

Engaging ASHAs in Rural Marketing of Health Products:

A Community Based PPP Model for Enhancing Health Outcomes in the State of Uttar Pradesh



Photo credit: Shuvi Sharma

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Abbreviations and Acronyms

UP	Uttar Pradesh
IMR	Infant Mortality Ratio
MMR	Maternal Mortality Ratio
NRHM	National Rural Health Mission
ASHA	Accredited Social Health Activist
NFHS	National Family Health Survey
MDGs	Millennium Development Goals
JSY	Janani Suraksha Yojana
NHSRC	National Health Systems Resource Centre
ANC	Antenatal Care
RTI	Reproductive tract infections
ORS	Oral Rehydration Solution/ Salts
IFA	Iron Folic Acid
DDK	Disposable Delivery Kit
DOTS	Directly Observed Treatment – Short course
IMNCI	Integrated Management of Neonatal and Childhood Illness
TSC	Total Sanitation Campaign
CHW	Community Health Worker
PPP	Public-Private Partnership
MBPH	Market-based Partnerships for Health
VHCs	Village Health Champions
AWC	Anganwadi Centre
ICDS	Integrated Child Development Scheme
OCPs	Oral Contraceptive Pills
ECPs	Emergency Contraceptive Pills
TB	Tuberculosis

Introduction

The state of health in Uttar Pradesh (UP), despite steady improvement continues to be a cause of major concern, threatening to reverse the developmental gains of the state and the country as a whole. Over the years, a number of health related schemes and initiatives introduced at regular intervals in the state, have contributed in improving key health indicators such as the Infant Mortality Ratio (IMR) and Maternal Mortality Ratio (MMR). However much remains to be done, suggesting the need for not only better investment and planning, but also innovative ways of providing healthcare. More than 6 years after the launch of the National Rural Health Mission (NRHM), the Accredited Social Health Activist (ASHA) has emerged as a significant actor in improving the health situation especially among women and children. However, there is scope for further strengthening her role in achieving the health outcomes of the state.

This paper proposes that engaging ASHAs strategically and judiciously in rural marketing of health products, complementing her primary function as laid out in NRHM program, will not only contribute to her income and motivation but also provide communities with a basket of health products to choose from, thereby improving the overall health situation at the household level.

Understanding Key Health Issues in the State

Over population, poor IMR and MMR and a number of communicable diseases cause tremendous burden on the state as well as the families in the state. According to the 2011 Census provisional data, the state has contributed 18.4 percent of the population growth of the country in the last decade. An average household in the state comprises of 6 persons. With 3 out of 4 households in rural areas, UP has the largest rural population in the country¹. Of a population of nearly 200 million², about 30 million are below the age of 6 years.

The MMR declined from 440 in 2004-06 to 359 in 2007-09; yet it is significantly higher than the national average of 212³. The IMR in the state is 67 per thousand live births, much higher than the national average of 53⁴, which itself is very high when compared to the global average. Even within the state, the IMR in rural areas is 70, as compared to 49 in urban areas⁵.

Unplanned pregnancies are relatively common. If all women were to have only the number of children they want the total fertility rate would be 2.3 instead of 3.8 in Uttar Pradesh. **(NFHS III)**

Among the under five population, diarrhoea is another major cause of mortality. The economic burden on health services caused due to diarrhoeal diseases is immense; while no specific data for UP is available, it is estimated that up to one-third of total paediatric

¹ Census of India, 2001

² 199,581,477 million as per Census 2011 provisional data

³ http://censusindia.gov.in/vital_statistics/SRS_Bulletins/MMR_release_070711.pdf Accessed on July 26, 2011

⁴ SRS, 2008

⁵ SRS, 2008

admissions in the country are due to diarrhoeal diseases and up to 17% of all deaths in indoor paediatric patients are diarrhoea related⁶. The total number of deaths due to diarrhoea in the age group of 0–6 years accounted for 22% of total rural deaths in the country⁷.

Optimal hand-washing with soap can reduce diarrhea by 45 percent. Since the 1970s, ORS has saved an estimated 50 million lives globally.

