explore the activities and challenges faced by Accredited Social Health Activist (ASHA) workers in Kerala, India. By combining quantitative survey data with qualitative insights from interviews, the research aims to provide a holistic understanding of the vital role played by ASHA workers in delivering primary healthcare services to rural communities. The quantitative data will be analyzed using descriptive statistics, while the qualitative data will undergo thematic analysis. Although the study has certain limitations detailed below, and a small sample size for Case Studies, the chosen research design aligns effectively with the study's objectives and research questions.

2.4 METHODOLOGY

Questionnaire-based field surveys, focus group discussions and case studies were used for collecting primary data. The data analysis has been conducted using both quantitative and qualitative methods. The quantitative data has been analyzed using descriptive statistics, frequencies and cross table analysis. The qualitative data has been analyzed using thematic analysis, which involves identifying and coding themes in the data. The data analysis has been conducted using SPSS Version 20. The research design for this study is appropriate for the research questions and objectives. The rationale for using mixed methods approach is that, mixed-methods approach will allow the researcher to collect both quantitative and qualitative data, which will provide a more comprehensive understanding of the activities and problems of ASHA workers in Kerala. The survey will allow the researcher to collect data from a large

number of ASHA workers, while the interviews will allow the researcher to collect in-depth data from a smaller number of ASHA workers. In our study we have used the qualitative study to test the authenticity of the survey findings.

2.4.1 Sample Design

The sample design for this study is a simple random sample. This type of sample design is used to ensure that the sample is representative of the population as a whole.

For the survey, 5% of the population has been selected through random sampling method. From each district, 5% of the population has been selected for the survey which comes to 1400 The population in each district are different, A random sample of ASHA workers was selected from each district. The total sample size was 1318 ASHA workers. However, only 1171 ASHA workers completed the survey.

The direct survey was conducted with a sample of 1171 ASHA workers. The focus group discussion was conducted with a sample of 5 groups of ASHA workers.

Table 2 District--wise Distribution of Total ASHA Workers and the sample

DISTRICT	NO. OF ASHAs	5% OF THE TOTAL
Thiruvananthapuram	2616	130
Kollam	2019	100
Pathanamthitta	1041	52
Alappuzha	2060	103
Kottayam	1555	77
Ernakulam	2333	116
Idukki	1047	52
Thrissur	2341	117
Palakkad	2357	118
MPM	3225	161
KKD	2065	103
WYD	872	43
KNR	1984	99
KSGD	933	47
TOTAL	**26,448**	**1318**

Despite these limitations, the sample design is appropriate for the research questions and objectives. The simple random sample will ensure that the sample is representative of the population as a whole. The survey method will allow the researcher to collect data from a large number of ASHA workers. The focus group discussion and in-depth interviews will allow the researcher to collect in-depth data from a smaller number of ASHA workers.

2.4.2 Tools for Data Collection

a. Questionnaire

Questionnaires were developed to collect data from ASHA workers. The questionnaires were validated with experts in the field and a pilot study was conducted. After the pilot survey, the questionnaires was corrected and updated with the results of the pilot survey.

b. Focus group discussions

A focus group discussion (FGD) is a qualitative method to obtain in-depth information on concepts, perceptions, and ideas of a group, and to explore the meanings of survey findings that cannot be obtained otherwise. An FGD also authenticates the survey findings.

Total of five focus group discussions were conducted with 8-10 number of ASHA workers, with a check list. In order to get a cross section, the FGDs were conducted in coastal area, tribal area, urban area, rural area and a mixed area. In order to get south north differences, Trivandrum and Ponnani coastal areas were selected. The case studies were conducted with a sample of 3 ASHA workers, with two tribal women and the state secretary of the ASHA workers union. The focus group discussions and in-depth interviews could authenticate the survey findings.

c. Case Study

The case study on Accredited Social Health Activists (ASHA) workers provides an in-depth exploration of their roles, challenges, experiences, and contributions within the healthcare system. This case study aims to shed light on the significance of their work, the obstacles they encounter, and the impact they have on community health. We could alsounderstand how they manage the time, both at home and in the hospital, what is the attitude of others on them, viz. their senior's attitude, attitude of the family members, attitude of the neighbors and the common public.

Through this exercise, we could get to know some of the grey areas of the issues of ASHA workers.

2.5 ORIENTATION FOR FIELD INVESTIGATORS

Each survey team was made up of MSW students from Department of Sociology, Kariavattom Campus, Kerala University headed by Programme Coordinator. There were 17 Field investigators who conducted the survey across Kerala. A one-day training programme for the research team of the survey was conducted on 25 January 2023 in student Facilitation Centre, University of Kerala at PMG Junction, Thiruvananthapuram.

2.6 STAGES OF DATA COLLECTION

The various stages of primary data collection included questionnaire-based surveys, FGD, personal interviews.

2.7 DATA ANALYSIS

Data was analysed using SPSS Version 20 package. The analysis plan for quantitative data was designed in a manner to exclude all possible errors during data processing. Numerical values were assigned to the responses in the questionnaire/interview schedule. Frequency tables were generated to highlight the behaviour of independent variables and their distribution over various responses. The bivariate tables and statistical measures were used to do further statistical analysis.

2.8 LIMITATIONS OF THE STUDY

This research study has a few limitations that have been listed below:

1. The study primarily relies on self-reported data from ASHA workers, which is subjected to response bias or social desirability bias, though the confidentiality and anonymity has been maintained.
2. The research may not have fully captured the perceptions and experiences of other stakeholders, such as community members, healthcare administrators, and policymakers, whose perspectives could have provided a more comprehensive understanding of the ASHA scheme's effectiveness.
3. The study did not explore in-depth the factors influencing the implementation and functioning of the ASHA scheme at the administrative and policy levels. Investigating these factors could have revealed valuable insights into the broader challenges faced by ASHA workers.

4. As the ASHA scheme was started relatively recently, very little secondary information was available. As mentioned in the review of literature, there is a scarcity of comprehensive research and data on the long-term impact and effectiveness of the ASHA scheme, which limited the scope of this study.

5. Due to the absence of proper documentation in Community Health Centers or Family Health Centers (Formerly Primary Health Centers) including appointment letters, Appraisals, Report submitted etc. secondary information could not be collected as expected at the field level.

6. The data collected was based on a cross-sectional design, providing a snapshot of the current situation. A longitudinal study would have offered insights into changes and developments over time.

CHAPTER 3
EVALUATION- RESULTS AND INTERPRETATION

3.1 INTRODUCTION

Keeping in mind the question how far the ASHA has succeeded in achieving its declared objectives, efforts were taken to collect authentic data from major stakeholders. This section analyses the data collected, and its interpretation throws light on the scheme's operations and the need to make certain changes in order to further strengthen the programme and thus benefit society at large. The analysis is done in three parts. The first part discusses the results of the field survey conducted among the 1172 out of roughly about 27000 ASHA workers.

The study explored the living conditions, social status, social security, economic security, attitude of doctors, nurses and public towards ASHA's, and their suggestions for improving the conditions.

The data analysis revealed that ASHA workers in Kerala face a number of challenges, including:

- Low wages
- Lack of social security
- Poor working conditions

- Gender discrimination
- Lack of sufficient and proper training

Despite these challenges, ASHA workers play a vital role in the health care system in Kerala. They are responsible for providing a wide range of services, including:

- **Health Awareness and Education:** ASHA workers educate and create awareness among community members about various health-related issues, preventive measures, and healthy practices.
- **Maternal and Child Health:** They play a significant role in promoting maternal and child health by encouraging antenatal care, safe institutional deliveries, postnatal care, immunizations, and proper nutrition for both mothers and children.
- **Family Planning Guide:** ASHA workers provide information about family planning methods and promote family planning practices to promote reproductive health.
- **Immunization Campaigns:** ASHAs actively participate in immunization campaigns, ensuring that all eligible individuals, especially children, receive the required vaccinations.
- **New-born Care:** They provide support and guidance to new mothers in caring for their new-born, including information about breastfeeding and new-born hygiene.
- **Referral and Escort Services:** They help in referring patients to higher healthcare facilities for specialized care and also assist patients in reaching healthcare centers.
- **Health Monitoring and Reporting:** ASHAs keep track of health-related data, maintain records of vital health indicators, and report health information to the appropriate authorities.
- **Nutrition and Sanitation:** They promote good hygiene practices, sanitation, and nutrition in the community to improve overall health.
- **Facilitating Government Schemes:** ASHA workers help community members access various healthcare benefits and services provided by the government.
- **Mobilizing Communities:** They encourage community participation in health-related activities and advocate for community involvement in healthcare decisions.
- **Health Camps and Awareness Events:** ASHA workers organize health camps and awareness programs to address specific health concerns and promote health-seeking behaviour.

- **Assisting in Birth and Death Registration:** They assist in the registration of births and deaths within the community.
- **Empowering Women:** ASHAs empower women by providing guidance on health, nutrition, and self-care, and supporting their overall well-being.

The data analysis and interpretation chapter of the study provides valuable insights into the challenges and opportunities facing ASHA workers in Kerala. The findings of the study can be used to inform policy decisions and improve the lives of ASHA workers.

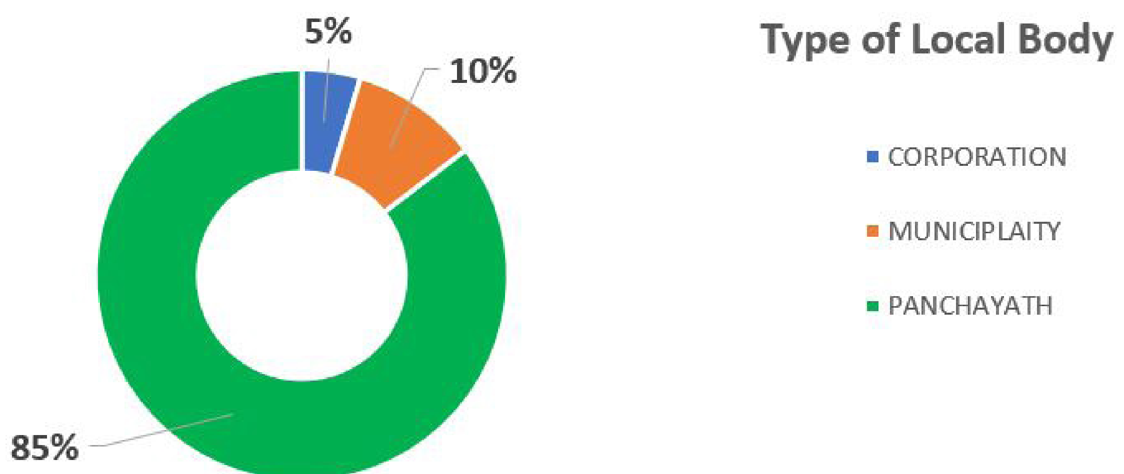
The collected data was written in excel sheet and the analysis was done using descriptive statistics. The level of significance was kept at 0.05 levelled. Analysis and interpretation of data is based on the objectives of the study and hypotheses to be tested.

3.2. SOCIO-DEMOGRAPHIC PROFILE

3.2.1 Location

The data from the table highlights the distribution of ASHAs based on the rural-urban population divide in the State. According to the survey responses, 4.6% of the ASHAs are situated in Municipal Corporation areas, 10.0% are from Municipality areas, and the remaining 85.4% of ASHAs are located in Grama Panchayath areas.

Figure 6: Percentage distribution of ASHAs according to their type of local body

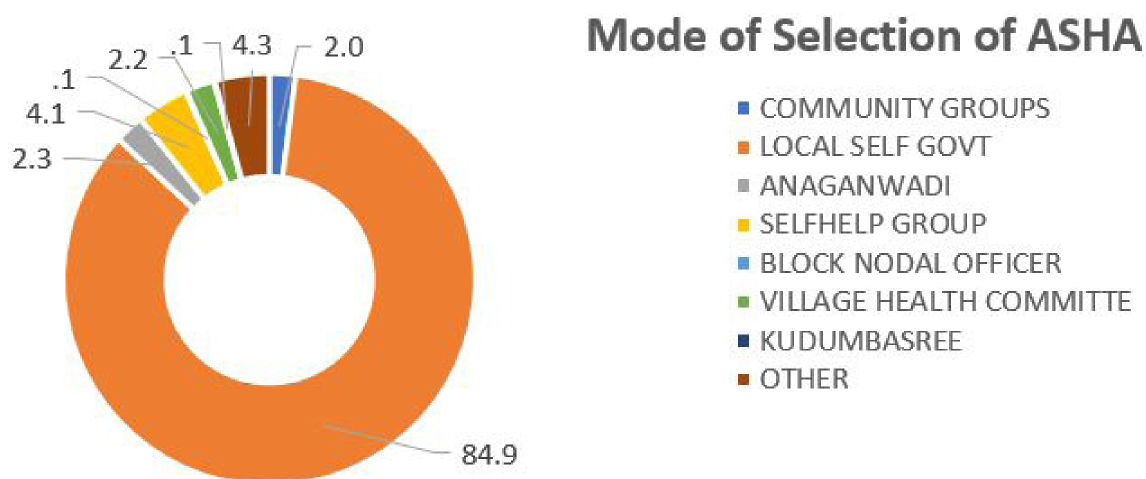


3.2.2 Mode of Selection

The data presented in the table highlights the distribution of ASHAs based on their Mode of Selection. According to the survey responses, the selection methods are as follows:

- 2.0% of ASHAs are selected through community groups, 2.3% are selected through Anganwadi, 4.1% are selected through Self-help Groups, 0.1% are selected through Block Nodal Officer, 2.2% are selected through Village Health Committee, 0.1% are selected through Kudumbasree, 4.3% are selected through other means of selection methods.
- The majority of ASHAs (84.9%) are selected through Local Self Government.

Figure 7: **Percentage distribution of ASHAs according to Mode of Selection**



3.2.3 Age Category

Table 3: Percentage Distribution of ASHA Workers According to Age Category

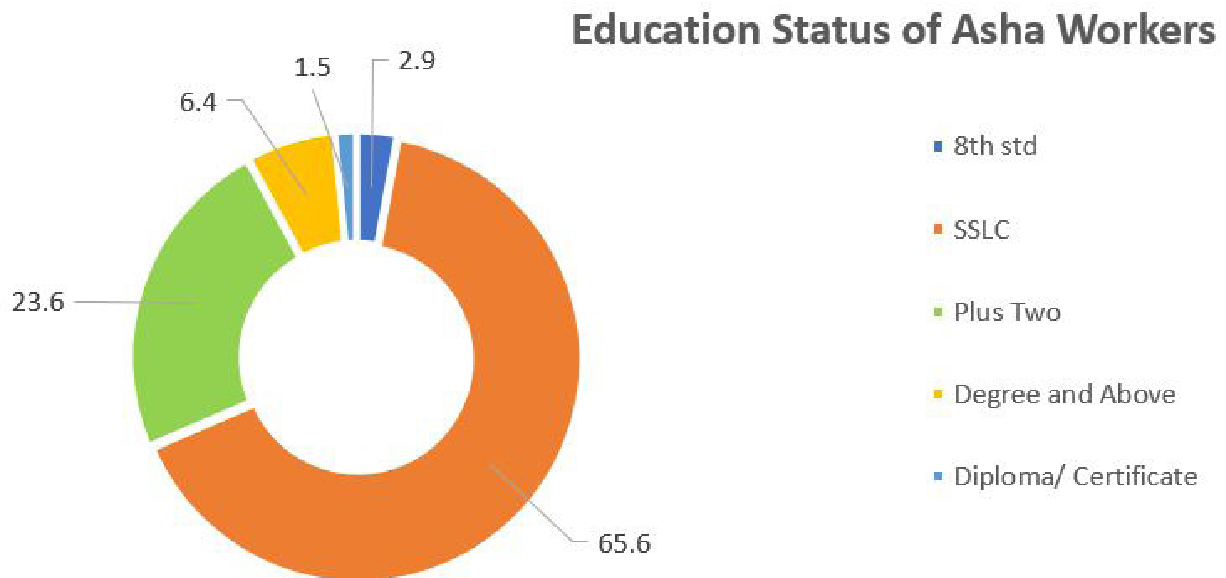
Age Category	Frequency	Percent
20-30	6	.5
31-40	89	7.6
41-50	631	53.9
51-60	442	37.7
61 & above	3	.3
Total	**1171**	**100.0**

The table provides insights into the Age category-wise distribution of ASHAs in the State based on the selected sample. According to the survey results, among the responding ASHAs, 0.5% fall below the age of 30, 7.6% belong to the 31-40 age group, 53.9% are in the 41-50 age group, 37.7% are in the 51-60 age group, and only 0.3% are above 60 years old.

3.2.4 Education Status

The data represented reveals the distribution of ASHAs in the State based on their Education Status. The survey indicates that among the ASHAs who participated, 2.9% have an educational qualification of 8th Standard or below, 65.6% have completed SSLC (Secondary School Leaving Certificate), 1.5% hold a Diploma or Certificate after 10th Standard, 23.6% have completed Plus Two/Pre-Degree, and 6.4% possess a degree or higher qualification.

Figure 8**: Percentage distribution of ASHAs according to Education Status**



3.2.5 LSG wise distribution of ASHAs based on their age

Table 4: Distribution of ASHAs according to Age Category in LSGs

			LSG			Total
			CORP	MUN	PAN	
Age Category	20-30	Count	1	1	4	6
		% within Age Category	16.7%	16.7%	66.7%	100.0%
	31-40	Count	8	11	70	89
		% within Age Category	9.0%	12.4%	78.7%	100.0%
	41-50	Count	29	71	531	631
		% within Age Category	4.6%	11.3%	84.2%	100.0%
	51-60	Count	16	34	392	442
		% within Age Category	3.6%	7.7%	88.7%	100.0%
	61 & Above	Count	0	0	3	3
		% within Age Category	0.0%	0.0%	100.0%	100.0%
Total		Count	54	117	1000	1171
		% within Age Category	4.6%	10.0%	85.4%	100.0%

The data presented in the table clearly demonstrates the LSG (Local Self Government) wise distribution of ASHAs based on their age. Among the ASHAs who responded to the survey:

For those below 30 years old:

- 16.7% reside in Corporation areas,
- 16.7% reside in Municipality areas, and
- 66.7% reside in Grama Panchayath areas.

For those between 31 to 40 years old:

- 9% reside in Corporation areas,
- 12.4% reside in Municipality areas, and
- 78.7% reside in Grama Panchayath areas.

For those between the ages of 41 – 50:

- 4.6% reside in Corporation areas,

- 11.3% reside in Municipality areas, and
- 84.2% reside in Grama Panchayath areas.

For those between the ages of 51 – 60:

- 3.6% reside in Corporation areas,
- 7.7% reside in Municipality areas, and
- 88.7% reside in Grama Panchayath areas.

Additionally, it is worth noting that 100% of the ASHAs above 60 years of age work in Grama Panchayath areas. This is also a reason for the great acceptance of ASHA workers and recognition that they are health workers among the public especially in the rural areas.

3.2.6 LSG Education Status of ASHAs based on their age

Table 5: Educational Status of ASHA Workers according to Age Category

			Educational Qualification					Total
			8th Std	SSLC	Plus Two	Degree & +	Dip/Cert	
Age Category	20-30	Count	0	1	1	3	1	6
		%	0.0	16.7	16.7	50.0	16.7	100.0
	31-40	Count	0	36	40	11	2	89
		%	0.0	40.4	44.9	12.4	2.2	100.0
	41-50	Count	15	416	156	36	8	631
		%	2.4	65.9	24.7	5.7	1.3	100.0
	51-60	Count	17	314	79	25	7	442
		%	3.8	71.0	17.9	5.7	1.6	100.0
	61 & +	Count	2	1	0	0	0	3
		%	66.7	33.3	0.0	0.0	0.0	100.0
Total		Count	34	768	276	75	18	1171
		%	2.9	65.6	23.6	6.4	1.5	100.0

The data presented in the table clearly demonstrates the Education Status wise distribution of ASHAs based on their age. Among the ASHAs who responded to the survey:

For those below 30 years old:

- No ASHAs are below SSLC qualification, 16.7% are SSLC qualified, 16.7% are Plus Two qualified, 50% are Degree qualified, 16.7% are Diploma/ Degree Qualified

For those between 31 to 40 years old:

- No ASHAs are below SSLC qualification, 40% are SSLC qualified, 44.9% are Plus Two qualified, 12.5% are Degree qualified, 2.2% are Diploma/ Degree Qualified

For those between the ages of 41 – 50:

- 2.4% ASHAs are below SSLC qualification, 65.9% are SSLC qualified, 24.7% are Plus Two/ Pre Degree qualified, 5.7% are Degree qualified, 1.3% are Diploma/ Degree Qualified

For those between the ages of 51 – 60:

- 3.8% ASHAs are below SSLC qualification, 71% are SSLC qualified, 17.9% are Plus Two/ Pre Degree qualified, 5.7% are Degree qualified, 1.6% are Diploma/ Degree Qualified

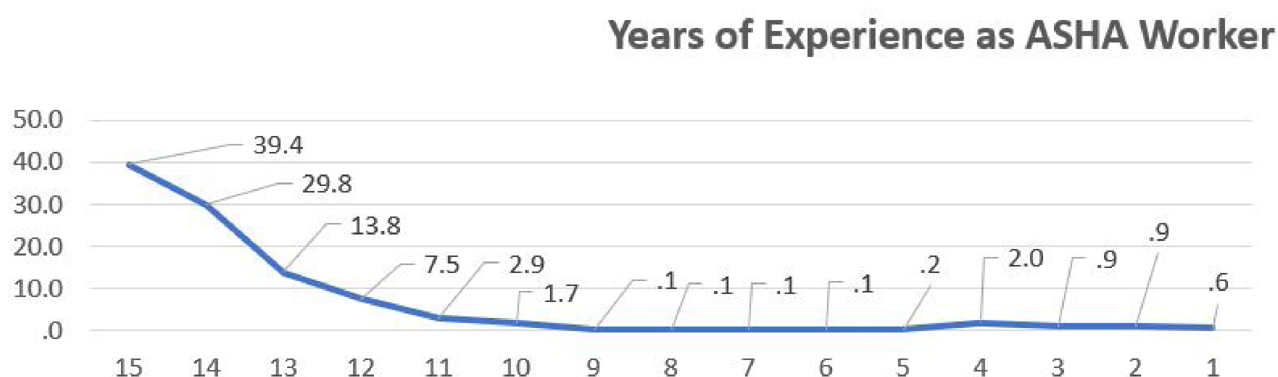
For those between the ages of 51 – 60:

- 66.7% ASHAs are below SSLC qualification, 33.3% are SSLC qualified. No ASHAs above 60 years of age have qualified above SSLC.

3.2.7 Years as ASHA Worker Experience

The table presents the distribution of ASHA Workers based on their years of experience. The survey data indicates the following percentages for each category: 0.4% of ASHAs are newly joined, 0.2% have up to 1 year of experience, 0.9% have 2 years of experience, 0.9% have 3 years, 2% have 4 years, and 0.2% have 5 years. ASHA workers with 6, 7, 8, and 9 years of experience collectively constitute 0.4% of the population. Those with 10 years of experience make up 1.7%, while those with 11 years make up 2.9%, and those with 12 years account for 7.5% of the sample population. Furthermore, ASHAs with 13 years of experience constitute 13.8% of the sample. Notably, the highest proportion of ASHAs falls into the 14 and 15 years of experience categories, making up 29.8% and 39.4% of the population, respectively.

