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Contribution of Accredited Social Health Activist (ASHA) under the Community Health Model of National Health Mission, India

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Abstract--- Introduction: *Under the Community Health programme of National Health Mission (NHM), one of the key component is providing a trained female Community Health Worker (CHW) named as Accredited Social Health Activist (ASHA) in every village of the country to serve the most marginalized and vulnerable rural population.*

Methodology: *Quantitative data collection method was used in this research. The data was collected from a purposive random sample of 309 ASHA which were interviewed through a structured questionnaires on their knowledge and practices on child health.*

Results: *88% ASHAs were found with Correct Knowledge of Complementary Feeding, 92% ASHAs had Correct Knowledge of ORS preparation, 85% ASHAs had Knowledge of Timely Initiation at correct age of Pediatric IFA syrup, 88% ASHAs had Knowledge on correct Pediatric IFA quantity, 94% ASHAs were found with Knowledge on correct Pediatric IFA frequency, 61% ASHAs had Correct Knowledge on danger sign detection, and 36% ASHAs were found with Correct Knowledge on SNCU discharge instructions. 84% ASHAs were found to be providing regular and structured Home visits to mothers on Child Health, 88% ASHAs were providing counselling on complementary feeding, 80% were ASHAs providing counselling on Exclusive Breastfeeding feeding, 92% ASHAs were providing counselling on ORS use during Diarhoea episodes, 85% ASHAs were providing counselling on Pediatric IFA supplementation, 61% ASHAs were providing counselling on danger Signs detection, However, only 10% ASHAs had referred sick infants to health facilities.*

Keywords--- *Knowledge and Practices of ASHAs, Home Visits, Counselling.*

I. INTRODUCTION

India accounts for 21 per cent of under-five death and more than quarter neonatal deaths globally (UNICEF, Levels and Trends in Child Mortality, 2014). As per the World Bank report, the Under Five Mortality Rate (U5MR) in India is 52 in 2013 showing a decline from 57 out of 1000 live birth in 2011 (World Bank, 2015). The current Infant Mortality Rate in India is 33 infant deaths per 1000 live births (Sample Registration System 2017). Under the Community Health programme of NHM, one of the key components is providing a trained female Community Health Worker (CHW) named as Accredited Social Health Activist (ASHA) in every village of the country to serve the most marginalized and vulnerable rural population. The key activities performed by ASHA are providing home

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visits and counselling to mother with infants on the following interventions:

- Maternal health
- Newborn and Child health
- Reproductive Health & Family welfare
- Adolescent health

II. LITERATURE REVIEW

CHWs identifies pregnant women and new-born in need of medical care, promote health care seeking, and provide counselling for improving home based practices throughout pregnancy period, new-born and childhood. As a link between a community and the public health facility, CHWs encourage treatment and follow-up. Community health workers are important pillar of primary public health care system. Effective implementation of community health strategies requires support at the policy level, training, supportive supervision, performance appraisal and logistics & supplies. Additionally, community health workers have received increased responsibilities for many health and development programs, and extension of their responsibilities needs to be considered carefully [1]. Outcomes from the available assessments provide context to our exploration in the performance of ASHA workers in India. A study on community health workers in Bangladesh during 1972, implemented under the health programme to improve rural health, recommends that financial incentives are primary inspiring factor and high drop-out rates are mainly due to discontent with the payment levels in proportion to the time invested by community health workers.

