

# Impact of COVID-19 on routine healthcare services and ASHAs

Bihar, Odisha, and Uttar Pradesh

September, 2020



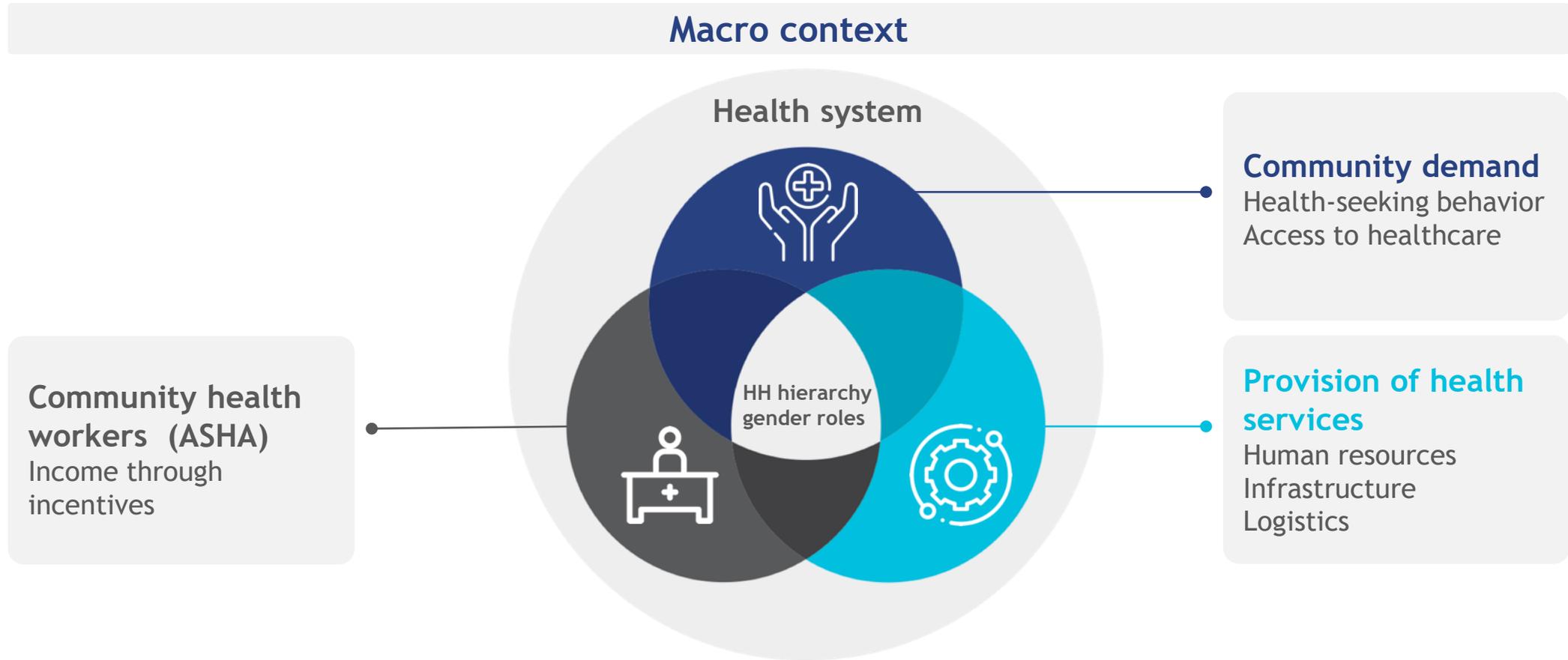
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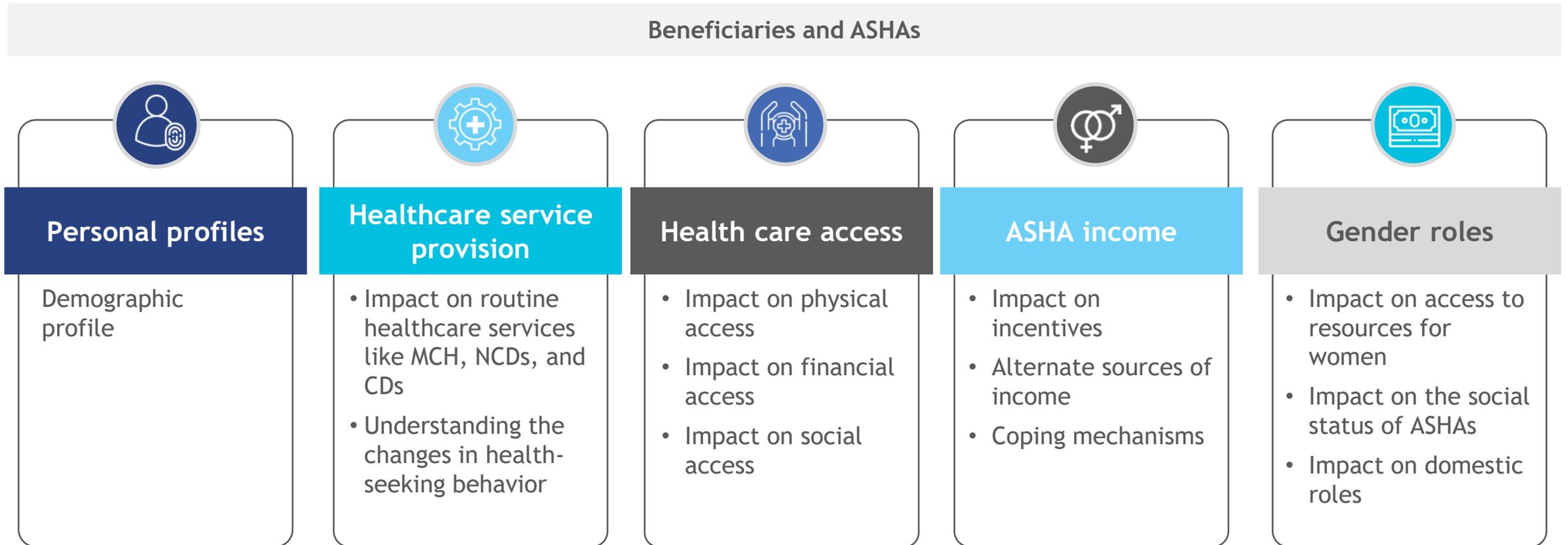
## Executive summary

# Key elements of the health system framework: These elements work together for larger public health goals



Scientific insights are required to comprehend and model the relationship of these elements to achieve a dynamic equilibrium leading to desired health outcomes. Based on this framework, the study identified three critical elements and explored the impact of COVID-19 on them. These elements included the provision of health services, community demand, and ASHAs. The study of larger health systems and the macro environment that affects health systems is beyond the scope of this study.

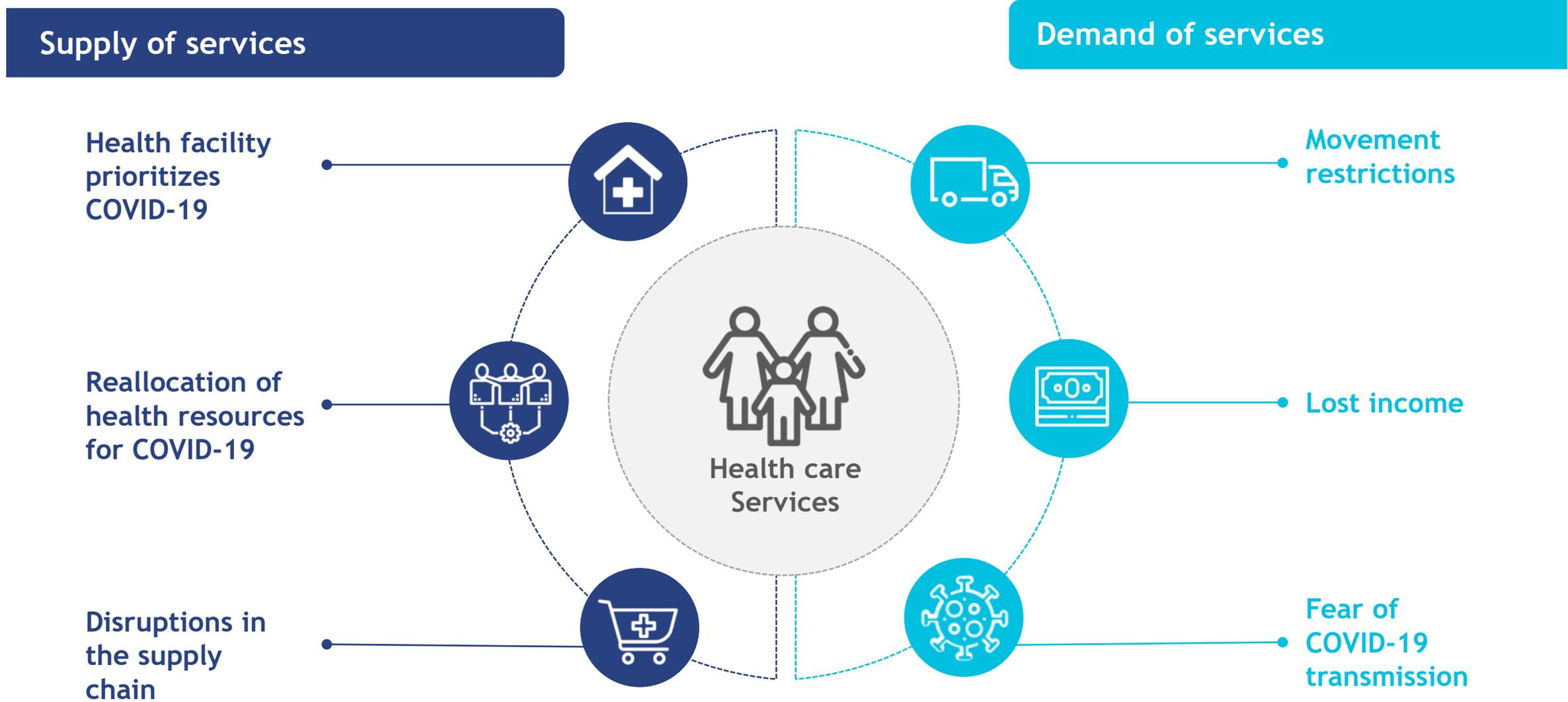
# A structured approach was followed to gather insights on the impact of COVID-19 on the health system interface



