

# National Rural Health Mission With Special Emphasis On Asha Workers

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*Abstract: ASHA the lady health activist in the rural area is smoothening and promoting the health scenario of the rural women. Being a female she is working as custodian of the promotion of health status of females in her village. Interviewing the ASHA workers it is found that they are enjoying empowerment both social and economic empowerment. It has been found that this village lady with some basic education and health training performing the best. Her status in the family as well in the society has increased. Another important fact to be mentioned here is that the both the female is working as the promoter of health condition of the society one as a distributor (ASHA) and other as the receiver (the rural woman) of health care services.*

*Keywords: Asha health activists, custodian, empowerment.*

## I. INTRODUCTION

Medical profession is one of the oldest profession of the world and is the most humanitarian one. There is no better service than to serve the suffering, wounded and the sick. Inherent in the concept of any profession is a code of conduct, containing the basic ethics that underline the moral values that govern professional practice & is aimed at upholding its dignity. Medical ethics the values at the heart of the practitioner-client relationship. In the recent times, professionals are developing a tendency to forget that the self regulation which is at the heart of their profession is a privilege in return for an implicit contract with society to provide good competent and accountable service to the public. It must always kept in mind that doctors are the noble profession and aim must be to serve humanity otherwise this dignified profession will lose its true worth.

There has been mushrooming of hospitals after liberalization introduced in India in 1991 with the raising off import restrictions new and advanced medical gadgets and Hi-tech computerized equipments have become part and parcel of modern hospitals.

National Rural Health Mission or NRHM as it could be established on the basis of its mission documents was a

Government of India intervention to correct the public health sector of the country. It was launched in April 2005 and had continued until March 2012. In fact Government of India had adopted a time bound and mission oriented approach to correct the public health situation in the country (MOHFW 2005). However it was all the probability that it would further continue during the 12th plan period starting from April 1, 2012. It was found that National Rural Health Mission was a combination of several programs including population stabilization, disease control, nutrition, water & sanitation, improvement of workforce, infrastructure, and logistics. Therefore it could say that National Rural Health Mission was like a sunshade or a podium under which several health and development programs were implemented however the main focus was towards providing financial and know how assistance to states to eliminate the gaps existing in terms of work force, infrastructure, and logistics. In addition it further took in hand health determinants especially nutrition to an extent. For all such diversified approaches National Rural Health Mission had to establish wide spread sectoral and intersectoral convergences, public private partnerships, forging alliances with developmental partners and outsourcing of some key supportive and medical services. It could be further evident from the NRHM framework of implementation

(MOHFW 2005) that National Rural Health Mission had recognized the need to make optimal use of the non-governmental sector to strengthen public health systems to increase access to medical care for the poor. National Rural Health Mission attempted a major shift in the governance of public health by giving leadership to Panchayati Raj Institutions and other local bodies in matters related to health at district and sub-district levels. Although the programs of the National Rural Health Mission was implemented in all the 35 states and union territories of the country however NRHM mission documents had stated that eight Empowered Action Group (EAG) states like Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Rajasthan, Orissa, Uttar Pradesh and Uttaranchal, 8 North Eastern states and the hilly states of Himachal Pradesh and Jammu & Kashmir were highly focused.

According to the NRHM Mission document the centre objective of National Rural Health Mission was to create fully functional health facilities within the public health system. It was therefore expected to provide a certain service guarantee at each level of the health care delivery system starting from a Health Sub Centre to a District Hospital. Under NRHM all existing societies relevant to Reproductive and Child Health, National Program for TB, Malaria, Blindness, and Integrated Disease Surveillance were integrated into a unified health mission or society. Therefore National Rural Health Mission was evidently an ambitious program expected to consolidate all existing disease control programs under a common umbrella while simultaneously improving the infrastructure and capacity of the health care system in the country. As per NRHM mission documents and Framework of implementation the outcome from National Rural Health Mission was expected in form of reduction of Infant Mortality Rate (IMR) from a level of 62 to 30. Further it was targeted that the Maternal Mortality Rate (MMR) would be cut to 100 from a level of 330 in the year 2004-05. On the similar pattern the total fertility rate (TFR), malarial mortality rate, Kala Azar mortality rate were expected to down to 2.1, 70 percent, 100 percent respectively in the year 2012. Likewise, it was expected to bring down filarial /microfilaria rate, dengue mortality rate and leprosy prevalence rate to 100 percent, 50 percent, and below 1 percent respectively in the year 2012. Further National Rural Health Mission aimed at maintaining the tuberculosis cure rate at 85 percent through the entire mission period. Up gradation of all community health centers to the tune of Indian Public Health Standards, increase in the bed occupancy rate of first referral units from less than 20 percent of referring cases to over 75 percent and cataract operations to 46 lacks until 2012 were also targeted. National Rural Health Mission further aimed to engage 400,000 female Accredited Social Health Activists and double the number of Auxiliary Nurse Midwife in Health Sub Centers (MOHFW 2005). Absolutely it could say that National Rural Health Mission was expected to improve the overall access of rural people to a reasonable and inexpensive, primary healthcare.

## II. INTERNATIONAL COMMUNITY HEALTH WORKERS PROGRAMMING

For the purpose of this paper, we review three large-scale CHW programmes from Bangladesh, China, and Iran that have been relatively successful. While these programmes differ in some programme design from the ASHA, they are relevant in many ways: (a) India and China are rapidly growing economies with enormous populations, (b) Bangladesh shares its borders with India and faces similar health and economic problems as many adjoining states in India, particularly West Bengal and Bihar, and (c) Iran's programme has developed at considerable scale and has achieved remarkable coverage in the course of two decades.

