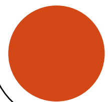
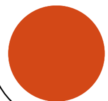
The ASHA in Maternal Health

Roles, Outcomes and Challenges



What the presentation covers

- Brief Update on the ASHA programme
- Role of ASHA in maternal health: Functionality and Effectiveness
- Challenges and Opportunities



Important Milestones and Current Figures

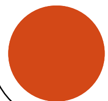
2006: ASHAs for 18 high focus states and in tribal districts in others

2009: Demand from other states: Scaled up across the country.

Now: 8.63 lakh ASHAs except in Goa, non tribal areas of Tamil Nadu, Puducherry, and Chandigarh

	ASHAs selected	Population Density
High Focus States	489424	1/895
North Eastern States	53785	1/692
Non High Focus States	319457	1/999*
Union Territories	790	1/635
Total	**863521**	

**Excluding Delhi and Tamil Nadu*



Who is an ASHA?

- Woman : Local residence: one ASHA per 1000 population, covers smaller population in geographically dispersed areas
- Selected by the community , facilitated by NGOs/ANMs Gram Sabha decides, and endorsed by Gram Panchayat.
- Preferably married
- Education : preference for at least 8th class schooling, relaxed in areas where candidates are not available
- Works 3-5 hours a day , 15 to 18 hours a week
- Forms a team with the AWW and ANM
- Integral part of the Village Health, Sanitation and Nutritio Committee

How does the ASHA spend her time?

1. ***Home Visits:*** all houses initially, families at risk- subsequently and then visits to priority HH- approximately 15 to 18 hours per week.
2. ***VHND participation:*** Platform where all outreach services are provided: Immunization, ANC, PNC- approx. one day per month.
3. ***Visits to a health facility-*** the review meeting, (1 day pe escort function- as required
4. ***Village level meeting***: convening VHSNC, SHGs (appr three hours/month)
5. Maintaining **her** diary and register- not more than one hour- except when initially developed

Three complementary roles of the ASHA

A. ***A facilitator or link worker*** – where there is low use of health services, the ASHA enables people to access health services

B. ***A volunteer and activist-*** to enable access to health entitlements and reaching the marginalized.

C. ***A community level care provider-*** important for he credibility, to respond to local health needs, particular in in underserved areas. Closely linked to healt outcomes

- *All three roles defined in the guidelines: initially a lir worker in in the RCH 2 design, active civil socie intervention enabled the articulation to incorporate a three roles*
- **Getting the mix right is the challenge. If limited to link worker role – she is unable to reach the marginal this results in a huge missed opportunity to save lives.**

Other Key Features of the programme

1. Continued Training and Support – 15 to 20 days per year.
2. Support structures: The facilitator, the block and district coordinator, and the state ASHA resource center and state programme management.
3. Drug kit, an equipment kit and a communication kit to facilitate her tasks
4. Performance Based Incentives
5. State- NGO partnership at all levels- through ASHA mentoring groups, involving NGOs in training, support and supervision
6. Supportive village level collectives- VHSNC
7. A Performance Monitoring System

How is she Supported?

Sub block

- ASHA Facilitator and ANM

Block

- VHSN
- ASHA Mobilizer
- Block Programme Manager

District

- Accounts/ Data assistant
- Manager
- ASHA Resource Centre

State

- DPM/ District
- State Health Society
- ASHA Mentoring

Status of Support structures -
At state , district, block and sub block level

At all four levels	At three levels	At two levels	At one level or none
Bihar Chhattisgarh Jharkhand Rajasthan Uttrakhand	Madhya Pradesh Orissa	Uttar Pradesh	
Tripura	Arunachal Pradesh Assam Manipur Meghalaya Nagaland		Mizoram Sikkim
Maharashtra	Gujarat Karnataka Punjab	Delhi	Andhra Pradesh Haryana J & K Kerala Tamil Nadu

Training Modules

- ✓ Module 1 to 4 – Intro; MCH; Family Planning, ARSH; 4 – National Health Programmes, AYUSH and Management of minor illness
- ✓ Module 5- Leadership and Empowerment
- ✓ Module 6 & 7 – Skills that Save lives – competency based modules for developing life saving skills. Duration: 20 days- in four rounds of five days each. Ideally within 18 months.

