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Research Paper

ROLE AND PERFORMANCE OF ACCREDITED SOCIAL HEALTH ACTIVISTS (ASHAs): A MICRO LEVEL INVESTIGATION IN GADAG DISTRICT OF KARNATAKA STATE

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ABSTRACT

One of the key components of NRHM was to appoint a trained community health activist called 'ASHA' in each and every village of the country. The strategy was that ASHA will be trained to work as an interface between community and the public health system. It was envisaged that ASHA should be a resident of the village preferably in the age group 25-45 years and should have education above eighth standard. Moreover, ASHA will be chosen through a rigorous process of selection involving various community groups, self-help groups, anganwadi institutions, the block nodal officer, district nodal officer, the village health committee and the gram sabha. This paper focuses on examination and study to know socio-economic characteristics of ASHA, and to study the Role and Performance of ASHAs in study area. This paper is based on complete primary level data and using simple statistical tools like average percentage charts and table. Study concludes that the role and performance of ASHAs in village level its good. Now a days in village level institutional deliveries increasing trend because of ASHAs that's why government appoints more number of ASHA in village level and give to training before joining of ASHAs their work. It helps to serve their services in good way. And government gives incentive money in time to ASHAs. It helps to lead there family and doing works effectively. And gram panchayath leaders involve in conducting the health programmes at village level. It helps to increase the awareness about the health facilities to rural people.

KEY WORDS: *ASHAs. Health Workers. Health Indicators. Health Infrastructure. Health Services.*

INTRODUCTION

National Rural Health Mission was launched in April 2005 by GOI. The mission seeks to provide effective healthcare to rural population, especially the vulnerable sections of the society through Inter-sectoral Convergence. Under National Rural Health Mission (NRHM) many innovations have been introduced in the states to deliver healthcare services in an effective manner. One of the key components of NRHM was to appoint a trained community health activist called 'ASHA' in each and every village of the country. The strategy was that ASHA will be trained to work as an interface between community and the public health system. It was envisaged that ASHA should be a resident of the village preferably in the age group 25-45 years and should have education above eighth standard. Moreover, ASHA will be chosen through a rigorous process of selection involving various community groups, self-help groups, anganwadi institutions, the block nodal officer, district nodal officer, the village health committee and the gram sabha. Some of the key activities of ASHA are:

1) ASHA will be empowered with knowledge and a drug kit to deliver first-contact healthcare.
2) She will be a promoter of good health practices and will also provide a minimum curative care.
3) She will provide information to the community on determinants of health.
4) She will counsel women on birth preparedness, importance of safe delivery, breastfeeding and complimentary feeding, etc.
5) She will mobilize the community and facilitate them in accessing health and health related services available at facilities.
6) She will act as depot holder for essential provisions being made to all habitations like ORS, IFA, etc.

To enable ASHA to carry out the aforementioned activities professionally, capacity building of ASHA was

considered as very important. After recruitment, ASHA will have to undergo series of training episodes to acquire the necessary knowledge, skills and confidence for performing her spelled out roles. The guidelines issued on ASHA envisage a total period of 23 days training in five episodes. To achieve this, five training books were developed - first book is on vision of NRHM, identification of body organs, sanitation, and knowledge about the public health system; second book is devoted to issues related to maternal and child health; third book includes family planning, RTIs/STIs & HIV/AIDS and adolescent reproductive and sexual health; fourth book discusses national health programs like AYUSH, and management of minor ailments; and book five aims to strengthen her role as a health activist. After a period of 6 months of her functioning in the village, it was proposed that she will be sensitized on HIV/AIDS issues including STI, RTI, prevention and referrals and also trained on new born care. The ASHA will receive performance-based incentives for promoting universal immunization, referral and escort services for reproductive & child health (RCH) and other healthcare programmes, and construction of household toilets. (Concurrent Evaluation of NRHM Karnataka Report 2009)