CHW programmes around the world largely focus on primary care services like maternal and child health, nutrition, family planning, immunizations, water and sanitation, communicable disease control, and basic curative care for some common illnesses. Most CHW programmes enrol female health workers, due to the large importance of maternal and child health, but there are also notable programmatic examples of male community health workers in Iran, Egypt, Thailand, Bhutan, and Bolivia (Catalyst 2005, 2007; Brown 2006).

Selection criteria, especially education levels, vary widely between programmes; India employs largely low-literacy women, while Iran's national programme requires Class 11 pass. Quality and productivity of work depend on quality of training and support received by the CHWs in the field. However, both lack of sufficiently educated candidates and dissatisfaction of overqualified candidates are reasons for attrition. Incentives also vary widely, and include income-generation schemes and social prestige.

## III. THE STATE OF PUBLIC HEALTH IN INDIA

- ✓ India has registered significant progress in improving life expectancy at birth, reducing mortality due to Malaria, as well as reducing infant and material mortality over the last few decades. In spite of the progress made, a high proportion of the population especially in rural areas, continues to suffer and die from preventable diseases, pregnancy and child birth related complications as well as malnutrition. In addition to old unresolved problems, the health system in the country is facing emerging threats and challenges. The rural public health care system in many States and regions is in an unsatisfactory state leading to pauperization of poor households due to expensive private sector health care. India is in the midst of an epidemiological and demographic transition – with the attendant problems of increased chronic disease burden and a decline in mortality and fertility rates leading to an ageing of the population. An estimated 5 million people in the country are living with HIV/AIDS, a threat which has the potential to undermine the health and developmental gains India has made since its independence. Non-communicable diseases such as cardio-vascular diseases, cancer, blindness, and mental illness and tobacco use related illnesses have imposed the chronic diseases burden on the already over- stretched

health care system in the country. Premature morbidity and mortality from chronic diseases can be a major economic and human resource loss for India. The large disparity across India places the burden of these conditions mostly on the poor and on women, scheduled castes and tribes especially those who live in the rural areas of the country. The inequity is also reflected in the skewed availability of public resources between the advanced and less developed states.

- ✓ Public spending on preventive health services has a low priority over curative health in the country as a whole. Indian public spending on health is amongst the lowest in the world, whereas its proportion of private spending on health is one of the highest. More than Rs. 100,000 crores is being spent annually as household expenditure on health, which is more than three times the public expenditure on health. The private sector health care is unregulated pushing the cost of health care up and making it unaffordable for the rural poor. It is clear that maintaining the health system in its present form will become untenable in India. Persistent malnutrition, high levels of anaemia amongst children and women, low age of marriage and at first child birth, inadequate safe drinking water round the year in many villages, overcrowding of dwelling units, unsatisfactory state of sanitation and disposal of wastes constitute major challenges for the public health system in India. Most of these public health determinants are correlated to high levels of poverty and to degradation of the environment in our villages.

Thus, the country has to deal with multiple health crises, rising costs of health care and mounting expectations of the people. The challenge of quality health services in remote rural regions has to be met with a sense of urgency. Given the scope and magnitude of the problem, it is no longer enough to focus on narrowly defined projects. The urgent need is to transform the public health system into an accountable, accessible and affordable system of quality services.

The National Rural Health Mission (NRHM) was launched on 12 April, 2005 throughout the country with special focus on 18 States, viz. eight Empowered Action Group (EAG) states (Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Orissa, Rajasthan, Uttar Pradesh and Uttarakhand), eight North Eastern States and the hill States of Jammu and Kashmir and Himachal Pradesh which had poor health indices. The aim of the Mission is to provide *accessible, affordable, accountable, effective and reliable* healthcare facilities in the rural areas of the entire country, especially to the poor and vulnerable sections of the population. The key strategy of the NRHM is to bridge gaps in healthcare facilities, facilitate decentralized planning in the health sector, provide an overarching umbrella to the existing programmes of Health and Family Welfare including Reproductive and Child Health-II, Vector Borne Disease Control Programme, Tuberculosis, Leprosy and Blindness Control Programmes and Integrated Disease Surveillance Project. It also addresses the issue of health in the context of a sector wide approach encompassing sanitation and hygiene, nutrition etc. as basic determinants of good health and advocates convergence with related social sector departments

such as Women and Child Development, AYUSH, Panchayati Raj etc.

The NRHM seeks to provide health to all in an equitable manner through increased outlays, horizontal integration of existing schemes, capacity building and human resource management. The Mission envisages increasing expenditure on health, with a focus on primary healthcare, from the level of 0.9% of GDP (in 2004-05) to 2-3% of GDP over the mission period (2005-2012).

#### OBJECTIVES OF THE PROGRAMME

The main objectives of the NRHM are:

- ✓ Reduction in child and maternal mortality;
- ✓ Universal access to public services for food and nutrition, sanitation and hygiene and universal access to public health care services with emphasis on services addressing women's and children's health and universal immunization;
- ✓ Prevention and control of communicable and non-communicable diseases, including locally endemic diseases;
- ✓ Access to integrated comprehensive primary health care;
- ✓ Population stabilization, gender and demographic balance;
- ✓ Revitalize local health traditions & mainstream AYUSH, and
- ✓ Promotion of healthy life styles.
  - Pharmacist under the Indian Public Health System (IPHS) model.
  - Single doctor PHCs shall be upgraded to two doctor PHCs by mainstreaming AYUSH practitioner.

