Author’s response to reviews

Title: What do Accredited Social Health Activists need to provide comprehensive care that incorporates non-communicable diseases? Findings from a qualitative study in Andhra Pradesh, India

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Author’s response to reviews:

To The Editor,

BMC Human Resources for Health
Many thanks for the opportunity to amend our manuscript. Below we address issues raised by Reviewers. We have also incorporated corresponding changes in the revised manuscript that is attached.
We hope this letter and the updated paper satisfy your publication requirements.

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In the format:

Full editorial/reviewer comment
# Followed by author response
Reviewer(s)' Comments to Author:

Reviewer 1:

1. This is an important article- but I see this more as a documentation or description of what is happening with regard to CHW role in NCD control. Its analytic role requires to be strengthened. The authors have collected extensive qualitative data from different sources- but have used only
parts of it. For example one fails to see the community perceptions despite so many (5) FGDs and interviews with 47 members of the community. I would suggest that the findings present what each stakeholder group has to say on these three themes as different from the others and in what they overlap. Clearly for example medical officers who are permanent employees or regular employees could have a different view from program managers of the ASHA program. The former could be disparaging their role and the latter very supportive of it. Community, ASHA, ANM, MO and program managers may agree that they are un-recognised, overburdened and that they aspire to be part of the systems- but I would have liked to see how they differ on why it is so and the desirability of giving them a different role.

2. The failure of the ASHAs to engage with NPCDCS could be because
a) of an implementation failure where the implementing officers are not convinced of desirability and feasibility of it . How much time and effort is going into NPCDCS by the others in the system. the usual experience is that not only ASHAs- everyone is focussed only on some select areas of RCH and two or three disease control programmes.
b) because there is a lack of seriousness in implementing NPCDCS itself. If the ASHA or ANM were to identify the cases- is the required continuity of care and organization of services at other levels as required for managing NCDs in place? If they are not in place that could be the main reason while ASHAs could be held responsible for the same? I find the complete lack of information on the readiness of the program to deliver the required services as a lacunae. ASHA can facilitate and raise awareness - but if the services are not there- she is not responsible, and she would be justified in not pushing the program. or
c) is there some design side failure in the organization of NCD service

# Thank you for these insightful comments. The focus of the paper is not so much on the failure of ASHAs to engage with NPCDCS, which we agree may be due to a combination of factors including implementation failure. Indeed, while the design of NPCDCS is robust on paper, its roll-out lacks detail and is too ambitious for one cadre (ANM) to achieve on their own. Our focus in this manuscript focus was to explore the factors that facilitate or constrain ASHAs’ role in providing comprehensive primary care that incorporates NCD care. The study was conducted in Guntur, where NPCDCS has been launched and NCD management is being provided to the community. The aim of the study was to identify the challenges and enablers for the ASHAs to provide effective NCD care. As we conducted our study, we realised that while the policy documents highlight the role of ASHAs in the program, in reality, there is a gap between policy and implementation. ASHAs are not recognised as members of the NPCDCS service delivery team and medical officers’ opinion was that ASHAs are not competent enough to provide these services. However, ASHAs do provide NCD care to their community without receiving any NCD specific training or remuneration. The tasks they are performing are part of
ANMs targets and were not officially assigned to ASHAs. (Page 13, lines 4-10; page 13, lines 22-25; page 14, lines 1-9).

3. Despite being overburdened and underpaid the ASHA persists and aspires- this much is clear. Can we say the same about the regular employee? Does the qualitative studies provide understanding of why she does so? Is it expectation of future state action, is it agency? is it social and community pressures?

Since the study is completed- I do not envisage any further data gathering by the authors. But surely there must be information on these three above areas in such extensive qualitative data. If there is, it would be good to bring it in.

# We have now clarified, the expectations of the ASHAs and how they are still willing to help their communities despite of their current complains (Page 12, line 24, page 13, lines 1-2)

4. A small edit - pg 7 line 40- I think authors intend to say translated into English. Not back-translated. One could back-translate the translation of the questionnaire- but not an interview?