(http://www.path.org/files/IMM_solutions_global_killer_pp15-26.pdf)

The interplay between the large unmet need for family planning in the state (33.8 percent)⁸, relatively low literacy levels, high concentration of population in rural areas, high levels of rural poverty, gender disparity and

limited access to quality health services results in poor maternal health, high MMR, IMR and under five deaths and morbidity.

National Rural Health Mission and the role of ASHAs in the context of UP

The improvement in health related indicators has witnessed significant acceleration with the launch of the NRHM in 2005, which aims to achieve health related Millennium Development Goals (MDGs) as well as control specific diseases, and improve the nutritional status of children and mothers. This is particularly evident in the area of institutional deliveries which has more than doubled since the introduction of the Janani Suraksha Yojana (JSY), a cash benefit scheme under NRHM.

One of the key components of the NRHM is to provide every village (or a population of 1000) with a trained female community health worker called an accredited social health activist (ASHA). ASHA helps the community to liaise with the government health system with special focus on JSY. The NRHM guidelines on ASHAs state that the “ASHA will be the first port of call for any health related demands of deprived sections of the population, especially women and children, who find it difficult to access health services.”⁹ Empowered with knowledge and a drug-kit to deliver first-contact healthcare, “every ASHA is expected to be a fountainhead of community participation in public health programmes in her village.” She works closely with Auxiliary Nurse Midwives (ANMs) and Anganwadi workers (AWWs) to conduct community-level activities¹⁰. She is critical and central to the entire design and strategy of the NRHM and her performance is, therefore, crucial for the success of the programme. The ASHA usually fulfills 10 critical functions for the community where she operates.

⁶ Park K. Jabalpur, India: Banarsidas Bhanot Publishers; 2000. Park's textbook of preventive and social medicine.

⁷ NICED. NICED background papers Burden of Diseases in India. New Delhi: MHFW, Government of India; 2005. Estimation of the burden of diarrhoeal diseases in India; pp. 182–188. Available from http://www.whoindia.org/LinkFiles/Commission_on_Macroeconomic_and_Health_Bg_P2_Estimation_of_the_burden_of_diarrheal_diseases_in_India.pdf [cited 20 August 2010]

⁸ DLHS 3

⁹ http://mohfw.nic.in/NRHM/RCH/guidelines/ASHA_guidelines.pdf

¹⁰ Anganwadi centers are community-level, government-sponsored child and mother care centers.

Core functions of ASHA

1. Create awareness and provide information to community
2. Counsel mothers on birth preparedness, safe delivery, feeding practices, immunization, family planning, RTI, etc.
3. Facilitate community access to health care and health facilities
4. Accompany pregnant women and children to health facility
5. Provide care for minor ailments
6. Act as depot holder for ORS, IFA, DDK, Oral pills, condoms
7. Provider of DOTS
8. Newborn care and treatment of childhood illness (IMNCI)
9. Inform birth and deaths, disease outbreaks
10. Construction of Toilets for TSC (Total Sanitation Campaign)- Not included in UP state policy for ASHAs

On an average, an ASHA worker covers one village; however, owing to the large population in UP, many ASHAs, in effect, cover 2 villages. A study conducted by the Columbia University in 4 states in India¹¹ indicates that, an ASHA in UP covers approximately 23 households per week and works nearly 26 hours per week which includes 13 hours for ANC, 7 hours for accompanying the expectant mother for delivery and nearly 6 hours for other activities (listed above).

Scope for strengthening the ASHAs functions and impact in the state: understanding the key challenges

A 2011 evaluation by the National Health Systems Resource Centre (NHSRC) emphasizes, like a number of other evaluations, that while the ASHA programme has been established at a grand scale and now serves an integral role in the public health system, the ASHA's functionality and effectiveness must be further optimized.

To be successful on a large scale, any Community Health Worker (CHW) programme, such as the ASHA initiative, needs careful planning, secure funding, active government leadership and community support. In order to carry out their tasks successfully, CHWs need regular training, supervision, and reliable logistical support¹². While the planning, selection, training and supervision for the ASHAs is robust and there is considerable government leadership on NRHM as a whole, funding for ASHAs remains an area of concern.