Figure 9: **Percentage distribution of ASHAs according to Years of Experience**



3.2.8 Years as ASHA Worker according to Age Group

Table 6: Years of working as ASHA Worker according to Age Group

			Number of Years as ASHA			Total
			0-5 Years	6-10 Years	11-15 Years	
Age Category	0-30	Count	5	0	1	6
		%	83.3	0.0	16.7	100.0
	31-40	Count	18	3	68	89
		%	20.2	3.4	76.4	100.0
	41-50	Count	28	17	586	631
		%	4.4%	2.7	92.9	100.0
	51-60	Count	2	4	436	442
		%	0.5	0.9	98.6	100.0
	61 &	Count	0	0	3	3
		%	0.0	0.0	100.0	100.0
Total		Count	53	24	1094	1171
		%	4.5	2.0	93.4	100.0

The data presented in the table clearly demonstrates the number of years of experience wise distribution of ASHAs based on their age. Among the ASHAs who responded to the survey:

For those below 30 years old:

- 83.3% in the below 30 age group have less than 5 years of experience,
- 16.7% in the below 30 age group fall in the 11 – 15 years of experience

For those between 31 to 40 years old:

- 20.2% in the between 31 - 40 age group have less than 5 years of experience.
- 3.4% in the between 31 - 40 age group fall in the 6 - 10 years of experience.
- 76.4% in the between 31 - 40 age group fall in the 11 – 15 years of experience.

For those between the ages of 41 – 50:

- 4.4% in the between 41 - 50 age group have less than 5 years of experience.
- 2.7% in the between 41 - 50 age group fall in the 6 - 10 years of experience.
- 92.9% in the between 41 - 50 age group fall in the 11 – 15 years of experience.

For those between the ages of 51 – 60:

- 0.5% in the between 51 – 60 age group have less than 5 years of experience
- 0.9% in the between 51 – 60age group fall in the 6 - 10 years of experience.
- 98.6% in the between 51 – 60age group fall in the 11 – 15 years of experience.

Additionally, 100% of the ASHAs above 60 years of age have 11 – 15 years of experience group.

3.2.9 Marital Status

The table illustrates the distribution of Marital Status among ASHA workers. According to the survey, among the participating ASHAs, the majority, 89.8%, are married. A very small percentage, 0.1%, are unmarried, and 10.2% were once married but are now single.

Table 7: Marital Status of ASHA Workers

Status	Frequency	Percent
Married	1051	89.8
Unmarried	1	.1
Married but Single	119	10.2
Total	1171	100.0

3.3. KNOWLEDGE ABOUT WORKING CONDITIONS AND TRAINING PROFILE

3.3.1 Duties and Responsibilities of ASHA Workers

Table 8: Duties and Responsibilities Undertaken by ASHA Workers

Duties/ Responsibilities	Frequency	Percent
• Health Awareness and Education • Maternal and Child Health • Family Planning Guide • Immunization Campaigns • New-born Care • Referral and Escort Services • Health Monitoring and Reporting • Nutrition and Sanitation • Facilitating Government Schemes • Mobilizing Communities • Health Camps and Awareness Events • Assisting in Birth and Death Registration • Old age support through Ardram Scheme	1171	100.0

The table sheds light on the duties and responsibilities of ASHA workers, as well as their awareness regarding these tasks. According to the survey, all participating ASHAs (100%) are fully aware of their duties and responsibilities and have provided detailed descriptions of their day-to-day activities.

3.3.2 Proof of Appointment

Table 9: Whether Proof for Document of Appointment Received

	Frequency	Percent
NO	1171	100.0

From the given table, the following inference can be drawn regarding whether any proof for appointment was given at the time of appointing ASHAs:

1. No Proof Given: The entire dataset (100%) indicates that no proof of appointment was given to ASHAs at the time of their appointment. This suggests that ASHAs were not provided with any formal documentation or proof to verify their appointment as ASHA workers.

Overall, the table indicates that ASHAs were appointed without any formal proof or documentation at the time of their appointment. This lack of documentation may have implications for the official recognition and support of ASHAs in their roles as frontline health workers. Having proper documentation can be crucial for ASHAs to access various benefits, training opportunities, and official recognition, and it may also facilitate smoother coordination with healthcare authorities and community members. Therefore, it is important to address this gap and ensure that ASHAs are appropriately recognized and provided with the necessary documentation to carry out their responsibilities effectively. (Table 3.11 and Fig. 3.11).

3.3.3 Awareness about Working Hours

Table 10: Awareness about Working Hours as per Guidelines

	Frequency	Percent
Aware	413	35.3
Unaware	758	64.7
Total	1171	100.0

The table provides insights into the distribution of ASHA workers' awareness regarding their designated working hours. According to the survey, among the participating ASHAs, the majority, comprising 64.7%, are unaware of the stipulated working hours they are supposed to adhere to. Instead, many of them responded that they work seven days a week without any holidays or medical leaves, even though there might be some stipulations in place.

On the other hand, approximately one third of ASHAs (35.3%) are indeed aware of their stipulated working hours.

3.3.4 Reported Working Hours

The data represented the distribution of ASHA workers' current working hours.

1. Majority Work Above 8 Hours per Day: The largest proportion of ASHAs, accounting for 49.1%, reported working for more than 8 hours per day. This suggests that a significant number of ASHAs are putting in long hours to fulfil their responsibilities and serve their communities effectively.

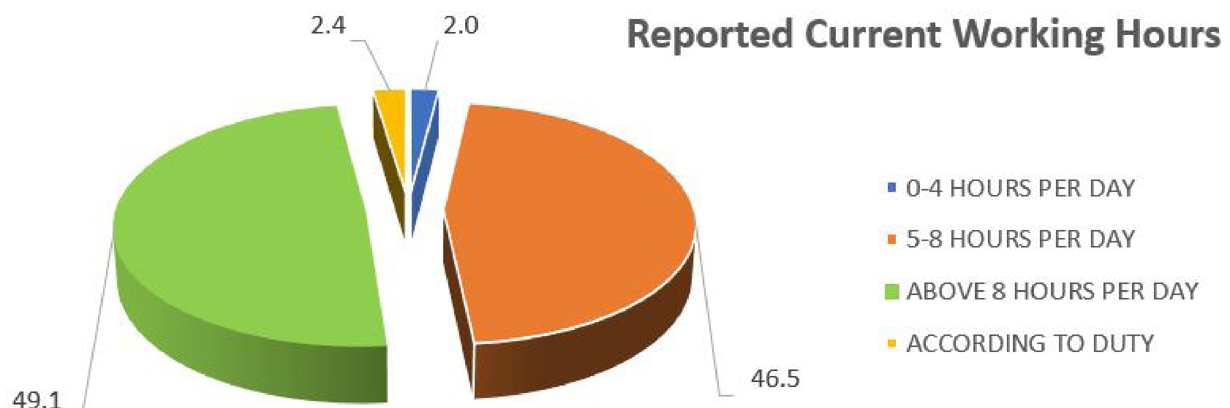
2. Substantial Number Work 5-8 Hours per Day: Approximately 46.5% of ASHAs reported working between 5 to 8 hours per day. This indicates that a considerable portion of ASHAs adhere to a regular working schedule within this time range.

3. Few 0-4 Hours per Day: Only a small fraction of ASHAs, amounting to 2.0%, reported working for 0 to 4 hours per day. This could be due to various factors such as part-time employment or a lower workload in certain areas.

4. Some Work According to Duty: A minor proportion (2.4%) of ASHAs mentioned that they work according to their duty. This category might include those ASHAs who work on an on-call or irregular basis, responding to specific healthcare needs as required.

Overall, the table indicates that a significant number of ASHAs are putting in long working hours, with almost half of them working for more than 8 hours a day. This highlights the dedication and commitment of ASHAs towards their role as frontline health workers in their communities. It also emphasizes the importance of considering their well-being, workload management, and ensuring that their efforts are adequately recognized and supported to maintain the quality of healthcare services they provide.

Figure 10: Percentage distribution of ASHA's reported current working hours



3.3.5 Honorarium Received

Table 11: Present Honorarium of ASHA Workers

	Frequency	Percent
Six Thousand	1171	100.0

The table presents an overview of the distribution of ASHA workers' current honorarium status. According to the survey, all participating ASHAs (100%) reported receiving a monthly honorarium of INR six thousand. However, when considering that ASHA workers are required to work approximately 8 hours per day throughout the month, the average daily pay-out for them amounts to just INR 200. This disparity raises concerns about the adequacy of their compensation.

As per the Rajya Sabha Unstarred Question No. 2165, answered on the 22nd of March, 2022, the Central Government declared that a fixed incentive of only INR 2000 is provided to ASHA workers across the country. However, the Government of Kerala has taken steps to improve this situation by granting additional sanctions of INR 4000, bringing the total honorarium for ASHA workers in the state to INR 6000.

In comparison, in states where the Minimum Wage Act is implemented, the guaranteed minimum wage for domestic labor stands at approximately INR 13,000, resulting in an average daily minimum wage of around INR 520. This significant difference highlights the disparity between the current honorarium of ASHA workers and the minimum wage standards set in the state.

The data underscores the importance of addressing fair compensation for ASHA workers, ensuring that their efforts and dedication in providing essential healthcare services are appropriately recognized and remunerated.

3.3.6 Awareness about the Source of Honorarium

The data presented provides valuable insights into ASHA workers' awareness regarding the source of their honorarium. The survey reveals a varied distribution of responses among the participating ASHAs, reflecting their perceptions and understanding of where their honorarium comes from.

- **Government of Kerala (48.9%):** Nearly half of the ASHA workers (48.9%) reported that, based on their understanding, their honorarium is provided by the Government

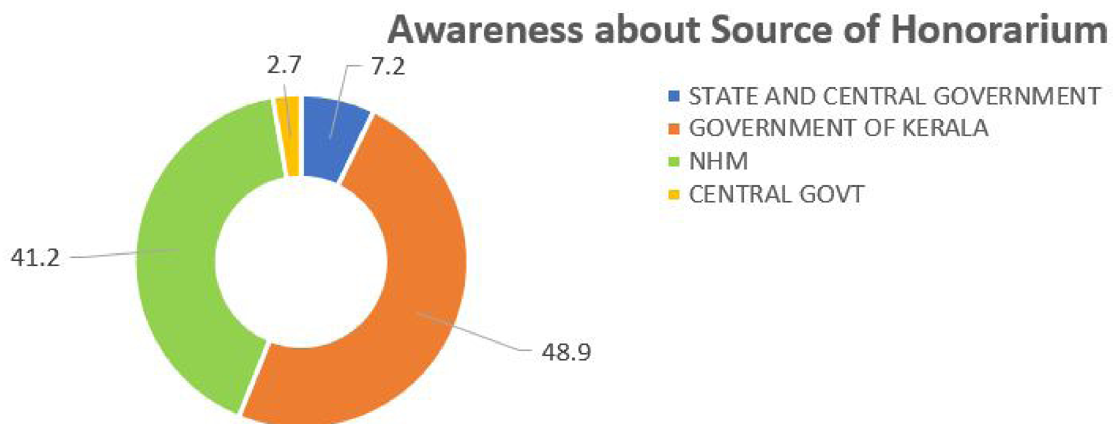
of Kerala. This indicates that a significant portion of ASHAs is aware that the state government is responsible for disbursing their monthly payments.

- **National Health Mission (41.2%):** More than 40% of ASHAs (41.2%) believe that their honorarium is disbursed by the National Health Mission. The National Health Mission is a flagship health program implemented by the Central Government to address various health issues, including maternal and child health, and it plays a role in supporting ASHA workers across the country.

- **Both State and Central Governments (7.2%):** A small percentage of ASHA workers (7.2%) reported that they believe both the State and Central Governments together release their honorarium. This perception might stem from a collective understanding that funding and support for ASHA workers' honorarium come from both levels of government.

- **Central Government (2.7%):** A very small proportion of ASHAs (2.7%) believe that the Central Government is solely responsible for providing their honorarium. It is essential to note that while a portion of financial support come from the Central Government, the actual disbursement and management of funds are done through the State Government machinery.

Figure 11: Percentage distribution of ASHA's awareness about the source



3.3.7 Punctuality in Honorarium disbursement

Table 12: Punctuality of Honorarium Disbursement

	Frequency	Percent
No	1171	100.0

The table provides valuable insights into ASHA workers' responses regarding the punctuality of honorarium disbursement. The survey results reveal a significant and concerning trend, as all participating ASHAs (100%) reported that their monthly honorarium has never been disbursed on time.

This finding highlights a critical issue faced by ASHA workers, indicating that the timely payment of their honorarium has been consistently problematic. Punctual and regular payment is essential for the financial stability of ASHA workers, as they rely on their honorarium to support themselves and their families. (Table 12).

3.3.8 Reason for Delay in Honorarium disbursement

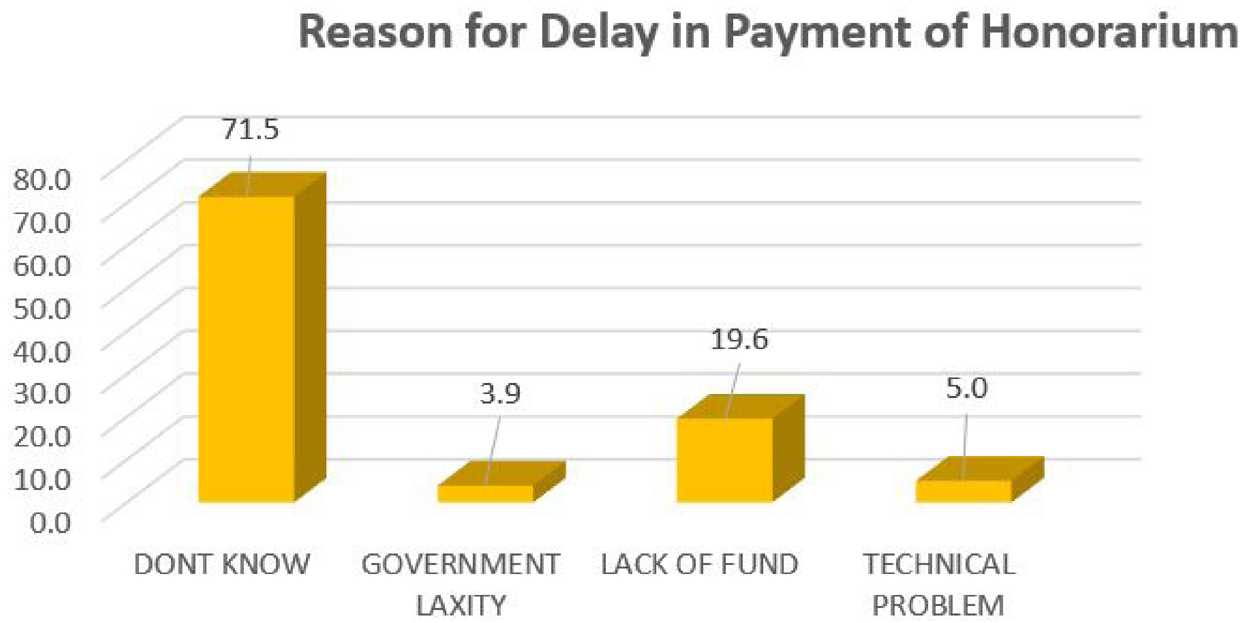
The given figure representation provides insights into the awareness among ASHA workers about the reasons for the delay in the disbursement of their honorarium. From the survey results, we can infer the following:

1. **Lack of Awareness:** The majority of ASHA workers (71.5%) seem to have little to no knowledge about the reasons behind the delay in receiving their honorarium. This suggests that a significant portion of the respondents is unaware of the specific factors causing the delay.
2. **Government Laxity:** A small percentage (3.9%) of ASHA workers believe that the delay is due to government laxity or negligence. This indicates that some respondents perceive administrative or bureaucratic issues as a potential reason for the delayed payments.
3. **Lack of Funds**: About 19.6% of the respondents believe that the delay in disbursement is a result of the government's lack of funds. This suggests that a notable proportion of ASHA workers believe that insufficient budget allocation is causing the delay in receiving their honorarium.
4. **Technical Problems:** A smaller fraction (5.0%) of ASHA workers think that technical problems could be responsible for the delayed payment of their honorarium. This implies that a few respondents believe that issues related to technology or systems might be causing the delay.

Overall, the table reveals a lack of clear awareness among ASHA workers about the exact reasons for the delay in the disbursement of their honorarium. While some respondents speculate that it could be due to government laxity, insufficient funds, or technical problems, the majority are uncertain about the specific cause. This indicates a need for improved

communication and transparency to address the concerns of ASHA workers and ensure timely payment of their honorarium. (Fig.12)

Figure 12: Percentage distribution of awareness about the delay in disbursement of ASHA's monthly honorarium



3.3.9 Whether Training Received other than Basic Training

From the given figure, we can draw the following inferences regarding whether ASHAs have received any training other than their basic training:

1. **Training Received:** The majority of ASHAs, constituting 71.1%, have received additional training beyond their basic training. This suggests that a significant proportion of ASHAs have undergone further education and skill development to enhance their capabilities in providing healthcare services.

2. **No Training Received:** Approximately 28.9% of ASHAs have not received any additional training beyond their basic training. This indicates that there is a considerable group of ASHAs who may not have had access to continuous professional development or specialized training in specific healthcare domains.

Overall, the table indicates that a significant number of ASHAs have received additional training, which is encouraging as it implies efforts to improve the knowledge and skills of these healthcare workers. However, the percentage of ASHAs who have not received any further training also highlights the need for ensuring that all ASHAs have access to continuous

learning opportunities to keep them well-equipped and updated in their roles as frontline health workers. Providing ongoing training and professional development can contribute to the quality of healthcare services delivered by ASHAs and their ability to address the diverse health needs of their communities effectively. (Fig. 13)

Figure 13: Percentage distribution of awareness about the delay in disbursement of ASHA's monthly honorarium

3.3.10 Details of Training Received

Table 13: Punctuality of Honorarium Disbursement

	Frequency	Percent
Communicable Disease, Non-Communicable Disease, Palliative care training	10	.9
Communicable Disease, Non-Communicable Disease, Palliative care training and IT training	133	11.4
IT Training only	205	17.5
IT and Palliative care training	14	1.2
Non-Communicable Disease Training	400	34.2
No Training Received	338	28.9
Palliative care and other health service Training	71	6.1
Total	**1171**	**100.0**

Based on the data in the table, the following inferences can be drawn about the details of training received by ASHAs other than their basic training:

1. **Non-Communicable Disease Training:** The largest proportion of ASHAs (34.2%) have received training specifically focused on non-communicable diseases. This suggests that a significant number of ASHAs have been equipped with knowledge and skills to address health issues related to non-communicable diseases such as diabetes, hypertension, cardiovascular diseases, etc.

2. **IT Training:** Approximately 17.5% of ASHAs have received training related to information technology (IT). This indicates that a notable portion of ASHAs has been trained in utilizing technology, which can potentially enhance their efficiency and effectiveness in delivering healthcare services and data management.

3. **No Training Received:** A considerable number of ASHAs (28.9%) have not received any additional training beyond their basic training. This may indicate a gap in providing continuous professional development to this group of ASHAs, which could be important for improving their capacity to serve the community effectively.

4. **Combination of Trainings:** Some ASHAs have received a combination of different types of training:

- Communicable Disease, Non-Communicable Disease, Palliative Care Training: 0.9% of ASHAs fall into this category, indicating a small fraction has received training covering multiple aspects of health care.

- Communicable Disease, Non-Communicable Disease, Palliative Care, and IT Training: 11.4% of ASHAs have received a comprehensive training program covering communicable diseases, non-communicable diseases, palliative care, and information technology.

5. **Palliative Care and Other Health Service Training:** 6.1% of ASHAs have received training in palliative care and other health services. This indicates a portion of ASHAs have been trained to provide specialized care to individuals with life-limiting illnesses and may have knowledge about a range of health services beyond their basic training.

Overall, the table illustrates the varying levels of training received by ASHAs, with a substantial number having received training in non-communicable diseases, and a significant portion still not having received any additional training beyond their basic training. To ensure effective community healthcare delivery, it is essential to continue providing professional development opportunities and addressing the specific needs of ASHAs in different health-related domains. (Table 13)

3.3.11 Whether Received Trainings were Sufficient

From the given figure, we can draw the following inferences regarding the sufficiency of the received trainings for ASHAs (Accredited Social Health Activists):

1. **Insufficient Training:** The majority of ASHAs, comprising 56.7%, responded with "NO" when asked if the received trainings were sufficient. This suggests that a significant proportion of ASHAs feel that the training they have received so far is not adequate or comprehensive enough to fulfil their responsibilities effectively.

2. **Sufficient Training:** Only 14.4% of ASHAs responded with "YES," indicating that they believe the training they have received has been sufficient to equip them with the necessary knowledge and skills for their roles.

3. **Not Applicable (NA):** A considerable number of ASHAs, amounting to 28.9%, responded with "NA," indicating that they might not have received any additional training beyond their basic training. As a result, they might not have a basis to judge whether the received training was sufficient or not.

Overall, the table indicates that a significant proportion of ASHAs express concerns about the sufficiency of the training they have received. This highlights the importance of addressing the training needs of ASHAs, providing continuous professional development, and ensuring that they have access to quality education and skill enhancement programs. Adequate and comprehensive training is crucial to empower ASHAs to deliver high-quality healthcare services and fulfil their vital roles as frontline health workers effectively. (Fig. 14)

Figure 14: Percentage distribution of ASHA's response about the adequacy of received trainings

3.3.12 Requirement of Additional Trainings

From the given data on the requirement for additional training among ASHAs, we can draw the following inferences:

1. **Health Care Training + First Aid:** About 22.0% of ASHAs expressed a need for additional training in health care and first aid. This suggests that a significant portion of ASHAs feel that enhancing their knowledge and skills in healthcare practices and providing first aid is important for their roles as frontline health workers.

2. **Health Care and IT Training + Medical Equipment (BP Apparatus, Glucometer etc.):** The largest proportion of ASHAs, accounting for 40.5%, expressed a requirement for a combination of health care and IT training, along with training in using medical equipment. This indicates that a substantial number of ASHAs believe that having expertise in both healthcare practices and technology, as well as the proper utilization of medical equipment, is essential to enhance their effectiveness in providing healthcare services.

3. **IT Training + Medical Equipment (BP Apparatus, Glucometer etc.):** Approximately 20.6% of ASHAs stated a need for training in IT skills along with learning how to use medical equipment. This highlights the importance of technology-related training for ASHAs, as it can aid them in data management, communication, and improving overall efficiency in their roles.

4. **No More Training Needed:** A notable percentage of ASHAs, comprising 16.9%, expressed that they believe they do not need any more training beyond their existing knowledge and skills. This group might feel confident in their abilities and may have already received comprehensive training.