#### IV. ACCREDITED SOCIAL HEALTH ACTIVIST (ASHA)

##### A. INTRODUCTION

One of the core strategies proposed in this mission was to create a village level social activist, designated as ASHA for every village with a 1,000 population. This was aimed to provide primary medical care, advice the villagers on sanitation, hygiene, antenatal and postnatal care, escorting expectant mothers to hospital for safe delivery etc. To perform her activity in a proper manner, the NRHM has envisaged capacity -building of the ASHA through training and motivating them through a performance -based compensation. It was suggested that ASHA would be chosen by and accountable to the Panchayat. She would act as an interface between the community and the public health system. As an honorary volunteer ASHA would receive performance-based compensation for promoting variety of primary health care services in general and reproductive and child health services in particular such as universal immunization, referral and escort services for institutional deliveries, construction of household toilets, and other healthcare interventions.

In order to enable the states for proper implementation, ASHA guidelines were formulated by the Ministry of Health and Family Welfare (MOHFW), Government of India (GoI) wherein institutional arrangements, roles and responsibilities,

integration with ANMs and Anganwadi workers (AWW), working arrangements, training, compensation, fund-flow etc have been discussed. Many states depending on the local context modified the guidelines to suit their requirements, in the true spirit of the NRHM guidelines of decentralized programme management

ASHA is the first port of call for any health related demands of deprived sections of the population, especially women and children, who finds it difficult to access health services. She is a trained female health activist in the community who creates awareness on health and its social determinants and mobilizes the community towards local health planning and increased utilization and accountability of the existing health services. She is a good promoter of health practices.

#### B. CRITERIA FOR SELECTION OF ASHA

- ✓ One ASHA has to be in place for a population of 1000.
- ✓ ASHA must be a women resident of the village (Married/widow/divorced), and preferably in the age group of 25 to 45 years.
- ✓ She should be literate women with formal education up to Eighth standard. In the case of special circumstances require relaxation of the educational qualification of ASHA, the district Health Society needs to send the proposal to the State Health Society with full justification for seeking approval from Ministry of Health and Family Welfare, Government of India.
- ✓ She should have effective communication skills, leadership qualities and be able to reach out to the every section of the community.
- ✓ Adequate representation from disadvantaged population groups should be ensured to serve such groups better.

10,000 ASHA's have been engaged in the state so far. However during the year 2012-2013, engagement of 2000 additional ASHAs has been approved in the Programme Implementation Plan (PIP). ASHAs are in the majority of the villages and have been trained in Module I to V. In the year 2012-13, the ASHAs will be trained in Module VI-VII. Uniforms to ASHA in High Focus Districts @ Rs. 1000.00 and in other districts @ Rs. 750.00. The amount has to be e-transferred to the account of ASHA.

All the payments to ASHAs be made through payees account Cheque/ electronic transfer on 10<sup>th</sup> of every month.

ASHAs are not paid any fixed monthly remuneration. However, they are paid performance based incentives.

#### C. SUSTENANCE AND MOTIVATIONAL FACTORS

The sustenance of the programme depends on the long - term motivational factors for the ASHAs to keep her going with spirit and enthusiasm. To analyze this aspect, factors such as job satisfaction, compensation, recognition, training, capacity building, monitoring, supervision and utility of her job were considered. The most important factor motivating them for this job is to earn some money as indicated by the majority of the ASHAs. The second most important factor is that this job gives them opportunity to serve the community as well. The ASHA is a volunteer, this philosophy is subscribed

by some of them, and still some others also aspire for a government job in this process. The most important finding is that most of them are satisfied with their job and also happy with the nature of work. Most of them feel that their prestige has gone up in the village due to their engagement as the ASHA. All the ASHAs opine that the community considers their job useful. Monetary compensation is an important motivational factor for the ASHAs. The community members unanimously find the role of the ASHA very useful for them.

#### D. TRAINING OF ASHAS

The scheme envisages a three -pronged strategy- induction training followed by a periodic training, and on the job training. The induction training is for 23 days over a year. The first round may be of seven days, to be followed by another four rounds of training, each lasting for four days. Though the training material is produced at the national level, states have the freedom to modify the contents as per local needs. The training materials will include facilitators guide, training aids and resource materials of the ASHAs. The induction training will be followed by periodic training for about two days, once in every alternative month for all ASHAs. This training will be of interactive sessions to help refresh and upgrade their knowledge and skills and solve the problems they are facing, monitor their work and keep up their motivation and interest. The ASHAs need on the job support in the field, both during the initial training phase and later also.

The process of training of the ASHAs has been evaluated by interviewing them and also the ANMs. All the ASHAs have been imparted induction training for a week at places like PHC and CHC.

#### E. KNOWLEDGE OF ASHAS

The knowledge of ASHAs on the nature of the activities and job responsibility is the pre - requisite for effective service delivery. The ASHAs have been interviewed to assess their knowledge about their job responsibilities. It reveals that most of the ASHAs have comprehended accompanying pregnant mother to hospital and counselling community on safe delivery, ANC/PNC, breastfeeding, immunization, contraception and prevention of RTIs/STIs as their role and responsibility. As regards their job responsibilities like creating community awareness on determinants of health, mobilising the community to access healthcare services at different facilities, depot holder of medicine and DOTS provider and motivating the community for construction of household toilets, nearly half couldn't specify.

