Knowledge Assessment of ASHA Worker Regarding Their Roles, Responsibilities and Health Services: With Special Reference to the Ratlam District of Madhya Pradesh

By

Pankaj Shah

Dissertation submitted for the partial fulfillment of the

MBA Rural Management

Academic year, 2015-2017

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TO WHOMSOEVER MAY CONCERN

This is to certify that **Pankaj Shah** student of **MBA Rural Management** from **The IIHMR University, Jaipur** has undergone dissertation training at National Health Mission, Madhya Pradesh from 6th February 2017 to 6th may 2017.

The Candidate has successfully carried out the study designated to him **"Knowledge Assessment of ASHA Worker Regarding their Roles and Responsibilities and Health Services"** during dissertation training and his approach to the study has been sincere, scientific and analytical.

The dissertation is in fulfilment of the course requirements.

I wish him all success in all his future endeavours.

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In recognition of having successfully completed his

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And has successfully completed his study on

"Knowledge Assessment of ASHA Worker Regarding their Roles and Responsibilities and Health Services"

(With special reference to the Ratlam district of Madhya Pradesh)

Duration of three months (February 2017 – April 2017)

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He comes across as a committed, sincere & diligent person who has a strong drive and zeal for learning

I wish him/her all the best for future endeavors

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Signature of Student

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CERTIFICATE BY SCHOLAR

This is to certify that all ethical issues have been considered while collecting data for my dissertation titled **"Knowledge Assessment of ASHA Worker Regarding their Roles, Responsibilities and Health Services"**

Signature of Student

Pankaj Shah

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EXECUTIVE SUMMARY

The main objectice of National Health Mission (NHM) is to rainforce the healthcare delivery system with a straight objective on the requirment of the poor and vulnerable communities among the urban slum rural population. One of the main branch of the NHM is to select one ASHA (Accredited Social Health Activist) per 1000 population in the rural areas with the goal of assist the community to access health services. She is expected to make awareness on health and its aspects, mobilizing the community into the health planning, and increase utilization of the existing health services facilities.

In this study the ASHAs who respond to the questionnaire accquire to understand their roles and responsibilities but Researcher's field visits and qualitative and quantitative data collection shown otherwise. ASHAs were even not able to express their all their job responsibilities and roles. Without a clear understanding of one's own responsibilities as an ASHA, performance and effectiveness cannot be improved. Furthermore, we also believe that there is potential for ASHAs to take on some additional roles outside those originally prescribed, such as helping develop village health plans, registration of vital events with the ANM/AWW, and community based new born care. Inclusion of these additional activities would increase associated financial incentives. Additionally, ASHAs are currently claiming to work approximately 25 hours a week, which provides potential to increase her responsibilities, which would therefore increase her incentives as well. Additional responsibilities within her scope of capabilities should be considered.

The ASHAs plays the role of bridge between the health searvices and communities. Yet there are several gapes in ASHA programme as, lack of capicity building, skill upgradation, refresher training, access to healthcare and basic health searvices to the communities. The effectiveness of ASHA programme and the keep update their knowleged it needs regular and continuous supervision but there are various weak link in this system. The clear strategies and methods for monitoring need can be establish with a linelist of the monitoring and supervision activities as well the refresher and skill upgradaatio to be taught to the supervisors those who will organise these activity. In this study done in Bilpank block of Ratlam, it came that many of the ASHA are providing services to more than 1000 population in respected areas where they works. The remote population in Bilpank block of Ratlam district is spread in large areas and devided by hills. Because of these natural barriers, the ASHAs most of the time failed to visit certain areas and area of the population that remained unserved and unreached for health searvices. The ASHAs are

very intrested for their responsibilities like registration of women who are pregnant, immunization, ANC/ PNC but the rejected areas are where they are not able to perform well are the VHSNC monthly meeting, mobilizing community for family planning and searving to remote areas.The activities linked to monetary incentives ASHA do it with priority and other activities are done with less intrest and less importance. There are 36 type of incentive made for ASHA worker, but most of the ASHAs were not aware about the incentive which are made for them even they shows lack of interest to check their bank account to check the payment is done or not. The ASHA interviewed, reported that they have received kits and supplies which were incomplete and not in proper way. Else other was not having proper kits and supplies, some of the kits were expiry dated. The majority of ASHAs are having lack knowledge on proper doses of drugs and use of supplies. Another operational problem is Anti natal care and post natal care, ASHA only focus on registration of the pregnant women and institutional delivery because she get incentive for it. In ANC visit and PNC visit ASHA shows lack of interest. Most of the ASHA were unable to conduct meeting in the rural community because they said it is hard to mobilizr the rural people and motivate them for certain aspects, sahyogi meeting should be done before the ASHA monthly meeting so that they can influence te ASHA on their monthly meeting. On family planning component, as it is a sensitive health aspect, it is important to convince community to adopt family planning method and routine follow up on regular basis but it is not done by the ASHA. Also they use to feel shy communicating family planning method in front of the mass. Majority says that they only convince to female usually.

For improving the knowledge of ASHA worker regarding their roles and responsibilities and health services as well as well as for effective and efficient work there should be an restructure dividation of the population catered by each ASHA should be as per the community process guideline which is one asha should work for the 1000 population of the same village where she lives. In the areas which are geographically difficult and with natural barriers like- hills, desart etc, the norm couil be relaxed and new ASHA can recruited in that area where there is no ASHA. For effective health outcome and efficient work there is need of proper capacity building of ASHA worker, there should be proper monitoring to check ASHA training and for those who have completed all the trainings and module there should be a half yearly refresher training on running basis.

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The Dissertation opportunity I had with National Health Mission, Madhya Pradesh was a great opportunity for learning and professional development. I consider myself very lucky individual as I got opportunity to be a part of it. I am grateful for having a chance to meet with many professionals and experts who led me in this dissertation period.

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It is my radiant sentiment to place on record my best regards, deepest sense of gratitude to, Dr. Yogiraj Mishra, for his careful and precious guidance, love and support which were extremely valuable for both theoretically and practically. Last but not the least I wish to thank my colleagues for their immense support and guidance.

I perceive this opportunity as a big milestone in my career development. I will strive to use gained skills and knowledge in the best possible way, and I will continue to work on their improvement, in order to attain desired career objectives. Hope to continue cooperation with all of you in the future,

Sincerely
Pankaj Shah
Student- MBA RM 04

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ABBREVIATIONS

ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWW	Anganwadi Worker
CHW	Community Health Worker
FGD	Focus Group Discussion
JSSY	Janani Shishu Suraksha Yojana
MCH	Maternal and Child Health
MoHFW	Ministry of Health and Family Welfare
PHC	Primary Health Centre
PNC	Postnatal Care
PRI	Panchayati Raj Institution
SC	Sub Centre
VHW	Village Health Worker
WHO	World Health Organization
ICDS	Intregrated Child Development Service
VHSNC	Village Health Sanitation and Nutrition Committee
DOTS	Directly Observed Treatment Short course
RNTCP	Revised National Tuberculosis Control Programme

SECTION 1 - INTRODUCTION:

According to WHO, "Community Health Worker (CHW) are men and women chosen by the community, and trained to deal with the health problems of individuals and the community, and to work in close relationship with the health services. They should have had a level of primary education that enables to read, write and do simple mathematical calculations" (WHO 1990).

A developing country especially like India has seen so many ups and down particularly in health sectors before and after Independence. Many health programs in health sectors are failed in the past or could not achieve certain objectives. The importance of Health in the process of sustainable development and improving the quality of life of our citizens, Government of India launched National Rural Health Mission (NRHM) to address the health needs of rural population, especially the underprivillaged sections of society. With the objective of providing effective, efficient and affordable healthcare to rural population in India, the NRHM aims to appoint a female volunteer activist known as ASHA (Accredited Social Health Activist) in every village and slum, selected from the domicile village itself. The National Rural Health Mission (NRHM) launched in April, 2005 has completed 11 years of implementation and is now commencing its second phase as National Health Mission (NHM). In last year's ASHA programme is one of the largest community health worker programme in the world, and is considered a effective contributor to serve people.

ASHA is a health activist which act as a bridge between the rural people and health service

outlets and play important role, in achieving national health mission goals which are, decrese IMR/MMR/TFR and population stabilization. The effectiveness of ASHA worker largely depends on thir training and support from both the health system and the community. The ASHA's capicity bilidind and to make them skilled and upgrated it is important to provide them the proper induction, orientation and time to time monitoring. There are totally 3 types of training meant for ASHA for their capacity building and skill upgradation. The induction training which should be done within the 20 days of ASHA selection. As induction training is done than there are various periodic trainins as per the module wise of health searvices and their responsibilities. Once the training started there should be refresher training on time to time. This training should be always interactive sessions and done bt the skilled master trainer to refresh and upgrade their knowledge and skills and solve the problems they are facing, and monitor the work ASHA does and keep them enthusiastic and help out to perform their task, duties and responsibilities smoothly.