Overall, the data indicates that there is a demand for additional training among ASHAs, particularly in areas such as health care, first aid, IT skills, and the utilization of medical equipment. Addressing these training needs is crucial to empower ASHAs and ensure that they have the necessary expertise and capabilities to provide high-quality healthcare services to their communities effectively. By tailoring training programs to meet these specific requirements, ASHAs can be better equipped to face the challenges of their roles as frontline health workers.

Table 14: Requirement of Additional Trainings

	Frequency	Percent
Health Care Training +First Aid	258	22.0
Health Care and It Training + Medical Equipment	474	40.5
IT Training + Medical Equipment	241	20.6
No More Training Needed	198	16.9
Total	1171	100.0

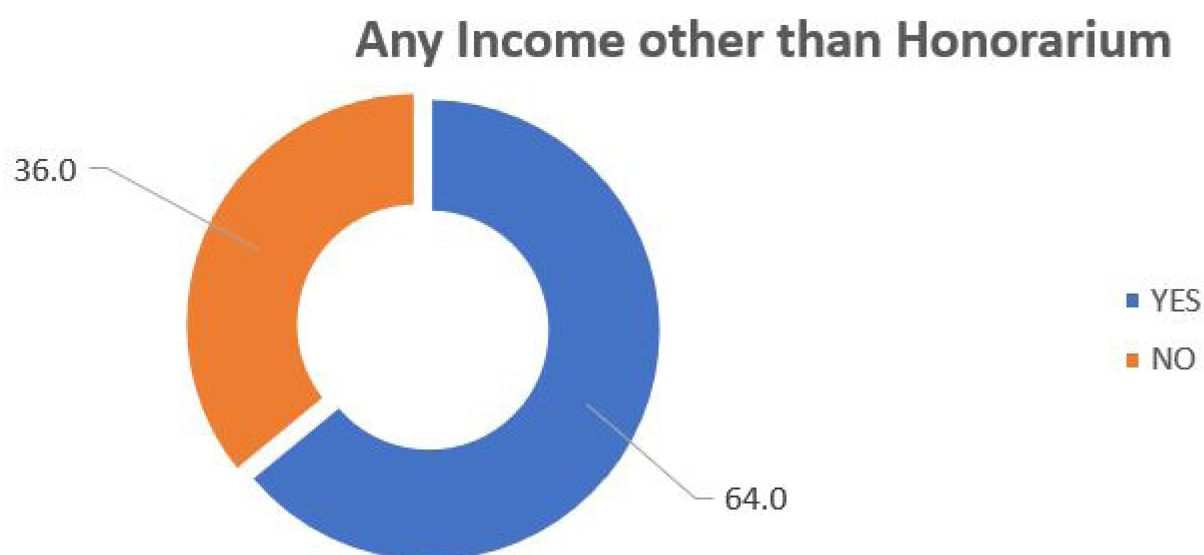
3.4 INCOME AND SOCIAL SECURITY PROFILE

3.4.1 Any Income other than Honorarium

The figure sheds light on whether ASHA workers are getting any , as well as their awareness regarding these tasks.

1. Additional Income: A significant majority of ASHA workers, constituting 64.0%, reported having income other than the honorarium they receive.
2. No Additional Income: Approximately 36.0% of ASHA workers stated that they do not have any income other than the honorarium they receive (Fig. 15).

Figure 15: Percentage distribution of ASHAs Response about Income other than Honorarium



3.4.2 Any Income other than Honorarium from within the work they do

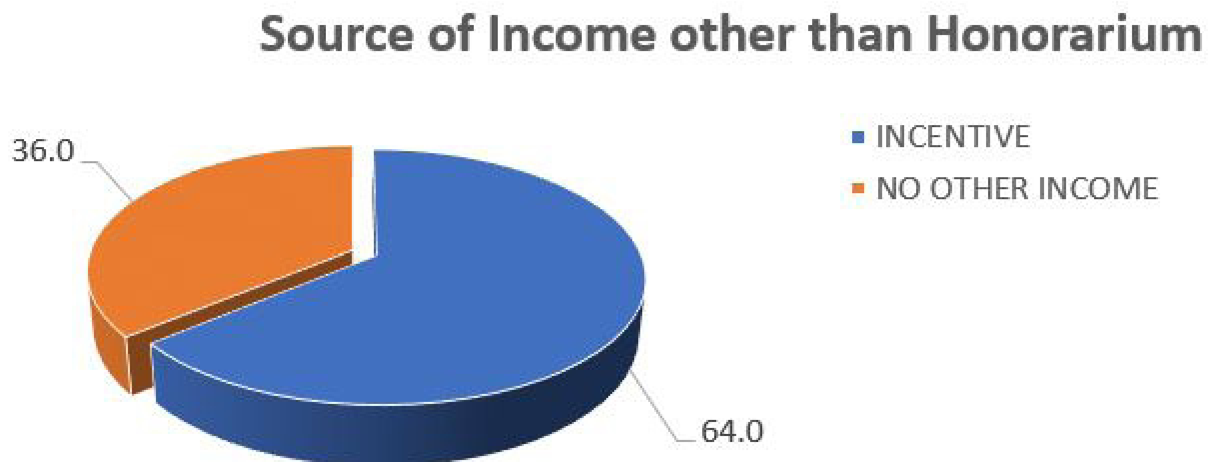
From the given data on the source of additional income for ASHA workers from within the work they do, we can draw the following inferences:

1. Incentive as Source of Additional Income: The majority of ASHA workers, constituting 64.0%, reported receiving incentives as a source of additional income. Incentives could be provided as rewards or bonuses for achieving certain healthcare targets or milestones. This suggests that a significant proportion of ASHA workers are motivated by such incentives, and it might encourage them to perform better in their roles.

2. No Other Income: Approximately 36.0% of ASHA workers stated that they do not have any other source of income apart from their regular earnings. This implies that a considerable number of ASHA workers rely solely on their primary income, which is the honorarium they receive for their services as ASHAs.

Overall, the data indicates that a significant portion of ASHA workers receive incentives as a form of additional income. These incentives could serve as a means of recognition and encouragement for their efforts in providing healthcare services to their communities. However, it is important to ensure that the incentive system is fair, transparent, and aligns with the overall goals of improving healthcare outcomes and community engagement. Additionally, the proportion of ASHA workers without any other income highlights the potential financial challenges they may face, making it crucial to consider ways to improve their financial well-being and support them in fulfilling their essential roles as frontline health workers.

Figure 16: Percentage distribution of ASHAs declaration about source of income other than honorarium



3.4.3 Availing of Holidays

Table 15: Response on availing of Holidays

	Frequency	Percent
Yes	359	30.7
No	812	69.3
Total	1171	100.0

From the given data on ASHA workers' response about getting a day off on national and state holidays, he following inference can be drawn:

1. No Day Off on Holidays: The majority of ASHA workers, comprising 69.3%, reported that they do not get a day off on national and state holidays. This indicates that a significant proportion of ASHA workers are expected to work even on public holidays.

2. Some Get Day Off: Approximately 30.7% of ASHA workers stated that they do get a day off on national and state holidays. This suggests that there is a portion of ASHA workers who are granted leave on public holidays.

Overall, the data highlights that a considerable number of ASHA workers do not receive a day off on national and state holidays. This lack of time off on public holidays could have implications for their well-being, work-life balance, and overall job satisfaction. It is essential to consider the importance of rest and leave for frontline health workers like ASHAs, who play a vital role in providing healthcare services to their communities. Providing appropriate leave benefits and ensuring a reasonable work schedule can contribute to the overall welfare and efficiency of ASHA workers, ultimately leading to better healthcare outcomes. (Table 15).

3.4.4 Subscription to Insurance

From the given data on the subscription to insurance of ASHA workers, we can draw the following inference:

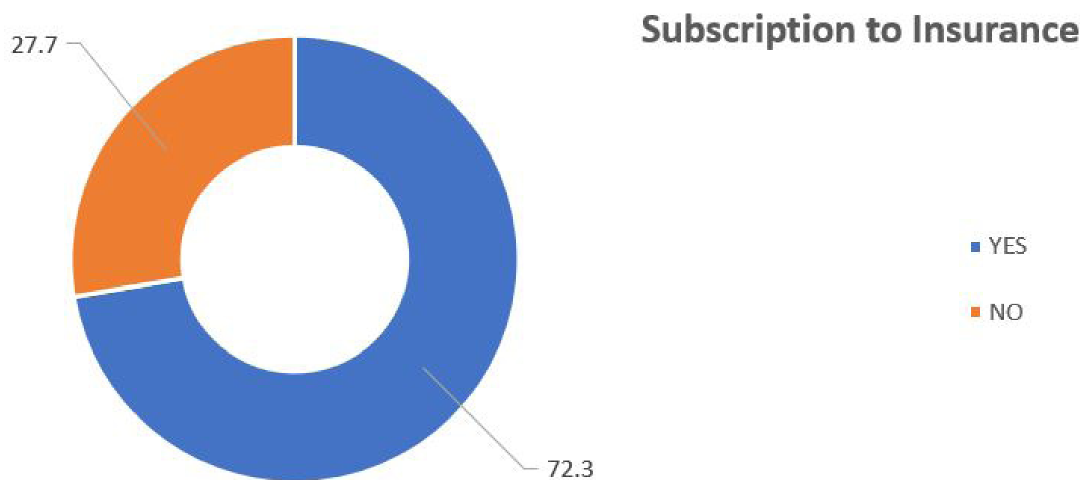
1. **Insurance Subscription:** The majority of ASHA workers, comprising 72.3%, reported that they have subscribed to insurance. This indicates that a significant proportion of ASHA workers have opted for insurance coverage.

2. **No Insurance Subscription:** Approximately 27.7% of ASHA workers stated that they do not have insurance coverage. This suggests that there is a notable portion of ASHA workers who have not subscribed to any insurance plan.

Overall, the data indicates that a significant majority of ASHA workers have chosen to subscribe to insurance. However, it is crucial to note that the current insurance coverage provided to ASHA workers through the Pradhan Mantri Jeevan Jyoti Beema Yojana (PMJJBY) and Pradhan Mantri Suraksha Beema Yojana (PMSBY) by the Government of India only offers benefits in the event of death or permanent full or partial disability. Unfortunately, these insurance schemes do not provide financial protection and security for unforeseen medical expenses or emergencies.

The fact that a portion of ASHA workers still do not have insurance coverage raises important concerns. It is necessary to understand the reasons behind this and take measures to improve awareness and accessibility of insurance options for ASHA workers. Ensuring the well-being and financial stability of ASHA workers is essential, and providing comprehensive insurance coverage that addresses their healthcare needs could be an important step in supporting their valuable contributions to the healthcare system.

Figure 17: Percentage distribution of ASHAs Response about Insurance Subscription



3.4.5 Details of ASHA's Subscription to Insurance

From the figure on the details of insurance for ASHA workers, we can draw the following inferences:

1. **Lack of Awareness:** A small proportion of ASHA workers (1.8%) responded with "DON'T KNOW" regarding the details of their insurance coverage. This suggests that there is a lack of awareness or clarity among some ASHA workers about the specific insurance scheme they are enrolled in.

2. **No Insurance:** Approximately 27.7% of ASHA workers stated that they have “NO INSURANCE.” This indicates that a significant portion of ASHA workers do not have any insurance coverage, leaving them vulnerable to financial risks associated with healthcare expenses.

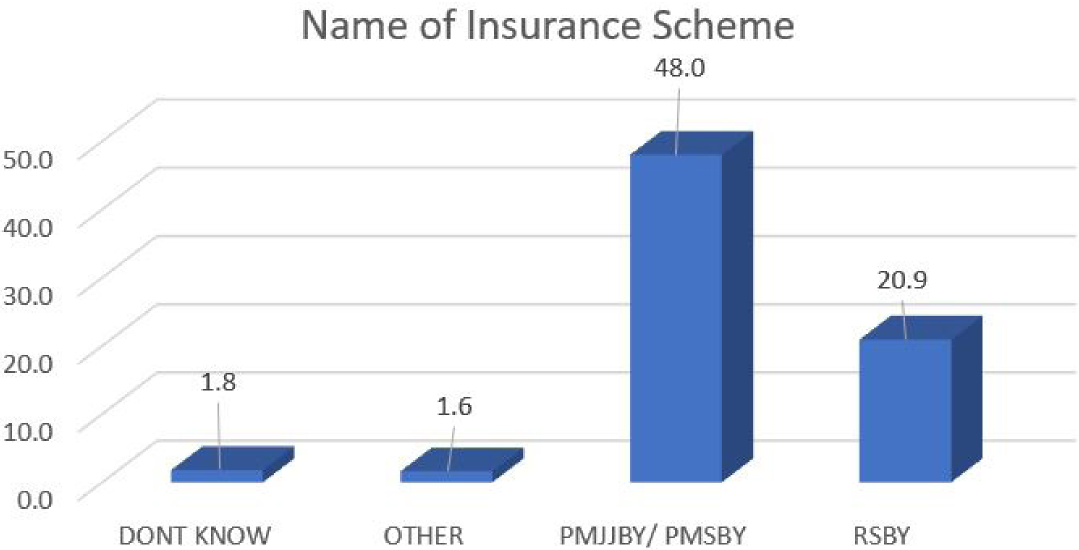
3. **Other Insurance:** Only a small percentage of ASHA workers (1.6%) mentioned “OTHER” insurance schemes. The details of these alternative insurance schemes are not specified in the data.

4. **PMJJBY/PMSBY:** The majority of ASHA workers, comprising 48.0%, reported being enrolled in the Pradhan Mantri Jeevan Jyoti Beema Yojana (PMJJBY) and Pradhan Mantri Suraksha Beema Yojana (PMSBY). These are government-sponsored insurance schemes that provide benefits in the event of death or permanent full or partial disability.

5. **RSBY:** About 20.9% of ASHA workers stated that they have RSBY (Rashtriya Swasthya Bima Yojana) insurance. RSBY is a government-sponsored health insurance scheme that aims to provide financial protection to families below the poverty line.

Overall, the data reveals a mix of insurance coverage among ASHA workers. While a significant number are enrolled in the government-sponsored PMJJBY/PMSBY and RSBY schemes, a notable portion does not have any insurance coverage. Addressing the lack of awareness and expanding insurance coverage to all ASHA workers could be essential steps to ensure their financial security and well-being, especially given their critical role in providing healthcare services to communities. (Fig. 18).

Figure 18: Percentage distribution of ASHAs response about Details of Insurance Scheme they are subscribed to



3.4.6 Details of Subscription to Welfare Schemes

Table 16: Response about Welfare Scheme Subscription

	Frequency	Percent
Yes	301	25.7
No	870	74.3
Total	1171	100.0

From the given data on ASHA worker's subscription to welfare schemes, we can draw the following inference:

1. **Low Welfare Scheme Subscription:** The data shows that a significant majority of ASHA workers, comprising 74.3%, have not subscribed to any welfare scheme. This suggests that a large proportion of ASHA workers are not benefiting from any specific welfare program or support.
2. **Limited Welfare Scheme Subscription:** Only 25.7% of ASHA workers reported subscribing to welfare schemes. This indicates that there is a relatively small percentage of ASHA workers who have availed themselves of welfare programs or support.

Overall, the data highlights that the majority of ASHA workers do not have subscriptions to welfare schemes. This lack of participation in welfare programs may indicate potential challenges or gaps in accessing social security measures and benefits for ASHA workers. Ensuring that ASHA workers have access to welfare schemes and social support can be essential in addressing their needs and improving their overall well-being. It is crucial to explore ways to increase awareness about available welfare schemes and promote their enrollment to better support ASHA workers in their critical roles as frontline health workers. (Table 16).

3.4.7 Details of Subscription to Welfare Schemes

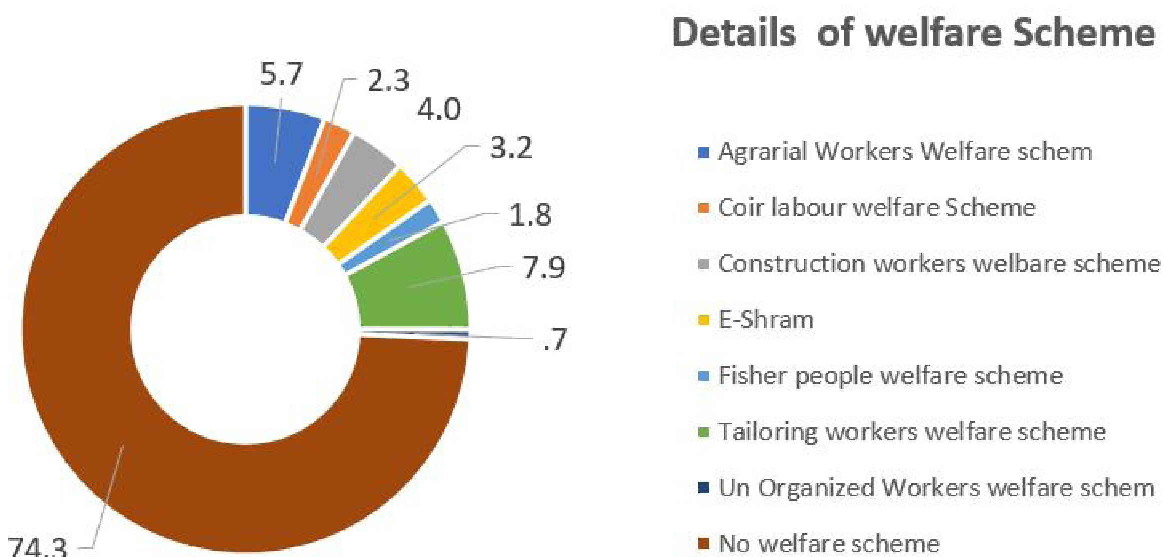
From the given data on the details of subscription to welfare schemes by ASHA workers, we can draw the following inference:

1. **Limited Subscription to Welfare Schemes:** The majority of ASHA workers, comprising 74.3%, reported that they have not subscribed to any welfare scheme. This indicates that a significant proportion of ASHA workers have not enrolled in specific welfare programs designed to support workers in various sectors.
2. **Participation in Various Welfare Schemes:** Among the ASHA workers who have subscribed to welfare schemes, there is a distribution across different welfare programs:

- **Agrarian Workers Welfare Scheme:** 5.7% of ASHA workers are part of this scheme, which provides support and benefits to those engaged in agriculture-related work.
- **Coir Labour Welfare Scheme:** 2.3% of ASHA workers are enrolled in this scheme, which offers welfare benefits to workers involved in the coir industry.
- **Construction Workers Welfare Scheme:** 4.0% of ASHA workers are part of this scheme, which aims to provide assistance to laborers in the construction sector.
- **E-Shram**: 3.2% of ASHA workers are part of this scheme, which is a digital platform for workers in the unorganized sector to access social security benefits.
- **Fisher People Welfare Scheme:** 1.8% of ASHA workers are enrolled in this scheme, which provides support to individuals engaged in fishing activities.
- **Tailoring Workers Welfare Scheme:** 7.9% of ASHA workers are part of this scheme, which offers welfare benefits to those involved in tailoring work.
- **Unorganized Workers Welfare Scheme:** Only 0.7% of ASHA workers are part of this scheme, which focuses on providing support to workers in the unorganized sector.

Overall, the data indicates that while there is participation in various welfare schemes by some ASHA workers, the majority do not have subscriptions to any welfare scheme. This suggests that there might be opportunities to increase awareness and facilitate access to welfare programs for ASHA workers to improve their socio-economic well-being. Ensuring that ASHA workers are aware of and can avail themselves of suitable welfare schemes can be beneficial in recognizing and supporting their essential contributions as frontline health workers.

Figure 19: Percentage distribution of ASHAs Knowledge about Name of Welfare Scheme



3.4.8 Details of other Financial Aid

Table 17: Response about other Financial Aid from Government

	Frequency	Percent
No	1171	100.0

From the given data on financial aid received from the government by ASHA workers, we can draw the following inference:

1. No Financial Aid: The entire dataset (100%) indicates that ASHA workers have not received any financial aid from the government. This suggests that, based on the information provided, there has been no direct financial support or assistance provided to ASHA workers by the government.

Overall, the data highlights that ASHA workers have not received any financial aid from the government. This lack of financial support may have implications for the economic well-being of ASHA workers, who play a crucial role in delivering healthcare services to their communities. Ensuring appropriate financial aid and support for ASHA workers could be essential in recognizing and valuing their contributions as frontline health workers and in improving their overall socio-economic conditions.

3.5. ATTITUDE AND SOCIAL ACCEPTANCE PROFILE

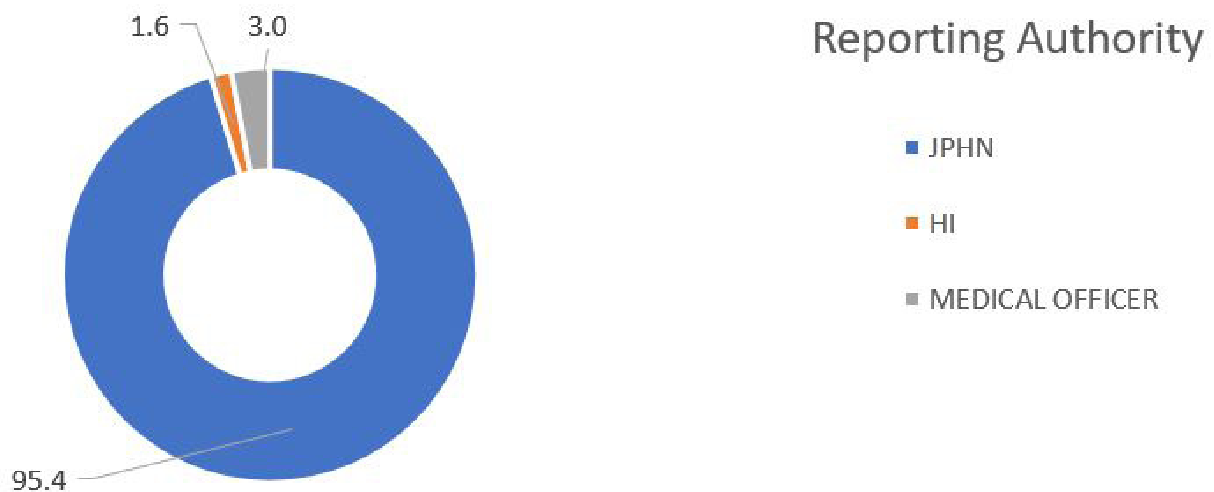
3.5.1 Awareness about Reporting Authority

From the given data on the awareness of ASHA workers about their reporting authority, we can draw the following inferences:

1. **Reporting Authority:** The majority of ASHA workers, constituting 95.4%, reported that their reporting authority is the JPHN (Junior Public Health Nurse). This indicates that a significant proportion of ASHA workers are aware that they are required to report to the Junior Public Health Nurse in their respective healthcare system.
2. **Limited Awareness:** A small percentage of ASHA workers (1.6%) mentioned the Health Inspector (HI) as their reporting authority. Similarly, 3.0% of ASHA workers stated that the Medical Officer is their reporting authority. This suggests that a smaller portion of ASHA workers may have limited awareness or confusion about their specific reporting authority.