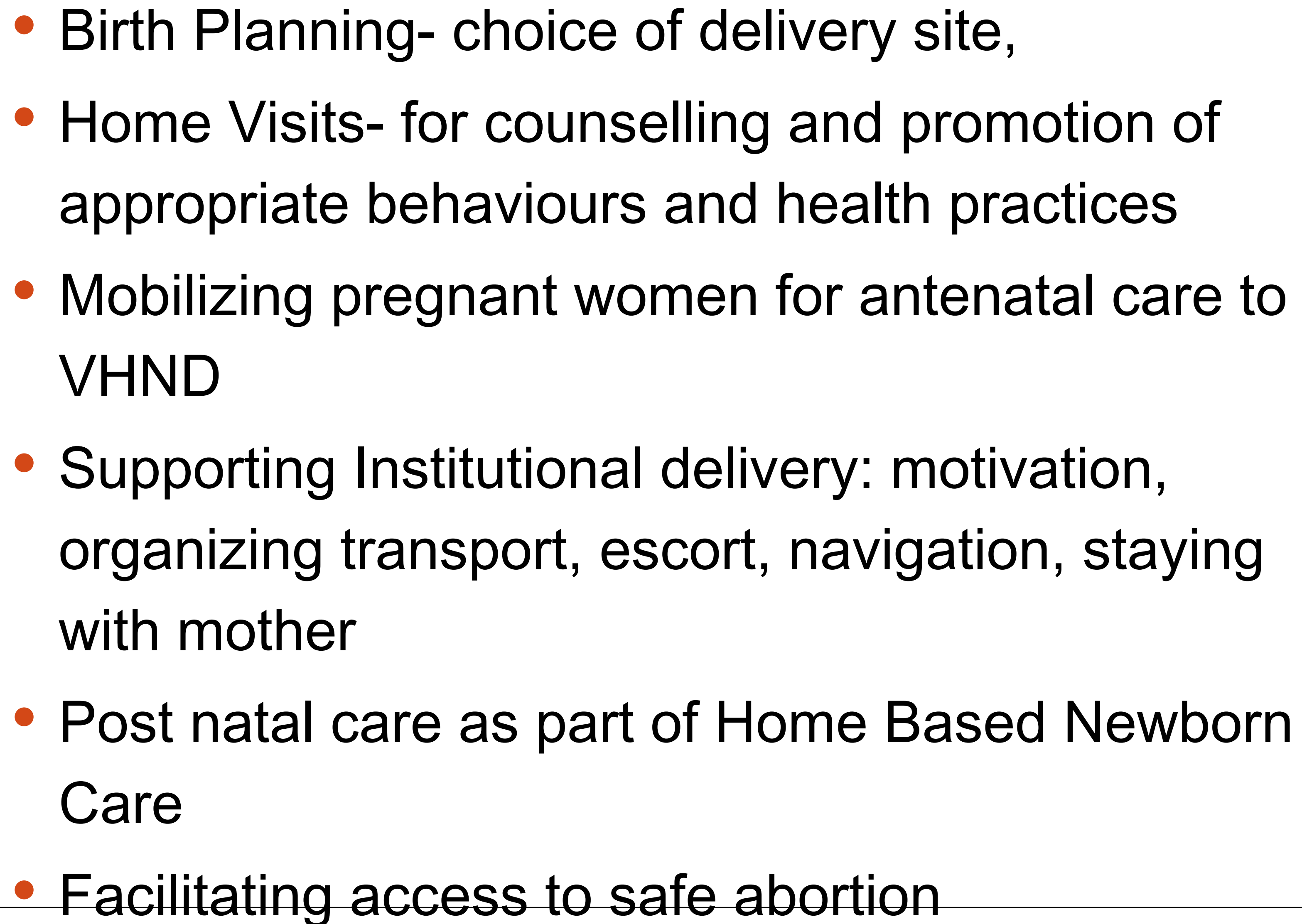
Incentives and Payments : existing status

- A mix of monetary and non monetary incentives:
- Performance based incentives for over 30 specific tasks
- Most regular the JSY, Immunization- Others: DOTS, FP, HBNC, Sanitation
- Fixed + Performance based in –Rajasthan, Sikkim, Kerala, and West Bengal
- Findings from surveys and evaluations show that ASHAs earn on an average – Rs.500 – Rs.1000 per month.
- Majority of the states reported over 90% ASHAs have bank accounts : Delays are fewer but exist

Non Monetary Incentives

- ID- cards for self esteem and helps to negotiate the health center.
- ASHA help desk, ASHA rest houses, ASHA help line
- Pension schemes, welfare fund, scholarships, ASHA Radio /ASHA newsletter, Common uniform, Bicycle, cell phones, umbrella

The role of the ASHA in Maternal Health....JSY and more



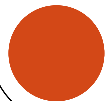
The ASHA in maternal health…..
What the evaluations tell us..