This finding is significant in the light of the fact that one of the key motivational factors which drive ASHAs are financial gains and since delivery and site -related events are financially rewarding, they are becoming the areas of primary interest to the ASHAs. A strategy should be devised wherein the ASHAs develop expertise in other significant areas of her activity spectrum such as helping develop village health plans and facilitating registration of vital events with the ANMs/AWWs

#### F. FUNCTIONING OF ASHA

- ✓ Activities as mentioned in the table above and mobilizing the pregnant Ladies for Antenatal check ups/ dropouts for immunization.
- ✓ Accompanying the pregnant ladies to the institution for delivery.
- ✓ Tracking of pregnant women from early registration in the trimester up to post natal care after delivery in her respective areas.
- ✓ Tracking of children up to full immunization stage.
- ✓ Maintenance of ASHA diary.
- ✓ Record of house hold visits, under one year children, pregnant ladies and eligible couple register
- ✓ Assisting the FMPHWs and AWWs in organising Village Health and Nutrition Days.
- ✓ Facilitating the monthly meeting of VHSNC followed by the meeting of women and adolescent girls.
- ✓ Maintenance of register in which all the services provided viz registration of pregnant women, ANC, immunization, oral pills, IUCD, sterilization male female, referral of sick newborns/children/infants, spacing methods etc are recorded with signature of the health person.
- ✓ Monthly reports generated by asha as per her diary is to be consolidated at Sub Centre level.
- ✓ Asha is a main service provider for Home Based Neonatal Care. She has to provide new born care through a series provider for home visits which include the skills for weighing the newborns, measuring newborn temperature, ensuring warmth, promoting hand washing, providing skin, cord and eye care, supporting exclusive breast feeding, accessing low birth weight babies.

#### G. THE ACTIVITIES WHICH ASHA ARE UNABLE TO PERFORM

Few of the ASHAs have indicated that they are unable to motivate the community for construction of toilets and not able to organize meeting. Besides, a few of them have also pointed out that they are not able to take serious patients to higher facilities, stay with the patients in the hospital, do paper work of the JSY and other register/records and distribution of condoms and oral pills. Except for the activities like taking patients to higher centres and staying with them in the hospital, this observation is indicative of the lack of capacity and skills of the ASHAs. This can be overcome by paying special attention on these specific issues during capacity building exercises and timely guidance by supervisors for executing these important tasks including referrals.

#### H. SOCIAL ACCEPTANCE AND COMMUNITY SUPPORT

The ASHAs have to work in the community for the rural poor. They have to motivate every household and generate awareness in the community for ANC, PNC, safe delivery practices, immunization, importance of breastfeeding, family planning and sanitation etc. Their work will be accomplished if they are well -accepted and supported by the community. FGD that was conducted indicate that ASHAs are well -

accepted in the community and considered as a friend to the household especially for the pregnant and lactating mothers and children. The PRI members, community members, and mothers who participated in the FGDs, are very out spoken in their praise for the ASHA.

#### I. COMMUNITY SATISFACTION AND EXPECTATIONS

The level of community satisfaction was judged during interviews with the PRI members, AWWs and community members. All of them have emphasised on the role of the ASHA as a facilitator for institutional delivery, immunization of mothers and children and distribution of some medicines. The AWWs have also expressed positive views on the activities of the ASHA in the community. The FGDs among community members reveal that the community members are by and large satisfied with the work of the ASHA. She is mainly involved on the promotion of institutional delivery and immunization. One universal demand that emerges from the community is that the ASHA should have sufficient stock of the medicines for the common ailments like fever, diarrhoea, cold, cough and minor injuries. All the ASHAs have indicated that community members are happy with their work and they also do give credit for it. However majority are of the opinion that the community expects more work from them.

#### V. DESCRIPTION OF STAKEHOLDERS INVOLVED: STAKEHOLDERS ANALYSIS

The main stakeholders involved in the programme are PRI Members, ASHAs, AWWs, ANMs, Community members, District level officials, State level officials, officials at national level. Figure 3 shows the various stakeholders as per their level of involvement in the programme. The first level stakeholders who are the main stakeholders include are ASHAs, PRI Members, AWWs, ANMs and local Community members. These stakeholders are at the grass root level and are the visible faces of the scheme in the community. The second level stakeholders who are not directly related to the programme include CDMO, ADNO, NGOs working in public health, and the government's Ministry of Health and Family Welfare at state level. These stakeholders though not coming in direct contact with the public but are responsible for the implementation of the scheme in many ways. Stakeholders involved at the third level are the Ministry of Health and Family Welfare at National level, also the global community. Stakeholder power analysis is depicted in figure 4 showing the stakeholders main features like their key interest in the programme, their impact etc.

#### VI. PROVISIONS OF INDIAN CONSTITUTION RELATED WITH NRHM

The Indian Constitution, in the Article 21 and Directive Principles of State Policy, has already emphasised that ensuring better health services to its people in a welfare state.

