

# A Rapid Appraisal of SAHIYYA (ASHA) in Jharkhand

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## PREFACE

Despite significant improvements made in the past few decades, the public health challenges are not only so huge but are also growing and shifting at an unprecedented rate in our country. The concerns shown by the organisations at the global level indicate that in view of the resurgence of various epidemics, both infectious and non-infectious, the situation can be handled only through a public health management approach. This urgency was realised and expressed in the Public Health Conference as the “Calcutta Declaration”, which called for creating appropriate structure for public health professionals and promoting reforms in public health education and training.

The National Institute of Health and Family Welfare initiated a Public Health Education and Research Consortium (PHERC) with the objective of networking and engaging in partnerships with public health institutions in the country to enhance their research capacity. As the nodal agency for imparting in-service training to health personnel and conducting research under the NRHM, the Institute is an ideal partner to bring the Department of Community Medicine in medical colleges, nursing colleges and other public health education and training institutions in the healthcare delivery system into the mainstream healthcare system, and also to provide a platform for building networks for capacity building in these institutions.

Currently, under the National Rural Health Mission many innovations have been introduced in the states to deliver healthcare services in an effective manner. State programme managers would wish to know how well these innovations are performing so that in case of gaps they could take corrective measures to achieve the stated objectives. There has been an increasing recognition for incremental improvements in the programme delivery system by undertaking quick and rapid health systems research and engineering the feedback into the processes. An impending need was discerned to develop a cluster of institutions and strengthen their capacities on rapid appraisal methodologies for generating programme relevant information at local and regional levels.

The Rapid Assessment of Health Interventions (RAHI), a collaborative effort with the United Nations Population Fund (UNFPA), is a unique initiative taken under the wider umbrella of the 'Public Health Education and Research Consortium (PHERC)' of the National Institute of Health and Family Welfare to develop partnerships with different organisations working in the field of health and family welfare. The project objective is to accelerate programme implementation in the identified states by providing them with timely and appropriate research inputs for addressing priority implementation problems. The specific objectives of this initiative are to develop a network of state/regional

institutions for conducting health systems research and to provide technical support for steering locally relevant research based on the specific issues identified by the state/district programme managers.

During the first phase of the RAHI Project, the UNFPA India Office supported 12 health system research projects. In this phase, five low-performing states, viz. Madhya Pradesh, Jharkhand, Chhattisgarh, Uttar Pradesh and Orissa, were included. Initially, proposals were invited from medical colleges, NGOs and other health institutions. After rigorous screening of the proposals by the Technical Advisory Committee (TAG) consisting of eminent public health experts, 12 projects were finalised in a national workshop conducted at the NIHFV. The faculty of the NIHFV provided technical support for the finalisation of tools, training to investigators, planning and monitoring of data collection. A quality assurance mechanism was developed in consultation with the members of TAG and experts from the UNFPA. The progress of the projects was reviewed by the TAG from time to time. A draft report entitled **“An Assessment of Sahiyya (ASHA) in Jharkhand** by the Department of Preventive and Social Medicine, Rajendra Institute of Medical Sciences, Ranchi Jharkhand, was finalised by the institute in consultation with the UNFPA.

It is envisaged that the findings and recommendations of this study would trigger a series of follow-up measures by the programme managers concerned in the state. We also feel strongly about continued need for optimum engagement of available human resources in community medicine, paediatrics, obstetrics, and gynaecology departments of the medical colleges in such assessments. Such initiatives by the programme managers will end the current isolation of medical colleges and will be conducive for incorporating such public health interventions during undergraduate and post graduate training.

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We would also like to thank all District Medical and Block Medical Officers of the ten Block PHCs and other functionaries for providing us with vital inputs.

Also, we express our gratitude to all our respondents in this research without whose cooperation the study would not have been completed.

We also extend thanks to CINI, Jharkhand for their assistance in study.

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## ABBREVIATIONS

ANC	Antenatal check-up
ANM	Auxiliary nurse midwife
ASHA	Accredited social health activist
AWW	Anganwadi worker
BCG	Bacillus Calmette Guerin
BMO	Block Medical Officer
BPL	Below poverty line
CDMO	Chief District Medical Officer
CS	Caesarean section
FGD	Focus group discussion
FRU	First referral unit
HSR	Health system research
IDI	In-depth interview
JSY	Janani Surakhya Yojana
NFHS	National Family Health Survey
NRHM	National Rural Health Mission
NIHFW	National Institute of Health and Family Welfare
PHC	Primary health centre
PNC	Postnatal check-up
RAHI	Rapid Assessment of Health Interventions
RCH	Reproductive and child health
SBA	Skilled birth attendant
PSM	Preventive and social medicine

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## EXECUTIVE SUMMARY

The National Rural Health Mission (NRHM) proposes to appoint a community -level health worker who has been named ASHA or an accredited social health activist. The ASHA acts as a first point of contact with the healthcare facility and the community in her village .In Jharkhand, Sahiyya is the term used in place of ASHA.