China timely adopted the concept of community health workers which were called barefoot doctors in 1950. Later structural reforms in 1978 resulted in an uneducated health labour force which was inadequately trained. This resulted in a community health worker system agonized with poor quality healthcare. Iran is an example where properly trained CHWs for two years have resulted favourable health outcomes of declined maternal mortality and increased life expectancy. CHWs were better trained to handle larger responsibilities efficiently while upholding quality standards in Iran [2]. CHWs were proposed as means for connecting gaps between health care delivery and rural communities. CHW programmes have shown great improvements in child and neonatal health outcomes, and it has been suggested that adequately paid CHWs becomes an essential part of public health systems. Payment to CHWs can possibly influence their motivation and effort. Generally, public health programmes follow a social, monetary and mixed market method for payments. Mindful empathy of the differences, and what is offered by everyone, is important in selecting the most appropriate payment method accordingly. [3]. NHM appointed a health worker at the community level which was named as ASHA which acts as a primary contact person for health care facilities to the community in her villages [4]. In India, the Home Based New-born Care programme by ASHA workers under NHM was introduced in 2011 for reducing neo-natal mortality rates (NMRs). ASHAs get cash incentives for conducting six post-natal visits at home for providing new-born care [5]. In

Jharkhand state of India, Sahiya is the term used for community health workers. Sahiya are the essential representatives of the community health programmes. The Sahiyas are nominated by the Village Health Committee as the outreach workers to support the health service providers on primary health issues with a focus on

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reproductive, maternal child and adolescent health services [6]. The ASHA project under the community health program widely covers all the major states with poor social and demographic indicators such as high mortality & fertility rates and inadequate health infrastructure. This community health project purposes to train one activist in every village of the country, which is a woman with adequate education at the primary level to create responsiveness about primary health care and its social elements. It also mobilizes local community towards health planning, and to increase demand in the vulnerable sections of the population including women and children for available public health care services [7]. A public health care system at the primary level shall ensure equity-based universal coverage of services which are acceptable to majority of population. ASHAs are community level workers and the achievements of National Health Mission in India completely depends on the efficiency and effectiveness of these ASHA workers. ASHA performs essential role in primary health outreach in the rural areas. She is an indispensable element of community health services by generating awareness on primary health and motivating community towards local health issues. The ASHA program in India has resulted into improved utilization of maternal, new-born & child health services at community level. She also collaborates with local governments for addressing the primary health needs of the community. Since the inception and implementation of community health programme, most of the health indicators have shown improvement i.e. decline in Maternal Mortality Ratio (MMR), Infant Mortality Rate (IMR) and Total Fertility Rate (TFR). Through active participation of ASHA workers, India is making extraordinary gains in the improvement of primary health. ASHA's are integral part of National Health Mission and social life in the villages. [8]. In one of the research study on ASHA workers around 86% of them had inadequate knowledge on new-born health care practices. Around 70% were aware about various causes of diarrhoea, however 92% were unaware about signs of the dehydration. Around 68% and 69% had lack of knowledge on measles & pneumonia diseases respectively. Close to 81% were aware about symptoms of malaria, however only 59% of them, knew curative treatment of malaria in children. The mean age of ASHAs that were interviewed was 27.8 and around 70% of them were secondary educated. [9]. A monthly group meeting led by the ASHA serves as a forum for discussion on diverse topics that range from dealing with menstruation to the importance of ANC and PNC, management of diarrhoea, healthy eating practices, good hygiene, and safe water. They are also taught about the importance of delaying marriage and motherhood. Vocational training and recreational activities are a part of the agenda and the girls participate in plays with these themes, staged regularly in their own village and others. Breaking into songs about diarrhoea and clean water is part of the group practice. In fact, one of the rules of the group is to begin each session with a song. [10]

Objectives

Measuring the contribution of Accredited Social Health Activist (ASHA) under the Community Health Model of National Health Mission through assessment of knowledge and practices of ASHAs.

III. METHODOLOGY

Quantitative data collection method was used in this research.

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Sample Size

The sample size for ASHA and mothers has been calculated using % Postnatal care by ASHAs. Absolute admissible error of ±10% (confidence interval) at 95% confidence level; design effect of 1.5. The non-response rate of 10% have been considered while calculation of sample size.

For calculation of sample size of ASHAs for baseline assessment, the indicator has been used for sample proportion (p). ">80% ASHAs were aware on Post-natal care, Birth preparedness counselling, safe delivery, new-born and child care practices", Knowledge Status of ASHAs of Jaipur City, International Multispecialty Journal of Health (IMJH)), December 2016.

