ROLE OF ASHA IN PROVIDING MATERNAL AND CHILD HEALTH SERVICES THROUGH PRIMARY HEALTH CENTRES IN RURAL TELANGANA

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ABSTRACT: *The role of ASHA services helps in identifying the efficiencies and correcting the working pattern of their services with each patient right from registration to delivery of baby so that services through PHCs can be extended and also no. of patients per each ASHA can be increased with less work load. The aim of this study is to evaluate the role of ASHA in providing maternal and child health (MCH) Services at Primary Health Centres (PHCs) in Nizamanbad district of Telangana. The study was conducted with the help of 162 sample respondents (ASHA workers) from 4 Mandals (out of 36 Mandals) and two each PHC's from 4 Mandals was considered for a period of three (03) months. The criteria in selecting the sample respondents (ASHA workers) is with having more than two (02) year of experience only considered. Finally, this study found that i) there is no significant association between age and knowledge; ii) there is no significant association between educational qualifications and knowledge; and iii) there is no significant association between experience and knowledge of ASHA in providing maternal and child health services through PHCs in rural Telangana.*

Keywords: ASHA services, Maternal and Child Health Services, services effectiveness.

1. INTRODUCTION

Accredited social health activist (ASHA) is a literate woman resident of village married/ widowed/ divorced, preferably in the age group of 25 to 45 years. One ASHA is being employed for a village with more than 1000 residents. ASHA is chosen through a selection process involving various community groups, self-help groups, Anganwadi institutions, the Block/Mandal Nodal Officer, District nodal officer, the village Health committee and the Grama Sabha. ASHA is a health activist in the community who intend to create awareness on health and its social determinants and mobilize the community towards local health planning and increased utilization and accountability of existing health services (Shukla, A and Bhatnagar, 2012). Earlier there were no such health activities for the needs and wants of the rural people. These health care activities were performed when the government realized the fact that majority of the rural people died because of improper medical treatment. The people in those areas did not know how to take treatment if they are affected by disease like malaria, chikungunya, and cholera and they didn't have any easy access to the basic healthcare services (hospitals). As a result, the birth rate decreased because women did not get proper care and treatment while they are pregnant.

2. ROLE OF ASHA IN PROVIDING MCH SERVICES IN RURAL TELANGANA

ASHA worker act as bridge between community and health facilities should improve the community by providing health education. ASHA also has a role of counseling pregnant women about antenatal care, birth preparedness and danger signs during pregnancy (Mishra, 2012). Across India, many states involved ASHA workers in national health programme's and in response to a range of communicable and non-communicable diseases. They get

salaries based on performances, not a fixed salary like government servants. In the past ASHA workers resorted their protests and demonstrations to secure wage hikes and timely increments. Recently state government directed senior officials to conduct study on implementation of maternity leave with pay for ASHA workers (Nellisserry, S.J, 2013). Kaur M, Oberoi S, Singh J, Kaler N, Balgir RS (2022) examined the role of accredited social health activist (ASHA) workers act as a “bridge” between rural people and health service outlets and play a central role in achieving national health and population policy goals. The study concludes that ASHA workers have good knowledge regarding various aspects of antenatal period, but when it comes to postnatal period and care of the newborn, there are some lacunae. These aspects of newborn care need to be reinforced into the refresher trainings of the ASHA workers in Punjab.

The National Rural Health Mission (NRHM) was launched on 12th April 2005 with a great motive to deliver adequate health care to the rural population with priority towards poor women & children. One of the main plans of the NRHM is to give every village in the nation with a trained female community health activist i.e., Accredited Social Health Activist (ASHA). Who will create awareness on health and its components and mobilize the community towards local health education and increased utilization and accountability of the existing health services. The ASHA is main interface or bridge between the community and the public health system. The national ASHA mentoring Group (NAGM) was constituted by the Ministry of Health & Family Welfare in July 2005 to serve as an applied and consultative body for the ASHA programme and to extend support to the Governments in overall implementation, mentoring and monitoring of these great initiative service programme.