¹¹ Nirupam Bajpai and Ravindra.H.Dholakia. Improving the Performance of Accredited Social Health Activists in India. Working Paper No. 1, Working Paper Series, Columbia Global Centres.
http://globalcenters.columbia.edu/southasia/files/mumbai/content/pdf/Improving_the_Performance_of_ASHAs_in_India_CGCSA_Working_Paper_1.pdf

¹² Ibid.

In various studies, ASHAs frequently cite financial incentive as a major motivating factor for their work. At least 25 percent of ASHAs feel that the monetary compensation they receive is not sufficient for the effort that they put in. Increasing incentives or adding additional incentives to activities is therefore recommended¹³. Additionally, there are delays in payment due to inadequate logistical support systems in the state. Approximately 60 percent of ASHAs complain about delays in receiving their incentives. Given that most ASHAs work without a fixed salary, a delay in payment can pose serious concerns for job satisfaction and retention of ASHAs¹⁴.

Table 1. ASHAs' self-reported motivating factors for becoming ASHA¹⁵

Motivating Factors for becoming an ASHA	% of ASHA who said this was a motivating factor	Of those ASHA that reported this as a motivating factor, did the rewards meet their expectations?		
		Did not meet	Met	Exceeded
Financial Incentive	93.5	27.8	30.5	41.7
To get more exposure in the village	91.9	20.3	32.8	46.9
To improve village health facilities	99.2	13.9	23.0	63.1
Social Prestige	96.7	20.2	27.7	52.9
Peer pressure	85.4	23.8	25.8	50.5
Others	35.8	18.2	24.9	56.7

It must also be noted that most ASHAs work only 3-4 hours a day. No doubt this part time arrangement suited them in the beginning as most of the ASHAs who were selected were married and had a family. However, with their growing recognition as a health care worker, they may be more inclined to take on additional health related activities that enhance their income as well as social prestige.

Engaging ASHAs in rural marketing: an option for strengthening their motivation and enhancing community's access to a basket of healthcare products

The National Institute of Health and Family Welfare (NIHFW) appraisal of NRHM (in Cuttack, Orissa) showed that the distribution of medicine is a key factor for addressing the common ailments at the community level and also a catalyst for community acceptance and participation. However, about a quarter of the ASHAs interviewed did not even receive medicine kits, and among those who had received the kits, these were found to be incomplete.¹⁶ Ultimately unless the services and healthcare products reach the end users, it is safe to conclude that achieving the MDG targets or the health-for-all goals will remain beyond reach.

¹³ Ibid

¹⁴ Ibid.

¹⁵ Ibid

¹⁶ A Rapid Appraisal of Functioning of ASHA Under NRHM in Cuttack, Orissa. 2007-08. NIHFW, NIAHRD, UNFPA. <http://nihfw.org/pdf/RAHI-I%20Reports/Cuttack/CUTTACK.pdf>.

There is growing evidence that communities across all income categories are willing to pay for better health services. The 61st National Sample Survey shows that despite being one of the poorest states, UP ranks only below Kerala in terms of out of pocket expenditure on healthcare as a percent of total expenditure on consumption needs. An average household in UP spends 7.38 percent¹⁷ of its consumption expenditure on health care. It is in this environment that the concept of public-private partnership (PPP) has gained ground. As the state scales up PPP models for improving access to health services, it is pertinent to explore the potential for such partnerships not only at the level of hospitals and health care facilities but also at the grassroots level. In this, the ASHA will no doubt play a pivotal role.

The ITC *e-Choupal* is one such successful PPP model working in the rural areas of UP, among other states, where the initial design and focus on agriculture was expanded to cover health information and products in partnership with the Market-based Partnerships for Health (MBPH)¹⁸ Project. It will be useful to understand its operations and effectiveness while exploring the potential for engaging the ASHAs in similar forms of rural health marketing. Whereas several such models exist across the country and are at various stages of development, the example of *e-Choupal* has been taken for this paper, as one such successful model which has proven its effectiveness in the low resource settings of rural UP. Reference to this model does not preclude the lessons and parallels that can be drawn from other similar models.

