

Analysing the experience, knowledge and challenges of ASHAs regarding newborn and child health: A case study of Uttarakhand

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Introduction:

The year 1978 saw the recognition of the prominent role played by the community health workers as providers of primary health care to the community through the Alma Ata Declaration by the World Health Organization. Despite the continuance of the concept of community health workers across the world, it was officially introduced in India only in 2005. The Accredited Social health Activist (ASHA) programme is an essential and critical component of the National Rural Health Mission (NRHM). Community Health workers, commonly called ASHA in India are women selected by the community and they also reside within the community. They are trained and supported to function in their own village to improve the health status of the community through securing people's access to health care services, which in turn enables improved health care practices and behaviours. The ASHA programme was initially introduced in the High Focus states under NRHM of which Uttarakhand State is a part.

The ASHAs have played an instrumental role in providing primary health care to the community and especially in ameliorating the status of maternal health in the country. This is quite evident from the increasing rates of institutional deliveries that have been possible due to the major role played by the ASHAs.

However, when it comes to newborn and child health, India is lagging far behind. Rather it is the highest contributor to neonatal deaths and almost 20 percent of under-five deaths occur in India. Studies have shown that improvement in health facilities alone is not sufficient to avert a large proportion of child deaths because facility based services often emphasize curative care over prevention and because children from poor families are less likely to access health facilities than wealthier families. Analysis of different health care delivery approaches shows that outreach and family-community care in combination at 90 percent coverage could result

in an 18-37 percent reduction in neonatal mortality, even with no change in facility-based care services. A controlled trial in rural India showed that home based neonatal care and management of sepsis can more than halve neonatal mortality in a high-mortality setting.

In a study conducted in rural India authors Aggarwal et al, concluded that the knowledge level of Community Health Workers is a crucial aspect of health systems affecting the coverage of community-based newborn health care programmes, as well as adherence to essential newborn care practices at household level. [1] In another study based in Rajasthan, authors found the knowledge and motivation level of ASHAs in child health care to be higher as compared to the maternal health care. [2]

Objectives:

In light of this, it is very important to understand the role of ASHAs as link workers, bridging the gap between vulnerable newborns and infants, and health service centres. Therefore, this study has been taken up with the objective of understanding the perceptions and experiences of ASHAs as well as of stakeholders of the ASHA programme in strengthening newborn and child health. This study attempts to evaluate the knowledge of ASHAs with respect to newborn and child health according to ASHA Training module 6 and 7 and to check the effectiveness of Module 6&7 training in helping ASHAs identify problems associated with neonatal and child health. It will also attempt to understand the difficulties faced by the ASHA workers in providing health services to the newborns.

It is expected that results from this study would be useful in assessing the current knowledge of ASHAs and their contribution towards better newborn and child health. It would be helpful in rethinking, if need be, the effectiveness of the ASHA program and making it more efficient and valuable in saving newborn and child lives.

Specifics of Module 6 and Module 7

Between July 2010 and December 2010, states developed a training strategy for rolling out training of ASHA in Module 6 and 7. [6] These modules of ASHA Training build on Modules 1-4 and are aimed at building competency among the ASHA on asset of life saving skills to be provided to Mothers and New Born Children at the level of the community. Part C of both Modules 6 and 7 deals with New Born Health.

ASHA's are primarily expected to play two major roles: one relates to facilitation and provision of healthcare and the other relates to supportive and mobilisation activities.

The first role includes the activities of Home Visits: the ASHA should visit the families living in her allotted area (usually her own village) for two to three hours every day, for at least four or five days a week. However, if there is a newborn in the house, a series of five visits or more becomes essential. The second responsibility of the ASHAs is to attend the Village Health and Nutrition Day (VHND): On one day every month, when the Auxiliary Nurse Midwife (ANM) comes to provide immunisation and other services in the village, ASHA will promote attendance by those who need the Anganwadi or ANM services and helps with service delivery. The third work is to accompany a pregnant woman or some other neighbour who requests her services for escort to health facility. The second role of ASHAs includes holding village level meeting of women's groups, and the Village Health and Sanitation Committee (VHSC), for increasing health awareness and to plan health work and maintain records which would make her more organised and make her work easier, and help her to plan better for the health of the people.

With regard to Newborn Health and Child Health, it is expected that ASHA Workers

1. Visit every newborn as per the schedule, and provide essential home-based care as well as appropriate referral in case the newborn is sick.
2. Disseminate all the relevant information about immunisation to the community and provide support to access the same.
3. Provide counselling and support for prevention of illness such as malaria, recurrent diarrhoea and respiratory infection and also manage malnutrition and anaemia
4. That every child below five years with diarrhoea, fever, Acute Respiratory Infection (ARI) and worms, brought to her attention is counselled on whether referral is immediately required

or whether, given the problems of access to a doctor, first contact curative care with home remedies and drugs in her kit, the child can be managed.