ASHA: Accredited social health activist workers are a community of female health activists trained to facilitate the work of public health care in their community as a part of nationwide public health system

ASHA is expected to fulfill her role through major activities in the community:

- ASHA should visit the families living in her allotted area at least for 4-5 days a week, per day 3-4 hours, with first priority being allotted to families with ages people, scheduled castes ad tribes. Home visits are intended for health awareness and precautionary care. Home visits are needed not only for the services that ASHA provides for reproductive, maternal, newborn and child health interventions, but also for non-communicable diseases, disability, and mental health. The ASHA should prefer homes where there is a pregnant woman, newborn, child below two years of age, or a malnourished child first. ASHA should visit to the household where there is a new born at least once a month, a series of six visits or more becomes essential.
- The ASHA should promote presence of villagers at the monthly Village Health and Nutrition Day by those who need Anganwadi or Auxiliary Nurse Midwife (ANM) services and help with counseling, health education and access to services.
- ASHA usually involves travel with a pregnant woman, sick child, or some member of the community needing facility-based care. The ASHA is expected to attend the monthly review meeting held at the PHC.
- As member secretary, sarpanch, the ASHA is expected to help conduct the monthly meeting of the sanitization and nutrition awareness programme at village by providing awareness and guidance to its functioning. These meetings can be conducted with additional habitation level meetings, if necessary for providing health education to the community.

- Maintaining records which help ASHA in keeping patients' health data which will be helpful in aged people who cannot maintain records and also in organizing her work. Maintaining records also helps in visits to pregnant women according to trimesters.

Working of ASHA: The Block/Mandal medical officer at the block level will be in charge of ASHA functional activities. The Officer who is assigned as District level organizer for the ASHA to be assisted by Block/Mandal Facilitators (one facilitator for every 10 ASHAs). Block/Mandal Facilitators could be appointed as the first set of guidelines on ASHA already issued States. The Block/Mandal Facilitator may be necessarily women or else male members if any already appointed Block Facilitator may continue. The Block Facilitators should provide report on the functions of ASHAs to the BMO & Block/Mandal level organizers. They shall also visit the ASHAs in villages.

3. PRIMARY HEALTH CENTRE

PHC also known as public health Centre, First PHC established in 1952 and there are more 887 Primary Health Centres (PHCs) are in existence in the State of Telangana whereas there are 31,053 PHCs functioning in India. These PHCs are interstate rural and urban health care providers in India, where a single physician present in the clinic to undergo minor surgeries or deliveries without complications. PHCs are essential in providing primary health services like prevention care and basic treatment for common health issues PHCs are differentiated based on the complexity and severity of health issues i.e., primary, secondary, tertiary and quaternary. The Medical Officer at PHC will arrange a meeting every month which would be attended by ANM and ASHAs, LHVs and Block Facilitator. During this period, the health status and socio-economic status of every community will be reviewed. Incentives to ASHAs under various schemes could be organized on same day so that ASHA need not visit the PHC regarding incentives. States should implement that payments to ASHA are made on time through a simplified procedure. The ASHA kits also could be refilled time to time. Replenishment of kit should be on time, automatic and through a simple procedure.

In the existing ASHA guidelines, at the district level a District Nodal Officer has been provided. The District Nodal Officer is to be an officer nominated by the Civil Surgeon. However, as has been mentioned above, managing the various aspects of the functioning of more than 1,000 ASHAs will not be a simple task without adequate human and financial resources. It is, therefore, now proposed that each District Nodal Officer would be supported by a community mobilizer who would have the qualification of master of social work (MSW). A Data Assistant may also be provided to satisfactorily discharge the work. Functional activities under primary health centre:

- Providing basic medical care, maternal-child health including family planning.
- Safe water supply and basic sanitation.
- Prevention and control of indigenous diseases.
- Collection and reporting of vital statistics.
- Education about health and referral services.
- National health programmes and schemes implementation.
- Training of health guides, health workers, and local dais and health assistants.
- Basic laboratory workers, etc.

Brief Profile of Nizamabad District: Erstwhile Nizamabad district has 36 Manadals with more than 6.00 lac households and consists of 43 PHCs with more than 4000 sub-centres. A significant number (more than 27,000) of ASHAs working in Telangana out of which more

than 1000 ASHAs working in Nizamabad district. There are 310 members belonging to ASHA worker community in select four Mandals. Each PHC consists of 1 supervisor, 1 HEO, 1 medical officer, 2 ANM and other paramedical staff.