**General Objective:** To review the implementation status of the Sahiyya programmes in Jharkhand and suggest suitable measure for its effective implementation.

### Methodology

#### Study Area

In Jharkhand, 10 blocks (excluding those blocks in pilot study of 2003) were randomly selected.

**Study Subjects:** The following stakeholders were the subjects in this study:

1. Women who delivered within past six months
2. Village health committee members
3. Sahiyyas
4. AWWs
5. ANMs
6. MOICs
7. CMOs

### SALIENT FINDINGS

- Around 24.2 percent (87 out of 360) women who are interviewed have heard about Sahiyya, while 92.2 percent (80 women) who have heard of Sahhiya, can recognise Sahiyya within the hamlet.
- Women are aware that Sahiyya helps pregnant women for early registration with the ANM, who encourages and facilitates people to receive healthcare services facility from health centres and advises them on health. She also encourages the community to receive ICDS services from the Anganwari.
- Many women who know about Sahiyya (40.8 percent) have got the advice from her during counselling about going to a rural hospital if any type of complication occurs. Only 23 women (around 7 percent) have got advice to go to private hospitals if any type of complication occurs.
- Sahiyya helps the women in getting medicine

- It gives immunization for their children
- It helps women get coupons under the Janani Surksha Yojna (JSY).
- It also helps the pregnant women ANC check -ups.
- Out of total, 95.4 percent (83 women) women are educated and 94.7 percent these women consider that Sahiyya helps them in solving their problems.
- About 88.6 percent of women received ANC during last pregnancy; 86 percent of them registered with ANMs and around 89 percent of received TT during her antenatal check-ups.
- Women share various types of health -related problems with Sahiyya. They also share their health-related problems like problems during pregnancy like fever, leg pain, weaknesses, stomach pain and diet advice etc. They also get immunization for their children.
- Women get various types of pregnancy-related advices from Sahiyya. While 27 women got advice on breastfeeding, 11 women got advice on keeping baby warm, 29 women got advice on cleanliness, 11 on family planning, 17 on diet (*like tiranga bhojan*) and 20 on rest during pregnancy.
- Around 19 percent went for institutional delivery. It has also been found that of those women who received PNC, around 88 percent got their health checked by a doctor, while 9 percent received health check -ups by ANMs/nurses.
- It has also been found that women got help from Sahiyya to avail of the services of the JSY scheme.
- Around 35 percent of the women got support during their last pregnancy from *Sahiyya*.

#### **Kind of services received from Sahiyya**

- Identification of pregnancy
- Help during antenatal check-ups
- Received medicines
- Share health related problems
- Help in immunization, and
- Advice on pregnancy related diet.

#### **Key Recommendations**

- Proper incentives for Sahiyya's work should be paid timely
- Capacity-building should continue in the field of maternal and child health including basic health and hygiene and adolescent health

- Sahiyya should be linked with different health schemes of government to facilitate their motivation and work properly
- At the district level convergence meeting should be organised at least once a month at the Civil Surgeon's Office in the presence of the AWWs, the ANMs, Sahiyya and members of village health committees. So Sahiyya can understand her responsibilities.
- Private and charitable hospitals at block level should be accredited for JSY scheme and list should be made available to Sahiyyas
- A proactive attempt to complete the incomplete trainings of Sahiyyas should be attempted to ensure that they approach the beneficiaries with full knowledge and confidence and provide right services to them
- Communication on regular basis with all health functionaries can lead to effective decision-making. Modification in field strategies for home visit on regular basis for better uptake of services including the JSY and Sahiyya should be planned.
- Intensification of IEC activities in the community especially focusing at the MCH from registration to PNC component.

# CHAPTER I

## INTRODUCTION

The National Rural Health Mission (2005-12) was launched to provide effective healthcare to the rural populations throughout the country in general and with special focus on those states which have weak public health indicators and/or weak health related infrastructure. It aims at bringing about architectural corrections in strengthening public health management and healthcare delivery system for optimisation of the benefits of various health initiatives aimed at rural masses.

The key components of the Sahiyya include provision of a female health activist in each village, preparation of village health plan in association with the local team headed by the Panchayat Health and Sanitation Committee, strengthening rural hospitals for effective curative care by making the stakeholders accountable to the community through the Indian Public Health Standards (IPHS), and to work towards vertically integrating the Health and Family Welfare Programmes and funds by optimum usage of funds and infrastructure by strengthening the delivery of primary healthcare system.

