



FEMALE FRONTLINE COMMUNITY HEALTHCARE WORKFORCE IN INDIA DURING COVID-19



REPORT BY BEHANBOX

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BehanBox is a platform for in-depth, investigative and research driven journalism on gender issues. We have been reporting on the state of healthcare workers in India since the beginning of the pandemic.

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Abbreviations

ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
AWC	Anganwadi centers
AWH	Anganwadi Helper
ANM	Auxiliary Nurse Midwives
DAWA	Delhi ASHA workers' Union
ICDS	Integrated Child Development Scheme
MCTS	Mother and Child Tracking System
MoFHW	Ministry of Health and Family Welfare
NRHM	National Rural Health Mission
NFHS	National Family Health Survey
PHC	Primary Health Centers
PPE	Personal Protective Equipment

Executive Summary

1 million Accredited Social Health Activists (ASHA), 2.6 million Anganwadi workers (AWWs) and an entire cadre of Auxiliary Nurse Midwives (ANMs) have been at the forefront of Covid-19 response system in India. The three cadres of female frontline health workers, for decades, have been engaged in strengthening primary health care outreach and community nutrition programs across the country. While their work has been crucial to India's health care system, they have often been underpaid and undervalued.

During the pandemic, the task of monitoring and conducting syndromic surveys, disease surveillance, data reporting, public health messaging, delivering essential food and ration services to keep hunger and malnutrition at bay among their routine tasks, fell on these three cadres of workers at the community level.

During the pandemic, all 3 cadres routinely clock over 12 hour work days and are on call the rest of the time, reported feeling alienated and undervalued for the disproportionate burden they bear in India's battle against Covid-19 without adequate pay or indeed personal protection and state support. India's pandemic response was heavily reliant on the underpaid, undervalued and invisible labour of its community healthcare workforce.

In the first of its kind study in 10 states across India, we explore the role of ASHA, Anganwadi and ANM workers during the pandemic, the economic vulnerabilities, the physical and mental health burdens of the workers and most importantly, the crucial demands of the health care workers for an adequate policy response by the central and state governments.

The study was conducted in the states of Assam, Bihar, Haryana, Jharkhand, Karnataka, Maharashtra, Madhya Pradesh, Delhi, Telangana, and Uttar Pradesh.

Summary of Findings

Through information gathered from interviews with 201 frontline health workers across the 3 cadres, here is an overview of study findings.

Burden of Work: All three cadres of workers reported a higher burden of work and field duties during the pandemic. ASHA and AWWs have been responsible for the bulk of Covid-19 related surveys, policing of quarantine centres, monitoring of containment zones, distribution of food rations over their regular set of non-Covid tasks. On an average, work hours have increased from 6-8 hours a day to almost 12-15 hours of work per day, while being on call for almost 24 hours.

Drop In Incomes: ASHA workers who receive incentive based honorariums saw their incomes drop between Rs 1000-5000 during the pandemic due to suspension of routine tasks such as immunization, pre and ante natal care etc. 86% of ASHA workers reported a drop in their incomes during the pandemic due to loss of incentives. ASHAs reported not receiving many incentive components corresponding to all the tasks they carry out. Central government mandated Covid-19 incentive of Rs 1000 between January to September, over 31% of ASHA workers we interviewed said they had not received the incentive yet. Many respondents among ASHA, AWWs and contractual ANM workers reported experiencing an average delay of 1-6 months in receiving their remuneration.

Debt Burden: ASHA and AWWs reported experiencing debt burden due to inadequate remuneration and delay in payments amidst job losses in their families. The recorded estimates of debt burden range between Rs. 10,000 to even Rs 1,00,000 among ASHA and AWWs. The pandemic has exacerbated debt situations as many have had to invest in android mobile phones for their children's online classes, out of pocket expenditure for protective gear, in food and medical expenses even as there has been an overall loss in family income during the period of lockdown. 19% respondents recorded that they have sold household assets and pawned jewellery to meet expenses or borrowed from self-help groups, family members, co-operative banks for loans.

Protective Equipment: During the pandemic disbursement of masks, gloves and sanitizers for health workers by the government has been inadequate. At the time of interviews, 28% of healthcare workers had not received PPEs at all from the government. ASHAs and AWWs in most districts across all states noted that they received safety kits only 2-3 times since the beginning of pandemic duty in March 2020. In many districts, ASHA, AWW and ANMs reported stitching masks, buying soap and sanitizers for personal use as well as community distribution.

Discrimination and Violence against health workers: Frontline healthcare workers have reported instances of discrimination and violence both from within the community and other healthcare staff and government officials including the police during the pandemic. There have been many recorded cases of assault on ASHA workers by community members especially in Haryana, Delhi, Telangana, Uttar Pradesh ASHA workers. The pandemic has also worsened existing, caste, religious and ethnic tensions existing between communities.

Covid Deaths: Several ASHA workers in Bihar, Madhya Pradesh, Delhi, Assam and Jharkhand have reported to have died, either due to Covid-19 infection or mishaps such as road accidents and even exhaustion while doing their healthcare duties. Insurance payouts to their families have been hard to come by.

Mental and Physical Health: The bulk of Covid tasks has impacted physical health of workers. Many reported loss of weight, body pain, fluctuating blood pressure and haemoglobin levels. Fear of infection and debt burden has exacerbated anxiety and stress levels, adversely impacting mental health of ASHA and AWWs.

Background of Community Health Worker Programs

Auxiliary Nurse Midwives: The post of the Auxiliary Nurse Midwife was created as early as 1952, for addressing maternal health, midwifery and child health services. However, the violent imposition of sterilization measures during the 1970s overseen by the Indira Gandhi regime marked a shift away from narrow focus on family planning as a public health policy. Initially imagined as primary agents of family planning services, since the 1970s, the mandate of ANMs began evolving to include a range of preventive and curative services at the village level. With the expansion of their role, ANMs transitioned from temporary to permanent staff within the health system and were reclassified as female Multi-purpose Workers (MPV). In the rest of the report, we refer to this cadre of workers as Auxiliary Nurse Midwives (ANMs).

Anganwadi Workers: India's Integrated Child Development Services program (ICDS) was established in 1975 after an inter-ministerial survey in 1972 revealed that child care programmes in India were not having the desired impact. The Anganwadi worker- a community health worker empanelled with the ICDS- was instituted with nutritional care of communities, particularly pregnant women and children between the ages of 0-5 years. At present ICDS is estimated to be the world's largest integrated childhood program.

ASHA Workers: The Accredited Social Health Activist Scheme (ASHA) was an important intervention of the National Rural Health Mission (NRHM) launched as a public health program in 2005. ASHA workers, within the NRHM program have been envisioned as elected community members who help implement the various components of the programme. ASHA workers, form the world's largest community healthcare workforce and have been instrumental in improving maternal and child health outcomes and reducing the communicable disease burden in India.

Literature Review

Health systems and planning in India have been explored in great detail in social science literature, with contributions from public health experts, community medicine practitioners, civil society actors. (Amrith 2007; Banerjee 2004) In delineating the political culture of health system initiatives in post independent India, Amrith (2007) and Banerjee (2004) note that leaders of newly independent India had ambitious plans for instituting nation-wide public health care systems. The discourse of health as socially determined and public health as a matter of state concern, as a nationalist project that would liberate the massed of oppressed, colonized people was manifest in 1946 Sir Joseph Bhore Committee Report. The Bhore Committee report as part of the first Health Survey and Development Committee established in 1946, gave the impetus for setting up Primary Health Centres that would provide holistic preventive and curative care to entire rural populations.

In this context, we note that India has three cadres of women health workers' Auxiliary Nurse Midwives, Accredited Social Health Activists and Anganwadi workers who are responsible for primary health care services and communitization of health care.

