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Knowledge of ASHA workers under NRHM on Antenatal, Postnatal and family planning Services.

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ABSTRACT

Good health status of women not only enables them to enjoy long, healthy and creative lives, also assures healthy child or healthy family. In India pregnant women die due to a combination of important factors like, poverty, ineffective or unaffordable health services, lack of political, managerial and administrative will. All these factors culminates in a high proportion of home deliveries by unskilled relatives and delays in seeking care and that in turn adds to the maternal mortality rates. To reduce the maternal and infant mortality the Government of India had adopted a time bound and mission oriented approach to correct the public health situation in the country in April 2005 , through National Rural Health Mission (NRHM) The main objective of National Rural Health Mission was to create functional health facilities within the public health system. Accredited Social Health Activists (ASHA) are appointed under NRHM, who provides MCH services to the pregnant women and children. The present paper is based on an empirical study to analyse the Knowledge of ASHA workers on Antenatal, Post natal and Family planning services in Chitoor district of Andhrapradesh.

KEYWORDS NRHM, Maternal Mortality, Infant mortality, ASHAs, Public health.

Indtroduction:

The National Rural Health Mission (NRHM) was launched by the Government of India in April 2005, with a time bound and mission oriented approach to correct the public health situation in the country. The NRHM was a combination of several programmes including population stabilization, disease control, nutrition, water and sanitation, improvement of workforce, infrastructure, and logistics. In addition it further took in hand health determinants especially nutrition. National Rural Health Mission envisages equitable and quality health care services to rural women and children in the country.

The main objective of National Rural Health Mission was to create functional health facilities within the public health system. The NRHM was expected in the form of reduction of Infant Mortality Rate (IMR) from a level of 63 to 30. It was targeted that Maternal Mortality Rate (MMR) reduced from 330 to 100 in the year 2012. The NRHM aimed to engage 400,000 female Accredited Social Health Activists (ASHAs) and double the Number of Auxiliary Nurse Midwife (second ANM) in Sub centers. (NRHM 2005-2012 MHFW)

The salient features of NRHM programme are

- Provide accessible, affordable, accountable, effective and reliable health care facilities in rural areas, especially to poor and vulnerable sections of population.
- Reduce to Maternal Mortality Rate 100 per 100,000 live births by 2012
- Reduce Infant Mortality Rate to 30 per 1000 live births by 2012
- Engage 400,000 female Accredited Social Health Activists (ASHAs) and the double number of Second Auxiliary Nurse Midwife in health Sub Centers.

ASHAs: Accredited Social Health Activist are appointed under NRHM which provides MCH services to the pregnant women and children. ASHA worker's Role performance includes the bringing children for immunization, accompanying pregnant women for delivery cases to health facility, health awareness activities, providing ANC counseling, working with Anganwadi worker, registration of births and deaths, motivating and mobilizing community on health and sanitation aspects, family planning information, timely referrals of pregnant women to the hospitals .

The present paper is based on an empirical study on "Role performance of ASHA workers carried out in the Chittoor district of Andhrapradesh.

Objectives of the present study

- To analyse the Knowledge of ASHA workers on Antenatal, Post natal and Family planning services.
- To analyse the record maintenance of ASHAs

SAMPLING TECHNIQUE AND SIZE

For the present study Chittoor District was selected purposively in view of the convenience of the researchers. The period of data collection was from October 2014 to March 2015.The respondents of the study were the ASHAs functioning under NRHM in the rural areas at PHC level in Chittoor district of Andhrapradesh.. Out of the 2514 ASHAs Two Hundred and Fifty were selected randomly from the three Revenue Mandals i.e, Madanapalli, Tirupati and Chittoor as respondents of the present study.

METHODS AND TOOLS FOR DATA COLLECTION

A Semi structured Interview Schedule was used as the tool for data collection and the data was collected through personal interview with the ASHAs. In addition to this information on certain aspects like performance of workers on different activities on clinic days, their targets and achievements were collected from the records by verifying the regular dairies of workers and by observation.

Table-1: Percentage distribution of ASHAs knowledge on Antenatal care

S.NO	ANTENATAL CARE	TOTAL	
		FREQUENCY (N=250)	PERCENTAGE (%)
1	Safe motherhood	213	85.2
2	Period for registration of ANC	153	61.2
3	Minimum Antenatal visits	30	12.0
4	Causes of maternal mortality	275	70.0
5	Investigations for Pregnant women	249	99.6
6	Kit used for pregnancy confirmation	228	91.2
7	Anaemia means	213	85.2

8	Supplementation during pregnancy	166	66.4
9	Iron rich food	218	87.2
10	Time to start Iron tablets	39	15.6
11	No. of Iron tablets used	154	61.6
13	Effects of iron tablets	115	46.0