ASHA Selection-At a glance: Selection of ASHAs is near completion in all states according to the norms laid during the first phase of NRHM. The general norm ASHA selection is 'One ASHA per 1000 population'. When the population exceeds one thousand, another ASHA can be engaged. Where there is more than one ASHA in a village, each ASHA needs to be allocated a set of households so that no households, particularly those in the periphery and outlying hamlets are missed. In tribal, hilly and desert areas, the norm can be relaxed to one ASHA per habitation, depending on the workload, geographic dispersion, and difficult terrain. In urban habitations with a population of 50,000 or less. The motive of urban health mission is to cater the population of more than 50000 or less in specially the slum areas of the urban.

Criteria for Selection

- ASHA should be a woman resident of the same village preferably 'Married, widow, divorce or Separated' and preferably in the age group of 25 to 45 years.
- ASHA should have leadership quality, effective communication and zeal to cater the community accordingly
- The education qualification shuld be atleast 8^{th} pass, in case of not getting the eligible ASHA relexaction can be made.
- ASHA should have family and social support to find out the time to perform their task effectively.
- The educational and age criteria can be relaxed if no suitable woman with this qualification is available in the area.

- Adequate representation from disadvantaged population groups should be ensured to serve such groups better.

National Rural Health Mission (NRHM) Presently a total of 873,759 ASHAs are in position in the country, against the target of 9,52,533 (91.7 % selected), under National Rural Health Mission (NRHM). This reflects that the target for ASHA selection has been revised by 5139 ASHAs since the last update published in January 2016. Of this increase, 3347 is accounted for by the high focus states alone - as Chhattisgarh and Madhya Pradesh have raised their target by about 1778 and 2194 respectively. However, Rajasthan has decreased its target by 635. Non-High Focus states have together increased the target by 1062, and North East States by 756 while Union Territories have increased it by 24 ASHAs. The total number of ASHAs in position has also increased by 16,404. Of this increase, the addition of 6678 ASHAs comes from the eight high focus states, while another 9085 is from non-high focus states. North Eastern states have added 678 ASHAs to their total, and UTs have added nine ASHAs.

In Madhya Pradesh under National Rural Health Mission total proposed/Targeted ASHA's were 62851, against to this target total 59001 ASHA's are currently working/selected. This is 93.87% against to target. Under the National Urban Health Mission 4200 ASHA's were targeted, against to this target 3850 ASHA's are currently working/selected. This is 92% of total against to target.

(*Source by- NHSRC website)

1. **Roles and Responsibilities of ASHA:** the roles and responsibilities of ASHA worker include the field visit, create awareness and provide information to the community on health, sanitation, nutrition and hygiene aspects. The role of asha for mobilizing the community is to do proper house to house visit and repo building with the community and influence them to accept healthy practices.

Her roles and responsibilities would be as follows:

2. ASHA responsibility is to create awareness and provide information to the community on health, sanitation, nutrition and hygiene aspects. The role of asha for mobilizing the

community is to do proper house to house visit and repo building with the community and influence them to accept healthy practices.

3. She should do councelling of women and families on birth, importance of instution delivery, ANC/PNC, breastfeeding and complementary feeding, full immunization, imphassis on family planning and basically to provide promotive and preventive care among the community.

4. ASHA another role is to mobilize the community and facilitate them for access to primary health and related services available at the village/sub-centre/primary health centres, such as Immunization, Ante Natal Check-up (ANC), Post Natal Check-up (PNC), ICDS, sanitation and other services being provided by the government.

5. ASHA use to work with Village Health, Sanitation and Nutrition Committee to develop a comprehensive village health plan, and promote convergent action by the committee on social determinants of health. In support with VHSNC, ASHAs will assist and mobilize the community for action against gender based violence.

6. She act and arrange escort and accompany to the pregnant women & children for requiring treatment and any kind of health searvices, institutional delivery, she escort the pregnant women to the nearest hospital or healthcare facility.

7. ASHA has to provide community level preventive, promotive and curative care for minor ailments such as diarrhoea, fevers, care for the normal and sick newborn, childhood illnesses and first aid. She will be a provider of Directly Observed Treatment Short-course (DOTS) under Revised National Tuberculosis Control Programme. She will also act as a depot holder for essential health products appropriate to local community needs. A Drug Kit will be provided to each ASHA. Contents of the kit will be based on the recommendations of the expert/technical advisory group set up by the Government of India. These will be updated from time to time, States can add to the list as appropriate.

8. The ASHA's role as a care provider can be enhanced based on state needs. States can explore ` the possibility of graded training to the ASHA to provide palliative care, screening for non- communicable diseases, childhood disability, mental health, geriatric care and others.

9. The most important role of ASHA is to provide information about the births and deaths in her village and any unusual health problems or disease outbreaks in the community to the Sub-Centres and Primary Health Centre. construction of household is also pramoted by the ASHA under the total sanitation and mobilize them to use toilets.

The ASHA will fulfil her role through five activities:

1. Home Visits: The roles of ASHA is to do proper home visits and house to house field inspection/survey. As we know that asha work as a bridge between community and health searvices/facility so here roleis to do house to house visit in her particular area and identified the targeted group like pregnant women, malnurished children, amenic girls and child etc or any kind of desiese outbreak information or awareness is done by the ASHA during her field visit

2. Attending the Village Health and Nutrition Day (VHND): There is provision of Village level health and nutrition day in every villlage in a month. ASHA usr to play important role in VHND to bring the patients in the camp and motivate them for the same.

3. Visits to the health facility: The anothe role of ASHA is to visit the health center on time to time, bring the serious patient in the nearest health center and have proper communication with the health facilities.

4 Holding village level meeting: There is provision of Village level Health Sanition and Nutrition committee. ASHA play important role in this comittee. The aim of this committee is to collectively bring out the results or outcone for the village level health, sanitation and nutrition realted issues and anothe role of ASHA is to organise village level meeting on time to time.

5. Maintain records: The another task of ASHA worker is to maintaing the record and database. ASHA has to fill some certaing register and data of her working village which healps to the primary health center and sub center and other health intervention. For effective healthservice providing the maintaining records plays important role.

Capacity Building of ASHAs: Capacity building of ASHA is a continuous process. Capacity Building of ASHA worker is critical in enhancing her effectiveness to achieve the desired healthcare outcomes. ASHA needs more skills for her to be effective – as a facilitator, as a

community level health care provider, and as a health activist. Training of the ASHA is a continuous process, and the duration and skills specified below are the absolute minimum, which must be achieved for every ASHA. States can set their own upper limit on the number of days of training.

Training Strategy: The training strategy includes-

1. Induction Training: All newly selected ASHAs will undergo an eight day induction training to orient her to her role and responsibilities, provide the skills of community rapport building and leadership, and an understanding of the health system and rights based approach to health.

2. Skill based Training for key competencies in women and children's health and nutrition: This is a twenty day training to be completed in four rounds within the first eighteen months of joining. All ASHAs are required to be certified in a set of competencies related to basic healthcare services like maternal and child care, sanitation, nutrition and other health concern such as malaria and tuberculosis.

3. Supplementary and Refresher Trainings: Subsequently at least fifteen days of training annually should be planned in which new topics and skills can be added. These can also serve to reinforce existing skills in areas where the ASHAs need further inputs. The new skills would be specific to local needs. Skills in certain areas such as disability screening, mental health counselling, or other skills that the state would like to prioritize can be taught to selected ASHAs rather than all ASHAs in a particular area. She could then provide such services to larger set of villages. The PHC review meetings can be used as a forum for such training. States will develop modules with central assistance as needed for state specific issues as appropriate.

Key features of ASHA training: ASHA training is designed in multiple levels. There are three levels of training and each level is expected to have a committed; Full time cadre of trainers and corresponding training sites.

- A national team of trainers trained and accredited at the national training sites. The national trainers are a mix of the faculty of the national training site, trainers deputed from

other Public Health Organizations, or freelance trainers who can be called upon when required.

- A team of master and state trainer train to the ASHA and other trainer.
- A team of ASHA trainers for each district drawn from the sub district level, trained and accredited at the state level training sites.
    - ASHA trainer should conduct the training for ASHA in the convineant site of their approach.