Several authors who have evaluated the functioning these community health worker programs have highlighted issues pertinent to the performance of these three levels of cadres. In the context of ASHA workers, Banerjea (2018) notes that they are treated as voluntary care-givers whose work is trivialized as low-skill women's work. Gaitonde et al (2017) note, while ASHAs were originally envisioned as community activists within the National Rural Health Mission (NRHM), they have an underwhelming role engaging with systemic issues of the health system in the villages. As outliers in the official medical staff hierarchy in the NRHM, they have little bargaining power with staff at primary health centres, hospitals and dispensaries.

Very few studies have been done evaluating the outcome of the ANM program. In a placebo- controlled trial conducted between 2002 to 2005, among 1620 ANM functionaries, Derman et al. (2006) note that ANMs facilitated 5.6 % reduction in maternal mortality, by effectively administering oral misoprostol to reduce rates of acute postpartum hemorrhage and acute severe postpartum hemorrhage. Agrawal et al. (2012) found that coverage of antenatal home visits and newborn care practices also increased with proper training of ANMs. ANMs are mandated to remain on call 24 hours a day but due to security issues, inadequate facilities at the sub center and family pressure, ANMs are unable to provide 24-hour medical assistance Iyer and Jesani (1995) have noted that ANMs face issues of security at the medical subcenters. Mavalankar and Vora (2008) highlight the problem of “nonresident” ANMs, as many ANMs choose to not spend their entire day in the subcenters which impacts their readiness to respond to emergencies.

In the context of Anganwadi workers, John et al (2020) note that the performance of AWWs is impacted by organizational factors such as availability of program resources such as food rations at the Anganwadi centres, systemic corruption and caste dynamics of a particular region The authors note that individual factors such as financial remuneration play an important role in the participation and performance of all three cadres of workers. (John et al 2020) As a result, programmatic changes such as better remuneration, improved working conditions and supportive management are vital for better outcomes of health worker schemes.

In the backdrop of this existing literature we have evaluated the role of these three cadres of workers during the Covid-19 pandemic. In doing so we contribute to existing literature on community health worker programs from the vantage point of an ongoing pandemic. All three cadres have been directed towards Covid duty and have been pivotal for pandemic prevention and control. We note that issues of caste discrimination, physical security, payment and training continue to impact community health worker programs. In the Covid-19 context we further explore work burden, debt burden, physical violence, availability of safety equipment and other issues that have impacted workplace experience of ASHA, ANM and Anganwadi workers. We also explore the specific ways in which all three cadres of workers have been carrying out their tasks during the pandemic.

Research Methodology

We have adopted a mixed methodology approach to obtain qualitative narratives as well as quantitative data on key issues pertinent to work and wage situations of ASHA, ANM and Anganwadi workers during the pandemic.

As tools of research, we administered separate interview schedules for each category of worker. We also created separate questionnaires for Union leaders among ASHA, ANM and AWWs to elicit specific information on data flows and chain of hierarchy among health workers.

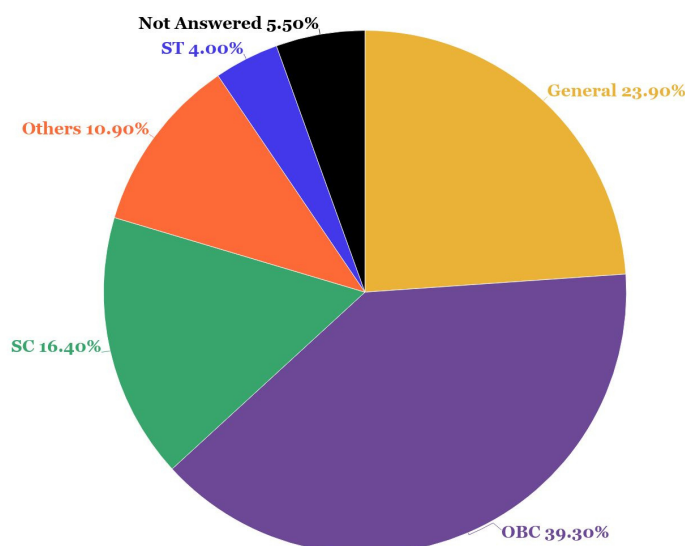
Our study was conducted in 10 states: Assam, Bihar, Haryana, Jharkhand, Karnataka, Maharashtra, Madhya Pradesh, Delhi, Telangana, and Uttar Pradesh. All our interviews were telephonic due to the pandemic and widespread nature of our sample.

We have conducted qualitative interviews on the burden of work, payment, debt, toll on mental and physical health of frontline health workers. For all cadres of workers, we have sought quantitative information and provide statistical indicators on average debt burden, payment delays, hours of work, distance travelled in the context of Covid-19 duty.

Sampling

Our total sample size is 201 healthcare workers which includes 95 ASHA workers, 77 Anganwadi workers and 29 ANMs. Our sample of healthcare workers has been drawn to reflect regional representation, COVID infection rates, social and economic indicators. These include Genreal (23%), OBC (39.3%), SC (16.4%) ST (4%) and others (10.9%)

HCW By Social Category



Our sample of women workers are a representative sample with a mix of urban and rural, household head status (women headed households), SC/ST and Upper castes, districts that are Covid Red zones (to understand the work burden and other anxieties) and states with tribal and hard-to reach populations.

Limitations

Initially, we had aimed to conduct 250 interviews between the months of October and December across 10 states. However, due to several ground level challenges, we were able to conduct 201 interviews. There have been several challenges which have impacted the number of interviews conducted by our investigators. Health workers have not responded due to work burden or have not consented to interviews due to fear of state reprisal. Madhya Pradesh and Bihar went into bye-elections between October and December, causing a delay and number of responses. In some cases, husbands of ASHA workers intervened between investigator and respondent either by restricting their conversations or talking on their behalf. Across states, ASHA and Anganwadi workers have been involved in protests and demonstrations demanding better work and wage conditions. During protests, particularly in the state of Maharashtra, respondents have been unavailable for interviews. Despite the above limitations, our study presents coherent narratives and data points that elucidate the experiences of frontline health workers engaged in pandemic duty. These study findings, due to small sample sizes are indicative of situations on ground and experiences of healthcare workers.

Burden of Work

Burden of Work Among ASHA workers

As a community health worker, an ASHA worker caters to a population of 1000–1500 people in her area. Apart from the routine tasks of prenatal and antenatal check-ups, immunization, communicable and non-communicable disease surveillance, ASHA workers across states have been at the frontline of Covid-19 duty performing crucial Covid activities. These include:

Door-to Door Surveys: Across states ASHA workers have been conducting syndromic surveys, checking for Covid-19 symptoms among community members. In the states of Haryana, Karnataka and Delhi, ASHA workers have been assigned 10–12 rounds of Covid-19 related surveys at the time of conducting the interviews. In each round they have had to collect descriptive information of medical histories, occupation, demographic details of several categories of individuals. Each round of survey for a designated population cover had to be completed within a week.

Besides Covid related surveys, they have had to perform other surveys as well. In Haryana, ASHA workers had to distribute AYUSH ministry recommended Ayurvedic ingredients to every household.

In Uttar Pradesh, ASHA workers were assigned additional surveys during Diwali and Chatt Puja as a large number of people returned to their villages to attend these festivals. ASHA workers in Karnataka were asked to get all pregnant women tested for Covid-19, without which they were not allowed inside healthcare facilities.

Contact Tracing: Across all states, ASHA workers have been involved in contract tracing of suspected Covid-19 patients through detailed listing of travel and contact histories. Particularly in the context of the migrant returnees and travellers from abroad, in early months of the lockdown, they were involved in listing details of travel, contact persons of every person entering the village.

Policing Quarantine Centres: In the early months of the pandemic, Covid-19 positive patients were either sent to hospitals or institutional quarantine centres, which was the task of ASHA workers.

