ORIGINAL RESEARCH PAPER
Volume-8 | Issue-11 | November - 2019 | PRINT ISSN No. 2277 - 8179 | DOI : 10.36106/ijsr
INTERNATIONAL JOURNAL OF SCIENTIFIC RESEARCH

DEVELOPMENT COMMUNICATION APPROACHES AND ASHAS (ACCREDITED SOCIAL HEALTH ACTIVISTS) UNDER NATIONAL HEALTH MISSION: A FEASIBILITY STUDY IN SELECTED DISTRICTS OF GUJARAT, INDIA

Community Science

Ms. Megha Sidhpura — Assistant Professor and Ph.D. Research Scholar Department of Extension and Communication, Faculty of Family and Community Sciences, The Maharaja Sayajirao University of Baroda, Vadodara, Gujarat

Dr. Anjali Pahad* — Professor and Guide Department of Extension and Communication, Faculty of Family and Community Sciences, The Maharaja Sayajirao University of Baroda, Vadodara, Gujarat *Corresponding Author

ABSTRACT

National Health Mission has a prescribed roles and responsibilities for Accredited Social Health Activists (ASHAs). ASHAs are considered to be the first port of Information and health care provider at community level.
The present study aimed at preparing profile of ASHAs and Development Communication Approaches used by them while performing their duties. Thirty ASHAs from tribal, rural and urban area were selected purposively and in-depth interviews were conducted to gather the required data. Major findings highlighted upon limited provision of Development Communication media by the Government. The Media usage of ASHAs are also highlighted through the study that those media were used at optimum by the ASHAs. The selected ASHAs expressed their needs for new Development Communication media and its timely supply to foster their performance and service delivery. It was suggested to develop need-based media to facilitate strategic and effective communication activities at grassroot level.

KEYWORDS

Accredited Social Health Activists (ASHAs), Development Communication approaches, Roles of ASHAs, National Health Mission

INTRODUCTION:

National Health Mission, second phase launched in 2012-13, has a well-defined implementation framework till grassroot communities both in urban and rural areas across the nation. It has well prescribed roles and responsibilities for all health care providers be policy makers, Consultants, Doctors, facilitators, Auxiliary Nurse Midwives (ANMs), Village Level Health Worker (VLHW) and ASHA.

In present research 'Development Communication Approaches' has been operationally defined that 'combination of Health Communication tools and methods broadly known as IEC ;and Health Information Technology system broadly known as ICT used under NHM for the purpose of creating awareness, promoting, motivating, escorting, mobilising community people for availing health services, bringing desirable behavioural change, strengthening health machinery and Health Management Information System across all stakeholders.'

ASHAs are first port of Information and health care provider under National Health Mission (NHM). ASHA being the grassroot level health activist under NHM, her responsibility as Link worker, mobiliser and service provider using Inter Personal Communication approach with beneficiaries and health care machinery is very crucial and significant.

Thus, it was felt important to study about ASHA who is first port of information and health care provider. The in-depth investigation regarding her needs related to Development Communication Approaches for the effective delivery, the hurdles if she faces during her work a feasibility study with following objectives was planned.

OBJECTIVES OF THE STUDY:

1. To prepare **profile** of the ASHAs of the selected districts of Gujarat state.
2. To study **roles and responsibilities** performed by the ASHAs by using **Development Communication Approaches** in the selected districts of Gujarat state
3. To find out **barriers** faced by the ASHAs of the selected districts of Gujarat state in relation to following aspects:
- Personal
- Seniors (ANM, Facilitator, Doctor etc.)
- Co-workers (ASHA, AWW etc.)
- Community
- Usage of Development Communication approaches viz. Activities and IEC /ICT
- Transportation
4. To study the **felt need** for Development Communication Approaches expressed by the ASHAs of selected districts of Gujarat state
5. To seek **opinions** of the ASHAs regarding Development Communication Approaches viz. Activities and IEC /ICT

METHODOLOGY:

The present investigation was carried out in two districts, which were selected purposively i.e. Vadodara and Chotaudepur. An In-depth interview schedule was developed. Data collection was done during June-July 2017 personally by the researcher.
The ASHAs from these districts were approached through purposive and snow ball sampling techniques. The final sample consisted of 12 Urban, 9 Rural and 9 Trible ASHAs. Permission from respective district level health departments were taken in advance and ASHAs were asked for their consent to be part of the feasibility research.

