DH
DECCAN HERALD
IN PERSPECTIVE

Covid in rural areas: Empower ASHAs

Overcoming disenchantment among workers is crucial for a functional response system

ALLEN P UGARGOL & ARNAB MUKHERJI

As India's second Covid-19 wave declines, its rural spread is of significant concern. Karnataka is a case in point— the highest state test positivity rate was 39.7% on May 17. In rural areas like Hallegere village in Mandya, the test positivity rate was already 60% by May 11. By May 31, test positivity rates for talukas of Hunsur, Nanjangud, KR Nagar, HD Kote and Periyapatna remained as high as 74.38%, 66.22%, 58.62%, 55.77% and 55.2%, indicating a rural Covid-19 hotspot, even as state test positivity declined to 13.37%. Not only does the rural wave have a different time trajectory, but the rural health infrastructure is also much poorer. With Dr Michael Ryan at WHO forecasting Covid-19 to achieve endemic status, the readiness of our rural health system is critical if we are to avoid devastating consequences reported in our cities.

By design, rural health infrastructure is minimal and referral in nature. It is meant to cater to community health needs for Reproductive and Child Health (RCH) and health promotive and preventive activities. The robust need for testing, diagnostics, and in critical cases, oxygen is not the rural health system's strength. In fact, the first responder for rural Covid-19 cases in most communities is an Accredited Social Health Activist (ASHA). They are now recruited in almost all gram panchayats of sufficient size. Traditionally, trained to focus on RCH, ASHAs are frontline workers spreading messages on birth preparedness, safe delivery etc. through home visits. In pre-Covid-19 time, this would allow for sharing information that might be seen to be too personal or culturally inappropriate in public. Our pre-Covid-19 door-to-door walks with ASHAs reveal strenuous routines, starting before people can leave for work. With very heavy data reporting expectations, they work into the day. We reached out to several ASHAs, mentors, and facilitators to see how they were faring during the second Covid-19 wave.

Most ASHAs have access to detailed Covid-19 treatment protocols and understand basic Covid-19 management. However, key challenges remain due to the lack of local availability of doctors, nurses, drugs, testing, medical equipment, other supplies and of course, vaccines. Even patients with mild symptoms need triaging by a medical team, access to drugs, diagnostic evaluation and medical advice. More serious cases need urgent referral to more equipped clinical establishments. ASHAs have received a Covid-19 management kit, but beyond the face shields, masks, and gloves that remain important, there is little by way of the system that an ASHA can depend on to monitor, track progress and recommend severe cases to hospitals in a timely manner.

Several initiatives taken by different state governments are taking shape to respond to this. Maharashtra may create 30-bed clinical units in each gram panchayat to provide health services locally. The government of Karnataka has announced support for a Gram Panchayat Task Force Committee (GPTC), endowed with Rs 50,000 to each. Family Task Force Committee (FTC) mapped onto 50 families will report into the GPTC and consist of ASHAs, bill collectors, SHG members and members of society in the village. The focus of FTCs is to monitor people under home isolation through home visits, help arrange food and medicines for vulnerable communities, advise those who cannot isolate at home to move to a Covid-19 Care Centre and provide teleconsulting support to families twice a day and monitor temperature, oxygen levels and pulse rates and identify ideal locations for vaccination drives. While this is very ambitious it is also achievable provided required supplies, equipment, financial assistance and leadership are available.

Forming and managing Covid Care Centres in the villages and managing a network of these would be critical as a pandemic response network. In addition, ensuring the provision of medicines and supplies and networking facilities with government established Covid management centres for secondary and tertiary care are the need of the hour. Sourcing local information and triangulating patient records, pharmacy data, availability of diagnostic test kits will be critical to any system trying to manage rural, decentralised Covid-19 treatment. ASHAs as the frontline resource will be the lynchpin for any gram panchayat initiative. They already support many existing government programs—Ayushman Bharat, Atal Pension Yojana, and Covid-19 surveys. Extending Covid-19 programmes within a feasible working environment will be critical for any rapid rural response system to handle Covid care.

However, our conversations reflect dissatisfaction with their work conditions. Poor recognition of their role, limited integration in the health system and delays in payments were frequently reported; on occasions, they have been on strike. However, ASHAs are keen to support their communities during the pandemic. Overcoming disenchantment and disillusionment among this crucial last-mile workforce will be a necessary condition to ensure a fully functional and decentralised pandemic response system that covers rural areas.

(The writers are part of Health Policy Group, IIM Bangalore)