A very fascinating development in the Indian Constitutional jurisprudence is the extended dimension given to Article 21 by the Supreme Court in the post-Maneka era. The Supreme Court has asserted that in order to treat a right as a Fundamental Rights, it is not necessary that it should be expressly stated in the constitution as a Fundamental Right. Political, social and economic changes in the country entail the recognition of new rights. The law in its eternal youth grows to meet the demands of the society. The right to life enshrined in Article 21 has been liberally interpreted so as to mean something more than mere survival and mere existence or animal existence. It therefore includes all those aspects of life which go to make a man 'life meaningful, complete and worth living. The Supreme Court has asserted that Article 21 is the heart of the Fundamental Rights. The Supreme Court has taken the view that in order to treat a right as a Fundamental Rights, it is not necessary that it should be expressly stated as a Fundamental Rights. Accordingly, the Supreme Court has implied a whole bundle of human rights out of Article 21 by reading the same along with some Directive Principles.

In *Paramanand Katara v. Union of India*. The Supreme Court has considered a very serious problem existing at present in a medico legal case the doctors usually refuse to give immediate medical aid to the victim till legal formalities are completed. The Supreme Court has now very specifically clarified that preservation of life is of paramount importance. Once life is lost, status quo ante cannot be restored. It is the duty of the doctors to preserve life whether the concerned person be a criminal or an innocent person. Article 21 casts on the state an obligation to preserve life. The court has made the following pithy observation in this connection;

“A doctor at the government hospital positioned to meet this state obligation is, therefore, duty bound to extend medical assistance for preserving life. Every doctor whether at a Government hospital or otherwise has the professional obligation to extend his services with due expertise for protecting life. No law or state action can intervene to avoid / delay the discharge of the paramount obligation cast upon members of the medical profession. The obligation being total, absolute and paramount, laws of procedure whether in statutes or otherwise which would interfere with the discharge of this obligation cannot be sustained and must, therefore give way.....

The court has also observed;

“Article 21 of the constitution casts an obligation on the state to preserve life. The patient whether he be an innocent or be a criminal liable to punishment under the laws of the society, it is the responsibility of those who are incharge of the health of the community to preserve life so that the innocent may be protected and the guilty may be punished. Social laws do not contemplate death by negligence to be tantamount to be legal punishment. Every doctor whether at a government hospital or otherwise has the professional obligation to extend his services with due expertise for protecting life”.

The matter has been taken one step forward in *Paschim Banga Khet Mazdoor samity V. State of west Bengal*.

A mazdoor fell from a running train and was seriously injured. He was sent from one government hospital to another and finally he had to incur an expenditure of Rs 17,000/ on his

treatment. Feeling aggrieved at callous attitude shown by the various government hospitals, he filed a writ petition in the Supreme Court under Article 32. The court has ruled that the constitution envisages establishment of a welfare state, and in a welfare state, the primary duty of the government is to provide adequate medical facilities for the people. The government discharges this obligation by running hospitals and health centres to provide medical care to those who need them. “Article 21 imposes an obligation on the state to safeguard the right to life of every person. Preservation of Human life is thus of paramount importance”.

The court has insisted that government hospitals and the medical officers employed therein are duty bound to extend medical assistance for preserving human life. Failure by a government to provide timely medical treatment to a needy person violates his right to life guaranteed by Article 21. In the instant case, petitioner's right under Article 21 has been violated when he was denied treatment when he was in a critical state and needed immediate medical attention. Since his right under Article 21 was denied by government servants, the State is liable to pay him compensation for breach of his right guaranteed under Article 21. The Court awarded him a sum of Rs.25000/- as compensation. Moreover, the Court issued several directions for avoidance of any such incident in future and to ensure immediate medical attention and treatment to persons in real need.

The Court has laid stress on one very crucial point, viz., the State cannot plead lack of financial resources to carry out these directions meant to provide adequate medical services to the people. The State cannot avoid its constitutional obligation to provide adequate medical aid to the people on account of financial constraints.

The Court has also said that other States, though not parties to the present case, should also take necessary steps to implement the directions given here. The Court also expected that the Government of India would render necessary assistance in the improvement of medical services in the country.

## VII. CONCLUDING REMARKS

Women's individual characteristics like age and education have often been observed to make a significant impact on obstetric health care seeking behaviour in rural areas, both from public as well as private health facilities. Further, women's education not only improves their likelihood of seeking obstetric care, but also facilitates utilization of public health facilities for complete immunization of children. More educated women also report higher utilization of contraceptive methods. Nevertheless, we still find son-preference is still deep rooted in rural areas as still usage of permanent methods improves much faster amongst women with at least two sons. Households background factors like better economic and sanitation conditions in the households characterized by higher incomes, separate toilet facility within residential premises, availability of potable drinking water, etc. depict significant and positive impact in promoting utilization of health care facilities, whether private or public, amongst women during pregnancies, deliveries, and post-natal period. Such

background factors also depict strong impact on seeking children's immunization services, promotion of usage of contraception services, and even treatment for chronic diseases, from public as well as private health care facilities. It may be of interest to mention that economically and socially better off chronic patients depicted higher utilization of public compared to private health facilities for the treatments. Impact of some of the program initiatives and enhanced outreach of health services on obstetric care, child immunization, family planning, and chronic disease control have turned out to be significant even after controlling socioeconomic, demographic and cultural factors in rural India. Role of ASHA turns out to be extremely important in promoting utilization of public Health care facilities for MCH care, Family Planning and treatment of Chronic Diseases.

