

Working Together?

Convergence and coordination related to the functioning of ASHAs in Chhindwara District, Madhya Pradesh

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BACKGROUND

Under the National Rural Health Mission (NRHM), the Accredited Social Health Activist (ASHA) has been identified as an effective link to address the poor utilization of maternal and child health (MCH) services by rural pregnant women. She is envisaged to be a health activist in the community who will create awareness about health and mobilize the community towards health planning and increased utilization and accountability of the government health services available at the anganwadi centre (AWC), sub-centre (SC) and primary health centre (PHC) such as immunization, antenatal care (ANC), post natal care (PNC), supplementary nutrition and sanitation.

The ASHA, anganwadi worker (AWW) and auxiliary nurse midwife (ANM) are proposed to form the core of the Village Health Team and work together to develop the Village Health Plan in consultation with dais, other stakeholders and local opinion leaders. The anganwadi centre is the core institution for activities relating to delivery of health, family welfare and nutrition services at the village level and also serves as the institutional base for the ASHA at the village level. The ANM is supposed to supervise and provide feedback to the ASHA in her functioning.

This study was undertaken to examine intersectoral coordination and convergence of ASHAs with health functionaries and representatives from other departments like the Department of Women and Child Development (WCD) and Panchayati Raj Institution (PRI). The findings of this study are envisaged to be used for recommendations to policymakers for the revision and extension of NRHM beyond 2012.

STUDY OBJECTIVES

- To understand the convergence and coordination of ASHAs with other village level government functionaries (ANM, AWW) and institutions (PRI).
- To understand the barriers and motivating factors that have direct bearing on effective functioning of the ASHAs.

STUDY SETTING

Chhindwara is one of 48 administrative districts of Madhya Pradesh, occupying 3.85% of the area of the state. The district has a hilly terrain and PHCs and health centers are situated in hamlets far from the villages. It has a significant tribal population (35% as per 2001 Census) and Schedule Caste (SC) population (12% as per 2001 Census). The predominant tribes living in the study area are Pardhan, Gond, Mawasi and Baharia. In 2011, Chhindwara had a population of 2,090,306 of which male and female populations were 1,063,302 and 1,027,004 respectively. The literacy rate as per 2011 Census is 72.2%.

The study was conducted in three blocks—Tamia, Parasiya and Junnardeo. These blocks were purposively chosen as Madhya Pradesh Vigyan Sabha was previously involved in Community Based Monitoring of health services under NRHM in these blocks and had a good understanding of NRHM functioning in the areas.

METHODOLOGY

The study was both quantitative and qualitative in nature.

Sample: For the quantitative study, 100 ASHAs were selected from the 3 study blocks (25 from Tamia, 35 from Parasia and 40 from Junnardeo). The number 100 was arbitrarily chosen but the distribution was done using a proportion based on the population in each of these districts. The names and time of appointment of ASHAs was listed. A criterion for selection was ASHAs having a minimum of three years of work experience so that the respondents had adequate years of experience and exposure to the health care system. From the screened lists, the required number of ASHAs were randomly selected using a lottery method. In addition, qualitative data was collected from ANMs, AWWs, PRI members, VHSC members and the community.

Data collection: An interview schedule was used to collect information from ASHAs. The interview schedule had domains on ASHA functioning, community and provider cooperation with ASHAs and coordination and convergence

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between ASHAs and other government functionaries like ANMs, AWWs, and panchayat members. Five focus group discussions (FGDs) using FGD guides were conducted with ASHAs, ANMs, AWWs and villagers to understand the community's perception of how the ASHAs were functioning.

Data was collected by MPVS workers who underwent two days of training. They collected data from mid-February to mid-April 2011. Data from interviews was entered into Excel and analysed using SPSS. Data from FGDs was analysed using scrutinizing and coding.

Ethical issues: Ethical clearance for the study was obtained from the Institutional Ethics Review Committee of School of Public Health, SRM University. Data collection was done after seeking informed consent and explaining the purpose of the study to all respondents.

Limitations: Mountainous terrain caused difficulty in reaching small hamlets. The two methods were applied independently of each other so issues raised through one method could not necessarily be answered through the other.

FINDINGS

ASHA profile

Ninety four percent of ASHAs were under the age of 40 and 6% were between ages 40 and 54 years. More than half of them had a high school education. The majority (95 %) of ASHAs were Hindus and 43 % belonged to Scheduled Tribes (ST) and 36 % belonged to SC. Around 74 % of ASHAs had attended orientation trainings at least five times.