MAJOR FINDINGS:

Frequency and percentages were calculated to analyse the data of close ended responses. Moreover, for open ended items, list of responses was prepared. Then transcripts were analysed for common themes. Major findings are as follow.

Profile of the selected ASHAs:

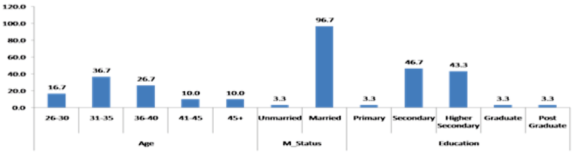

Figure-1 Percentage distribution according to Age, Marital status and Education

- Little more than one third i.e. 36.7 percentages of the ASHAs belonged to 31-35 years of age group and almost all (96.7%) ASHAs were married, having education up to secondary (46.7%) and Higher secondary (43.3%). only one of the ASHAs had studied up to Primary level, which is in extreme condition acceptable under appointment norms prescribed in the Guidelines of National Health mission.

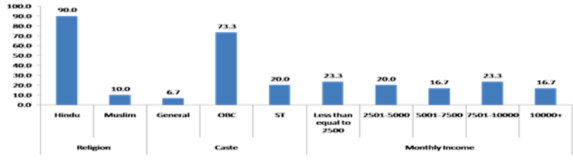

Figure-2 Percentage distribution according to Religion, Caste and Monthly income

- Very high majority (90%) of the ASHAs were Hindus and majority (73.3 %) belonged to Other Backward Caste (OBC) category.
- The monthly family income of ASHAs varied from less than twenty-five hundred to more than ten thousand in almost similar fashions.
- Majority (66.7%) of the ASHAs lived in joint family and majority (63.3%) had more than six members in their family.

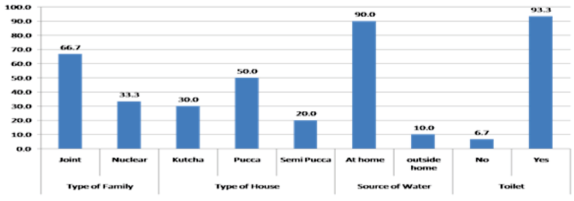

Figure-3 Percentage distribution according to type of family, and house, sources of water and availability of toilet

- Among the household assets all the ASHAs had Electricity supply and a fan at their place and very high majority of them possessed watch, toilet, water supply/source, mobile, cart, chair, cooker and mattress, 93.3, 93.3, 90.0, 90.0, 86.7, 83.3 and 83.3 respectively.
- Majority (70.00%) and Few (10%) of the ASHAs watch TV and listen to radio respectively for 1-2 hours per day as a source of entertainment, information, and news. However, little less than half (46.7%) and some (16.7%) of the ASHAs read newspaper and magazine respectively for getting information and news in detail.
- High majority (86.7%) and some (13.3%) ASHAs possessed Cell phone and Smart phone respectively. They used it for calling at health centre, patients and family members for coordinating their activities, appointments and scheduling of meeting as well as assuring their family members about their safety at field.
- Less than half (43.3%) ASHAs possessed work experience of 7-9 years as a health worker which was prior to their joining as ASHA under NHM.

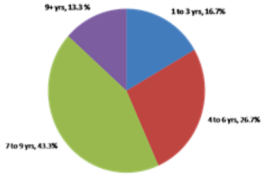

Figure-4 Percentage distribution according to years of experience as Health worker

- Majority (60%) of the ASHAs belonged to the category of high level of work experience i.e. eight and more than eight years as ASHA.
- Majority (73.3%) of the ASHAs earned on an average less than or equal to four thousand rupees as incentive per month for the last three months for the services extended by them.
- With regard to the knowledge about general health care, majority (73.3%) of the ASHAs scored higher than the mean score.