## Research methodology

The study was based on mixed-methods research methodology wherein quantitative findings were triangulated with qualitative enquiries to gather deeper insights. It was conducted across three states of Uttar Pradesh, Odisha and Bihar, with a sample of 120 ASHAs and 120 low-income households.

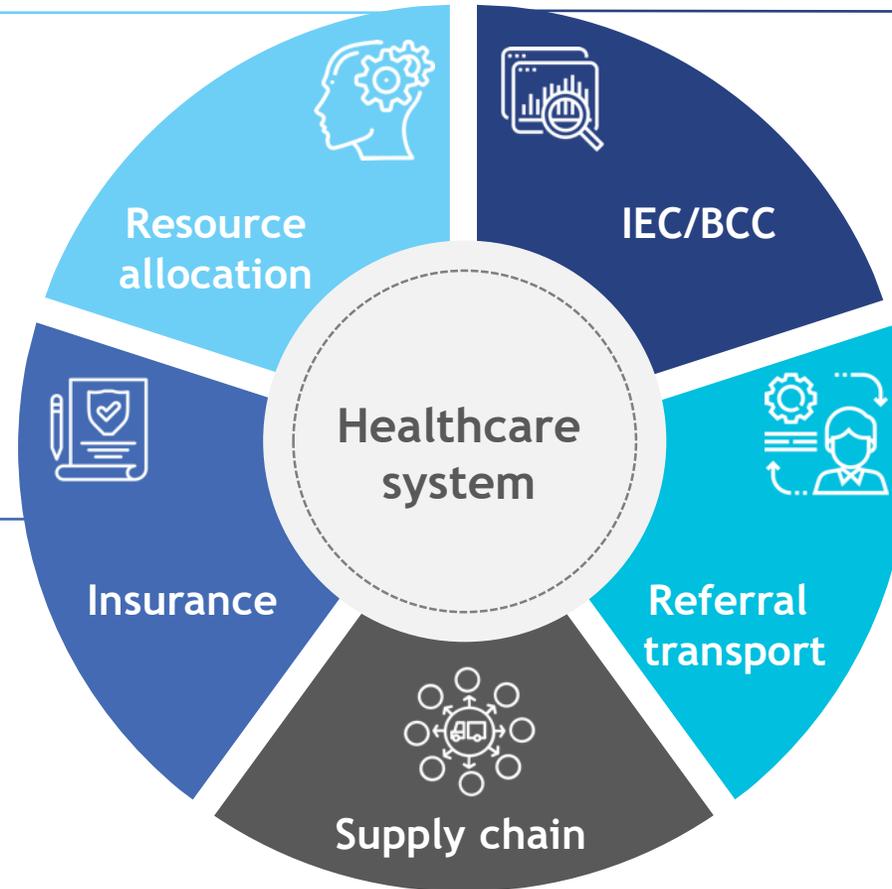
# Key findings: Various factors affected health care during COVID-19, including ASHAs



# Key recommendations: Due to the circumstances around COVID-19, the calls for a larger transformation in our healthcare system have resurfaced

Allocate more resources and redeploy existing resources rationally to ensure timely services

Improve insurance coverage to prevent impoverishment due to out-of-pocket expenditure on health



Introduce robust social behavior communication change interventions to alleviate people's fear of COVID-19 and the associated social stigma

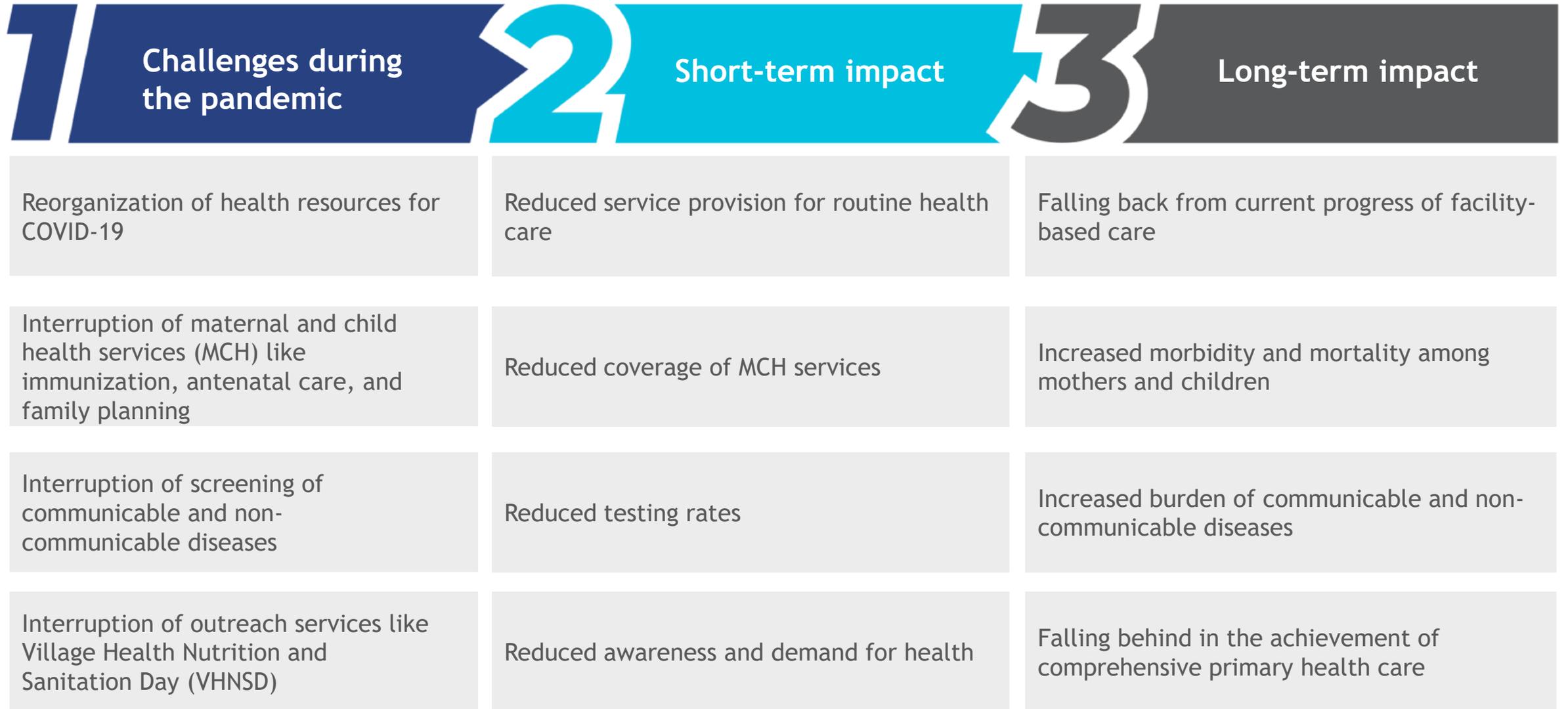
Streamline the availability of referral transport, more so to compensate for interrupted public and private transport during pandemics

Ensure leak-proof supply chains of essential healthcare supplies until the last mile



**Impact on the provision of  
health services:  
Insights from ASHAs**

# Impact on the provision of health services: Key findings



# ASHAs believe that the reorganization of routine resources for COVID-related provisions leads to dissatisfaction among the public

71%

of ASHAs reported the reallocation of existing resources for COVID-19

66%

of ASHAs reported that the reallocation of resources for COVID-19 adversely affected routine healthcare

## Qualitative insights

### Redesigning healthcare services

- ASHAs reported that many public hospitals were converted into COVID-19 facilities. This led to a shift of routine services to other facilities and caused discomfort to the general public.
- The redeployment of hospital staff at COVID-19 centers or for COVID-related activities affected their availability for routine health care.