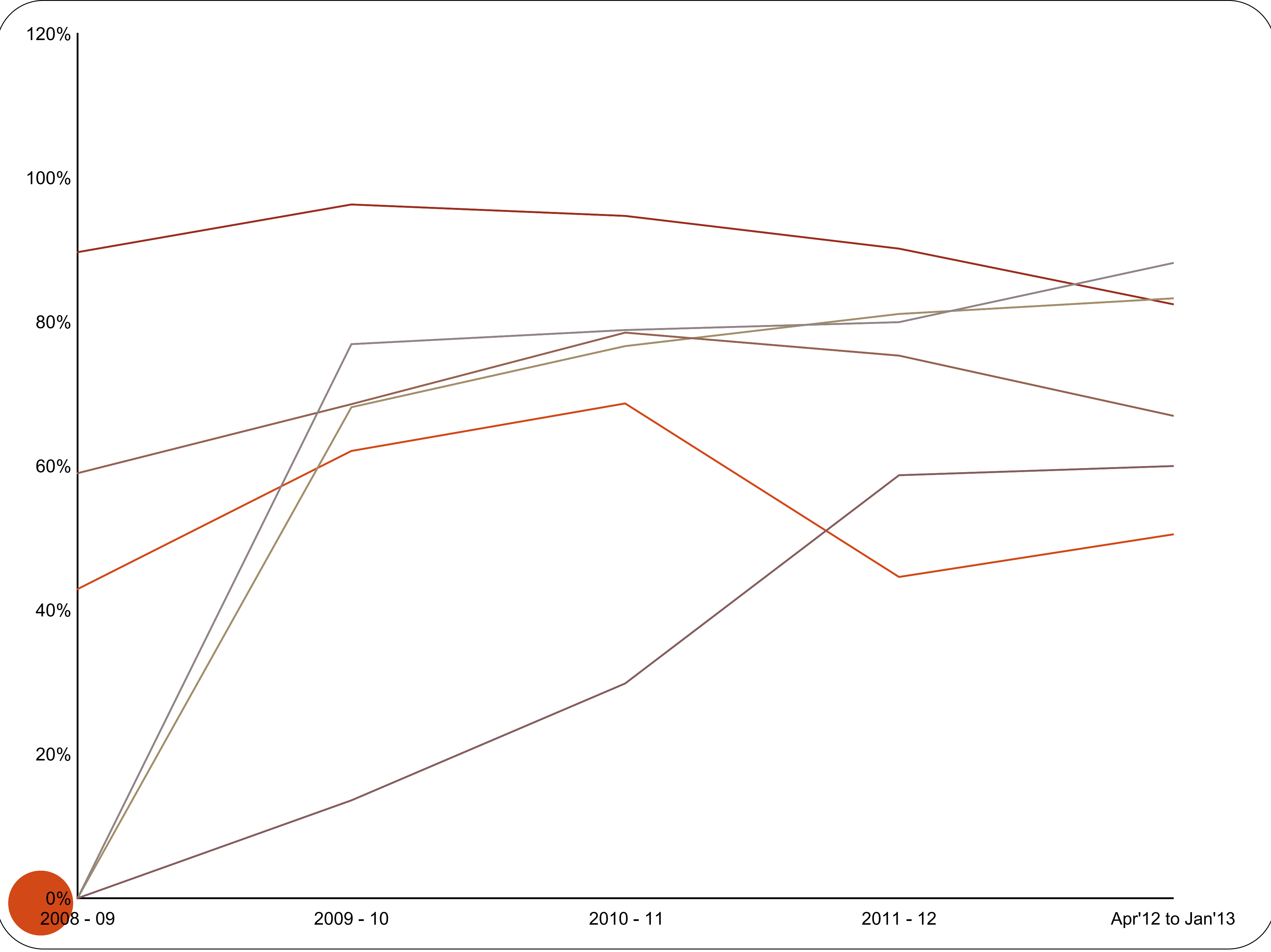
How Functional? How Effective?