Frequent visits of such key health workers, carrying kits and distribution of common medicines And proper counselling makes significant impact in motivating pregnant women to visit nearby SCs and PHCs for the antenatal care. Further, important role of ASHAs in motivating pregnant Women to make use of public health care facilities for delivery care. For delivery care primarily FRUs, implying District Hospitals and Community Health Centers, are getting utilized and seem to be responsible for improvements in institutional deliveries. As FRUs are supposed to be adequately equipped and staffed for emergency obstetric care because of having proper operation. Theatres, surgeons, gynaecologists and paediatricians, accessibility to emergency transport, ready Availability of blood in case of emergency operations, etc. The analysis clearly highlights that utilization of public health facilities for the delivery care is also primarily increasing because of motivational efforts and support of key health workers like ASHAs/ANMs/VHNs. Also ASHA's home visits and counselling promotes utilization of family planning services primarily from public health facilities. Further, the visits and counselling promotes utilization of chronic disease control services for which most of the patients visit District Hospitals for the treatment. Holding of village health and nutrition days and meetings of village health and sanitation committees facilitates increased utilization of public health facilities for delivery care, postnatal care, children's immunization, family planning services, chronic disease control services, antenatal care. Similarly proximity to public health facility depicts strong impact on its utilization. Since peripheral health facilities like Sub Centres and Primary Health Centres are primarily utilized for antenatal and postnatal care, family planning services and children's immunization, thus further training and retraining of key health workers like ASHAs, ANMs and VHWs would further promote their utilization. Many a times ASHAs had expressed their desire to include vaccinating also in their training schedules and thus it would further strengthen children's immunizations and antenatal care programme. Since, utilization of FRUs, District Hospitals and Community Health Centers, is predominantly for institutional deliveries and seeking treatment of chronic ailments, thus further strengthening and consolidation of adequate facilities in such institutions and provision of referral or emergency transport in peripheral areas and centers would further promote wider utilization of public health facilities for obstetric care and further improve institutional deliveries.

In the conclusion it can be said that ASHA the lady health activist in the rural area is thus smoothening and promoting the health scenario of the rural women. Being a female she is working as custodian of the promotion of health status of females in her village. Interviewing the ASHA workers it is found that they are enjoying empowerment both social and economic empowerment. It has been found that this village lady with some basic education and health training performing the best. Her status in the family as well in the society has increased. Another important fact to be mentioned here is that the both the female is working as the promoter of health condition of the society one as a distributor( ASHA) and other as the receiver (the rural woman) of health care services.

#### VIII. ANALYSIS OF THE FINDINGS

- ✓ Many of the ASHAs are catering to a population of more than the stipulated norm of 1,000. Some population in some of the villages in the Budgam district is spread over large areas and intercepted by hills and rivers. Due to these natural barriers, the ASHAs even failed to visit certain areas and certain section of the population remained un - served and un-reached.
- ✓ The ASHAs are very keen on some of their job responsibilities like registration of pregnant women, ANC/ PNC, immunization, but the neglect areas are motivating the people for construction of toilets, participation in VHSC and development of comprehensive village health plan, family planning, adolescent education etc. The activities linked to financial incentives are getting priority and other activities are given less importance by the ASHAs.
- ✓ Transportation of expectant mothers is a major problem. In the villages, the transport services are not available specially at night time. Further the charges are much higher than the sanctioned amount for transportation. Since ASHA is the link between community and health service, any delay in transportation may lower her credibility in the community which may decrease her effectiveness.
- ✓ The entire compensation received by ASHAs per month is very low which is quite inadequate for their sustenance. The members in the community, PRIs and ANMs have indicated the inadequacy of the compensation to the ASHAs. Further majority of the ASHAs are not getting incentives in time. This is a negative motivational factor which needs to be tackled.
- ✓ Few of the ASHAs reported they received medicine kits which were incomplete in many respects. The majority of ASHAs lack knowledge on proper doses of drugs. They are not able to use AYUSH medicines that are in the kit because of lack of knowledge about the doses and utility of these drugs.
- ✓ While accompanying the expectant mothers to the institutions and staying there the ASHA has to incur more expenditure on food, stay etc. than the sum provided to her under the scheme.
- ✓ Another operational problem is when ASHA provide all the approved services of ANC and immunization but fail

to get the incentive if she missed the opportunity to accompany the mother to the health facility due to some reasons. The most important reason for such incidence is lack of communication on that critical moment, or due to the unwillingness of the beneficiaries to inform her. Besides, she also loses the incentive if the client opted for the delivery in private hospital or nursing home.

- ✓ More than a quarter of ASHAs are unable to conduct meeting in the community because they are unable to motivate the target group

