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Title of the paper

ASHAs in India: Gender, Voluntarism and Performance Based Payment

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Introduction

Understanding the nature of women's work in health care requires broadening of our understanding about the site of health care and the layered location of women workers based on education, occupational skill and remuneration. In health care nurses constitute the biggest skilled occupational group followed by community health workers (CHWs) and personal care takers. The first two categories can be located within the formal healthcare system in India. Community Health Workers play an important role in dispensing healthcare services to remote and far-off areas and in meeting the health workforce shortage in such areas. Over the last decade, globally there has been a resurgence in the CHWs to offer health care to the population in a well-coordinated way through cost-effective health services and ensuring quality. During the first decade of the 21st century with the absence of skilled healthcare workforce in remote rural and urban slum spaces and push for universal health coverage, India witnessed a second wave of expansion of CHWs through Accredited Social Health Activists[1] (ASHAs) who are primarily women. Under the National Rural Health Mission (NRHM), India initiated the Accredited Social Health Activists (ASHAs) Programme in 2005. ASHAs are envisaged as honorary volunteers who will be remunerated through performance-based payment (PBP); one of the largest in the world. Presently the programme is in place in 35 states and Union Territories. ASHAs are recognised as female honorary volunteers compensated based on 'honorarium' under different national health programmes and earning from the social marketing of various healthcare products. In the second phase of NRHM (2012) under the revised guidelines for community processes it was emphasised to maintain its 'voluntary nature' assuming it does not interfere with their other source of livelihood (GoI, 2013). Earning from this activity was seen as a 'monetary compensation' for the time invested. As per the NRHM programme, ASHAs are to work as 'link worker', 'service provider' and 'health activists'.

[1] The ASHA model is based on the Mitanin programme that had been developed by the Government of Chattisgarh in partnership with civil
This paper has been adapted from Roy, B. (forthcoming) The Comparative Study of Community Health Workers Programs' in South Asia, Working Paper, Public Services International (South Asia).

Analysis of the healthcare workforce through the gender lens shows that there is a clear gendered way of employing men and women in the formal and informal healthcare system with women being overrepresented in unpaid or underpaid jobs (Standing, 2000). In health sector three–quarters of volunteers are women (ILO, 2018). Globally 70% of CHWs are women, with 18% comprising of both women and men, and 12% of male CHWs (Lehman and Sanders, 2007). In sub-Saharan Africa, 68 per cent of community health workers are women who are young, unpaid (43%), receive stipends (23%) and 59% have received primary education (ILO, 2018). In South Asia, women from poor educational background take up the work of CHWs with little or no job security. They try to meet the gaps of the health sytem by risking their own health and livelihood (George, 2008). In 1997, in India, there was a policy to gradually shift from male CHWs (Village Health guides) to women CHWs (Prasad and Muraleedharan, 2007 and UNICEF, 2004). Women became the new target of recruitment for the CHW role with the launch of the Reproductive and Child Health Programme in 1997 in India. This perpetuates that the healthcare work among the community of mothers, children, senior citizens is women's work which can go uncompensated as 'volunteer labour' and in the process unrecognise the semi-skilled aspects of the CHWs work (George, 2009).

Presently, there are 1 million ASHAs in the country (EPW, 2019). All the high focus states[2] have close to or have 95% of ASHAs in place (NHM, 2018). Most of the major states have more than 90 to 95% ASHAs in place. In rural areas, each ASHA covers on an average a population of 910 people (ibid). Due to their hilly geography, North Eastern States have the lowest average population coverage (at 664 people per ASHA), while it is average in high focus states and non-high focus states is at 890 and 983 respectively. Average population coverage has decreased in states of Odisha and MP from 810 to 784 and from 901 to 891 respectively (ibid). They are largely from the socially disadvantaged background.

[2] Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Orissa, Rajasthan, Uttarakhand, Uttar Pradesh and Assam, consisting of 284 districts.