SECTION 2 - REVIEW OF LITERATURE:

Using community volunteer member for proving the health services to community is a idea which is prevelent for last five decades. Aroud the world there are many examples of such programme to link communities with the health system. The use of these community members or activist to cater certain public health services to communities is a concept that has came out. There are many programme and experiences throughout the world with ranging from large-scale, national programmes to community-based initiatives. As we know that ASHAs plays major role in bridging access and coverage of health services in rural and remote areas and can actions that lead to better health outcome. With special emphasis on maternal and child health. To bring out their roles and responsibilities successfully, it is necessary one should provide training in regular intervals, monitoring, invigilation, engagement as well as mobilization. ASHA full potential to be usefull as an health asset to represent as an important health resource to extend basic health care to underserved populations that coud be be tapped.

The ASHA programme is the biggest in its extent in as a largest volunteer workforce in india as well as world. The ASHA programme is one of the lafgest as an volunteer health activist programme, they are not fully paid employees, they are activist paid for the activities which are ment for the incentive provision as per the government. There are total 36 types of incentive made for ASHAs, after intervention of therse provision one can get the particular incentive amount. ASHAs studies have been widely documented in health literature, few are;

1. **SEARCH NGO in Maharashtra state:** The Society for Education, Action, and Research, first time in india they started home-based neonatal care in the tribal area and district of Maharashtra in the year of 1980s. Village health workers use to conduct birth attendance antenatal and postnatal services, birth attendance, mobilizing the tribal communities and aware then accordingly. As per result attribute decreased neonatal mortality almost 20% compared to the control population. The nutrition counseling interventions of the SEARCH inforce to a significantly decrese in the low weight babies birth, and other targeted interventions outcome in a particular decreasment in other cases a substantial decrease in the incidence of co-morbidities and other neonatal problems.
2. **Mitanin in Chhattisgarh state:** With partnership with civil society, Mitanin programme has been launched by the chattisgarh government in 2002. This programme acted as a model for the ASHA programme. Mitanins were well trained and mobalized and oriented to conduct household outreaching which is including essential care for the newborns,

counselling for nutritional requirment and managing childhood illness and further addirtional activities like- access to basic public services, activities for women empowerment and mobilization for Integrated Child Development Services. There was no salary provision for Mitanin, but they receive a piece of land for cultivation or by other means, as decided by the villagers. More than 60000 Mitanin are now serving more then 70000 remote areas and they are supported by 3000 active women supervisors. The The credit goes to Mitanin for decresing the state IMR from 85 in 2002 the second highest in the country to 65 in 2005. The underweight children proportion was down to 61% to 52%, and full immunizations has incresed from 22% to 49% in chattisgarh trible villages.

3. **Evaluation of ASHA programme:** The National Health Systems Resource Centre (NHSRC) evaluated the ASHA programme in 2011, in evaluation it came out that ASHA programme is working in large scale and plays important role in indian public health system. But its functioning and further effectiveness could be improved which came out. The NHSRC has focused on underpar performance in some areas of work like- newborn care, ANC, postnatal care, family planning and nutrition and reason behind it is due to lack of capacity building, training and support. States are ultimately responsible for revising training curriculum—though progress is very low because of the poor institutional and infrastructural support and lack master trainer to support ASHA—and many have done amendments for the selection of ASHA and Trainings to fulfil accordingly.
4. **Community Health Workers addressing social determinants:** The concept of CHWs as a concept is prevelent for more than 5 decads (Lehmann & Sanders, 2007). The CHW is defined by the WHO "Community health workers should be members of the communities where they work, should be selected by the communities, should be answerable to the communities for their activities, should be supported by the health system but not necessarily a part of its organization, and have shorter training than professional workers" (Lehmann & Sanders, 2007:3).

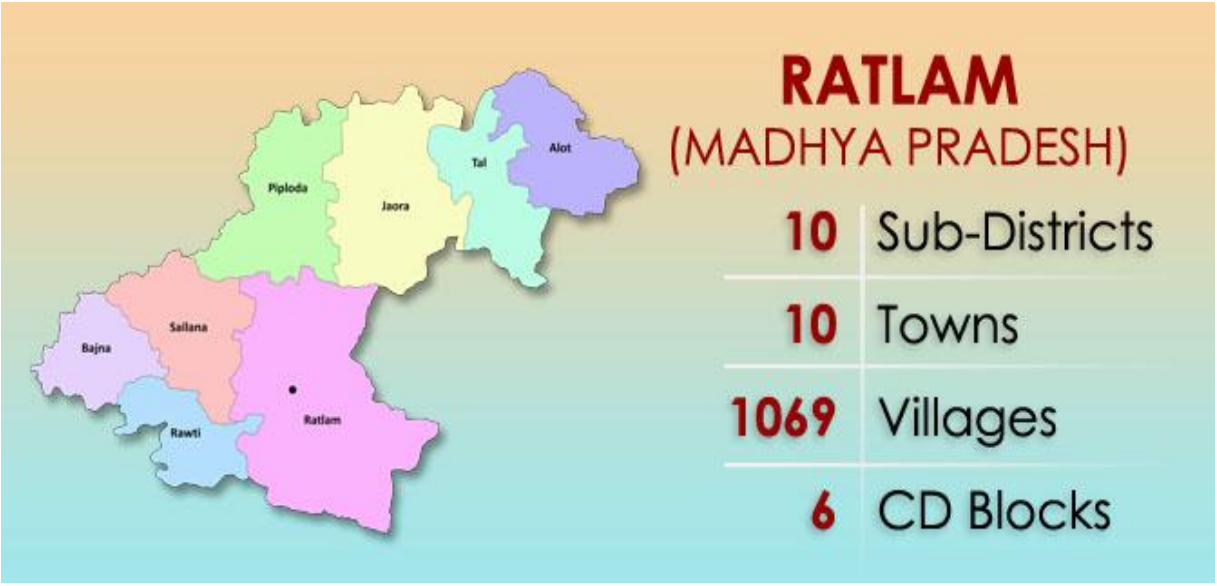
SECTION 3 - OBJECTIVE:

- To evaluate the knowledge of ASHA workers regarding their roles and responsibilities and health services.
- To provide recommendations for desire efficacy of the ASHA programme.

SECTION 4 - ORGANISATIONAL OVERVIEW: National Rural Health Mission was launched in 2005 to cater health needs of underserved rural areas. Further encompasses its two Sub-Missions in April 2013, the National Rural Health Mission (NRHM) and the National Urban Health Mission (NUHM) and it is merged as National Health Mission. The major components oth the mission are strengthening health sysytem in rural and urban slum areas, Reproductive Maternal-Neonatal-Child and Adolescent Health (RMNCH+A) and Communicable and Non Communicable Diseases. The cision of NHM is achievement of universal access to equitable, affordable & quality healthcare services that are accountable and responsive to people's needs.

SECTION 5 – METHODOLOGY:

Overview: The purpose behind this field survey of ASHAs was to collect data regarding their perception about their roles, responsibility, training, effective knowledge etc. The purpose of this study is not to generate inclusice dataset for involving abstraction and comparison, but to get better information and view on several factors and variables collected from the field that is not available from the secondary sources. Bilpank block of Ratlam distict was selected for sampling. Bilpank is a village situated in Ratlam block of Ratlam district in Madhya Pradesh. Situated in rural area of Ratlam district of Madhya Pradesh, it is one of the 170 villages of Ratlam block of Ratlam district. As per the administration register, the village has 662 families. According to Census 2011, Bilpank's population is 3431. Out of this, 1752 are males while the females count 1679 here. This village has 452 kids in the age group of 0-6 years. Out of this 234 are boys and 218 are girls. The count of occupied people of Bilpank village is 1625 while 1806 are non-working. And out of 1625 occupied people 414 individuals are completely dependent on agriculture. Block was selected in recommendation and suggestion with District Programme Manager and other officials with the help of norms that are Block population size, distance from the District Hospital etc



Methods: The questionnaire was meant for the ASHA workers is included in the appendix. The questionnaire was meant in English language. Questionnaires were filled by researcher in presence of all ASHAs individually via interview, and each one of question was explained them, the ASHA was asked to give her answers. The survey work was done in the presence of the block

team members. For any confusion or translation on any word or question, block team member who could translate language were available to respond.

Source of data: Data was collected from Primary and Secondary sources

Primary Data- Primary data was collected through primary sources available with:-

- Interview of Accredited Social Health Activists
- Focus group discussion(FGD)
- Bilpank block office of the Ratlam districts of Madhya Pradesh.