#### IX. RECOMMENDATIONS: A WAY FORWARD

- ✓ An assessment of the population catered to by each ASHA should be made at the PHC and sub-centre level under the guidance of district NRHM office and redistribution of areas should be made among the ASHAs so as to keep the population norms limited to 1000 or less. In sparsely populated areas intercepted by hills and rivers, the norm should be relaxed.
- ✓ The neglected areas in her functioning are to work with VHSC which are either non - existence or non functional in most cases. The VHSC should be revamped or constituted and ASHAs should be motivated to prepare comprehensive health plan. Possibility of providing incentives for the purpose should be explored.
- ✓ ASHAs should also be oriented to give importance to the job of motivating for the family planning measures and adolescent education.
- ✓ Compensation for ASHAs should be suitably increased. Payment should be done at the work site without any delay through cheque. Possibility of making direct release of money up to PHC level should be explored by the NRHM. The compensation of the ASHAs in comparisons to her contribution is quite meagre. Further, capacity building and more compensation would encourage her to do the job with enthusiasm and spirit.
- ✓ While monitoring the performance of the ASHA the Village Health Committee should ensure that the disbursement of compensation to the ASHA and beneficiary mothers is timely and proper. The activities like formulation of village health plan through VHSC, awareness and motivation for construction of household latrines, motivation for family planning and adolescent education by the ASHAs should be monitored by the health authorities.
- ✓ Capacity building training should be imparted to the ASHAs by appropriate master trainers strictly following the training guidelines at PHC level preferably in residential mode.
- ✓ Refresher training at regular interval should be imparted at PHC block and district level on specific topics.
- ✓ The irregularity in the area of supply of medicine kits should be investigated and appropriate action should be taken. The ASHAs must get the medicine kits complete in all respects and replenished regularly.
- ✓ The sub-centre should be equipped with infrastructure, logistics and instruments so that non-complicated normal

delivery can be conducted by the trained staff at the sub - centre level in remote inaccessible areas.

- ✓ Possibility of providing mobile phones to the ASHAs could be considered so that they can have connectivity with the community and health facility, transport vehicles, without any hassles.
- ✓ In the context of our literature review, our study, our analysis of the findings, and on the basis of the broad knowledge and experience of the authors, I suggest the following recommendations for the improvement of ASHAs' performance in India in the categories of Recruitment, Roles and Responsibilities, Training, Incentives and Compensation, and Supervision and Monitoring.

#### RECRUITMENT (for future ASHA recruitment)

- ✓ Ensure community involvement in selection of ASHAs
- ✓ Ensure ASHA is motivated, has leadership skills, and perhaps most importantly, has the ability to communicate ideas and learnings in a way that is comprehensible and accepted by the community
- ✓ Consider implementing a knowledge test for hiring of new ASHAs
  - Given that mere education level as a recruitment criteria has often not shown to be indicative of a community health worker's capability to perform her work, a brief aptitude test can be considered. Candidates can be provided with brief reading materials in advance, and be tested on these materials to determine comprehension and communication. If proven to be a successful criteria of selection, this may eventually replace the education criteria.
- ✓ Ensure ASHA candidate is fully aware of her roles and responsibilities and the potential financial rewards and future career track
- ✓ Ensure that the appropriate number of ASHAs are in place in order for each ASHAs coverage population to be limited to 1000
  - Develop a mechanism to recruit additional ASHAs as needed in order to keep up with the increasing rural population

#### X. ROLES AND RESPONSIBILITIES

- ✓ Develop a clearly defined, finite list of responsibilities for the ASHA so that she is fully aware of the roles and activities she must fulfil\*16
  - A suggested list of responsibilities and skills needed is included in Appendix 3
  - Ensure that distinct roles and responsibilities are clearly communicated between the ASHA, ANM, and AWW, to avoid overlap and increase efficiency
- ✓ Re-examine responsibilities of ASHAs to streamline responsibilities and maximize benefit (public health, incentives, and otherwise) between other key health workers in area

- ✓ On the other hand, consider expanding the ASHAs role to conduct additional activities that are within her capabilities
  - Consider additional activities that have a significant public health impact, local demand, complement existing outreach, and those that ASHAs express a desire to be part of; such activities include, for example, additional focus on disease management, newborn care\*, referral for complications, etc.,
- ✓ Consider appointing an additional *female* community worker who is dedicated to nutrition activities, to complement the ASHAs work.

#### TRAINING

- ✓ Induction training should be decentralized to the district level to ensure that all new ASHAs receive training before working in the field
- ✓ A full-time training structure and full-time trainers should be implemented in order to ensure that there are no gaps in training in each state.
- ✓ Consider condensing ASHA training modules to a shorter, concise version, given that ASHAs are currently not able to digest the amount of information conveyed in these books
- ✓ During training sessions, include lessons for ASHAs on how to convey complex information in a simplistic manner (in addition to content-based training)
- ✓ Develop and provide ASHAs with pictorial job aids for each key health topic that is easily transportable to help ASHAs during their activities\*
  - ASHAs require a very clear, tangible aid in order to assist in their ability to remember key information and clearly communicate this information when doing outreach work
- ✓ Provide a brief, two day refresher training for all ASHAs on a yearly basis with a newly developed, condensed syllabus
- ✓ Implement —ASHA Radio, an innovation seen in Assam, in all states in order to provide ASHAs with a new and interesting avenue through which they receive on going on-the-job training as well as information about new illnesses and important events
- ✓ Revamp training for use of medical kits, in order to ensure ASHAs are aware of how and when to use each medicine, how to ensure constant supply of medicine, and how to use the medical kit in a way to complement their work\*.

#### XI. INCENTIVES/COMPENSATION

The NHSRC recommendations for the ASHA programme indicate that ASHAs should be provided a monthly-retainer related to her standard activities, on top of which performance-based incentives should be provided; this thinking aligns with earlier recommendations that have not been included in this paper.