A Functional ASHA and an Effective ASHA

Functionality = (combination of Training Content, Support/Incentive Policy, Role perception as mandated by supervisors , **and** her own perception (agency)

Effectiveness-= Functionality + Skills + Systems Support (supplies, transport, access to referral, quality of care)

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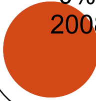

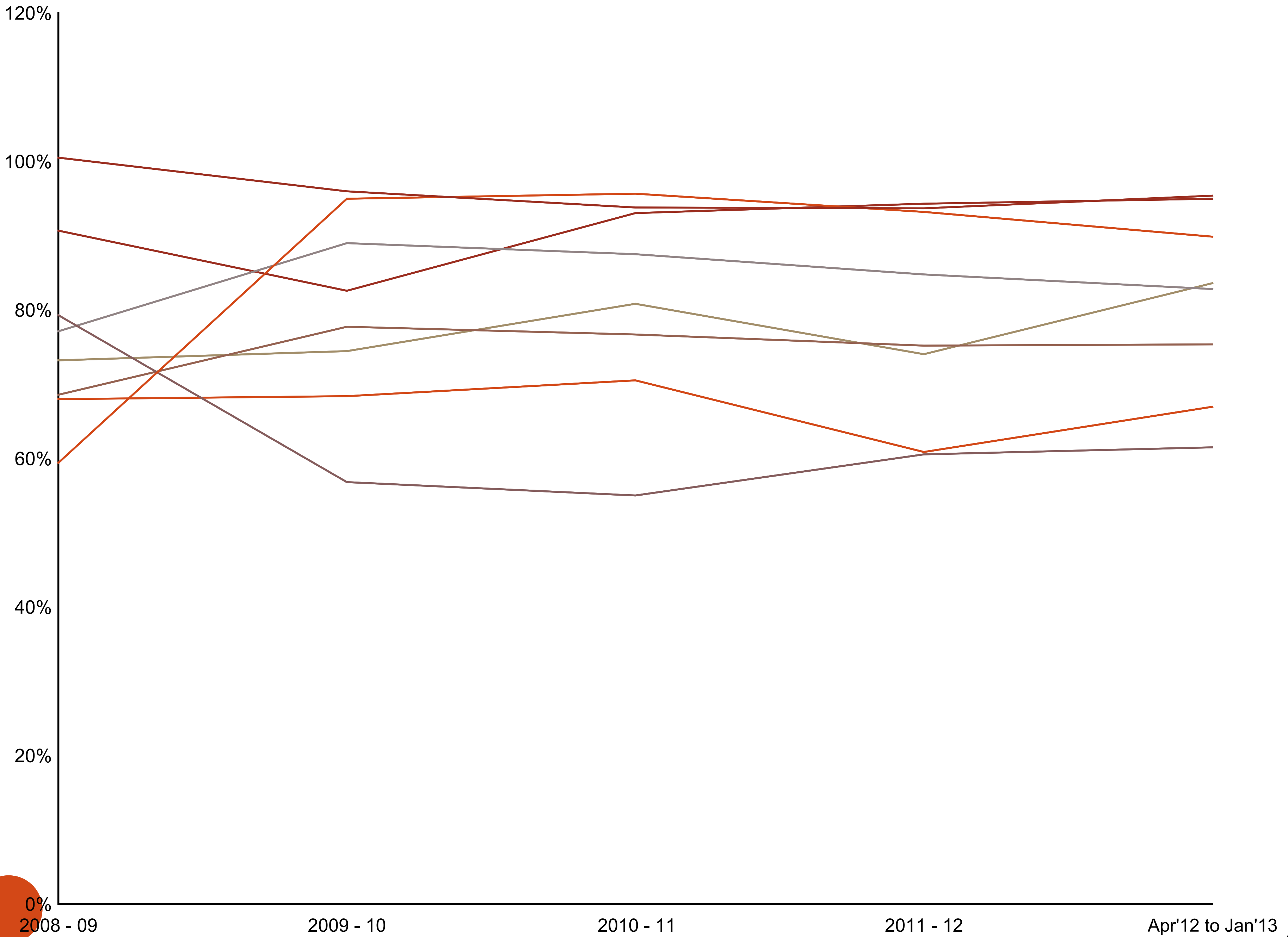
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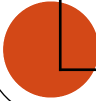