Secondary Data- Secondary data was collected from the following sources:-

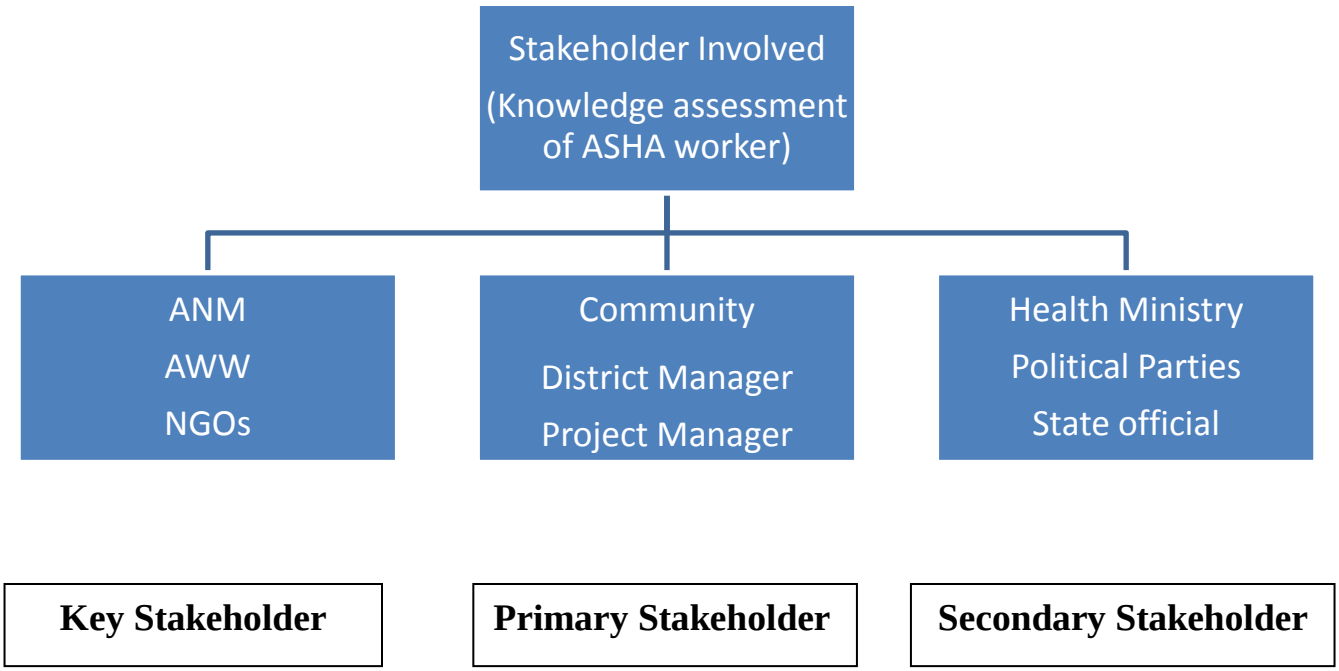
- Journals
- Books
- NHSRC community process guideline
- Produced materials published by health/government departments etc.

Sampling: ASHA list was taken by ASHA software of NHM Madhya Pradesh and the meeting was called at the Public Health Center Bilpank, interviewed with randomly selected ASHAs from the list and presence in the meeting. The sample size of ASHAs was 145 from Bilpank block of Ratlam.

Study design: A cross sectional study was conducted, with enquiry made from a preformed questionnaire. The study was conducted in the period of February-April, 2017.

SECTION 6 - STAKEHOLDERS ANALYSIS: The stakeholders which are involved in the ASHA programme, Training and capacity building of ASHAs are Panchayati Raj Institutions Members, ASHA, AWW, ANM, Community, Block and District level officials, State level officials, health ministry etc. Table 3 shows the all three types of stakeholders as per their level of involvement of their nature directly and indirectly. The key stakeholders are the main stakeholders include ASHAs, PRI Members, AWW, ANM and local Community members. Key stakeholders are at the grass root level and they are the primary faces of the capacity building and knowledge improvement of ASHA programme in the. Primary stakeholders who are not directly related to the programme include community's people, professional working in public health, and the government at state and national level. These stakeholders generally do not come in direct but they are responsible for capacity building of ASHA and their knowledge improvement in many ways. Stakeholders involved at the secondary level are the health ministry, political parties and state officials. The Stakeholder matrix and analysis is given below which can be despite the importance of stakeholder and their influence. Stakeholder analysis is showing the stakeholders involvement like their interest in the programme, impact of their involvement which is directly or indirectly etc.

Figure: 1



Stakeholder Analysis Matrix:

Table: 1

Stakeholder	Key interest	Importance	Influence
NGOs	1- To trained ASHA workers as per upcoming module. 2- Skill up gradation and capacity building	High	High
ANM	1- Guide ASHA in bringing the beneficiary and provide health services. 2- guide ASHA as resource persons in healthcare	Medium	High
District Manager	1- Preparation of integrated training plan 2- Making available health related database	High	Medium
State officials	1- Organising divisional and district level workshops and trainings for district and block officials	Low	Low

As above mention stakeholder analysis matrix NGOs come first in high importance and high influence because NGOs are signed for ASHA training, their orientation and capacity building, completion of training module is responsibility of the NGO in planned time period and maintain the quality of training. ANM comes in medium importance and high influence because ASHA worker works under ANM and ANM guide ASHA workers and mobilize them to bring patient and provide them needy health services which she is responsible for. District manager use to integrate training plan of ASHA workers which is an important aspect of their capacity building and knowledge so district manager comes in high importance, though district manager not directly connected with the ASHA workers so comes in medium influence. On next level state officials use to do planning, organising workshop, monitoring etc, as of result they comes in low importance and low influence in onset of knowledge assessment of ASHA worker.

SECTION 7 - RESULTS AND FINDINGS:

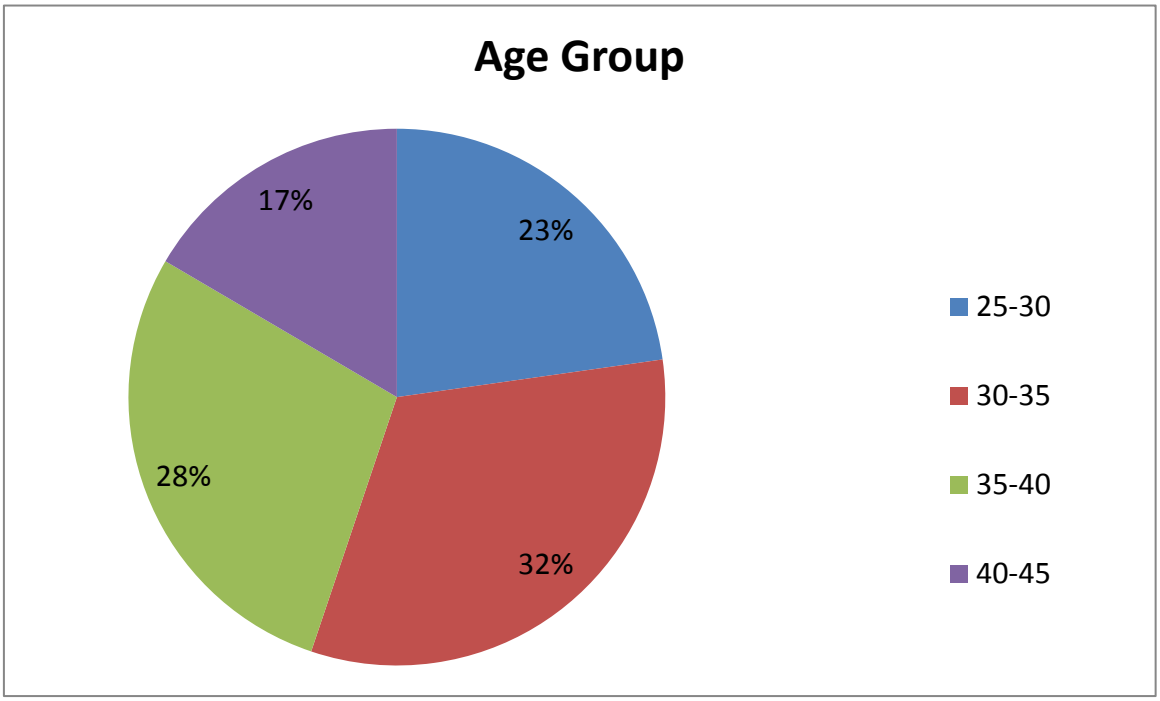
Personal Information of ASHA:

Table: 2

S. No.	Characteristics of ASHAs	Output
1.	No. of ASHAs Surveyed	145
13.	Percentage of working in Residence Village	98.78
14.	Average No. of Years of Service	5
15.	Average Population served/ ASHA	836

As per analysis of the questionnaire and findings of the data the results which came are, total 145 ASHA workers were interviewed in Bilpank block of Ratlam district. The personal information which was collected shoes theat 98.78% of ASHA workers lives in same village where they work, this is a good number. Because as per the community process guideline the ASHA shuld work in same village where she lives or belong to. The data which was collected from respondent tell us that average number of years of service is 5 year. Most of the ASHA worker are continuously working since the emergence of the NRHM. The community process guideline strictly says that 1 ASHA should be on 1000 population, if population is more than 1000 there should be selection of another ASHA in village and population should be divided accordingly. In Bilpank block 836 is average population ASHA work with. The segregation of population is must be follow for the effective and efficient health outcome, as we know ASHA worker are bridge between health services and community. In personal information it was asked that how many training ASHA has gone through? Most of ASHA has gone through the trainings. Out of 145 ASHAs, 7 ASHAs were there who have never attended ay of the training, though 5 of them were newly selected ASHA, still they were not get induction training, which is mandatory for all newly Joined ASHA as soon as they join the programme. The norms regarding the ASHA selection are followed as it is founf that most of them are 8th or more class passed. The norms regarding donicile status and marital status are also followed same as community process guideline. The guideline criteria of the ASHAs envisage that they should be resident of same village and must be an 8th standard pass.

Figure: 2



In this research study the participants were divided into 4 age groups; 25 to 30 years, 30 to 35 years, 35 to 40 years and 40 to 45 years. The guideline which is ment for the ASHAs selection clearly mentioned that they should be having age limit of 25 -45 years. 23% were in the age group of 25-30 years, 32% were in the age group 30-35 and 28% were in 35-40 age group and 17% were in 40-45 age group. It shows that majority of respondents were in age group of 30-35. The majority of age group is young so it is good that most of the ASHAs are young, which shows that they can effetely do field visits, their assign task given.

Educational Status: in order be to successful for ASHA it in importent that they should be educated and well knowledge about the serviced they are use to be recruited. Because they are the representative and bridge between the community and health searvices so it is essential to be have knowledge, skill and well performance. In questionnaire the educational status was divided into 5 parts; 8th, high school, intermediate, graduation and post graduation. 38% of the ASHA workers are having education of 8th standard, which is as per the community process guideline that ASHA worker should be minimum 8th pass. 28% of the ASHA worker were high school passed, 19% of ASHA worker were intermediate passed which shows that Bilpank block has educated and literate ASHA workers. 10% of ASHA worker was graduate and 5% ASHA was post graduate.

Figure: 3

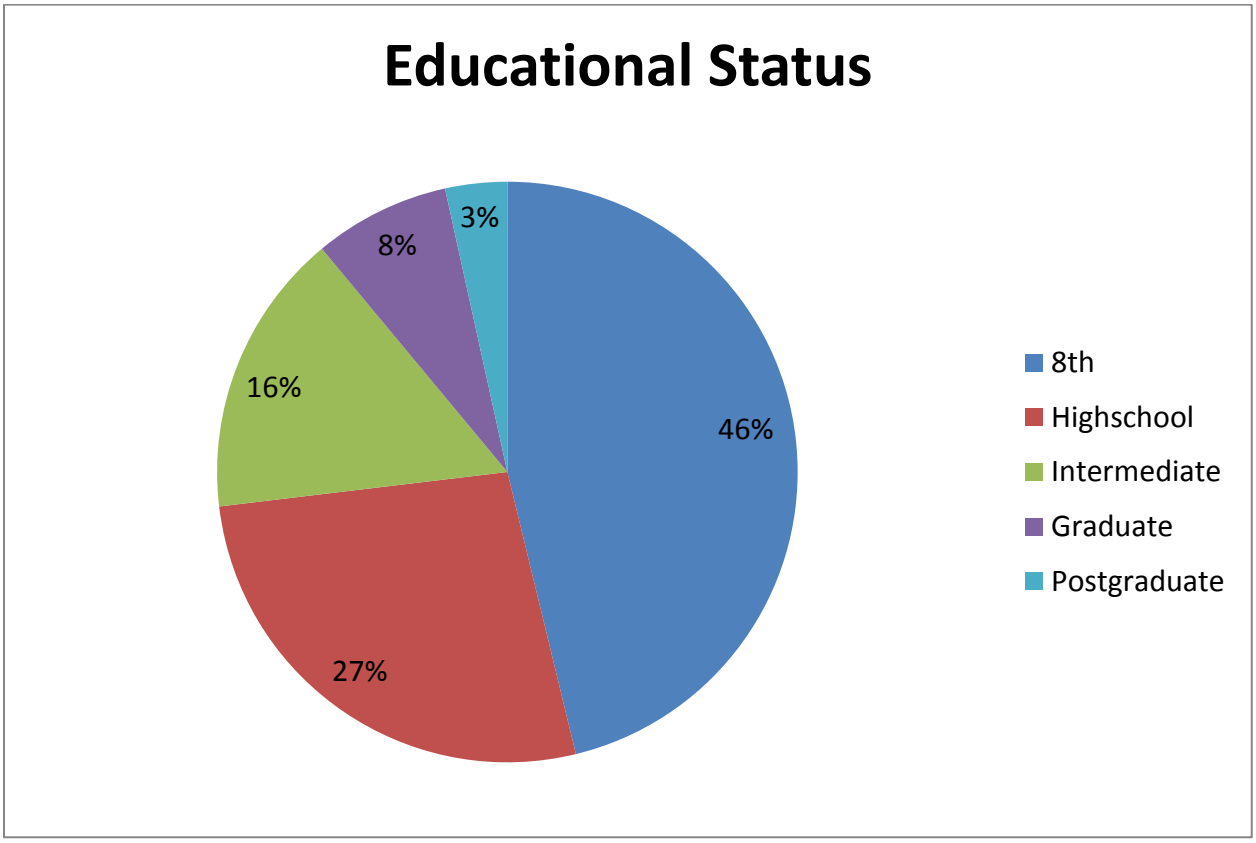
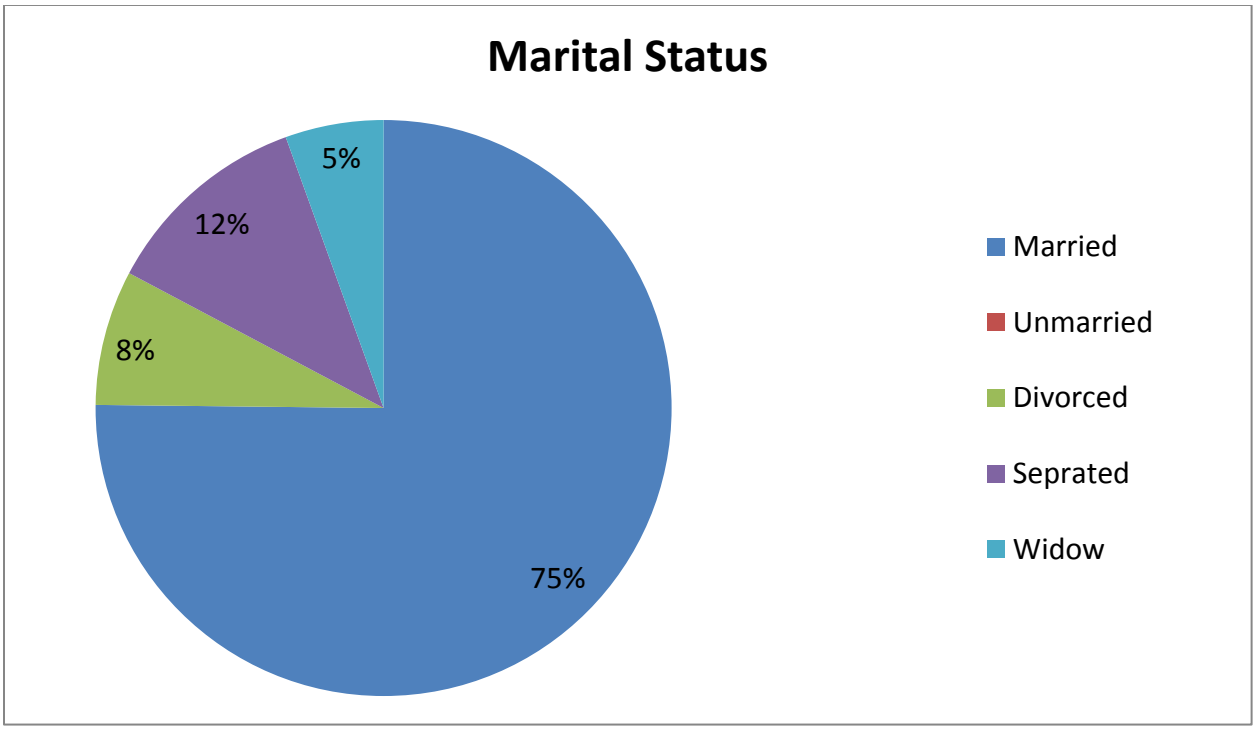