The ASHA is to be nominated by the VHC/Gram Sabha as outreach worker or link worker as an individual living in the community. She is selected by the community and is oriented towards supporting the service providers on health issues with focus on reproductive and child health needs and services. Both VHCs and ASHAs are measures that will enable the community members to take health in their own hands and seek the services that are needed.

### **Operationalisation of Sahiyya in Jharkhand**

The concept of a female health worker assisting the rural people avail of health services in some of the blocks in Jharkhand is not new. Even before the launch of the NRHM, some NGOs successfully experimented with 'Sahiyya' a local word meaning 'friend' or 'saheli' in the state.

Sahiyya is a volunteer who is supposed to assist the villagers for their health needs and bridge the gap between the healthcare system and community. She is also expected to motivate the community to avail of the services that are available in health sub-centres such as immunization, ANC, PNC and consumption of IFA tablets etc. She should have the skill to identify the complicated and high risk cases thereby motivating villagers to

avail of proper services at HSCs/PHCs and is also responsible for counselling adolescent girls regarding their nutrition, personal hygiene and life skills as potential knowledgeable mothers.

Sahiyyas are selected in different phases excluding blocks covered by NGOs earlier. In the Phase-I (pilot) in 2005, Sahiyyas were selected and trained in 34 blocks. These blocks were within six districts namely, Ranchi, Hazaribag, Jamtara, Dumka, East Singbhu m, Gumla and Saraikela-Kharswa. In the second Phase, which is ongoing now, selection process has been completed in the rest of the blocks and is now undergoing training. The Sahiyya was selected by VHC of the Gram Sabha.

## **Rationale**

Need of a systematic study to understand the implementation status of Sahiyya and the needs of further programmatic inputs with a view to increase the effectiveness of the scheme led to this research to suggest suitable measures to the policy -makers in the state.

## **General Objective**

To review the implementation status of the Sahiyya programmes in Jharkhand and suggest suitable measure for its effective implementation.

## **Specific Objectives**

- To study the functioning of Sahiyya in Jharkhand
- To assess the acceptability of Sahiyya in the community, and
- To study the linkage between Sahiyya and other health functionaries (ANMs/AWWs)

## **CHAPTER II**

### **METHODOLOGY**

#### **Study Area**

Ten blocks of Jharkhand located in the six districts of Ranchi, Hazaribagh, Jamtara East Singbhum, Gumla and Saraikela-Kharswa.

#### **Study Design**

Cross-sectional descriptive study.

#### **Type of Study**

Formative Research.

#### **Study Subjects**

- Women who delivered within past six months
- Village health committee members
- The Sahiyyas
- The AWWs
- The ANMs
- The MOICs
- The CMOs

#### **Sampling Design**

A multi-staged stratified random sampling method.

The study was conducted in the blocks where selection and training of the Sahiyyas is complete.

## Selection of Blocks and Villages

The list of blocks where the Sahiyya program has been implemented during Phase-I was procured. These blocks were grouped in two categories: i) high-performing blocks, and ii) low-performing blocks. A total of 10 blocks (located in the six districts, five from each category) were selected. Overall, two blocks from Ranchi district, three blocks from Hazaribagh district, two from Jamtara district, and one each block from Gumla, Saraikela - Kharsawan, East Singhbhum districts were included in the study.

From each block, two sub-centres were selected, one close to the block headquarters (within 10 km) and the other a distant one (>10 km.). In each sub-centre, one randomly selected village was covered. If the required number of eligible women was not available there, another adjoining village was covered.

**Table 1: Selected Blocks under Study**

<i>Details of Sampling</i>		
<b>Name of Blocks in Sahiyya Phase-I</b>	<b>Name of Selected Block</b>	<b>District</b>
Kuchai, Saraikela, Kharsawana, Chandil, Ichagarh	Chandil	Saraikela - Kharsawan
Jamtara, Narayanpur, Nala, Kundhit	Jamtara, Narayanpur	Jamtara
Kanke, Ormanjhi, Namkom, Bundu, Chandil	Kanke, Ormanjhi	Ranchi
Bishnupur, Sisai, Palkot, Ghaghra, Raidih	Sisai	Gumla
Patanga, Potka, Ghatsila, Jamshedpur, Baharagora	Potka	Jamshedpur
Sadar, Ichak, Chauparan, Barkagaon, Bishnugarh Gola, Mandu, Katkamsandi, Padma, Barhi	Ichak, Bishnugarh Mandu	Hazaribagh
TOTAL NO. 34	10	06

The following sample of respondents was selected from the identified districts, blocks and villages.