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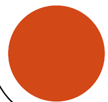
Role played by ASHA at the institution in cases where she escorted the women for delivery

Sample size - Institutional Deliveries - **2759**	**% of cases when ASHA escorted women**	Helped in getting admission	Helped in receiving treatment faster	Helped in buying the drugs	Provide encouragement	Helped in taking care of the newborn child	Helped in getting JSY incentive	Helped in obtaining food
All	**66.9**	**82**	**61.3**	**34**	**29.3**	**28.4**	**34.2**	**6**
Madhepura	81.6	96.1	69.8	40.3	34.9	27.9	25.6	2.3
Raigarh	45.9	78.9	58.9	23.3	22.2	11.1	12.2	1.1
Koriya	61	81.3	55.6	29.2	40.3	25	17.4	6.3
Bastar	69.1	76.9	53.8	20	36.9	26.9	11.5	4.6
Garwah	49	76.2	41.6	12.9	10.9	3	13.9	0
Dumka	45.3	88.3	90.9	51.9	55.8	29.9	27.3	9.1
Anugul	94.3	73.4	67	47.2	23.4	25.9	58.2	9.6
Nabrangpur	94.3	81.4	70.7	28.9	38.9	39.3	44.6	8.2
Morena	56.3	95	85.5	62	29.6	27.9	44.1	5
Hanumangarh	38.3	83.8	55	17.1	36.9	29.7	21.6	0.9
Kaushambhi	91.9	81.2	34.9	27.2	12.3	41	44.1	8.4
Bageshwar	53.8	74.6	55.6	30.2	25.4	12.7	7.9	4.8

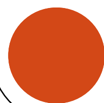
PNC visits of ASHA and ANM

	ASHA			**ANM**			**ASHA**	**ANM**
	<1st day	2nd-3rd day	4th-7th day	<1st day	2nd-3rd day	4th-7th day	Never	Never
All	**23.1**	**34.3**	**19.9**	**3.7**	**8.7**	**7.4**	**32.1**	**62.4**
Madhepura	36.7	32.9	19	5.1	3.2	0	20.3	84.8
Raigarh	19.9	23.5	17.3	8.7	8.7	7.1	40.8	75
Koriya	25.4	28.8	17.8	6.8	10.2	3.4	33.5	77.5
Bastar	47.3	42	26.6	4.8	13.8	11.7	20.2	57.4
Garwah	7.3	15	4.9	0	1	0.5	61.7	96.1
Dumka	41.2	19.4	9.4	2.9	4.1	1.2	40.6	61.8
Anugul	22.7	65.2	55.9	4.7	14.4	16.7	0	0
Nabrangpur	36.7	49.8	12.1	6.1	18.2	19.9	0	0
Morena	16	19.8	6.3	0.3	4.4	1.6	52.2	86.2
Hanumangarh	13.1	26.6	16.6	3.8	14.1	11.7	56.6	71
Kaushambhi	9.9	45.1	28.5	0.4	0.7	1.1	26.1	94.7
Bageshwar	11.1	22.2	13.7	2.6	5.1	5.1	49.6	83.8



From Household listing- 22,992 women

Proportion of Women with parity >1 who had delivery at home during previous pregnancy and opted for Institutional Delivery for their recent pregnancy - N-1777

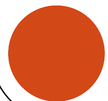


Coverage

	Service user A	Service User B
Kerala	84.69	90.44
Orissa	75.87	75.31
W.B	67.24	81.87
Assam	76.89	67.19
Rajasthan	76.43	67.44
AP	**49.90**	**76.79**
Bihar	**72.54**	**45.20**
Jharkhand	**59.67**	**46.49**

Reasons for low coverage (16-51% being missed)

- Geographic dispersion
- Social barriers and marginalization
- Inability to respond to felt needs due to low skills and poor support.
- Little understanding of necessity of universal care- voluntary- so does what she can do easily or only reaching those who are likely to bring in an incentive