Overall, the data highlights that the vast majority of ASHA workers correctly identify the Junior Public Health Nurse (JPHN) as their reporting authority. This is an important finding as having clear awareness of the reporting structure and hierarchy is crucial for effective coordination and communication within the healthcare system. However, there is a need to address the limited awareness among a smaller proportion of ASHA workers who mentioned the Health Inspector (HI) or Medical Officer as their reporting authority. Ensuring that all ASHA workers are well-informed about their reporting hierarchy can enhance their efficiency and contribute to better healthcare service delivery in their communities.

Figure 20: Percentage distribution of ASHAs declaration about source of income other than honorarium



3.5.2 Attitude change of Family Members after being selected as ASHA worker

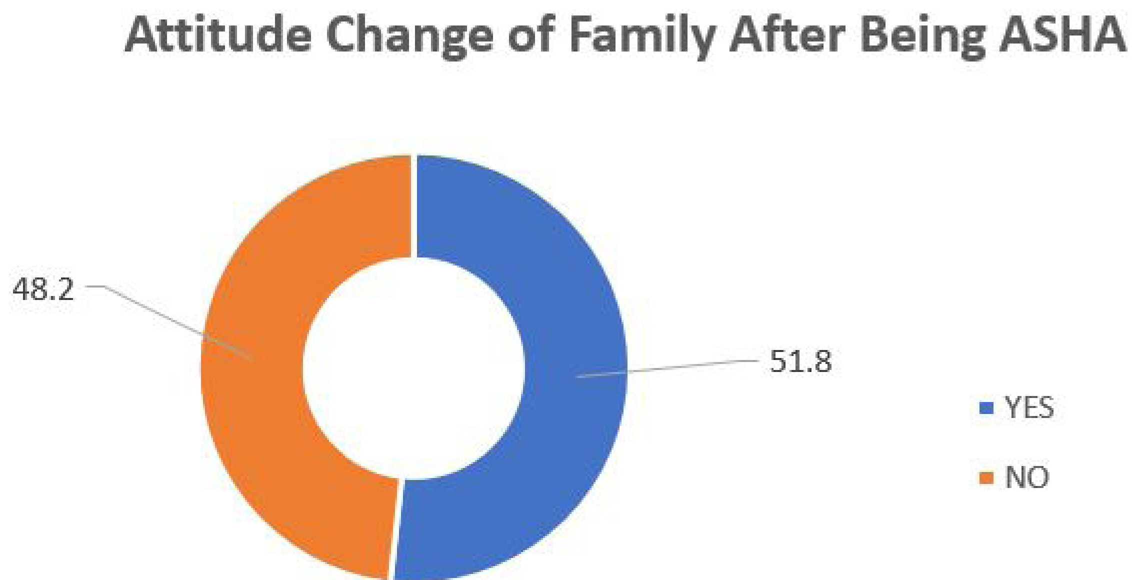
From the given data on the attitude change of family members after being selected as ASHA workers, we can draw the following inference:

1. **Positive Attitude Change:** A significant proportion of ASHA workers, comprising 51.8%, reported that there was a positive attitude change in their family members after they were selected as ASHA workers. This suggests that a large number of ASHA workers experienced support, encouragement, or a positive shift in their family members' attitudes towards their role as ASHA workers.

2. **No Attitude Change:** Approximately 48.2% of ASHA workers stated that there was no attitude change in their family members after they became ASHA workers. This indicates that for almost half of the ASHA workers, their family members' attitudes remained unchanged after they started working as ASHA's.

Overall, the data indicates that a significant portion of ASHA workers experienced a positive attitude change in their family members after being selected as ASHA workers. This positive shift in attitude could play a crucial role in supporting and motivating ASHA workers in their roles as frontline health workers. It is essential to recognize and appreciate the support provided by family members, as it can significantly impact the well-being and effectiveness of ASHA workers in delivering healthcare services to their communities. Additionally, understanding the factors contributing to attitude change can help improve support systems and create an enabling environment for ASHA workers in their challenging yet essential responsibilities.

Figure 21: Percentage distribution of Attitude Change of Family After Being ASHA



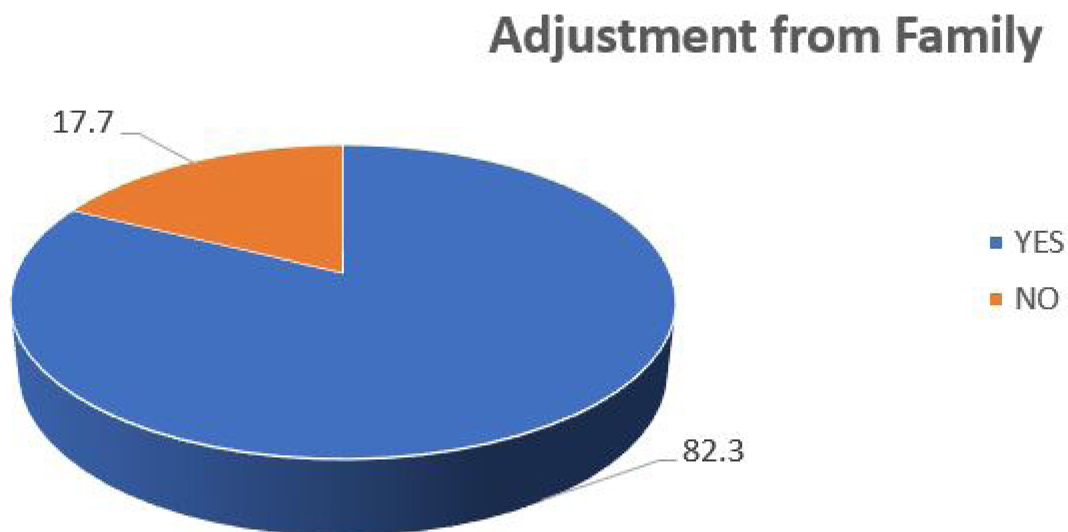
3.5.3 Adjustment of the family while performing the duties as ASHA worker

From the given data on the adjustment of family members while performing the duties and responsibilities as ASHA workers, we can draw the following inference:

1. **Positive Adjustment:** The majority of ASHA workers, comprising 82.3%, reported that their family members have made a positive adjustment while they perform their duties and responsibilities as ASHA workers. This suggests that a significant proportion of ASHA workers have received support and understanding from their family members in managing their work as frontline health workers.
2. **Limited Adjustment:** Approximately 17.7% of ASHA workers stated that their family members have not fully adjusted to their roles as ASHA workers. This indicates that there is a smaller portion of ASHA workers whose family members might face challenges or difficulties in accommodating the demands of their work.

Overall, the data indicates that a significant majority of ASHA workers have received positive adjustment and support from their family members while performing their duties as ASHA workers. This support from the family can be crucial in helping ASHA workers manage their responsibilities effectively and maintain a work-life balance. However, there are some ASHA workers whose family members might need additional support or understanding to fully adjust to the demands of their roles. Recognizing the importance of family support and addressing any challenges they might face can contribute to the well-being and success of ASHA workers in delivering healthcare services to their communities.

Figure 22 : Percentage distribution of Adjustment of the family while performing the duties as ASHA worker.



3.5.4 Household Chores performed by ASHA worker before leaving for the duty

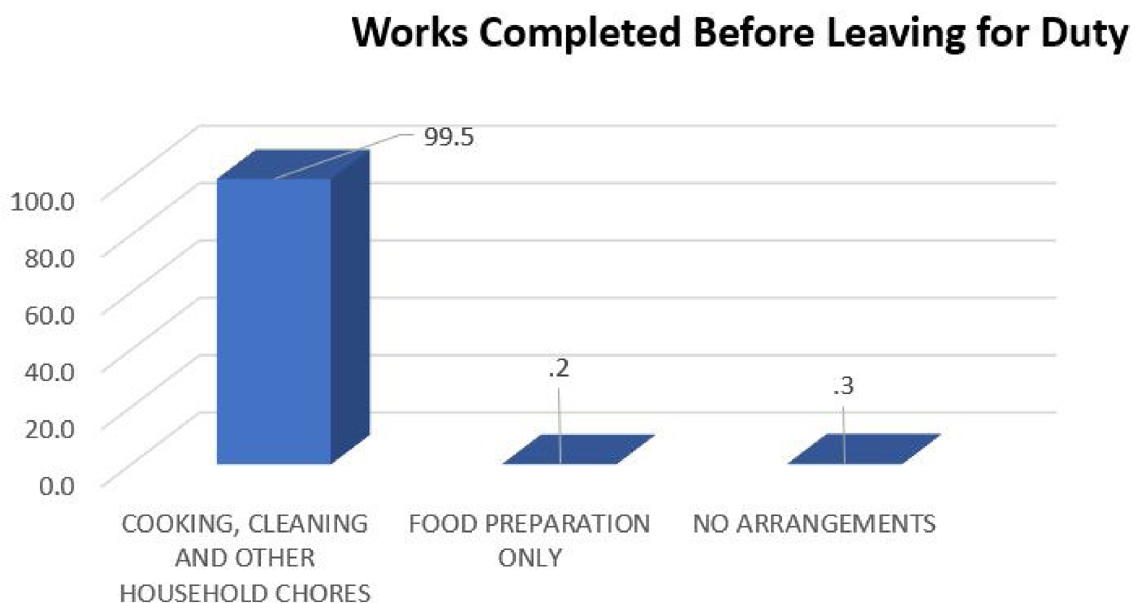
From the given data on the household chores completed before leaving for duty as ASHA workers, we can draw the following inference:

1. Household Chores Completion: The vast majority of ASHA workers, comprising 99.5%, reported that they complete various household chores before leaving for duty. These chores include cooking, cleaning, and other household tasks.

2. Limited Preparations: Only a very small percentage of ASHA workers (0.2%) mentioned that they complete food preparation only before leaving for duty. Additionally, a minor proportion (0.3%) stated that they make no arrangements for household chores before leaving.

Overall, the data highlights that the majority of ASHA workers ensure that essential household chores are completed before they leave for their duty. This dedication to managing household responsibilities before attending to their work as frontline health workers demonstrates the commitment and multitasking skills of ASHA workers. Balancing both professional duties and household responsibilities can be challenging, and ASHA workers' efforts to make arrangements before leaving for duty are commendable. Acknowledging and supporting ASHA workers in their efforts to manage these responsibilities can contribute to their overall well-being and effectiveness in delivering healthcare services to their communities.

Figure 23 : Percentage distribution of ASHAs response about the Works Completed Before Leaving for Duty



3.5.5 Response of ASHAs about the Attitude of Doctors towards them

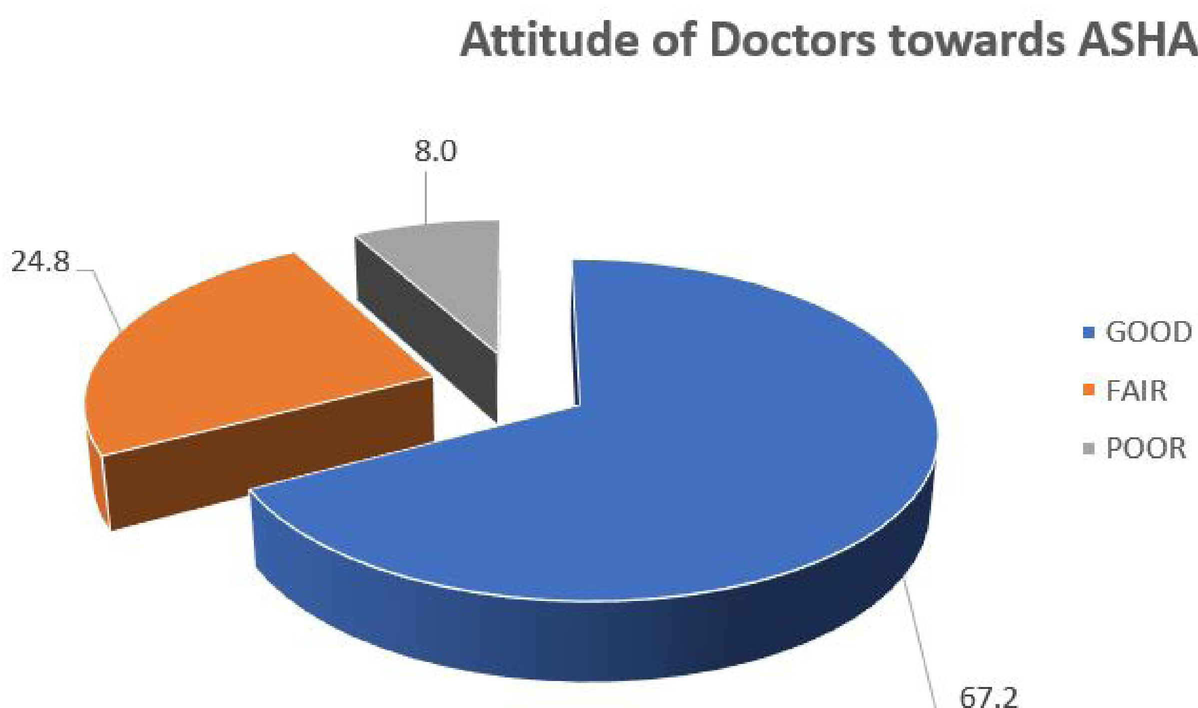
From the given data on the response of ASHA workers about the attitude shown by doctors, we can draw the following inferences:

1. **Positive Attitude from Doctors:** The majority of ASHA workers, comprising 67.2%, reported that doctors showed them a "GOOD" attitude. This indicates that a significant proportion of ASHA workers have experienced positive interactions and support from doctors while working together in the healthcare system.
2. **Fair Attitude from Doctors:** Approximately 24.8% of ASHA workers stated that doctors' attitude towards them was "FAIR." This suggests that there is a portion of ASHA workers who perceive the attitude of doctors as neutral or moderate, without being overly positive or negative.

3. **Poor Attitude from Doctors:** A small percentage of ASHA workers (8.0%) mentioned that doctors showed them a "POOR" attitude. This indicates that there are some ASHA workers who have experienced negative or unsupportive behavior from doctors while carrying out their duties.

Overall, the data indicates that the majority of ASHA workers have had positive experiences with doctors, as they reported a "GOOD" attitude from them. However, there are also ASHA workers who feel that doctors' attitudes have been "FAIR" or "POOR." Addressing any concerns regarding attitudes and fostering positive working relationships between ASHA workers and doctors can contribute to better collaboration and improved healthcare service delivery. Ensuring mutual respect and support among all healthcare professionals is essential in creating a harmonious and effective healthcare system that benefits the community as a whole.

Figure 24 : Percentage distribution of Attitude of Doctors as reported by ASHA Workers



3.5.6 Response of ASHAs about the Attitude of Nurses towards them

From the given data on the attitude of nurses towards ASHA workers as reported by the ASHA workers themselves, we can draw the following inferences:

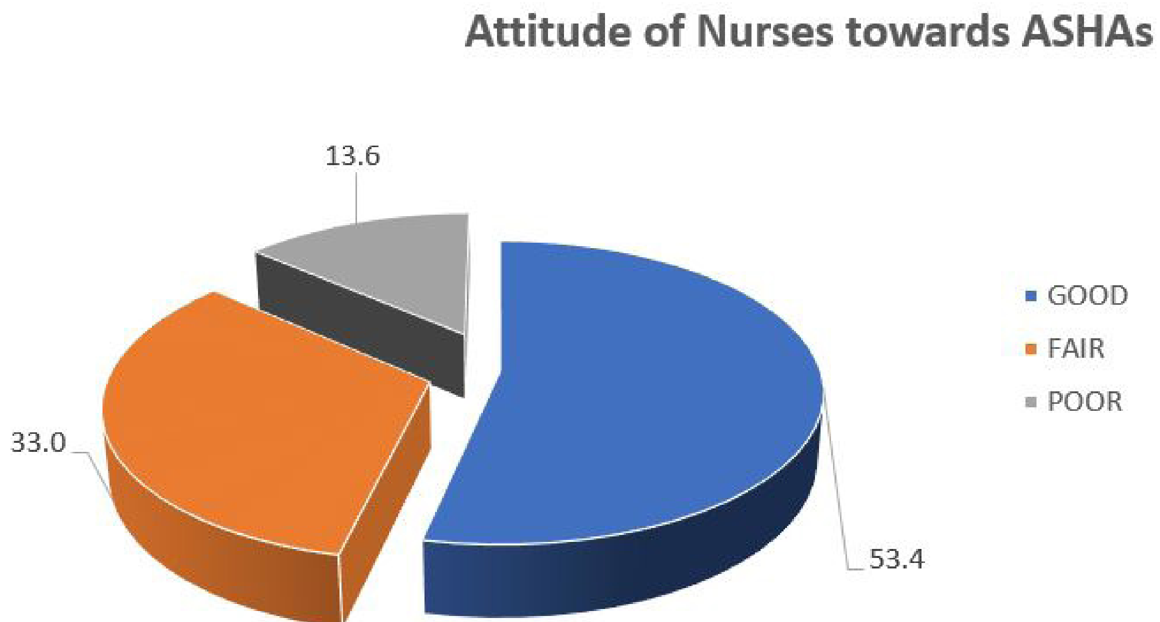
1. **Positive Attitude from Nurses:** A significant proportion of ASHA workers, comprising 53.4%, reported that nurses showed them a "GOOD" attitude. This suggests that a majority of ASHA workers have experienced positive interactions and support from nurses while working together in the healthcare system.

2. **Fair Attitude from Nurses:** Approximately 33.0% of ASHA workers stated that nurses' attitude towards them was "FAIR." This indicates that there is a sizable portion of ASHA workers who perceive the attitude of nurses as neutral or moderate, without being overly positive or negative.

3. **Poor Attitude from Nurses:** A notable percentage of ASHA workers (13.6%) mentioned that nurses showed them a "POOR" attitude. This indicates that there are some ASHA workers who have experienced negative or unsupportive behavior from nurses while carrying out their duties.

Overall, the data indicates that a significant number of ASHA workers have had positive experiences with nurses, as they reported a "GOOD" attitude from them. However, it is essential to address the concerns raised by ASHA workers who reported a "POOR" attitude from nurses. Fostering positive working relationships and mutual respect between ASHA workers and nurses can enhance teamwork and collaboration within the healthcare system. Ensuring a supportive and harmonious environment among healthcare professionals, benefits both the staff and the patients, ultimately contributing to improved healthcare service delivery and patient outcomes.

Figure 25 : Percentage distribution of Attitude of Nurses as reported by ASHA Workers



3.5.7 Response of ASHA's about the Attitude of Patients towards them

From the given data on the attitude of patients in the Community Hospital settings towards ASHA workers as reported by the ASHA workers themselves, we can draw the following inferences:

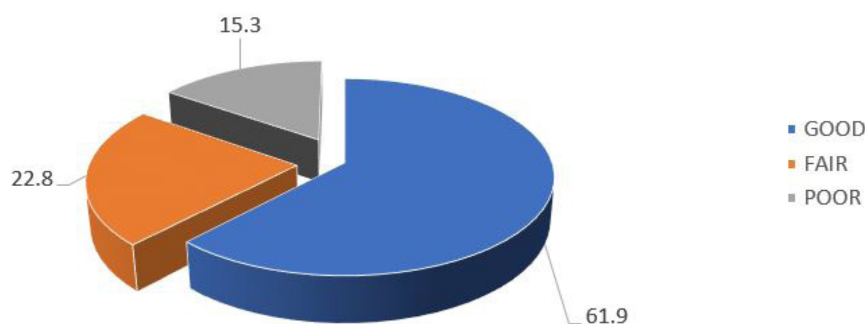
1. **Positive Attitude from Patients:** The majority of ASHA workers, comprising 61.9%, reported that patients in the Community Hospital settings showed them a "GOOD" attitude. This indicates that a significant proportion of ASHA workers have experienced positive interactions and support from patients while providing healthcare services.

2. **Fair Attitude from Patients:** Approximately 22.8% of ASHA workers stated that patients' attitude towards them was "FAIR." This suggests that there is a sizable portion of ASHA workers who perceive the attitude of patients as neutral or moderate, without being overly positive or negative.

3. **Poor Attitude from Patients:** A notable percentage of ASHA workers (15.3%) mentioned that patients in the Community Hospital settings showed them a "POOR" attitude. This indicates that there are some ASHA workers who have experienced negative or unsupportive behavior from patients while carrying out their healthcare duties.

Overall, the data indicates that a majority of ASHA workers have had positive experiences with patients in the Community Hospital settings, as they reported a "GOOD" attitude from them. However, it is crucial to address the concerns raised by ASHA workers who reported a "POOR" attitude from patients. Encouraging empathy, respect, and effective communication in healthcare interactions can lead to a more positive and supportive environment for both ASHA workers and patients, ultimately benefiting the health outcomes of the community.

Figure 26 : Percentage distribution of Attitude of Patients as reported by ASHA Workers



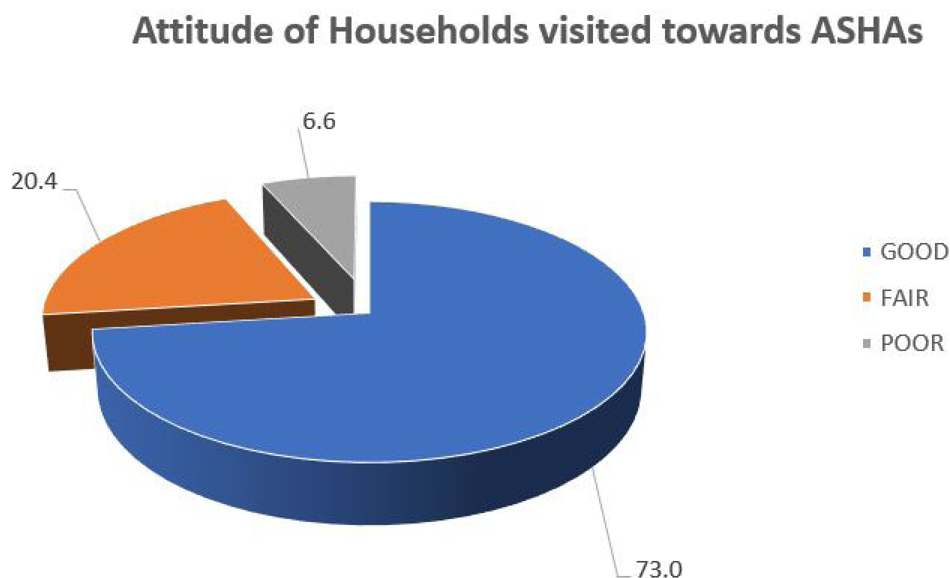
3.5.8 Response of ASHA's about the Attitude of People towards them from the Households they are visiting in the line of duty

From the given data on the response of ASHA workers about the attitude of people towards them from the households they are visiting in the line of duty, we can draw the following inferences:

1. **Positive Attitude from Visited Households:** The majority of ASHA workers, comprising 73.0%, reported that people from the households they visit show them a "GOOD" attitude. This indicates that a significant proportion of ASHA workers have experienced positive interactions and support from the community members they serve.
2. **Fair Attitude from Visited Households:** Approximately 20.4% of ASHA workers stated that the attitude of people from the households they visit is "FAIR." This suggests that there is a sizable portion of ASHA workers who perceive the attitude of the community members as neutral or moderate, without being overly positive or negative.
3. **Poor Attitude from Visited Households:** A notable percentage of ASHA workers (6.6%) mentioned that people from the households they visit show them a "POOR" attitude. This indicates that there are some ASHA workers who have experienced negative or unsupportive behavior from the community members during their visits.