**Healthcare Providers:** Six Civil Surgeon-cum-CMO of the districts and 10 Block Medical Officers were respondents at the planning and administration level. One each ANM from ten blocks, one each AWW from the 10 blocks and 10 Sahiyyas from each block (60) were selected randomly. One group of village health committee members was also selected on the basis of their availability for FGD in each block.

**Women:** A list of women who delivered in the last six months was procured from selected villages under each block. From each village, 18 women were randomly selected for the study. If sufficient number of respondents was not available in the village, then the nearby village (within the same sub -centre) was considered for the study to complete the sample.

## **Duration**

Data Collection: From October to November 2007. Total duration of project was 12 weeks.

## **Data Collection Methods and Field Work**

All the research staff were provided two days of hands -on training on research guidelines, tools and research issues including field training and pre -testing before commencement of the actual field work.

To ensure the quality of data, the members of the core team conducted FGDs and in -depth interviews of the district authority. The PIs/Co -PIs were supported by one field staff who was responsible for taking notes during FGDs and IDIs. As many as 10 FGDs and six IDIs of CMO were divided among PIs and Co -PIs.

Field supervisors conducted remaining IDIs and interviews with beneficiaries along with investigators. They were responsible for organising the FGDs. In -depth interviews and FGDs were recorded to assure data quality after taking consent of respondents.

The workload for each block was one FGD, eight IDIs and 36 interviews using semi -structured schedule. Given the short time for appraisal, separate teams worked simultaneously to cover the six districts. These teams completed the interviews of mothers, Sahiyas, ANMs, AWWs and MOICs in five weeks.

Following techniques were used to collect the data:

- Interview using semi-structured schedules
- In-depth interviews using guidelines
- FGDs using guidelines.

All the data collected were triangulated to have a clear idea of the findings at the time of analysis.

A summary of the study subjects, sample size and data collection technique and tools is shown in Table No.2.2.

**Table 2: Sample Covered, Tools and Techniques Used for Data Collection**

<b>Stakeholders</b>	<b>Number</b>	<b>Data Collection method and Tools</b>
Women who delivered within past 6 months	360 ( 36 per block)	Interview-Semi structured schedule
Civil Surgeons-cum-CMOs	6 (1 per district)	Interview-In depth interview checklist
BMOs	10 (1 per block)	
Sahiyyas	60 (6 per block)	
ANMs	10(1 per block)	
AWWs	10(1 per block)	
Village Health Committees	1 Per Block	FGD -FGD Checklist

### **Quality Assurance**

The PI and Co-PI supervised the data collection operation and also carried out CMO/MOICs interviews, FGDs along with the field supervisor. During supervision it was ensured that the correct procedure of data collection was followed and data quality was maintained. Tape recording was done as far as possible to ensure data quality.

### **Data Analysis/Data Processing**

Data entry of quantitative data, namely, women interview schedules and editing of data was completed in December 2007. The data was fed into a specific analysing computer software package called the Statistical Package for Social Sciences (SPSS). Qualitative data analysis of IDIs of Sahiyyas, AWWs, ANMs, Civil Surgeons and CMOs/MOICs were done on the NIHFV guidelines.

**Table 3: Score and Adjectives used in the Study for Qualitative Data**

<b>Score Proportion of Respondents</b>	<b>Adjectives Used</b>
--	------------------------

<10 %	Very few
10-24 %	Some
25-49 %	Approximately half
50-74 %	Majority/Over half
75-89 %	Most
>90 %	Almost all

## **Ethical Clearance**

The project structure was examined and cleared by the Review Board of the Ethical Committee of NIHFV for ethical considerations.

## **CHAPTER III**

### **FINDINGS AND DISCUSSION**

#### **Sample Size and Result Status**

In this study, 10 blocks of six districts were taken. Overall two blocks of Ranchi district, three blocks of Hazaribag district, one each block of Gumla, Saraikela- Kharsawan, East Singhbhum districts and two blocks of Jamtara district considered for the study.

#### **Socio-Demographic Characteristics**

The mean number of usual male residents in the household is 3.8 and of usual female resident are 3.6. Majority of families are of nuclear type. Mean number of married females in reproductive age group is 1.5. Most of the respondents are Hindus, followed by Muslims and Sarnas. Majority of these women are illiterate and belong to Backward Classes. Women doing private service/business were sparse, meaning most of them are housewives. Significantly, as many as 90% of them are from BP families.

