The ASHA Programme — How NGOs Can Strengthen the Last Mile

An ASHA — Accredited Social Health Activist — is a woman selected from her own village, trained in basic health promotion and service facilitation, and deployed as a link between her community and the formal health system. She is not a nurse. She is not a doctor. She is a trusted...

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B practice-note Health & Nutrition

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- Visit pregnant women regularly, ensure they complete antenatal check-ups, and accompany them to institutional delivery
- Track newborns and children under five for nutrition and immunisation
- Identify and refer sick newborns, children, and mothers to PHCs and CHCs
- Distribute ORS packets, iron-folic acid tablets, chloroquine, and other essential medicines from her drug kit
- Mobilise communities for immunisation days, health camps, and awareness activities
- Identify and refer people with symptoms of TB, malaria, and other priority diseases
- In the expanded ASHA role under Ayushman Bharat: screen for hypertension, diabetes, and common cancers

She is paid through a performance-linked incentive system — she receives money for each institutional delivery she facilitates, each immunisation she records, each JSY beneficiary she registers. This is not a salary; it is a set of task-based payments.

When this system works well — and the evidence shows it can — an ASHA produces measurably better maternal and newborn health outcomes. Districts with higher concentrations of functional ASHAs have significantly higher rates of institutional delivery, antenatal check-up completion, and child immunisation.

When it does not work, the reasons are specific and documented.

Why ASHAs Underperform in Tribal Odisha: Six Documented Barriers

Understanding these barriers is the prerequisite for knowing where NGOs add value. You cannot fix a problem you have not correctly diagnosed.

Barrier 1: Payment delays and inadequacy

ASHAs are not volunteers — or rather, they are not supposed to be. They are supposed to receive performance-linked payments for each service delivered. In practice, across multiple states including Odisha, payment delays are systemic. An ASHA who facilitated three institutional deliveries in January may receive her payment in April or May — or not at all, if paperwork was incomplete.

The consequences are straightforward: motivation drops. An ASHA who is spending her own money on transport to accompany pregnant women to facilities, waiting for reimbursement that arrives six months late or not at all, will progressively reduce her efforts to activities that do not cost her money out of pocket.

In tribal Odisha, payment delays are more severe because: block-level health administration is stretched thin; physical distance from the PHC makes paperwork submission harder; some ASHAs have limited literacy and struggle with the documentation process that functions as an invoice.

Barrier 2: Drug kit gaps

The ASHA drug kit — which should contain paracetamol, ORS, iron-folic acid tablets, chloroquine, condoms, a delivery kit, and other essentials — is a core part of what makes ASHAs credible and trusted in their communities. An ASHA who visits a sick child and has nothing to offer loses credibility; an ASHA with a full kit and the knowledge to use it is valued.

Drug kit refills are supposed to happen at the monthly VHSNC (Village Health, Sanitation and Nutrition Committee) meeting or at the sub-centre. In remote tribal blocks, these refills are frequently delayed or incomplete. An evaluation across states found Odisha had comparatively high rates of ASHAs carrying drug kits — 80% reported visiting households with kits — but gaps in specific medicines are still common, particularly in the most remote areas.

Barrier 3: Language barriers

In Odisha's tribal districts, ASHAs often speak Odia as their primary language while the communities they serve speak Gondi, Kharia, Santali, Bonda, Kui, or another tribal language. This is not a trivial problem. Health communication — about birth spacing, danger signs in pregnancy, appropriate complementary feeding, when to seek care — requires nuance that does not survive language barriers intact.

The 2025 systematic review on ASHA performance specifically identified tribal areas in Jharkhand and Odisha as facing "language barriers and limited community trust" as acute constraints. An ASHA who cannot communicate with her community will default to activities that do not require communication: accompanying women to facilities, handing out tablets, facilitating immunisation camps. The health promotion and education work — which requires genuine dialogue — will not happen.

Barrier 4: Inadequate supervision and mentoring

An ASHA is supposed to be supervised by her ANM (Auxiliary Nurse Midwife) stationed at the sub-centre. In remote tribal blocks, the ANM may cover a sub-centre serving

populations spread across several villages accessible only by difficult roads. Monthly supervision visits are aspirational; fortnightly visits are rare.

The evidence on ASHA performance is consistent: supervision and training are among the most significant positive predictors of ASHA effectiveness. Conversely, inadequate supervision is one of the most frequently documented barriers. An ASHA who has not had meaningful supervision in months will have lost confidence, lost knowledge of protocol updates, and lost the motivation that comes from professional recognition and support.

Barrier 5: Excessive workload and expanding scope

The ASHA role has expanded significantly since the programme's launch in 2005. Under Ayushman Bharat and subsequent policy additions, ASHAs are now expected to screen for NCDs, conduct home visits for newborns, manage expanded immunisation schedules, and fill substantially more documentation than the original programme required. This documentation burden is particularly acute for ASHAs with limited literacy, for whom completing the required forms is laborious and time-consuming — which delays their payments, which reduces their motivation.

A tribal ASHA managing 150–200 households across a geographically dispersed settlement is already at the limit of what is achievable. Adding NCD screening without proportional support is not expanding the programme — it is diluting it.

