



The contribution of Accredited Social Health Activist (ASHA) under National Rural Health Mission (NRHM) in the implementation of Comprehensive Primary Health Care in East Champaran District , Bihar (State) India



Dr Vandana Kanth, Dr. Jameela George & Dr. Anil Cherian, EHA - INDIA

Introduction

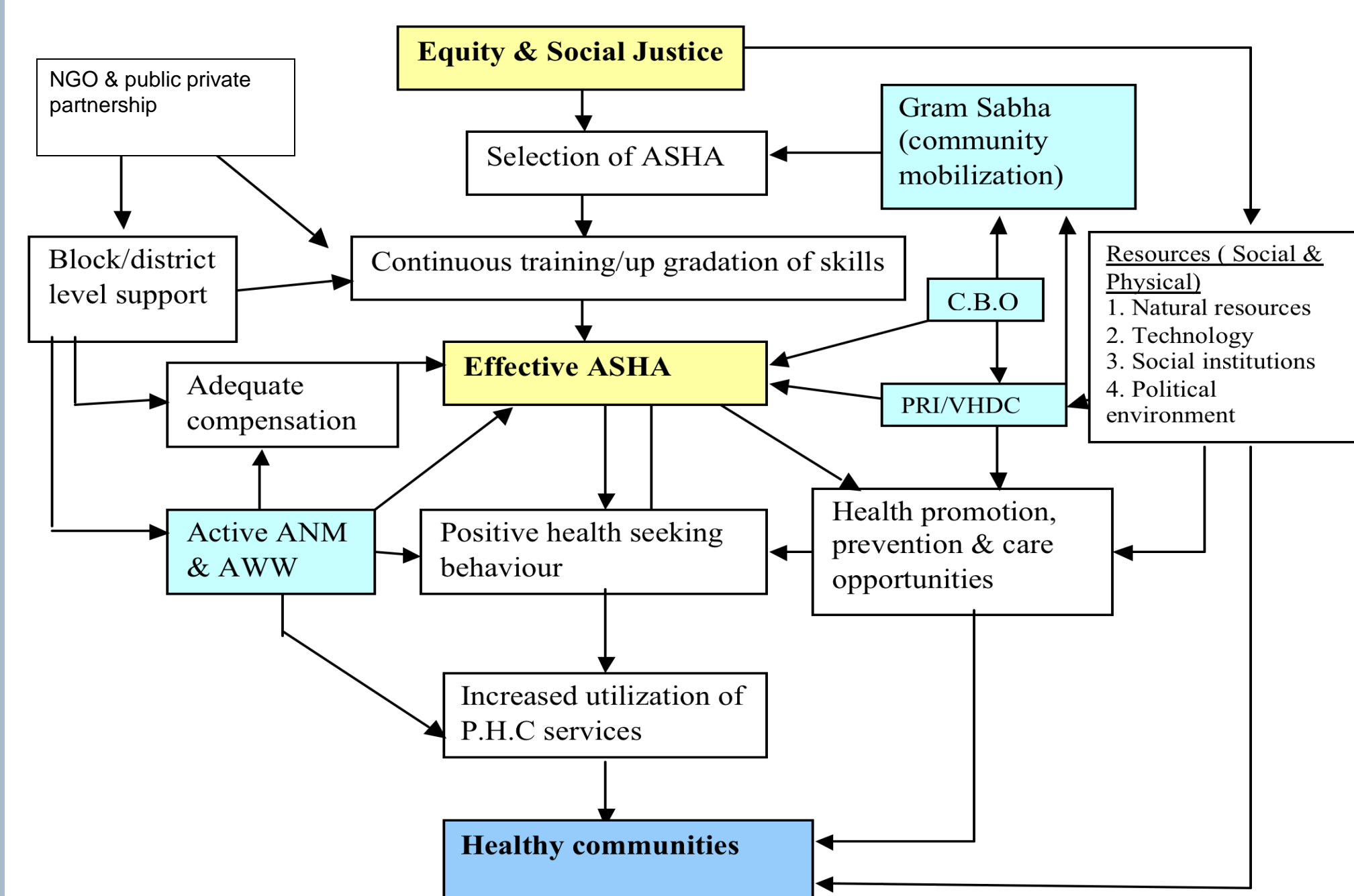
The National Rural Health Mission (NRHM) in India 2005-2012 was launched to revitalize a crumbling public healthcare system. A cornerstone of the reforms was the introduction of a cadre of women from villages/hamlets called Accredited Social Health Activists (ASHA). The ASHA represent the latest in a long series of approaches by the government to incorporate a village level health worker.