Absolute error = ± 10; p = 80.5; q = 19.5; Design effect = 1.5; Non response rate = 10%; Z = 1.96 (set by convention according to the accepted α error for two-sided effect at 95% confidence interval) Sample Size = $[(1.96)^2$ X (80.5) X (19.5) X (1.1) X (1.5)] / $(10)^2$

Total Sample Size = 100 ASHAs per district and total 300 ASHAs in three districts of Alwar, Dausa and Bharatpur.

A mix method with qualitative and quantitative data collection, was used in this research. Quantitative data was collected from a purposive random sample of 309 ASHA which were interviewed through a structured questionnaires, whereas Qualitative data was collected from 30 ASHAs through three FGDs in rural areas of three districts of Alwar, Bharatpur and Dausa in Rajasthan.

During the FGDs ASHAs were asked about various challenges that they face in terms of infrastructure & support systems that are available to them for delivering their tasks as a community health worker to achieve health outcomes.

IV. RESULTS

Table 1: ASHA Knowledge on Promoting Child Health

Indicators	**Alwar (N=110)**	**Bharatpur (N=102)**	**Dausa (N=97)**	**Overall (N=309)**
Knowledge				
ASHAs with Correct Knowledge of Complementary Feeding (%)	91	78	94	88
ASHAs with Correct Knowledge of ORS preparation (%)	97	90	88	92
ASHAs with Knowledge of Timely Initiation at correct age of Pediatric IFA syrup (%)	94	74	88	85
ASHAs with Knowledge on correct Pediatric IFA quantity (%)	94	84	87	88
ASHAs with Knowledge on correct Pediatric IFA frequency (%)	94	96	94	94
ASHAs with Correct Knowledge on danger sign detection (%)	62	61	59	61
ASHAs with Correct Knowledge on SNCU discharge instructions (%)	39	32	35	36

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Table 2: ASHA Practices for Promoting Child Health

Indicators	Alwar (N=110)	Bharatpur (N=102)	Dausa (N=97)	Overall (N=309)
Practices				
ASHAs providing regular and structured Home visits to mothers on Child Health (%)	85%	93%	75%	84%
ASHAs providing counselling on complementary feeding (%)	91%	78%	94%	88%
ASHAs providing counselling on Exclusive Breastfeeding feeding (%)	84%	72%	84%	80%
ASHAs providing counselling on ORS use during Diarhoea episodes (%)	97%	90%	88%	92%
ASHAs providing counselling on Pediatric IFA supplementation (%)	94%	74%	87%	85%
ASHAs providing counselling on danger Signs detection (%)	62%	61%	59%	61%
ASHAs Referring sick infants to health facilities (%)	10%	9%	11%	10%

V. DISCUSSION

ASHA Knowledge on Child health

88% ASHAs were found with Correct Knowledge of Complementary Feeding, 92% ASHAs had Correct Knowledge of ORS preparation, 85% ASHAs had Knowledge of Timely Initiation at correct age of Pediatric IFA syrup, 88% ASHAs had Knowledge on correct Pediatric IFA quantity, 94% ASHAs were found with Knowledge on correct Pediatric IFA frequency, 61% ASHAs had Correct Knowledge on danger sign detection, and 36% ASHAs were found with Correct Knowledge on SNCU discharge instructions. (Table 1)

ASHA Practices on Child health

84% ASHAs were found to be providing regular and structured Home visits to mothers on Child Health, 88% ASHAs were providing counselling on complementary feeding, 80% were ASHAs providing counselling on Exclusive Breastfeeding feeding, 92% ASHAs were providing counselling on ORS use during Diarhoea episodes, 85% ASHAs were providing counselling on Pediatric IFA supplementation, 61% ASHAs were providing counselling on danger Signs detection, However, only 10% ASHAs had referred sick infants to health facilities. (Table 2).

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