#### **Functioning of Sahiyya**

#### **Awareness about Sahiyya**

Out of 360 women interviewed, 87 women (24.2%) heard about Sahiyya and 80 (22.2%) could recognise Sahiyya of her tola (village).

**Table 4: Socio-demographic profile of women aware about Sahiyya**

Characteristics	Those aware of Sahiyya		Those not aware of Sahiyya		All respondents	
	No.	%	No..	%	No..	%
Religion						
Hindus	71	81.61	214	78.39	285	79.17
Muslims	10	11.49	29	10.62	39	10.83
Christians	1	1.15	0	0.00	1	0.28
Sarnas	4	4.60	28	10.26	32	8.89
Others	1	1.15	2	0.73	3	0.83
Total	87	100.00	273	100.00	360	100.00
Categories						
Scheduled Castes	14	16.09	34	12.45	48	13.33
Scheduled Tribes	13	14.94	82	30.04	95	26.39
Backward Classes	56	64.37	137	50.18	193	53.61
Others	4	4.60	19	6.96	23	6.39
Don't know	0	0.00	1	0.37	1	0.28
Total	87	100.00	273	100.00	360	100.00
Education						
Matriculate and above	18	20.69	18	6.59	36	10.00
7th Class	14	16.09	42	15.38	56	15.56
4th Class	11	12.64	47	17.22	58	16.11
Illiterate	44	50.57	166	60.81	210	58.33
Total	87	100.00	273	100.00	360	100.00
Occupation						
Cultivator	25	28.74	96	35.16	121	33.61
Daily labourer	5	5.75	6	2.20	11	3.06
Private service	0	0.00	2	0.73	2	0.56
Housewife	55	63.22	163	59.71	218	60.56
Unemployed	1	1.15	0	0.00	1	0.28
Others	1	1.15	1	0.37	2	0.56
No response	0	0.00	5	1.83	5	1.39
Total	87	100.00	273	100.00	360	100.00
BPL						
Yes	76	87.36	248	90.84	324	90.00
No	11	12.64	25	9.16	36	10.00
Total	87	100.00	273	100.00	360	100.00

Awareness about Sahiyya is lesser among the Scheduled Tribes respondents and those belong to the Sarna religion. There is a need for special campaigns amongst these groups to enhance their knowledge about the scheme and its utility.

Education has little impact on the awareness about the scheme except for respondents who are Matriculate and above.

Also, occupation and their BPL status have no impact on the awareness level.

**Table 5: Awareness about Sahiyya in High-performing and Low-performing Blocks (n=360).**

Awareness about Sahiyya	High Performance Blocks	Low Performance Blocks
Yes	63 (34.4%)	24 (13.6%)
No	120 (65.6%)	153 (86.4 %)

It is seen that women of high-performing blocks are more aware of the Sahiyya programme. This may be due to better functioning of peripheral health workers in those areas.

### **Awareness Among Health Functionaries**

All the ANMs and AWWs interviewed are aware of the Sahiyya, while VHC members have vague some knowledge that something like Sahiyya is functioning in their area.

**Table 6: Services Provided by Sahiyya**

Service (n=87)	No.	Percent
Early registration of pregnant women with ANMs	15	17.2
Encourage the community to receive health facility	37	42.5
Promote community to receive ICDS facilities from AWCs	5	5.7
Advice on health related issues	14	16.1
Others	16	18.4

Out of 87 women, around 17.2 percent (15 women) said that Sahiyya helped them with early registration with ANMs, 37 women (42.5 percent) in getting health care services from the village health centres, while 14 women said that Sahiyya advised them on health and only 5.7 percent women (5 women) reported that Sahiyya encouraged them to receive ICDS services from Anganwari centres. However, these percentages declines drastically when we draw them against the total sample of 360.

**Table 7 : Help during Pregnancy**

<b>Help (n=87)</b>	<b>No.</b>	<b>Percent</b>
Sahiyya visited during pregnancy or later	44	50.6%
Sahiyya helped when it is needed during pregnancy	34	39.1%

A little over half of the (50.6%) who are aware of the scheme said that Sahiyya visited during pregnancy. Getting medicines, immunization, assistance in procuring JSY coupons and ANC are some of the help the Sahiyya provides.

**Table 8: ANC Services**

<b>ANC</b>	<b>Those who have heard about Sahiyya (n= 87 )</b>	<b>Those who did not hear about Sahiyya (n= 273)</b>	<b>Total (n=360)</b>
	<b>No. (%)</b>	<b>No. (%)</b>	<b>No. (%)</b>
Any ANC	80 (92.0%)	239 (87.5%)	319 (88.6%)
No ANC	7 (8.0%)	34 (12.5%)	41 (11.4%)

Overall, 88.6% women had ANCs and the difference between those who are aware and who are unaware about the scheme is not much. It may be due to the fact that the Sahiyya programme is in the early phase and has not made any remarkable impact on the community.