Roles and Responsibilities performed using Development Communication Approaches (i.e. Methods and materials)

- For 'Creating Awareness and providing Information', all the ASHAs reported that they made home visits and nearly one fourth of them attended NHM meetings. During these activities, majority (70.00%) used *Mamta card* (Health Card) and register; and nearly half (46.7%) used chart, poster and flip books.
- ANC and PNC for mother and new-born' aspect was taken care with the help of 'home visit' by all the ASHAs followed by 'Health centre visit' by forty-four percentage. Where in majority of them (76.7%) used *Mamta card* (Health Card) /register, 53.3 percentages used chart/poster/flip books followed by 43.3 percentages used personal interaction.
- To mobilise and facilitate villagers for accessing health facilities, majority (86.7%) ASHAs used 'Home visit' followed by 23.3 percentage use 'Visit to Health Centre' method. It was highlighted by nearly half of the ASHAs about unavailability of material/media to facilitate their task of mobilising and facilitating people in accessing health facilities.
- All the selected ASHAs made 'Home visit' to coordinate and facilitate in Village Health plan and Village Health and Nutrition Day (*Mamata Day*) However, materials used to perform this responsibility were mobile phone/smart phone and landline by 82.6 and 52.2 percentage of ASHAs respectively to coordinate with officials involved therein.
- Out of 30, only 18 ASHAs adopted method and material 'to encourage beneficiaries (i.e. pregnant and lactating mothers with their children, adolescents etc.) to seek benefits' under NHM. They all visited door to door and majority (73.3%) having personal conversation with beneficiaries to encourage and avail benefits on Mamata day.
- Majority i.e. 24 ASHAs, arrange for escort or they themselves accompany pregnant women and children for the treatment or admission required by them. However, they do not have any materials for this work, half of them (i.e.12 ASHAs) used mobile phone/smart phone to arrange an escort or taking appointment at health centre.
- Majority (75.00 %) ASHAs performed the duty of 'Providing primary medical care for minor ailments and DOTS' wherein high majority (84.00 %) visited home and used *Mamta Card* (Health card) or register for explaining and recording the primary medical care provided by them.
- ASHAs act as a 'Depot holder' for the local community people for this they used personal interaction (81.8%) and *Mamta card* (Health Card) and register (72.7%).
- Majority (21 ASHAs) perform their responsibility of 'providing service to newborn and children for minor ailments' through Home visit (90.5%) and at *Mamta Day* (76.2%) by using personal interaction (85.7%) and chart, poster, flipbook, mobile phone and smart phone by 23.8 percentage of ASHAs.
- For 'Providing first-hand information of Birth/Death and outbreak of diseases', 24 ASHAs used following methods i.e. home visit, health centre visit and attending VHND 79.2%, 58.3% and 37.5 % respectively. For this work they used register, Mobile phone/ smart phone, *chopania* (leaflet) /booklet distribution and chart/posters/flipbook by 70.8 percentage, 62.3 percentage, 38.3 percentage and 12.00 percentage respectively.

Need Expressed for Development Communication materials by the ASHAs

Out of 30 respondents, 24 ASHAs expressed their need for smart phone, followed by video projection facilities, Flip book and posters by 19, 16 and 15 ASHAs respectively.

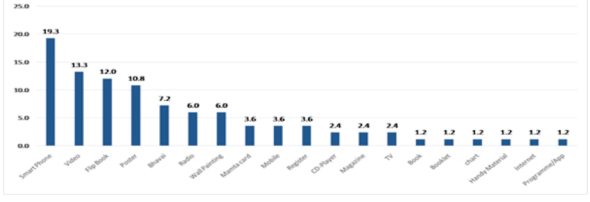

Figure-5 Percentage distribution according to Development Communication materials/Facilities needed

Barriers faced by the ASHAs

Barriers reported by ASHAs were qualitatively analyzed and classified under three categories viz. Barriers related to 'Facilities for IEC/BCC', 'Beneficiaries and Communities' and 'Authorities/Seniors and co-worker'.

