Capacity Building of ASHA in the Monthly Meeting Platforms in PHC and CHC in Uttar Pradesh, India

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Research Article

ABSTRACT

Introduction

The engagement of women community health workers has been recognized as one key strategy to tackle the emergent shortage of health workers in developing countries. The ASHAs are instituted by the state as part of National Rural Health Mission of the Government of India for the grassroots health care delivery. The capacity building initiatives and empowerment of the local women are crucial for effective health care delivery of large section of rural population. The current study explores some of the crucial variables of the capacity building initiatives at the monthly meeting platforms at CHC/PHC in the state of UP.

Research Methodology

A total of four districts of Uttar Pradesh were selected purposively for the study and the data collection was conducted in the villages of the respective districts with the help of a pre-tested structured interview schedule with both close-ended and open-ended questions. In addition, in-depth interviews were also conducted amongst the ASHAs and a total 250 respondents had participated in the study.

Results

A large majority (90 percent) of the ASHAs attended and benefitted from the monthly meetings at various PHCs in their respective districts. The total duration of these meetings varied from 2-3 hours each in different districts and mainly the agenda of these meetings were review of daily work, training and problem solving. Additionally various other topics were covered in the meetings such as cord care and new-born care; however certain topics such as interpersonal skills, gender and equity were not dealt adequately. Difficulty and poor attendance in the meetings were also reported from Banda District of Bundelkhand region due to inaccessibility, challenges in travelling and frequent rescheduling of the meetings. Primarily the Health Education Officers were the leading facilitators of these meetings in the four districts. The benefits of these meetings were cited by the ASHAs as those built their level of confidence while working in the community and the inputs also enhanced the required level of knowledge on different health issues. At the same time, they also reported that their counseling skills as well as the quality of home visits had improved.

Conclusions

The process of capacity building of ASHAs in the monthly meeting platforms could be considered as a significant strategy in developing the community health workforce. These meetings and training platforms are optimally utilized to

improve the level of motivation, confidence, work skills, quality and quantity of their home visits. The meetings are more effective if the areas such as regular guidance, work related problem solving, record keeping and documentation of activities were discussed frequently.

Keywords: ASHA, Community Health Workers, Community Participation, Empowerment

INTRODUCTION

Worldwide there is growing significance in the community health workers (CHW) programme; however, is a paucity of evidence with respect to CHWs' role in community participation and empowerment. Utilizing community members to provide certain essential health services to the communities they come from is a concept that has been around for at least six decades. In India, the Accredited Social Health Activists (ASHAs) are the community health workers instituted by the Ministry of Health and Family Welfare (MoHFW) as part of the National Rural Health Mission (NRHM) [1]. The health sector in India is rather intriguing while there is continuous improvement in health indicators; the development is not on par with India's impressive economic growth [2]. Thus considering the large population size of the country it necessitates involvement and engagement of adequate number of significant primary field staffs, who provide outreach services at the point of care, often in the patient's home. In case of any further need for additional diagnostic and clinical interventions, the patients are transported to the Primary Health Centers for the evaluation and treatment of a Medical Officer.

Background of ASHAs

The ASHAs emerged in India's public health system during the launch of NRHM in 2005; the same pioneering impetus was witnessed in the state of Uttar Pradesh. Their induction training included the GOI-prescribed introductory module which includes a total of 8 training modules over a 23 day training schedule. In 2007-08, with the efforts of the Vistaar project (2006-2012), the program implementation plan utilized the existing platform of monthly meetings at the PHC and CHC level for continued capacity building of the ASHAs [3]. These meeting platforms were designed to upgrade the capacities of ASHAs so that they can improve their performance, alongside the priorities of the community and the structure of the health care delivery system [4].

In each block, the ASHAs are divided into four groups and monthly meetings are held for each group, which the ASHAs are expected to attend. In the initial phase, the emphasis was given on home-based newborn care, as the government of UP was rolling out the comprehensive child survival program [5]. Although they are appointed by Panchayati Raj Institutions (PRI), the ASHAs perceive themselves as incentive-based workers of the public health system; they do not link themselves with the PRI [6]. The community behavior tracking survey conducted in UP in 2015 also studies these platforms as capacity building of ASHAs. It recommends qualitative improvement in the use of these platforms so that it leads to effective interaction between the community and frontline workers like ASHAs [7]. Another study in 2012 states that educational qualification of ASHAs did not make a difference to health outcomes but duration and content of training did make a difference [8]. This establishes the importance of the monthly platforms at the CHCs and PHCs. The evaluation study of the Comprehensive Child Survival Program mentioned above also emphasizes on the effective use of these monthly platforms to build the capacity of ASHAs in the state of Uttar Pradesh [5]. The current study done in 2016 examines the status of these platforms, process of using these platforms, explores how the ASHAs have benefited from the process and how they have used the learning in their work.