Table 1: Basic Characteristic of CHWs in India

INDIA	Basic Characteristics
Local Name Of CHW	Accredited Social Health Activists (ASHAs)
Year Started	2005
Compensation	'Honorary Volunteer' performance linked compensation
Age Group	25-45 years
Edu. Qualification	Should be qualified preferably up to 10th Standard or higher
Selection Process	Involves various community groups, self-help groups, Anganwadi Institutions, the Block Nodal officer, District Nodal officer, the village Health Committee and the Gram Sabha.
Coverage	One ASHA for every village at a norm of one per 1000 population

Overall in the low-middle income and low income countries CHWs experience low status and precarios working conditions. They are either unpaid or underpaid and receive some non-monetary incentives (ILO, 2018). ASHAs contribution to the overall economy goes unrecognised. This paper precisely takes a look at the present PBP system in India and what it means for the ASHAs where the issue of voluntarism, remuneration, informalization of work within the public sector and gendered nature of work has not been enough explored. In this context, we review the growing body of evidence in India about how performance incentive or compensation systems have been developed, function in practice and how individuals respond and adapt to them over time, drawing primarily on examples from different states. The effort is to explore and understand how the PBP system is being implemented and the challenges of implementing PBP.

Performance Based Payment in Health Sector

In health care, pay for performance model can be traced back to US in the 1990s when it was 'small and experimental' in nature. It was later adopted by the OECD and low-middle income countried like Brazil, India and China for the primary health care and hospitals during the first decade of this century. The purpose of this new form of provider targeted payment model was to orient payment with performance measures and health system objectives related to quality, care coordination, health improvement, and efficiency (Cashin

et al., 2014). The PBP from the operations management and human resource perspective PBP works as means to control the behavior of the employee – i.e. employees' performance (output) will improve with the incentives. WHO recognizes PBP payment as a means to sustain programme and as one of the motivational factors as CHWs from LMIC are poor.

In India under National Rural Health Mission, it was decided that CHWs i.e. ASHAs would be financially remunerated through activity or task based incentive was considered as one of the motivational factors. By-design even though the ASHAs are defined as volunteers but PBP introduced incentive regime into this programme. Incentive regime establishes a contractual relationship with the ASHA and in principle negates the voluntary nature of ASHAs work. The decision of the government to keep ASHAs as volunteers, not sanction them as full time employees and earn based on task specific incentives was premised on a number of reasons. It was believed that all-women cadre of CHWs will not get into malpractices and focus more on the care and co-ordination aspect of clinical care; secondly, this position was made voluntary in nature because the Ministry of Finance was not in favour of creating a large new government cadre with a long term commitment for salaries, related benefits and pension. It was felt that respective states should develop their capacity to manage such positions later (Ved et. al, 2019).

Nature of ASHAs Work

State wise there is wide variation in the roles and tasks ASHAs (Sundararaman et al., 2012; Saprii et al., 2015) with an overall emphasis on MCH. The central government has approved over 43 tasks for which the ASHAs can claim incentives (Kaur, 2019). Different states have reported the following roles: supporting women during ANC and PNC; supporting disease control programmes, Village Health and Nutrition Days; playing a key role in Palliative care in Kerala and NCD; reporting of births and deaths, high risk pregnancy cases, low birth-weight babies in Madhya Pradesh (GoI, 2015). They also carry a drug kit to provide first contact curative care for symptomatic treatment. Overall their nature of work has led to 'unprecedented mobility and public exposure' (Dasgupta., et al., 2017).

ASHAs are found in remote villages which lacks the presence of doctors (Saprii et al., 2015). Doctors and nurses view them as link workers who help in treating minor illnesses, delivering services for pregnant women and children (Saprii et al, 2015; Fathima et al., 2015). However, interviews with them showed that they understood the role of activist very little and trainings did not attend to this aspect at all (Fathima et al, 2015). Even though ASHAs are reaching out, they do show a lack of clarity in doing their tasks and roles (GoI, 2015; Bajpai and Dholakia, 2011). They need more training and capacity building. Overall they perceived themselves more as link workers or facilitators (ibid).