# This has now been modified

Reviewer 2:
Thank you for submitting this article. Overall, it was a relevant piece of work with some interesting findings particularly within the Indian context. I outline my reflections below, including suggesting some important revisions that stem from this review

1. The introduction reads as if ASHAs have been deployed as part of the current health care system to take on the NPCDCS tasks. However, in conclusion it states they are unrecognized and aspire to be part of health system. Please clarify what you mean by this for readers who may not be familiar, given that you initially state that they are part of the health system.

# Thank you for your comments. This has now been clarified to distinguish between primary healthcare team recognition and NPCDCS service delivery team recognition. (Page 9, lines 1-9) and (Page 13, lines 6-14)

2. The manuscript has clearly defined questions about understanding the role of ASHAs and challenges in their work conditions, especially related to taking on additional tasks related to NCD control. However, the paper doesn’t clarify what they are expected to deliver. NCDs cover a wide breadth of very variable chronic conditions - what is expected of them? What is part of their (new) remit? What kind of training have they received? If this was part of the process - which it appears to be - this needs to be explicitly stated or clarified.

# The manuscript reported the tasks to be performed by ASHAs as per the NPCDCS policy documents review. (Page 8, lines 18-23).
ASHAs receive an intensive 21 days initial training mainly focusing on their maternal and child health role. This manuscript focus on the role expansion of the ASHAs to incorporate NCDs activities. We have now clarified that ASHAs did not receive NCDs-specific training before providing NCD services. (Page 8, lines 7-11)

3. Overall study design is appropriate, just requires the descriptive data to be further clarified. The ASHA are a recognized member of the team at policy level. So arguably they are a formal
member of the team bureaucratically, but it appears that what you have reported is that on the ground they are not recognised nor empowered to fulfill their role(s). Rather than simply unrecognised, they are not empowered at the local level. You need to be explicit about what specific NCDs issues ASHAs have been / will be offered formal training in. Also to explicitly say they receive no formal training to date, if this is the case. This is a key finding in itself. Also is there anything in place formally to assess their ability and determine the quality of care they are providing (in relation to NCD control, or more generally)? What do you mean by “official delegation of services” - can you explain that with examples? You state they are a recognized member of the team at policy level but is that an official recognition? It appears that you are getting at the fact that this is not clearly defined at an official level. Recognition of the breadth required to be covered by these workers and the reality on the ground of achieving this level of training and experience in an ad hoc fashion should be discussed.

# We have now clarified the situation for the ASHAs and how they are recognised as part of the primary care team but not specifically part of the official NPCDCS team on the ground. (Page 8, line 7-11; page 13, lines 4-15).

4. One thing that hasn't been discussed is the level of experience and exposure of ASHAs prior to taking on these roles. The recommendations are very broad and well known, however they don't add to current knowledge - can you highlight more clearly what is novel in this study? There are issues around the baseline knowledge and breadth of knowledge these community health workers are expected to obtain in real-time in order to fulfil their roles and responsibilities. This may mean that this current strategy isn't workable and perhaps focusing on key areas of interventions for particular NCDs might be something to consider in the discussion. The area around the ASHAs feeling out of depth and lacking knowledge and formal training in addition to lack of empowerment from co-workers at a primary health care workers is an important one. However, perhaps the key message should be framed around focused structuring of training and the magnitude of expectation as to what individuals should cover. The perceived breadth of knowledge required as great by the workers is an interesting issue as is the perception of colleagues at the local health centre.

A recent Lancet collection would seem relevant to add to the discussion.
https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)32172-X/fulltext

# The manuscript discusses the importance of the prerequisite basic level of education for the ASHA candidates, to ensure their ability to learn new knowledge and skills to provide quality care service. (Page 11, line 24, page 12, lines 1-2). We have now highlighted it further in our discussion section. (page 13, lines 22-25; page 14, lines 1-12).

It has now been clarified that the ASHAs are not appropriately utilised by the health system as part of the NPCDCS, although all stakeholders agree that ASHAs are particularly well positioned to provide NCD care to the community if provided with adequate NCDs training. (Page 13, lines 4-15).