International Journal of Research and Review
www.ijrrjournal.com E-ISSN: 2349-9788; P-ISSN: 2454-2237

Original Research Article

Evaluation of ASHA workers under NHM in Katihar Sadar and Korha Block of Katihar District

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ABSTRACT

Background- In 2005, Government of India launched National rural health mission in hopes to bridge the gap between healthcare delivery system to the needed community. One of the key strategies under the National Rural Health Mission is having a community health worker who is an Accredited Social Health Activist (ASHA) for every village with a population of 1000.

Objectives-

1. To evaluate the work performance of ASHA workers in their field practice area
2. To gather feedback given by the ASHA workers regarding incentives received by them and the challenges they face during their disposal of duties and responsibilities.

Methods and Methodology

The present study is conducted in the Chaapi and Hazipur village of Katihar sadar Block, and Kolasi village of Korha Block of Katihar District (Bihar). In this study Purposive Sampling is used for selecting the sample of ASHA. Total 45 villages ASHAs were interviewed using predesigned semi-structured questionnaire from June to October, 2018.

Results: Maximum numbers (68.89%) of ASHA were qualified to 8th Standard and only 2.22% respondents were having qualification of graduate and above. About 71.11 % and 17.78 % of the respondents spent 2-4 hours and 4-6 hours a day respectively for catering to health services in rural areas. Majority of the ASHA belongs to Upper Lower (33.33%), Lower middle (28.89%) and Upper lower (28.89%) socio economic status. 77.78 % of the respondents agreed that the main purpose to join as ASHA was to financially support their family. About 55.56 % joined as ASHA to do social work. Only 64.44 % of the ASHA were able to diagnose dehydration and its reasons. 88.89 % of the respondents were able to test anemia and also ensures treatment for it. About 77.78 % of the respondents were able to screening of pregnant woman for problems and danger signs and referral, and 73.33 % have interpersonal communication skills. Majority of the ASHA workers (88.89%) suggested that the honorarium that they get should be regularised and 77.78 % suggested for improving transportation facilities and 86.67 % opinionated to have periodic retraining and upgrading their knowledge and skill base.

Key Words- NHM, ASHA workers, Feedback, Immunization

INTRODUCTION

In the year 2005, National Rural Health Mission, a sub-mission of NHM was established with the aim to provide attainable, economical health care services to the vulnerable areas of society, i.e. rural areas. In other words, it aims to do the vital compositional adjustment in the essential human services conveyance framework, with an arrangement of activity that incorporates a guarantee to build open use on well-being. NRHM Framework for

Implementation, (2005) states that the Empowered Action Group (EAG) States and in addition North Eastern States, Jammu and Kashmir and Himachal Pradesh have been given unique core interest by NRHM. It likewise tried to curtail the Maternal Mortality Rate (MMR) in the nation from 407 to 100 for each 100000 live births, Infant Mortality Rate (IMR) from 60 to 30 for every 1000 live births and the Total Fertility Rate (TFR) from 3.0 to 2.1. [1]

One of the key strategies under the NRHM is having a community health worker who is an Accredited Social Health Activist (ASHA) for every village with a population of 1000. These ASHA workers should preferably be female, in the 25-45 years age group and have a qualification of at least eighth class. [2]

The discourse on the ASHA's role centres around three typologies - ASHA as an activist, ASHA as a link worker or facilitator, and ASHA as a community level health care provider. She will counsel women on birth preparedness, importance of safe delivery, breastfeeding and complementary feeding, immunization, contraception and prevention of common infections including reproductive tract infection/sexually transmitted infection (RTIs/STIs) and care of the young child. 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. [3]

ASHA will be given performance based compensation/remuneration. She can earn good amount of money by taking responsibility of patients by promoting institutional deliveries (allowance under Janani Suraksha Yojana), VHSC, nutritional and national programs. There is a provision for non-monetary compensation in the form of recognition, awards given at state level meetings of ASHA. [4,5]

The Objectives of the Study is to evaluate the work performance of ASHA workers in their field practice area and to gather feedback given by the ASHA workers regarding incentives received by them and the challenges they face during their disposal of duties and responsibilities.