Within given framework of tasks of ASHAs and their social conditions there is little scope left for them to be social activists. In Chattisgarh, Mitanins (local name for ASHAs) mobilized women against alcoholism, and had taken up the issues of domestic violence with the local police (Nandi, 2012).

Compensation System and its Nature

Under NRHM, ASHAs are envisaged as honorary volunteers with an honorarium and performance based incentives (PBI). State governments are given the flexibility to design their own incentives to ASHAs, including based on state specific requirement and activities. The performance based payment (PBP) to the ASHAs in India is one of the largest in operation in the world. From 2018 onwards ASHAs will get a minimum of Rs.2000/- (USD 29) per month from current Rs. 1000/- (USD 14.5) per month for routine activities. This is in addition to other task-based incentives approved at Central/State level. Some States have introduced fixed monthly honorarium for ASHAs[3] out of the State budget[i] (GoI, 2016). In majority of the state's, incentives are tied to the number of beneficiaries served. Incentives for the same work vary across states. Now over 15 states use their state budgets to provide equal incentive earned under National Health Mission (NHM) (NHM, 2018a).

[3] In Andhra Pradeshn, earlier they were given Rs 3000/- as homararium and Rs 5000/- as incentives - so total Rs 8000/- per month.

Large number are joining ASHA programme to earn money (Panda et al., 2018). ASHAs continue to earn on average Rs 1500/- (USD 21) to 2000/- (USD 29) of incentive per month (Shet et al., 2018; GoI, 2015). There are state level variations in ASHA monthly income. In 2018, from Odisha state it was reported that ASHAs varied between Rs. 5000/- (USD 72) to Rs.10,000 (USD 144) per month (Panda et al., 2018). The maximum they can get for an activity is Rs. 5,000/- (USD 72) for administering medicines to drug-resistant tuberculosis patients; Rs 1000/- (USD 14) for facilitating permanent contraceptive methods, Rs.50/- (USD 0.72) for early registration of pregnancy (Sarin et. al., 2016) to just Re 1 for distributing an ORS (oral rehydration solution) packet (Kaul, 2019). But ASHAs say they normally earn through antenatal care (Rs 300: USD 4), institutional delivery (Rs 300: USD 4), family planning (Rs 150: USD 2) and immunisation rounds (Rs 100: USD 1) as cases of other diseases are not many in number. Their monthly remuneration is directly dependent on what type of activities they get to do per month (Kaul, 2019). The current amount of payment was not proportional to the work done by the ASHAs.

A study from the state of Manipur showed that financial incentives are among the top three motivating factors. To improve their performance it was suggested that the pay scales need to be re-evaluated (Saprii et al., 2015). ASHAs expressed that incentives they earn through Janani Suraksha Yojana[ii] is one of their main source of earning. They explained that it shapes their work and performance level. (Saprii et al., 2015). ASHAs considered this work as additional part time work and almost all (90-100%) demanded a regular salary. For community mobilisation, home visits and sanitation work ASHAs do not receive any money (ibid). Even though they are important aspect of their work but no incentive acted as a disincentive for them. Within these three activities some activities shoved within them that went uncompensated (Sarin et al., 2016). It is observed that incentive per job is not enough and also all kinds of job were not covered. For example transporting women for institutional delivery was covered but for ANC services travel was not covered. Of late in districts of

Rajasthan, ASHAs are maintaining ASHA Diary to record their activities and there are used as the basis for making payments and assessing ASHA performance (GoI 2015).