Module 6 lists the essential Skills for an ASHA with regard to Care of the Baby at the time of Delivery, Schedule of Home Visits for the care of the Newborn, Examining the Newborn at Birth First examination of newborn, Breastfeeding, Keeping the Newborn Warm and Management of fever in newborn. These are the broad domains wherein detailed roles and responsibilities of ASHA Workers have been listed down.

Module 7 provides guidelines for ASHA and what to do in regard of High Risk Assessment and Management of Low Birth Weight/Pre-Term Babies; Breastfeeding Low Birth Weight/Pre-Term babies; Asphyxia Diagnosis and Management and Neonatal Sepsis: Diagnosis and Management.

Study Area and Methodology:

The study undertook qualitative research and collected primary data using focused group discussions in the State of Uttarakhand. The State of Uttarakhand was formed in the year 2000 as the 27th State of India, when it was carved out of northern Uttar Pradesh. Located at the foothills of the Himalayan mountain ranges, it is largely a hilly State, having international boundaries with Tibet in the north and Nepal in the east. On its north-west lies Himachal Pradesh, while on the south is Uttar Pradesh. Uttarakhand was one of the High Focus States where National Rural Health Mission was launched. Also it is one of the States which were first to complete their training of ASHAs in Module 6 and Module 7.

The sample included ASHAs who have received Module 6 and 7 training from the state. Discussion focused on testing their knowledge of newborn and child health and care giving which included topics such as breastfeeding, immunization, management of fever in newborn, diarrhoea, worm infestation, essential new born care etc. Apart from discussion on training of ASHAs, job satisfaction, incentives, participation in community activities, family support, availability of drug kits etc were also explored. ASHA workers also discussed the factors affecting their performance and also gave a few suggestions to improve upon the existing situation.

Discussions were also conducted with ASHA Facilitators and State ASHA coordinator to know the status of ASHA Training, understand management processes and explore experiences of ASHA scheme in strengthening newborn and child health. The study also includes review of secondary literature taken from several government reports.

Training of ASHA Workers

It has been recognised that equipping ASHAs with knowledge and skills required to perform the assigned roles will be crucial element in the programme. Capacity building of ASHA is a continuous process and for this an intensive training programme has been launched by the Government. All ASHAs are expected to undergo modular training to acquire the necessary knowledge, skills and competencies that enables them to perform their three roles of facilitator, activist and community level care provider. In addition refresher training is also conducted to prevent loss of acquired skills and knowledge.

It is the quality of training which includes how the messages are highlighted in the training material, the transaction of the manuals and most important, training evaluation that determines knowledge outcomes. The books or manuals are made available during the training period. These books not only have the detailed description of content but also are full of descriptive pictures which add to easy understanding of ASHAs.

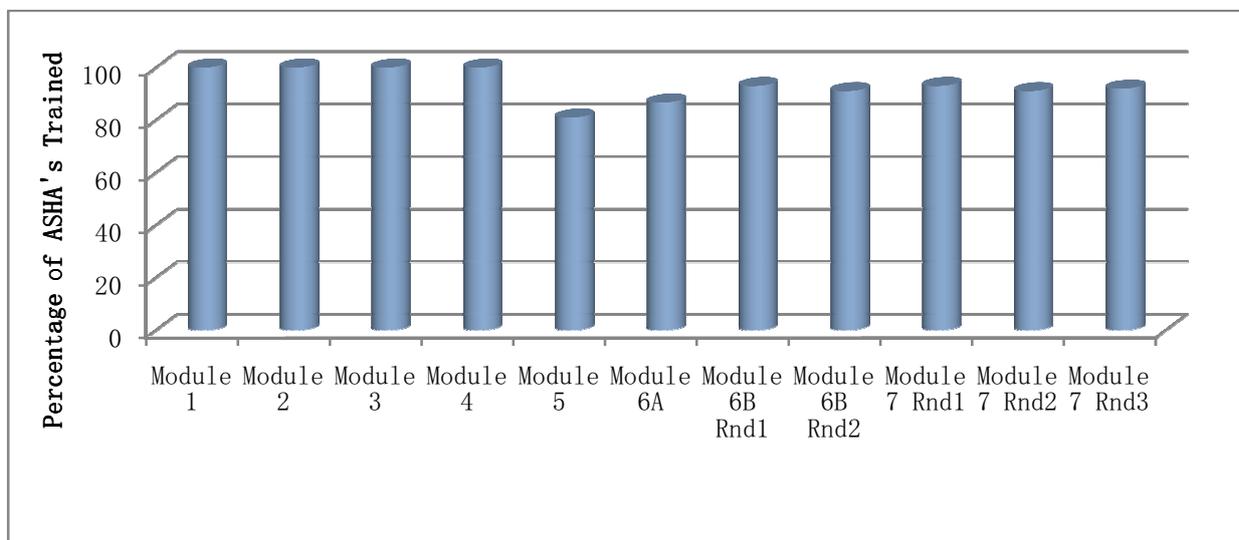
With regard to Modules 6 and 7; it was decided that ASHA and ASHA facilitators will be trained over twenty days in four rounds of training. Each training round is expected to last for five days with a gap of eight to twelve weeks between the training rounds to allow the ASHA to practice the skills she has learnt in the training. The ASHA facilitators will receive additional training on supportive supervision, mentoring and field support for ASHA.