Box:1 Barriers related to 'Facilities for IEC/BCC'

- 'Smart phone is not given'
- 'Payment of salary/incentives is usually delayed'
- 'Medicines/drugs are not available on time'
- 'ASHA diary is not given on time'
- 'Identity card is not given by Government'
- 'Uniform is not given to us, we face identity crises'
- 'Transportation for visiting to interior places is not provided.'
- 'Laptop is not given'
-'IEC-BCC materials are not enough.'

It can be derived from Box:1 that the selected ASHAs faced many barriers with regard to 'Facilities for IEC/BCC'. They have reported unavailability of smart phone, laptop, transportation, uniform and insufficiency of IEC/BCC materials as barriers to some extent. However, it is important to record that ASHAs were provided with uniform during 2018-2019 in the same areas. Barriers; delay in supply of Diary and stock of medicines were faced to great extent.

Box:2 Barriers related to 'Beneficiaries and Communities'

- 'Difficult to convince people for adapting better practices/availing benefits'
- 'Anti-social people harass us on field'
- 'We have to bear with disrespectful behaviour '
-'Beneficiaries are reluctant'
- 'People/Beneficiaries are unaware about problems and felt needs'
-'Beneficiaries do not inform about their health issues and decisions'
-'Beneficiaries do not listen to us'
-'Beneficiaries prefer to visit private hospitals than PHC/CHC'
- 'Beneficiaries do not come on time'
- 'Beneficiaries do not behave/respond properly during home visit'
- 'Beneficiaries fight during group meetings for snacks/other material benefits

From the above box:2 the selected ASHAs expressed that they face difficulty in convincing people for adapting better practices/availing benefits to great extent.

And all other barriers related to beneficiaries were faced to less extent as reported by the ASHAs.

Box:3 Barriers related to 'Authorities/Seniors and Co-workers'

- 'Anganwadi Workers are not cooperative'
- 'Anganwadi Workers behave rudely'
- 'ANM is not recruited/ not available'
- 'Malaria worker is not recruited/ not available'

The selected ASHAS reported that barriers related to 'Authorities/ Seniors and Co-workers' were faced by them to less extent.

Box: 3 reflects that ASHAs' these barriers are mostly associated with behavioural issues with Anganwadi Worker and unavailability of ANM and Malaria worker.

Opinions of ASHAs regarding Use of Development Commu nication Approaches (i.e. IEC and ICT) under NHM

- It was opined by the Selected ASHA that IEC approaches help in easy explanation of health-related concepts which can be remembered for longer period of time.
- Moreover, it was reported that ICTs fasten the delivery time and large number of masses can be reached easily in times of emergencies and outbreak of disease. Because of emergence and usage of new media like mobile phones, computer and internet arousal of interest in beneficiaries can be observed.

DISCUSSION AND CONCLUSION:

The feasibility study provided an insight into the subject and findings highlighted the scope and relevance of in-depth study. Its major findings helped researcher to uncover and understand present availability, use, need, problems and opinions for Development Communication Approaches expressed by the selected ASHAs working in Vadodara and Chotaudepur districts of Gujarat State.

The findings highlighted that ASHAs are performing their roles and responsibilities using limited IEC strategies available with them. These IEC materials (i.e. *Mamta card, Mamta diary* and register) were provided by Government under NHM.

With respect to ASHAs and their certain characteristics previous researches have recorded their observations. Among them, Arya, K. (2016) have observed almost similar trends regarding age and education; Murthy and Vijayraman (2012), Zulliger et. al. (2013) mentioned that even with limited education, Community Health Workers were significant provider of IEC including facilitation to support client's entry and maintenance in formal health system,

Hospital Visit made by ASHAs at least once in a week to seek information related to health care services, nutrition, drugs etc. (Arya K.,2017). Thakur et. al (2017) noted the availability of adequately trained ASHAs at the village level to mobilise community members regarding different health issues.