ASHAs are local women trained to act as health educators and promoters in their communities. The Indian MoHFW describes them as health activist(s) in the community who will create awareness on health and its social determinants and mobilize the community towards local health planning and increased utilization and accountability of the existing health services. Their tasks include motivating women to give birth in hospitals, bringing children to immunization clinics, encouraging family planning (e.g., surgical sterilization), treating basic illness, and injury with first aid, keeping demographic records, and improving village sanitation. ASHAs are also meant to serve as a key communication mechanism between the healthcare system and rural populations. She will act as a depot older for essential provisions being made available to all habitations like Oral Rehydration Therapy (ORS), Iron Folic Acid Tablet(IFA), chloroquine, Disposable Delivery Kits (DDK), Oral Pills & Condoms, etc.(Wikipedia, the free encyclopedia)

ASHAs must primarily be female residents of the village that they have been selected to serve, who are likely to remain in that village for the foreseeable future. Married, widowed or divorced women are preferred over women who have yet to marry since Indian cultural norms dictate that upon marriage a woman leaves her village and migrates to that of her husband. ASHAs preference for selection is they must have qualified upto 10, preferably between the ages of 25 and 45, and are selected by and accountable to the gram panchayat (local government). If there is no suitable literate candidate, a semi-literate woman with a formal education lower than eighth standard, may be selected. (Wikipedia, the free encyclopedia)

Although ASHAs are considered volunteers, they receive outcome-based remuneration and financial compensation for training days. For example, if an ASHA facilitates an institutional delivery she receives 600/- and the mother receives 1,400/- . ASHAs also receive 150/- for each child completing an immunization session and 150/- for each individual who undergoes family planning. ASHAs are expected to attend a Wednesday meeting at the local primary health centre (PHC); beyond this requirement, the time ASHAs spend on their CHW tasks is relatively flexible.(Wikipedia, the free encyclopedia) Initially ASHA scheme is implemented in during 2008 this scheme is implemented in the all districts of Karnataka State. In Karnataka State ASHAs are working in Under NRHM. 34860 ASHAs were selected and28946 were trained in Karnataka.

In Gadag district there are total 39 Primary Health Centres, 183 sub-centres, and 1 district Hospital. To strengthen primary health centre and improve the health status of villagers under NRHM, district health mission was implemented in Gadag district. Each village and each primary health centre of Gadag district has ASHAs. There are total 564 ASHA working in the Gadag district. To provide medical care to villagers their role is very important. In this context the present study made an attempt to examine the role and performance of ASHAs in improvement of institutional delivery and health status of village in Gadag district.

THE OBJECTIVES OF THE STUDY

The following are the specific objectives of the present study:

- To know socio-economic characteristics of ASHAs.
- To study the Role and Performance of ASHAs in study area.

METHODOLOGY AND STATISTICAL TOOLS

The present study has been carried out only in four villages of two talukas i.e. Ron and Mundaragi of Gadag district in Karnataka State. The present study was based on the primary as well as secondary data. Universe of the present study was the total ASHAs in Gadag district and there were 564 ASHAs working when study was conducted. Out of 564, for study purpose 56 ASHA are being selected in the year 2016. Out of 39 Primary health centre (PHC) in Gadag district, 4 PHC's were randomly selected for the study. Data was collected by interview technique using semi structured questionnaire. For study purpose simple statistical tools are used like Average percentage, Pai charts, Bar chart, are used.

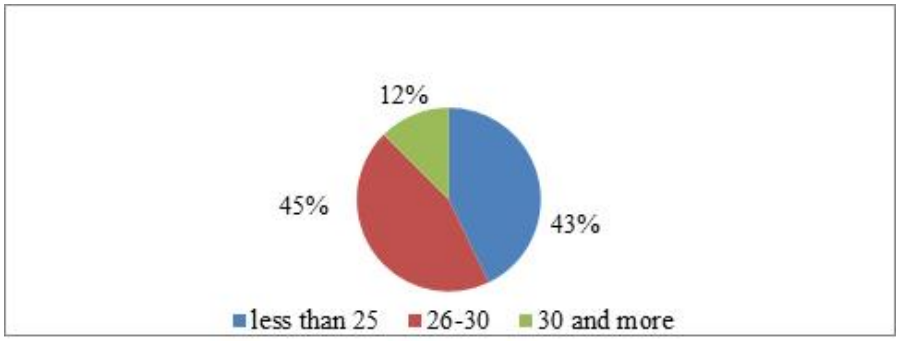
RESULT AND DISCUSSION

Respondent's socio-economic background:

This section discusses the socio-economic background of selected samples. The socio-economic background of respondents is studied in terms of age, marital status, religion, caste, education, type of family, members of family, and annual income of family, of ASHAs. ASHA scheme is particularly implemented under NRHM to improve the health status of villagers particularly women and children and provide health care facilities of primary health centre to the villagers. Primary Health Centres are the corner stone of rural primary health care in India. These are the important workplaces of social health activists. While studying the role of ASHAs in the improvement of health status of villagers, it is essential to know the village and PHC of each ASHA.

Chart 1 represents age-wise distribution of the respondents. By observing this, it shows that out of 56 respondents 12 percent belong to the age group of 20-25, 45 percent belong to the age group of 26-30, and 43 percent belong to the age group 30 and more. Majority of women are belonging to the age group of 26-30. This is because of NRHM guidelines and majority women prefer to work after marriage and children.

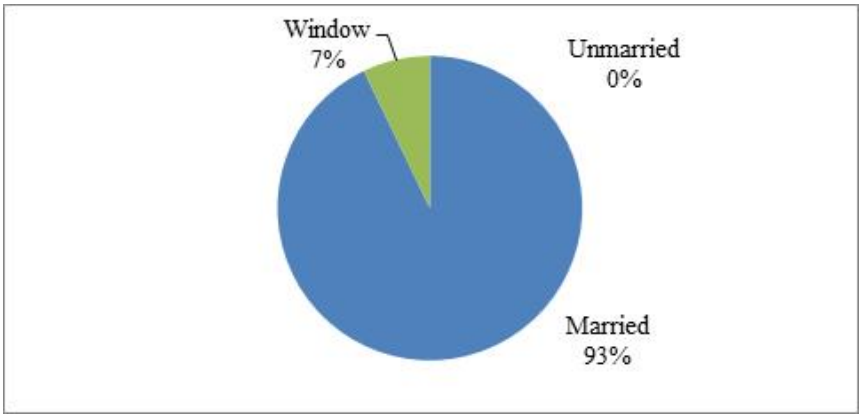
Chart No: 1 Age-Wise Distribution of the Respondents (In Percentage)



Sources: *Primary Data*

Chart No 2; represent distribution of the respondents by marital status. This chart shows that out of 56 respondents 93 percent respondents are married and others 7 percent respondent are widow. The study conclude that majority of ASHAs are married.

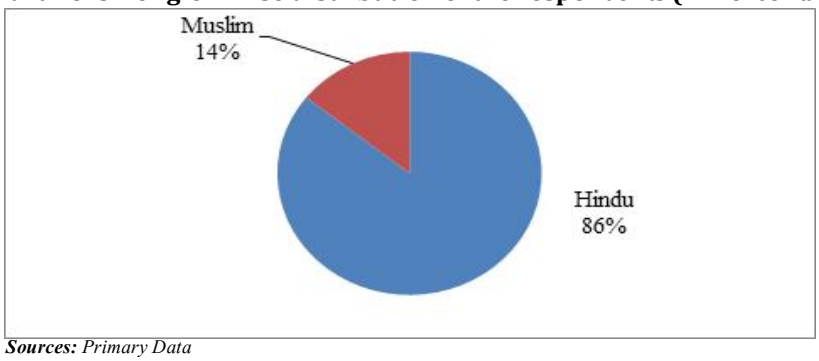
Chart No: 2 Distribution of respondents by marital status (In Percentage)



Sources: *Primary Data*

Chart No 3 indicates religion-wise distribution of the respondents. This chart shows that out of 56 respondents, 86 percent are Hindu, 14 percent is Muslim. In the study are.