The model is a combination of technology (facilitated through *e-Choupal* infrastructure) and community, interfaced through a 'sanchalak' (operator), who interacts with the local community and hence binds all members of the rural populace. *e-Choupal* has partnership with reputed organisations in the healthcare segment, who bring their core expertise in medical care at both ends of the spectrum – starting from rural initiatives to super-specialty hospitals.

ITC e-Choupal Rural Health Model: A Case Study

Created by ITC over the last decade, *e-Choupal* provides the "last mile" complementary solution for rural communities by introducing high-tech and high quality services in low income settings. In general, the *e-Choupal* project constitutes a network of rural kiosks, providing a number of services for rural population. It is a rural procurement and marketing infrastructure which combines internet connectivity with physical infrastructure to give rural communities greater access to information, goods and markets for their crops.

¹⁷ Soumitra Ghosh. Catastrophic Payments and Impoverishment Due to Out-of-Pocket Health Spending: The Effects of Recent Health Sector Reforms in India. Asia Health Policy Program working paper #15. July 2010

¹⁸ As USAID India's flagship private health sector project, the Market-based Partnerships for Health (MBPH) provides technical assistance to private sector initiatives; focuses on strategic partnerships and helps foster commercial alliances to address a wide range of health issues including reproductive health, maternal and child survival, tuberculosis, water, hygiene, HIV/AIDS. Aimed at delivering health impacts that are commercially viable and scalable, one of the key focus areas of the project is to develop commercial sector interest in the public health issues being addressed by it, in the lower socio-economic sections in urban and rural India

Over the years, the scope of activities under the *e-Choupal* umbrella has increased substantially; apart from offering procurement services and providing information on enhancing farm productivity, the network now supports information dissemination around a diverse range of issues, sale of products and services through ITC-owned exclusive retail network (known as *Sagars*) at select locations.

Due to extensive outreach of ITC, its proven commercial viability in various states in India, its focus on improving the quality of life in rural India, MBPH tied up with the company to leverage the *e-Choupal* infrastructure towards improving the health outcomes in otherwise underserved areas of rural India. It is one of the largest rural marketing networks in the country, thereby offering a tremendous scope for scale up of health services. As part of this tie-up, ITC *e-Choupal* has introduced rural health services and products as part of its network; the model is focused on increasing access to public health products among rural communities through a team of community-based health workers, branded as Village Health Champions (VHCs).

The team of VHCs recruited by the program act as the access points for the intervention health products. These products are stocked at the *e-Choupal* rural hypermarkets, known as *Choupal Sagars*; the VHCs visit these outlets to buy the health products at wholesale prices at least once a month. These products are then sold to the village communities by the VHCs at retail prices, giving VHCs an additional source of income through retail margins. The pilot is being implemented in two districts of UP, namely, *Gonda* and *Chandauli*. More than 66 VHCs are currently operational in these two districts.

In general terms the profile and functions of the VHCs and the ASHA have much in common. The only significant difference is that the VHCs promote products at a price to the communities whereas the ASHAs provide access to services and products at a cost to the state.

Profile of the Village Health Champions (VHCs)

VHCs are women, trained in various public health issues, meant to act as community health workers within their geographies. They are expected to create awareness around key public health issues like family planning, reproductive health, child diarrhoea etc. to improve the overall health as well as living standards within their communities. They are also expected to earn an income through the sale of relevant public health as well as complementary products¹⁹ within their operating geography. They are an integral part of the *e-Choupal* channel network and are expected to operate as per ITC *e-Choupal*'s guidelines.

An analysis of their function and the current status of the program opens up the opportunity for exploring possibilities of adding rural marketing functions to the ASHA role, to increase her productivity as well as give her additional income earning avenues.

¹⁹ The initial product basket is expected to consist of condoms, oral contraceptives, ORS, reading glasses and general purpose OTC health and wellness products.

This note entails engaging ASHA in rural marketing activities, in addition to her basic functions as envisaged by the NRHM.