Due to the large waves of migrant returnees returning to their homes, ASHAs had to be on-call for 24 hours in a day, meet and collect details on any outsider coming into their area. Particularly in rural areas, due to lack of police personnel, ASHA workers have been policing quarantine centres.

In the later months of the pandemic, ASHAs were also responsible for ensuring that families followed home isolation protocols.

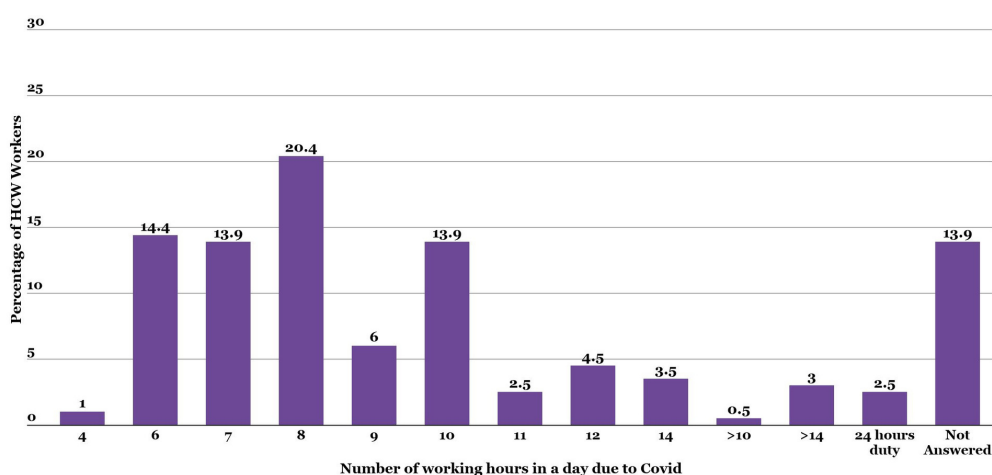
First-point-of-contact for community members: As a first point of contact for the community, ASHA workers' roles stretched beyond usual work hours, being on call round-the-clock, to attend to any health complications in the community.

"We have to arrange for an ambulance to get people tested, especially when medical staff at the PHC or the police officials were unresponsive" said Kavita Devi, ASHA worker in Khagaria district of Bihar.

Working in Containment Zones: As a Covid-19 control measure, areas with a high number of Covid-19 cases are notified as containment zones with restricted entry. In many states, ASHA workers risked their lives working inside containment zones without adequate facilities. In Delhi, ASHA workers were tasked to identify each Covid-19 patient in a containment zone and asked to survey 50 houses surrounding each Covid-19 case for the purpose of contact tracing. In containment zones, ASHAs also had to set up testing camps, collect and maintain information on all persons tested.

ASHA workers, on an average, have had to visit 25-50 households each day. ASHA facilitators, visited anywhere between 50-100 households on any given day.

As a result of the increased pandemic duties, ASHA workers have, on an average, had to work in the field for 8- 14 hours everyday including weekends.



Even during the lockdown they had been arranging vaccination sessions and pregnant women checkup in anganwadi centres, following all social distancing protocols. As community members are scared to go for vaccination and pregnant women checkup, they were also engaged in door-to-door counselling.

Non-Covid Work During the Pandemic

ASHA workers across states were roped in to conduct many non-pandemic and non-healthcare related duties.

Election Duty in Madhya Pradesh and Bihar : ASHA workers were placed on election duty for sanitization and thermal screening protocol in polling booths.

Madhya Pradesh: As part of Dastak Abhiyaan, to address Under 5 malnutrition related mortality rates, ASHA workers have been conducting block level PDS surveys to enumerate families that are in need of ration kits.

Telangana: ASHA workers were roped in for flood relief duty in the state in the month of October. ASHA workers were also assigned survey duty for updation of a newly launched land management website called Dharani.

Footnotes

- Dastak Abhiyaan is an Madhya Pradesh state government initiative to address child malnutrition through active screening of children with severe anaemia, malnutrition, pneumonia and iodine deficiency. http://www.nhmmp.gov.in/WebContent/CHN/Dastak_guidelinenew/Concept_Note_on_Dastak_Abhiyaan_MP_20_04_17.pdf accessed on 1.01.2021
- Telangana Government has initiated a digital land records management website for which ASHA workers have been collecting data. <https://dharani.telangana.gov.in/homePage?lang=en> accessed on 1.01.2021
- Integrated Child Development Scheme is the world's largest early childhood care and development program introduced on 2nd October, 1975. <http://icds-wcd.nic.in/icds.aspx> cessed on 1.01.2021.
- <https://www.mygov.in/campaigns/poshanabhiyaan/>
- <https://www.mygov.in/campaigns/poshanabhiyaan/>

Apart from surveillance and quarantine work, ASHA workers were involved in distributing essential medicines, sticking Covid-19 seals on households and public health messaging.

While a bulk of non-covid work was halted across several states during the lockdown months, they have resumed since the lockdown lifted. ASHA workers while continuing with ongoing Covid duties are also conducting polio drives, antenatal care visits, disease surveillance for tuberculosis, leprosy, cataract and cancer among other duties.

Burden of work among Anganwadi Workers

Anganwadis workers (AWWs), as Integrated Child Development Scheme (ICDS) scheme workers are mainly responsible for keeping track of mother and child health indicators, running Anganwadi centers which provide cooked meals and pre-school training to young children. Anganwadis also organize 'Poshan Maah' in the month of September as part of POSHAN Abhiyaan- a central government programme to encourage community participation in addressing malnutrition.

During the pandemic, cooked meal services have halted due to the closure of most Anganwadis. AWWs have been distributing dry rations to individual households through door-to-door visits or by inviting family members over to the centre during these times.

As part of the ICDS scheme which is responsible for nutritional care of communities, AWWs' efforts at distributing rations to households during the pandemic are crucial in addressing the food security issues among poorer households in the country. As the latest data from Phase I of National Family and Health Survey-5 survey report shows, there has been a 7.5% increase in the prevalence of anaemia among women in the age group between 15-49 years and 15% increase in anaemia in children aged between six months and five years.

AWWs have recalibrated their duties to ensure that primary women and child care remains on track during the pandemic. To avoid the risk of infection, they have been carrying out home visits to weigh children and organizing prenatal check-ups for small batches of pregnant women at medical subcenters. We visit them (women of the village) and ask them if their period is on time, register their names and ask them to come to the sub-centre so that the ANM can guide them. Sometimes if due to covid they are unable to come then we reschedule but we make sure that they get the vaccine.’ said Purnima Mohan, Anganwadi worker at Charaideo district, Assam.

Along with their core activities in tracking community health and nutrition, Anganwadi workers duties overlapped with those of ASHA workers in many states which include conducting syndromic surveys, ensuring home quarantine and public health messaging.

Burden of work Among Auxiliary Nurse Midwives (ANMs)

Each ANM supervises 6-8 villages as part of her duty. During Covid-19 ANMs were conducting field visits for contact tracing and syndromic surveys and conducting Covid-19 tests as well as work in containment zones.

In states like Madhya Pradesh and Karnataka, ANMs were part of emergency teams on call for spot-checking of every patient in case of any complications. In some instances, ANMs have also had to work as laboratory technicians.

‘We have been conducting tests ourselves since the lab technicians were on strike’, said Sunita Kumari, ANM worker in Khagaria district of Bihar.

ANMs interviewed across states mentioned that their work hours have increased to 10-11 hours per day during the pandemic. Apart from 10 to 11 hours of work in the field, they also have to work on digital updation of data.

‘Before Covid-19 we would have 6-8 hours of work. During Covid-19 times, we have worked throughout the night to update details online. Sometimes I would also have to ask my friends or my husband to help me out with the digital work’, said Kumari Diksha, an ANM worker at Gadchiroli district in Maharashtra.