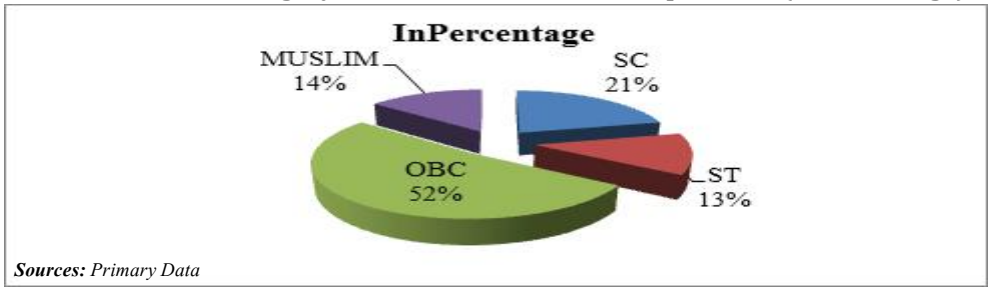
Chart No: 3 Religion-wise distribution of the respondents (In Percentage)



Sources: *Primary Data*

The caste-category wise distribution of the respondents is given in the Chart 4. This chart indicates that out of 56 respondents, 52 percent respondents are from OBC category, 21 percent respondents are from SC 13 percent respondents are ST category and 14 percent respondents are Muslim.

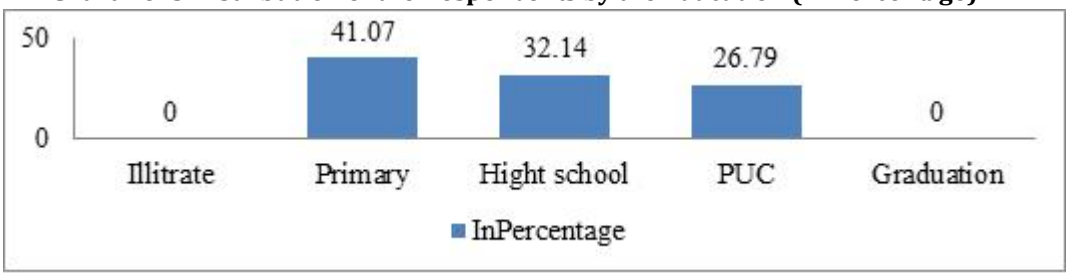
Chart No: 4 Caste-category wise distribution of the respondents (In Percentage)



Sources: *Primary Data*

Out of 56 respondents, 41.07 percent respondents have primary education, 32.14 percent respondents have education up to High school, and only 26.79 percent respondents have education up to PUC. Majority of respondents have primary education. Data has shown in the below chart no. 5.

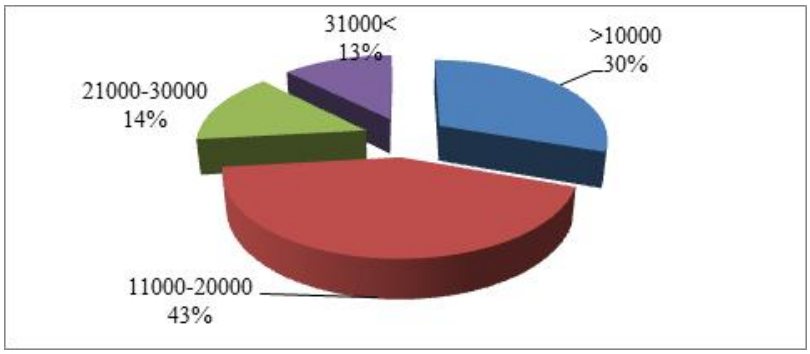
Chart No: 5 Distribution of the Respondents by the Education (In Percentage)



Sources: *Primary Data*

Chart 6 indicates the annual income–wise distribution of the respondents. Out of 56 respondents, 30 percent are from the income group of bellow10, 000, 43 percent are from the income group of 11,000/- to 20000/- and 14 percent respondents are from the group of 21000/- to 30000/-, only 13 percent respondents are from the income group of 31,000/ - and more.