There have been frequent cases of irregular (Saprii et al., 2015), part payment (Sarin et al., 2016) and inadequate payment (Bajpai and Dholkai, 2011). It is observed that honorariums remain pending for five to six months. As a result they often do not get to know what is the consolidated amount they are due for? ASHAs in Rajasthan, Bihar, Chattisgarh, Uttar Pradesh and Manipur expressed the demand for regular salary (Bajpai and Dholkai, 2011; Som, 2016; Sarin et al., 2016). In some cases they also take up secondary employment to sustain their families (Panda et. al., 2018; HRLN, 2017). In Chattisgarh due to lack of alternative source of income and despite delays in payments incentives became crucial for ASHAs' families (Som, 2016). A HRLN (2014) report shows, ASHAs in Delhi are given six point targets and in case of incomplete work they get only Rs. 500/- per month. In Punjab ASHAs were penalised for not addressing incentive based activities. ASHAs were concequently dropped out of this programme. ASHAs have felt earning through activity based incentives a big challenge as this forces them to work on hidden health care targets. This also compels them to be part of various national health programmes to keep up their performance (Panda et. al., 2018).

Recognition and non-financial support is considered important for retaining and sustaining ASHAs as volunteers (*underpaid workers within the formal health care system)*, and their motivation and performance (Wang et al., 2012). Beside monetary incentive, ASHAs are given access to social security schemes as non-monetary incentives. In nine states they were enrolled under schemes such as medical and life insurance, educational support to children, pension and maternity leave. Chhattisgarh, Jharkhand, Kerala and Assam have introduced new schemes designed specifically to cover ASHAs and ASHA facilitators. In remaining five states (Delhi, Gujarat, Madhya Pradesh, Odisha and Sikkim), ASHAs were enrolled under different scocial security schemes (GoI, 2016). In 2018, Government of India agreed to enroll ASHAs and ASHA facilitators under social security schemes namely, the Pradhan

Mantri Jeevan Jyoti Bima Yojana[4] (10,63,670) and Pradhan Mantri Suraksha Bima Yojana[5] (9,57,303). This goes to show that the state is trying to indirectly compensate ASHAs work and yet eludes from giving ASHAs formal employment and giving mining wages.

Nonetheless, ASHAs feel that this has enabled them to earn income and contribute to the household's financial wellbeing. In India, for ASHAs from the rural and marginalized area, being CHWs has emerged as an avenue for future employment and empowerment. This has given them a sense of financial independence and self-confidence with respect to relations with their husbands and parents-in-law (Sarin et al., 2016). This work has also given ASHAs dignity, self-confidence and recognition (Shet et al., 2018). It contributes towards individual transformation for poor women who entre work wage employment like this (Kabeer, 1997). In spite of the empowering effects of the incentives they are also cause of distress (Sarin et al., 2016) and 'helplesness' (Shet et al., 2018). Sometimes families did not agree with the work they carry home against the level of compensation ASHAs are paid. Community people disbelieved when they got to know ASHAs are not paid salaries and they are paid selectively based on their tasks (Sarin et al., 2016). Hope for permanent work and salary pushes them to continue to work as CHW.

Their monetary compensations remain inadequate compared to their workload. Revised set of guidelines for NRHM Community Processes 2013 stated that they should have a flexible work schedule working only about three to four hours per day on about four or five days per week, 'except during some mobilization events and training programmes.' However, they are currently working for approximately 25 hours a week that is more than the recommended hours (Bajpai and Dholakia, 2011). The proposed duration of ASHAs work clearly challenges the reality and undermines the voluntarism of the ASHAs as CHWs. The

[4] Pradhan Mantri Jeevan Jyoti Bima Yojana is a government-backed Life insurance scheme in India. It was launched in 2015.
[5] Pradhan Mantri Suraksha Bima Yojana is a government-backed accident insurance scheme in India. It was launched in 2015.

literature on compensation to the CHWs do suggest that they need adequate remuneration particularly when economies have got marketized and social services highly privatized.