Overall, the data indicates that a majority of ASHA workers have received a positive attitude from the households they visit while carrying out their duties. This positive response from the community members can be a valuable source of encouragement and motivation for ASHA workers in their roles as frontline health workers. However, addressing the concerns raised by ASHA workers who reported a "POOR" attitude from visited households is important. Building trust, fostering open communication, and promoting community engagement can help improve relationships between ASHA workers and the households they serve, ultimately contributing to better healthcare service delivery and community health outcomes.

Figure 27 : Percentage distribution of Attitude of visited household as reported by ASHA Workers



3.6. DIFFICULTY AND REFERRAL PROFILE AND SUGGESTIONS OF ASHA's

3.6.1 Reported any difficulty during the work by ASHA's

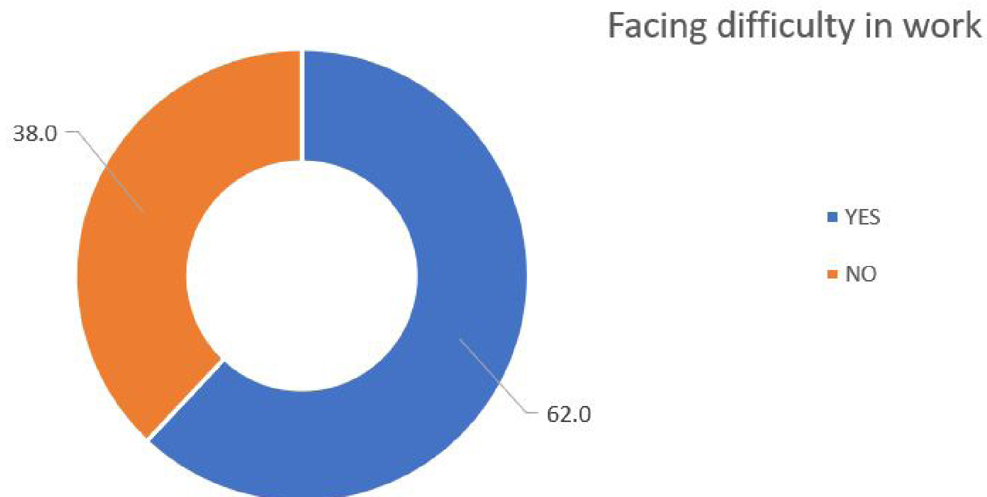
From the given data on whether ASHA workers faced any difficulty in the line of duty or in their family life, we can draw the following inference:

1. **Difficulties Faced:** The majority of ASHA workers, comprising 62.0%, reported that they have faced difficulties in the line of duty or in their family life as ASHA workers. This indicates that a significant proportion of ASHA workers have encountered challenges or obstacles while performing their duties or managing their family responsibilities.
2. **No Difficulties:** Approximately 38.0% of ASHA workers stated that they have not faced any difficulties in the line of duty or in their family life. This suggests that there is a smaller portion of ASHA workers who have not encountered significant challenges in their work or family roles.

Overall, the data highlights that a considerable number of ASHA workers have faced difficulties in the line of duty or in their family life. Working as ASHA workers can be demanding, involving community engagement, health service delivery, and managing household responsibilities. The challenges they face could include time constraints, lack of resources, emotional stress, or balancing work-life responsibilities. Providing adequate support systems,

training, and resources for ASHA workers can help address these difficulties and contribute to their well-being and effectiveness in serving their communities. Additionally, recognizing and addressing the challenges they face can enhance the overall quality and sustainability of the ASHA program in providing essential healthcare services at the grassroots level.

Figure 28 : Percentage distribution of Reported any Difficulty during the Work by ASHA Workers



3.6.2 Nature of the reported difficulty faced during the work

From the given data on the nature of difficulties faced by ASHA workers while performing their duties, we can draw the following inferences:

1. **COVID-Related Work:** The most significant challenge reported by ASHA workers is "Covid Related Work," with 34.4% of them facing difficulties related to their responsibilities during the pandemic. This indicates that the ongoing COVID-19 pandemic has added significant workload and stress to ASHA workers as they play a crucial role in pandemic response and community healthcare during this time.

2. **Health Issues:** Approximately 11.7% of ASHA workers reported facing difficulties due to "Health Issues." This suggests that some ASHA workers might be dealing with their health problems, which can impact their ability to perform their duties effectively.

3. **Income Related:** "Income Related" difficulties were reported by 15.6% of ASHA workers. This implies that some ASHA workers might be facing financial challenges or concerns related to their income, which can affect their motivation and well-being.

4. **Mental Stress:** 16.1% of ASHA workers reported facing "Mental Stress" in their roles. This highlights the psychological challenges and pressures that ASHA workers may experience while working in the healthcare field.

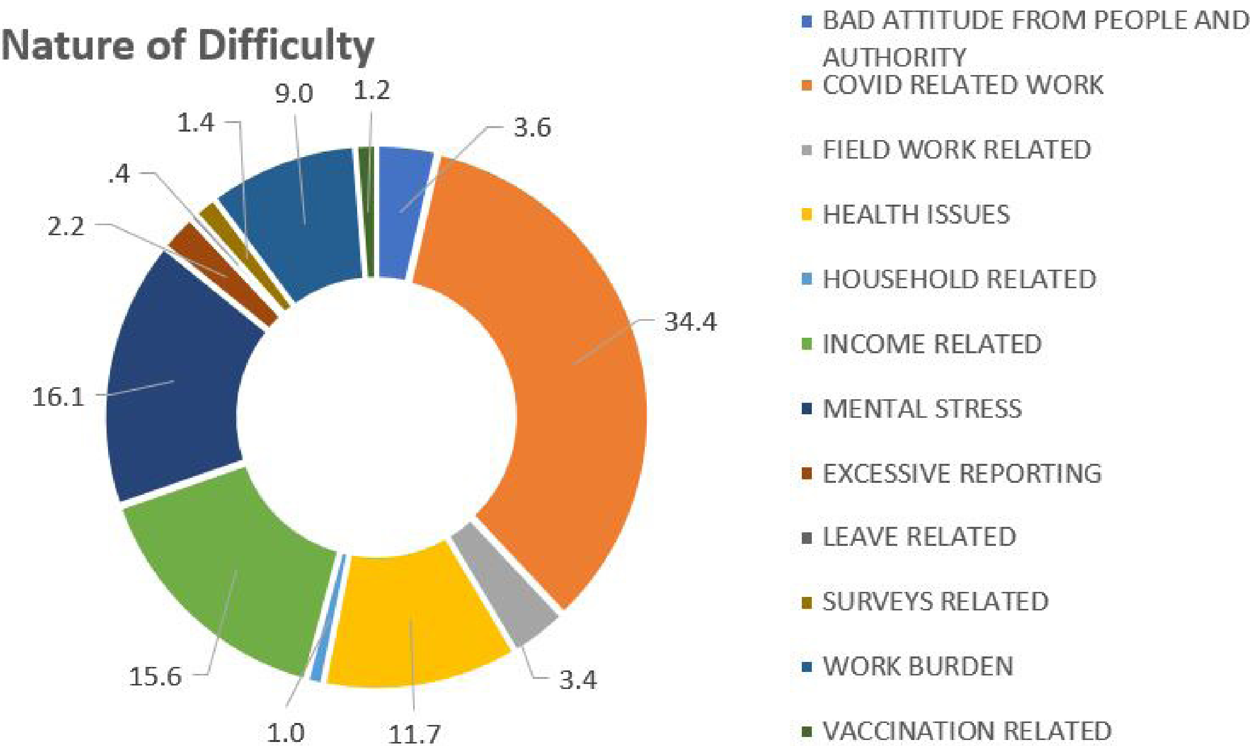
5. **Work Burden:** "Work Burden" was reported by 9.0% of ASHA workers, indicating that they may be facing excessive workloads and responsibilities, which can lead to physical and mental exhaustion.

6. **Bad Attitude from People and Authority:** A small percentage (3.6%) of ASHA workers reported facing "Bad Attitude From People And Authority," which can contribute to feelings of frustration and demotivation.

7. **Other Difficulties:** The remaining difficulties mentioned, such as "Field Work Related," "Household Related," "Excessive Reporting," "Leave Related," "Surveys Related," and "Vaccination Related," were reported by smaller percentages of ASHA workers.

Overall, the data reveals a diverse range of difficulties faced by ASHA workers in their roles. The challenges encompass various aspects of their work, health, finances, and personal life. Addressing these difficulties and providing appropriate support, training, and resources can be crucial in ensuring the well-being and effectiveness of ASHA workers in delivering healthcare services to their communities. Recognizing and addressing these challenges can also contribute to the sustainability and success of the ASHA program in achieving its goals of improving community health and healthcare access.

Figure 29 : Percentage distribution of ASHA Worker's Reported Nature of Difficulty



3.6.3 Response on whether the ASHA workers refer their friends or Family to take up the duty of ASHA Workers

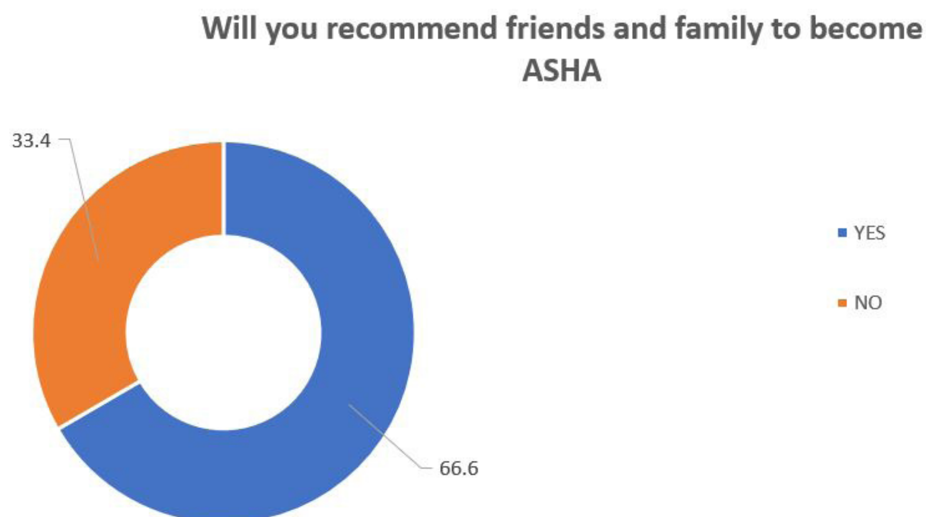
From the given data on whether ASHA workers would recommend their friends and family to become ASHA workers, we can draw the following inferences:

1. **Positive Recommendation:** A majority of ASHA workers, comprising 66.6%, stated that they would recommend their friends and family to become ASHA workers. This indicates that a significant proportion of ASHA workers have a positive view of their role and believe that it could be a valuable and meaningful career choice for others as well.

2. **No Recommendation:** Approximately 33.4% of ASHA workers mentioned that they would not recommend their friends and family to become ASHA workers. This suggests that there is a smaller portion of ASHA workers who might have reservations or concerns about encouraging others to join the ASHA program.

Overall, the data highlights that a considerable number of ASHA workers have a positive perception of their role and believe that it could be a beneficial opportunity for others as well. The fact that a significant majority would recommend their friends and family to become ASHA workers indicates a level of job satisfaction and belief in the importance of the work they do. However, understanding the reasons behind the reservations of ASHA workers who would not recommend the program could be valuable in identifying areas for improvement and ensuring that ASHA workers' concerns are addressed. Creating a supportive and positive environment for ASHA workers is essential in encouraging their continued dedication and contribution to the healthcare system and the well-being of their communities.

Figure 30 : Percentage distribution of Response about whether Recommend friends and family to become ASHA Worker



3.6.4 Response of ASHA workers who would refer their friends or Family to take up the duty of ASHA Workers

From the given data on the reasons why ASHA workers would refer their friends and family to take up ASHA worker duty, we can draw the following inferences:

1. **Social Service:** The most prominent reason reported by ASHA workers, with 40.9%, is "Social Service." This indicates that a significant proportion of ASHA workers see the role of an ASHA worker as an opportunity to engage in meaningful social service and make a positive impact on their communities.

2. **Freedom of Duty Time:** Approximately 15.4% of ASHA workers mentioned "Freedom of Duty Time" as a reason to refer their friends and family to become ASHA workers. This suggests that ASHA workers appreciate the flexibility in their duty hours, which allows them to manage their work-life balance effectively.

3. **Job Satisfaction:** "Job Satisfaction" was reported by 14.7% of ASHA workers as a reason to recommend the role to others. This implies that ASHA workers find their work fulfilling and rewarding, contributing to a higher level of job satisfaction.

4. **Mean of Income:** A significant proportion of ASHA workers, comprising 13.3%, see the role as a "Mean of Income," suggesting that the financial aspect of the job is a motivating factor for them.

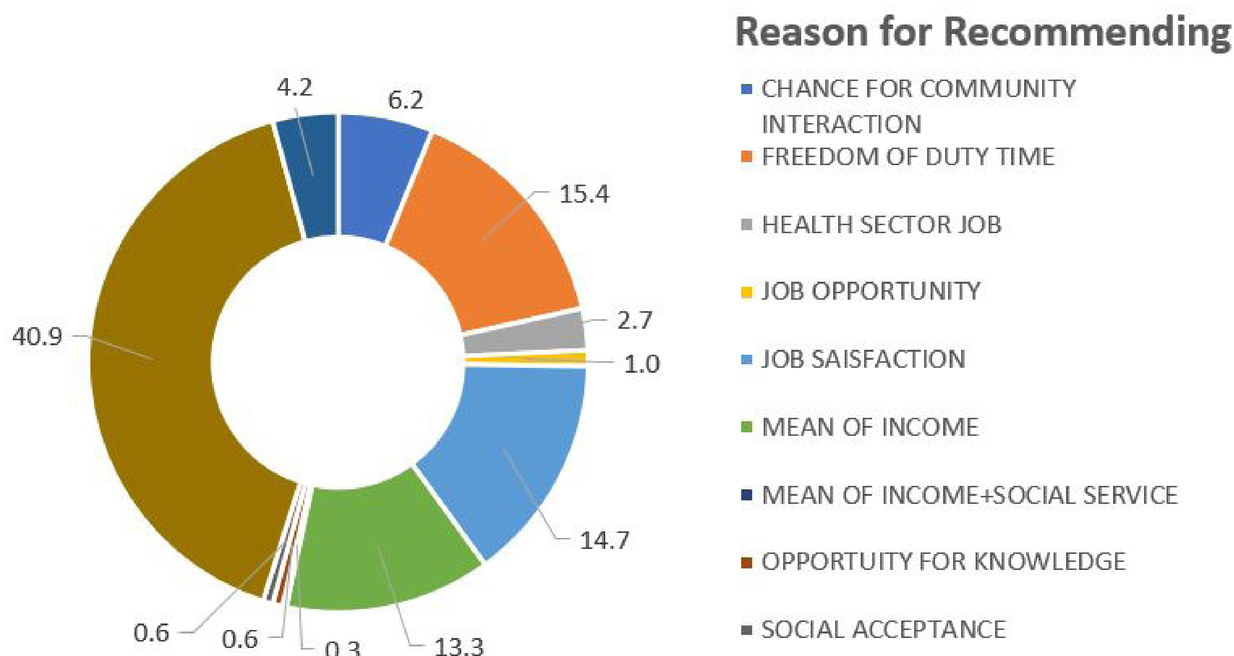
5. **Chance for Community Interaction:** Approximately 6.2% of ASHA workers mentioned "Chance For Community Interaction" as a reason. This highlights the importance of community engagement and interpersonal relationships in their roles.

6. **Social Status:** "Social Status" was reported by 4.2% of ASHA workers, indicating that the role of an ASHA worker may carry a level of social recognition or respect.

7. **Health Sector Job and Job Opportunity:** These reasons were cited by a smaller percentage of ASHA workers (2.7% and 1.0%, respectively).

Overall, the data reveals that ASHA workers find the role of an ASHA worker appealing for various reasons, including the opportunity for social service, job satisfaction, flexibility in duty hours, and financial benefits. The significance of community engagement and the potential for positive impacts on their communities are also motivating factors for ASHA workers. Recognising and leveraging these positive aspects can help in attracting and retaining dedicated individuals to the ASHA program, ultimately contributing to improved healthcare services and community health outcomes. (Fig. 31).

Figure 31 : Percentage distribution of ASHAs Recommending Family and Friends to take up the Volunteership.



3.6.5 Response of ASHA workers who would not refer their friends or Family to take up the duty of ASHA Workers

From the given data on the reasons why ASHA workers would not recommend their friends and family to take up ASHA worker duty, we can draw the following inferences:

1. **Insufficient Income:** The most significant reason reported by ASHA workers, with 65.7%, is "Income not Sufficient." This suggests that a significant proportion of ASHA workers feel that the income provided for their duties as ASHA workers is not adequate to meet their financial needs and obligations.

2. **High Workload:** Approximately 11.0% of ASHA workers mentioned "High Workload" as a reason for not recommending the role to others. This indicates that ASHA workers might find their workload to be excessive, leading to potential burnout and stress.

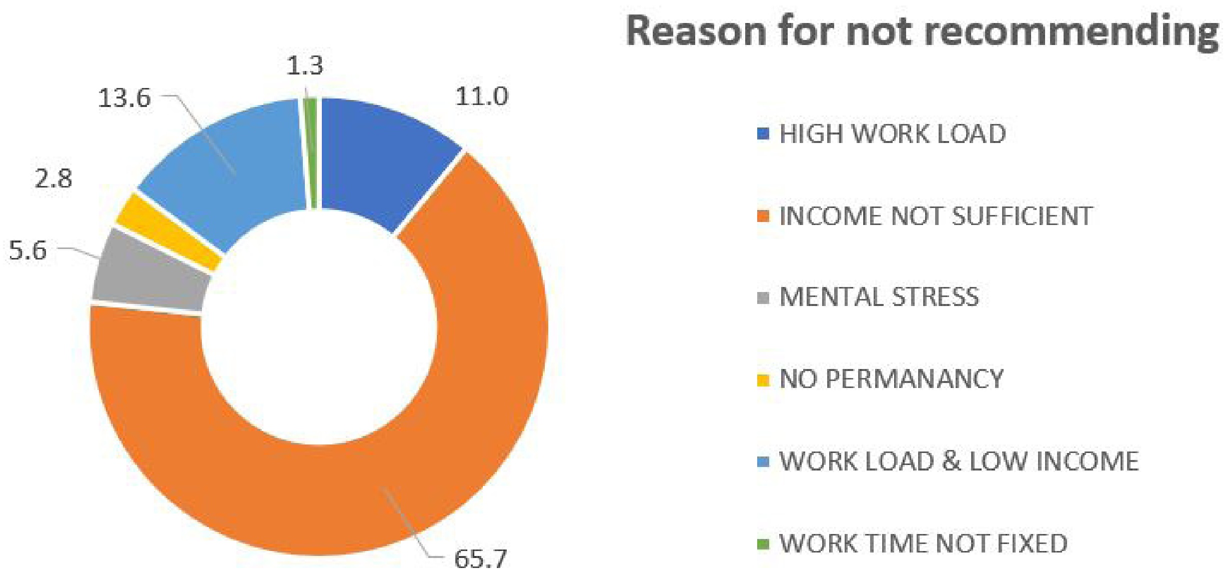
3. **Workload and Low Income:** For 13.6% of ASHA workers, the combination of "Workload & Low Income" seems to be a significant concern. This suggests that the combination of heavy workload and insufficient income can be a challenging aspect of the ASHA worker role.

4. **Mental Stress:** "Mental Stress" was reported by 5.6% of ASHA workers, indicating that the job may come with significant mental strain and pressure.

5. **No Permanency and Work Time Not Fixed:** These reasons were cited by smaller percentages of ASHA workers (2.8% and 1.3%, respectively).

Overall, the data indicates that several aspects contribute to ASHA workers' hesitancy in recommending the role to their friends and family. The primary concerns revolve around the adequacy of income, workload, and the mental stress associated with the job. Addressing these concerns and providing better financial support, reasonable workloads, and mental health support can be essential in attracting and retaining dedicated individuals to the ASHA program. Improving the overall working conditions and addressing the reasons for not recommending the role can lead to higher job satisfaction, improved retention rates, and a more effective and motivated ASHA workforce in delivering healthcare services at the community level. (T Fig. 32).

Figure 32 : Percentage distribution of ASHAs response about why not recommend family and friends to take up the Volunteership.



3.6.6 Response of ASHA workers whether they have any suggestions for improving the work and life quality

Table 18 : Response for whether ASHA workers have suggestion for Improving the life and work quality.

	Frequency	Percent
Yes	759	64.8
No	412	35.2
Total	1171	100.0

From the given data on whether ASHA workers have any suggestions for improving the life and work environment quality, we can draw the following inference:

1. **Suggestions for Improvement:** The majority of ASHA workers, comprising 64.8%, responded "YES" when asked if they have any suggestions for improving the life and work environment quality. This indicates that a significant proportion of ASHA workers have valuable insights and recommendations to enhance their working conditions and overall quality of life.

2. **No Suggestions:** Approximately 35.2% of ASHA workers responded "NO," indicating that they do not have any specific suggestions for improvement at the moment. This suggests that there is a smaller portion of ASHA workers who might not have immediate recommendations to offer.

Overall, the data highlights that a majority of ASHA workers are proactive and willing to provide suggestions for improving their life and work environment quality. This willingness to share feedback and ideas can be a valuable resource in identifying areas for improvement and implementing changes that can positively impact ASHA workers' well-being, job satisfaction, and effectiveness in delivering healthcare services. Encouraging and actively seeking input from ASHA workers in shaping the policies and practices that affect their work can contribute to a more supportive and empowering environment, ultimately benefiting both ASHA workers and the communities they serve. (Table 18).

3.6.7 Response of ASHA workers whether they have any suggestions for improving the work and life quality

From the suggestions provided by ASHA workers regarding improving the work environment, we can draw the following inferences:

1. **Workload Reduction (39.9%):** A significant percentage of ASHA workers feel that their workload is substantial and suggest that efforts should be made to reduce their work burden.
2. **Quality Training (48.4%):** Almost half of the ASHA workers believe that enhancing the quality of their training can improve their effectiveness in providing healthcare services.
3. **Basic Life Care Equipment (39.8%):** A considerable proportion of ASHA workers advocate for providing them with essential equipment for basic life care in the field, indicating their need for proper tools to carry out their duties effectively.
4. **Decent Honorarium (97.6%):** Overwhelmingly, ASHA workers emphasize the importance of receiving a decent honorarium, reflecting the financial recognition they seek for their vital role in community health.
5. **Permanency (38.1%):** A notable percentage of ASHA workers express the desire for permanent appointments, indicating their interest in long-term job security and stability.
6. **Welfare Measures (90.3%):** A significant majority of ASHA workers emphasize the need for various welfare measures to improve their overall well-being and job satisfaction.
7. **Medical Leave, Maternity Leave, Duty Off (50.1%):** Half of the ASHA workers suggest the importance of having access to medical leave, maternity leave, and days off on public holidays to ensure their health and work-life balance.
8. **Uniform (37.3%):** A notable proportion of ASHA workers suggest the provision of uniforms, which could contribute to their identification and professionalism in the community.
9. **Travel Allowance/Conveyance (62.9%):** A significant number of ASHA workers advocate for travel allowances or conveyance support to facilitate their mobility while performing their duties.
10. **Grievance Redressal Mechanism (55.9%):** More than half of ASHA workers recommend establishing a grievance redressal mechanism, indicating their desire for a platform to address concerns and challenges.
11. **Retirement Benefits (53.0%):** A considerable percentage of ASHA workers express the importance of retirement benefits, reflecting their concern for financial security after their service.