As medical subcenters were functional across most states, routine non-covid related activities such as vaccination and Antenatal Care duties were undertaken by the ANMs. They have provided these services at the doorsteps of the community as well.

Honorarium Payments During The Pandemic

In most states, except Andhra Pradesh, Kerala, Karnataka, Haryana, West Bengal and Sikkim, ASHA workers do not get a fixed monthly payment.

ASHA workers are entitled to Rs 2,000 a month, doubled in October 2018 from Rs 1,000 by the central government (and in some cases like Assam topped by by Rs 1000 extra from the state government) for a set of 8 tasks. ASHA workers also earn incentives for 66 tasks, ranging from Rs one for every oral rehydration solution (ORS) packet distributed to Rs 300 for each institutional birth and antenatal care and so on.

On an average, ASHA workers earn anywhere between 8000 and 10000. As many routine activities such as immunization, pregnant women check ups, Home based Newborn Care (HBNCs), were suspended during the lockdown period, ASHA workers across states saw a drop in their incomes sometimes by half.

86% of ASHA workers we interviewed reported a drop in incomes from March onwards.

In Telangana, their incomes dropped anywhere between Rs 3000-5000 and in Haryana and Bihar by Rs 1000-1500.

Covid-19 Incentive

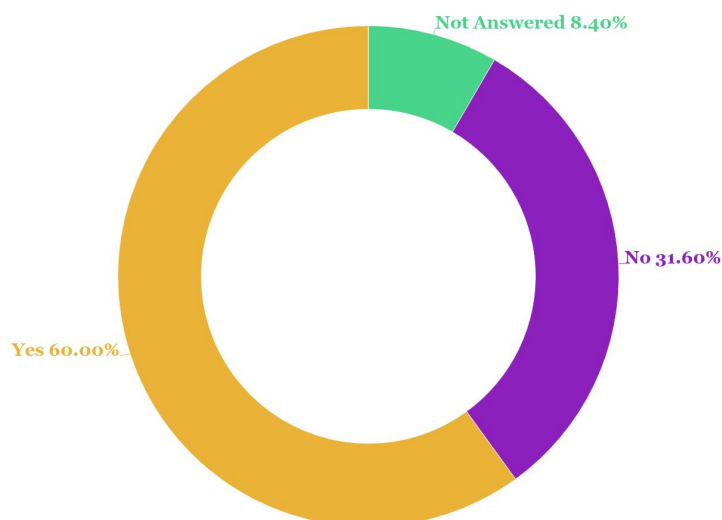
In April 2020, Ministry of Health and Family Welfare (MOHFW) announced Covid-19 incentive of Rs. 1000 incentive for all ASHA workers for the period of January to June. Later extended till September. States like Delhi, Maharashtra and Karnataka announced additional incentives.- Rs 500 for 50 houses surveyed in Delhi and a one time extra incentive of Rs 3000 in Karnataka.

However, ASHA workers in across states have experienced delays in receiving this incentive- in some districts they have not received the incentives for all months. In Khagaria district, Bihar and Bidisha district of Madhya Pradesh ASHA workers had not received Covid-19 incentive until November when the interviews were conducted.

Footnotes

- https://nhm.gov.in/New_Updates_2018/In_Focus/2DO_AS_MD_ASHA_incentives.pdf accessed on 1.01.2020

Number of ASHAs who received the Covid Incentive



31% of ASHA workers had not received the Covid-19 incentive at the time of the survey

In Haryana, ASHA workers noted that they had received their Covid-19 incentive until July. In Jind district of Haryana, ASHA workers organized protests demanding PPE and increase in payments, as a result of which ASHA workers were denied their August incentive.

Payment Delays

Regular honorarium payments for ASHA workers are almost always delayed. They have to maintain meticulous records of the tasks that they perform to claim their payments. For instance, in Bihar, ASHA workers receive payments after they submit vouchers for the tasks they have completed. But often, supervisors hold back the vouchers themselves.

‘We have to submit a full daawa pramaan patra (vouchers for proof of work) every month but we don't get to fill it every month. If you ask the government, it will tell you that all data regarding these documents are updated digitally. But the ground realities are absolutely opposite of that’, said one ASHA worker in Bihar’s Khagaria district.

The incentive based payments, apart from causing variations in pay among ASHA workers, is also reliant on the completion of task, submission of documentary proof and supervisory approvals- all of which were affected during the pandemic causing a considerable drop in their incomes.

51% of ASHA workers reported a delay in honorarium payments. 12% of them have not been paid for 3 months, while 5% reported delays of 6 months.

At the time of this study, ASHA respondents noted experiencing 2 to 6 months' delay in receiving payments. Moreover, several tasks they undertake remain unpaid for. In Assam and Bihar ASHA workers reported not being paid for Home Based Natal Care visits and in Madhya Pradesh, they have not received incentives for tuberculosis work for over 8 months.

Bihar and Jharkhand, ASHA workers reported that block-level authorities often refuse to sign off for payments without bribes. In Karnataka, details of completed tasks have to be uploaded by nurses and ANMs at the Primary Health Centre on the Mother Child Tracking System (MCTS), failing which ASHA workers lose out on incentives.

"First, our incentives are not paid in the same month as the portal is updated. When we ask them, they accuse us of not updating properly. That's not even our work. The nurses are supposed to do it who are negligent and we end up not getting paid for our work", Geetha, ASHA worker at Bellary district of Karnataka.

Neela Devi, an ASHA worker in Mulugu district of Telangana, notes there are discrepancies in payments received by workers in tribal and non-tribal areas in the state. In tribal areas ASHA workers have received payments in the range of Rs 2000-3000, whereas in other non-tribal districts workers were paid in the range of Rs. 7200-7500. On complaining to the District Medical Health Officer, officials responded that due to lower numbers of Covid cases, ASHAs working in tribal areas have been paid less.

Footnotes

- <https://digitalindia.gov.in/content/mother-child-tracking-system-mcts> accessed on 1.01.2020
- <https://pib.gov.in/PressReleasePage.aspx?PRID=1602394> accessed on 1.01.2020

Honorariums of Anganwadi Workers

Anganwadis receive fixed honorariums for their duties. As per government data, the present rate of honoraria paid to the Anganwadi workers (AWW) & Anganwadi Helpers (AWH) Rs. 4500/- and Rs.2,250/- per month respectively.

Over and above central govt honorariums, every state with a few exceptions pay additional honorariums to AWWs and AWHs. The total income of Anganwadi workers range between Rs. 4500-7500 per month across states.

However, Anganwadi workers reported delays ranging from 2-4 months, some even up to 10 months, in receiving their regular honorariums.

60% Anganwadi Workers reported delays in honorariums. 20% have not been paid for 2 months.

Above all, Anganwadi workers are not entitled to the extra Rs 1000 a month Covid-19 incentive that was announced for ASHA workers for doing Covid duties.

Number of months for which the honorarium is pending ASHA	None	1	2	3	4	5	6	7	8	10	12	Not Answered
	37.9	5.3	11.6	11.6	6.3	3.2	5.3	1.1	0	2.1	4.2	11.6

Number of months for which the honorarium is pending Anganwadi	None	1	2	3	4	5	6	7	8	10	Not Answered
	40.3	5.2	19.5	7.8	6.5	2.6	1.3	1.3	1.3	1.3	13

Number of months for which the honorarium is pending ANM	None	1	2	3	4	5	6	7	8	10	12	Not Answered
	51.7	3.5	6.9	6.9			3.5					27.6

Salary and Benefits of ANMs

As government healthcare staff, ANMs receive fixed payments that range between a basic salary of Rs. 22500- 31000 across states. In Karnataka, however, ANMs receive as low as Rs. 10000 as monthly salary. In Chikkaballapur district, Karnataka the salaries have been slashed to Rs. 7000 per month as ANMs had protested demanding work and wage benefits.

