

Study of Factors Influencing Ashas in Performing Their Roles and Responsibilities

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Abstract - The paper, is written based on the study of factors influencing ashas in performing their roles and responsibilities.

INTRODUCTION

CHW provides valuable contribution in generating awareness in the community towards health, hygiene, improves coverage of communities towards health services. Evidences have suggested that CHWs can conduct tasks to improve health outcomes in the community, with focus on child health. CHWs are trained to perform activities to implement health programmes at the community, however still do not provide services which have most significant health impact. The quality of services provided by CHWs have quality issues in some of the countries.

In order to get effective contribution from CHWs, they have to be appropriately selected, trained and continuously supported. CHW programmes require substantial support in terms of planning, training, supervision, management and logistics. CHW programmes neither a substitute for fragile public health system nor an economical substitute for providing easy access to health care for deprived, marginalized and rural populations. Several programmes have failed to achieve results due to impractical expectations from community health programmes, which has unreasonably destabilized the credibility of CHW concept.

CHW programmes are susceptible, unless they are decisively entrenched in communities. There are evidences which suggests that CHWs struggle to mobilize community to change child care practices which their families are following for years. Various examples of successful Community Health Programmes implemented through CHWs are Nepal through local mobilization and Bangladesh supported by non-governmental organizations and community based organizations. Many health programmes based on CHWs last through the lifetime of the mobilization efforts and weaken or fails completely whenever mobilization thrust is lost.

It is clearly evident that, there is growing awareness and need in the health sector for the increased value of contribution provided by community health programmes involving CHW for generating awareness on public health service. However, community health programmes have

some limitations such as social determinants, cultural practices followed by the families in the rural areas, ability of CHWs to mobilize community and generating awareness regarding public health services and getting the ownership from the community for scalability. It is essential to understand and discourse the prospect of CHW programmes which is one of the key challenge in institutionalizing community participation in public health service delivery.

CHWs are legitimately eligible for demanding regular service conditions and receiving basic entitlements as an employee, and facilitate their incorporation in the mainstream as fully functional member of the public health system and not as peripheral participants. The process of integration in the main health system will have to be a gradual process. There is a need to redefine the basic features of Community Health Programmes worldwide. Public Private Partnership (PPP) model for implementing Community Health Programmes with the help of CHWs, Bangladesh community health programme has been the most effective and regarded as one of the most successful public health programs amongst all the developing countries in the world.

ASHA PROGRAMME IN INDIA

ASHAs are incentivized for conducting home visits for providing counselling support to mothers with infants up to one years of age. ASHAs could play an important role in improving child health indicators in rural parts of India through social mobilization. ASHAs can further contribute in reducing child morbidity and mortality, if supported with trainings, supportive supervision and incentives for motivation. It is clearly evident that, there is growing awareness and need in the health sector in India for the increased value of contribution provided by ASHAs for generating awareness on public health services. Significant improvement in key child health indicators in Rural parts of three districts of Alwar, Bharatpur and Dausa between 2005 and 2015 can be directly associated with the contribution and attribution by ASHA workers. Independent assessments have also suggested, increased contribution of ASHA

workers in improving child health outcomes in districts where ASHAs are provided additional training on Child Health interventions and improving social mobilizations skills.

Analysis between NFHS 3 & NFHS 4 of Rajasthan, reveals significant improvement in Child health interventions between 2005 and 2015. All the child health indicators have significantly improved, especially immunization (26.5% increased to 54.8%), child morbidity, stunting (43.7% reduced to 39.1%) and underweight rates (39.9% reduced to 36.7%). During NFHS, data on knowledge and practices of ASHAs on child health has not been collected. Therefore, it was important to collect data from ASHAs, one of the important pillars of Public Health System and only support at community level health services in India. Additionally, knowledge and practices of mother beneficiaries served by ASHA workers was also not assessed in NFHS 4 to measure the outcome of social mobilization by ASHA workers.

The analysis of the primary data collected from ASHA interviews revealed, ASHAs are conducting home visits to mothers with infants less than one-year-old; they found to have adequate ORS, Paediatric IFA syrup and they were distributing and counselling mothers for its correct use; and ASHAs had appropriate knowledge on Complementary Feeding and detection of danger signs in infants that require referral to health facilities. Whereas, the analysis of primary data collected from mothers counselled by ASHAs on child health interventions, has revealed major contribution of ASHAs in improving child health practices of mothers. Therefore, findings and results obtained from the primary data collected from ASHAs and mothers directly correlates to and vindicates the improvement remarked in child health indicators derived from comparative analysis between NFHS 3 and 4 on child health indicators.

The ASHAs training seems to be less effective at improving thematic knowledge related to community mobilization and inter-personnel communication skills of ASHAs. The research shows a significant increase in the number of mothers receiving home visits and that these home visits became more closely aligned to child health protocol with more mothers reporting receipt of counselling during home visits.