“

Our PHC was reserved for COVID-19. All other services like lab testing, ANC, and normal deliveries were shifted to a nearby PHC. However, it is 4-5 km farther from our village. As there was no public transport, people did not want to go there.

- An ASHA, Bihar

”

“

I went to a public hospital first, but I was told that they are treating COVID-19 patients only. Then I had to consult a private doctor and take medicine from him.

- A male respondent, UP

”

# Routine services were affected due to COVID-19 while emergency services were uninterrupted

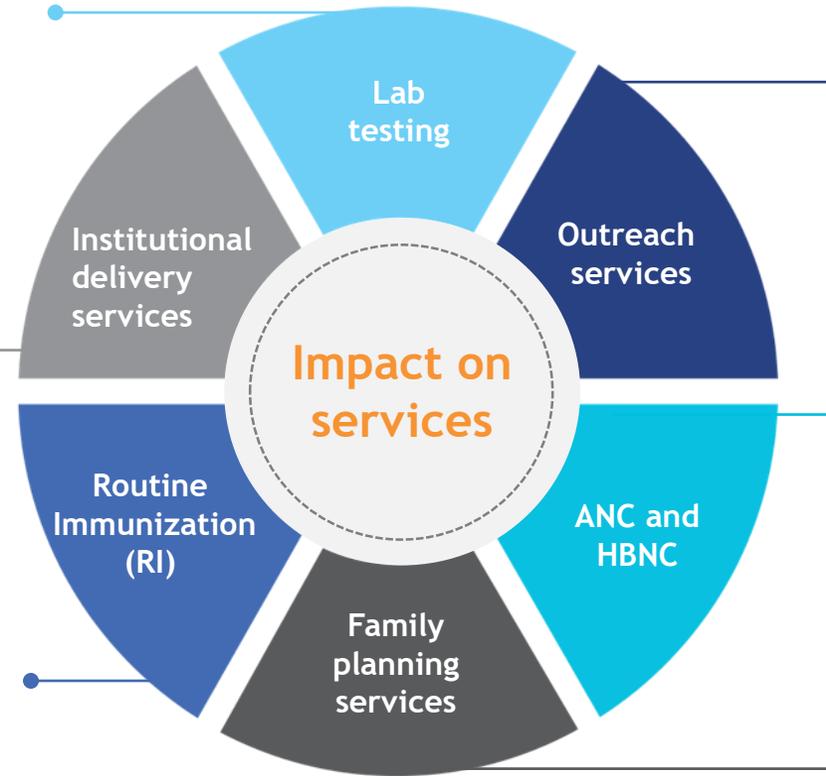
“ Interrupted ANC checkups cause difficulties for people. A pregnant woman came to me multiple times to get her ultrasound done but I could not help her as nothing was open.  
-An ASHA from Bihar

“ Since the lockdown, the ANM didi is not coming every week for diabetics and blood pressure checkups like she used to do before COVID-19.  
-An ASHA from Odisha

65% of ASHAs reported a decline in the screening of NCDs, although the treatment of existing patients was not hampered. Testing for NCDs and CDs was done in emergency cases only. Gol data also reports a 63% dip in lab tests in April, as compared to January.

17% of ASHAs reported interruptions in the provision of institutional delivery at public hospitals. NHM data also reported a 35% fall in deliveries in April, as compared to January.

38% of ASHAs reported that RI services were affected, while 23% reported an interruption. No sessions of immunization were held in April and May in most places. This was in line with HMIS data that reported a 64% dip in sessions in April, as compared to January

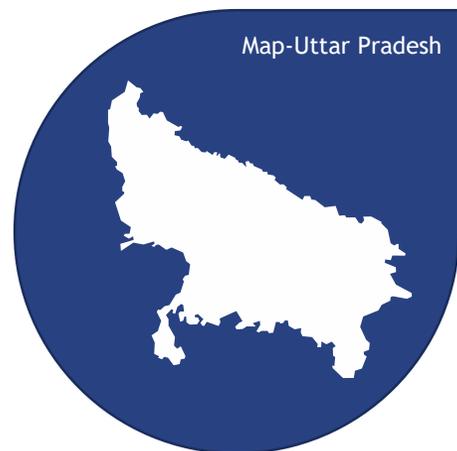


VHSNDs, HBNC, and ASHA meetings were not held in most areas in April or May, following social distancing guidelines.

63% of ASHAs reported decreased ANC, Antenatal care under PMSMA was not provided in April and May in most locations but was resumed in June. 47.5% of ASHAs reported a decrease in HBNC as families feared getting infected. This is in line with Gol data that reported a 51% dip in April, as compared to January.

Female sterilization was interrupted in Bihar. 37% of ASHAs reported a demand for the service with no provision. Across the three states, ASHAs reported stockouts of family planning commodities for community distribution.

# Delayed or poor provision of services was not uncommon, owing to COVID-related challenges: Case studies from ASHAs



## Case story: Uttar Pradesh

An ASHA reported calling the ambulance to take a pregnant woman for delivery. However, the ambulance was busy in transporting a referred patient to a district hospital. The woman had to give birth at home.

“The delivery happened at home because of delayed access to ambulance and hospital. I took care of the mother for nine months but in the end, it was all in vain.” - The ASHA worker

One of the ASHAs in the neighboring village was referred by a PHC to the district hospital for a C-section. However, she opted to deliver at a nearby private hospital due to the greater distance to the district hospital, transportation issues during the lockdown, and the unavailability of an ambulance. The ASHA suffered postpartum hemorrhage and died due to the time lost in decision-making and reaching the hospital.

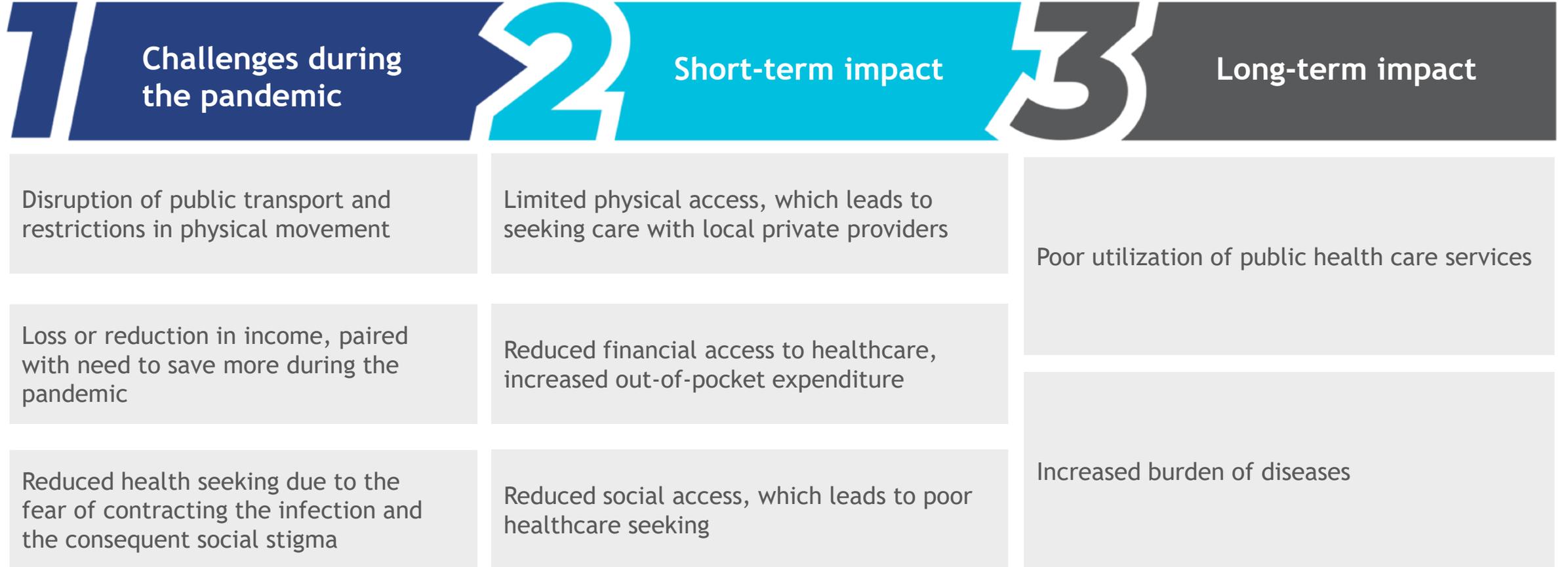
## Case story: Bihar





**Impact on community  
demand: Insights from  
beneficiaries**

# Impact on the provision of health services: Key findings



# Physical access: Limited public transport and restrictions on movement leads to “second delay” in seeking healthcare

44%

Respondents depend on public transport to commute to the hospital, which was not available during COVID-19.