The present set of reforms under NRHM must be viewed in the context of the global efforts to establish " Comprehensive Primary Healthcare" (CPHC) and revitalize Health for All. CPHC in concept involves equity in the access to health care, reducing vulnerability of communities to ill health through community empowerment and an attempt to address the social determinants of health.

Research Aims & Objectives

- To explore if any apparent contradictions in the stated roles of the ASHAs as per the NRHM guidelines and their current practice.
- To study the recruitment & training process of ASHAs, the nature and levels of community support and their effect on their ability to contribute to CPHC in communities.
- To study the contextual factors (enabling and barriers) affecting the ASHAs functioning, specifically to bring about improvements in health seeking behaviours, increasing utilisation of primary care services, timely referrals to appropriate secondary levels of care, building community capacities to assess, analyze and act on social determinants of health.

Conceptual Framework



Methodology

Study Design: Cross sectional study conducted between February 2009 to August 2010

Location : The study was done in two blocks , comprising of 43 Panchayats (Local Government Units & 187 villages of East Champaran district of Bihar State in India.

Methods: Mixed methods were used which included both Qualitative & Quantitative methods

Qualitative Methods: 60 Focus Group Discussions (FGDs) with various community based organizations (CBO's) such as women's group , farmer's group & PRI institutions were held. 10 FGDs were held with ASHAs in both the blocks. Key informant interviews were conducted with the Health Educators, Medical officers of PHC & the State co-ordinator of ASHA. Participatory methods with Community groups such as Venn Diagram (Chappati) & Ranking methods were also used.

Quantitative methods: Structured interviews were conducted with 199 ASHAs , 17 ANMs , 255 AWW, 15 Panchayat members and 11 Mukhiya's (Villages chiefs). A household KPB (Knowledge Practice & Behaviour) survey of the community was used to assess the effectiveness of the ASHAs. 299 households were included in the sample which were selected using a multi-level stratified systematic sampling.



Values underpinning our research

The universal right to the health of people irrespective of race, religion, gender, political belief, economic or social condition

-Social justice and social solidarity

-Equity, the reduction of unfair differences in health status, access to health care and access to various institutions (like education / social security schemes)

-Respect for dignity of persons and the communities.

RESULTS – Profile of ASHAs

- Most of the ASHAs were between 20-30 years of age (77%). The median age was 28
- 90% of ASHA came from the Hindu community. The remaining were Muslim.
- All the ASHAs had completed middle school. However only 33% had completed high school.
- 56.7% were from the backward class and 5.5% were from the schedule caste. 38 % were from the upper class.
- Except for one ASHA all have been ASHAs for at least a year and 62 % have been recruited within 2- 3 years
- All the ASHAs were permanent residents of the village. The minimum duration of stay in the village was 6 years and a few lived for more than 20 years in the same village. Majority lived in the village for more than 10 years (62%).
- Most of the ASHAs worked in their own villages. Before becoming ASHAs, most of them were house wives.
- On average, ASHAs worked three times a week for about three hours a day covering about five households in a day & around 16 households a week .

Results & findings (Specific)

1. Apparent contradictions in the stated roles of the ASHAs and their current practice.

- Only 22% of ASHAs had some understanding of their roles as given by the NRHM Guidelines. 78% of the ASHAs had no or little to no understanding of their roles.

Government health workers (Nurse midwives & Child development workers), village leaders and other community stakeholders also had a limited understanding regarding the roles of the ASHA. Most of them perceived them as additional line workers under the Reproductive and Child health programme and that their roles were mainly to register pregnant women, mobilize the community to utilise the immunisation services and to provide support to mothers during the time of delivery.