According to a 2013 MoHFW Report [3] on the update of ASHA Programme, Uttarakhand had a positive impact of the NGO's role in the training of ASHAs. It highlighted its strong partnership with NGOs and shared that both state ARC and district level ARCs are run by local NGOs and function in close coordination with the State officials. With regard to Module 6 and 7 training for ASHAs, the report documented that Uttarakhand had completed up to Round 3 of the two Modules with 90% to 93% coverage. More details tell that 6 state trainers were trained in Round 1 and 5 in Round 2. 231 District trainers trained in Round 1

and 203 in Round 2. 10313 ASHAs (93%) trained in Round 1, 10064 (91%) in Round 2 & 10209 (92%) in Round 3 of five days each. Uttarakhand had also completed training of facilitators in Handbook for ASHA Facilitators. 544 out of total 550 (99%) ASHA facilitators were trained in Round 1 and 2 (7 Days) & 539 were trained in Round 3.

Based on the data taken from the State NHM Website of Uttarakhand, Figure 1 plots the Percentage of ASHA's who have been trained in each module. According to the available data, each ASHA worker in the State has received training for the first four modules, ie the percentage is a full 100 percent. Around 80% ASHA's have been trained in Module 5. The percentage of ASHA's trained in Module 6 and Module 7 lies between 91% to 93%.

Figure 1: Module Wise Percentage of ASHA's trained in the State of Uttarakhand



Findings:

Profile of Participant AHSAs:

Among the ASHA's with whom the Focus Group Discussions were held, the mean age of ASHA workers was 40 years. The youngest among the groups was 32 years old and the oldest was 57 years old. As a key component of the NHM, it is preferred that ASHA must be in the age group of 25 to 45 years. 96% of the ASHAs were found to be married women. The selection criterion of ASHA Workers requires them to be literate; however preference in selection is given to those who are qualified up to 10th standard. This is however relax able in case no suitable person with this qualification is available. The entire group of participant

ASHAs was literate. 20% were qualified up to 8th standard. 29% were 10th passed and 30% were class 12th passed. Around 15% had attained graduation or higher levels of education. 56% of the participant ASHAs belonged to Other Backward Classes and 16% to Schedule Caste. 86% belonged to Nuclear Families and 14% lived in Joint Family. Mean Household Income of the ASHA Workers was found to be Rs.8000 per month.

Of the ASHAs surveyed, 42% had joined the programme in the year 2006, 29% in the year 2007, 5% in 2012, 13% in 2013, and remaining had joined post 2014. Each ASHA on average served a population of size 1540. The Average number of pregnant women registered in last one year by each ASHA was 30 with minimum being 15 and maximum 58.

During the discussions it was found that each ASHA workers was equipped with the knowledge on general health issues, especially related to common infections, and be able to provide information on access to services and preventive and promotive aspects of healthcare. They possessed the required skills and knowledge to explain the basic maternal and child health services, educate on preventive and promotive aspects of maternal and child health, and provide some measure of immediate relief and advice if there is any illness.

However when asked to list the specifics of Module 6 and Module 7, only a few were able to recall and that too not very precisely. On being asked particular questions related to newborn care or child health, most of them reverted with correct answers. For instance, when asked whether one should bathe the new born baby until its weight is 2000gm, all replied that one shouldn't do so. They were ware of the breastfeeding practices, immunisation schedules, food supplements etc. Thus ASHA's are familiar with the content of Module 6 and Module 7 and know it in practice but they are unable to list it as per the Module Manuals.

ASHA workers receive performance –based incentives and the participating ASHA's were found to be well aware of the amount of incentives that are attached with each activity. As reported, they receive 600 for Institutional deliveries in rural areas and 400 in urban areas under JSY. For each HBNC Form they receive 250 as incentive. Rs100 is received for attending monthly block meetings. For immunisation they receive Rs.150 per child. It was reported that on an average the monthly earnings of ASHA vary between Rs.1500- Rs3000.