- ✓ Provide ASHAs with identity cards and uniforms so as to increase their recognition in the community
- ✓ Increase compensation for travel-related and other miscellaneous expenses
  - Derive an algorithm for providing compensation for travel based on cost of transportation methods and distances to cover; for example, ASHAs in rural areas will have fewer methods of transportation and longer distances to travel
  - Provide compensation for food provided during Village Health and Nutrition Days in order to ensure ASHAs are not paying for this with their own money
  - Provide each ASHA with a bicycle as a potential mode of transportation
- ✓ Provide ASHAs with waiting room facilities at PHCs, CHCs, and Hospitals so that they have a comfortable place to stay when they accompany their patients for institutional delivery
- ✓ Consider providing ASHAs with mobile phones and/or monetary credit for phones in order to increase accessibility and communication between ASHAs and other health workers and supervisors
- ✓ Provide greater monetary incentive for birth spacing
  - For example, provide a monetary incentive for ASHAs who successfully encourage a woman to insert an IUD (intrauterine contraceptive device) within the first month of delivering her first child
  - Consider spacing schemes for families and supporting ASHA for couples to wait before having children
- ✓ Increase monetary incentives for permanent methods of birth control, including tubectomy and non-scalpel vasectomy, and make the incentives equal for both methods
- ✓ Provide monetary compensation for ASHA for each stage of a woman's pregnancy and/or point of service provision for each child a woman delivers, irrespective of pregnancy number\*
  - For example, provide monetary incentives for registration of pregnant woman, for each antenatal care visit, and for institutional delivery, to ensure ASHA is compensated throughout the woman's pregnancy
  - Consider providing monetary incentive for home-based newborn follow-up
- ✓ Provide monetary incentives for full immunizations beyond primary immunizations (e.g. boosters, Vitamin A)
- ✓ Ensure all ASHAs have bank accounts
  - During induction training, assist each individual ASHA to create a bank account in her name
  - For incentives, ensure that all payments to ASHAs are made through wire transfer only (no checks or cash payments)
- ✓ Reduce delays in compensation\*
  - Ensure all payments are made through wire transfers (eliminate use of check and cash payments)
  - Consider implementing a regular schedule for paying each ASHA; for example, keep a log of all the

activities completed during the month and pay each ASHA at the end of the month on a regular basis

- Provide ASHAs with self-addressed post-cards for them to fill out when they experience delays, or provide a phone number they can SMS to report delays; make someone in the Health department responsible to follow up with compensation delays\*
- ✓ Provide increased opportunity for upward movement for ASHAs, in order to motivate engagement and continued performance\*
- For example, consider performance-based bonuses or an increase in incentives for every year of completion
- Consider enrolling an ASHA into a training school to become an ANM after five years of work and successful recommendations

## XII. SUPERVISION AND MONITORING

- ✓ Assign a specific supervisor for ASHAs so that there is specific oversight and monitoring of ASHAs' performance
  - All states should fulfil the current mandate to implement the —ASHA Facilitator role (as in Assam) as a supervisor who keeps track of ASHAs' performance
  - Given that ANMs have a critical working relationship with ASHAs, it is also imperative that they be provided support to make this relationship an effective one, both in terms of data reporting as well as task defining; for example, ANMs should not only be trained on technical activities, but also on how to manage and follow up on data that the receive from ASHAs
- ✓ Institute a formal review process every six months so that ASHAs performance is monitored and tracked\*
  - This can perhaps form the basis for performance/growth related bonuses and upward movement in their careers
  - Ensure that this additional monitoring is done with minimal additional paperwork

## A SNAPSHOT - A NEW INNOVATION FOR ONGOING TRAINING FOR ASHAs

- ✓ ASHAs play a major role in the implementation of all MCH related schemes of NRHM, as they are the ones who directly communicate with the community that they belong to. Therefore, NRHM recognizes the importance of keeping ASHAs updated with various kind of information related to MCH services and schemes, building communication capacity enabling them to effectively engage at the family level and hold dialogues with mothers. Keeping this communication need in mind, The ASHA radio programme an initiative of NRHM, the programme also targets the health issues that are prevalent in the community keeping the community as the target

audience. In this way, the ASHAs can work effectively as they are aware about the current programmes and health issues that need to be discussed with the community

- ✓ The ASHA Radio Programme is a useful tool to upgrade the knowledge level of ASHAs regarding various aspects of health (Importance of Immunization, Family Planning, Safe Drinking Water, Malaria, Anemia, Breastfeeding, Diarrhea, Sanitation, Measles, Tuberculosis, Anti-Tobacco and other health related issues prevalent in the community), communication and hygiene, practices. The state also runs health campaigns (anemia, Vitamin A, etc.) every month and this helps in getting the community to attend VHNDs to avail free services and freebies that are associated with the monthly health campaign.
- ✓ The programme is broadcast on Wednesdays during day & this has further helped the cause as it provides an opportunity for the ASHA to have the village women listen to these programmes who have gathered at the Anganwadi centers..
- ✓ The ASHAs can provide feedback as well as write into the programme if they have any questions on pre-paid postcards that are provided to them from the PHC. The queries received by All India Radio are shared with NRHM. This feedback mechanism is very useful way of obtaining information from the ground with regard to programme functioning. However it is also essential to address these queries over the next programme broadcast. Other feedback mechanisms such as SMS, Telephone complaint services could be looked at to increase the efficiency of receiving feedback.
- ✓ However, there are challenges due to poor radio signal in many areas of the state, which needs to be addressed along with sustaining the interest of the community & the ASHAs in the programme by innovative measures, and addressing the communication needs properly.

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