There are delays in payments as in the case of other frontline healthcare workers. They receive their payments in bulk, particularly during festivals such as Durga Puja and Diwali when payment cycles are renewed.

The other notable observation was the difference between permanent ANMs and those hired on contract, who earn less than the former category. In Madhya Pradesh ANMs working on contract reported that they were paid a monthly salary of Rs. 15000, while the permanent staff were paid an average of Rs. 22700 and did not receive other social security benefits like maternity leave etc.



Debt Burden Of Healthcare Workers

Severe delays and loss of honorariums and incentives, coupled with out of pocket expenditures have resulted in new cycles of debt among all three categories of healthcare workers.

The Covid-19 incentive for ASHA workers, even in states where they have been regularly disbursed, has not been sufficient to make up for the loss of incentives. Rs 1000 which translates to Rs 33 a day have been described by all ASHA workers as a ‘joke’

“Government pays Rs 30,000 to Rs 40,000 every month to staff whose job it is to sit under the fan and wait for our reports. We risk our lives and what do we get? Rs 33 a day. Would you risk your life for this money? ,” said an angry Champaben Rathwa, an ASHA working in Sonagadh in Bhavnagar district of Gujarat.

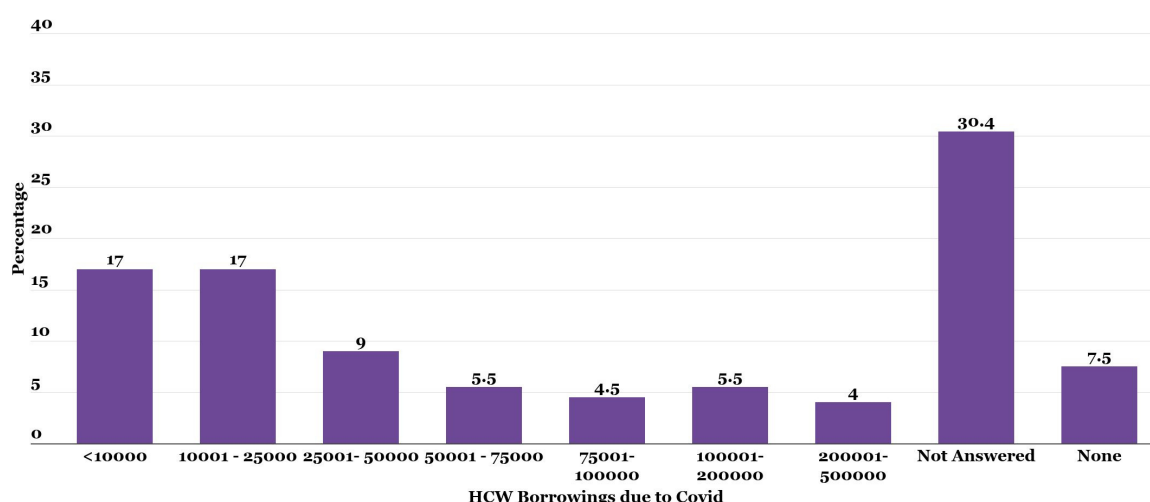
Even in pre-pandemic times, ASHA workers who come from very poor families and marginalised communities, such as Dalits and Adivasis, found it difficult to run their households on their honorariums. Lockdown and pandemic related job losses of other members of their families has led to further economic vulnerability.

‘On an average, ASHA workers reported debt incurred during the pandemic ranging from Rs. 10,000 to 40,000. In some instances, ASHA workers reported a debt burden of over 1 lakh rupees.

‘I had to pawn my Mangalsutra during the pandemic because we needed Rs. 5000. We are drowning in debt! We had to take out both our children, studying in 8th and 9th grade from school. We had a lot of dreams, but now we have nothing left’, rued Pramila Karma, an ASHA worker in Khargone district of Madhya Pradesh.

Often, ASHA workers take up extra jobs to meet their expenditure needs leading to a severe disruption in their work-life balance and disturbance in their household dynamics.

"I had to work in farms to earn more. I had to convince the medical staff to pay me for whatever time I work on the farm because I am generally late because of this for survey work. I would work on farms till 12 noon following which I would complete the health survey and report to my supervisor and be done by 1. Then I had to go home and finish my household work like cooking and cleaning. I would report for additional ASHA duties by 2 PM and come back only after 6 PM. How else can I manage?"----- Sudarshana, an ASHA worker in Satara district of Maharashtra.'



In many states, such as Telangana, ASHA workers reported taking loans from microfinance groups and private moneylenders. Many ASHA workers, like Ishrat Jahan in Delhi and Minara Begum in Assam reported selling personal belongings, jewellery, household assets such as mobile phones and washing machines to meet their family expenses.



**19 % of HCW had to
sell/pawn any assets during
Covid**

Anganwadi workers, while receiving fixed monthly honorarium, reported incurring debts during the pandemic due to severe delays in payments. In Uttar Pradesh, AWWs received bulk payments for the previous months just before the Diwali festival in November.

Educational and medical expenses form the bulk of the debt burden. Due to increasing debt burden, AWWs avoid seeking medical help for their own physical ailments.

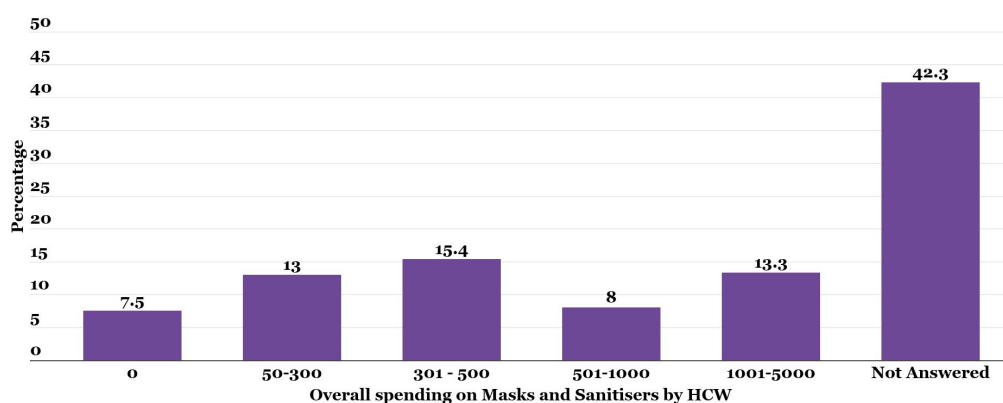
In many states, AWWs mentioned that they had to borrow money on interest to pay rent for the Anganwadi centers which do not operate out of government buildings. 24.3% AWCs out of 13.63 lakh operational AWCs (rural and urban) are currently operating in rented buildings. Rent payments from the government are often delayed by the government, sometimes upto 6 months, and even when they are reimbursed to the AWWs, the interest amount is not.

Some AWWs organize themselves and join self-help groups which lend money to struggling workers. In Assam, self-help groups have been pivotal in providing credit to AWWs

Footnote

• <https://pib.gov.in/PressReleasePage.aspx?PRID=1541558> accessed on 1.01.2020

ASHA, ANM and Anganwadi workers have to take upon out of pocket expenditure while on duty. During the pandemic, health workers reported spending upto Rs. 1500 on protective equipment, food and water, stationery etc. ANMs across states also incur expenses out of their own pockets for activities such as paying rent for the sub centres they operate from as government buildings have not been allotted.



Moreover, most workers reported that they neither receive any travel allowance, nor any government vehicle for conducting field visits. During the lockdown, the lack of transport created further issues.