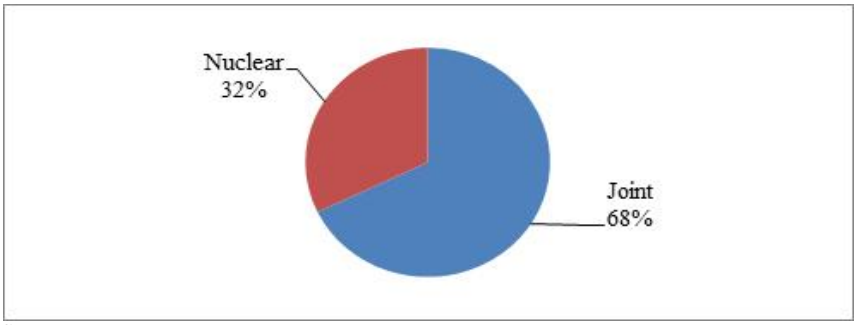
Chart No: 6 Annual Income–wise Distribution of the Respondents (In Percentage)



Sources: *Primary Data*

Bellow Chart 7 shows the distribution of the respondents by the type of family. Out of 56 respondents, 32 percent respondents have nuclear family, whereas 68 percent have joint families in the study area.

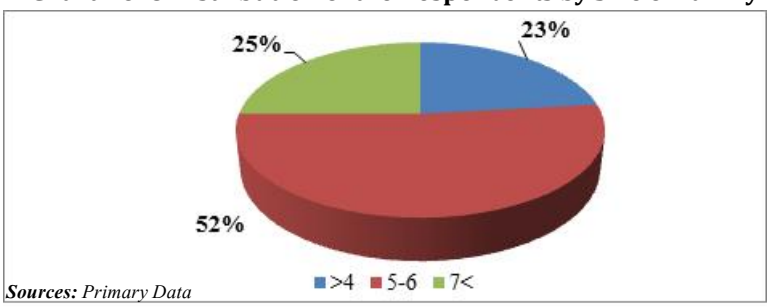
Chart No: 7 Distribution of the Respondents by the Type of Family



Sources: *Primary Data*

Below chart 8 shows the distribution of the respondents by size of family. Out of 56 respondents, 23 percent have less than 4 members in their family, 52 percent have 5 to 6 members in their family and 25 respondents have above 7 members in their family in the study area.

Chart No: 8 Distribution of the Respondents by Size of Family



Sources: *Primary Data*

ROLE AND PERFORMANCE OF ASHAs

Bellow table no.1 indicates the role and responsibilities of ASHAs in the study area. Among appointed ASHAs, majority of them are appointed through Gram Panchayath. Its 73.22 percent and 26.78 percent respondents are appointed through ANMs in the study area. 30.36 percent ASHA respondents served less than a year, most of 57.14 percent respondents served 1-2 year, and only 12.5 percent respondent served more than 2 year. Percent distribution of ASHA by population served, 25.57 percent of ASHA were serving more than 1000 population. 60.71 percent of ASHA reported serving 501 to 1000 population and only 10.71 percent serving less than 500, in the study area. One of important role of ASHAs conducting programme relating to health facilities and health awareness programmes. Bellow table 1 represents the meetings and programmes related to health awareness conducted for villagers by ASHA. Majority of ASHAs told that they conducted nearly 1 to 3 the meetings and programmesfor villagers. In the study area 60.17 percent respondent conducted meeting 1-3 times and 30.36 percent respondents conducted meeting 4-6 times; only 8.93 percent respondents conducted the meeting more than 7 times in the year of 2014-15. NRHM programme have some sub programme related to heath. Table 1 also presents ASHA's awareness about major sub programmes of NRHM. About 100 percent of ASHA knew that JSSY and Madilu kit program, and 85.71 percent knew the Prasuthi Araike , 92.86 percent knew Tayi Bhagya. 78.57 percent respondents knew the JSSY sub programme of the NRHM. And ASHAs also have awareness about JSY fund facilities under NRHM. Table 1 indicates the Number of Pregnant women taken to institutional delivery in the study area are 10.71 percent respondent. 1-5 number of Pregnant women are taken to institutional delivery, and 30.36 percent respondents 6-10 number of Pregnant women are taken to institutional delivery, and 46.43 percent respondents 10-20 number of Pregnant women taken to institutional delivery. Only 12.5 percent respondents more than 20 number of Pregnant women are taken to institutional delivery in the time of 2014-15 in the study area. Finally 62.5 percent ASHAs have highly satisfied their work, and 37.5 percent respondents have satisfied in their work in the study area.

