

ASHA and Her Role in District Mental Health Program: The COVID-19 Pandemic at Chikabalapura

Narasimha murthy M^a, C.D.Venkatesh^b

^aCentre for women studies, Bangalore University, Bangalore-560056, India

^bCentre for women studies, Bangalore University, Bangalore-560056, India

Abstract

COVID 19 pandemic has posed challenges for public mental healthcare delivery, particularly in LAMI countries such as India. However, this unique situation has also brought in opportunities to revisit the health system and optimally utilize the available resources. In this brief report, we report one such new initiative in which existing community health workers (CHWs), known as ASHAs (Accredited Social Health Activist) acted as a bridge between patients with mental illness and the District Mental Health Program (DMHP) of Chikabalapura district of Karnataka State, India. They maintained continuity of care of 82 patients by delivering mental healthcare services to the patients' doorstep. This has paved the way to rethink and revisit their role in public mental healthcare delivery not only during COVID-19 times, but also beyond.

KEYWORDS: Accredited Social Health Activist , Community Healthcare Worker (CHW) · District Mental Health Programme (DMHP) , COVID- 19

Introduction: Chikabalapura is a rural district in Karnataka, A South Indian State. In March 2021, the lockdown was announced in India due to COVID 19 and consequently, the mental healthcare delivery system was adversely affected. However, this scenario created unique opportunities to review and redefine the role of existing Community Healthcare Workers too (particularly the Accredited Social Health Activists; ASHAs). In this report, we wish to bring to light, an initiative that hitherto did not exist in public mental health care delivery in India: the role of ASHAs in ensuring continuity of care for those with severe mental illnesses'. These experiences have the potential to inform a transformational change in their and similar other community healthcare workers larger role in public mental healthcare delivery in India.

District Mental Health Program (DMHP) of Chikabalapura

DMHP services in Chikabalapura has been functional since 2016. The activities includes

- (1) clinical services for new and follow up patients,
- (2) Information, Education and Communication (IEC) activities to create awareness about mental illness and reduce stigma,.
- (3) training of medical officers, para medical staff, teachers, firemen, Anganwadi worker and ASHAs worker as part of capacity building.

Along with these, there are targeted interventions like Care at Doorsteps, School Mental Health Programme, College Counselling Programme, Workplace Stress Management Programme, District Counselling centres and crisis helpline etc. The

activities of the Chikabalapura DMHP has increased from 2016 (the time when it became fully operational) to the present.

Role Played by the ASHAs in Chikabalapura DMHP During the COVID 19 Pandemic

After the onset of pandemic, because of the lockdown and travel restrictions, many persons with mental illnesses did not have access to services and hence ran the risk of discontinuing essential medications (that are essential for continuity of their care) which could have resulted in the relapse of their illness leading to rehospitalisation, poor psychosocial outcomes, poor quality of life, reduce effectiveness of subsequent treatment and increased suicide (Semahegn et al.2018). After liaising with the DMHP team (headquartered in the District hospital), ASHAs made a list of such patients (who required medications), collected the same, and ensured their availability to the needy. For such patients who were able to go to the nearby primary health centres (PHCs), medications were made available there. More importantly, for those who were unable to travel, medication delivery was ensured at their respective homes with adequate COVID safety measures such as social distancing and wearing masks while interacting with the patients. They also encouraged patients to use these safety precautions and to reach out to local hospital if they have symptoms of COVID. All these patients were already diagnosed and were known to DMHP care. During these visits, wherever necessary, teleconsultations were provided by the DMHP Psychiatrist as per the Telemedicine guidelines of India.

Role of Community Healthcare Workers in Public Mental Healthcare Delivery

The Alma Atta Declaration in 1978, recognised that key to the community health is the provision of primary health care and this realization has led to the utilisation of community health workers (CHWs) for achieving this goal (WHO, 1978). CHWs work in the community, selected by and answerable to the community for whom they work. They receive briefer training than the health care professionals and are supported by the health system (Frankel and Doggett 1992). They help the doctors and nurses in activities such as health promotion and serve as “helping hands” (Scott and Shanker 2010; Walt and Gilson 1990). In low and middle income countries (LAMICs), they play a key role in delivering services in the health system to the poor and underserved populations and thus bridge the human resource and financial gaps (WHO, 2007). The roles, responsibilities, training and incentives for the CHWs vary across the world according to the programs in which they are involved. India’s flagship program in health, National Rural Health Mission (NRHM) launched in 2005 initiated the Accredited Social Health Activist (ASHA) Programme with the aim of community participation in the health system. ASHAs are female community health workers and they form one of the world’s largest community health force (Liu et al. 2011). Each ASHA caters to one thousand people and they serve as the link between the government health care services and the community, mitigating the cultural and social barriers and enhancing the community participation (Lipekho et al. 2015). They receive service and performance-based incentives for performing their primary duties such as referral and escort services for institutional deliveries and facilitating immunization (Wang et al. 2012). However, utilizing services of ASHA workers for mental health was not existent. This has started to change. Apart from the above example, there are a couple of reports of their role in psychiatric case-finding (Reddy et al. 2014; Ibrahim et.al.2020). The authors believe that unlike the other non-communicable diseases like Hypertension and Diabetes (Abdel-All et al. 2019),

ASHAs can easily fit into the mental health system and the mental health work can easily be integrated into their routine without any extra burden. For example, quick screening, counselling and referral to treatment centres and other social welfare agencies can easily be achieved. Efforts in the past were less successful for non-communicable diseases because the tasks involved certain medical procedures such as measuring blood pressure and blood glucose levels which are considered difficult by the CHWs. As part of the DMHP, the CHWs like ASHAs can be trained in identification, referral and delivering simple psychosocial interventions. They also can play a role in overcoming barriers for acceptability of mental health services in the community such as stigma, myths, and lack of awareness (Rasaily et al. 2017). Such training is happening in states such as Karnataka where almost 47,000 ASHA workers have been trained in the field of mental health. The training includes recognition of mental health disorders such as schizophrenia, depression, anxiety and alcohol use disorders, basic counselling, and referral to the treatment centres (Armstrong et al. 2011; Kallivayalil 2018).

Research projects in the communities have shown that lay health workers can effectively be used in task shifting for depressive disorders. This has been shown to be cost-effective (Buttorff et al. 2012). The Ministry of Health and Family Welfare, Govt. of India has made provision for two CHWs per Primary Health Centre (PHCs) dedicated to deliver mental health services (Policy Group 2012). The Ayushman Bharat Initiative through the establishment of Health and wellness centres (HWCs) also proposes that the health services (including dispensing medicines) should be delivered by non-physician health workers, mid-level health providers, Multipurpose and ASHA workers (Mishra 2012). ASHAs have a respected position in their local communities and can be effectively integrated into the existing health systems.

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