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.

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Introduction: The National Rural Health Mission (NRHM) in India 2005-2012 was launched to revitalise 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 represents 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 revitalize the health for all agenda and promote Comphrehensive Primary Healthcare (CPHC). 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.

The overarching research question that we are seeking to answer is " How can the contributions of the ASHA to Comprehensive Primary Healthcare be strengthened".

The research aims and objectives of this study were;

1. To study the apparent contradictions in the stated roles of the ASHAs' and their current practice.
2. To study the recruitment & training process of ASHA's, the nature and levels of community support and their effect on their ability to contributing to CPHC in communities.
3. To study the contextual factors (enabling and barriers) affecting the ASHA's functioning, specifically in 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

Methodology: The study was undertaken in two blocks comprising of 43 Panchayats (Local Governance Units) & 187 villages in East Champaran District in North Bihar in India between 2009-10. Mixed methods were used. ***Qualitative methods*** included 60 Focus Group Discussions (FGDs) with various community based organizations (CBO's) such as women's group , farmer's group & PRI institutions. 10 FGDs were held with ASHAs in both the blocks . Key informant Interviews were conducted with the health educators, medical officers of Primary Health Centres & the state co-ordinator ASHA.Participatory methods with Community groups such as Venn Diagram (Chappati) & Ranking methods were also used. . Structured interviews were conducted with 199 ASHA's , 17 ANM's , 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 ASHA's.

Findings of the study:

- Only 22 % of ASHA's in the District had some understanding of their role as given under the NRHM ASHA guidelines. The remaining 78% ASHA had little to no knowledge about what their roles were.
- Government health workers (Nurse Midwives & Child development workers), village leaders and other community stakeholders had a limited unerstanding regarding the roles of the ASHAs. 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, mobilise the community to utilise the immunisation services and to provide support to mothers during the time of delivery. Most of them did not perceive the care of the newborn (< 18 %) or the promotion of family planning services (< 13%) to be part of their role. More importantly they did not feel that they were a community health educator, or that their work involved addressing other social determinants of health like food security, water or sanitation. There were no major differences in their understanding except that the Auxilliary Nurse Midwives (ANM) who are the frontline health workers also felt that ASHAs should be involved in TB Care and prevention.
- The most common tasks actually undertaken by the ASHAs matched these perceptions. 59% of the ASHAs were involved in registering pregnant mothers, 31-34% involved in facilitating the immunisation

of pregnant mothers and children, 30% accompanied mothers for institutional delivery, 22% in mobilising women for antenatal care.

- None of the ASHAs were involved in any village local health planning, facilitation of Below Poverty Line (BPL) cards provision (this is categorization of households based on a means testing), promotion of toilets and were not linked to the Village Health & Sanitation Committee /Panchayat – all roles listed in the ASHA Manual published by NRHM.
- The role of the ASHA as a social health activist is not understood by any of Anganwadi workers, ANM, Panchayat members, Mukhiya. Most ASHA's interviewed confused social activism with volunteer work.
- The study found 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.
- The recruitment and training of ASHA's in East Champaran Bihar have not been done as prescribed by the NRHM norms. Most of the ASHA's (65 %) were recruited by the Village headman (Mukhiya) and in one of the two blocks studied; the medical officer of the PHC selected 33.9% of the ASHA's. The gram panchayat was involved in the selection of less than 10% of ASHA's.
- The training of the ASHA was very varied. One third of the ASHA's in Adapur block were not even trained at induction. The remaining of the ASHA's only received 7 days of initial training which the PHC medical officer conducted. The main training method used was reading from the manual.
- The ASHA's were hardly supported by the Panchayat. The Village headmen (Mukhiya) were only involved with their recruitment. Even the assistance that they received from Auxiliary Nurse Midwives or the Anganwadi worker was limited. Only 40% of ASHA's said they received assistance from ANM's and 60% from Anganwadi workers. The main assistance from the ANM was in immunization of children and pregnant mothers and from the Anganwadi (Child Development) worker it was in identifying pregnant women.

Discussion:
The study findings show that the ASHAs understanding about their roles and responsibilities is very limited. The recruitment, training and on going support to the ASHAs is inadequate for them to play a comprehensive role as conceived by the NRHM. While the Mitanin programme in Chhatisgarh (around which the ASHA programme was modeled), has been much more successful, the major difference when compared to the study findings was the greater involvement of civil society in the whole process of induction of ASHAs and a better training process.

The study also brings out the fact that even the other stakeholders like the ANM, Anganwadi worker; Village Mukhiya and Panchayat have not been educated about the role of the ASHAs. Village Health & Sanitation committees have not been formed in Bihar. So we see that the ASHA is hardly supported by other stakeholders in terms of participation and engagement of the community to the overall CPHC approach.

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.

Conclusion:
There have been some major gaps in the roll out of the ASHAs in Bihar as revealed by the study. The effectiveness of Community Health Worker will largely depend on the training and support from from both the health system but much more from key stakeholders from the community. Engaging the community and getting them involved in the planning and roll are critical and civil society organisations must actively partner with the Government if the CPHC approach is to work.

Addendum: The study results have been presented at State & National Forum. Some important changes have already been implemented in the ASHA programme in Bihar State. NGO's have now been invited to be involved in ASHA training and support. The concept of ASHA mentoring is being introduced.