41%

Respondents took more than half an hour to reach a hospital during COVID-19, which is more than the “time to care” norm of being able to reach the nearest facility within half hour

“

I used to travel by a rickshaw earlier or call an ambulance for my pregnant wife. Now, all ambulances are on COVID duty and we do not want to risk getting infected by calling an ambulance.

- A male respondent, Bihar

”

“

My wife is eight months pregnant. Before the lockdown, the doctor visited us and charged INR 300 per visit. We could also go to the city hospital 10km away. Due to the lockdown, the doctor cannot visit. I am unable to take my wife to the hospital for antenatal care as I have no private vehicle. I contacted an ASHA for help but instead of a home visit, we were asked to come to the PHC. I cannot carry my wife on the cycle to the PHC. What should I do?

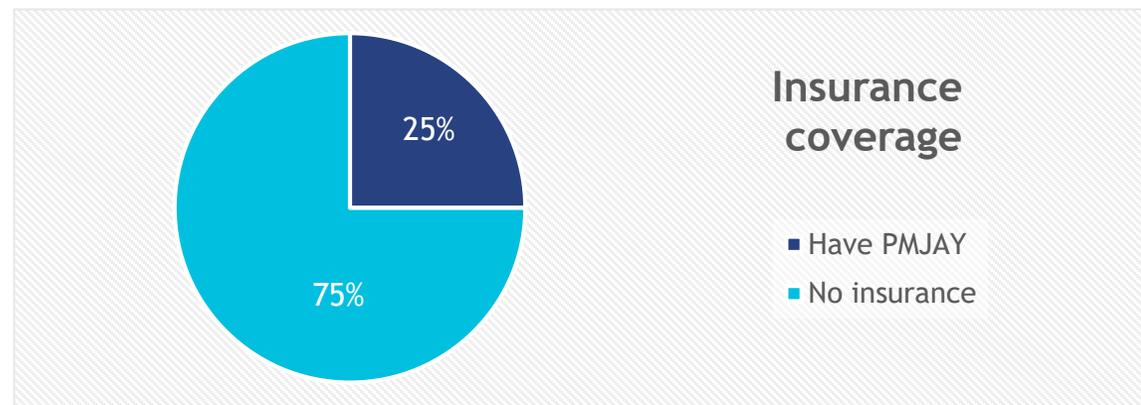
- A male in Odisha

”

## Qualitative insights

- **The unavailability of public transport**, such as buses, autorickshaws, and taxis, combined with restrictions on movements, adversely affected physical access to health care.
- The people who depend on public transport to commute to hospitals **had to hire private vehicles or borrow their neighbor’s vehicle** to reach the hospital. The situation was more troublesome for people with comorbidities.
- Many people were **scared to use ambulances** since they were also used to transport patients with COVID-19.
- Most challenges regarding physical access were experienced during the lockdown. The situation improved once the lockdown restrictions were lifted

# Financial access: Reduced income, inflated prices, and the need to save more during the lockdown left people with little money to spend on health care



**54%**

reported having more money before COVID-19 to access health care

**14%**

had to forgo or postpone their healthcare visits during COVID-19 due to the costs involved\*

**31%**

reduced spending on essentials like food and clothing to cover healthcare costs during the lockdown\*

“

Since public transport was not available, we hired a private car to visit the hospital. It cost us INR 400-500. Earlier, I never spent more than INR 200 to go to the hospital. - A male, Bihar

”

## Qualitative insights

- **Out-of-pocket expenditure on health has increased.** People now have to buy masks. In a few cases, private doctors increased their fee by 5-10% while the cost of medicines has increased by 10-15%. Many people have started visiting nearby private doctors rather than public hospitals located farther away, which has increased the cost of care. Hiring private transport in the absence of public transport has also increased this cost by about 25% for some people.
- **Reduced income was a major barrier** in access to health care, caused primarily by job losses during the lockdown. Households had to prioritize between competing expenses on essentials and health. Some people who suffer from chronic non-communicable diseases postponed seeking care due to monetary problems.
- Many people are using their savings or taking loans from friends and relatives to meet the expenditure on healthcare. Generally, **people have cut down on expenditure** as they want to save up for unplanned emergencies, such as an illness.
- People have been distress selling their agricultural produce to finance healthcare essentials, such as medicines.

\* Out of N=29 who fell ill during the lockdown

# Social access: Fear of contracting the infection and social stigma leads to “first delay” in seeking care

71%

Respondents reported being worried about contracting COVID-19 at healthcare facilities

Secondary data suggests that the dip in institutional deliveries across UP, Bihar, West Bengal, Jharkhand, Odisha, and Chhattisgarh could be attributed to the lack of public transport and the fear of contracting COVID-19.

“

Social stigma associated with COVID-19 is prevalent in society. If I get COVID-19, people will look at me as if I have made a blunder and failed to protect my family.  
- A male respondent, Odisha

”

“

Seven pregnant women were due to deliver in the last two months. Five of them gave birth at home. People are scared and they don't want to go to hospital due to the fear of contracting COVID-19 infection there.  
-An ASHA from Bihar

”

## Qualitative insights

Respondents delayed seeking care as much as they could due to the fear and stigma attached

Respondents avoided seeking care as due to the presumption that they are suffering from COVID-19. This uncalled social pressure restricts hospital visits by the community.

Private clinics in villages have stopped functioning due to the lockdown while public hospitals are treating COVID-19 patients on priority.

Many people believe that hospitals are only treating COVID-19 patients and hence do not visit hospitals. This perception is based on interactions within their social network.

42%

Blamed COVID-19 for restricting their access to healthcare

8%

Reported their families did not allow them to seek care due to the fear of social stigma and contracting COVID-19

10%

Believe that the quality of routine healthcare has degraded due to COVID

12%

Believe that hospitals are only treating COVID-19 patients



## Health-seeking practices of beneficiaries during COVID-19

# The lack of access to routine healthcare provisions due to COVID-19 forced people to seek alternatives?: ASHAs

In their catchment areas, ASHAs noticed the following trend:



“ I took a patient with Tuberculosis to the PHC. The staff was busy with COVID-19 patients and did not test him. They told us to visit the next day. The next day, they took a sample and referred us to the district hospital in Nawada. The patient got irritated and went to a private lab. - An ASHA from Bihar ”

“ I tracked incoming migrants and took them to the PHC to get tested for COVID-19 but the testing was denied. I had to then set up a temporary quarantine facility for all migrants in my fields to isolate them. No systemic support was provided to the incoming migrants. - An ASHA from Bihar ”

## Qualitative insights

- ASHAs have become the “go-to” person in their community to seek health advice. During the lockdown, people contacted ASHAs through telephones to avoid leaving their homes.
- The greater distance to public hospitals, a lack of public transport during the lockdown, and the fear of contracting the infection **encouraged people to explore nearby specialty options**. In most cases, these involved private clinics.
- Due to the interruptions in some service provisions like **lab testing at public hospitals**, people approached **private labs for emergency testing**.

# Beneficiaries look forward to telemedicine as a feasible alternative to physical hospital visits

## Qualitative insights

### Most respondents were positive about telemedicine.

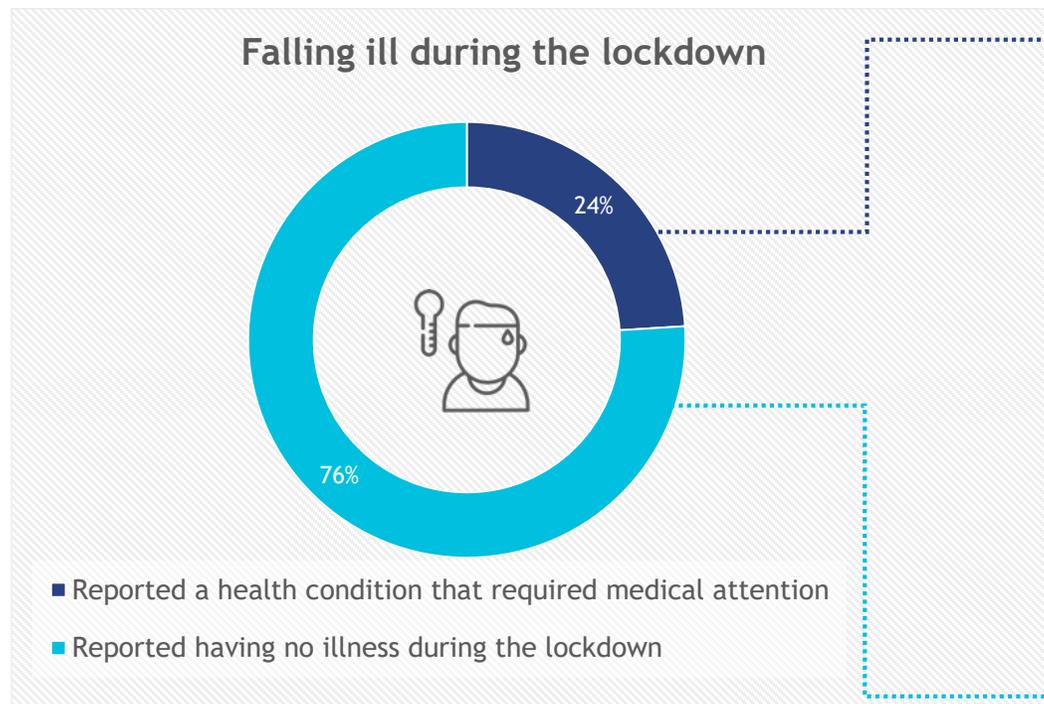
However, they had some apprehensions around its use. A few of them are listed below:

- Some people were happy to hear about the service as it would help them deal with minor health problems and save time as well as the cost of travel. However, others were skeptical of the service as they **had trust issues**. They raised questions like “How can we ensure the person on the other end of the phone is a real doctor?”
- **Telemedicine is considered a solution to the issues that surfaced during the lockdown or for similar emergencies**, rather than an alternative to routine healthcare services.
- The **acceptance of telemedicine was directly proportional to the distance between the residence of individuals and the hospital**. The level of satisfaction from current health services also influenced the attitude of people toward telemedicine. Those dissatisfied with the current system preferred telemedicine.
- The **lack of personal physical examination and touch** made respondents skeptical of telemedicine.