### **Type of ANC Services**

As many as 85.3% women received three or more ANCs. The difference between the two groups who are aware and not aware about Sahiyya is not significant.

But, the quality of services differs. Among those aware about the scheme, 53.8% had weight measurement, 51.3% had BP measurement, 50.0% had urine test and 51.3% had blood test done. While among those who are not aware about Sahiyya, 41.0% had weight measurement, 36.0% had BP measurement, 39.7% had urine test and 41.8% had blood test.

Among those who are aware about, 93.8% got two TT injections, 90.0% were given IFA tablets and 42.5% were advised on pregnancy care. While among those who are unaware of the scheme, 94.1% got two TT injections, and 78.7% were given IFA tablets. However, most of the (87.5%) women were not advised about pregnancy care by anyone.

### **Reason for no ANC Services**

Most of the women aware about Sahiyya but did not have ANC done said that they had lack of time or thought it to be expensive. While half of those who did not know about the scheme thought it to be unnecessary and expensive. Other reasons cited include lack of accessibility, awareness and family support. This means that there is lack of communication efforts from the government in regard to this very important scheme especially in terms of the fact that this is a completely free service as most of those who avoided getting ANCs done did so due to perceived fear being expensive.

**Table 9: Delivery**

Place of delivery	Those who heard about Sahiyya (n=87)	Those who did not hear about Sahiyya (n=273)	Total (n=360)
	No. (%)	No. (%)	No. (%)
Home delivery	66 (75.9 %)	227 (83.2%)	293 (81.4%)
Institutional delivery	21 (24.1%)	46 (16.8%)	67 (18.6%)

Only 24.1% women who are aware about Sahiyya and 16.8% of those who aren't aware about Sahiyya had institutional delivery. The difference is not significant ( $p=0.1283$ ). Overall institutional delivery was 18.6%.

The women who are aware of the scheme but delivered at home were asked about what Sahiyya advised them about delivery. Significantly, only 22.7% women got a n advice from Sahiyya to deliver at CHCs/pre-identified institutions, while a large majority of 77.3% got no advice at all.

When they were asked as to why they did not deliver at the health facility, 44.6% said they had cost considerations, while 35.4% thought it to be unnecessary. Transportation problem (9.2%) and lack of knowledge about health facility (3.1%) were other responses. Women unaware about the scheme had similar replies. But, problem of transportation was also prominent among these (23.8%).

### **PNCs**

26.4% women who were aware had PNC, whereas 15% of those unaware also had PNCs. The difference is significant ( $p=0.0153$ ). Sahiyya helped only 30.4% women in PNCs.

**Table 10: Availability of Sahiyya and their work performance within the village**

Performance(N=87)	No..	Percent
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Sahiyya is easily available in the community	78	89.7
Women share health related problems with Sahiyya	19	21.8
Sahiyya is knowledgeable	83	95.4
Sahiyya is doing her work sincerely	54	62.1
Women are satisfied with Sahiyya's services	51	58.6

Most of the women who heard about Sahiyya reported that Sahiyya was easily available; a few of them also said that they shared their health related problems with Sahiyya. This means that the women are still hesitant in communicating with Sahiyya.

Of those women who shared their problems with Sahiyya, almost all women said that Sahiyya showed her interest to solve the problem.

According to almost all women, the Sahiyya is knowledgeable. Regarding performance, majority of women said that their Sahiyyas do their work very sincerely.

According to most of the health functionaries, Sahiyyas are available but some have complained that Sahiyyas are not doing work properly.

### **Concerns Shared with Sahiyyas**

Women share their various health problems with Sahiyyas. Prominent among them are pregnancy-related like fever, leg pain, weaknesses, stomach pain and dietary advice etc. Among health issues of children, they mainly share immunization. However according to a few Sahiyyas, people mostly talk about the immunization of their kids. This may be the result of the Catch-up Round Scheme introduced in the state. They also discuss health of pregnant women and kids. But non-pregnancy-related discussions are infrequent. This may explain the still high home delivery rates prevalent in the sample blocks and draws special attention for developing communication skills of Sahiyyas to talk to more prospective mothers and draw them into the safety net of this scheme provided by the government.

### **Information about JSY and its Usage**

Of those 87 women who heard about Sahiyya, 19 heard about JSY too, and out of these, a few of women used it too. When asked about the source of information from JSY users, two said that they got information from Sahiyya, while rest of the women got

information from ANMs and AWWs. Significantly, none of the women who were unaware of Sahiyya heard about the JSY.

