ORIGINAL ARTICLE

Framework to Improve Coordination Amongst Ministries to Strengthen ASHA Program in India: Based on the Assessment of ASHA program in Rural Rajasthan

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Abstract

Background: Community Health Workers (CHW) are groomed under community established healthcare programmes and supported by primary health care approach. Under the Community Health Programme (CHP) of National Health Mission (NHM), trained female CHW named as Accredited Social Health Activist (ASHA) has been deployed in every village of India to serve the most marginalized and vulnerable rural population. **Methodology:** A mix method with qualitative and quantitative data collection was used in this research in three districts of Alwar, Bharatpur and Dausa in Rajasthan. Quantitative data was collected from 309 ASHAs selected through Simple Random Sampling Method and Qualitative data was collected from 30 ASHAs, selected through purposive sampling. **Results:** A significant relationship was found between ASHA Knowledge, Skills and Practices as a dependent variable and ASHAs trained on Community Mobilization and Inter-personal Communication, Supportive Supervision Visits received and Timely Incentives as Independent Variables. 65% ASHAs received Supportive Supervision, 56% ASHAs received support from Panchayat Raj Institutions (PRI), 17% were able to meet PRIs and 13% ASHAs were able to request PRIs for support in community mobilization. ASHAs revealed heavy workload, societal & personal issues and socio-cultural beliefs & practices as important factors. ASHAs felt they need better quality of training material and methodology on community & social mobilization. This study provides a framework to improve coordination amongst ministries of Government of India to strengthen ASHA program.

Keywords

Coordination; Framework; Ministries; ASHA; Program; Assessment; Rajasthan; India.

Introduction

CHWs are groomed under community established healthcare programmes and supported by primary health care approach. India is a country with a population of 1.21 billion (1). 260.3 million (estimated) are below poverty line, including 193.2

million in rural areas. India accounts for 21 per cent of under-five death and more than quarter neonatal deaths globally (2). The Under Five Mortality Rate (U5MR) in India was 37 in 2017 (3) showing a decline from 74 in 2006 (4). The Infant Mortality Rate (IMR) in India was 33 in 2017 (3).

Under the CHP of NHM, a key component is providing trained female CHW named as ASHA in every village of the country to serve the most marginalized and vulnerable rural population. ASHAs are the residents from the same village in 25 - 45 years age group. Her selection process includes self-help groups, community groups, block nodal officers, Anganwadi Institutions, village health & sanitation committee member and local self-government. The key activities performed by ASHA are:

- Maternal health
- Newborn and Child health
- Reproductive Health & Family welfare
- Adolescent health

ASHAs knowledge and Practices

Despite the training given to ASHAs, lacunae still exists in their knowledge regarding various aspects of child morbidity and mortality of children under 5 years of age. Frequency and quality of training of ASHA workers needs strengthening and periodical refresher training should be conducted for all of the recruited ASHA workers. The success of ASHA worker mainly depends on the training from health system and support from and community (5, 6). Majority of them were not aware about their role in behaviour modification regarding infant feeding. Reorientation training programmes are required to improve their efficacy. Frequency and quality of training of ASHA workers also needs strengthening (7).

Infrastructure and Support system for ASHA workers

Research studies on ASHAs suggests that the supply side & demand side features needs to be addressed and policies & strategies needs to be implemented to strengthen coverage of health interventions (8). There is an absence of supervision of ASHAs and gap existed in the knowledge and practices among mothers counselled by ASHA workers. Poor utilization of reproductive and child health services reduced opportunities for ASHA and counselling of mothers on safe child care practices (9). One of the researches revealed that 80% of the ASHAs that were interviewed, expressed their dissatisfaction towards incentives and other working conditions (10). ASHAs were institutionally restricted by the incentive-based remuneration structure; stiff hierarchical structure of health system; poor institutional support; and limited participation at the community level. Progressive policy on CHW programs are required for tangible institutional support structures to support ASHA in fulfilling their responsibilities (11). Strengthening of community health systems or community participatory supervisory systems in harmonization with community program-health systems are required through a more structured approach with a formal mechanism of supervision in order to meet the needs of community at large (12).