“Telemedicine is a good idea nowadays, especially during the lockdown. We can ask the doctors about our diets and how to take care of our health. This service may not be needed once the lockdown is over but right now, it is very important.  
A male respondent, Odisha”

“How can a doctor diagnose you without seeing you and touching you, and that too on a telephone.  
- A male respondent, Bihar”

# The Pandemic influenced the practices and perceptions of health care seeking: Beneficiary perspectives



## Practices

- Common ailments included fever, gastric issues, and joint pain.
- Every respondent opted for an allopathic provider and 62% sought care within five days of falling ill.
- 59% of the people went to private providers while 34% chose public hospitals. People preferred private hospitals due to the availability of all specialties under one roof, reduced waiting time, and better quality services. For instance, some respondents reported visiting a private hospital due to the lack of USG and X-ray facilities at the PHC.
- Older people, pregnant women, and children preferred going to the nearest facility.
- 24% of people stopped their treatment midway when they felt better, to save expenditure on medicine.

## Preferences

- These respondents focused on the prevention and precautions for COVID-19. This included drinking herbal concoctions and following the government-imposed restrictions of staying at home.
- They treated minor ailments like cold and headache at home or bought medicines from the local pharmacy.
- Their preferences were similar to those who fell ill. It was a prevalent belief that hospitals were crowded and hotspots for contracting infections.

“

*Jab tak kuch emergency nahi aaye, hum bahar kyun jaye?  
Chhoti moti beemari ke chakkar mein kahi hospital me  
corona na ho jaaye.*

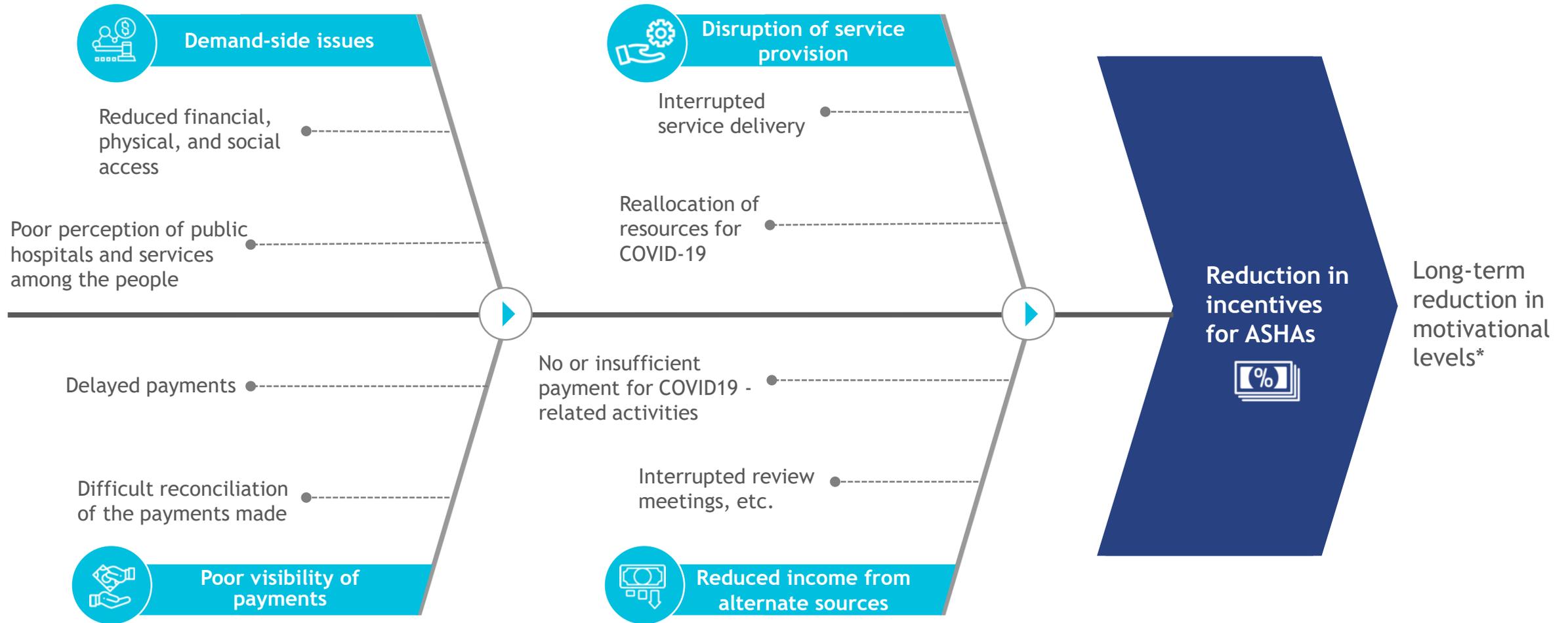
**- A male respondent, UP**

”



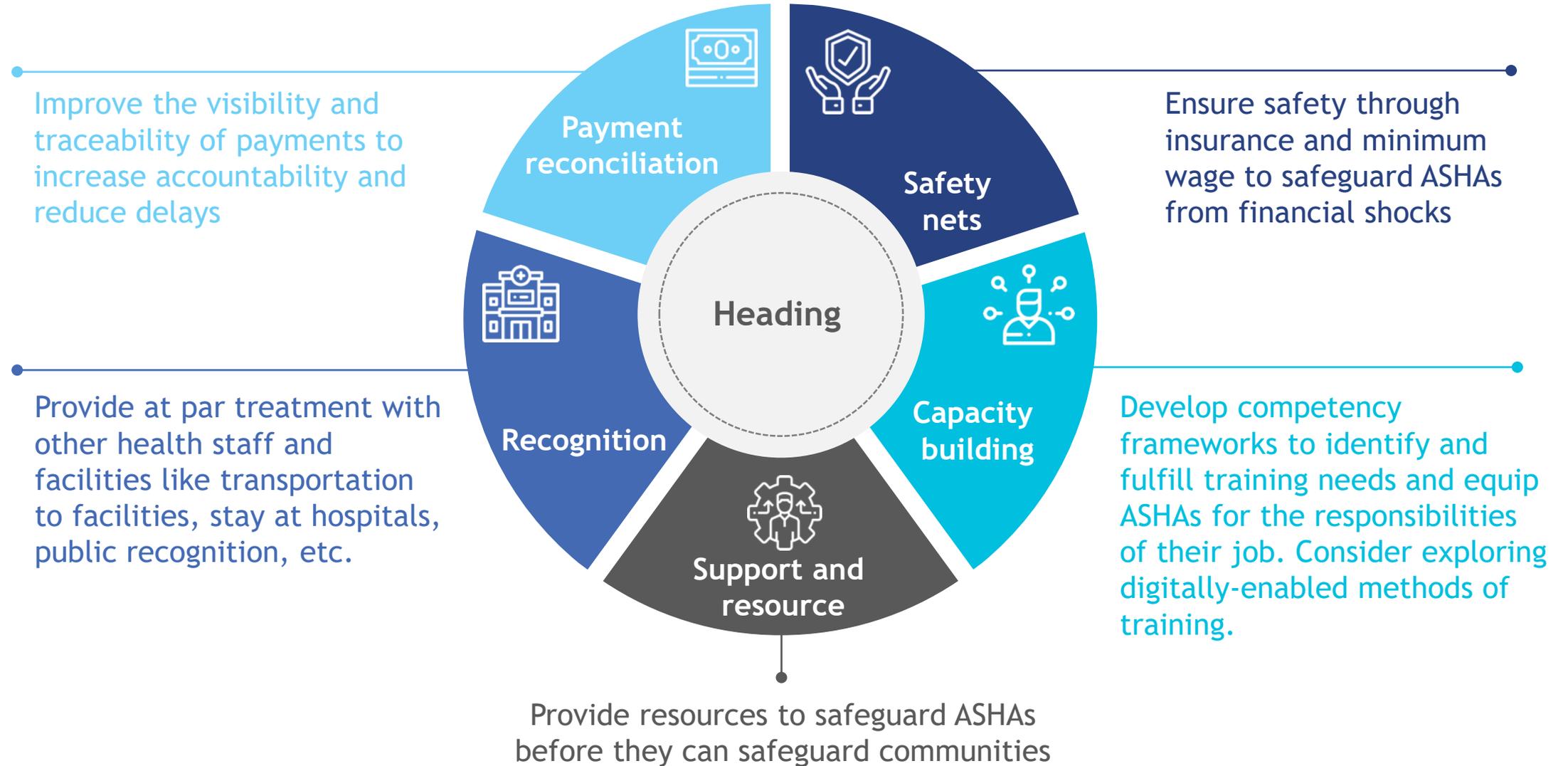
## Insights from ASHAs into the impact of COVID-19 on their income