PBP impacting Task and Activity and Dropout

Wangs and his colleagues (2012) found ASHAs gave the maximum time to two services i.e. institutional deliveries and immunisation over the other tasks as they were directly linked to financial incentives. PBPs makes them focus more on measurable aspects of healthcare (Som, 2016; Saprii et al., 2015). This process has impacted their roles as community mobilisers. Community mobilisation does not get enough attention as as there is no incentive to do such work besides cultural and gender norms (Som, 2016; Saprii et al., 2015) which also prevents them from doing community level work. In some instances ASHAs are not residing in the same village that they work for (Bajpai and Dholakia, 2011). Promotional activities like postnatal and new born care, awareness on hygiene and sanition got marginalised as ASHAs gave less attention due to less incentive (Wang et al., 2012). They did not play a very significant role as DOTS providers, and in managing minor ailments and organising village health meetings (Fathima, et al 2015). ASHAs are also one of the key family planning administrators. They give priority to sterilisation over the spacing methods as that allows them to earn more incentive and there is no incentive for the provision of family counselling services to each household (HRLN, 2017). With the complicated nature of health sector, PBP is designed in such a way that tasks which are easily measurable gets priority and tasks with less incentives face neglect increasing the moral hazard costs. As noted this process within PBP system further narrows the scope of vertical health programmes and limits the opportunity of making health intervention comprehensive in nature (Wang et al., 2012). Secondly, it also shows that for low-skilled CHWs like ASHAs with no protected minimum wages, incentives fail to work as rewards. Under such circumstances, incentivized activity is viewed more as an avenue to increase the total monthly income. At the same time it is also viewed by ASHAs as a demotivating factor (Panda et. al., 2018).

Dropout among ASHAs

The 2015 Lancet Commission for Women and Health highlights how no compensation, or low and inconsistent income leads to high attrition rates among the CHWs in addition to no career mobility. Lehmann and Sanders (2007) indicate that where CWHs worked as volunteers or received no remuneration there CHW programmes have become unsustainable. One of the common reasons for CHWs to discontinue is lack of remuneration (ibid). In India there is low acknowledgement of absenteeism/attrition among ASHAs. In the Report of the Working Group on NRHM (2012-17) attrition rate of ASHAs ranges between 5% and 15% (Planning Commission 2011). However the possibility of a higher incidence of absenteeism/ attrition was indicated as 96 (28.2%) ASHAs were missing during data collection (Bhatia, 2014). Getting selected in other national health programmes acted as a major reason for attrition (ibid). Annually the average dropout rate of ASHAs is in the range of 2-5% across states (GoI, 2015). High turnover rate is detrimental for the sustainability of the programme and to build CHW's skills and capacity. In the state of Delhi the level of cumulative attrition among ASHAs is 24% and the annual rate of attrition is 14% (GoI, 2014-2015). Overall high dropout / turnover / attrition rate decreases the stability of the programme, with high demand on human and financial resources for recruitment and training (Haines et al, 2007; Bhattacharya et al., 2001; Yiu et al, 2001).

Demand for Minimum Wages

Working for more than prescribed hours with increasing tasks and responsibilities, is considered as a scope for increasing incentives and benefits as well (Panda et. al., 2018; Bajpai and Dholakia, 2011). In the Eleventh meeting (2013) of the National ASHA Mentoring Group (AMG) it was expressed that

> *'We should not be bound by the structure of four to five hours of work for ASHA, and activities of the ASHAs should be increased with a corresponding increase in the incentives, so that she can get up to Rs. 4000-5000 per month for up to 8-9 hours of daily work.' (GoI,* 2013*).*

The above statement clearly undermines the recommended hours ASHAs should work. Rather it is suggestive of how ASHAs can enhance their monthly income through incentives based on additional work and long and odd hours of work for the government schemes as it is happening in the state of Telangana. Sometimes depending on the nature of work they are also working on all seven days. This is clearly a full time occupation without recognising them as workers, and their salary is not in line with minimum wages. The 45th Session(2013) of the Indian Labour Conference (ILC) recommended to recognise ASHAs as workers, provide for minimum wages, social security and pension. Even though the ASHAs are considered as 'a game changer for the NHM' the policy makers continue not to consider their demand for income guarantee (NHM, 2017). They seem to split between work at guruanteed minimum wages and voluntary work with honorarium and incentives. The policy makers carry on to suggest to provide ASHAs with 'additional activities' to 'increase their quantum of incentives' (NMH, 2017). However, there was a caution that one has to do this carefully as this may increase the attrition of ASHAs since generally they receive 'low payments' (ibid). This reflects the resistance of the policy makers to accept ASHAs as government employees.