Engaging ASHAs in rural marketing: assessing viability

Both NRHM, *e-Choupal* and other such initiatives such as Project Shakti have been in existence for a few years; an analysis of their effectiveness and the guidelines for both the programmes is essential for assessing the viability of engaging the ASHA worker in rural marketing. In this context three questions must be asked:

- Why would the ASHA be interested in rural marketing?
- Why should the state be interested in engaging the ASHA in rural marketing?
- Do the existing guidelines for ASHA offer the possibility for this partnership?

To answer these questions, it is important to analyze some key aspects of the ASHA's functions.

The ASHA institution offers states the flexibility to define package of services and compensation: The ASHA program gives states flexibility to adapt ASHA guidelines in terms of the services delivered and the package of compensation. States are allowed to modify the amounts or paying mechanism in keeping with the local priorities. For example, in West Bengal, the payments to ASHAs are not tied to the number of beneficiaries served, but rather consist of a fixed payment for the provision of various services²⁰. Some states have even modified the guidelines laid down by the Government of India regarding the selection and role of ASHAs. For example, in Rajasthan, they were earlier employed as *Sahyogini* at the Anganwadi Centre (AWC) under Integrated Child Development Scheme (ICDS) receiving a regular salary. In Chhattisgarh, ASHAs were earlier employed as *Mitanin* to support ANMs in their routine activities. After NRHM was launched in 2005, these states did not follow the routine procedure of selection of ASHAs owing to the particular situation of the already existing workforce. Similarly, under the Norway India Partnership Initiative, states like MP, Bihar, Orissa and Rajasthan introduced the *Yashoda* or *Mamta* as a quick response by the State Health Societies of these states for addressing quality of newborn and related maternal care. In these states, the *Yashoda* or *Mamta* took over from where the ASHA completed her tasks²¹.

ASHA remuneration varies across states: Several discrepancies exist in incentive rates across states. For example, while all ASHAs receive Rs. 600 for institutional deliveries (the nationally prescribed amount), ASHAs in Rajasthan receive only Rs. 250. They do receive a Rs. 150 transport allowance per delivery which is calculated separately; however, the total incentive is still Rs. 200 lower than in other states. ASHAs are supposed to receive Rs. 75 for Pulse Polio Days, but those in Chhattisgarh receive only 50. Only ASHAs in Rajasthan receive the Rs. 150 (the nationally prescribed amount) for immunization days, while those in other states receive as little as Rs. 50. ASHAs in Bihar claim to receive no money for village health and sanitation days or toilet promotion.

²⁰ Government of West Bengal, Department of Health and Family Welfare. ASHA Implementation Guidelines.

²¹ Operational Guidelines for Yashoda/Mamta. NIPI, 2010.

<http://mpnipi.org/yashoda/yashodaoperationalguideline2010.pdf> accessed on 22.07.2011

Only in Rajasthan do ASHAs receive a fixed salary of Rs. 500 per month in addition to various activity-related incentives. In all other states in India, their monthly income is on an incentive only basis.

ASHAs have the time for additional activities: Most ASHAs work 26-28 hours a week which is at best 60-70 percent of the standard full-time employment. This provides potential for taking on additional responsibilities, which would, in turn increase her incentives. ASHAs visit on average 3 to 4 households per day in a village. Their working hours are almost invariant whether they handle one village or two, or whether they handle 450 people or 1500 people. In fact, some ASHAs are engaged in other regular work and treat this as additional part time work. The Columbia University study suggests that there is potential for ASHAs to take on some additional roles outside those originally prescribed and additional responsibilities within her scope of capabilities should be considered.

Motivation matters: Monetary compensation is not the sole motivation factor for the ASHAs. The desire to serve the community, increase their knowledge, becoming a part of the formal health system and the prestige associated with the position are additional reasons for becoming an ASHA. In a study with ASHAs in 4 states it can be seen from the Table I (above) that for most of the ASHAs in these states the desire to improve health facilities in the village is the primary motivating factor, which is in line with the NHSRC's findings from the evaluation of the ASHA programme.

Keeping this in mind, and building on the initial design of ASHAs working only part-time, career progression for the ASHA can include further engagement in health outreach activities, thereby enhancing her status as a health care worker in the community. By engaging her in additional health activities including rural marketing of locally relevant health products she may enhance her income as well as consolidate her image and prestige as a health care worker.