Challenges of ASHA workers in providing health services delivery

The overall knowledge of ASHA workers was sufficient in the field of Maternal Child Health (MCH) but there is a need for mitigation of few key challenges, which would significantly contribute to improvement of ASHA's work profile (10). There are a number of challenges for ASHAs i.e. ill-equipped, dispensaries, scarcity of resources, irregular incentives, workload, non-materialization of things, failure to achieve target, inadequate support from leaders, and no value of ASHAs. For most of ASHAs the finance gained from their work is very less as compared to their hard work (13). Access by ASHAs to fair monetary incentives commensurate with effort coupled with the poor functionality of the health system are critical elements limiting the role of ASHAs both within the health system and within communities in rural India (14). As the programme continues to evolve, critical comparative research that constructively feeds back into programme reforms is needed, particularly related to governance, inter-sectoral linkages, ASHA solidarity, and community capacity to provide support and oversight (15). The ASHAs outlined problems encountered in dispensing duties into categories, such as, economic (no fixed economic incentives), logistical (lack of transportation) and workload (serving large population). The role of an ASHA worker was perceived to be more of a link worker / facilitator rather than a community health worker or a social activist by the rural communities (16). One of the research study found that composition of all the 17 Village Health Sanitation Committees (VHSCs) surveyed did not meet the NHM guidelines and lacked participation from school teachers and ASHA

workers. There was very low awareness among the members about functions of the committee (17). Within the health facility sphere, VHSNCs were hindered by the severely under-resourced health system. Increased support is required, from VHSNCs, to enable frontline health workers to facilitate their functionality. ASHAs experience adverse consequences in their ability to inspire trust and credibility in the community (18). ASHA faces several challenges in delivering their tasks at community level, which includes availability of logistics, technical knowledge on health, lack of community support, social & cultural practices of communities on health & nutrition (11,13,19).

Research Gap

Based on the literature review of all the articles, a research gap was identified that research studies have not been conducted for assessing the infrastructure and support systems that are available for ASHA workers to undertake community mobilization for health service delivery.

Objectives

- To evaluate the community mobilization skills of the ASHA workers
- To assess the challenges faced by ASHA workers in health services delivery due to lack of infrastructure and support systems

Methodology

Sample Size: The sample size for ASHA and mothers has been calculated using % Postnatal care by ASHAs. Absolute admissible error of +10% (confidence interval) at 95% confidence level; design effect of 1.5. The non-response rate of 10% have been considered while calculation of sample size.

For calculation of sample size of ASHAs for baseline assessment, the indicator has been used for sample proportion (p). “>80% ASHAs knew their role in Post Natal Check-up, counselling women for Birth preparedness, safe delivery, exclusive Breast feeding, complementary feeding, Personal hygiene and sanitation”, Knowledge Status of Accredited Social Health Activist (ASHA) of Jaipur City, International Multispecialty Journal of Health (IMJH)), December 2016.

Absolute error = + 10; p = 80.5; q = 19.5; Design effect = 1.5; Non response rate = 10%; Z = 1.96 (set by convention according to the accepted α error for two-sided effect at 95% confidence interval)

Sample Size = [(1.96)2 X (80.5) X (19.5) X (1.1) X (1.5)] / $(10)^2$

Total Sample Size = 100 ASHAs per district and total 300 ASHAs in three districts of Alwar, Dausa and Bharatpur.

A mix method with quantitative and qualitative data collection, was used in this research in rural areas of three districts of Alwar, Bharatpur and Dausa in Rajasthan. Quantitative data was collected from 309 ASHA selected through Simple Random Sampling Method and interviewed through a structured questionnaires. Whereas, qualitative data was collected, through FGDs from 30 ASHAs, selected through purposive sampling.

During the FGDs, ASHAs were asked about various challenges that they face in terms of infrastructure & support systems that are available to them for delivering their tasks as a community health worker to achieve health outcomes.