Medical Apathy and Deaths On Duty

Several ASHA workers in Bihar, Madhya Pradesh, Delhi, Assam and Jharkhand died, either due to Covid-19 infection or mishaps such as road accidents and even exhaustion while doing their healthcare duties.

In Bihar, at least a dozen died while conducting Covid-19 related surveys in Motihari, Surajgarha, Muzaffarpur districts according to the ASHA workers's union leader Shashi Yadav.

‘Some ASHA workers fell sick but they weren’t tested. Doctors in the PHC would not even touch them. Sick ASHA workers were thrown out of the PHC. One of them died outside a private clinic.’

T

The Ministry of Health and Family Welfare, announced Rs. 50 lakh insurance coverage under the 'Pradhan Mantri Garib Kalyan Package Insurance Scheme for Health Workers Fighting COVID-19' for all public and private healthcare providers and frontline health workers in the event of loss of life due to Covid-19 infection or while doing Covid-19 related duty. Some states, such as Bihar, announced extra insurance payouts on top of the central government insurance for all families of deceased Covid-19 patients.

In many states, insurance payouts to ASHA workers' families have been hard to come by. In Bihar, none of the ASHA workers' families received insurance money because of bureaucratic loopholes. The Government of Bihar mandated an FIR to be lodged and a postmortem report to claim insurance payout. What kind of an FIR would be lodged if an ASHA worker died due to exhaustion while surveying on foot for hours?", asks Shashi Yadav. So many such deaths went unrecorded.

Similar narratives were reported from Assam, where an ASHA worker's family in Barpeta district was denied insurance on the pretext that the worker had passed away while on Covid-19 duty and not due to the Covid-19 infection.

In Delhi, almost 150 ASHA workers tested positive for Covid-19 along with their entire families who have not received any medical support.

'ASHA workers may receive ambulance service but there is no support for infected family members. There are no safe spaces for ASHAs like hotels for doctors. ASHA go to isolation centres, get patients tested and then go back to their own homes", said Kavita Yadav, Delhi ASHA Workers' Union leader

Footnotes

- <https://www.mohfw.gov.in/pdf/FAQPradhanMantriGaribKalyanPackageInsuranceSchemeForHealthWorkersFightingCOVID19.pdf> accessed on 1.01.2020
- https://www.business-standard.com/article/pti-stories/nitish-announces-rs-4-lakh-ex-gratia-for-13-covid-19-deaths-in-bihar-120052401073_1.html accessed on 1.01.2020

Culture of Bribes

ASHA and Anganwadi workers reported a prevalent culture of bribery to access their own honorariums which significantly impacts their payments, particularly in the states of Bihar and Jharkhand.

‘Block level officers ask us to pay Rs 100 as bribe from our incentives. The cumulative cut can go upto INR 1000. What are our honorariums anyway that we can pay that bribe? So we ask them to keep our incentive money. Everything runs on threats’, said ASHA worker from Deogarh district of Jharkhand.

Many supervisors take bribe from Anganwadi workers because they do not know how to digitally upload data. Currently, they demand 2 kilos pure Desi ghee and 1 quintal wheat to upload Mother and Child Tracking data on digital apps every month’, said Hazra Najmi, AWW leader at Bhopal district of Madhya Pradesh.



Training For Healthcare workers

ASHA workers receive preliminary training either from government medical staff or from NGOs.

However, for carrying out their Covid-19 duties, ASHA workers received short durations of online as well as in-person training on social distancing protocols, public health messaging as well as persuading people to go to quarantine centres. In the early months of the pandemic, ASHA workers in many states mentioned that they were deputed to field duties without any training whatsoever. They picked up information on safety protocols from sources such as radio and television.

AWWs receive training for their regular duties as well as periodic refresher training courses at the public health centre. For carrying out Covid-19 duties, AWWs reported to have received no on-site physical training. ‘We have learnt as much as we could from the television’, said Monjumoni Gogoi of Jorhat district, Assam.

ANMs received preliminary training both online and on-site for Covid-19 duties. Due to their close interaction with the medical staff at PHC and dispensary, ANMs are able to access medical supplies, particularly protective equipment and sanitizers. ANM respondents mentioned that their subcenters are well-equipped with requisite medical and diagnostic supplies.



Facilities For Healthcare Workers

Even before the pandemic, ASHA workers had very little facilities provided by the government both within the healthcare facilities and as well as on the field duties. As healthcare workers who have to attend to pregnant women and other patients and accompany them to hospitals, they are rarely provided with waiting and rest rooms within the hospitals-especially because they are not designated as kin of the patients. They are made to wait outside the hospitals and PHCs. During field duty ASHAs face considerable difficulty in accessing public toilets. Many ASHA workers reported lack of access to water and long gaps between meals during field visits, which has an adverse impact on their physical health.

“Sometimes we need to stay at the hospital the entire night but we can't use the restroom. We don't even get drinking water even on very hot days”, said Pramila, an ASHA worker in Khargone district of Madhya Pradesh.

During the pandemic, most ASHA workers reported lack of separate isolation facilities after discharging their risky duties which involved coming in direct contact with Covid-19 patients.

“The Government could designate a small room on the outskirts of the village for us to isolate and sanitise ourselves. After risking our life all day, we are concerned about going back to our homes and infecting our families”, said Lakshmi, an ASHA facilitator from Bhind district in Madhya Pradesh.

During the pandemic, however, ANMs have faced difficulty in conducting field visits due to lack of government vehicles. As ANMs are responsible for supervision of 8-10 villages, they faced great difficulty in covering the entire area, particularly during the lockdown.

Similarly, AWWs have faced difficulty in accessing toilets during their work hours, which leads them to use facilities in nearby schools. Ministry of Women and Child Development, data shows that Anganwadi centres in most states have no toilet facilities. 93% of AWCs in Arunachal Pradesh and 68% in Odisha did not have toilet facilities.



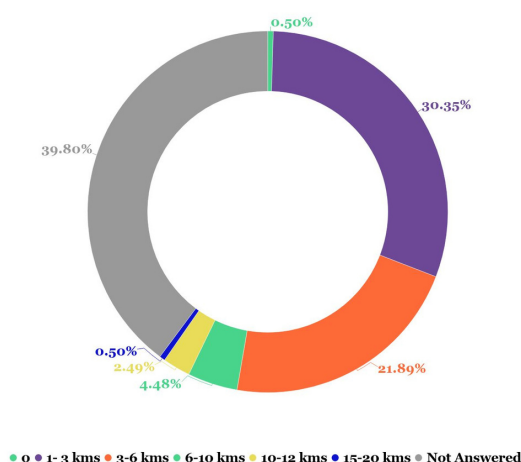
Physical Health of Healthcare Workers

All three cadres-ASHA, ANM and Anganwadi workers- reported high levels of physical and mental exhaustion during the pandemic.

ASHA and Anganwadi workers have had to conduct their household visits and surveys largely on foot. On an average ASHA workers have had to walk 3- 6 kms per day in rural areas and 10 kilometers or more in urban areas.

In the absence of government transportation, both before and during the pandemic, ASHA workers have faced severe levels of physical exhaustion during the summer months from April to June (in some states beyond June as well). This was particularly difficult in urban areas where they have had to cover large distances.

Daily distance walked per day



Footnote

- https://rajyasabha.nic.in/rsnew/Committee_site/Committee_File/ReportFile/16/123/314_2020_3_14.pdf accessed on 1.01.2020

ASHA workers also reported that they are not allowed to travel in the ambulance when they accompany patients to hospitals. They were asked by the healthcare staff to either walk or make their arrangements for transport.

ASHA workers reported weight loss, knee and joint pains especially during the pandemic. ASHA workers like Kavita Devi of Patna in Bihar had to undergo surgery for her knee pain. Rekha Malvi, an ASHA worker in Bhopal district of Madhya Pradesh reported taking painkillers to numb her physical pain and exhaustion during the pandemic.