Those who did not use JSY were reluctant because they were not interested or did not get information from Sahiyya.

A few women availing of JSY benefits draws urgent attention for redrawing the strategic role envisaged under NRHM and it should lead to taking immediate corrective steps for making their presence more worthy for long-term sustainability of this scheme.

### **Acceptability of Sahiyya by the Community**

The awareness about Sahiyya in the community is low. Still, majority of those who know about Sahiyya said that the Sahiyya was doing her work sincerely and that they were satisfied with her services. Most of them told that Sahiyya helped them when asked for.

According to the Sahiyya, there are mixed responses in the community. Some of them get due respect, while some others are welcomed by only those people who listened to them carefully and also followed their advice .

*“Ham jaha jate hain, log chay pani puchhte hain.”*

[“When we go, people ask us to have tea/water,”] said a Sahiyya.

### **Acceptability by Healthcare Providers**

The ANMs have accepted the role of Sahiyya in healthcare delivery and most of them work in co-ordination.

*“Sahiyya ke aane se kam karne me asani ho gaya hai. Jarurat parne par ham apna dawai bhi dete hain.”*

[“With the availability of Sahiyya, our work has become easier, sometime we send our medicines also through them,”] said an ANM.

The acceptability of Sahiyya by the majority of the AWWs seems to be low and majority of them do not work with her in co-ordination. Probably because both are being peripheral health workers selected from within the village, there is some competition among them. Most of the AWWs are of the opinion that Sahiya does not contact them and is not easily accessible.

Most of the MOICs and CMOs consider Sahiyya important for the society but since they are not involved in her selection process, they have less confidence in them.

## **Linkages between Sahiyya and other Health Functionaries**

### **Linkages with ANMs**

Almost all ANMs agree that they get help from Sahiyya in immunization. Some also take help in identifying pregnant women and ANC. Almost all Sahiyyas opine that ANMs help them in receiving drugs and they also seek help in immunization. In some areas, ANMs take assistance of Sahiyya in home visits, health education and health programmes like Catch-up Round, malaria, pulse-polio etc.

However, CMOs and MOICs complain that they have not seen good coordination between ANM and Sahiyya. In their opinion, ANMs may not know Sahiyya or even of their villages.

It appears that though Sahiyya is doing some health related work in the village, especially in the field of immunization, she is neither recognised at the PHC nor by the district health functionaries.

### **Linkages with AWWs**

The linkage between AWW and Sahiyya is low. More than half of interviewed AWWs have not received any help from Sahiyya. Those who have received help is largely for distribution and immunization. They also do not provide assistance to Sahiyya. However, some work together for immunization.

*“Koi koi madad karti hai, koi kuchho nahi”.*

[“Some help, and some don’t.”] said an AWW.

Sahiyyas also say that AWWs do not ask them for help. In some places, they help AWWs in collecting children for immunization and THR distribution.

The cause for imperfect linkage may be that some AWWs think Sahiyya as their competitor and lack of clarity about Sahiyya’s roles.

## **Linkages with CBOs and VHCs**

The linkage of Sahiyya and VHCs is at low and is limited to selection of Sahiyya and infrequent meetings in which there is some discussion about health issues.

In almost all the blocks, some Sahiyyas are already attached to some CBOs, mostly Mahila Mandals. But, so far their activities related to health are concerned, linkages are not observed.

*“Hamin mahila mandal me paisa jama karai la. Aur kono madad nai milat hai ”.*  
[“We invest our money in Mahila Mandal. Apart from that we get no help from them,”] said a Sahiyya.

In most of the places, regular VHC meetings do not take place. Places where meetings are held, MCH and hygiene practices are discussed. Sahiyyas are aware of the VHCs but they do not know about meetings in most places.

## **Problems in Sahiyya Programme Implementation**

### **Involvement of Programme Managers/Providers**

The government health functionaries were not involved in Sahiyya selection in the first phase. Their role in training was minimal as technical experts, came only in some areas. This led to lack of interest among them. They also did not receive any orientation training on NRHM and ASHA in most areas.

### **Selection and Training of Sahiyya**

Selection of Sahiyya is being as done by the VHC, and their training by NGOs with help from government health officials. Most of the Sahiyyas feel that they need more training and refresher courses and suggest that annual refresher training on common health issues is much needed for them.

Similar is the opinion of ANMs and AWWs. Most of them do not know about Sahiyya training. They also say that there should be better and regular training of Sahiyya. VHC members also feel that Sahiyyas should be properly trained.