Most of the ASHAs displayed a positive attitude towards learning new skills and were willing to undergo trainings and were motivated to serve community, however they discussed several gaps in health care delivery system which restricts their effective functioning.

One of the most important tools of ASHAs is the ASHA Drug Kit. She provides basic level care to community using the drugs and equipments contained in the kit. ASHAs in the Haridwar District of Uttarakhand shared that they have not received the Kit since 2014. They are somehow managing with few supplies provided by the PHC-CHC. Even in these supplies, sanitary napkins, paracetamol tablets, iron tables are not provided. Moreover ASHAs frequently face scarcity of Immunization Cards in which they can maintain records and are forced to manage with zerox copies. Such stock-out of drugs and commodities limit the activities of ASHA Workers and is a matter of concern. A study by Garg et al, in the State of Haryana revealed that only 57.14% of the ASHAs received drug kit, immediately after training. The authors rightly proclaim that “Availability of drug kit helps ASHAs in not only attending some primary medical care needs, but also builds confidence of community in ASHAs as someone available in hour of need”.

ASHAs complained of long delays in their incentives. For a delivery in March 2013, one of the ASHAs is yet to receive her incentive. They also expressed that the present level of incentives are quite low and should be raised. Also at times pregnant women seek care from private care providers at the time of delivery even when the entire pregnancy has been monitored by the ASHA. Thus ASHAs end up losing their incentives. However the ASHA workers realize that such behaviour o the part of pregnant women was built on the instances of them not getting adequate care at the public health facilities.

They shared that it is not only them but even the JSY Beneficiaries have not received Payments for past 2 years. This leads to breakdown of community’s trust on ASHA’s. During the discussions it came out that Hospitals and other delivery points have no facility for overnight stay of ASHAs. They spend night on benches during night deliveries. ASHA’s are made to invest time and energy in surveys and are not given any additional money for such surveys. This according to them takes a lot of their personal time away. Such gaps in the healthcare delivery system have a major impact on ASHA Workers level of motivation and translate into their work.

When asked what according to them the reasons behind neonatal deaths are, it came out that malnourishment and illiteracy among the poor and negligence in general are the more prominent causes. Some of the ASHAs suggested that instead of giving monetary benefits to mothers under the JSY, they should instead be given nutritious food and other supplements during entire pregnancy period. ASHAs expressed that rural societies have deep rooted belief in traditional practices of new born care and it becomes very difficult to make them abandon these. They also talked about the role of 'Dai' and conveyed that if some 'Dai' handles one or two critical pregnancies successfully, all villagers start preferring Dai over institutional medical care.

Discussion with the ASHA Support System

Discussions were also held with ASHA Facilitators who act as ASHA support in the field. The ASHA facilitators are supposed to interact with ASHAs at least twice a month, one of which has to be on the field to monitor the ASHA on work. The exercise is aimed at providing on-the-job support for ASHA. This would help ASHAs to be more effective. ASHA facilitators also coordinate with the ASHAs during the review meetings.

The roles and responsibilities of the ASHA Facilitators include mentoring and supervising the ASHAs. Each of the facilitators has a clear protocol of activities to follow for the mentoring visit to the ASHAs, collecting health related information as observed by ASHA, manage the health problems that ASHAs encounter, providing update for the review meetings etc. They also assign tasks to ASHAs and help them in planning their course of action. ASHA Facilitators coordinate with Village Pradhans and other official to facilitate smooth working of ASHA's. They are responsible for addressing grievances of ASHAs and keep them motivated.

The ASHA facilitators conveyed that regular training of ASHAs is necessary and is very useful. They reported that all ASHA workers work hard and inspite of the small amount of incentive that they receive, and are motivated to serve the community. They requested an increment in the ASHA incentives and provision of some amount as fixed monthly salary. This according to them would act as a strong motivating factor.

Conclusion:

The study was taken up with the objective of understanding the perceptions and experiences of ASHAs in strengthening newborn and child health. It attempted to evaluate the knowledge of ASHAs with respect to newborn and child health according to ASHA Training module 6 and 7 and to check the effectiveness of Module 6&7 training in helping ASHAs identify problems associated with neonatal and child health. It also attempted to understand the difficulties faced by the ASHA workers in providing health services to the newborns.

It was found that ASHA's are familiar with the content of Module 6 and Module 7 and know it in practice but they are unable to list it as per the Training Module Manuals. ASHA Workers believe that a strengthened training system and increased frequency of trainings would help them in increasing their efficiency at work and would keep them updated.

What came out from the discussion was that inadequate healthcare delivery mechanism hampers the working of ASHAs and reduces their motivation. This also lowers the trust of community on ASHAs. Such issues of stock-out of drugs and other crucial supplies and delayed payments of ASHA incentives need immediate attention.

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