“We are not able to eat properly, not able to sleep properly. We are made to run around for reports, for tests and other ASHA tasks. This has been impacting our health”, said Geetha, an ASHA Union leader in Bellary district of Karnataka.

Anganwadi workers, as part of their Covid-19 duties, were required to deliver rations individually to households at their doorsteps due to the closure of Anganwadi centres. Almost all state governments had declared household delivery of rations. AWWs have had to haul heavy ration kits on their shoulders.

‘We had to collect 50 kgs rice and 15 kgs matar’ mentioned Jaya, Anganwadi worker in Mariani district of Assam.

In Khammam district of Telangana, Anganwadi workers mentioned that they had to collect food from the ration shops for community distribution.

‘We had to carry 100 kg for 2-3 km, sometimes even walk upto 10 kms for ration distribution’ said , Koteshwari, an AWW in Khammam district, Telangana. AWWs noted that transporting heavy loads of ration for distribution also resulted in added transport expenditure for them.

In Assam, AWWs reported that they were threatened with dismissal, when they questioned the overburdening and increased scope of their work. AWWs also noted incidence of weight loss, lowered haemoglobin levels and physical exhaustion, sometimes even tragic consequences- such as Shagufta Khan, an Anganwadi worker in Bhopal district of Madhya Pradesh who suffered a miscarriage.

‘ The ministry we work under is called the Ministry of Women and Child Development. We are also women and we have children, but does the government care about us? I had to do Covid duty while I was two months’ pregnant while doing roza (fasting during the holy month of Ramzan) during peak summer. I lost my baby and my health has deteriorated’ said Shagufta, who has been mourning the loss of her baby.

ANMs reported similar physical ailments in joints, knees and exhaustion. Frontline health workers have reported heightened levels of mental stress arising from pandemic duty. Fear of infection, on field physical attacks and discrimination against frontline health workers have impacted mental health outcomes of all three cadres of workers. Debt burden has added another layer of stress for healthcare workers.



Mental Health of Healthcare Workers

As work hours have increased with most workers remaining on-call for almost 24 hours, which has had an adverse impact on personal relationships and household dynamics, sometimes leading to domestic abuse too.

“ Family discord is rampant among the families of the ASHA workers. Because we do not have fixed work hours and we get such little money. This triggers fights within the family, between daughter-in-law and mother-in-law, between husband and wife, with children”, Tutumoni Lahon, ASHA worker in Kamrup metro district.

The burden of Covid work has exacerbated fear of infection for healthcare workers. ASHA and AWWs reported severe mental stress, particularly in the initial months of the pandemic.

‘We feel so much fear. Even we have children and have to , we take care of the world, but who cares for us? I tell my children not to come close to me.’ mentioned Shiksha, ASHA worker Mayur Vihar district, New Delhi.



**23 % of HCW faced verbal
abuse during COVID**

Collection and reporting of data with short turnaround cycles has also caused physical and mental exertion for health care workers. Loss of sleep due to reporting obligations also adds to severe health outcomes. ‘Sometimes I have to stay up late after doing household chores to finish writing reports’ mentioned Jaya Anganwadi worker in Mariani district, Assam.

During the pandemic, several workers have had to discontinue their children’s education, unable to afford android phones for digital classes causing severe anxiety for workers.

To deal with mental and physical stress accruing to pandemic conditions, many workers noted that while they do not have official grievance redressal mechanisms, they have found some support among fellow workers and some higher officials. In many districts, Block Medical Officers, health staff at the Primary Health Centre have directly addressed instances of verbal and physical abuse against ASHA workers. In Delhi, the Delhi ASHA workers’ Union (DAWA) has been at the forefront of demanding strict action against community members who have assaulted ASHAs on duty.

Family members have been important sources of support for all cadres of workers.

Protective Equipment

Protective protective equipment (PPEs), even basic ones, such as masks, gloves and sanitisers were not provided by the government to ASHA and Anganwadi workers, despite the fact that they have been at the frontlines and in direct contact with the community and potential risk of Covid-19 infection. ASHA workers reported using their dupatta (cloth scarves) to protect themselves from infections while on field duty.

Across states, and indeed at the national level, demand for adequate safety gear have been the central demands of frontline healthcare workers.



28 % of HCW did not receive any masks and sanitisers from the government during Covid while 15% received the safety gear only once

In most states such as Bihar, Delhi, UP, Karnataka healthcare workers reported that they received PPEs only twice since the pandemic outbreak. Wherever healthcare workers did receive masks, they were of mediocre quality.

ASHA workers complained that while other healthcare staff like doctors, nurses, laboratory technicians received full PPE gear only after they came in contact with infected patients, they have had to contend with improvised solutions such as handkerchiefs, saree ends or dupattas.

In many states, ASHA and Anganwadi workers have been stitching masks for personal use as well as for distribution among community members and even to patients who visited the subcenters. In some cases, ASHA workers distributed masks they received to Anganwadi workers.

In some districts ASHA and Anganwadi workers received masks, sanitizers and thermometers from NGOs such as the Premji foundation or private companies such as Bata in Nashik (Maharashtra). In other states, self-help groups were instrumental in stitching and distributing masks for healthcare workers.

ANMs, however, have had better access to PPEs as they are attached to the PHCs and medical dispensaries through the health subcenters. In Madhya Pradesh, ANMs reported receiving PPE kits, gloves, masks and sanitizer 15 times. They also received pulse oximeters and thermometers. It was not uniform however.

In Gadchiroli district of Maharashtra, ANMs reported not receiving any PPE kits. Similarly, in Bihar, ANMs reported that they were denied protective equipment by the government. In Khagaria district, ANMs were asked to buy safety kits for their personal use.

They gave us PPEs only in the early days. After that they asked to purchase on our own. We were asked to write to the Chief Secretary of Health Ministry about our grievances about lack of PPEs but government did nothing', said Sunita Kumari, an ANM at Khagaria district.

Frontline healthcare workers have reported instances of discrimination and violence both from within the community and other healthcare staff and government officials including the police during the pandemic. In many states, ASHA workers we surveyed, mentioned that they have been suspected and vilified for being carriers of the Covid-19 infection themselves. Tutumoni Lahon, ASHA union leader in Assam said that they were called "Corona Wallahs" within the community. They have not been allowed inside homes despite their years of work within the communities they serve

Discrimination and Violence On Healthcare Workers

In some states, ASHA workers reported being denied entry into PHCs and dispensaries by medical staff. In many instances, ASHA, ANM and AWW workers have had to seek assistance from village sarpanch, panchayat officials and even the police to put patients into quarantine, convince them to get Covid-19 tests done.

In Delhi, ASHA workers reported that Covid-19 surveys became even more challenging as many families feared that the information was collected for the National Citizenship Register, which was the reason for all India protests during late 2019 and early 2020. Several ASHA workers were attacked in South and North-east Delhi, reported an ASHA worker in Karawal Nagar of North-east Delhi

Pandemic surveys and duties were interrupted due to inter-group tensions within communities.

‘Among the Muslim communities, there was grave suspicion that an ASHA worker belonging to the Bodo community was conspiring them which lead to some tension for the ASHA workers’, said an ASHA leader in Assam.

ASHA workers, in several states, faced physical threats and grievous violent attacks against them. The Haryana ASHA workers Union collected cases of 20 ASHA workers, in 22 districts, who were physically attacked by the community. The union leaders mentioned that they received little help from the police and authorities, sometimes even greater vilification by them.

In Uttar Pradesh ASHA workers were chased away by community members with threats of violence.

In Telangana, ASHA workers were attacked while visiting households for antenatal and prenatal checkups. In Karnataka, community members threw chilli powder at ASHA workers and some were beaten with rods.

ASHA leaders mentioned that the reason for hostility among the community was the inadequate public messaging by the government who did not understand the nature of the pandemic and were themselves very scared.