Results

ASHA Knowledge on Child health

88% ASHAs were found with Correct Knowledge of Complementary Feeding, 92% ASHAs had Correct Knowledge of ORS preparation, 85% ASHAs had Knowledge of Timely Initiation at correct age of Pediatric IFA syrup, 88% ASHAs had Knowledge on correct Pediatric IFA quantity, 94% ASHAs were found with Knowledge on correct Pediatric IFA frequency, 61% ASHAs had Correct Knowledge on danger sign detection, and 36% ASHAs were found with Correct Knowledge on SNCU discharge instructions. (Table 1)

ASHA Practices on Child health

84% ASHAs were found to be providing regular and structured Home visits to mothers on Child Health, 88% ASHAs were providing counselling on complementary feeding, 80% were ASHAs providing counselling on Exclusive Breastfeeding feeding, 92% ASHAs were providing counselling on ORS use during Diarhoea episodes, 85% ASHAs were providing counselling on Pediatric IFA supplementation, 61% ASHAs were providing counselling on danger Signs detection, However, only 10% ASHAs had referred sick infants to health facilities. (Table 2)

Regression Analysis between dependent and independent variables

During the regression analysis taking ASHA Knowledge, Skills and Practices as a dependent

variables and ASHAs trained on Community Mobilization and Inter-personal Communication, Supportive Supervision Visits received by ASHAs and Timely Incentives Received by ASHAs as Independent Variables, a significant relationship between dependent and independent variables were found. (Table 3), (Table 4) and (Table 5)

ASHA's support system for supervisory and from panchayat

In terms of getting support from ASHA Supervisors and Panchayat members, only 65% ASHAs received Supportive Supervision visits from ASHA supervisors. Only 56% ASHAs received support from Sarpanch / PRI, whereas only 17% ASHAs were able to meet the Sarpanch / PRIs for getting their support and only 13% ASHAs were able to request Sarpanch / PRI for getting their support in home visits and community mobilization. (Table 6)

Analysis of Qualitative data from ASHA's interviews

During replying to the qualitative open-ended questions, ASHAs revealed heavy workload along with societal and personal issues prevented them from completing tasks satisfactorily. Approximately half of the ASHAs perceived lack of respect for them in the community, their lack of credibility in the community and socio-cultural beliefs & practices as important factors preventing them from community mobilization of mothers and families. Almost half of the ASHAs also felt that they are overburdened or lacked planning skills to prioritise and complete home visits; currently they seemed to focus more on antenatal care and delivery cases. The qualitative data also provided evidence of low priority given to home visitations by some of the ASHAs. ASHAs believe the need better quality of training material and training methodology on community & social mobilization in order to achieve envisaged outcomes of community mobilization. ASHAs also expressed their need for getting better support from AWW in terms of plotting weight of the infant on the Growth Chart of Mother and Child Protection Card (MCP) card and detection of malnourished children).

Conclusion

ASHAs are facing difficulties in mobilizing mothers and families on child health. ASHAs have adequate skills on child health, however they lack proper support from the health systems, AWWs and Panchayat members to help them in community mobilization. The quality of the training material and training methodology of ASHA workers on community & social mobilization is not enough. Ministry of Health and family Welfare also needs special effort to coordinate with other ministries of Rural development and Ministry of Women and Child Development to establish cohesive links between ASHA, AWW and Panchayat members to support ASHA in delivering their community mobilization portfolio effectively. Governments and policy makers should work toward increasing health coverage and reintroduce commitments for comprehensive primary health care by accentuating horizontal programs and system approaches (20).

Recommendation

Optimizing ASHA program requires evidence-based policies, execution of programmes and coordination amongst different ministries. This research aims to inform efforts by planners, policy makers, and managers to improve ASHA programme through an integrated approach to strengthen primary and community health care systems. These are the first set of evidence-based global guidelines for health policy and system support to optimise community health worker programmes. Key considerations for implementation include the need to work towards strengthening Organisational and Supportive Supervision mechanisms, Support Systems from Panchayati Raj Institutions and Support from Other Health workers at the community level. There is a need to revisit the components of ASHA training module and revamp their training methodology to emphasize more on the community mobilization aspect. Ministry of Health and family Welfare also needs special effort to coordinate with other ministries of Rural development and Ministry of Women and Child Development to establish cohesive links between ASHA, AWW and Panchayat members to support ASHA in delivering their community mobilization portfolio effectively. A framework to improve coordination amongst ministries of Government of India to Strengthen ASHA Program, with identified gaps in the areas of Organizational and Supportive Supervision Mechanisms; Support from Panchayati Raj Institutions; Support from Other Health workers at the community level along with Recommendation for Strengthening ASHA program is mentioned in (Table 7).