Table 1: Perceptions on the role of the ASHAs in the community (* =multiple response)

Role of ASHA's as per NRHM Guidelines	ASHA (N=199)*	ANM (N=17)1	AWW (N=255)3*	PRI (N=42)*	Community (N=299)
Registration of pregnant women	58.8	76.47	74.9	42.5	81.92
Immunization services(Tetanus+ Polio immunization)	66	64.7	50.58	57.1	65
Care of pregnant women	39	35.29	47.05	90.5	29.62
Facilitate institutional delivery	30.2	76.47	52.29	42.9	59.62
Utilization of family planning services	14.1	8.26	8.67	7.1	45.77
TB treatment	14.6	52.94	35.68	0	0
Awareness towards health (sanitary practices)	7	47	34	0	0
Leprosy work	13.1	0	0	0	0
Care of new born	3	17.64	17.25	0	23.08

Table 2: Activities currently undertaken by the ASHAs

S. No	Activities	Number n=199	Proportion
1	Registration of pregnant women	117	58.8%
2	Immunization of children	68	34.2%
3	Immunization of pregnant women	63	31.7%
4	Accompany mothers for institutional Delivery	60	30.2%
5	Mobilising women for ANC checkup	45	22.6%
6	Supportive Care of pregnant women	32	16.1%
7	TB Care and Prevention	29	14.6%
8	Family planning services	28	14.1%
9	Leprosy care and prevention	26	13.1%
10	Awareness/ Health Teaching women health	14	7.0%
11	Home Care of new born	6	3.0%

The most common tasks undertaken by the ASHA's matched the perceptions shown above. 59% of the ASHA's were involved in registering pregnant mothers. 31-34% were involved in facilitating the immunization of pregnant mothers and children. 30% accompanied mothers to the hospital for institutional delivery. 22% mobilized women for Antenatal care.

None of the ASHA's in this study were involved in any village health planning, facilitation of Below Poverty Line (BPL) card provision, promotion of toilets, and were not connected to village health & Sanitation Committee all roles listed in the NRHM guidelines.



2. To study the recruitment & training process of ASHA's, the nature and levels of community support and their effect on her ability to contributing to CPHC in communities.

Most of the ASHAs were selected (figure 1) by the Village chiefs (Mukhiya -65%) or by the medical officer (21%). Only 13% of the ASHAs were recruited by the local village council (Gram panchayat). Community involvement in the selection of the ASHA was minimal.

22% of ASHAs had no training at induction & most of the ASHAs were trained by the Medical Officer of the PHC. Maximum duration of training was 7 days and on the average received 4 hours of training per day (figure 2).

53 per cent of ANM & about 64 per cent of AWW were working in collaboration with ASHA. Collaboration of ASHA with peripheral health workers (AWW & ANM) was mostly seen with the care of the pregnant women , immunization of the young children & providing information about the pregnancy status of the women in the community .

None of the ASHAs were linked to CBOs or were linked to panchayat or VHSC in any form .

None of the ASHA received any drug kits. ASHAs perceived that they were mostly accountable to the medical officer & the mukhiya. The concept of being accountable to the community was not there.

Most of them perceived themselves to be public employees and not volunteers. There were problems identified by ASHA during their monetary transactions of which delayed payment was the major one. Similarly late payment was the major problem identified by the peripheral health workers.

The roles played by the ASHA were determined by the incentives that they received.

The activist role of ASHAs was not clear to them. In most of the FGDs ASHAs preferred to remain silent or said " I don't know" when asked about their activist role.