Recognizing this potential the Government of India announced a scheme in October 2011 that allows ASHA workers to sell condoms and other contraceptives door to door at a nominal fee. For example a pack of three condoms is priced at Re. 1 whereas one tablet of an Emergency Contraceptive Pill (ECP) is to be sold at Rs.2. The scheme is to be implemented in 233 districts of 17 states across the country. Under the scheme the Chief Medical Health Officer will provide condoms and oral contraceptives to ASHA workers for distribution. The ASHA workers would be imparted training for this social marketing initiative.

Link between awareness generation and health products: A number of areas where ASHAs are providing awareness have an automatic link to the products that they could simultaneously make available to the families.

For example:

Area of awareness generation²²	Possible product category
Sanitation and hygiene	Soaps, disinfectants, sanitary napkins
Prevention of illnesses	Mosquito repellants, vitamins and mineral supplements, IFA, water purification tablets
Mobilizing community for use of family planning measures	OCPs, ECPs, condoms
Dealing with outbreak of diseases such as diarrhoea	ORS

Given her close engagement with families, especially women, the ASHA worker can assist in identifying the communities' needs, modifying the product basket based on the changing requirements of the communities, or responding to seasonal priorities. For example treated bed nets can be promoted during the season when the risk of malaria is heightened.

Optimising ASHA's home visits and time: Usually households in a village are scattered and ASHAs are already reaching out to these families. The amount of time the ASHA spends in the field on activities per day or in a week depends on how the ASHA decides to divide her time to perform her tasks. The ASHA is not a full time employee and in the absence of a formal reporting structure, the hours of work depend on factors related to the availability of work in the catchment area, the distance she needs to travel and the motivation. Thus providing her with a product basket will help her maximize the gains both for the communities and for herself in the same visits without making extra effort by (a) offering more information and products to the households during their visit and (b) earning additional income through sale of products to the households. The possibility of additional income will serve as a motivation for her home visits.

Engaging ASHAs in rural marketing: the justification

Prior to making any recommendation it is pertinent to understand the factors that will make rural marketing acceptable and attractive to the two key stakeholders, namely the ASHA worker and the government. The assessment of the viability of engaging ASHAs in rural marketing leads to the following responses to the three queries posed in the beginning of the previous section:

The ASHA will be interested in taking on the additional role of promoting a basket of relevant health related products as is being done by the VHCs in the *e-Choupal* model because it will:

- enhance her income and add to her motivation

²² Comprehensive list of awareness generation areas published in Earth Institute and IIM-Ahmedabad Survey of ASHAs, 2010

- help consolidate her status as a health care worker
- fit easily with her everyday work and help her to achieve maximum benefits from her household visits
- contribute to her aspiration of improving the health situation of the community

The state could be interested in engaging the ASHA in rural marketing as it will:

- provide additional incentive and motivation to the ASHA
- give the option of full time work to her and thereby contribute in making the model more sustainable, without additional cost to the state
- contribute to the overall health outcomes of the state

Additionally, the existing NRHM guidelines for ASHAs offer the possibility for this partnership as:

- there is inbuilt flexibility in the guidelines with regards to the kind of work the ASHA can do and the remunerations etc.
- nothing in the guidelines prevents ASHAs from taking up any *additional* work, and rural marketing matches well with her usual profile and functions
- most significantly, the additional activities will only further contribute towards achieving the impact indicators set out for the ASHAs in the NRHM Guidelines, namely:
 - o IMR
 - o Child malnutrition rates
 - o Number of cases of TB/leprosy cases detected as compared to previous year

These impact indicators can be better achieved if ASHAs combine the dual function of enhancing the access of communities to services along with product marketing.

Risk analysis: Whereas a strong case is made for engaging ASHA in rural health marketing, such an initiative should be planned keeping in mind possible risks that could arise during the process of combining her basic function of a health activist with that of an entrepreneur. One such risk is of her excessive involvement in product marketing at the detriment of her public service role. This may also result in changing her public image to that of a commercial entity. The other major risk is of her possible exploitation by various manufacturers for specific brand promotion through provision of additional incentives.