“If the Government had done proactive messaging and allayed the fears within the community, then members of the public would have been less hostile to us”, said Sunita Rani, an ASHA worker and union leader in Haryana.

In many instances, the hostility was also an extension of the caste based discrimination that ASHA workers from Dalit, Adivasi and Muslim communities faced in their everyday lives.

“Attacks on ASHAs from Dalit communities in Haryana are high especially from the landed community strongmen as a means to assert their caste supremacy once again”, said Surekha, general secretary of the Haryana ASHA workers union.

In Narsampet district of Telangana, one ASHA worker from the Erkal community attempted suicide after being subjected to workplace harassment by her supervisory staff. In Karnataka, Geetha, ASHA union leader noted that there is widespread caste based discrimination against lower caste and Dalit ASHA workers. In Haryana’s Karnal district, ASHA workers reported that upper caste community members refused to divulge Covid-19 related information to Dalit ASHA workers. In Uttar Pradesh ASHA workers were chased away by community members with threats of violence.

Rekha Sanyar, an ASHA worker in Madhya Pradesh said that upper caste households made her sit on the floor and did not allow her to drink water or tea from household utensils during survey visits.

‘It pains me to see them behave that way. When there are child deliveries, these same persons drink from my hand’ mentioned Rekha.

Lack of transportation facilities and security during field duty has also exposed Anganwadi workers to physical assault and sexual violence. In Gadchiroli district, Maharashtra, an AWW was raped when she had gone to distribute food among women and children.

Hajira Baji, an Anganwadi worker Bhopal district Madhya Pradesh, noted that media disinformation linking the spread of Coronavirus with Muslim community after the Tablighi Jamaat incident adversely impacted the Anganwadi workers who were Muslims.

Coordination Among the Cadres of Healthcare Workers

ASHA ANMs and Anganwadi workers, as community healthcare workers often work in tandem within their communities. During the pandemic, all three categories of workers have been roped in for field duties in states, many times beyond the remit of their duties.

Since ANMs are permanent (in some cases contractual) government employees, they are higher in the bureaucratic ladder above ASHA and Anganwadi workers. While cooperation between them is essential in carrying out regular duties, as supervisors of ASHA workers, they share a contentious relationship. ASHA workers report that ANMs treat them rudely and even hold back authorisation for their incentive payments.

While ANMs reported that they share cordial relationships with other medical staff, they are also treated as marginal within the medical system. Whereas ANMs are trained as skilled birth attendants, most do not handle complex or even simple birthing procedures and refer patients to doctors at the Primary Health Centres. In some cases, ANMs reported abuse of power by higher officials sometimes recruiting them to do their household work.



How Data Flows In the Healthcare System

ASHA workers report to the ASHA facilitators, also known as Sahayikas. They, in turn, report the data to the ANMs and other officials at the PHC. the ANM at the subcenter. During the pandemic, data collected by ASHA workers did not receive their authorship. Apart from not receiving any recognition as healthcare workers, completely erases their work, say ASHA workers.

“Forget recognition, none of the reports we collect are signed by us. They are forwarded as reports of the Auxiliary Nurse Midwives (ANMs). Tomorrow when any audit of this pandemic is conducted, our work and contribution will remain invisible”, said Lakshmi Kaurav, an ASHA worker in Bhind district of Madhya Pradesh.

ANMs take advantage of ambiguity and make them work more, say ASHA workers. In many states like Haryana, Punjab, Delhi, Karnataka etc, most of the data reporting tasks have moved online. But ASHA workers say that the government neither gave them mobile phones nor internet packages to make the transition. Healthcare workers in these states with basic mobile phones had to spend out of their pockets to buy android phones to allow them to report data while those with better phones had to juggle with their children's online studies to find time to do the reporting.

Anganwadi workers also had to shift to online reporting. They have had to take pictures of people in quarantine and send it to the ANMs as part of their reporting. However, online data reporting has created a new set of problems for AWWs.

The government has given us a phone, a sim card and a power bank. But they are very poor quality. The battery only charges partially. It is difficult for us to upload our reports as the network is really bad in the village areas", said Mena Mech of Dibrugarh district in Assam.

In many states like UP and Karnataka, AWWs have been doing online reporting even before the pandemic. ANMs report to Lady Health Visitors, Block Medical Officers as well as the Primary Health Centre staff. Before the pandemic, ANMs were responsible for the bulk of data entry work on reproductive, child and family planning indices for a designated area. In Madhya Pradesh, they were required to update patient and family data into two android applications called Sarthak and Anmol.

ANMs note that the data entry work forms the bulk of their responsibilities. Older ANMs face great difficulty in management and online updation of data. 'I face great difficulties when the internet is not working. We get training every time whenever we have to upload new data. Government should create a specific position of data operators because it is not the work for ANM", said Shyama Singh, ANM at Singhourli district of Madhya Pradesh.

Footnotes

- <https://geoportal.mp.gov.in/Sarthak/Web/Login> accessed on 1.01.2020
- <http://anmol.nhmmp.gov.in/Home/Index.aspx> accessed on 1.01.2020

Demands

Demands of Healthcare Workers

ASHA Workers

- ASHA workers have mainly been demanding fixed salaries and regular payments. ASHA workers state that there should be a fixed salary ranging between Rs 10000-18000 for ASHA workers and a salary of at least Rs 24000 for ASHA facilitators.
- As government employees they demand Employee State Insurance (ESI), Provident Fund and Pension benefits.
- Covid-19 incentive for ASHA workers should be increased from existing Rs 1000 per month to at least Rs 300 for each day of Covid-19 work.
- ASHA workers demand travel allowance and waiting room facilities in hospitals. In Delhi ASHA workers demand that NGOs should not be made mediators between them and the government.
- ASHA workers also demand increased supply of disposable safety equipment during the pandemic.
- ASHA workers do not receive any insurance benefits. Although ASHA workers are supposedly covered under the Pradhan Mantri Jeevan Jyoti Bima Yojana. ASHA workers demand life and medical insurance cover. They also demand the Covid-19 insurance money is disbursed for deceased ASHA workers' families.
- Moreover, ASHA workers demand that harassment while on duty should be made a punishable offence which is acted upon swiftly, particularly during the pandemic.
- On retirement, ASHA workers receive a one-time-payment of Rs. 20,000. ASHA workers demand retirement benefits and pension between Rs. 2000-5000 as National Rural Health Mission employees.

Demands of Anganwadi Workers

Anganwadi Workers

- Anganwadi workers demand hike in their honorariums, provision for promotions and regularization of their employment.
- Anganwadi workers should be constituted as third grade and Anganwadi helpers are fourth grade government employees respectively along with employee benefits.
- Anganwadi workers also demand that the upper age limit for promotions should be removed and experienced Anganwadi workers should be promoted as supervisors.
- The introduction of the National Education Policy (NEP) has sounded warning bells among Anganwadi workers. The NEP aims to integrate pre-school and lower primary levels of school teaching. Anganwadi workers feel that it could lead to permanent termination of their posts. AWWs have been demanding that their posts be regularized so that they are not rendered jobless after implementation of the NEP.
- Anganwadi workers also do not receive any insurance benefits and thus demand medical insurance cover. As ICDS workers they have not received any information regarding their eligibility for the Rs. 50 lakh Covid-19 insurance scheme. AWWs demand that they should be insured, along with other health workers.

Demands of Auxiliary Nurse Midwives

Auxiliary Nurse Midwives

- ANMs in most states such as Madhya Pradesh, Karnataka, Uttar Pradesh and Bihar demand that a separate post for data-entry operators should be created at the sub centre.
- ANMs also demand that the discrepancy between salaries and benefits received by permanent and contractual staff which should be addressed.
- ANMs demand government insurance cover.

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