Relevance of the study

This study emphasizes the need to revisit ASHA training methodology, efforts to improve

coordination amongst different ministries of Government of India to support ASHA program in delivering community mobilization effectively and efficiently for achieving better health outcomes.

Authors Contribution

Al the three authors have contributed in the designing of the concept, definition of intellectual content, literature search, manuscript editing, manuscript review and guarantor. Additionally, Rajat Khanna has also contributed in the data acquisition, data analysis, statistical analysis and manuscript preparation.

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Tables

TABLE 1: ASHA KNOWLEDGE ON PROMOTING CHILD HEALTH

Indicators on Knowledge	Alwar (N=110)	Bharatpur (N=102)	Dausa (N=97)	Overall (N=309)
ASHAs with Correct Knowledge of Complementary Feeding	91%	78%	94%	88%
ASHAs with Correct Knowledge of ORS preparation	97%	90%	88%	92%
ASHAs with Knowledge of Timely Initiation at correct age of Pediatric IFA syrup	94%	74%	88%	85%
ASHAs with Knowledge on correct Pediatric IFA quantity	94%	84%	87%	88%
ASHAs with Knowledge on correct Pediatric IFA frequency	94%	96%	94%	94%
ASHAs with Correct Knowledge on danger sign detection	62%	61%	59%	61%
ASHAs with Correct Knowledge on SNCU discharge instructions	39%	32%	35%	36%

TABLE 2: ASHA PRACTICES FOR PROMOTING CHILD HEALTH

Indicators on Practice	Alwar (N=110)	Bharatpur (N=102)	Dausa (N=97)	Overall (N=309)
ASHAs providing regular and structured Home visits to mothers on Child Health	85%	93%	75%	84%
ASHAs providing counselling on complementary feeding	91%	78%	94%	88%
ASHAs providing counselling on Exclusive Breastfeeding feeding	84%	72%	84%	80%
ASHAs providing counselling on ORS use during Diarhoea episodes	97%	90%	88%	92%
ASHAs providing counselling on Pediatric IFA supplementation	94%	74%	87%	85%
ASHAs providing counselling on danger Signs detection	62%	61%	59%	61%
ASHAs Referring sick infants to health facilities	10%	9%	11%	10%

TABLE 3: REGRESSION ANALYSIS BETWEEN ASHAS KNOWLEDGE (DEPENDENT VARIABLE) & INDEPENDENT VARIABLES

ANOVA[a]					
Model	**Sum of Squares**	**df**	**Mean Square**	**F**	**Sig.**
Regression	71.415	3	23.805	21.875	.000[b]
Residual	331.912	305	1.088		
Total	403.327	308			
a. Dependent Variable: ASHAs Knowledge					
b. Predictors: (Constant), Trained on Community Mobilization and Inter-personal Communication, Supportive Supervision Visits received, Incentive Received by ASHAs					

Coefficients [a]					
Independent Variables	**Unstandardized Coefficients**		**Standardized Coefficients Beta**	**t**	**Sig.**
	B	**Std. Error**			
Constant	4.784	.193		24.824	.000
Trained on Community Mobilization and Inter-personal Communication	.896	.186	.258	4.817	.000
Supportive Supervision Visits received	-.247	.124	-.103	-1.986	.048
Incentive Received by ASHAs	.666	.133	.266	4.989	.000
a. Dependent Variable: ASHAs Knowledge					

TABLE 4: REGRESSION ANALYSIS BETWEEN ASHAS SKILLS (DEPENDENT VARIABLE) & INDEPENDENT VARIABLES

ANOVA [a]					
Model	**Sum of Squares**	**df**	**Mean Square**	**F**	**Sig.**
Regression	3.677	3	1.226	4.152	.007[b]
Residual	90.043	305	.295		
Total	93.720	308			
a. Dependent Variable: ASHA Skills					
b. Predictors: (Constant) Trained on Community Mobilization and Inter-personal Communication, Supportive Supervision Visits received, Incentive Received by ASHAs					

Coefficients [a]					
Independent Variables	**Unstandardized Coefficients**		**Standardized Coefficients Beta**	**t**	**Sig.**
	B	**Std. Error**			
(Constant)	3.623	.100		36.097	.000
Trained on Community Mobilization and Inter-personal Communication	.274	.097	.163	2.828	.005
Supportive Supervision Visits received	-.079	.065	-.068	-1.212	.227
Incentive Received by ASHAs	.078	.069	.065	1.121	.263
a. Dependent Variable: ASHA Skills					