Multiple Responses

The ASHAs have been interviewed to assess their knowledge about in antenatal services. From table 1 it has been revealed that most of the ASHAs were know about safe mother hood (85.2%) when the antenatal mother should be registered (61.2%) causes for maternal mortality (70%) the main investigations to be carried out for pregnant women (99.6%) kit used for the pregnancy confirmation (91.2%) the supplementation of essential drug during pregnancy (85.2%) the ingredient rich in Iron (66.4%). ASHAs were having lack of knowledge on Minimum visits required for pregnant women (12.0%) how many Iron tablets to be taken for prevention of anaemia (15.6%). Most of ASHAs were having good knowledge in Antenatal services this indicates the active participation of ASHAs in Antenatal services. According to the study conducted in chitoor district it has been reported that among the ASHAs 26 per cent were having average level of knowledge followed by 55.4% were having moderate level of knowledge and 23.0 percent were having high level of knowledge on ante natal health care services(Jayasree & Prasoona , 2014)

Table-2: Percentage distribution of ASHAs knowledge on Postnatal and Child care

S. NO.	ASHAs KNOWLEDGE ON POSTNTAL AND CHILD CARE	TOTAL	
		FREQUENCY (N=250)	PERCENTAGE (%)
1	Postnatal period	181	72.4
2	Postnatal complaints	149	59.6
3	Importance of baby with mother	226	90.4
4	Weight of the new born baby	158	63.2
5	Knowledge on Colostrum	34	13.6
6	Knowledge on weaning	109	43.6
7	Evil spirit influence on child	223	89.2
8	In weighing the baby the red colour indicates	184	73.6
9	Immunization protects the child	22	8.8
10	Points to be remembered during immunization	78	31.2
11	Common side effect of vaccination	245	98.0
12	Postponement of immunization	113	45.2
13	Reference to hospital after immunization	185	74.0
14	BCG vaccination	238	95.2
15	"0" (Zero) polio drops	244	97.6

Multiple Responses

The above table (No. 2) reveals the knowledge of ASHAs regarding postnatal and child health care. Majority of ASHAs were having knowledge in postnatal and child health care services like the duration of postnatal period (72.4%) Complaint s during postnatal period (59.6%) importance in keeping the baby with mother (90.4%) new born baby weight (63.2%) period to start weaning (43.6%) in weight measurement red colour indicates (73.6%) the common side effects of vaccination (98.0%) after immunization, when the baby should refer to hospital (74.0%) importance of BCG vaccination (95.2%) "0" polio drops (97.6%). ASHA workers were having minimum knowledge in postponement of immunization (45.2%) Points to be remembered during immunization (31.2%) immunization protects child from diseases (8.8%) knowledge on colostrum (13.6%). This reveals that ASHAs were having low level of knowledge in Immunization services and required induction training to refresh their knowledge.

41.2 percent of ASHAs were having average level of knowledge and 26.0 percent were having moderate level of knowledge and 32.8 percent were having high level of knowledge on postnatal and child health care services.

In this context it is important to state the findings of the study conducted by Shrivastava (2012) Despite of the training given to ASHAs, lacunae still exists in their knowledge regarding the various aspects of child health morbidity specially immunization services. Monthly meetings can be used as a platform for the reinforcement of various aspects of immunization services in children. Periodical refresher training should be conducted for all the recruited ASHA workers.

Table.3: Percentage distribution of ASHA worker's knowledge on family planning services

S. NO	ASHAs KNOWLEDGE ON FAMILY PLANNING/ ABORTION SERVICES	TOTAL	
		FREQUENCY (N=250)	PERCENTAGE (%)
1.	Investigation in infertility couples	242	96.8
2.	Emergency contraceptive pills	66	26.4
3.	Permanent contraceptives	178	71.2
4.	Chances of fertility during menstrual cycle	7	2.8
5.	Period of condom use after vasectomy	73	29.2
6.	Safe period for abortion	2	0.8
7.	Medical abortion	2	0.8
8.	Period of stay in hospital after abortion	158	63.2

Multiple Responses

The above table reveals the knowledge of ASHAs on family planning and abortion services. It shows that majority of the respondents were having low level of knowledge in family planning services. Only 2.8 percent responded for chances of fertility during menstrual cycle 0.8 percent responded for safe period for abortion, 29.2 percent stated for period for use of condoms after vasectomy followed by 26.4 percent respondent for emergency contraceptive pills.

ASHAs were having high level of knowledge in investigation for infertility couples (96.8%), period of stay in the hospital stay after abortion (63.2%), and permanent contraceptives (71.2%). More than fifty percent of ASHAs (51.2%) were having moderate level of knowledge, followed by 23.6 percent were having low level of knowledge and 25.2 percent were having high level of knowledge on family planning services.

Overall knowledge on NRHM programme :Among the ASHAs 62.0 percent were having average level of knowledge, followed by 49.2 percent were having moderate level of knowledge and 26.0 percent having high level knowledge on overall NRHM programme.