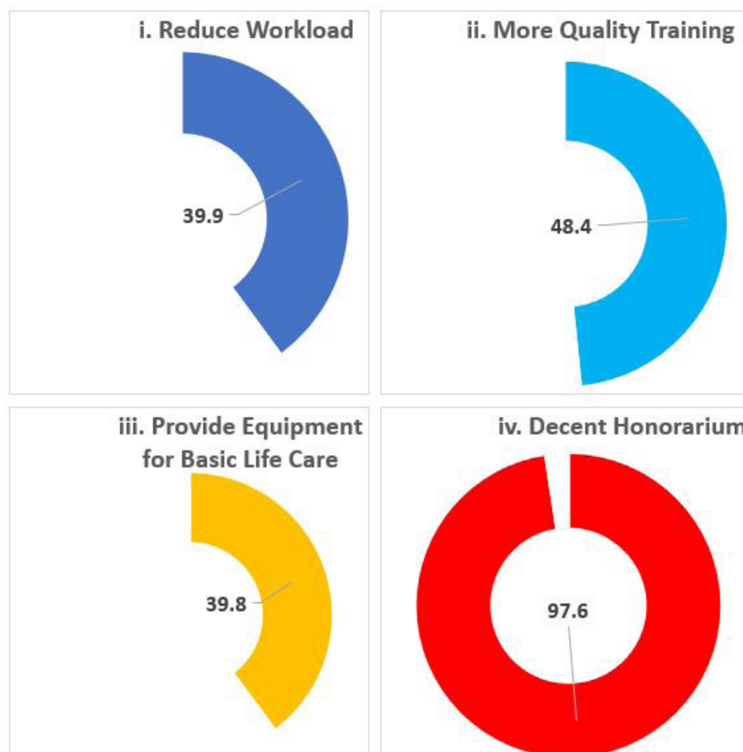
12. **Fixed Duty Time (51.0%):** Slightly more than half of the ASHA workers suggest having fixed duty timings, which could contribute to better work-life balance and predictability.

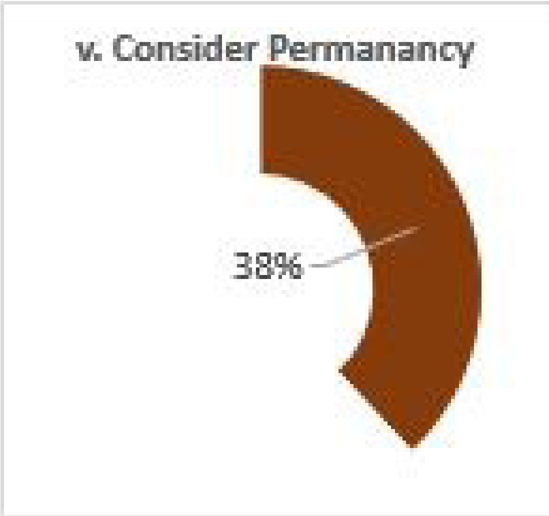
13. **Better Work Environment (78.8%):** The majority of ASHA workers stress the need for an improved work environment, indicating the significance of a supportive and conducive atmosphere.

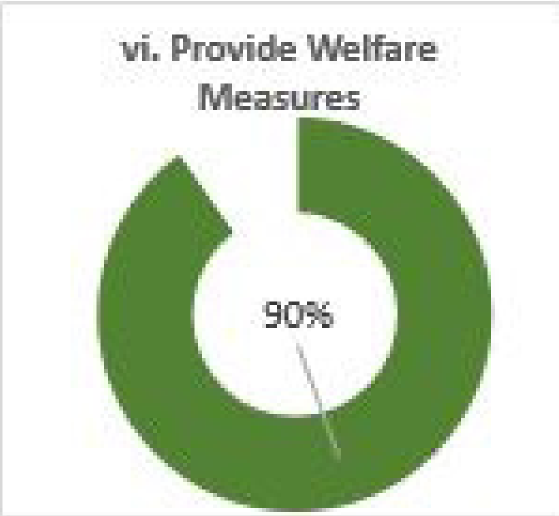
The suggestions provided by ASHA workers indicate several areas of concern and opportunities for improvement in the work environment. Addressing these suggestions can lead to increased job satisfaction, enhanced effectiveness in healthcare service delivery, and better well-being for ASHA workers. Policymakers and healthcare authorities should consider these suggestions seriously to ensure the success and sustainability of the ASHA program in Kerala.

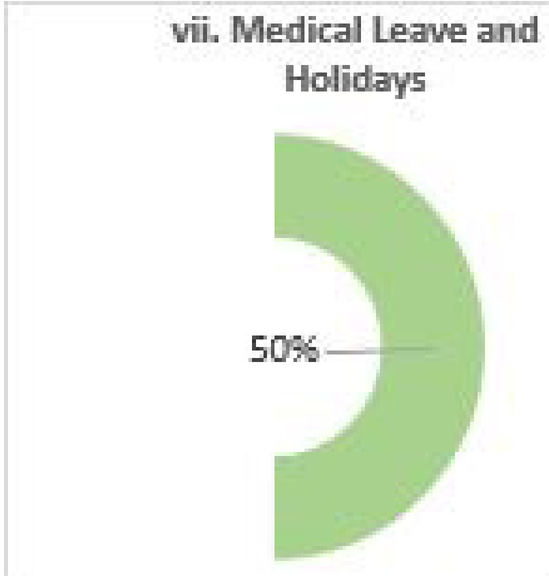
Overall, the data reflects a range of suggestions that ASHA workers believe would improve their life and work quality. These suggestions emphasize the importance of fair compensation, adequate training, job stability, welfare measures, and a supportive working environment. Addressing these suggestions can contribute to higher job satisfaction, increased effectiveness in healthcare service delivery, and improved well-being for ASHA workers, ultimately benefiting the communities they serve.

Figure 33 : Percentage distribution of Suggestions given by ASHA workers



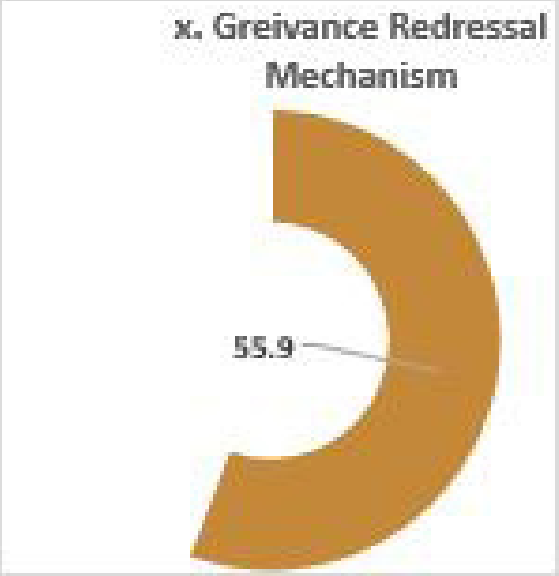

v. Consider Permanancy
38%

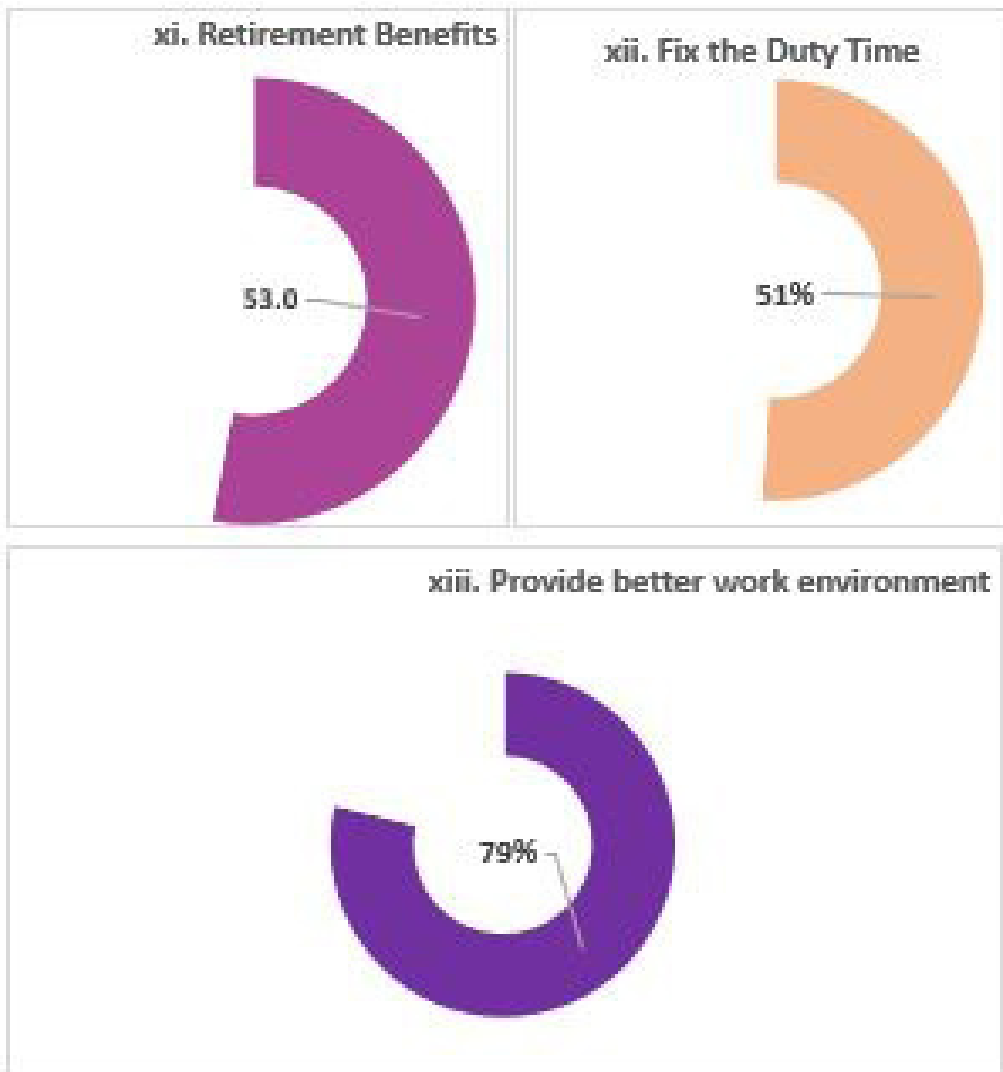

vi. Provide Welfare Measures
90%


vii. Medical Leave and Holidays
50%

viii. Uniform
37.3

ix. TravelAllowence/ Conveyance
62.9


x. Greivance Redressal Mechanism
55.9



3.7 CASE STUDIES

3.7.1 Case Study 1

I am Prema, hailing from Atholi in Calicut district. I come from a family of five, including three brothers and two sisters, myself being one of them. Due to financial constraints, my education was limited to pre-degree. My father, a coconut climber, struggled to support our family on meagre income, exacerbated by the responsibility of accommodating numerous relatives.

Facing financial difficulties, I got married at an early age, before turning 18, in an arranged marriage where expressing opinions was challenging due to the patriarchal family structure. Despite these challenges, I became a mother three years into marriage.

In the interim, I learned tailoring and worked as a teacher in Balussery. My journey into public service began when I became a Panchayat member, despite my family's unawareness of my past involvement with the student movement.

My political engagement expanded when I joined DYFI, becoming a people's representative in 2000. This experience provided me with skills in proposal preparation and estimates. My interest in service, particularly in care work, led me to participate in an NSS camp.

The ASHA program in Kerala, initiated by the former Health Minister Sreemathi Teacher in 2005, brought a new chapter in my life. Surprisingly, after a spirited interview, I was selected as an ASHA worker, which included a question about using copper-T.

Taking charge of the ASHA Union, I advocated for better wages and incentives. Out of 26,456 ASHA workers, 20,000 joined the union. I facilitated educational classes for ASHA workers on political, social, and health-related topics.

During the NIPAH virus epidemic, ASHA workers, including myself, played a crucial role by burning the deceased patients' dresses. Despite the challenges and mental toll during the 21-day incubation period, we gained public trust and empathy. This experience continued during the COVID-19 pandemic, where people reached out to us even at midnight, highlighting the vital role of ASHA workers in community healthcare.

3.7.2 Case Study 2

Asha, whose name has been changed for privacy, is a dedicated ASHA Worker with six years of experience. Residing in Pulpulli, Wynad, with her husband and two children, she faces unique challenges as her area is surrounded by tribal communities. The lack of proper transport and road facilities makes it difficult to reach households, many of which are situated inside forests.

Born into the Paniya community and having completed her education up to the tenth standard, Asha got married during her ninth standard. Despite facing initial challenges, her partner supported her education, motivating her to continue studying. However, due to family responsibilities and pregnancies, she had to postpone further studies.

Asha's journey as an ASHA Worker began when she was recommended for the role by hospital sisters who recognized her sociability and strong community connections. Initially promised a monthly stipend of Rs. 5000, the workload increased significantly, especially during the COVID-19 pandemic.

During the lockdown, Asha played a crucial role in assisting households, obtaining ration cards, purchasing essential items, and identifying COVID-19 cases. Despite facing fines for going out during the lockdown, she continued her efforts in serving the community. Asha also managed the organization of medical services, such as token distribution for outpatient services during the pandemic.

In addition to her routine duties, Asha learned to check sugar and blood pressure in households, leading to the identification and prevention of serious health issues. She actively participated in flood-related activities, including chlorination and cleaning.

Asha's dedication extends beyond routine healthcare. She shared an incident where her quick response saved a child who had difficulty breathing after mistakenly consuming breast milk. Another accomplishment involved counselling a young woman against continuous childbirth, ultimately convincing her to undergo family planning. Her routine involves waking up at 5 a.m., preparing meals, and ensuring her children are ready for school. She reaches the hospital by 9 a.m., handling various duties related to pregnant women, vaccinations, and check-ups. After returning home around 5:30 p.m., she continues with household responsibilities.

Despite the challenges, Asha finds her role satisfying, especially in positively impacting lives. She appreciates the trust and acceptance she has gained within the tribal community, where language barriers are minimal. Asha takes pride in being a valuable resource for her community, helping with tasks ranging from healthcare to administrative needs, and expresses a desire to continue making a meaningful difference.

3.7.3 Case Study 3

My name is Minnumol, and I reside in Pulpalli, Wynad, belonging to a tribal community. I am the eldest child in my family, with two sisters and a brother. My father is employed as a coolie, and my mother works to support the family. I completed my education up to the tenth standard but had to discontinue due to financial constraints. At the age of 18, I got married to a relative, and we have three children. Before becoming an ASHA worker, I worked as a tuition teacher. The opportunity to become an ASHA worker came through the Junior Public Health Nurse (JPHN) recommendation. Following an interview, I was selected for the role. Initially, I had limited knowledge about the responsibilities, but training sessions provided valuable insights. In a remarkable incident, I was called to the Thengupeetika colony, located deep within the forest, to assist a pregnant woman experiencing labour pains. Due to the delayed arrival of the ambulance, I had to perform an emergency delivery. Drawing on the training I received, I guided the woman through the process, successfully delivering the child and ensuring both mother and baby received prompt medical attention. While the incident

received appreciation, there were concerns about encouraging such practices. Nonetheless, the urgency of the situation and the absence of immediate medical assistance necessitated quick decision-making. This experience highlighted the need for comprehensive training to equip ASHA workers with the skills to handle diverse situations. Despite the challenges, I find joy in my ASHA work and acknowledge its role in providing me with strength, boldness, and valuable knowledge about the human body. I am currently pursuing opportunities through the Public Service Commission (PSC) test, but express my commitment to continuing as an ASHA worker, provided additional training opportunities are made available. More extensive training, I believe, would enhance our ability to support and assist women in need effectively.

3.8 FOCUS GROUP DISCUSSION

In this study, five Focus Group Discussions (FGDs) were conducted, each employing a dedicated checklist to facilitate data collection. The findings from these FGDs can be summarized as follows:

a. **Absence of Defined Working Hours:** The ASHA workers indicated that despite the official directive requiring them to work for only four days a week, their actual engagement extends throughout the week. During the occurrence of health crises like measles, viral fevers, cholera, or dengue fever, they must promptly inform the Junior Public Health Nurse (JPHN) and Junior Health Nurse (JHN). This necessitates immediate source selection, which involves inspecting households and their surroundings to ensure they are devoid of any potential infection sources. Although they are not explicitly mandated to perform these tasks, they are obligated to accompany personnel responsible for checks. In doing so, they are required to supervise and meticulously document findings. Failure to report any shortcomings could lead to questions being raised about their involvement. As a result, the ASHA workers need to remain highly vigilant.

b. **Comprehensive Hospital Duties:** These workers described their hospital duties, which span four days per month. These responsibilities involve aiding the Antenatal Care (ANC) process by monitoring patients' sugar levels and blood pressure. They are also expected to assist in operating theaters, distribute outpatient tickets, and announce patient names during OP hours, which typically commence at 7 a.m. and conclude around 6 p.m. The monthly schedule also includes child immunization, participation in Reproductive and Child Health (RCH) programs, and attendance at two meetings held on separate days. One of these meetings is related to ward sanitation, attended by the JPN, JPHN, and anganwadi workers, where ward sanitization strategies are devised, followed by fieldwork.

c. **Additional Administrative Responsibilities:** The ASHA workers perform Significant Other Birth (SOB) work, which entails the online registration of patients. Initially, they were assigned to cover 50 households, but this has since expanded to 20 houses daily within their ward. This duty involves collecting data concerning pregnant mothers, children with health concerns, elderly individuals, and bedridden patients, which is then shared with the relevant authorities.

d. **Palliative Care and Maternal Support:** These workers play a crucial role in palliative care, assisting nurses in changing catheters for catheter-using patients, conducting BP and sugar level checks, and maintaining records.

e. **Support for Pregnant Women:** ASHA workers ensure pregnant women receive adequate care, including access to proper nutrition, regular check-ups, and support from relatives. They visit homes to provide calcium tablets, iron supplements, and folic acid, instructing women on their proper use. In labor rooms, they assist Junior Health Nurses (JHNs) and Auxiliary Nurse Midwives (ANMs) with various arrangements.

f. **Community Acceptance and Support:** Despite encountering several challenges, ASHA workers reported that they enjoy widespread acceptance and support from local communities. This trust has grown, particularly following their efforts during the COVID-19 pandemic. Communities now turn to them not only for healthcare advice but also for assistance in scheduling appointments and accessing medical services.

g. **Challenges and Concerns:** The ASHA workers expressed several challenges, including insufficient supplies such as diapers, limited access to transportation in tribal areas, unequal distribution of incentives, and the absence of financial compensation for their service. Additionally, they highlighted the need for personal protective equipment (PPE) when interacting with patients in hospitals and demanded access to insurance benefits during illnesses, not just posthumously.

h. **Desire for Basic Amenities and Recognition:** Workers requested basic amenities like umbrellas, backpacks, and uniforms to facilitate their tasks. They emphasized the importance of recognition from healthcare authorities and expressed the belief that having a uniform would enhance their acceptance during community fieldwork. They also desired appreciation and recognition from the Junior Public Health Nurse (JPHN), Health Inspectors and Medical Officers.

i. **Importance of Training and Qualifications:** ASHA workers stressed the need for enhanced training programs, particularly in practical skills, given the varying educational backgrounds among workers, ranging from eighth-grade education to graduates with proficiency in English and Malayalam.

j. **Recognition and Identity:** The absence of a uniform was noted as a barrier when conducting fieldwork, leading to a lack of recognition. ASHA workers believed that having a uniform would enhance their identity and acceptance within the local communities.

k. **Safety and Insurance:** They also raised concerns about safety while working in hospitals, highlighting the importance of providing gloves and masks. They advocated for the timely availability of insurance benefits during illnesses, rather than after their demise.

l. **Willingness to Serve and Enhance Skills:** Despite these challenges, ASHA workers conveyed their unwavering commitment to serving their communities and expressed their readiness to take on additional responsibilities if provided with more training and support. They believe that their service is valued by the people and that they can make further contributions to healthcare access in their regions.

The Focus Group Discussions (FGDs) provide valuable insights that complement the research findings, offering a deeper understanding of ASHA workers' daily experiences, challenges, and aspirations within rural healthcare delivery. These discussions emphasize the necessity of addressing the identified challenges and reinforcing support for ASHA workers to maximize their contributions in enhancing healthcare accessibility in underserved regions.

In essence, the FGDs shed light on the unwavering dedication of ASHA workers and the hurdles they encounter in their multifaceted roles as frontline healthcare providers in rural areas. These challenges encompass workload, safety concerns, issues with incentives, and recognition. Consequently, it becomes imperative to tackle these issues comprehensively to empower ASHA workers, ultimately leading to improved healthcare access in underserved communities.

3.9 FINDINGS

The study titled "Enhancing Healthcare Delivery: A Comprehensive Investigation of ASHA Workers' Activities, Challenges, and Welfare Measures in Kerala" aimed to explore the challenges, experiences, and suggestions of Accredited Social Health Activists (ASHAs) in Kerala. ASHAs play a vital role in bridging the gap between the healthcare system and the community, ensuring primary healthcare services reach the most remote areas. This investigation sought to gain valuable insights into the areas where ASHA workers excel, the obstacles they face, and their recommendations for improving their work environment and overall effectiveness.

3.9.1 Findings:

1. **Workload and Honorarium:** The data analysis revealed that a significant number of ASHA workers (39.9%) suggested reducing their workload to improve their work environment. Additionally, 97.6% of ASHA workers advocated for a decent honorarium, indicating a widespread concern about financial recognition for their services.

2. **Training and Skill Development:** ASHA workers emphasized the need for more quality training opportunities (48.4%) to enhance their knowledge and skills. They expressed a desire for medical equipment to aid in providing basic life care during fieldwork (39.8%).

3. **Job Stability and Welfare Measures:** Many ASHA workers (38.1%) sought consideration for permanency in their roles to provide a sense of job stability. The majority (90.3%) recommended implementing welfare measures to support their well-being and job satisfaction.

4. **Flexible Work Hours and Leaves:** ASHA workers highlighted the importance of fixing duty hours (51.0%) and providing medical leave and public holidays (50.1%) to improve their work-life balance.

5. **Better Work Environment:** A significant proportion of ASHA workers (78.8%) stressed the need for an improved work environment to enhance their efficiency and effectiveness.