TABLE 5: REGRESSION ANALYSIS BETWEEN ASHAS PRACTICES (DEPENDENT VARIABLE) & INDEPENDENT VARIABLES

ANOVA [a]					
Model	**Sum of Squares**	**df**	**Mean Square**	**F**	**Sig.**
Regression	95.987	3	31.996	33.197	.000[b]
Residual	293.961	305	.964		
Total	389.948	308			
a. Dependent Variable: ASHA Practices					
b. Predictors: (Constant) Trained on Community Mobilization and Inter-personal Communication, Supportive Supervision Visits received, Incentive Received by ASHAs					

Coefficients [a]					
Independent Variables	**Unstandardized Coefficients**		**Standardized Coefficients Beta**	**t**	**Sig.**
	B	**Std. Error**			
(Constant)	4.246	.181		23.411	.000
Trained on Community Mobilization and Inter-personal Communication	.632	.175	.185	3.609	.000
Supportive Supervision Visits received	-.247	.117	-.105	-2.111	.036
Incentive Received by ASHAs	1.006	.126	.409	8.014	.000
a. Dependent Variable: ASHA Practice					

TABLE 6: ASHAS GETTING SUPPORT FROM PANCHAYAT / PRI MEMBERS

Child Health Practices	Districts			Overall
	Alwar	**Bharatpur**	**Dausa**	
ASHAs received Supportive Supervision visits	55%	62%	78%	65%
ASHAs received support from Sarpanch / PRI	63%	57%	38%	56%
ASHAs are able to meet the Sarpanch / PRIs for getting their support	23%	17%	9%	17%
ASHAs are able to request Sarpanch / PRI for getting their support	17%	14%	8%	13%

TABLE 7: FRAMEWORK TO IMPROVE COORDINATION AMONGST MINISTRIES TO STRENGTHEN ASHA PROGRAM

S.N	Gaps Identified	Concerned Ministries			Recommendation for Strengthening ASHA program
		MoHFW	MoRD	MWCD	
Organizational and Supportive Supervision Mechanisms					
1.	Home visitations not prioritized as important task	✓	✓		Joint planning and review meetings between PRIs & ASHA
2.	ASHAs not recognized as essential members of the team of frontline worker	✓		✓	Joint planning and review meetings between AWW, ANM and ASHAs
3.	Inadequate technical support and linkage with other frontline health workers (ANM/ AWW and ASHA supervisor) to enhance ASHAs' credibility and acceptance in the community.	✓		✓	Joint training and refresher planning and review meetings between AWW, ANM and ASHAs
4.	Inadequate performance assessments and reward mechanism for ASHAs through ASHA Supervisors, ANMs AWW and PRIs for quality and accountability.	✓	✓	✓	Joint performance assessments between AWW, ANM, PRIs and ASHAs
5.	Insufficient support from PRIs to ASHAs for VHNDs and VHNSCs.	✓	✓		Periodic meetings between PRIs and ASHAs
6.	Lack of handholding and mentoring of ASHAs for the micro planning of all their tasks including home visits.	✓	✓	✓	Microplanning exercises with support from PRIs & AWW at community level
Support from Panchayati Raj Institutions					
7.	Absence of relationships between ASHAs, PRIs at village level.	✓	✓		Joint planning and review meetings between PRIs & ASHA
8.	Ineffective utilization of VHSNCs for achieving better results PRI support.	✓	✓		Effective participation of PRIs, ASHAs and ANMs in VHSNCs.
9.	Non-involvement of PRI members to mobilize community to support ASHAs in community mobilization.	✓	✓	✓	Joint home visits by ASHAs, ANMs, AWW & PRIs
Support from Other Health workers at the community level					
10.	ASHA to be given due respect by the other front line health workers (ANMs and AWWs) for their community mobilization.	✓	✓	✓	Joint planning and review meetings between PRIs, ANM, AWW and ASHAs
11.	Enlist the help of ANMs/AWWs in communicating with families to emphasise the importance of the ASHAs' work and enlisting their support.	✓	✓	✓	Joint home visits by ASHAs, ANMs, AWW & PRIs