RESEARCH METHODOLOGY

Using purposive sampling technique, four districts were chosen from the four different economic regions of UP, namely Central, Eastern, Western and Bundelkhand. Further, the Government of UP in 2009 categorized the districts as per their development status using a composition of 36 indicators. Purposefully, the high developed district chosen for the study is Saharanpur from the western region, the medium developed district chosen for the study is Barabanki from the central region, the low developed district chosen for the study is Gonda from the eastern region and the very low developed district chosen for the study is Banda from the Bundelkhand region [9].

In the next step, purposefully two blocks were selected from each of the district and all the ASHAs in these blocks were chosen as the universe for the study. From the list of all the ASHAs in each of the two blocks, 31 ASHAs were chosen randomly from each block for the study. In this way, 62 ASHAs were chosen for the study from each of the districts. In Gonda district, 64 ASHAs were selected to make the total number of ASHAs for the study to 250. The data was analyzed using SPSS software to calculate the mean, median, standard deviation, minimum and maximum values of ASHAs attending these meetings at the PHC and CHC in the four study districts. The qualitative data was grouped into common thematic areas that emerged in the study which forms the basis of the ensuing results and discussion.

Research Tools

The ASHAs were interviewed using an in-depth, open-ended interview schedule which included a section on variables on socio-demographic and capacity building. The flow of the interview schedule had the identification particulars of the ASHAs in the first section. The next section was on the status and opinion of ASHAs on the training and monthly meetings at the CHC or PHCs. Subsequently the sections on the feedback of ASHAs on monthly meetings based on the work carried out in the field were included. The section dealt with the kind of topics covered during these monthly meetings and about the facilitators of these meetings. Finally, the ASHAs were requested to reply on how these learning experiences were helpful in their daily work/activities; thus indicating their perceived efficacy of the capacity building modules at the monthly meetings.

RESULTS AND DISCUSSIONS

In the following **Table 1**, the status and opinion of ASHAs on training and monthly meetings at the CHC or PHC is detailed.

Table 1. Status and Opinion of ASHAs on Training and Monthly Meetings at CHC/PHC.

District	Banda	Barabanki	Gonda	Saharanpur
No of ASHAs surveyed (n=250)	62	62	64	62
Percentage of ASHAs attending meetings	100	100	100	96.6
Percentage of responses that meetings are held on notified dates	90.4	100	100	96.8
Average duration of meetings (in hours)	2.8	2.18	2.39	2.14

The data in the above **Table 1** refers to the capacity building of ASHAs in the monthly meetings at the PHC/CHC; this platform was utilized for refresher and continued training for ASHAs. The data reflects that more than 90% of the ASHAs attended these meetings and over 90% of the meetings were held on the notified dates. Further, among the four districts, ASHAs of Banda district indicated that the least adherence of meetings to the notified dates. This could be attributed to the topography of Bundelkhand region that includes Banda district where the ASHAs face difficulties to travel from their village to the PHCs or CHCs. Another reason is the rescheduling of these meetings without prior information to all the ASHAs. The average duration of these meetings ranged from 2 to 3 hours and in each meeting and 30-35 ASHAs attended these meeting which are also verified from the PHC record.

Table 2. Number of ASHAs Who Normally Attend the Meeting with the Respondent.

Districts	Mean	Std. Deviation	Median	Minimum	Maximum
Banda	33.26	17.104	30.00	2	88
Barabanki	31.00	4.443	30.00	18	40
Gonda	28.78	6.565	30.00	15	42
Saharanpur	36.37	10.119	40.00	1	50
Total	32.32	10.975	32.00	1	88

The above **Table 2** shows that there is significant variation in attendance across all districts. In Saharanpur and Banda, the ASHAs reported that the meetings were frequently rescheduled without prior information; hence these two districts have low minimum score.

Table 3. Percentage of ASHAs Providing Feedback on Various Work Done in the Monthly Meetings.

District	Banda	Barabanki	Gonda	Saharanpur
Training/capacity building session	100	98.4	98.4	100
Review of work	100	100	100	100

Submission of report	100	87.1	100	91.9
Problem identification/solving	100	83.9	90.7	91.9
Sharing of work related data	100	82.3	96.9	90.4

The above **Table 3** indicates that in these meetings, more than 90% of the ASHAs in all the four districts agreed that training and review of various activities done in these meetings. However, as opined by the ASHAs, among the 4 districts, training and review of work were done better in Banda and Barabanki districts than Gonda and Saharanpur districts. Submission of report and work-related problem identification and solving were done better in Banda and Saharanpur in comparison to the other two districts. Sharing of work related data in the meetings were done poorly in Barabanki and Saharanpur districts, despite being the two more developed districts among the four. This implies there are considerable influence of various basic elements like training, review of work and problem solving that are responsible for conducting the meetings effectively. However, the common implication is that this is a suitable opportunity with enough scope to use this platform effectively.