3.9.2 Validation of Research Findings with Case Studies:

The case study analysis provides a strong validation of the research findings regarding ASHA workers' roles and challenges:

1. **Empowerment through Education:** The case studies confirm that education is a powerful tool for empowerment among ASHA workers. The women in the case studies overcame initial educational barriers to become knowledgeable healthcare providers. This validates the research finding that education is a driving force behind ASHA workers' ability to serve their communities effectively.

2. **Emergency Response and Training:** The analysis highlights the ASHA workers' ability to respond to emergencies, such as childbirth or disease outbreaks. However, it also acknowledges their need for additional training. This aligns with the research's emphasis on the importance of training to equip ASHA workers with the skills and confidence to handle critical situations.

3. **Community Engagement:** The case studies emphasize the deep ties between ASHA workers and their communities, which enable them to understand local health needs and foster trust. This validates the research's assertion that community engagement is a key factor in ASHA workers' effectiveness as healthcare providers.

4. **Advocacy and Empowerment:** The case studies illustrate how ASHA workers use their positions to advocate for better working conditions, wages, and healthcare access, both for their communities and themselves. This aligns with the research's recognition of ASHA workers as advocates and underscores the importance of supporting their efforts for policy change.

5. **Health Crisis Management:** The involvement of ASHA workers during health crises, often at personal risk, confirms their dedication to supporting their communities during challenging times. This aligns with the research's acknowledgment of ASHA workers' role in managing health crises.

In conclusion, the case study analysis validates the research findings by demonstrating real-life examples of ASHA workers embodying the identified themes. These case studies provide concrete evidence of ASHA workers' resilience, commitment, and capacity to bring about positive change in healthcare systems, especially in underserved areas.

3.9.3 Validation of Research Findings with Result of the FGD:

Research Finding 1: ASHA Workers Work Beyond Official Timings

- **Validation:** The FGD participants confirmed that ASHA workers often work beyond official hours, particularly during health crises. They mentioned that there is no fixed timing for their work and that they must be available when needed.

Research Finding 2: Hospital Duties and Long Hours

- **Validation:** The FGD revealed that ASHA workers have hospital duties four days a month, with extended working hours from 7 a.m. to 6 p.m. on all days of week. They assist in various healthcare tasks and handle outpatient services, corroborating the research finding.

Research Finding 3: Routine Responsibilities

- **Validation**: The FGD participants mentioned several routine responsibilities, such as immunization, attendance at sanitation meetings, and maintaining records of households they cover. This aligns with the research finding regarding routine tasks.

Research Finding 4: Palliative Care and Support for Pregnant Women

- **Validation:** The FGD confirmed that ASHA workers are actively involved in palliative care, supporting pregnant women during childbirth, and ensuring their well-being.

Research Finding 5: Community Acceptance

- **Validation:** ASHA workers expressed that they are well-accepted and trusted by the local community, particularly after their efforts during the COVID-19 pandemic. People rely on them for healthcare guidance and support, validating the research finding regarding community acceptance.

Research Finding 6: Challenges and Concerns

- **Validation:** The FGD participants highlighted challenges such as the need for more supplies, unequal distribution of incentives, and safety concerns, confirming the research finding related to challenges and concerns faced by ASHA workers.

Research Finding 7: Training and Qualifications

- **Validation:** ASHA workers in the FGD emphasized the importance of continuous training and skill enhancement, validating the research finding regarding the need for more comprehensive training.

Research Finding 8: Recognition and Identity

- **Validation:** ASHA workers in the FGD expressed the desire for a distinct uniform and recognition from healthcare authorities, aligning with the research finding about the need for recognition and identity.

Research Finding 9: Insurance and Benefits

- **Validation:** The FGD participants suggested that insurance benefits should be available during illness, not just posthumously, which supports the research finding related to insurance and benefits.

Research Finding 10: Basic Amenities

- **Validation:** ASHA workers in the FGD requested basic amenities like umbrellas, Travelling Allowances, and uniforms, validating the research finding regarding the need for basic amenities.

Research Finding 11: Willingness to Serve

- **Validation:** Despite the challenges, ASHA workers in the FGD expressed a strong commitment to serving their communities and taking on more responsibilities if provided with additional training and support, corroborating the research finding regarding their willingness to serve.

Overall, the results of the Focus Group Discussion validate and provide real-world context to the research findings, emphasizing the challenges and dedication of ASHA workers in rural healthcare delivery. The FGD highlights that ASHA workers face similar challenges and concerns as identified in the research, underscoring the importance of addressing these issues to enhance their effectiveness and improve healthcare access in underserved areas.

3.10 CONCLUSIONS

1. **Financial Recognition and Incentives:** The findings clearly indicate that a major concern among ASHA workers is the need for a decent honorarium and financial recognition for their dedicated services. Implementing a grading system as suggested, which links performance to financial incentives, could motivate ASHA workers and improve their job satisfaction.
2. **Skill Development and Training:** ASHA workers expressed a desire for more training opportunities and medical equipment. Addressing these concerns by providing regular and quality training programs can empower ASHA workers to deliver better healthcare services and positively impact community health.
3. **Job Stability and Welfare Measures:** Considering the recommendations for permanency and welfare measures, creating a conducive and supportive work environment is crucial to retaining skilled ASHA workers and ensuring their well-being.
4. **Work-Life Balance and Flexibility:** Providing fixed duty hours and leaves as suggested can contribute to a better work-life balance for ASHA workers, leading to improved job performance and reduced stress levels.
5. **Community Engagement:** ASHA workers are deeply rooted in the community, and their efforts in community mobilization and health awareness are pivotal. Recognizing and promoting community engagement can further strengthen their role in improving community health outcomes.
6. **Monitoring and Evaluation:** Regular monitoring and evaluation of ASHA workers' performance, community impact, and skill development are essential to ensure the effectiveness of the suggested grading system and other interventions. Based on the evaluation, ASHA workers may be given grading based on their performance, matrices, years of experience and training acheivements.
7. **Feedback Mechanism:** Establishing a feedback mechanism to solicit input from ASHA workers and the community can foster a participatory approach and ensure that their voices are heard in decision-making processes.

In conclusion, addressing the findings and implementing the suggested improvements can contribute to enhancing the role and effectiveness of ASHA workers in Kerala. Collaboration between healthcare authorities, policymakers, and ASHA workers themselves is essential in implementing these recommendations and ensuring the success of the ASHA program in Kerala.

The data analysis chapter provides valuable insights into the activities and challenges faced by ASHA workers in Kerala. Through a comprehensive examination of various aspects of their roles, the study sheds light on the experiences of ASHA workers and identifies potential areas for improvement. The findings reveal both positive aspects and areas that require attention to enhance the effectiveness and well-being of ASHA workers.

The study found that a significant majority of ASHA workers have a positive perception of their roles, with many willing to recommend the position to others. Their intrinsic motivation for social service and the flexibility of duty hours contribute to job satisfaction. However, concerns were raised regarding financial aspects, particularly the adequacy of the honorarium and workload management.

Regarding the work environment, ASHA workers expressed the need for various improvements. Key suggestions included reducing workloads, providing more quality training, offering medical equipment for basic life care in the field, and ensuring a decent honorarium. Additionally, considerations for job permanency, welfare measures, medical leave, fixed duty time, and a better overall work environment were emphasized.

Challenges such as COVID-19 related work, health issues, and mental stress were also identified. These challenges underscore the need for additional support and resources to enable ASHA workers to effectively cope with their responsibilities.

In conclusion, the data analysis chapter highlights the essential role played by ASHA workers in the healthcare system of Kerala. Their dedication to community service and the desire to improve healthcare outcomes are evident. However, to ensure their continued commitment and effectiveness, it is crucial to address the identified challenges and implement the suggested improvements. Policymakers, healthcare authorities, and stakeholders should collaborate to enhance financial support, provide necessary training, manage workloads, and create a supportive work environment.

The findings provide a valuable foundation for evidence-based decision-making and policy formulation. By implementing the recommendations outlined in this chapter, the healthcare system in Kerala can further strengthen the ASHA program and empower ASHA workers to deliver quality healthcare services to the community. This chapter serves as a crucial reference for future studies and initiatives aimed at improving the activities and problems

faced by ASHA workers in Kerala, ultimately contributing to better healthcare outcomes and community well-being.

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CHAPTER 4
SUGGESTIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

The study titled "Enhancing Healthcare Delivery": A Comprehensive Investigation of ASHA Workers' Activities, Challenges, and Welfare Measures in Kerala" aimed to delve into the challenges faced by Accredited Social Health Activists (ASHAs) in Kerala and explore potential solutions to enhance their effectiveness and well-being. ASHAs play a pivotal role in the primary healthcare system, bridging the gap between healthcare services and the community. Understanding the suggestions and recommendations provided by ASHA workers is crucial in devising strategies to improve their working conditions and empower them to deliver quality healthcare services.

This section presents a comprehensive set of suggestions and recommendations based on the findings of the study and the insights shared by ASHA workers. These proposals aim to address the key areas identified as crucial for optimizing the performance and job satisfaction of ASHA workers. The suggestions cover various aspects, such as financial recognition, skill development, job stability, work-life balance, community engagement, monitoring and evaluation, feedback mechanisms, collaborative support, recognition, and capacity building.

By carefully considering and implementing these suggestions, Kerala's healthcare system can strengthen its primary healthcare delivery and enhance community health outcomes. The welfare and empowerment of ASHA workers are pivotal in building a resilient and responsive

healthcare system that reaches even the most remote areas of the state. The following section outlines the specific recommendations in detail to provide a roadmap for policymakers, healthcare authorities, and stakeholders involved in improving the working conditions and impact of ASHA workers in Kerala.

The following suggestions and recommendations are proposed to improve the working conditions and effectiveness of ASHA workers:

1. Establishment of a Government Commission:

- To comprehensively address the welfare of ASHAs, it is recommended that the state government establish a dedicated commission. This commission should be entrusted with the responsibility of overseeing ASHAs' well-being, advocating for their rights.
- The commission should consist of experts in healthcare, social welfare, and community development, as well as ASHA representatives, to ensure a balanced and inclusive approach.
- This body will play a pivotal role in streamlining policies, disbursing resources, and providing a platform for ASHAs to voice their concerns, ultimately fostering a more supportive and responsive environment for ASHAs in Kerala.

2. Financial Recognition and Incentives:

- Considering the important nature of their work and the cost of living in Kerala, a minimum honorarium of approximately 13,000 INR per month is recommended in the light of Kerala Minimum wage notification 2023. This would provide a significant boost to their financial stability and recognition.
- Implement a grading system that links performance to financial incentives. This can motivate ASHA workers to excel in their roles and enhance job satisfaction.
- Ensure timely and regular payment of honorarium to ASHA workers to alleviate financial hardships and boost their dedication.
- ASHAs should be provided with income in par with the workload and working hours, in doing so, the present honorarium amount may be recalculated considering the inflation rate etc., and extra amount can be provided according to the gradation.

3. Skill Development and Training:

- Offer regular and high-quality training programs to ASHA workers to enhance their knowledge and skills in healthcare service delivery.

- Provide access to medical equipment and resources necessary for basic life care during fieldwork to improve the quality of healthcare services.
- Training should be specific according to the nature of the demand and ASHAs could be used to record and update online, stats on health at individual level (BP, Sugar etc) and community level (incidence of non-communicable diseases etc),
- This could help the state to create the foot soldiers at grassroot level addressing the epidemiological transition in the state.

4. Job Stability and Welfare Measures:

- Consider permanent appointments for ASHA workers to provide job stability and attract skilled candidates.
- Introduce welfare measures such as health insurance, support for children's education, and other benefits to improve their overall well-being.
- Providing ASHAs with uniforms can help community members easily identify them. This could foster trust and respect among the population.
- Allocate a fair travelling allowance or provide suitable conveyance options to ASHA workers to facilitate their movement within the community. Determine a reasonable travelling allowance (with a ceiling amount of 1000 INR) that accounts for the distance and frequency of field visits.

5. Work-Life Balance and Flexibility:

- Fix duty hours to promote work-life balance and prevent burnout among ASHA workers.
- Allow sufficient medical leave including maternity leave and public holidays to ensure their physical and mental well-being.
- Provide standardized uniforms for ASHA workers, promoting a professional image and enhancing their recognition within the community. Collaborate with designers and stakeholders to develop a comfortable and functional uniform that aligns with the local cultural norms and ensures easy identification. Uniform distribution should be carried out efficiently and on a regular basis to maintain a professional appearance.

6. Community Engagement:

- Encourage and support ASHA workers in conducting health awareness campaigns and community mobilization efforts to improve health outcomes.

- Involve ASHA workers in planning and implementing health programs at the community level to enhance community participation.

7. **Monitoring and Evaluation:**

- Establish a robust monitoring and evaluation system to assess ASHA workers' performance, impact on community health, and skill development.
- Use feedback from the monitoring process to identify areas of improvement and implement targeted interventions.

8. **Feedback Mechanism:**

- Establish a structured feedback mechanism that involves ASHA workers and community members to provide input on their experiences, challenges, and suggestions.
- Act upon the feedback received to address concerns and continuously improve the effectiveness of ASHA workers' roles.

9. **Collaborative Support:**

- Foster collaboration between ASHA workers, healthcare professionals, and community stakeholders to create a supportive ecosystem for community healthcare.
- Establish regular forums for sharing experiences and best practices among ASHA workers to promote learning and knowledge sharing.

10. **Recognition and Appreciation:**

- Recognize and appreciate the contributions of ASHA workers at various levels, from the community to the state, to boost their morale and motivation.
- Acknowledge their efforts through awards and commendations to inspire a sense of pride in their role as frontline healthcare providers.

11. **Capacity Building:**

- Invest in capacity building programs for ASHA supervisors and trainers to enhance their ability to support and mentor ASHA workers effectively.
- Promote a culture of continuous learning and improvement within the ASHA workforce.

4.2 GRADING SYSTEM FOR RECOGNISING THE SERVICE OF ASHAS

The implementation of a grading system for Accredited Social Health Activists (ASHAs) is a significant step towards recognizing and incentivizing the essential role they play in the healthcare system. ASHAs are grassroots healthcare workers who act as a bridge between the community and the healthcare delivery system. Their dedication and commitment to providing primary healthcare services, promoting health awareness, and ensuring better health outcomes for the community are commendable.

Introducing a grading system for ASHA workers will bring structure and objectivity to their performance evaluation, creating a fair and transparent mechanism to assess their contributions. The grading system aims to not only recognize exemplary performance but also to motivate and support ASHA workers in their continuous efforts to improve healthcare delivery.

This introductory note explores the rationale and potential benefits of implementing a grading system for ASHA workers. It highlights the objectives, key considerations, and potential challenges that need to be addressed during the implementation process. Furthermore, the note underlines the significance of community engagement and the importance of feedback loops to ensure the success and sustainability of the grading system.

By recognizing and appreciating the efforts of ASHA workers through a well-structured grading system, we can empower them to achieve even greater heights in community healthcare and strengthen the overall healthcare ecosystem. The following sections delve into the details of the proposed grading system, outlining its framework, assessment criteria, and potential impact on ASHA workers, communities, and healthcare outcomes.

By implementing these suggestions and recommendations, Kerala can strengthen its primary healthcare system and empower ASHA workers to provide accessible and high-quality healthcare services to the community. The welfare and recognition of ASHA workers are vital for building a healthier and more equitable society.

Based on the suggestions of ASHA workers and the findings of the study, a multi-dimensional grading system that encompasses various aspects of their roles and performance would be suitable for them. The grading system should be designed to recognize and incentivize ASHA workers for their dedication, skills, and contributions to community healthcare. Here are the key characteristics of a suitable grading system:

1. **Objective Criteria:** The grading system should have clear and objective criteria for assessment, ensuring fairness and transparency. It should consider both quantitative and qualitative indicators, such as the number of successful health interventions, completion of training programs, patient satisfaction feedback, and community engagement efforts.
2. **Performance-Based:** The grading system should be performance-based, where ASHA workers are assessed on their actual contributions and achievements rather than seniority or tenure. This approach will motivate ASHA workers to strive for excellence in their healthcare delivery.
3. **Skill Development and Training:** The grading system should recognize the importance of continuous skill development and training for ASHA workers. Participation in training programs and upskilling should be rewarded, as it enhances their capacity to deliver quality healthcare services.
4. **Community Impact:** The grading system should evaluate the impact of ASHA workers' activities on community health outcomes. Indicators such as immunization coverage, antenatal care visits, and maternal and child health outcomes should be considered to measure their effectiveness.
5. **Financial Recognition:** Given the significant concerns regarding the honorarium, the grading system should address financial recognition. ASHA workers who achieve higher grades could receive higher honorariums or additional financial incentives to improve their motivation and well-being.
6. **Job Stability:** Considering the suggestion for permanency, the grading system could incorporate considerations for job stability. High-performing ASHA workers with consistent excellence in their roles could be considered for permanent appointments.
7. **Support Mechanisms:** The grading system should be accompanied by support mechanisms for ASHA workers who may require additional resources or training to improve their performance. This may include counseling, stress management, or access to medical leave as needed.
8. **Community Engagement:** The grading system should involve community engagement in the assessment process. Gathering feedback from community members about the impact and effectiveness of ASHA workers' efforts can provide valuable insights for evaluation.
9. **Continuous Evaluation and Improvement:** The grading system should be subject to regular evaluation and improvement based on feedback from ASHA workers and other stakeholders. Continuous assessment will ensure that the system remains relevant and responsive to changing needs.

10. **Transparent and Inclusive:** The grading system should be transparent and inclusive, with clear guidelines and communication to ASHA workers. ASHA workers should have the opportunity to understand the criteria, participate in the process, and provide inputs for improvement.

In conclusion, a multi-dimensional grading system that considers objective criteria, performance-based evaluation, skill development, community impact, financial recognition, and support mechanisms would be suitable for ASHA workers. Such a system can serve as a motivating factor, recognizing and rewarding their valuable contributions to community healthcare and overall well-being. Implementing such a grading system would empower ASHA workers, enhance the quality of healthcare services, and strengthen the healthcare system in Kerala.

4.2.1 Grading System for ASHA Workers

Objective:

The grading system aims to recognize, incentivize, and support the dedication and contributions of ASHA workers in providing quality healthcare services and promoting community health in Kerala. The system is designed to foster professional growth, enhance job satisfaction, and improve overall healthcare outcomes.

4.2.2 Assessment Criteria:

1. ***Community Health Impact (40%):***
   - **Immunization Coverage:** Percentage of target population vaccinated for various diseases.
   - **Maternal and Child Health Outcomes:** Reduction in maternal and infant mortality rates, increased institutional deliveries, and improved child health indicators.
2. ***Healthcare Service Delivery (30%)***:
   - **Successful Health Interventions:** Number of successful health interventions conducted, such as antenatal check-ups, postnatal visits, and family planning services.
   - **Patient Satisfaction:** Feedback from beneficiaries regarding the quality and effectiveness of healthcare services provided.
3. ***Training and Skill Development (15%):***
   - **Training Attendance:** Participation in regular training programs, workshops, and skill development sessions.

- **Skill Enhancement:** Evidence of applying learned skills and knowledge in health-care service delivery.

4. ***Community Engagement (10%)**:*

- **Community Mobilization:** Efforts to engage and educate the community on health-related issues and behavior change.
- **Health Camps and Awareness Sessions:** Number of health camps and awareness sessions conducted in the community.

5. ***Financial Recognition (5%):***

- **Honorary Stipend:** ASHA workers will receive a monthly honorary stipend based on their grade, in addition to the existing honorarium.

4.2.3 Grading Levels and Incentives:

1. **Grade A - Excellent (85% and above)**: Monthly stipend increase of 20%, recognition at the state level, and eligibility for special training programs.
2. **Grade B - Very Good (70% to 84%):** Monthly stipend increase of 15%, recognition at the district level, and priority for training opportunities.
3. **Grade C - Good (55% to 69%):** Monthly stipend increase of 10%, recognition at the block level, and participation in skill development workshops.
4. **Grade D - Satisfactory (40% to 54%):** Monthly stipend increase of 5%, recognition at the cluster level, and access to online training modules.
5. **Grade E - Needs Improvement (Below 40%):** Support and mentoring to enhance performance, participation in refresher courses, and goal-setting for improvement.

4.2.4 Implementation and Feedback:

- The grading system will be implemented through a bi-annual assessment process, conducted by a committee comprising healthcare professionals, community representatives, and ASHA supervisors.
- ASHA workers will be provided with a self-assessment tool to document their achievements and challenges during the assessment period.
- Community members will have the opportunity to provide feedback on the impact of ASHA workers' activities through surveys and community meetings.
- Regular feedback sessions will be conducted to discuss the results, address challenges, and identify opportunities for improvement.

- The grading system will be subject to periodic evaluation and updates based on feedback and evolving healthcare needs.

The grading system aims to empower ASHA workers, recognize their contributions, and improve community health outcomes in Kerala. By providing financial recognition, training opportunities, and community engagement, the system seeks to motivate ASHA workers to excel in their roles as frontline healthcare providers. With a focus on community impact and skill development, the grading system ensures a comprehensive and holistic evaluation of ASHA workers' performance. By implementing this grading system, Kerala can reinforce the critical role of ASHA workers and strengthen the foundation of primary healthcare in the state.

4.3 GRADE PROMOTION SYSTEM FOR ASHA WORKERS:

4.3.1 Grade 1 (Entry Level):

1. ***Eligibility for GR-1:***

- Newly recruited ASHA workers who have completed their basic training and have less than one year of experience.

2. ***Assessment Criteria for Promotion to GR-1:***

- Successful Completion of Basic Training: ASHA workers must have successfully completed the required basic training program.

3. ***Promotion Benefits to GR-1***:

- Increment in Honorarium: ASHA workers promoted to GR-1 will receive a 10% increment in their honorarium.
- Training Opportunities: ASHA workers promoted to GR-1 will be eligible to participate in advanced training programs to enhance their skills and knowledge.

4. P***romotion Evaluation Period***:

- ASHA workers will be considered for promotion to GR-1 at the end of their first year of service, provided they meet the eligibility and assessment criteria.

4.3.2 Grade 2 (Advanced Level):

1. ***Eligibility for GR-2:***

- ASHA workers who have completed at least three years of service and have consistently demonstrated exemplary performance during their tenure.

2. ***Assessment Criteria for Promotion to GR-2:***

- Community Health Impact: ASHA workers must have demonstrated a positive impact on community health outcomes, such as improved immunization coverage, maternal and child health indicators, and health awareness.
- Healthcare Service Delivery: ASHA workers must have consistently provided quality healthcare services and received positive feedback from beneficiaries.
- Training and Skill Development: ASHA workers should have actively participated in training programs and effectively applied their acquired knowledge and skills in their roles.
- Community Engagement: ASHA workers must have shown active community engagement and mobilization efforts.

3. ***Promotion Benefits to GR-2:***

- Increment in Honorarium: ASHA workers promoted to GR-2 will receive an additional 15% increment in their honorarium, on top of the GR-1 increment.
- Professional Recognition: ASHA workers promoted to GR-2 will be recognized at the district and state levels for their exemplary contributions to community healthcare.

4. ***Promotion Evaluation Period:***

- ASHA workers will be considered for promotion to GR-2 at the end of their third year of service, provided they meet the eligibility and assessment criteria.