However, such risks can be managed or mitigated by developing safeguards when planning the initiative. For example, as the ASHA draws significant income from her current work, it is highly unlikely that she would allow rural marketing to overshadow her primary role as a health activist. However, she is much more likely to take this up as a complimentary activity both based on her convenience and the community's needs. However, this cost benefit analysis should be done together with the ASHA so that she understands the importance and financial relevance of not losing sight of her traditional functions.

Lessons from the recently launched government scheme for engaging ASHA workers in door to door sale of contraceptives suggest the need for developing a robust logistics and monitoring system to ensure uninterrupted supply of products to the ASHA Workers. Additionally there is need for training of ASHA workers on social marketing. However, given that a prolonged training of the ASHA workers has already been completed, a fresh training may create burden on the time of the ASHA Workers as well as on the health budget.

In this context it must also be outlined that a partnership between an initiative like the *e-Choupal* and the NRHM will also add value to the work of ASHAs. For example, it is well known that the success of the ASHA initiative depends on regular and reliable supervision; however this is a weak link in the system²³. The *e-Choupal Sanchalaks* could provide that support where needed. Similarly, necessary products, including medicines can be made promptly available ensuring no stock outs with the ASHA.

Potential exploitation by manufacturers for promotion of specific brands could be prevented by developing clear guidelines outlining the dos and don'ts of each stakeholder including the ASHA worker, product manufacturer, NRHM Programme Manager and the *e-Choupal* Co-ordinator.

Conclusion and the way forward

A key recommendation of an analytical study conducted with ASHAs in Bihar, Uttar Pradesh, Chhatisgarh and Rajasthan is that the state should “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...”²⁴.

Without doubt ASHAs are and should continue to be central to the NRHM programme. However, it is evident that many of them have time for additional work and their motivation levels will improve if their income and public image could be further enhanced. Building the capacity of ASHA's to undertake rural marketing will enable the state to experiment with a grassroots PPP model. Lessons from existing projects such as the *e-Choupal* or the Shakti project provide useful insights into the type and extent of training that may be required for building the ASHA's capacity for undertaking rural marketing. Under the *e-Choupal*, the VHCs are provided intensive training on public health issues. Additionally, VHCs are expected to serve as community-based public health entrepreneurs with the prime responsibility of creating awareness around priority health issues and thus generating demand for a range of products and simultaneously enhancing their access to health products.

²³ Nirupam Bajpai and Ravindra.H.Dholakia. Improving the Performance of Accredited Social Health Activists in India. Working Paper No. 1, Working Paper Series, Columbia Global Centres.

²⁴ Nirupam Bajpai and Ravindra.H.Dholakia. Improving the Performance of Accredited Social Health Activists in India. Working Paper No. 1, Working Paper Series, Columbia Global Centres.
http://globalcenters.columbia.edu/southasia/files/mumbai/content/pdf/Improving_the_Performance_of_ASHAs_in_India_a_CGCSA_Working_Paper_1.pdf

The success of social marketing projects, including the *e-Choupal* initiative provides evidence that rural and relatively poorer communities are ready to pay for products if convinced of their utility. By engaging ASHAs in the promotion of a basket of locally relevant health products of a range of manufacturers, the partnership between the public and private sector could be extended at the community level, towards achieving the MDG health goals in the state. However, it is also important that the ASHA institution is not misused or exploited by profit making manufacturers to promote specific brands, instead of product categories. To protect her and the communities against any possible manipulation, the state must develop clear guidelines and framework for the partnership, outlining the roles and functions of each partner and the conditions of the engagement, indicating clearly the non negotiable role of ASHAs and the goal of the partnership which is promotion of better health outcomes in the state. The guidelines must also clearly stipulate means to ensure specific category promotion as opposed to specific product promotion.

By way of next steps, the government, in partnership with PPP experts must undertake an environment scan to identify suitable grassroots PPP models such as *e-Choupal*. Based on an analysis of the models and in consultation with the experts, elements of partnerships between NRHM, especially the cadre of ASHAs and the private sector must be identified. Clear guidelines for such partnerships must be developed outlining the role of different stakeholders and formalized through a policy directive.

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