The FGDs revealed that some ASHAs were not residents of the village where they were appointed. As a result, such ASHAs were forced to travel long distances, affecting their service delivery. As the survey did not ask ASHAs their village of residence, this data could not be corroborated.

Coordination

Coordination with auxiliary nurse midwife (ANM):

According to the NRHM, the ANM is supposed to meet with the ASHA regularly to keep her informed about her activities and the local health status. ASHAs and ANMs are supposed to assist each other with various tasks, such as organizing Health Day and encouraging pregnant women to visit the sub-centres.

The findings revealed that, according to the ASHAs, there was good coordination between ASHAs and ANMs, especially with regard to organizing immunization camps, registering women for ANC, care during pregnancy, and providing family planning (FP) (Table 1). However, a significant

shortcoming is that 72% of ASHAs said that ANMs demand money from them for scheduling their honorarium.

Table 1 Percentage distribution of ASHA coordination with ANM	
ASHA's support to ANM(%)	ANM's support to ASHA (%)
ANC registration – 75	Spreading awareness about FP – 64
ANC check-up – 20	Meeting target for FP – 13
Organizing immunization programmes – 40	Anaemia education for pregnant women – 93
Organizing FP camp – 68	Blood pressure education for pregnant women – 87
Health education – 12	Danger signs education for pregnant women – 87
	Range of replenishing for various medicines (62 – 90)
	Sharing health report – 94

Coordination with anganwadi workers (AWWs):

The NRHM stipulates that the AWW should distribute medicine to the ASHA and meet with her regularly. The ASHA and AWW are to support each other in bringing women and children for immunization, nutritional supplement, checkups, and organize health days. Table 2 gives an overview of the coordination that the researchers found between AWWs and ASHAs.

Table 2 Percentage distribution of ASHA coordination with AWW	
ASHA's support to AWW (%)	AWW's support to ASHA (%)
Support in immunization programme – 78	Organizing VHSC – 65
Mobilizing pregnant women for nutrition – 52	Medicine distribution – 18
Outreach for ANC check up – 77	Inviting to AWW meeting – 59
Help in organizing VHND – 88	

The data reveals that good coordination existed during immunization, ANC, and in organizing the VHND and VHSC. However, gaps were observed in other activities such as medicine replacement and mobilizing women for nutrition supplements.

Coordination with panchayat: The study revealed relatively poor coordination between ASHAs and panchayat members, with 97% of ASHAs saying that they did not receive any help from the panchayats. While 72% of ASHAs reported discussing village nutrition issues with panchayat members, only 61% of ASHAs regularly attended panchayat meetings and 50% of respondents were associated with gram sabha. Around 30% of respondents faced opposition from panchayats while drafting the Village Health Plan and ultimately a mere 12% of ASHAs were engaged in developing it. In fact, 30% of ASHAs reported that they faced opposition from the panchayat in discharging their routine work. 54%

of ASHAs said that the panchayats did not organize any Swasthya Mela (Village Health and Nutrition Days) in their villages.

Coordination with health care centre: Around 46% of ASHAs reported that they were treated badly during their visit to the hospital with 21% complaining that they were treated like a health worker, 7% said they were treated like patients and 18% said that they were ignored like uninvited guests.

A total of 381 institutional deliveries took place in the last year in the study area and ASHAs accompanied them in 154 cases (40%). Of those cases, ASHAs took 80 (51%) in Janani Express and 69 cases (45%) in private vehicles and the remaining 5 cases in their own vehicle. In the last year, ASHAs tried 240 times to summon the Janani Express.

FGDs revealed that in many villages, Janani Express would not come inside the village. One participant said, *“In our village JSY express doesn’t come, instead they stop 2kms away from the village. So we have to carry our pregnant women on shoulders with a lot of difficulty.”*

ASHAs reported facing difficulty in procuring medicine from health centres, with 79% saying that for each medicine they had to go to the centre more than two times and even then medicine was usually not easily available.

Motivating factors

Around 69% of ASHAs said that their economic status had improved since taking up the role. Nearly all (96%) of the ASHAs said that their identity and respect in the village had improved. Around 42% reported that their decision-making

Table 3 Local Barriers to ASHA functioning	
Challenge	% of ASHAs
No cooperation from villagers	19
No cooperation or help from panchayat	97
No cooperation from community in furnishing Village Health Plan	37
Opposition from elite class	64
Opposition from panchayat in furnishing Village Health Plan	30
Opposition from own family	15

capacity had improved and 38% said that their leadership qualities had improved. Hence, personal growth, monetary compensation and public recognition could be motivating factors for the ASHAs.