Figure 1: ASHAs selection(structured interviews with ASHAs)

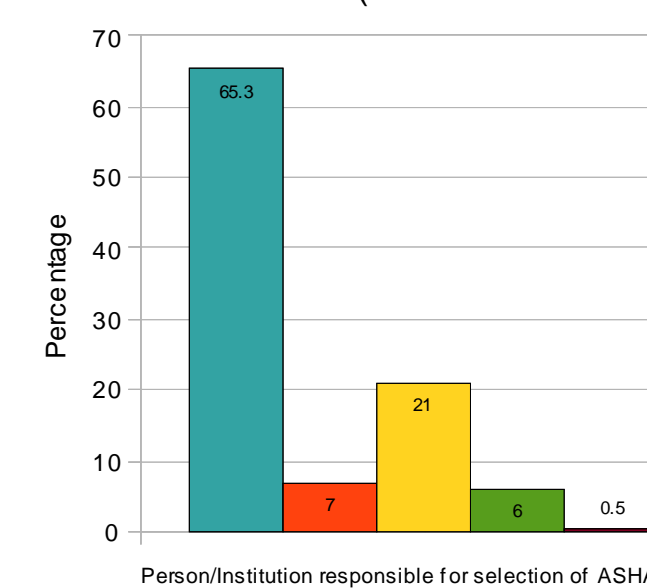


Figure 2: ASHAs training(structured interviews with ASHAs)

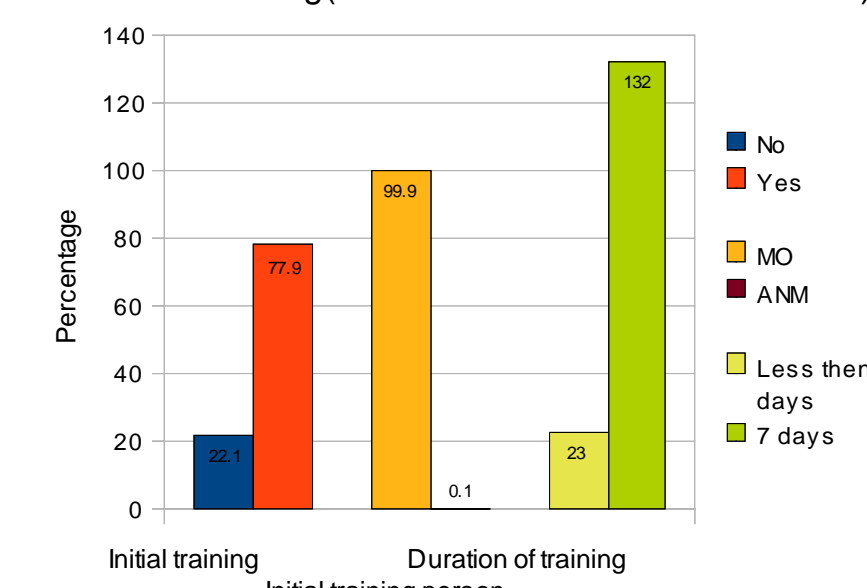


Table 2. Factors contributing to the ASHA's understanding about their roles

Bi-variate analysis (N = 199 ASHAs), Dependent variables = (poor knowledge/ good and adequate knowledge) suggests that the educational status (above or below 8th class), training factors or the guidance of the ANM or the AWW were not associated with the ASHA's understanding of their roles.

Variable	Odds Ratio	95% Confidence Interval		Significance
		LCL	UCL	
Educational Status	1.55	0.81	2.96	NS
Duration of training	2.65	0.76	9.28	Mildly significant
Length of training day	1.32	0.68	2.56	NS
Guidance by ANM	0.67	0.35	1.27	NS
Guidance by AWW	0.57	0.29	1.12	NS

3. To study the contextual factors (enabling and barriers) affecting the ASHA's functioning, specifically in bring about improvements in health seeking behaviors, increasing utilization of primary care services, timely referrals to appropriate secondary levels of care, building community capacities to assess, analyze and act on social determinants of health

ASHAs were classified as effective & not effective based on criteria. The health seeking behaviors, preventive behaviors, early recognition of illnesses, appropriate care behaviors at home, health care outside the home and in the community were determined .

Bi-variate analysis exploring the association of the health seeking behavior against two categories of ASHAs – those with a reasonable understanding and those with poor understanding of their roles was undertaken. It suggested that there was no significant association between the health seeking behavior of the community & ASHAs level of understanding of their role.