# Impact on the income of ASHAs: Key findings

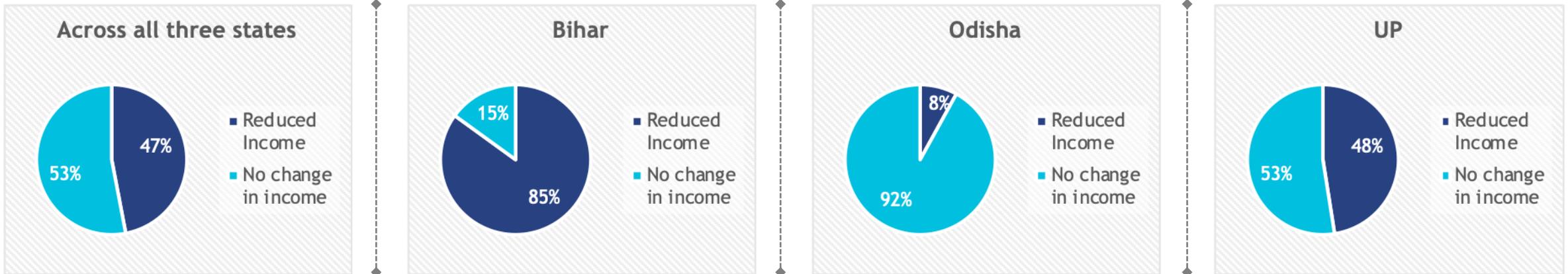


\*Though reduced incomes do not stop ASHAs from performing their activities as of now, long-term loss of income may affect the motivational levels of ASHAs and force them to seek alternate employment.

# Key recommendations: Can we utilize heightened attention on ASHAs during COVID-19 to facilitate larger policy and structural changes?



# COVID-19 affected the incentives of ASHA workers variably across the states



■ Income was reduced ■ Income remained the same

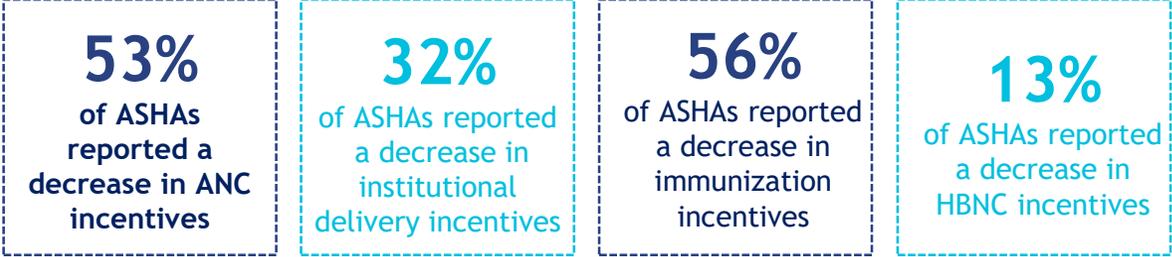
**Reasons for no impact on the incentives :**

- Additional COVID-related work and corresponding incentives were paid to ASHAs, such as INR 1000-1500 per household survey.
- This incentive was provided on time in Odisha, which led to minimal impact on their overall income. ASHAs in UP experienced some delays in these incentives. Bihar had the most delays in these payments, which had a major impact on the income of ASHAs.

**Reasons for the decrease in income from incentives**

- The demand for healthcare services fell due to the fear of contracting COVID-19 at the hospitals. Even the services that were uninterrupted, such as institutional deliveries, saw a fall in demand.
- A few services, such as antenatal care (ANC), immunization, and home-based newborn care (HBNC) were interrupted.

“ Due to lockdown, everyone was scared to go out. We could not take beneficiaries to facilities and hence earned no incentives. Our income reduced drastically. I could only take some pregnant women for delivery. There was nothing else I could earn from.  
- An ASHA worker from Bihar ”



# Not many ASHAs reported irregular payments due to COVID-19

However, the lack of transparency in the payment process continues to be a challenge that leads to problems in reconciliation for some ASHAs.

17%

of ASHAs reported more irregular payments due to COVID-19.

21%

of ASHAs reported difficulty in reconciling the payments they received concerning their claims. However, it was a routine issue unaffected by COVID-19.

## Qualitative insights

- A few ASHAs reported a **slight delay in payments in March and April**, mostly around HBNC and immunization.
- Most **ASHAs are unaware of the calculations** behind the payment, such as the amount they receive for each service every month. Some ASHAs received an amount that ranged between INR 2,000 and 4,000 during the lockdown. However, they are not clear what is it for. This is a chronic issue, with no correlation to the pandemic.
- Some ASHAs remained **ignorant of the payment credited into their account** since their accounts were not linked with their mobile phones. ASHAs were unaware of the payment status as they did not visit the bank to update their passbooks during the lockdown.

“

I received INR 9,000 for the period of April, 2019 to February, 2020 in one go. I have not received anything after that. There is no way of reconciling and knowing what services I have received this money for. The money we get never matches with our calculation of claims.

- An ASHA from Bihar

”

# The modalities of reporting were modified to prevent unnecessary travel and social gathering of ASHAs

## Change in reporting modalities for ASHAs

80%

Now submit their reports to their the ANM or ASHA facilitator

18%

Still visit the PHC to submit physical reports

2%

Report over a telephone

### Qualitative insights

#### Before the lockdown

- ASHAs used to submit their monthly reports to the PHC **physically** at the end of the month or during their review meeting at the PHC.

#### During the lockdown

- The **ASHA facilitator or ANM collects the forms** for all ASHAs under them and submits it at the PHC.
- Some ASHAs did not submit the forms but **reported their data over phone calls**.
- A few ASHAs submitted their forms while accompanying a patient to the PHC for their delivery.

“

Reports were collected and handed over to the ANM. Sometimes we send our reports through WhatsApp and submit the hard copies later.  
-An ASHA from UP

”

“

We submit the reporting format to the ANM whenever she comes and she updates it in the PHC.  
- An ASHA from Odisha

”

# The modalities of reporting were modified to prevent unnecessary travel and social gathering of ASHAs

## COVID-related activities performed by ASHAs

- 75%** Spread awareness on COVID-19
- 58%** Guide people on the preventive measures against COVID-19
- 54%** Track suspects or contacts and facilitate their visit to hospitals
- 61%** Frontline workers said they received incentives or payment for surveys
- 40%** ASHAs received COVID-19 training but no ASHA in Bihar received any training

### Qualitative insights

#### Paid COVID-19 activities

- All frontline workers reported having conducted a **survey of their households** to trace people suspected to have COVID-19. They were promised INR 1,000 for this survey.
- Another survey was conducted regarding **vulnerability mapping for COVID-19**. They were promised INR 1,600 for this survey .
- Though most ASHAs were involved in household surveys, **they did not seem to have any clarity on the additional incentives** due to them for the survey.

#### Unpaid COVID-19 activities

- ASHAs have been responsible for spreading awareness, tracking suspects or contacts and taking them to hospitals.
- However, **ASHAs reported they did not get any extra payment** for this.

“ Our ANM said we will get INR 1000 per month from April to June for the COVID-19 activities, such as tracing people and household surveys. We do not know what exactly the money is for or if we will receive this every month.  
-An ASHA from Odisha ”

# Many ASHAs had to depend on additional household income and revise their consumption patterns, owing to the reduced income

71%

ASHAs manage household expenses through the income of other family members

15%

ASHAs manage expenses through aid from the government

97%

ASHAs reported they could provide for personal essentials using household resources

## Qualitative insights

- **Additional sources of income:** Alternative sources of income included government aid, such as free ration under PDS as well as PMUY and PM-KISAN cash transfer. Respondents also borrowed from their local shopkeepers, started farming at home, and set up small shops.
- **Changes in consumption patterns:** Most respondents purchased only essential items during the lockdown. They reduced expenditure on clothes and food to maximize their savings.

“

We had to cut down our expenses, even on food. We eat whatever is available from the kitchen garden and what we get from the ration shop. We have to manage with a limited or no income.