Table No: 1 Role and Performance of ASHAs

Variable	Frequency	In Percentage
Appointed ASHA		
Gram Panchayath	41	73.22
Village Health Committee	0	0
ANMs	15	26.78
Community	0	0
Other	0	0
Numbers of Year Served		
Less than a Year	17	30.36
1-2	32	57.14
More than 2 year	7	12.5
Population Covered		
Less than 500	6	10.71
501-1000	34	60.71
1000 and more	16	28.57
No of Programmes Conducted		
1-3	34	60.71
4-6	17	30.36
7 and more	5	8.93
Knowledge about sub schemes of NRHM		
JSY	56	100
Madilu kit	56	100
Prasuthi Araike	48	85.71
Tayi Bhagya	52	92.86
JSSY	44	78.57
Number of Pregnant women taken to institutional delivery		
1-5	6	10.71
6-10	17	30.36
10-20	26	46.43
20<	7	12.5
Work Satisfied Level		
Very Good	35	62.5
Good	21	37.5
Bad	0	0

Sources: *Primary Data*

MAJOR FINDINGS OF THE STUDY

- Majority of women are belonging to the age group of 25-30. This is because of NRHM guidelines and majority women prefer to work after marriage and children.
- Out of 56 respondents, 41.07 percent have primary education 32.14 percent are have high school and 26.79 percent respondents are up to PUC.
- Out of 56 respondents, majority of respondents i.e. 43 percent respondent have annual income 11000/- to 20000/-.
- Appointed ASHAs majority of ASHAS appointed through Gram Panchayath, it is 73.22 percent, and 26.78 percent respondents are appointed through ANMs in the study area.
- In the study area 60.17 percent respondent conduct meeting 1-3 times and 30.36 percent respondents conduct meeting 4-6 time, only 8.93 percent respondents conduct the meeting more than 7 time in the year of 2014-15.
- ASHA's awareness about major sub programmes of NRHM. About 100 percent of ASHA knew that JSSY and Madilu kit program and 85.71 percent knew the Prasuthi Araike, 92.86 percent respondents knew the Tayi Bhagya and 78.57 percent respondents knew the JSSY sub programme of the NRHM.
- In the study area majority of respondents with 46.43 percent 10-20 number of Pregnant women are taken to institutional delivery only 12.5 percent respondents more than 20 number of Pregnant women are taken to institutional delivery.
- More than 80 percent respondent have problem faced by ASHA was "funds not available in time".
- The second commonly reported difficulty was about 64 percent of ASHA reported inadequate facilities for institutional deliveries as a problem.

CONCLUSION

The overall role and performance of ASHAs at village level is good. Now a day in village level institutional deliveries increasing trend because of ASHAs that's why government appoints more number of ASHAs at village level and give to training before joining of ASHAs their work. It helps to serve their services in good way. And government gives incentive money in time to ASHAs which helps them in leading their family and doing their works effectively. And gram panchayath leaders involve in conducting health programmes at villages level that helps to increase the awareness about the health facilities among rural people.

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