Figure: 4



ASHA must be a woman domicile of the same village – preferably she should be 'Married/Widow/Divorced/Separated, as per community process guideline. The data which researcher get through the questionnaire and mentioned in secondary data (ASHA software) do match each other. 75% of the Asha workers are married in Bilpank block, where as no one is unmarried. 8% of respondent are divorced, 12 % of Asha are separated and 5% of them are widow (mentioned in figure: 4)

Roles and responsibilities of ASHA workers:

The roles and responsibilities of an ASHA include as a healthcare facilitator, a healthcare service provider and a social health activist. Thoroughly her functions involve providing preventive, promotive and basic curative care and other health functionaries like motivate, educate and mobilize communities particularly for those belong to underprivilaged communities, for behavior change communication related to better health and create awareness on social determinants, promoting better utilization of health services, participation in health campaigns and enabling people to obtain health services. ASHA undertake the activities to spread awareness and provide knowledge and information to the masses on health aspects such as nutrition, water sanitation and hygienic practices, healthy living and working conditions, information on existing health services and the need for timely use of primary health. ASHA plays important role in mobilize the community and help people for health access and health related Services which are available at health centers etc.

Table: 3

S.No	Question No.	Yes	No	Don't know/ Rarely
1	9	123	5	17
2	10	108	4	33
3	11	97	10	38
4	12	89	37	19
5	13	131	3	11
6	14	103	23	19
7	15	83	43	19
8	16	79	25	41

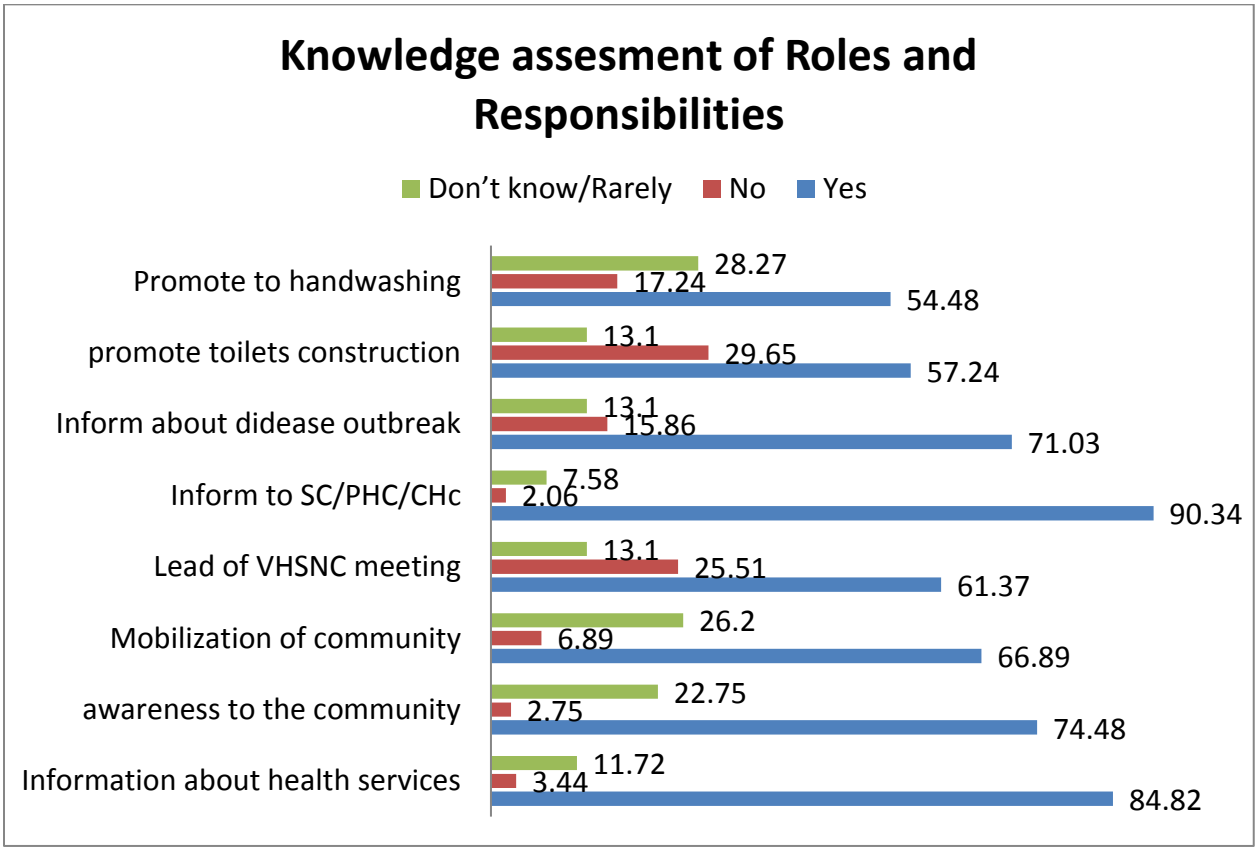
The knowledge of ASHA worker in terms of their roles and responsibilities which is reflecting in

Figure: 5 (questions are given below) shows that out of 145 ASHA, 85% said that they have information of all health services provide by government, 3% of them said they don't have information and 12% were confused about the health services so they have kept in rarely option. Same as to provide awareness to community, 74% said they use to aware the community, 3% said they do not get time to aware the community and 23% said that they rarely mobilize to the community. To provide information of disease outbreak, 71 % of ASHA said yes, 15 % said no and 13 % said that they rarely inform outbreak of the disease.

Questions asked to ASHA workers-

9. Do you provide information about existing health services?
10. Do you create awareness to the community on heath, nutrition and hygiene?
11. Do you mobilize the community for access to the healthcare services?
12. Do you lead village level monthly VHSNC meeting?
13. Is informing the Sub-centre/PHC/CHC about births and deaths in the village?
14. Do you inform Outbreak of health problem/disease?
15. Promoting construction of household toilets is your duty?
16. Promoting hand washing after toilet and before food handling

Figure: 5



Knowledge of ASHA workers on antenatal care:

Table: 4

S.No	Question No.	Yes	No	Don't know/Rarely
1	17	118	11	16
2	18	129	2	14
3	19	75	32	38
4	20	103	13	29
5	21	132	3	10