Barrier 6: Social barriers and community trust

In some tribal communities, ASHAs face specific social barriers: caste discrimination (an ASHA from a dominant caste community working in a Dalit hamlet, or vice versa); gender dynamics that prevent her from visiting households when men are present; traditional health beliefs that frame institutional delivery as culturally inappropriate; and distrust of formal health systems built from repeated experiences of poor care.

Building trust is slow. An ASHA who has been in the same village for five years and has consistent relationships with every household is transformatively more effective than

one who was newly appointed. The evidence shows ASHAs gain community acceptance through consistent, ongoing engagement over time — not through a single intervention.

Where NGOs Add the Most Value

Given these barriers, here is where NGO effort is most efficiently placed:

High-leverage role 1: Bridging the payment documentation gap

Many tribal ASHAs are losing payments because paperwork is incomplete or incorrectly filled — not because they have not done the work. Helping ASHAs understand the documentation system, accurately complete their monthly returns, and track which payments are outstanding and how to follow up is unglamorous but high-impact work.

Practical approach:

- At the monthly VHSNC meeting or at a regular community meeting, a trained NGO facilitator sits with the ASHA to review her record book — how many institutional deliveries did she facilitate this month? Are they all documented? Is the JSY form complete? Has she submitted it to the ANM?
- The NGO facilitator does not do the documentation for the ASHA — that undermines her competence and ownership. They sit alongside and guide, answer questions, flag missing information
- Track outstanding payments — if an ASHA facilitated five deliveries in the last three months and has received payment for two, the gap deserves follow-up with the block health office

This role requires someone with basic knowledge of ASHA programme documentation — which can be acquired from a one-day orientation at the block health office or from reading the ASHA guidelines (publicly available from the Ministry of Health website).

High-leverage role 2: Drug kit monitoring and advocacy

Know which medicines should be in the ASHA kit. At regular community visits, check what is actually in it. When medicines are missing or expired, document this and escalate — first to the ANM, then to the block health office if the ANM does not act.

This is advocacy, not service delivery. The NGO is not supplying medicine — that is the health system's job. The NGO is monitoring whether the health system is doing its job and creating accountability when it is not.

What to track:

- Date of last drug kit refill (should be monthly)
- Which medicines are currently available vs. which should be present
- Whether the delivery kit (including clean delivery equipment) is available
- Whether ORS packets are available in adequate quantity for predicted need

Document this data. Share it with the Block Medical Officer quarterly. A pattern of consistent shortages, documented and presented, is a legitimate basis for advocacy at the district level.

High-leverage role 3: Language bridging

If your NGO works in a tribal language community and has staff or community volunteers who are bilingual, you have a resource the health system frequently lacks. A community health volunteer who speaks both the tribal language and Odia can:

- Accompany the ASHA on household visits and translate health education messages
- Run community health education sessions in the tribal language (with the ASHA present and endorsed) that the ASHA cannot run herself
- Serve as a community interpreter at the PHC when tribal women attend without Odia fluency

This is not replacing the ASHA — it is augmenting her in areas where she has a structural limitation that is not her fault.

One thing to negotiate clearly: The ASHA should always be present and visibly involved when language support is provided. The NGO's volunteer should introduce themselves as supporting the ASHA, not as an alternative. If the community comes to associate health with the NGO rather than with the ASHA, you have made the programme less sustainable, not more.

High-leverage role 4: VHSNC activation

The Village Health, Sanitation and Nutrition Committee — theoretically present in every village with a functional ASHA — is the community governance structure for the ASHA programme. It is supposed to:

- Meet monthly
- Review community health data
- Plan local health activities
- Provide community oversight of the ASHA's work

In most tribal villages, VHSNCs are dormant or non-functional. They meet rarely, have no agenda, and produce no decisions. This is not because the structure is wrong — it is because nobody invested in making it functional.

What VHSNC activation involves:

1. Establish a regular monthly meeting time and location (afternoon of the first Monday of the month, at the school; be specific)
2. Ensure membership is inclusive — ASHA, AWW, panchayat member, community members including women
3. Create a simple agenda: what happened in health last month? What is planned next month? What problems need to be raised with the block?
4. Document the meeting — attendance, discussion, decisions — in a register

5. At every meeting, review the ASHA's service data: how many households visited, how many pregnant women registered, how many deliveries accompanied, how many children immunised

A functional VHSNC provides the ASHA with community accountability — which protects her from pressure from community members who want her to do things outside her role, and creates social recognition for the work she is doing.

This is genuinely important: an ASHA with a functional VHSNC behind her has a community institution supporting her work. One without is an individual woman facing a community alone.

High-leverage role 5: Supporting referral completion

One of the ASHA's critical functions is identifying sick newborns, complicated pregnancies, and other health emergencies and referring them to higher-level care. She often does this well. Where the system breaks down is in the follow-through — the family does not go, does not know how to access the facility, lacks transport money, or arrives at the PHC to find the doctor absent.