Range of Services

	Kerala	Orissa	WB	Assam	Raj	AP	Bihar	Jhar
Counseling women on all aspects of pregnancy	96.5	94	98.9	85.5	89.5	95	71	76.6
Accompanying women for delivery	57	94.5	52.2	92.5	86.5	93	94	89.3
Village or collective meeting	90	78	53.8	34.5	43	78.5	16	36
Visiting new born	90.5	92	84.8	55	76	91.5	66	20.8
Promotion & coordination for immunization	95.5	90.5	83.7	81	88.5	92	93	82.7
House hold visits	97	87.5	91.8	66.5	69.5	89	67	56.9
Nutrition counseling	88.5	70.5	72.8	25.5	53.5	87	39	46.7
Malaria related work	58.5	80	51.6	20.5	31.5	66.5	17	30.5
Consultation for minor illnesses without drug kit	58	66	45.1	40	27.5	43	9	16.8
Consultation for minor illness and use of drug kit	80	63.5	33.7	29	38.5	69	8.5	20.3
Tuberculosis related work	72	52	46.7	11	18	58.5	42	20.8

Functionality – % of service users A who were visited at least thrice by ASHA during antenatal period

Kerala – 86%,
Orissa- 73%, WB-75%,
Assam-67%,
Rajasthan- 61%,
AP-79%,
Bihar- 59%,
Jharkhand- 60%

Kerala- 89%,
Orissa- 70%,
WB- 49%,
Assam-54%,
Rajasthan- 52%,
AP- 82%,
Bihar- 21%,
Jharkhand- 51%

Effectiveness- % of service users A who received three ANCs or more

Care in Pregnancy

Kerala- 25%,
Orissa- 37%, WB- 26%,
Assam-18%,
Rajasthan- 26%,
AP- 33%,
Bihar- 26%,
Jharkhand- 27%

Skills- Foul smelling discharge as danger sign to look for.

Kerala- 97%,
Orissa- 93%,
WB- 65%,
Assam-72%,
Rajasthan & AP- 94%,
Bihar- 82%,
Jharkhand- 54%

Effectiveness- % of service users A who opted for institution delivery

Findings from the evaluation

- Performance correlated to role perception and consequent support.
- No co-relation of skills to education level- some co-relation to duration and quality of training.
- Training modules 2, 3 and 4 were surprisingly weak in the core messages.
- No trainer module to help transact skills, and no standardization of training.
- Strong perception amongst many implementers that ASHA should be only a link worker – so training and support structure given short shrift - ASHA is not seen as needing skills to help in illness or in behavior change or even identify danger signs
- Consequence- (at its worst) ASHA becomes a commission agent; gaming the system by reaching those likely to yield an incentive;
- States with weak perception of the mix of roles lagged behind in support structures and training- exclusive focus on incentives.

Findings from the evaluation

- Not uniformly an activist- but there is a significant minority, engaged in one or more of a range of possible activist functions.
- Overall 30% of the population still not being reached.
- ASHA represents a missed opportunity in addressing community based care for mothers, newborns, and children.
- Linkages to private sector – less than 5% in most districts sampled- occasional higher; but largely due to a collapsed public system.
- Drop-outs- not more than 5%.

Looking Ahead- Building a long term strategy

Three Sources of Resistance

- ***Professional***
  - Concerns about loss of custom
  - Concerns about demystification
- ***Industry***
  - Concerns about how she changes the public-private balance.
  - Current Inability- not necessarily always- to recruit her for marketing- social or otherwise.
  - The RMP is their natural ally- pharma and health care industry already has a nexus in place.
- ***Civil Society (sections)***
  - India: G 20,
  - "Poor Quality care for Poor women"

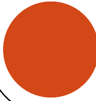
What we need to do now…

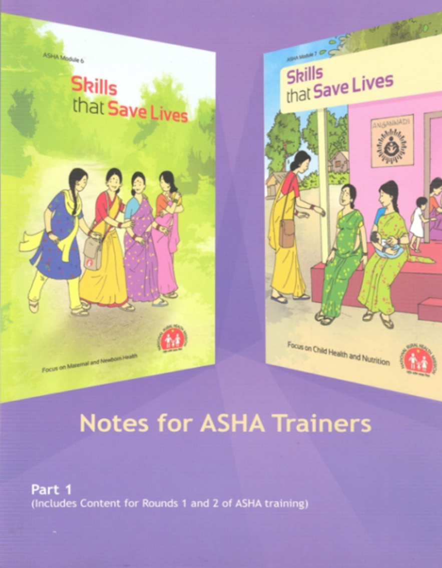
- **Pilot Models for improving community health care; CHILTS**- Community Health Innovations for Learning and Training Sites.