4. NEED FOR THE STUDY

The evaluation of ASHA services helps in identifying the efficiencies and correcting the working pattern of their services with each patient right from registration to delivery of baby. As a result, these services can be extended at each PHC and also no. of patients per each ASHA can be increased with less work load. Not only in MCH, ASHA services can be exposed to community where no one having awareness regarding role of ASHA in various programs such as immunization, contraception, prevention of STDs, breast feeding importance (Rao, T, 2013). Few studies have shown that service of ASHA was not complete in MCH services mainly in child health services. Hence this study is conducted to evaluate their services from registration of MCP card to 6months of baby age. Few studies have shown that services of ASHA are not complete in maternal and child health services. Hence this study was conducted to evaluate the roles and services of ASHA in Maternal and Child Health (MCH) services.

5. OBJECTIVES OF THE STUDY

The aim of the study is to realize the following:

1. To evaluate the role of ASHA in providing maternal and child health through PHCs in rural Telangana; and
2. To find out the association between age and knowledge; educational qualification and knowledge; and experience and knowledge of ASHA in the study area.

Hypotheses

The following null hypotheses were framed in tune with the above objectives.

1. There is no significant association between age and knowledge of ASHA.
2. There is no significant association between educational qualifications and knowledge of ASHA.
3. There is no significant association between experience and knowledge of ASHA.

6. RESEARCH METHODOLOGY

Data Source: For this study, both primary data and secondary data were used with the help of a structured questionnaire. A detailed Questionnaire form related to mother and child health services to evaluate ASHA's knowledge. In case of secondary was data collected through research articles, journals and NRHM guidelines. In this study sample size is 162 respondents out of more than 600 ASHAs, considered from 8 PHC's of from Nizamabad District of Telangana State was selected based on random sampling method. The sample size of the study is 162 out of more than 600 ASHA's and under 8 PHC's from four select Mandals. The criteria followed for selection of ASHA workers is with having more than 2 year of experience as ASHA's.The study was conducted at selected PHC's from four Mandals from Nizamabad District. The study took a period of three months for the collection of data, analysis of data, interpretation of results, discussion and conclusion of the study with relevant standards and procedures. The data collected for the study was evaluated by using Chi-Square Test with test of independence, calculated value and table value.

Formula, $X^2 = \sum \frac{(O-E)2}{E}$

Scope and period of the study: The study come across maternal and child health services performed by the ASHA within the selected PHC's in Nizamabad District. The number of ASHA working under

each PHC is ranging between 35-40 members. The data collected for a period of 3 months during May to July, 2023. There is no significant association between age and knowledge of ASHA. To find out is there any association between age and knowledge, educational qualifications and knowledge; experience and knowledge of ASHA.

7. DATA ANALYSIS AND INTERPRETATION

The study aims to evaluate the roles and services of ASHA regarding MCH services through various PHCs from select Mandals of Nizamabad District. For the analysis, a sample of 162 (ASHA workers) respondents was selected from selected four PHCs from Nizamabad District. The sample was selected based on simple random sampling method.

Based on the marks obtained by the ASHA with the given questionnaire form, answers are correlated with the socio-demographic factors such as age, educational qualification, and experience to prove that there is no significant association between knowledge and age, educational qualification and experience of ASHA under null hypothesis.

Table-1 Marks Frequency of ASHA

Poor (0 –5 marks)	Low (6– 10 marks)	Medium (11-15 marks)	High (16-20 marks)

Results to given questionnaire form shows that ASHA knowledge are in the range of medium to high, as there is no respondent who scored in the range of poor to low. Hence, the study continued between medium and high range of knowledge associated with age, educational qualification and experience

H_{01}= There is no significant association between age and knowledge of ASHA

Evaluation of ASHA knowledge based on the marks and different age groups, the results which obtained are considered as observed frequency i.e., by differentiating based on age groups and the marks obtained in that age group. In simple terms classifying ASHA age groups based on marks is observed frequency.

Table-2 Observed frequency

Knowledge	20-30 years	30-40 years	40-50 years	>50 years	Row Total
High	38	76	06	04	124
Medium	12	22	04	0	38
Column total	50	98	10	04	162

From the observed frequency values, expected frequency can be calculated by the given formula:

$$\text{Expected frequency} = \frac{\text{Row total*Column total}}{\text{Grand total (N)}}$$

Table-3 Expected frequency

Knowledge	20-30 years	30-40 years	40-50 years	>50 years	Row Total
High	19.13	37.50	3.82	1.53	124
Medium	5.86	11.49	1.17	0.46	38
Column total	50	98	10	04	162

Expected frequency values are equal to observed frequency values. Degree of freedom (DOF) = (no of rows – 1) (no of columns – 1) Here, no of rows = 2; No. of columns = 4; DOF = (2-1) (4-1) = 3; Degree of freedom = 3. Observed frequency and expected frequency are further applied with Chi-square test of independence formula in order to accomplish the Chi-square calculated value.