-An ASHA from Bihar

”

# Though COVID-19 has increased the workload for ASHAs and negatively affected their incentives, it has not affected their commitment to serve communities

75%

ASHAs continue their services as usual, following the COVID-19 safety protocols

76%

ASHAs reported no change in the number of beneficiaries they served

## Qualitative insights

- ASHAs continued facilitating peripartum services with adherence to safety norms like maintaining a social distance, usage of masks and sanitizers, and washing hands. ASHAs were also not allowed to take the baby's temperature or weigh them, to abide by the norms of social distancing.
- ASHAs see their work as service to the community and are empathetic and responsive toward the needs of communities in these tough times.

“

I am very happy to serve people who are in need as I believe service to mankind is service to God. Working during the lockdown has been very difficult but irrespective of the situation, I always stand with people during their emergencies.

-An ASHA from Odisha

”



## Concerns raised by ASHAs

# Regularization of jobs and fixed salaries were persistent demands during the pandemic

## Concerns



Lack of fixed salaries, leading to financial stress



Lack of resources to facilitate their roles, including protective gear



Sub-optimal capacity building



Subpar treatment of ASHAs as compared to other health staff

“

We get paid based on our work. We work day and night and get INR 2,000-3,000 per month. This is not enough. We should be given a fixed salary.  
- An ASHA from Odisha

”

## Qualitative insights



ASHAs reported being on duty 24/7, without any insurance or leave benefits. Some of them reported receiving fewer incentives than daily wagers. The lack of fixed salaries is a persistent demand and ASHAs have organized [multiple strikes](#) to raise this issue time and again.



The lack of protective gear during the pandemic was a common issue, as [evident](#) from multiple instances across India.



ASHAs feel more training around screening for communicable diseases like COVID-19 would equip them better for their role.



ASHAs highlighted that they face [disrespectful treatment](#) at PHCs. This includes the lack of proper spaces to stay at PHCs, among others.

“

We are called ASHA and we are also having a ASHA (Hope) of getting regular salaries.  
-An ASHA from Bihar

”

# ASHAs reemphasized the critical role of strengthening health systems to overcome pandemics like COVID-19

## Qualitative insights

### Need for awareness

ASHAs reported a lack of awareness among the people regarding various health aspects, particularly on the need for screening.



### Rationalization of human resources

ASHAs reiterated the need to have a female doctor at the PHC to encourage woman patients to visit the PHC. Even in hospitals that operate 24x7, doctors are not always available.



### Increase in resources at government hospitals

The resources at government hospitals are insufficient. They do not have enough beds and the hospitals are crowded at peak hours.



### Improvement in emergency services

Emergency services, such as ambulances are not available, particularly at night. People often have to pay a lot of money to hire an auto-rickshaw or taxi.



“

The building of CHC is worth millions, but there is no doctor available most of the time. What is the point of such a costly building without optimal services.

- An ASHA from Bihar

”



**Impact on gender  
roles and the  
household hierarchy**

# The time invested in household chores increased for all females, including ASHAs, during the COVID-19 pandemic

100%

Reported an increase in the time spent cleaning, cooking, and taking care of family members

## Qualitative insights

- The **gender roles have been reemphasized** during the lockdown.
- ASHAs, apart from serving their healthcare roles, now invest more time in household **chores like cooking and cleaning**. However, they did not complain about the additional burden.
- The time invested in household chores has also increased for other women. Most of their time is now spent **cleaning, cooking, and taking care of the elderly and children** in the household.

“

The time invested in HH chores has increased. Noone else will do the cleaning, cooking etc. we have to handle that also.  
- An ASHA from UP

”

# The communities and families of ASHA workers acknowledge their service during the pandemic

88%

ASHAs reported no negative change in the attitudes of their family members due to the increased workload or decreased income

88%

ASHAs reported no change in access to resources due to the decline in income

## Qualitative insights

- **Impact on the status of ASHAs in household:** The families of frontline workers continued to support them even though their work has increased and income has reduced.
- ASHAs noticed no negative change in attitude or behavior of their family members, which boosted their morale.
- Some respondents mentioned an improvement in their status within the household. The families of ASHAs now have **greater respect** for the work they do to contain COVID-19 in the area.

“

Earlier, my family members did not recognize the value of my job. Now they see me trace households during COVID-19 and treat me with more respect, even in the household.

-An ASHA from Odisha

”

# Respondents were not comfortable talking about any instances of domestic disharmony

8 out  
of 120

ASHAs reported instances of household arguments during the lockdown

4 out  
of 8

ASHAs attributed the arguments to control over the household income

4 out  
of 8

ASHAs attributed the arguments to casual “misunderstandings”

## Qualitative insights

- The only **positive responses** came from **ASHA respondents** who were interviewed by a woman. The arguments due to control over the household income seemed to **increase during the lockdown**.
- Male respondents were not willing to speak out on such incidents.
- A **desirability bias** influenced the responses as most respondents did not even admit to having a small argument in the household, which seems unrealistic.
- Having a spouse or family members around during the interviews **might have influenced the responses**.



## Appendix: Methodology and sample demographics

# A mixed-method study to understand the impact of COVID-19 on routine healthcare provisions and practices along with the income of frontline workers (ASHAs)

## Design of the study

The study was based on a mixed-methods research methodology wherein quantitative findings were triangulated with qualitative inquiries to gather deeper insights. It was conducted using telephonic interviews (CATI) between 25<sup>th</sup> June and 15<sup>th</sup> July, 2020.

## Sample size

We interviewed 120 ASHAs and 120 low-income households across three states of India—Uttar Pradesh, Odisha, and Bihar, where the health systems are not in a perfect state.

## Sample distribution for ASHAs

From each state, two districts were selected randomly. The respondents were also chosen randomly from a list of ASHAs. We selected a sample of 40 ASHAs per state.

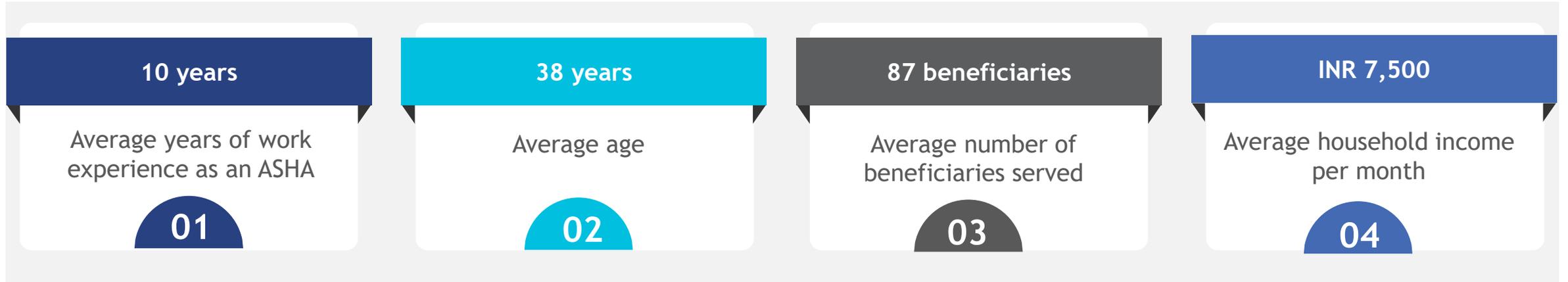
## Sample distribution for households:

From each state, 40 respondents were selected randomly from the database of BPL families sourced from a partner survey firm. The sample was spread across four districts from UP, seven districts from Odisha, and seven districts from Bihar.

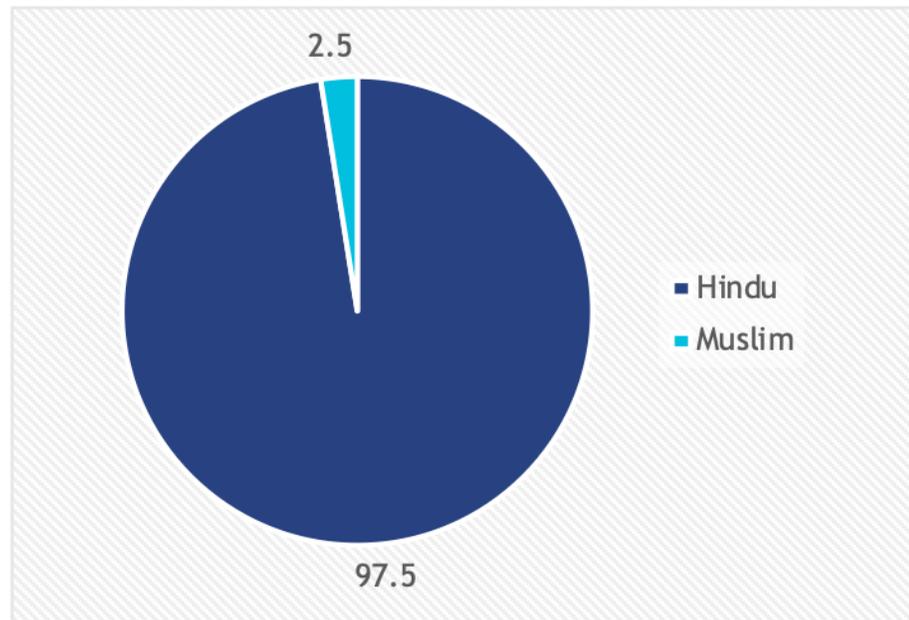
## Limitations of the study

The sample is not representative and the results from this study are indicative and directive only to provide insights on the research topic. As the study was conducted using telephonic interviews, those without access to phones were excluded from our sample.