MATERIALS AND METHODS

Out of 16 Primary Health Centre (PHC) in Katihar District, The present study was conducted in the Chaapi and Hazipur village of Katihar sadar PHC, and kolasi village of Korha PHC. The ASHA workers were contacted in their respective PHC during their monthly review meetings. After explaining the purpose of the study and obtaining oral consent, the study was conducted using interview technique. Information was collected in a pretested proforma by the investigator.

The study was conducted from June 2018 to October 2018. Total 45 villages ASHAs were interviewed using predesigned semi-structured questionnaire in their respective PHC during their monthly review meetings.

Data is sorted using Microsoft excel and analyzed used Epi info ver.7.0.

RESULTS

Educational Qualification	No. of Respondents	Percent
Primary	5	11.11
Middle	31	68.89
Secondary	4	8.89
Higher Secondary	4	8.89
Graduation and Above	1	2.22
Total	45	100.00

Table-1 Educational Qualification of ASHA

According to the above table, Maximum numbers (68.89%) of ASHA are qualified to 8th Standard and only 2.22% respondents are having qualification of graduate and above.

Socio economic Status	No. of Respondents	Percent
Upper	4	8.89
Upper Middle	13	28.89
Lower Middle	13	28.89
Upper Lower	15	33.33
Lower	0	0.00
Total	45	100.00

Table-2 Socio economic status of ASHA

Majority of the ASHA belongs to Upper Lower (33.33%), Lower middle (28.89%) and Upper lower (28.89%) socio economic status. It discloses that ASHA are

catering health services to support their household income.

Time spent by ASHA	No. of Respondents	Percent
0-2 Hours	1	2.22
2-4 Hours	32	71.11
4-6 Hours	8	17.78
6-8 Hours	4	8.89
Total	45	100.00

Table-3 Time spent by ASHA per day

The above table indicates the time spent by ASHA per day. It depicts that about 71.11 % and 17.78 % of the respondents spent 2-4 hours and 4-6 hours a day respectively for catering to health services in rural areas.

Purpose of joining ASHA	No. of Respondents	Percent
Financial Support	35	77.78
Social Status	10	22.22
Social Work	25	55.56

Table 4- Purpose of Joining ASHA

77.78 % of the respondents agreed that the main purpose to join as ASHA was to financially support their family. About 55.56 % joined as ASHA to do social work.

S/No	Skills Attained	No. of Respondents	Percent
1	Ability to conduct village meetings	37	82.22
2	IPC Skills.	33	73.33
3	Ability to maintain records	40	88.89
4	Ability to track beneficiaries and to update MCH / immunization Card.	41	91.11
5	Ability to do screening of pregnant woman for problems and danger signs and referral.	35	77.78
6	Ability to provide normal care to new born.	41	91.11
7	Able to counsel mothers about breastfeeding	43	95.56
8	Able to plan periodical home visits.	42	93.33
9	Able to track child immunization.	37	82.22
10	Able to diagnose dehydration and its reasons	29	64.44
11	Able to prepare and demonstrate ORS use to mother/caregiver	31	68.89
12	Able to test anemia and also ensures treatment for it.	40	88.89

Table-5 Skills Attained by ASHA

About 82.22 % ASHAs were able to conduct village meetings and 73.33 % have interpersonal communication skills. 91.11 % respondents were able to track beneficiaries, update MCH and immunization card. Above 77.78 % ASHA were able to do screening of pregnant woman for problems and danger signs and referral.

Feedback by ASHA	No.	Percentage
Monthly Honorarium	40	88.89
Staying problem at delivery centre	38	84.44
Transportation Improvement	35	77.78
Further Training as worker	39	86.67
Male Worker	29	64.44

Table-6 ASHAs Feedback

Majority of the ASHA workers (88.89%) suggested that the honorarium that they get should be regularised and 77.78 % suggested for improving transportation facilities and 86.67 % opinionated to have periodic retraining and upgrading their knowledge and skill base and also wanted to improve their position to escalate in position which is possible only when they are recognised as proper government employed and not honorary volunteers. Interestingly, about a 64.44 % of them found difficulty in counselling couples regarding family planning, especially about vasectomy. Despite the knowledge and awareness, they seem to suggest that male people can better create awareness amongst their peers and motivate them for the same.