Formula:

$$X^2 = \sum \frac{(O-E)\,2}{E}$$

Chi-square calculated value was obtained by initially calculating observed frequency minus expected frequency, then square to the value of observed – expected frequency later on divided by expected frequency. As we got DOF as 3 and significance level as 0.5 through Chi-square table, the accomplished table value = 7.815. The Chi-square calculated value for the hypothesis = 1.393 which is less than table value. Hence, it is found that there is no significant association between age and knowledge of ASHA.

H_{02}= There is no significant association between educational qualification and knowledge of ASHA

Evaluation of ASHA knowledge based on the marks and different educational qualifications, the results which obtained are considered as observed frequency i.e. by differentiating based on education and the marks obtained in that group of educational qualification. In simple terms classifying ASHA age groups based on marks is observed frequency.

Table-4 Observed frequency

Knowledge	Mid-school	10th class	Intermediate	Graduation	Row Total
High	04	78	36	06	124
Medium	0	20	18	0	38
Column total	04	98	54	06	162

Table-5 Expected frequency

Knowledge	Mid school	10th class	intermediate	Graduation	Row Total
High	1.53	37.50	20.66	2.29	124
Medium	0.46	11.49	6.33	0.70	38
Column total	04	98	54	06	162

As we got DOF as 3 and significance level as 0.5 through Chi-square table, the accomplished table value = 7.815. The Chi-square calculated value for the hypothesis = 3.87199 which is less than table value. Hence, it is found that there is no significant association between educational qualifications and knowledge of ASHA.

H_03= There is no significant association between experience and knowledge of ASHA

Evaluation of ASHA knowledge based on the marks and different experience groups, the results which obtained are considered as observed frequency i.e. by differentiating based on age groups and the marks obtained in that experience group. In simple terms classifying ASHA age groups based on marks is observed frequency.

Table-6 Observed frequency

Knowledge	>1 year	>3 years	>5 years	>10 years	Row Total
High	34	42	32	16	124
Medium	10	10	12	06	38
Column total	44	52	44	22	162

From the observed frequency values, expected frequency can be calculated by the given formula:

$$\text{Expected frequency} = \frac{\text{Row total*Column total}}{\text{Grand total (N)}}$$

Table-9 Expected frequency

Knowledge	>1 year	>3 years	>5 years	>10 years	Row Total
High	16.83	19.90	16.83	8.41	124
Medium	5.16	6.09	5.16	2.58	38
Column total	44	52	44	22	162

Chi-square calculated value was obtained by initially calculating observed frequency minus expected frequency, then square to the value of observed – expected frequency later on divided by expected frequency. As we got DOF as 3 and significance level as 0.5 through Chi-square table, the accomplished table value = 7.815. The Chi-square calculated value for the hypothesis = 0.650095 which is less than table value. Hence, it is found that there is no significant association between experience and knowledge of ASHA.

FINDINGS OF THE STUDY

1. *ASHA workers creating awareness at significant level* - ASHA are aware about contraceptive methods, immunization programs, breast feeding importance, birth registration suggestions, warm care and sanitizations etc. Many unwanted activities like instillation of oil in ear and nose, application of cow dung around umbilical and skin burn around umbilical cord are prevented by ASHA workers by creating awareness about their effects but still more most of the previous generation people in rural areas follow these false concepts. Women with primigravida in this decade are not able to bare pains of normal delivery and choosing for c-section are motivated and helped during delivery by ASHA will be key part protecting women from complications in future.
2. *ASHA workers heavily burden with increased work load* - The actual or average no of population per ASHA is 1000, but ASHAs under urban PHCs contain population more than 3000 which automatically increases the work load on ASHA and efficiency of work gets diluted.
3. *ASHA performed additional tasks which escalated their works* - ASHA workers who got assigned with different government schemes cannot perform their basic functions like attending deliveries and checkups with patient, due to diversions. They also performed additional tasks which escalated their works. In addition to their daily functions, they used to conduct symptom surveys, health awareness about COVID-19 precautionary cares, home delivery of medicines to quarantined families, tracing contacts and travelers and seize passports, giving instructions and monitoring patients

under quarantine and isolation. ASHA worker generally works for only 3-5hrs a day during antenatal and immunization programs. ASHA workers worked tirelessly they used to face transportation issues. There was a delay in the payment of their incentives for about 2–3 months, due to which they have faced a lot of financial crises.