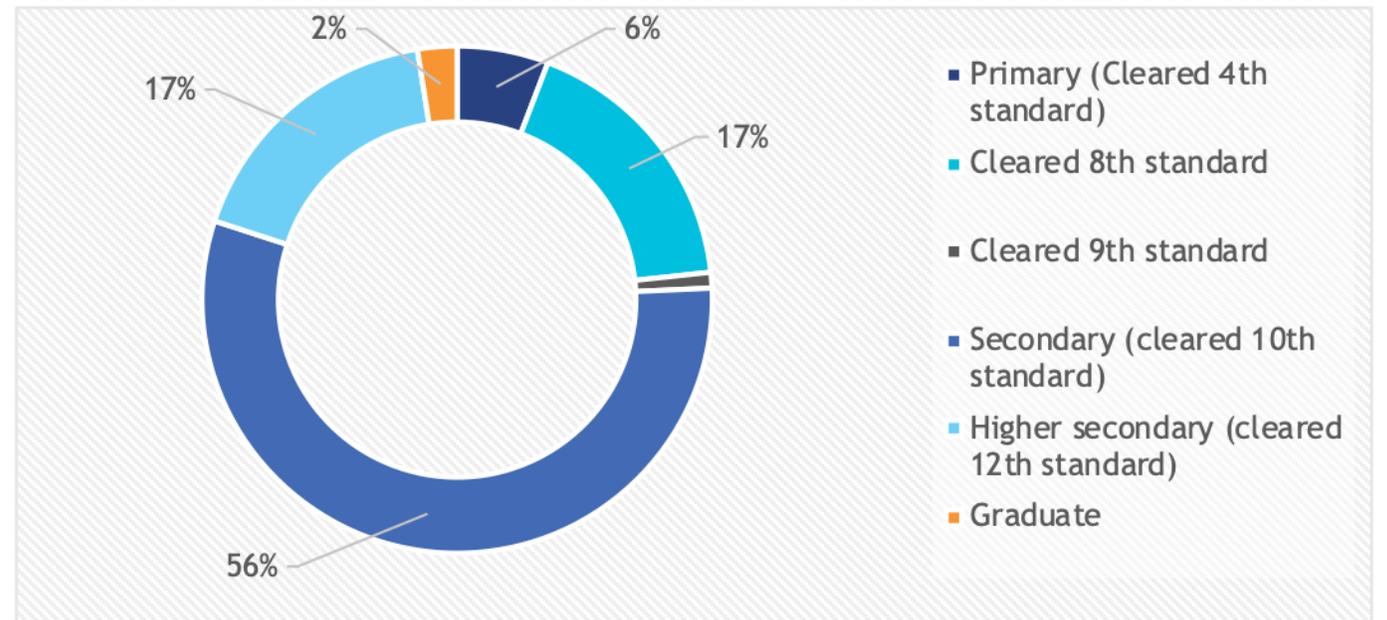
# Sample characteristics of an ASHA



### Religion

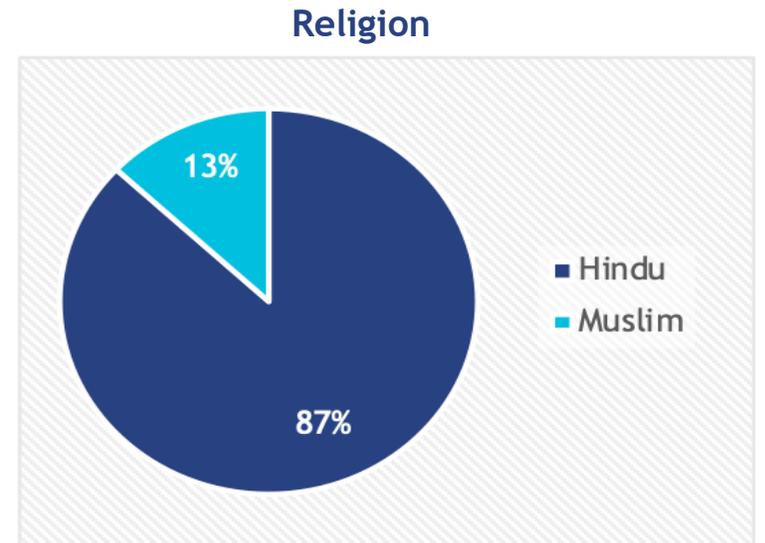
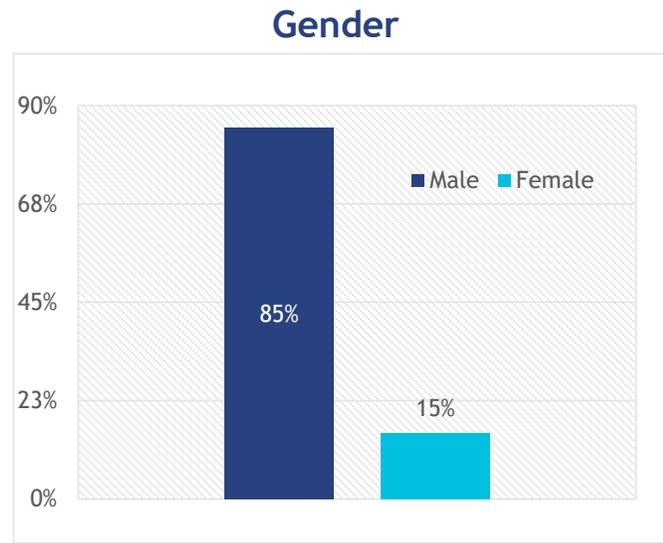
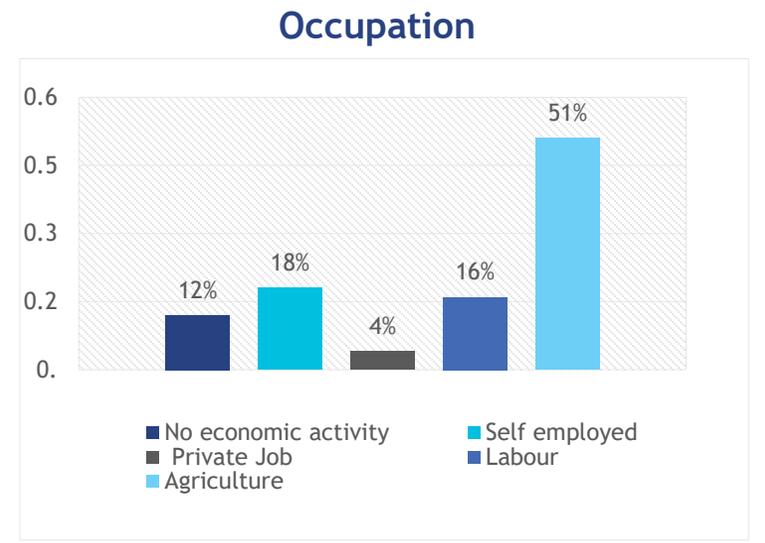
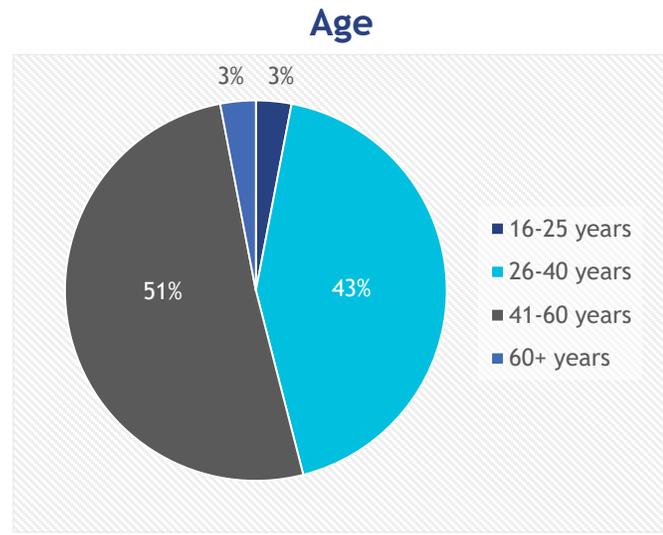


### Education



# Household sample characteristics

<p><b>82%</b> have school education</p> 	<p><b>13%</b> are graduates or postgraduates</p> 
<p><b>95%</b> live in rural areas</p> 	<p><b>5%</b> are migrants</p> 
<p><b>77%</b> live in <i>Pakka</i> houses</p> 	<p><b>98%</b> fall in the BPL category</p> 
<p><b>INR 9,828</b> is the average monthly income</p> 	



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