Barriers to effective functioning of ASHAs

For different ASHAs, non-cooperation and opposition from various local actors were barriers to their work.

ASHAs faced opposition from elites, panchayats and, in some cases, their own families. For some ASHAs, the beneficiaries themselves were non-cooperative. These presented significant barriers for the ASHAs.

While 18% of ASHAs reported no difficulties with AWWs, 36% reported non-cooperative behaviour. Additionally, 8% of ASHAs said that AWWs called for meetings without prior notice, creating inconvenience. Around 35% reported that AWWs took the JSY cases without giving information to ASHAs. Around 2% said that AWWs took their family planning cases and 1% complained of all of the above.

Around 63% of ASHAs shared that with the absence of a good public transportation system and the long distance between the villages and health care centres, they found it difficult to provide effective services to their beneficiaries.

The ASHA’s honorarium amount depends on the ANM certifying the work of the ASHA. Some ASHAs complained that the ANMs were resentful of them, and therefore did not certify their work, resulting in a reduced honorarium. As one ASHA said, “ANM feels though they provide ANC services but the benefit (JSY money) is going to the ASHA.” Most ASHAs faced great difficulty in receiving their honorariums. Around 88% said that they had to wait more than one month and visit the ANM more than three times before receiving their payment. Moreover, nearly half (48%) of ASHAs said they had to pay a bribe ranging from Rs 50-200/- to the ANM to get their honorarium.

Finally, ASHAs were not given proper recognition by health care providers when they took patients to the centres. Furthermore, ASHAs reported having difficulty procuring medicine and medical kits from the health centres to perform their duties. As many as 96% said that they did not receive any support during their stay at the hospital with their JSY cases. Every ASHA complained that there was no accommodation for them in the hospital, which is why only less than half of them stayed overnight with the patients they brought.

CONCLUSION

A number of flaws in the cooperation and convergence between ASHAs and various village-level actors were observed. Until these impediments are addressed, the rural population will not be adequately served by the NRHM. The study highlights that while the ASHAs were coordinating certain activities with AWWs and ANMs, there are flaws in the cooperation in such issues as honorarium payment and utilisation of untied fund. There is very little coordination between PRI members and ASHAs. ASHAs also face lack of

cooperation from the health care centres regarding medicine replacement, accommodations and Janani Express. Another significant finding from the study was that even though NRHM guidelines require local appointment of ASHAs, often women of one village were appointed as ASHAs for another village.

RECOMMENDATIONS

Community awareness: ASHAs will perform better if their communities are aware of the health services which they are entitled to and the role of the ASHA in providing them.

Remuneration policy: There is an urgent need to restructure the outcome-based remuneration policy to ensure that ASHAs receive payment and continue to be motivated to work.

Institutional support: Policy on ASHA programs should be backed by concrete institutional support structures to enable ASHAs to perform their duties. This support includes orientation for panchayat members, ANMs, AWWs and health department about the ASHA program and their responsibilities to their local ASHA.

Capacity building: There needs to be a stronger focus on skill development and practical experience for ASHAs, particularly in the functioning of the Village Health and Sanitation Committee and the Village Health Plan.

Supplies and facilities: ASHAs need to be continuously supplied with medicine and medical kits, as stipulated by the NRHM. They also need accommodations at the health centres for overnight stays. The Janani Express response must be increased.

Grievance redressal system: ASHAs need a grievance redressal system where they can voice concerns over their unmet needs and programme flaws, such as delay of honorarium and lack of support in health centres.

REFERENCES

1. Reaching the Unreached, Rapid Assessment studies of Health Programs Implementation in India, edited by Hagopian, House, Das, Centre for Health and Social Justice, by Nidhi Books, G-221, Gazipur, Delhi-110096
2. NRHM, MOHFW, Government of India, Facilitators Module for ASHA, Book No-5.
3. National Rural Health Mission (2005-12) Mission Document.
4. NFHS-MP, www.nfhsindia.org/data/mp/mpappc.pdf.
5. Government of Madhya Pradesh, National Rural Health Mission: Programme Implementation Plan 2006-2012, <http://www.mp.gov.in/health/nrhm/pip-nrhm.pdf>.
6. Jansankhya Sthirata Kosh, Health Facilities in District Chhindwara, MP, www.jsk.gov.in/mp/mp_chhindwara.pdf.

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About the Organization: Madhya Pradesh Vigyan Sabha is a registered non-governmental organization based in Madhya Pradesh. The organization is committed to support rural society through science popularization, environment protection, and sustainable development. The team consists of scientists, doctors, engineers, social scientists, academics, teachers, and students.

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