DISCUSSION

In our study 68.89% 0f ASHA educated up to 8th standard. The above finding is similar to the finding of Garg et al where 96.19% of ASHA worker completed 8th standard of the schooling. [6] According to our study majority of ASHAs socio economic status is upper lower (33.33%) which is similar to the study done by Singh et al where out of 135 ASHA, most of the ASHA 93 (68.9%) belong to class IV (upper lower) socioeconomic status. [7]

In the present study, 91.11% ASHA were able to provide normal care of newborn. A study done by Dinesh Paul in their study reported by ASHAs included keeping the child warm (84%), which is similar to our study. [8]

In the study done by Paul, the knowledge of ASHAs about initiation of breastfeeding within an hour; feeding colostrums; avoiding pre-lacteal feeds and exclusive breastfeeding for six months was reported by 96 percent, 99 percent, 92 per cent and 98 percent of ASHAs, similar to our study. [8]

In our study 82.22 % ASHA were able to track child for Immunization. Study done by Srivastava reported that 70.1% ASHA had good knowledge regarding importance of immunization and its adverse effects. [9]

Only 68.89% ASHA were able to prepare and demonstrate ORS use to mother/caregiver in our study. Saxena S et al reported similar finding, when the ASHA were asked about breastfeeding should be continued if the baby has diarrhoea, (54.7%). [10]

CONCLUSION AND RECOMMENDATIONS

It was concluded from the study that majority of ASHAs know their role and details except diagnosis of dehydration and use of ORS. The present study showed that knowledge is good in certain areas, but improvement is needed in terms of knowledge and skills to deliver child health services effectively. The feedback of ASHA volunteers seems valid as its best to regularise their honorarium for every month as it can act as major motivating factor. Facilitation of transport to them such as providing them cycles on subsidy could help them to dispose their duties more efficiently. She can always take the help of PHC personnel, in creating the awareness amongst her community

Limitations of study

- Sample size is small.
- Questions answered by respondents may have some biasness because some of ASHA have not maintained proper records of their performance.
- Primary study is restricted to Hazipur and Chaapi Village of Katihar Sadar block and Kolasi village of Korha block.

REFERENCES

1. National Rural Health Mission (2005).Framework for Implementation. Ministry of Health and Family Welfare. Government of India. Retrieved August, 2016, from http://www.nipccd-earchive.wcd.nic.in/sites/default/files/PDF/NRHM%20-%20Framework%20for%20Implementation%20-%20%202005-MOHFW.pdf
2. The government of India. NRHM-ASHA (2005) Guidelines. New Delhi: Ministry of Health and Family Welfare, 2005.
3. Ministry of Health and Family Welfare, Government of India. Guidelines on Accredited Social Health Activists (ASHA), 2015. Available at: www.mohfw.nic.in/NRHM/RCH/guidelines/ASHA_guidelines. Accessed 10 June 2015.
4. Government of India. National Rural Health Mission (2005-2012): Mission documents and monograph 1-6. Ministry of Health and Family Welfare, Nirman Bhawan, New Delhi, 2005. Available at: http://www.mohfw.nic.in/nrhm.html. Accessed 10 September 2014.
5. Government of India. Update on the ASHA programme. National Rural Health Mission. New Delhi: Ministry of Health and Family Welfare; Jan 2012.
6. Garg PK, Bhardwaj A, Singh A, Ahluwalia SK. An evaluation of ASHA worker's awareness and practice of their responsibilities in rural Haryana. National J Community Med. 2013;4(1); 76-80.
7. Singh A, Saxena SC, Srivastava VK, Martolia DS, Varma P, Sharma RP, et al. A Study of behavioural attitude of ASHAs in primary health centres of a community development block of Kanpur Nagar. Indian J Community Health. 2009;22(1):71-4.

8. Paul D, Shanta, Krishnan G, Singh P. Functioning of Accredited Social Health Activists in ICDS: An Evaluation. Health and Population - Perspectives and Issues. 2013;36 (3and4):78-89.
9. Shrivastava SR, Shrivastava PS. Evaluation of trained Accredited Social Health Activist (ASHA) workers regarding their knowledge, attitude and practices about child health. Rural and Remote Health (serial online); 2012: 1-7.
10. Saxena S et al. Appraisal of knowledge of ASHA regarding child health services provided under NHM in Bhojipura block, District Bareilly. Int J Community Med Public Health. 2017 Oct;4(10):3705-3711

How to cite this article: Pandey AK, Rani S. Evaluation of ASHA workers under NHM in Katihar Sadar and Korha block of Katihar district. International Journal of Research and Review. 2019; 6(5):214-218.

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