ASHA program has succeeded in establishing a home visitation platform for the first year of life within the community. The major conclusions from the data are summarised below:

- ❖ Home visitations during the child's first year are highly appreciated and considered beneficial by mothers, families, and health providers including ASHAs.
- ❖ Health and nutrition related knowledge of mothers improved as the frequency of home visitations increased. Nutrition components (i.e. timely

introduction of Complementary Feeding, benefits of regular weighing, correct interpretation of growth charts and an increasing trend towards Exclusive Breastfeeding:

- Home availability and knowledge about correct usage of ORS
- Home availability of Paediatric IFA, and overall awareness of its use & benefits for their 6-15 month old infants
- Value of hand washing for the child's health.
- ❖ Mothers' knowledge not being translated into practice in various domains like ORS preparation, IFA dosage and play and communication with infants.
- ❖ For some of the ASHAs home visitation are not a priority and immunisation, ANC and delivery related activities are main priorities.

ASHA as a Community Health Worker

ASHAs do not have credibility and they are not getting proper respect in the community as a health worker. The findings of this research have revealed that, ASHAs are not being able to completely mobilize mothers and families on community health. Although, ASHAs are able to improve the practices of mothers on child health, however the knowledge of the mothers is not improving adequately. ASHAs do not have adequate skills and proper support from the health systems, community and Panchayat members to improve knowledge of mothers. ASHAs are mainly trained on community health programs with some training on community mobilization also. However, the training material and training methodology on community & social mobilization is not enough. Quality of supportive supervision provided to ASHAs is also inadequate.

ASHAs as a Social Activists

ASHAs don't appear to be tuned in to what being associate activist suggests that or entails. ASHAs highlighted that they were for the most part taught to encourage achieving health targets like protection coverage and institutional delivery. ASHA trainings and superintendence are for the most part focused on institutional delivery and provision of services among the community, with the activist role receiving nominal focus.

Factors influencing ASHAs in performing their roles and responsibilities influence of monetary incentives

The financial incentives provided under JSY scheme is a vital factors shaping the performance of the ASHAs, their relationships with communities and also the health system. ASHAs have dependency on the JSY scheme, because of which they receive an adequate amount of compensation as other tasks are either poorly remunerated or not remunerated

at all. JSY provides the largest amount for incentives from the referral of delivery cases and escorting them to the health facility for institutional delivery. ASHAs take into account these amounts as their main source of income.

Selection of ASHAs

Mainly ASHAs are appointed by the leaders of the VHSNC. Their previous experience of working as volunteers plays an important role in their selection. Main reasons of most of the ASHAs for applying for the post of ASHA, were the amount of incentives that they will be paid and the sense of getting employment. This provides them an opportunity to upgrade their position in their family and in their communities. The selection process followed in maximum ASHAs largely depends on nepotism and undue influence by PRIs.

Training

ASHAs have a sense of satisfaction because the ASHA program provides them a chance to build their individual skills and get knowledge. Most of the ASHAs also believe that their personal growths are directly linked to the healthy behaviour of their families specially in their own skills on Child Health. A positive correlation was found between their training and their acceptance in the villages.

Institutional and Infrastructural Factors

The availability of medical kits to ASHA that includes basic drugs like paracetamol, antimalarial, IFA tablets vitamin B tablets, condom, ORS along with mobile phones were some of the most essential enablers for ASHAs specially for those ASHAs that are residing in the most remote areas. These enablers increase their efficiency and their acceptance in the community.

Gender and tradition

ASHAs are perpetually challenged by existing norms and practices in the community and expected gender roles limit performance of their professional tasks. As a woman, she is often anticipated to perform her household chores and take care of her children. Also serve her in-laws and other social obligations. They are also not allowed to participate and involve in the decision making processes relating to community matters. This restricts ASHAs to proactively participate in the health matters of the community. The tradition of home deliveries is a major obstacle in promoting delivery at the health facilities and ASHAs face difficulties in convincing families for delivery at the health facilities.

Difficult geographical terrain and physical mobility

The location of the villages, geographical terrain where ASHAs are working and their distances from the health facilities limits their ability to perform their roles effectively. Those ASHAs whose villages are far away from the main roads face a lot of difficulties in linking the community with the health facilities and have to travel massive distances to reach to the health facilities. Therefore,

the physical mobility plays an important factor that influences the performance of ASHA workers.

CONCLUSIONS

ASHA was originated in 2005 as part of the community health worker program in India. ASHAs have provided support in the health system and contributed significant improvements in Child health interventions in the rural parts of India including 3 districts of Alwar, Bharatour and Dausa in Rajasthan which were the geographical focus of this research study. The analysis of qualitative and quantitative data collected from ASHAs and Mothers, reveals that ASHAs have enough knowledge on community health.

ASHAs are not being able to completely mobilize mothers and families on community health. ASHAs are providing regular home visits to mothers to improve their knowledge and practices. ASHAs are able to improve the practices of mothers on child health, however the knowledge of the mothers is not improving adequately. ASHAs do not have adequate skills and proper support from the health systems, community and Panchayat members to improve knowledge of mothers. The quality of the training material and training methodology of ASHA workers on community & social mobilization is not enough.

MoHFW also needs special effort to coordinate with other ministries of RD and MWCD to establish cohesive links between ASHA, AWW and Panchayat members to support ASHA in delivering their community mobilization portfolio effectively. The quality of supportive supervision provided to ASHAs is inadequate which is required to mentor ASHAs in delivering their community mobilization tasks.

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