Table -4: Percentage Distribution of Maintenance of Records by ASHA

S. NO	CONTENT	FAIR (No) (%)	GOOD (No) (%)	EXCELLENT (No) (%)	TOTAL (No) (%)
1.	JSY register	28(11.2)	143 (57.2)	79 (31.6)	250 (100)
2.	Health register	21(8.4)	146 (58.4)	83 (33.2)	250 (100)
3.	ASHA dairy	19(7.6)	136 (54.4)	95 (38)	250 (100)
4.	Drug kit register	24(9.6)	162 (64.4)	65 (26)	250 (100)
5.	Birth and death register	22(8.8)	130 (52)	98 (39.2)	250 (100)

6.	Growth monitoring register	15(6)	128 (51.2)	107 (42.8)	250 (100)
7.	Immunization register	18(7.2)	110 (44)	122 (48.8)	250 (100)

The above table reveals the results of records maintained by the ASHAs were collected by observation and interview. ASHA's work was observed between 10 am to 4 pm. They are spending more time in official work like attending meetings and other health care programmes, Tuesday attending Antenatal clinics, Wednesday participating in immunization programme etc. Overall they are spending 4-5 hours in a day. Majority of ASHAs were entering the data in the sub-center only. Fifty percent of ASHAs (50%) maintaining the records regularly. Most of them scored good in maintenance of JSY register (57.2%), village health register (58.4%), ASHAs dairy (54.4%), drug kit register (64.4%), birth and death registers (52%), growth monitoring register (51.2), immunization register (44%). They voluntarily update the records weekly and ANMs also supervising and updating the records regularly. It is interesting to note that nearly fifty percent of ASHA's are maintaining the records excellently, especially immunization register (48.8%), growth monitoring register (42.8%), ASHAs dairy (38%)

From the above findings it has been observed that ASHAs are facing many problems and challenges in order to perform their roles effectively.

PROBLEMS AND CHALLENGES

- Transportation of expectant mother is a major problem in the rural areas.
- Entire compensation received by ASHAs per month is low which is quite inadequate for their sustenance.
- Medicine kits which were incomplete in many respects
- While accompanying the expectant mother to the institution and staying the hospital incur more expenditure on food, stay etc. than the sum provided to her under the scheme.
- Unable to conduct meetings in the community because they were unable to motivate the target group.
- ANM training schools are not meeting the increased demands of population.
- Supervision is limited to checking registers and there is no technical support available for the Second ANMs in the field area.
- Lack periodic in service training programme leading to lacunae in recent health care advances.
- Maximum time spending in entry of data in registers and sending of reports which intern reducing the time spending and in rendering up health care services.

Recommendation to improve efficiency of the ASHAs

- ASHA must be aware of their roles and responsibilities and the potential financial rewards and future career track
- Training is the backbone of capacity building and functioning of ASHAs. So it must be done timely, properly and effectively. A full time training structure and full time trainers should be implemented in order to ensure that there were no gaps in training.
- Provide a brief, two day refresher training for all ASHAs on a yearly basis with a newly developed, considered syllabus.
- In spite of the crucial importance given education and counseling, hygiene and sanitation, importance of exclusive breast-feeding, complimentary feeding, family planning, ORS use, preventing early marriages and gender discrimination etc. were not being found in the agenda of ASHAs. So these aspects must be emphasized during training and other meetings.
- The availability of medicinal kits with each ASHA along with regular replenishment of items inside it must be ensured
- Provision of waiting room facilities at PHC, CHC and hospitals to the ASHAs. So that they have a comfortable place to stay when they accompany their patients for institutional deliveries.
- Assign a specific supervisor for ASHAs so that there is a specific oversight and monitoring of ASHAs performance.
- Introduce a formal review process every six months so that ASHAs performance is monitored and tracked
- ANMs should have a critical working relationship with ASHAs; it is also imperative that they provided support to make this relationship effective both in terms of data reporting as well as task defining and providing the services.
- Provide increased opportunity for upward movement of ASHAs in order to motivate, engagement and continued performance by performance-based bonuses or increase in incentives for every completion of service or by fixed salary.
- Although it has been 10 years since the start of NRHM programme in the district, selection of the ASHAs is still not completed and in few places they were non-functional. This impacts the overall implementation of the programme. An attempt should be made to recruit the vacant position of ASHAs as early as possible.
- A provision of proper, well equipped one or two ambulances to transport the pregnant mothers and other serious patients must be made for each PHC. It can be done on private public partnership basis.
- Possibility of providing mobile phones and at least two wheelers to the ASHAs could be considered so that they can have connectivity with the community and health care facility and solve the transport problem.

To further enhance the role that the ASHAs current performance and provide supervision to identify shortcomings and address them to achieve the desired outcomes as envisaged when designing the ASHAs component under NRHM.

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