It is against this ASHA workers have build up opposition in colloboration with other health worker unions. In 2018, there were several agitations and strikes by ASHA workers not only in the national capital where they rallied from different parts of India but in 17 states with their several demands and the primary demand was to have fixed salary (Kaur, 2019). They have demanded to be accorded with employee status and a minimum pay of Rs 18, 000 per month (at par with the Seventh Pay Commission[6] recommendation for minimum wage of central government employees). Recently, National Health Mission is planning for ASHA's career progression and intending to publicly recognise their contribution with a cash award of INR. 20, 000/- and a citation for those who leave after 10 years of work (NHM, 2018). Of late, ASHAs from Maharashtra in alliance with Jan Swasthya Abhiyan (Peoples Health

[6] The 7th Central Pay Commission (7CPC), was constituted in India in February 2014 to review the principles and structure of emoluments of all central government civilian employees.

Movement: PHM) demanded pay hike. One of the senior health activist from PHM said that, 'Even if paid half of the minimum wages, it would cost the the state exchequer around Rs 360 crore, which is not a lot of money given that ASHAs are the first point of response in public healthcare' (TNN, 2019). Despite all the struggles which has emerged over the past 13 years, the ASHA programme continues to harbour the narrow view of ASHAs honourary volunteers and not with legal worker status.

Conclusio

ASHAs, a cadre of community health care worker which is often praised as an important workforce in expanding health service access whilst being underpaid and under-supported by the health system. In India over the years PBF has been promoted and implemented. With minimum honourarium topped up with PBP/PBI which varies from state to state depending upon their tasks, becomes the sole base for earning a certain level of income for ASHAs. This has resulted in combination of pay types with lack of transperancy and wide variations. Regardless of the social acceptability ASHAs have gained, they continue to work within precarious working condition, face long dues of their monthly remuneration, and at times accept punitive actions for their inability to meet the targets. It is under these circumstances CHWs in low and middle income countries are asked to share their time, knowledge and skill either freely or as under-paid workers. Mere incentivization (financial and non-financial) that is output/performance/result oriented, is overall exploitative and extractive in nature and undermines their capacities, skills, right to decent work and health and gender equality.

The experience of PBP to ASHAs in India shows that it does not help to cease the continuous demand for future fixed monthly salary and government employment. The state governments are yet not agreeing to provide income guarantee at a minimum level. It overall prevents them from integrating with the economy through their occupational roles and function in full capacity (Langer et. Al., 2015). PBPs with low honourarium continues to retain ASHAs as invisible subsidy to the formal health care system, economy and

community. Even though the altruistic motive of CHWs has been foregrounded by defining CHWs as volunteer workers, but different studies and evaluations brought out the weakness of this argument, as CHWs see this as a pathway for seeking a government job in the future. ASHAs as CHWs are core to the availability of health services and their quality improvement. Thus, it is realised that the burden of underpaid community health work in India falls on the ASHAs. In this process there is a need to engage with the ASHA workers organization and collectives to develop better pay regimes with right to decent work and recognize them as workers with right. At the same time the state in healthcare has to develop better systems of measuring and understanding programme management, sustainability and accountability and value. All this is critical in order to realize the four targets of United Nations' Sustainable Developments Goals (SDGs) by 2030: SDG 3 (health care for all), SDG 4 (education for all), SDG 5 (gender equality) and SDG 8 (decent work and economic growth).

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[i] These include States like Sikkim (Rs.3000/ -p.m.), Kerala (Rs.700/-p.m.), Rajasthan (Rs.1600/-p.m.), Haryana (Rs.500/-

[ii] Janani Suraksha Yojana (JSY) is an Indian Government scheme proposed by the Government of India. It was launched on 12 April 2005. It aims to decrease the neo-natal and maternal deaths happening in the country by promoting institutional delivery of babies.