Most of the referrals (47 %) were seen for Institutional delivery & the majority of the ASHA were referring the patients to the corresponding block PHC (86 %)

FGDs within the community revealed that utilization of the health services available at PHC had increased because ASHA were not only motivating but also taking the women for institutional delivery, providing more information about the available health services & incentives had led both ASHA and the people to PHC.

ASHAs not working or working mostly for their incentives were major reasons cited for ASHAs not building the capacity of the community to act on the social determinants of health.

Conclusion

ASHAs' understanding about their roles and responsibilities is very limited.

There have been some major gaps in the roll out of the ASHAs in Bihar.

The recruitment, training and ongoing support to the ASHAs is inadequate for them to play a comprehensive role as conceived by the NRHM.

The other stakeholders like the medical officers, ANM, Anganwadi worker, Village Mukhiya and Panchayat have not been educated about the role of the ASHA in the community.

ASHAs are hardly supported by other stakeholders in the health system such as Community based organizations, Panchayati Raj Institutions or Village Health & Sanitation committees.

Since there were a lot of shortcomings in the whole ASHA programme, the study was unable to identify any major factors responsible that would enable or bar an ASHA from being effective.

We attempted to categorize ASHAs into two categories – those with an adequate understanding and those with a poor understanding and to look for changes in the knowledge and behaviors of the villages that they served. However the findings were inconclusive.

The study suggests that it is highly unlikely that ASHAs contribute to revitalization of comprehensive primary health care by either mobilizing the community or addressing the social determinants of health.

Probable reasons for this are improper selection process, poor equipping both in terms of training but also the lack of support they receive.

Careful recruitment, adequate training and appropriate support from the health system and community could enable ASHAs to be effective and to contribute to CPHC in the community.

Recommendations

The gap between the understanding of ASHAs' roles as actually conceptualized & the perception at the field level should be bridged. It would be important to reorient the district health teams and train the ASHAs using the curriculum provided.

Training of PRI members / peripheral health workers /Govt. Health functionaries & NGOs about the ASHAs' role & NRHM should be considered.

An understanding of the ASHAs at state, district, block & the village level and the social determinants of health should be built up.

State-civil society partnerships to implement the programme at the state, district and block level should be considered along with development of SHRC.

The selection process of the ASHA need to be in the hands of Gramsabha as conceptualized in NRHM & this process needs to be seriously mobilized. There should not be any target oriented approach in the selection of ASHAs.

The process of selection should be preceded by community mobilization which is essentially a slow process and the best results would be achieved only when the process had entirely finished.

Rather than conducting "sporadic training" an ASHA mentorship programme with ongoing training and support from the trainers is important. Poor levels of literacy require more innovative training methodologies. A separate cadre of trainers may be necessary.

The ASHA need to be supported at the village level by health committees, the village health committee and the elected Panchayat & community based groups.

The interface with the public health system and the linkages with AWW, ANM & Medical Officers in PHC need strengthening at the public health system level. Greater collaboration and convergence with the Anganwadi (Child Development workers) and the Auxiliary Nurse Midwives needs be strengthened.

Some of the ASHAs need to be provided opportunities for up-gradation (ANM) and formal training.

Opportunities identified to advance more Comprehensive Primary Health Care

The concept of social determinants of health and the participation of the community in CPHC is not clearly understood within the health system.

Civil society involvement in ASHA training and mentoring is necessary along with a state level advocacy programme in Bihar – NRHM.

Linkages with important national campaigns like the Right to Information, the Right to Education and the Right to Food will be important (Right based approach).

Community leadership development and effective community monitoring are necessary to bring the NRHM into alignment with CPHC and to revitalize health for all.

ACKNOWLEDGEMENTS

"This work was carried out with support from the Global Health Research Initiative (GHRI), a collaborative research funding partnership of the Canadian Institutes of Health Research , the Canadian International Development Agency, Health Canada, the International Development Research Centre, and the Public Health Agency of Canada"