It was reported by some of the ASHAs that they have been provided with posters and flipbooks on ANC-PNC and new born care by Deepak Foundation-NGO working actively in Chotaudepur district. Moreover, programme or issue-based IEC materials like, leaflet, poster/charts, banners etc. are provided to the health workers for effective Health Communication activities.

Benefit of Health Communication Strategies are many, which have been enumerated by scholars in their researches too. Chib et al. (2012) evident benefits of mobile phone Ghosh and Saha (2013) the Health communication Campaign resulted in positive, significant net effect on awareness in identifying the signs and symptoms correctly for the general illnesses and reproductive ailments.

ASHAs would be able to perform in a better way if they have better accessibility to most suitable and appropriate Development Communication Materials to them for different content on health. There is a need to equip ASHAs with required skills in leading community meeting for awareness as to give training on handling computer, cell phone etc.

Hence, considering overall discussion, further in-depth analytical study focusing on profile of Health Care workers and various aspects like provision, use, benefits, barriers and needs related to Development Communication Approaches at large and Health Communication is recommended in parts of Gujarat state. The study would be able to provide a guideline for proper planning and utilization of budget allocated for IEC/ICT on most appropriate tailor-made model of Development Communication Approaches for not only for ASHA but everyone involved in public health sector specifically NHM. This will result into effective use of communication for delivering the health messages and role performance of grass root health care provider.

REFERENCES:

1. ASHA Programme guideline (2008) https://nrhm. gujarat. gov. in/images/ pdf/ASHA_Guidelines.pdf
2. Arya, K. (2016) Information Communication Technology Used by Health Care Worker (ASHA) of Uttarakhand. International Journal of Advanced Research ISSN 2320-5407, 4 (6) 1897-1902 http://dx.doi.org/10.21474/IJAR01/681 http://www. journalijar. com/ uploads/653_IJAR-10661.pdf
3. Chib, A., Cheong. Y., Lee, L., Cheryl, N., Tan, C. & Kameshwari, VLV. (2012). The Hope of Mobile Phones in Indian Rural Healthcare. Journal of Health Informatics in Developing Countries, 6 (1), 406-421. http:// www. jhidc. org/index. php/jhidc/article/view/81/118
4. Ghosh, S., & Saha, M. (2013). Health Communication and Behavioural Change: An Exploratory Study among Marginalized Communities in Rural West Bengal, India. Journal of Health Management, 15(3), 307–327. https://doi. org/10.1177/0972063413492038 https:// journals. sagepub. com/ doi/ abs/10. 1177/0972063413492038#articleCitationDownloadContainer
5. Murthy and Vijayraman (2012) Role of Mobile Phone in Health Worker's Work Routine, FRHS report, DOI: 10.2139/ssrn.2167757 http:// frhs india. org/ library/Role_of_mobile_phone-.pdf
6. National Health Mission: Implementation framework (2012-2017)https://nrhm.gujarat.gov.in/implementation-framework-plan-of-action.htm
7. Thakur, J. S., Jaswal, N., & Grover, A. (2017). Is Focus on Prevention Missing in National Health Programs? A Situation Analysis of IEC/BCC/Health Promotion Activities in a District Setting of Punjab and Haryana. Indian journal of community medicine: official publication of Indian Association of Preventive & Social Medicine, 42(1), 30–36. doi:10.4103/0970-0218.199795 https://www. ncbi. nlm. nih. gov/pmc/articles/PMC5349000/?report=printable
8. Rose Zulliger, Mosa Moshabela & Helen Schneider (2014) "She is my teacher and if it was not for her I would be dead": Exploration of rural South African community health workers' information, education and communication activities, AIDS Care, 26:5, 626-632, DOI: HYPERLINK "https://doi.org/10.1080/09540121.2013.841839" 10.1080/09540121.2013.841839https://www.tandfonline.com/doi/full/10.1080/09540121.2013.841839?scroll=top&needAccess=true