NGO role in referral:

- At community level: ensure families know in advance what to expect at the referral facility, what documents to bring (JSY card, Aadhaar, PMJAY card), and how to request ambulance service (108)
- Track referred cases — does the NGO field staff know which families were referred by the ASHA in the last month? Do they know whether those families actually went?
- When families have not followed through: understand why. Transport? Cost? Fear? Address the specific barrier. Don't lecture; remove obstacles.
- Advocate for functional ambulance availability: in remote tribal blocks, the 108 ambulance is the critical emergency link. When it is not functioning, document and escalate.

What NGOs Should Not Do

Being explicit about this avoids a common and damaging pattern.

Do not create parallel community health worker roles. If you train community volunteers to deliver health messages and home visits, and this becomes the primary health worker in the community rather than the ASHA, you have made the government system less functional, not more. Your volunteers will not be there when your funding ends. The ASHA will.

Do not run health camps that undermine PHC functioning. Health camps — periodic events where visiting doctors provide consultations — can be valuable for bringing specialist services to remote areas. But health camps that substitute for primary health centre functioning by providing services that the PHC is supposed to provide on a daily basis can actually reduce community utilisation of the PHC (why go to the PHC on a Tuesday when the camp comes once a month?). If you run health camps, run them for genuinely specialist services (dental, ophthalmology, specialist consultation) that the PHC genuinely does not provide.

Do not supply medicines that the government programme should supply. Providing medicine that the ASHA kit should contain feels helpful in the moment. Over time, it removes the accountability pressure that might actually fix the kit supply problem. The ASHA kit is empty because a system is failing. Filling it privately makes the system failure invisible.

Do not pay ASHAs supplementary honoraria. Multiple NGOs and CSR programmes have done this with the intention of addressing inadequate ASHA pay. The unintended effects: ASHAs start prioritising the NGO-funded activities that come with supplementary pay over their regular NHM activities; when the NGO funding ends, the ASHA feels a pay cut even though her ASHA income is unchanged; other ASHAs in the block hear about the arrangement and create equity problems. Advocate for government payment improvement instead.

Building the NGO-ASHA Relationship

Everything above rests on the quality of the relationship between your organisation and the ASHA. If she sees your organisation as monitoring her, judging her, or competing with her, she will not be an ally. If she sees your organisation as supporting her, advocating for her, and making her work easier, she will.

Practical relationship building:

- Introduce yourself to the ASHA before beginning any community health work. Explain what your organisation does and what it does not do. Ask what support she needs.
- Attend VHSNC meetings when possible — as a support presence, not as a leadership presence. The ASHA chairs, the community facilitates, the NGO staff observe and contribute when asked.
- When your staff observe something the ASHA is doing well — a home visited on time, a complicated pregnancy identified early, a family brought to an immunisation camp that had resisted — acknowledge it directly and specifically. ASHAs receive very little positive feedback.
- When your staff observe something concerning — misinformation given to a family, a referral not followed up — raise it through the mentor (ANM) or through the VHSNC, not directly and publicly with the ASHA. Private feedback, delivered supportively, is what produces change. Public criticism destroys the relationship.

Measuring Your Impact

If you are supporting ASHA functioning in a block or cluster of villages, what should improve?

Measures you can track:

- Proportion of pregnant women who have completed the recommended antenatal check-ups at the PHC (baseline vs. end-of-year comparison)
- Proportion of deliveries that were institutional (should increase)
- Proportion of children aged 0–2 who are fully immunised
- ASHA payment delays — average number of weeks between service delivery and payment receipt (should decrease with documentation support)
- VHSNC meeting regularity — how many of the last twelve months had documented meetings?

What you cannot and should not claim sole credit for: Any improvement in these indicators is the product of the ASHA's work, the health system's function, and your organisation's support. Document your specific contributions — the documentation support hours, the VHSNC meetings facilitated, the drug kit gaps escalated — separately from the health outcome data.

A Note on the Current ASHA Expansion

Under Ayushman Bharat and the government's Universal Health Coverage agenda, the ASHA's role is being expanded to include NCD screening (hypertension, diabetes, common cancers). This is an important and evidence-backed expansion — community-level NCD detection is the only way to address the rapidly rising NCD burden in tribal areas.

It is also, without additional support, an unfunded mandate. An ASHA who is already at the limit of her capacity, managing maternal and child health for 200 households across a dispersed settlement, cannot meaningfully add NCD screening without either more time, more support, or a reduction in her other responsibilities.

NGOs that want to support NCD integration should advocate for: adequate training in NCD screening tools; appropriate equipment (blood pressure monitors, glucometers — not all ASHAs have these); referral pathways to the District Mental Health Programme and NCD clinic that actually function; and compensation for NCD activities that is paid

promptly.

Related Knowledge Commons content: Health & Nutrition Sector Primer (Sector 08) · Practice Note: Mobile Health Clinics — Design for Remote Tribal Contexts · Practice Note: Mental Health Task-Sharing at Community Level

Evidence Grade: B — Multi-study. This Practice Note draws on the 2025 systematic review of ASHA maternal and newborn health performance (ScienceDirect), the J-PAL ASHA programme research documentation, Odisha NRHM programme evaluations, and field documentation from tribal Odisha health programmes. Last reviewed: April 2026.

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