4. *Problems faced by ASHA during covid-19, field work and other services* **-** Every health care worker and paramedical staff got affected during pandemic, whereas special mention to ASHA at ground level that carried vaccinations personally to every home or individual got suffered physically and mentally by getting ignored by relatives and neighbors for their extended services. ASHA workers got affected during pandemic than others because they are the one who conducted survey at ground level to find out people with symptoms, people travelled from foreign countries and notifying people who are not vaccinated. In some instances, even after ASHA advice people with female baby not ready for treating baby, if there is any neonatal issues after birth even after counseling by ASHA, later on ASHA got blamed for not consulting pediatrician.
5. *ASHA workers doesn't have any fixed salaries or wages* - Even after carrying out functions related to various levels of health care system ASHA workers doesn't have any fixed salaries or wages according to the work they perform. The government announced health insurance for other health workers busy with Covid-19 reducing, but the ASHA worker is voluntary workers, who are working under scheme they are not becoming the beneficiary.
6. *Irregular payments and performance based incentives* - Initially, they used to get the payments monthly; later on, and they were paid once in 3–4 months. After that, performance-based incentives were stopped, and only 1000/- for 1 month was given. They worked hard and took so much pain, but we didn't get rewarded for their services. Due to the lockdown, all the businesses were shut down daily wage workers suffered a lot increasing financial burden on their family members. ASHA with only source of income in the family suffered a lot as the other family members lost job.

SUGGESTIONS

1. There should be frequent training sessions and seminars on topics like newborn care, where ASHA are efficient in maternal care or intranatal care comparative to new born or post-natal care. So, training of ASHA in newborn care will be effective and safe for baby health assessment.
2. ASHA will be direct contact with patient and their family member's right from confirmation of pregnancy, ASHA has a role of counseling the patient and giving awareness regarding health condition and precautions, where communication will be the key. Hence, raising the standards of communication will be helpful in counseling in effective way so that patient and family can understand properly by providing Skill development programs.
3. The day-to-day activity of ASHA worker is to conduct survey in their recommended community, whereas every data will be entered in a register or notes which can make errors in patient and family details. Electronic survey record will be easy to work and evaluate the patient details and also can overcome data related issues with similar details also decreases the work load and increases efficiency in their activities.
4. ASHA should be trained particularly about Low birth weight babies (LBW) babies, vaccination weight, bathing time; feeding patterns and KMC (kangaroo mother care).
5. ASHA should be aware of neonates with meconium aspiration syndrome can have early signs of jaundice; poor feeding and weight loss can increase NNJ levels. Newly

trained ASHA should seek help of seniors while attending deliveries with complications which can reduce the risk by reacting early towards unexpected signs and symptoms during and after birth.

6. ASHA should also support pregnant women who consult private institution for delivery which will help the women physically and morally at the time of delivery. There should be retirement scheme for ASHA which help the service providers post-retirement to lead their life without seeking help from others. Health insurance and other facilities should be provided for ASHA which will help them in emergency conditions if they face any serious health issues. Other than day to day work every ASHA should be assigned with specific additional work based on their working capacity and ideology so that clumping of ASHA won't happen if any government scheme to be implemented and carried by service providers.

CONCLUSION

This study evaluates that the knowledge of ASHA regarding maternal care was good with very minute drawbacks during prenatal assessments. The importance of ASHA in educating and counseling patients regarding immunization, diet, anemia, consanguinity, feeding times are effective. The area where ASHA need to be improved are newborn care which are above basic level so that standards of providing overall health care will be improved like urine and stool passage duration after birth, suggestion of bottle feed, LBW babies, KMC etc. The challenges faced by ASHA to providing MCH services during pandemic are improper access to hospital which led to risk in emergency cases, transportation problems, lack of infrastructure and human resources in hospital due to overload of patients. ASHA requires motivation by providing them salaries and incentives timely in-order to boost their performances in MCH and other services. Orientation and training should be given to ASHA counseling of patient regarding family planning where ASHA requires impactful awareness, because families take their own decisions even after counseling. ASHA are successful in educating women with child with 0-15yrs for vaccination on time with minute drawbacks in LBW babies. ASHA have equal knowledge in awareness programs, community developments, sanitizations, contraceptives methods with mother and child care.

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