Government health officials were not involved in Sahiyya selection and training and this is a major lacuna in first phase of Sahiyya programme.

### **Financial Concerns**

Almost all of the Sahiyyas are not getting any incentive for their work. Some get money only during training and some get incentives during camps only. This has led to lack of motivation among them.

Almost all CMOs and MOICs admit that Sahiyyas are not getting any incentive as they are volunteers. Almost all the health functionaries suggest that there should be some fixed honorarium for Sahiyyas.

### **Poor Coordination**

There is inadequate linkage with ANMs and AWWs. The VHC meetings are not organised regularly. This has led to inadequate monitoring by village health committee.

### **Lack of Monitoring**

The monitoring at village level is not done as the VHC meetings are infrequent. There is need for better supervision at all levels.

## CHAPTER IV

### RECOMMENDATIONS

<b>Areas of Concern</b>	<b>Actions Recommended</b>
<p>Sahiyyas are simply working as volunteers in their respective villages and don't get any honorarium</p> <p>Illiteracy a cause of concern among Sahiyyas</p> <p>Stepping up linkages of Sahiyya with other government health functionaries like ANMs, AWWs etc</p>	<ul style="list-style-type: none"> <li>• Proper incentives for Sahiyyas' work and timely payment</li> <li>• Capacity-building should continue in the field of maternal and child health including basic health and hygiene and adolescent health</li> <li>• Sahiyya should be linked with different health schemes of government to facilitate their motivation and work properly</li> <li>• At the district level convergence meeting should be organised at least once in month at the Civil Surgeon's Office in the presence of AWWs, ANMs, Sahiyyas and members of village health committees</li> </ul>
<p>Private health facility is still a choice for many prospective mothers</p>	<ul style="list-style-type: none"> <li>• Since some people still access private facilities to undergo institutional deliveries, more private and charitable hospitals at block level should be accredited for the JSY Scheme and list should be made available to Sahiyyas</li> </ul>
<p><b>Programme Level Issues</b></p> <p>As institutional delivery entails more expenses and longer hospital stay, more assistance from Sahiyyas is required for some cases</p>	<ul style="list-style-type: none"> <li>• If mothers having institutional delivery incur additional costs on medicines, surgical items and spend more time in the health facilities leading to more time spent by Sahiyyas resulting in higher wage losses. In such cases Sahiyyas should be paid more.</li> </ul>
<p>Sahiyyas expect regular interactive sessions with health functionaries to solve field level problems</p>	<ul style="list-style-type: none"> <li>• Communication on regular basis with all health functionaries can lead to effective decision-making. Modification in field strategies for home visit on regular basis for better use of services including JSY and Sahiyya should be planned.</li> </ul>
<p><b>IEC</b></p> <p>Lack/non- availability of IEC material</p>	<ul style="list-style-type: none"> <li>• Intensification of IEC activities in the community especially focusing at the MCH from registration to PNC component</li> <li>• IEC material should be made available to Sahiyyas</li> </ul>
<p><b>Training</b></p> <p>Slow training process affecting quality of work</p>	<ul style="list-style-type: none"> <li>• A proactive attempt to complete the incomplete trainings of Sahiyyas should be attempted to ensure that they approach the beneficiaries with full</li> </ul>

<p>Re-training sessions, especially on maternal and child health focusing on major diseases in villages. Training needs based on field experiences still not conducted.</p> <p>Orientation of Sahiyyas on NRHM still required</p> <p>Basic knowledge of general, sexual health and hygiene is still required</p>	<p>knowledge and confidence and provide right services to them</p> <ul style="list-style-type: none"> <li>• Quality in training should be enhanced, post training field appraisal should be done and refresher training should be provided after conducting training need assessment</li> <li>• Orientation of appropriate health staff other than Sahiyya on NRHM should be done to enhance their ownership of the scheme and to provide additional support to Sahiyyas</li> <li>• Basic training is provided to the Sahiyyas, but training on knowledge of general, sexual health and hygiene can improve their functional level</li> </ul>
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### **Limitations of the Study**

The sampling was based on rapid appraisal approach, as it was done with the aim to assess the Sahiyya Programme. Though it denotes the programmatic issues with an attempt to suggest remedial measures, its results cannot be applied to the community as it is not a representative sample of the population.

### **Future Directions of Research**

In context of Jharkhand State, the concept of ASHA is quite newer than that of the Sahiyya. Now the state is following the module and guideline of the NRHM for the Sahiyyas too. So, in the future, studies can be carried out to examine the performance level including the JSY scheme of the Sahiyya. Other aspects of all round impact on implementation of the NRHM Programme and assessment of the health facilities can be studied.

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