Table 4. Percentages of ASHAs Proving Feedback on Topics Covered During Meetings.

District	Banda	Barabanki	Gonda	Saharanpur
Conducting group meetings in the community	100	93.6	98.5	100
Keeping the newborn warm	100	100	100	100
Cord care	100	100	100	100
Breast feeding	100	100	98.5	100
Role clarity in village health and nutrition days	100	100	100	100
Filling village health index register (documentation)	100	93.6	98.5	100
Birth preparedness	100	96.8	97	100
Inter personal communication skills	100	91.9	92.5	100
Estimation of number of pregnant women/newborn in the coverage area of each ASHA	100	91.9	89.5	100
Identification of danger signs in newborn and referral	100	93.6	98.5	98.4
Gender and equality	100	98.4	98.5	98.4

Analysis of the various topics covered through these meetings with respect to newborn care as replied by ASHAs is given in the **Table 4** above. ASHAs conducted group meetings in the community and the topic of how to go about group meetings was covered well among other topics. Other topics like keeping the newborn warm, breast feeding, cord care and role clarity in Village Health Nutrition Day (VHND) were also covered well. The topics such as filling Village Health Index Register (VHIR), birth preparedness, inter-personal communication skills and estimation of beneficiaries in the community for service coverage was covered poorly with respect to the other topics as reported by the ASHAs. The above data indicates that a sizable percentage of ASHAs agree that they are satisfied with the themes/topics discussed. Newborn care and cord care were universally addressed/discussed at all platforms. However, there is scope to address themes of inter-personal skills and gender equality more effectively.

Table 5. Percentage of ASHAs Reporting to Facilitators of Monthly Meetings.

District	Banda	Barabanki	Gonda	Saharanpur
Medical officer/medical officer in-charge	100	86	1.5	98.4
Health Education Officer	59	100	98.5	98.4
Investigator cum computer operator	3.2	1.6	1.5	8.0
Health supervisor	22.4	1.6	4.5	32

Lady health visitor	3.2	1.6	0.0	54.4
Auxiliary nurse midwife	0.0	0.0	0.0	0.0

Primarily, it was the Health Education Officer (HEO) of the PHC/CHC who took these sessions in the monthly meetings in all the four districts. Except Gonda, in the other 3 districts the medical officer in-charge conducted the sessions. As per the replies of ASHAs, among the facilitators, next in list are the LHV and the health supervisor who facilitated about half and one-third of these sessions in Saharanpur district. This showed that Saharanpur had variety of facilitators to facilitate these sessions in the monthly meetings (**Table 5**).

Table 6. Percentage of ASHAs Reporting on Ways the Meetings Helped.

District	Banda	Barabanki	Gonda	Saharanpur
Improvement in confidence to work in community	100	96.8	98.5	100
Improvement in communication and counseling skills	100	92	97	100
Increase in knowledge related to health issues	100	96.8	98.5	100
Increase in number of home visits	98.4	100	98.5	100
Increase in the quality of home visits	100	93.6	98.5	100
Able to fill village health index register	98.4	98.4	92.5	100
Able to use job-aides during home visits	98.4	100	83.5	100

The above **Table 6** indicates how these meetings have helped the ASHAs in their work. Most ASHAs replied that it has helped them in improving their confidence to work in the community. The ASHAs in all the districts agreed that their communication and counseling skills have improved. All the ASHAs informed that they have more knowledge on health issues. The ASHAs replied that these meetings helped them to do more home visits than before. The ASHAs replied that these platforms helped them to do quality home visits. The ASHAs also agree that these meetings had facilitated them to fill the VHIR that they were supposed to maintain for records. Among all the aspects, enabling ASHAs to use the job aides effectively was the poorest aspect. From this section, we can infer that, overall these monthly meetings had been effective platforms for capacity building of ASHAs and should be consciously leveraged for imparting appropriate skills. Most of the ASHAs agreed that their number and quality of home visits had improved as a result of attending these meetings. They also corroborated that the home visits are critical component to the complete package of Home Based New Born Care (HBNC) scheme launched to effectively engage ASHA for providing home based newborn Care.

CONCLUSIONS

The above results showed that the platforms like the monthly meetings at CHC and PHC are being attended by ASHAs. The facilitators of these meetings are primarily the Health Education Officers and not medical officers. In these meetings, the aspects generally addressed include: submission of reports, followed by review of work. Problem solving approaches related to work were seldom discussed. The aspects like filling the VHIR and the newborn care are not covered uniformly in all the four districts. However, the ASHAs agreed that the meetings have helped improved their confidence. The ASHAs also agreed that their home visits have improved both quantitatively and qualitatively as a result of these meetings.

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