4.4 MPLEMENTATION AND FEEDBACK:

- The promotion system will be implemented through an annual assessment and evaluation process, conducted by a committee comprising healthcare professionals, community representatives, and ASHA supervisors.
- ASHA workers will be provided with a self-assessment tool to document their achievements and contributions during the evaluation period.
- Community members' feedback on the impact of ASHA workers' activities will also be considered during the promotion evaluation.
- Regular feedback sessions will be conducted to discuss the results, address challenges, and identify opportunities for improvement.
- The promotion system will be subject to periodic evaluation and updates based on feedback and the evolving needs of ASHA workers and community healthcare.

The two-grade promotion system (GR-1 and GR-2) for ASHA workers provides a structured pathway for recognizing and incentivizing their contributions based on assessment criteria and years of experience. By linking promotion to performance and training opportunities, the system encourages ASHA workers to excel in their roles and continuously improve their skills. The implementation of this promotion system can elevate the motivation and professional growth of ASHA workers while strengthening the foundation of primary healthcare in Kerala.

4.5 FUTURE PROSPECTS OF ASHA SCHEME:

1. Strengthening Welfare Measures: Based on the survey and suggestions, the ASHA Scheme should prioritize the implementation of comprehensive welfare measures for ASHA workers. This includes providing health insurance, accident and disability insurance, life insurance, and retirement benefits to ensure their financial security and well-being.

2. Grading System for Career Progression: The proposed grading system can be integrated into the ASHA Scheme to offer career progression opportunities. ASHA workers can advance from GR-1 (Entry level) to GR-2 (Advanced level) based on their performance, years of experience, and completion of specialized training. This will motivate ASHA workers to continually improve their skills and knowledge.

3. Skill Development and Training: Enhancing skill development and training opportunities is crucial for ASHA workers to stay updated with best practices and emerging healthcare trends. Regular training sessions and workshops can be conducted to improve their expertise in maternal and child healthcare, disease prevention, and health promotion.

4. Recognition and Incentives: Acknowledging the efforts of ASHA workers through recognition and incentives will boost their morale and job satisfaction. The ASHA Scheme should establish a formal recognition program to appreciate outstanding performance and dedication.

5. Community Engagement and Feedback Mechanisms: Future prospects should focus on strengthening community engagement and establishing effective feedback mechanisms. ASHA workers can actively involve community members in healthcare decision-making and gather feedback on their services to improve program effectiveness.

6. Technological Integration: Leveraging technology can streamline data collection, monitoring, and evaluation processes. Mobile applications and digital platforms

can be utilized to enhance communication between ASHA workers and healthcare authorities, facilitating prompt support and guidance.

7. Mental Health Support: Recognizing the mental health challenges faced by ASHA workers, the ASHA Scheme should prioritize providing access to mental health support and counseling services. Regular well-being check-ups can be conducted to address burnout and stress.

8. Empowerment of ASHA Workers: The future prospects of the ASHA Scheme should focus on empowering ASHA workers as community leaders and health advocates. They can be given opportunities to lead health awareness campaigns and mobilize community participation in healthcare programs.

9. Research and Evaluation: Continuous research and evaluation are essential to measure the impact of the ASHA Scheme and identify areas for improvement. Feedback from ASHA workers, community members, and healthcare stakeholders can inform evidence-based decision-making.

10. Collaboration and Partnerships: The ASHA Scheme should foster collaborations with NGOs, civil society organizations, and other healthcare institutions to leverage resources and expertise. These partnerships can enhance the effectiveness of the scheme and promote innovative solutions.

In conclusion, the future prospects of the ASHA Scheme should revolve around empowering and supporting ASHA workers to deliver high-quality healthcare services. By implementing comprehensive welfare measures, providing career progression opportunities, and focusing on skill development and community engagement, the ASHA Scheme can continue to be a catalyst for positive change in India's primary healthcare system. It should prioritize the well-being of ASHA workers while ensuring equitable access to healthcare for all communities, ultimately leading to improved health outcomes and better community well-being.

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APPENDIX 1

GOVERNMENT OF INDIA MINISTRY OF HEALTH AND FAMILY WELFARE DEPARTMENT OF HEALTH AND FAMILY WELFARE

RAJYA SABHA UNSTARRED QUESTION NO. 2165 TO BE ANSWERED ON THE 22ND MARCH, 2022

SALARY AND ALLOWANCES OF ASHA WORKERS

2165: SMT. JHARNA DAS BAIDYA:

Will the Minister of **HEALTH AND FAMILY WELFARE** be pleased to state:

a. whether Government is considering a plan to increase the salary and allowances of ASHA workers;

b. if so, the details thereof, if not, whether any concrete step would be taken in this regard by Government in future; and

c. the number of instances when the salary and allowances of ASHA workers have been increased during the last five years?

ANSWER : THE MINISTER OF STATE IN THE MINISTRY OF HEALTH AND FAMILY WELFARE (DR. BHARATI PRAVIN PAWAR)

(a) to (c) ASHAs are envisaged to be community health volunteers and are entitled to task/ activity based incentives. ASHAs receive a fixed monthly incentive of Rs. 2000 per month for routine and recurring activities and the details are placed at **Annexure-I**. Additionally, they are provided performance-based incentives for a varied set of activities under various National Health Programmes and is placed at **Annexure-II**. States/UTs in their programme implementation plans have also been given flexibility to provide a range of monetary incentives to the ASHAs and the details is placed at **Annexure-III.**

After the launch of the Ayushman Bharat scheme with operationalisation of Ayushman

Bharat- Health and Wellness Centres (AB-HWCs), ASHAs are now additionally eligible for Team Based Incentives (TBIs) along with ANMs based on monitored performance indicators (up to Rs. 1000 per month).

The Government has also approved a cash award of Rs. 20,000/- and a citation to ASHAs who leave the programme after working as ASHAs for minimum of 10 years, as acknowledgement of their contribution.

The ASHA benefit package was introduced acknowledging significant contribution and commitment of ASHAs. The package providing coverage for:

i) Pradhan Mantri Jeevan Jyoti Beema Yojana (PMJJBY) with a benefit Rs. 2.00 Lakh in case of death of the insured (annual premium of Rs. 330 contributed by GOI).

ii) Pradhan Mantri Suraksha Beema Yojana (PMSBY) with a benefit of Rs. 2.00 lakh for accidental death or permanent disability; Rs. 1.00 lakh for partial disability (annual premium of Rs. 12 contributed by GOI).

iii) Pradhan Mantri Shram Yogi Maan Dhan (PM-SYM) with pension benefit of Rs. 3000 pm after age of 60 years (50% contribution of premium by GOI and 50% by beneficiaries).

However, in view of the significant contribution towards the COVID-19 pandemic related work by ASHAs, States were advised to pay an additional incentive of Rs.1000/- per month for those ASHAs engaged in COVID-19 related work using the resources of COVID-19 Health System Preparedness and Emergency Response Package.

Under the Pradhan Mantri Garib Kalyan Package, Insurance Scheme has been introduced for all health workers, including ASHAs. This insurance scheme provides an insurance cover of Rs. 50.00 Lakhs in-case of loss of life on account of COVID-19 related duty.

Annexure-I

The details of incentives for routine and recurring activities given to ASHAs

S. No.	Incentives	Incentives (from September, 2018)
1	Mobilizing and attending Village Health and Nutrition Days or Urban Health and Nutrition Days	Rs.200/ session
2	Conveying and guiding monthly meeting of VHSNC/MAS	Rs. 150
3	Attending monthly meeting at Block PHC/UPHC	Rs. 150
4	a. Line listing of households done at beginning of the year and updated every six months	Rs. 300
	b. Maintaining village health register and supporting universal registration of births and deaths to be updated on the monthly basis	Rs. 300
	c. Preparation of due list of children to be immunized on monthly basis	Rs. 300
	d. Preparation of list of ANC beneficiaries to be updated on monthly basis	Rs. 300
	e. Preparation of list of eligible couple on monthly basis	Rs. 300
	Total	**Rs. 2000/-**

Annexure-II

Details of performance-based incentives for a varied set of activities under various National Health Programmes		
	Activities	**Amount in Rs/case**
I	**Maternal Health**	

1	JSY financial package	
a.	For ensuring antenatal care for the woman	Rs.300/Rs.200 (Rural/Urban areas)
b.	For facilitating institutional delivery	Rs. 300/Rs.200 (Rural/Urban areas)
2	Reporting Death of women	Rs. 200 (reporting within 24 hours)
II	**Child Health**	
1	Home Visit-care of the New Born and Post-Partum mother etc. / Young Child / follow up	Rs. 250 /Rs. 50 per visit / Rs.150 only after MUAC is equal to normore than 125mm
2	**Intensified Diarrhoea Control Fortnight**	
a.	Week-1-ASHA incentive for prophylactic distribution of ORS to families with under-five children	Rs. 1 per ORS packet for 100 under five children
b.	Week-2- ASHA incentive for facilitating growth monitoring of all children in village	Rs. 100 per ASHA for completing at least 80% of household
c.	MAA (Mother's Absolute Affection) Programme	Rs. 100/ASHA/ Quarterly meeting
III	**Immunization**	
1	Full immunization for a child under one year/ up-to two years age	Rs. 100 /Rs. 75
2	Mobilizing children for OPV immunization / DPT Booster	Rs. 100 per day / Rs. 50
IV	**Family Planning**	
1	Ensuring spacing of 2 years/ 3 years after birth of 1st child / permanent limiting method after 2 children after marriage	Rs. 500 / Rs. 500 / Rs. 1000
2	Counselling, motivating and follow up of the cases for Tubectomy	Rs. 200 in 11 with high fertility rates states,Rs.300 in 146 MPV districts, Rs. 150/Rs200 in remaining states
3	Counselling, motivating and follow up of the cases for Vasectomy and NSV and Female Postpartum sterilization	Rs. 300 in 11 states with high fertility rates and Rs. 400 in 146 MPV districts and Rs. 200 in remaining states
Mission ParivarVikas- In selected 146 districts in six states-(57 in UP, 37 in Bihar, 14 RJS, 9 in Jharkhand, 02 in Chhattisgarh and 2 in Assam)		

4	Injectable Contraceptive MPA (Antara Program) and a non-hormonal weekly centchroman pill (Chhaya) - Incentive to ASHA	Rs. 100 per dose
5	Mission ParivarVikas Campaigns Block level activities	Rs. 150/ ASHA/round
6	NayiPahel - an FP kit for newly weds	Rs. 100/ASHA/Nayi Pahel kit distribution
7	SaasBahuSammelan- mobilize SaasBahu for the Sammelan- maximum four rounds	Rs. 100/ per meeting
8	Updating of EC survey before each MPV campaign	Rs.150/ASHA/Quarterly round
V	**Adolescent Health**	
1	Sanitary napkins to adolescent girls	Rs. 1/ pack of 6 sanitary napkins
2	Organizing monthly meeting with adolescent girls pertaining to Menstrual Hygiene	Rs. 50/meeting
3	Conducting PLA meetings- 2 meetings per month	Rs. 100/ASHA/per meeting
VI	**Revised National Tuberculosis Control Programme**	
1	For Category I/ Category II of TB patients (New cases/ previously treated of Tuberculosis)	Rs. 1000 for 42 contacts / Rs. 1500 for 57 contacts
2	For treatment and support to drug resistant TB patients	Rs. 5000 for completed course of treatment
3	For notification if suspect referred is diagnosed to be TB patient by MO/Lab	Rs.100
VII	**National Leprosy Eradication Programme**	
1	Treatment in pauci-bacillary cases /multi-bacillary cases of Leprosy - for 33 states (except Goa, Chandigarh &Puducherry).	Rs. 250 (for diagnosis) + Rs. 400/Rs.600 (for follow up)
VIII	**National Vector Borne Disease Control Programme**	
1	Malaria–Preparing Blood Slides/complete treatment for RDT or radical treatment of positive cases	Rs. 15 per slide/ Rs. 75 per positive cases
2	Lymphatic Filariasis-Listing of cases	Rs. 200
3	Acute Encephalitis Syndrome/Japanese Encephalitis	

	Referral of AES/JE cases to the nearest CHC/ DH/Medical College	Rs. 300 per case
4	Kala Azar elimination	
	Involvement of ASHAs during the spray rounds (IRS) / for referring a suspected case	Rs. 100/- per round / Rs. 500/per notified case
5	Dengue and Chikungunya	
	Incentive for source reduction & IEC activities for prevention and control of Dengue and Chikungunya in 12 High endemic States.	Rs. 200/- (1 Rupee /House for maximum 200 houses PM for 05 months- during peak season).
6	National Iodine Deficiency Disorders Control Programme	
	ASHA incentive for salt testing	Rs.25/ month (for 50 salt samples)
IX	**Incentives under (CPHC) and Universal NCDs Screening**	
1	Maintaining data validation and collection of additional information	Rs. 5/form/family
2	Filling up of CBAC forms of every individual	Rs. 10/per form/per individual
3	Follow up of patients	Rs. 50/per case/Bi-Annual
4	Delivery of new service packages under CPHC	Rs.1000/ASHA/PM
X	**Drinking water and sanitation**	
1	Motivating Households to construct toilet and promote the use of toilets and for individual tap connections	Rs. 75 per household

Annexure-III

State-wise details of monetary incentives provided to the ASHAs

1. Andhra Pradesh provides balance amount to match the total incentive of Rs.10,000/month;
2. Arunachal Pradesh-provides 100% top up;
3. Bihar- Rs.1000/- per ASHA per month linked with functionality of five specified 06 activities (started in FY 2019-20);
4. Chhattisgarh-75% of matching amount of the incentives over and above the incentives earned by an ASHA as a top up on an annual basis;
5. Delhi- Rs. 3000/- PM for functional ASHA (against the 12 core activities perform by ASHA);
6. Gujarat provides 50% top up;
7. Haryana- Rs. 4000/month from June-2018 and 50% top-up;
8. Himachal Pradesh- Rs. 2000/month;
9. Karnataka-Rs. 4000/month – recently introduced replacing the top up incentive;
10. **Kerala-Rs.5000/month in FY 2020-21;**
11. Odisha-Rs. 1000 /month from state fund launched on April 1st, 2018;
12. Rajasthan- Rs. 2700/month through ICDS;
13. Sikkim -Rs. 6000/month;
14. Telangana provides balance amount to match the total incentive of Rs. 6000/- pm;
15. Tripura provides 100% top up against 08 specified activities and 33% top-up based on other activities;
16. Uttarakhand- Rs.5000/year and Rs. 1000/month;
17. Uttar Pradesh- Rs.750/- per ASHA per month linked with functionality of five specified activities (started from March 2019); and
18. West Bengal-Rs. 3000/month.

കേരള ഇൻസ്റ്റിറ്റ്യൂട്ട് ഓഫ് ലേബർ ആൻഡ് എംപ്ലോയ്മെന്റ് (കിലെ)
തിരുവനന്തപുരം

കേരളത്തിലെ ആശപ്രവർത്തകരുടെ പ്രവർത്തനങ്ങളും പ്രശ്നങ്ങളും– ഒരു അന്വേഷണം.

ചോദ്യാവലി

1. ആശ വർക്കറുടെ പേര് :
2. ആശ വർക്കറുടെ ഫോൺ നമ്പർ:
3. വയസ്സ് :
4. വിദ്യാഭാസം :
5. വൈവാഹികനില :
6. വിവാഹിത/അവിവാഹിത/ ബന്ധം വേർപെടുത്തിയവർ/ /സ്ത്രീനായകത്വ കുടുംബം
7. കോർപ്പറേഷൻ/പഞ്ചായത്ത്/ മുനിസിപ്പാലിറ്റി :
8. ജില്ല :
9. കുടുംബാംഗങ്ങളുടെ വിവരങ്ങൾ:
10. ആശ വർക്കറായി സേവനം അനുഷ്ഠിക്കുന്നതിനു മുൻപ് താങ്കൾ മറ്റു ഏതെങ്കിലും ജോലിയിൽ പ്രവർത്തിച്ചിട്ടുണ്ടോ?
11. താങ്കളെ ആശ വർക്കറായി തിരഞ്ഞെടുക്കപ്പെട്ടത് ഏതു രീതിയിലാണ്
    a. കമ്മ്യൂണിറ്റി ഗ്രൂപ്പ് വഴി
    b. കോർപറേഷൻ / പഞ്ചായത്ത് വഴി
    c. അംഗനവാടി ഇൻസ്റ്റിറ്റ്യൂഷൻസ് വഴി
    d. സെൽഫ് ഹെൽപ് ഗ്രുപ്പ് വഴി
    e. ബ്ലോക്ക് നോഡൽ ഓഫീസർ വഴി
    f. വില്ലജ് ഹെൽത്ത് കമ്മിറ്റീ വഴി
    g. ഗ്രാമ സഭ വഴി
    h. മറ്റുള്ളവ, വ്യക്തമാക്കുക

12. താങ്കൾക്ക് ആശ വർക്കറായി എത്ര വർഷത്തെ സേവന പരിചയമുണ്ട്?

  a) നിയമ പ്രകാരം നിങ്ങളുടെ പ്രവർത്തി സമയം എത്രയാണ് ?

  b) നിങ്ങൾ ഇപ്പോൾ പണിയെടുക്കുന്ന സമയം എത്രയാണ് ?

13. താങ്കൾ പങ്കാളിയാകുന്ന ഉത്തരവാദിത്തങ്ങൾ എന്തെല്ലാമാണ് ? വ്യക്തമാക്കുക?

   a. സർക്കാരിൽ നിന്ന് ഇപ്പോൾ ലഭിക്കുന്ന ഹോണറേറിയം എത്രയാണ് ?
   b. ഇത് ലഭിക്കുന്നത് എവിടെ നിന്നാണ് ?
   c. ഹോണറേറിയത്തിൽ വർദ്ധനവ് ഉണ്ടായിട്ടുണ്ടോ?
   d. ഹോണറേറിയം ലഭിക്കുന്നത് എങ്ങനെയാണ് ? നേരിട്ട് / ബാങ്ക് വഴി
   e. ഹോണറേറിയം കൃത്യസമയത്ത് ലഭിക്കാറുണ്ടോ ? ഉണ്ട് / ഇല്ല

14. ഉത്തരം ഇല്ല എന്നാണെങ്കിൽ എന്തുകൊണ്ട്?

15. ഹോണറേറിയം കൂടാതെ മറ്റെന്തെങ്കിലും അധിക വരുമാനം ലഭ്യമാകുന്നുണ്ടോ?

    ഉണ്ട് / ഇല്ല

  a. ഉണ്ടെങ്കിൽ ഏതെല്ലാം?

16. താങ്കൾക്ക് അവധി ലഭിക്കാറുണ്ടോ? (വിഷു, ഓണം, റംസാൻ, ക്രിസ്തുമസ് എന്നിങ്ങനെയുള്ള അവധികൾ)

    ഉണ്ട് / ഇല്ല

17. ഏതെങ്കിലും ആരോഗ്യ ഇൻഷുറൻസ് പദ്ധതിയിൽ അംഗമാണോ?

    ഉണ്ട് / ഇല്ല

  a. ഉണ്ടെങ്കിൽ ഏതെല്ലാം?

18. മറ്റു ഏതെങ്കിലും ക്ഷേമപദ്ധതികളിൽ അംഗത്വമുണ്ടോ, ഉണ്ടെങ്കിൽ ഏതെല്ലാം?

19. ഏതെങ്കിലും ധന സഹായം സർക്കാരിൽ നിന്നും ലഭ്യമാകുന്നുണ്ടോ?

    ഉണ്ട്/ ഇല്ല

20. ഉണ്ടെങ്കിൽ ഏതെല്ലാം

21. ആശാവർക്കർമാരുടെ സേവനം മെച്ചപ്പെടുത്തുന്നതിലേക്ക് താങ്കൾക്കു എന്തെങ്കിലും അഭിപ്രായ നിർദേഷങ്ങൾ ഉണ്ടോ ?

    ഉണ്ട് / ഇല്ല

22. ഉണ്ടെങ്കിൽ വിവരിക്കാമോ?

23. താങ്കൾക്ക് എന്തെല്ലാം പരിശീലനം ലഭിച്ചിട്ടുണ്ട് ?

24. ലഭിച്ച പരിശീലനങ്ങൾ പര്യാപ്തമാണോ?

25. ഏതെല്ലാം മേഖലയിലാണ് താങ്കൾക്ക് പരിശീലനം ആവശ്യമായത് ?

26. താങ്കൾ ആരോടാണ് റിപ്പോർട്ട് ചെയ്യേണ്ടത്? (അതായത് താങ്കളുടെ മേലധികാരി ആരാണ്?)

27. താങ്കൾക്ക് തൊഴിലുമായി ബന്ധപ്പെട്ട എന്തെങ്കിലും കരാറുകൾ ലഭിച്ചിട്ടുണ്ടോ? (അപ്പോയ്ന്റ്മെന്റ് ഓർഡർ)

28. താങ്കൾ ആശാവർക്കർ ആയതിനുശേഷം വീട്ടിലുള്ളവരുടെ പെരുമാറ്റത്തിൽ എന്തെങ്കിലും മാറ്റം വന്നിട്ടുണ്ടോ?

29. താങ്കളുടെ സമയക്രമവുമായി കുടുംബാംഗങ്ങൾക്ക് പൊരുത്തപ്പെടാൻ സാധിക്കുന്നുണ്ടോ?

    ഉണ്ട് / ഇല്ല

30. വീട്ടിൽ എന്തെല്ലാം ക്രമീകരണങ്ങൾ നടത്തിയിട്ടാണ് താങ്കൾ ജോലിക്ക് എത്തുന്നത്?

31. താങ്കളോട് മറ്റുള്ളവരുടെ പെരുമാറ്റം എങ്ങനെയാണ് ?

    എ) നഴ്സുമാർ : നല്ലത് / കുഴപ്പമില്ല / മോശം

    ബി) ഡോക്ടർമാർ : നല്ലത് / കുഴപ്പമില്ല / മോശം

    സി) രോഗികൾ : നല്ലത് / കുഴപ്പമില്ല / മോശം

    ഡി) താങ്കൾ സന്ദർശിക്കുന്ന വീട്ടുകാർ : നല്ലത് / കുഴപ്പമില്ല / മോശം

32. തൊഴിലിൽ എപ്പോഴെങ്കിലും ബുദ്ധിമുട്ട് തോന്നിയിട്ടുണ്ടോ?

    ഉണ്ട് / ഇല്ല

33. ഉണ്ടെങ്കിൽ എപ്പോഴാണ് അങ്ങനെ തോന്നിയത്?

34. താങ്കളുടെസുഹൃത്തുക്കളെ/ബന്ധുക്കളെ ആശാവർക്കർ ആയി തൊഴിലെടുക്കാൻ താങ്കൾ നിർദേശിക്കുമോ?

    അതെ / ഇല്ല

35. അതെയെങ്കിൽ എന്തുകൊണ്ട്?

36. അല്ലെങ്കിൽ എന്തുകൊണ്ട്?

37. മേല്പറഞ്ഞവ കൂടാതെ മറ്റെന്തെങ്കിലും അഭിപ്രായമുണ്ടെങ്കിൽ രേഖപ്പെടുത്തുക.

FIELD INVESTIGATION TEAM

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