- **Estimate the CHW time, training and support requirements for each task added to her work load: E**mbed this in a continuity of care plan.

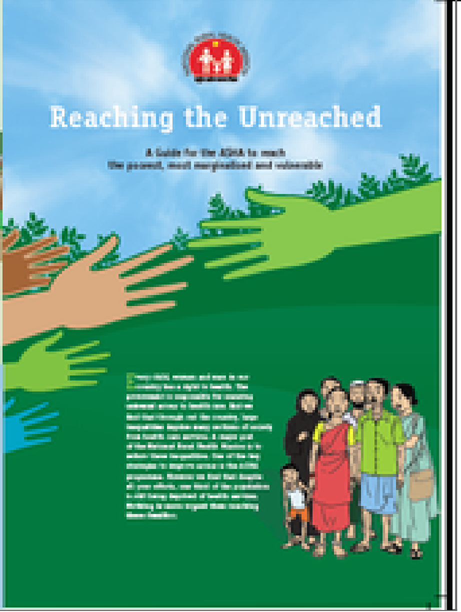
- **Stabilize the first ASHA- introducing certification**

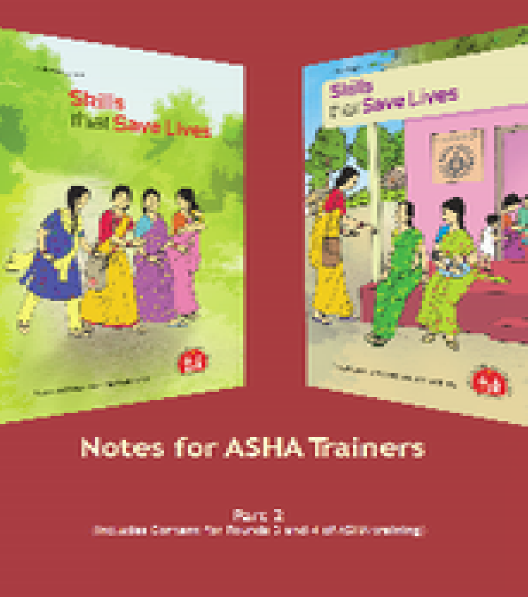
Basic Content of Equipment Kit

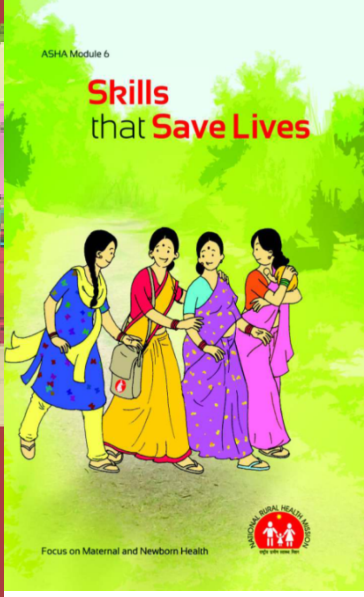


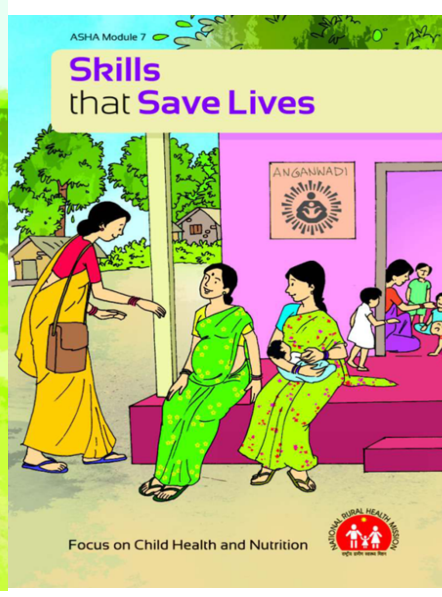


The Eight Fold Path









Training material

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Thank You