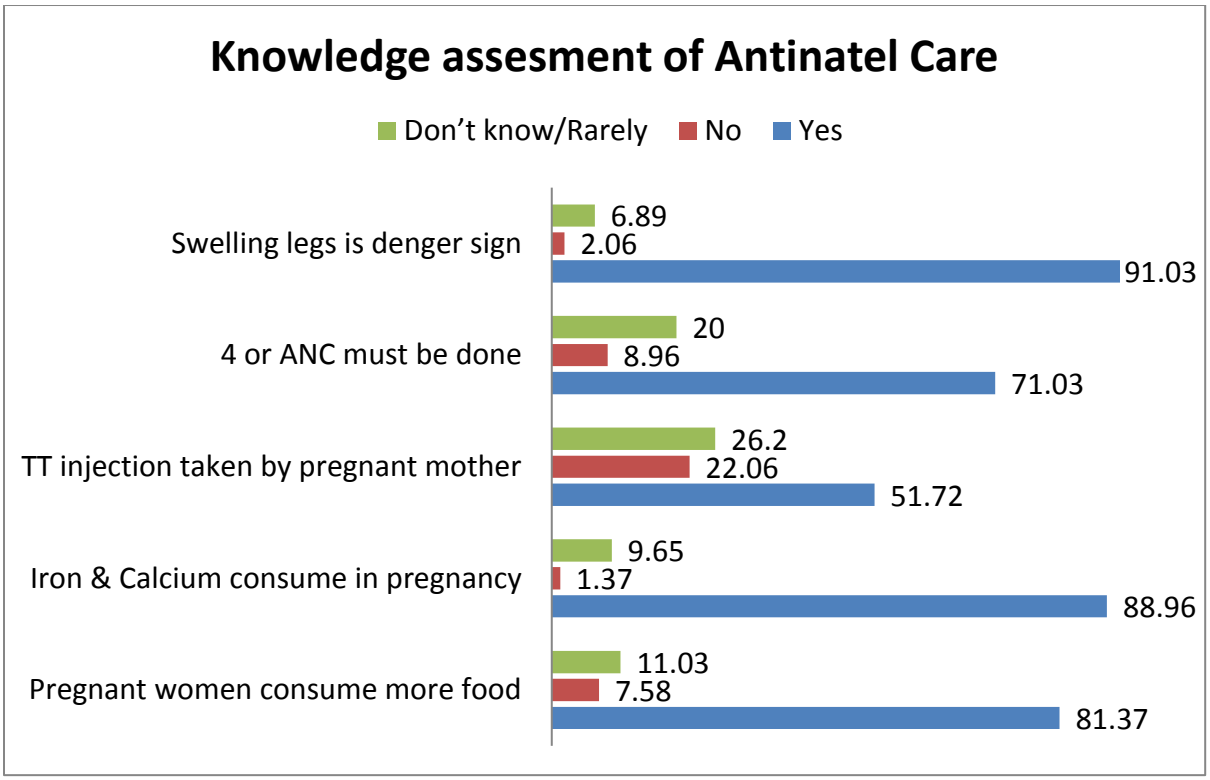
Questions asked to ASHA workers-

17. Should pregnant women consume more food during pregnancy?
18. Iron and calcium tablets should be consumed during pregnancy?
19. TT injection to be taken by the pregnant mothers?
20. Is it necessary to do Minimum of 4 ANC visits for every pregnancy?
21. Is swelling of legs is Danger signs of pregnancy in following?

ASHA provides Antenatal care to the beneficiary at time of the pregnancy. Pregnant women offered a series of services through ASHA, or sometimes with a specialist. At the time of home visit, ASHA should be give following information: Information about the development of the baby during pregnancy, advice about exercise, information regarding nutrition and diet, further explanation of antenatal screening and provide requiring supplement like iron and folic acid tablet, vaccination with support of ANM.

The data collected from respondent mentioned in table: 3 and figure: 6 reflects that, 81% of ASHA said that pregnant women should consume more food, 8%said no and 11% said they don't know about it. 52% of respondent said that TT injection should be taken by the pregnant mother, 22% said strictly no and 26% of respondent said they don't know. It is necessary to visit ANC by ASHA, their is provision of incentive for this visit, 71% said they do 4 ANC, 9% said no and 20% said they are not aware 4 ANC must be done. (Same as data of other question can be seen in the figure: 6 and table: 4)

Figure: 6



Knowledge of ASHA workers on postnatal care:

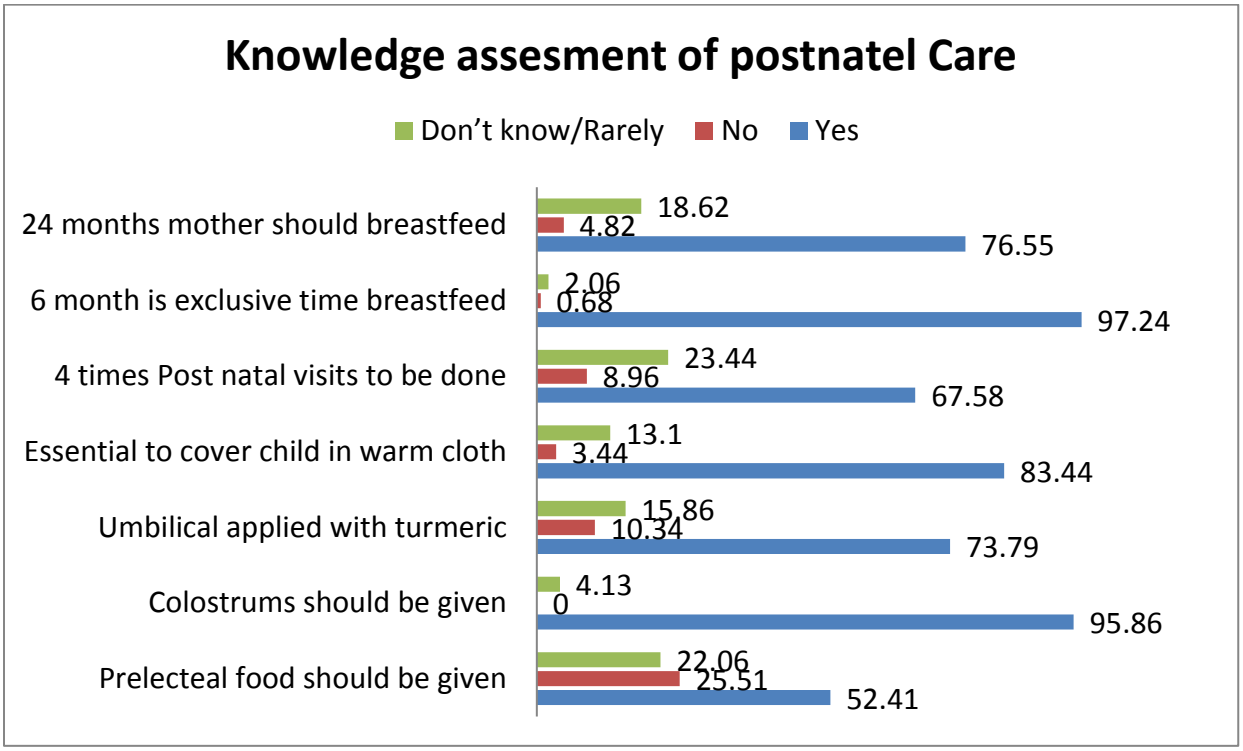
Table: 5

S.no	Question No.	Yes	No	Don't know/Rarely
1	22	76	37	32
2	23	139	0	6
3	24	107	15	23
4	25	121	5	19
5	26	98	13	34
6	27	141	1	3
7	28	111	7	27

The knowledge assessment of ASHA worker on post natal care component, total 7 questions were asked to the respondent, table: 5 and figure: 7 are reflecting the interpretation of post natal care. 52% respondent said that prelacteal food should be given to new born, 26% said strictly no and 22% was confused about this question. Same as 74% respondent said that umbilical cord is

applied with turmeric, 10% said no and 15% were unaware about it. About the breastfeeding, 97% respondent said that 6 month is exclusive time of breastfeeding, where in other hand 77% respondent said that more than 24 months mother should give breastfeed. 18% respondent were unaware about that mother should give breastfeed more than 24 months. To do post natal care is a important task done by the ASHA worker, during the interview 68%women said they do 4 post natal visit, 9% said only twice or thrice they visit for post natal and 23% said they rarely they do 4 post natal visit.

Figure: 7



Questions asked to ASHA workers-

9. Is Prelacteal feeds should to be given for new born?
10. Colostrums should be given?
11. Umbilical cord is applied with turmeric?
12. Is it essential to covering the child in warm cloth?
13. 4 times Post natal visits to be conducted?
14. 6 month duration is exclusive time of breastfeeding?
15. More than 24 months mother should give breastfeeding?

Knowledge of ASHA workers on general health:

Table: 6

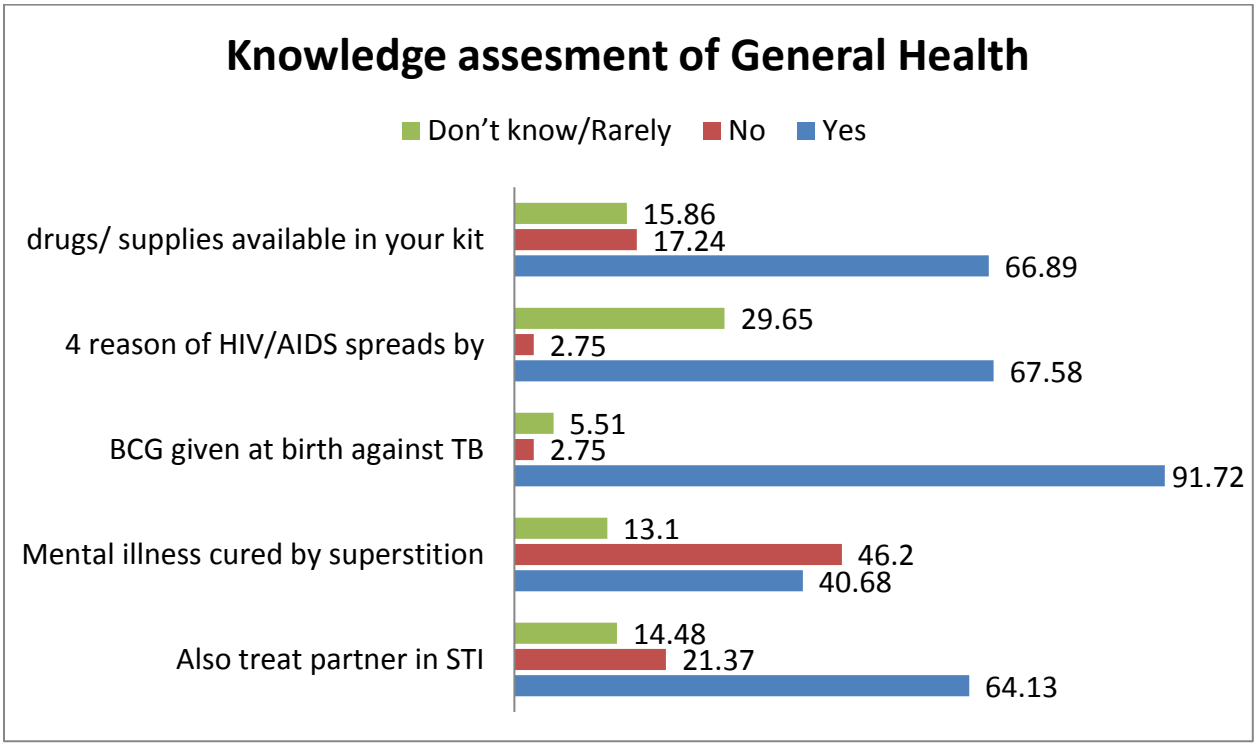
S.no	Question No.	Yes	No	Don't know/Rarely
1	29	93	31	21
2	30	59	67	19
3	31	133	4	8
4	32	98	4	43
5	33	97	25	23

Questions asked to ASHA workers-

16. In cases of sexually transmitted diseases, it is necessary to treat the partner?
17. Mental illness can be cured by beating the devil out of the patient.
18. BCG vaccine given at birth offers protection against Tuberculosis?
19. Do you know the 4 reason of HIV/AIDS spreads by: (if yes specify)
20. Are the following drugs/ supplies sufficiently available in your kit?

The data given in table: 5 and figure: 8 reflects that 64% women said that in case of STI it is necessary to treat the patient also, 21% said no and 14 % said they don't know. 41% respondent said that mental illness can cured by beating the devil because they have seen its result in society and they have faith on it, 46 % respondent said strictly no and 13% respondent said that sometimes it gives result so there result was rarely on it. There are 4 reason of HIV/AIDS, it was asked to respondent, the total who said yes further it was asked then to explain the reason. 68% respondent said ye and explained all 4 reason of HIV/AIDS. 3% was not able to give answer and 30% respondent gave only one or 2 reason of HIV/AIDS. It is necessary to keep all necessary drugs in kit by ASHA; 67% said yes they have all the drugs and supplies, 17% said no and 16% said few of them are available.

Figure: 8



Knowledge of ASHA workers on Family Planning:

Table: 7

S.no	Question No.	Yes	No	Don't know/Rarely
1	34	63	57	25
2	35	143	0	2
3	36	24	87	34
4	37	97	11	37
5	38	73	23	49
6	39	24	79	42

Questions asked to ASHA workers-

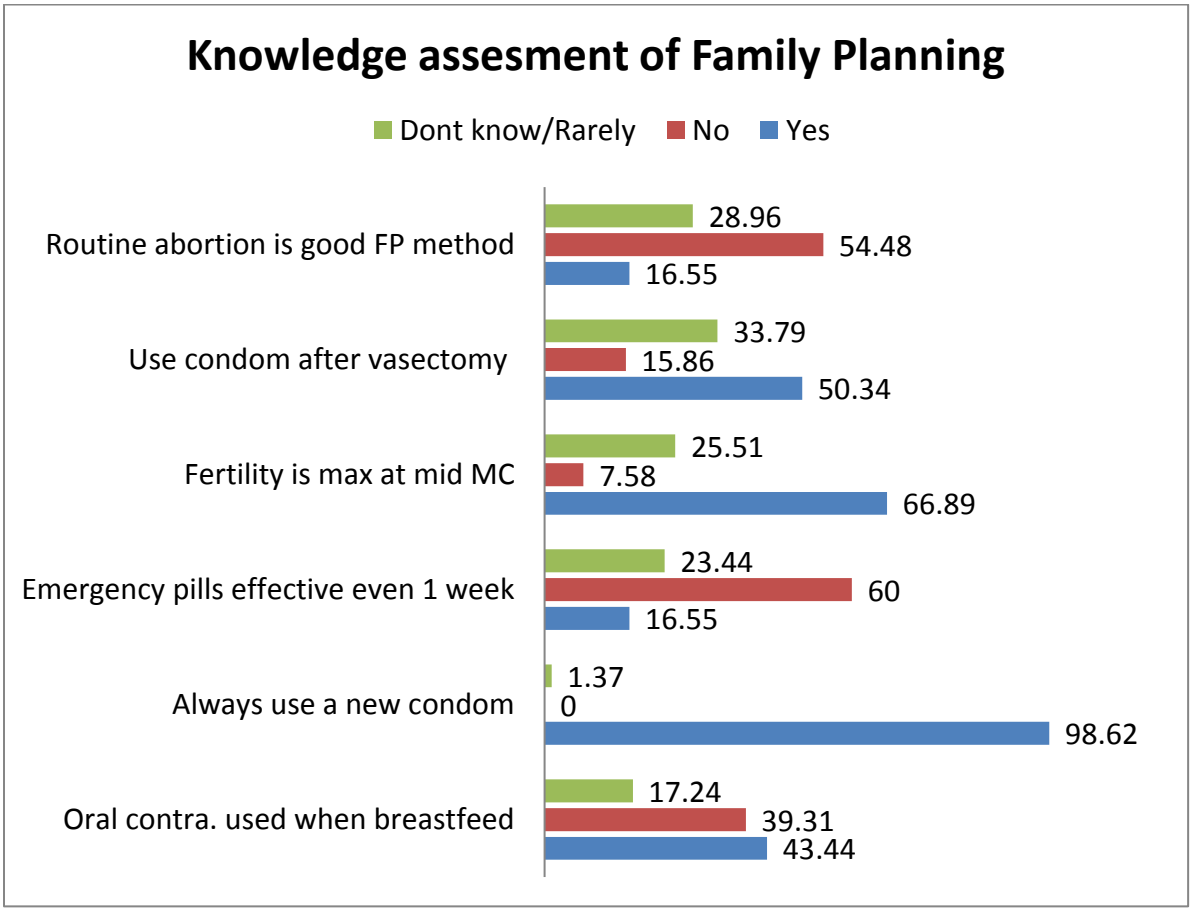
21. Oral contraceptives can be used when breastfeeding the child?
22. A new condom is to be used for each sexual act?
23. Emergency contraceptive pills effective even 1 week after unprotected sex?
24. Chances of fertility are maximum at middle menstruation cycle?

25. Condom should be used for 3 months after vasectomy?

26. Using abortion as routine family planning measure is good.

ASHA plays important role in mobilizing community for family planning, in this study as per the analysis we can see the data reflection in table: 6 and figure: 9 that 43.44% respondent said oral contraceptive can be used when breastfeeding the child, 31.31% said no and 17.24% were confused on it. 99% said that a new condom should be used for each encounter. Is emergency contraceptive can be taken after the one week of unprotected sex, on this question 17% respondent said yes, 60% strictly said no and 23.44% said they don't know about it. 67% respondent said that chances of fertility are more at mid of the menstruation cycle. 50% said that Condom is used after 3 months of vasectomy and on routine abortion 16.55% said is good and 54.48 said strictly no for it.

Figure: 9



SECTION 8: FACTOR ANALYSIS MATRIX:

Variables in Equation (Marital Status) in Roles and Responsibilities factor:

Step	Significant	EXP(Opt Ratio)
Marital 0		
Marital 1	.671	3.136
Marital 2	.O91	O.124
Marital 3	.098	1.620
Marital 4	.114	3.152
Constant	.347	1.230

The table no. 8 reflects that marital status 1, which is married workforce; they are 3.136 times more likely interested to fulfil their roles and responsibilities. The marital 2, which are widowed are o.124 times more likely interested to fulfil their roles and responsibilities. The Marital 3 which are divorced are more likely 1.620 times more likely interested to perform their roles and responsibilities and the marital 4, these are separated and more likely 3.152 times more likely interested to perform their task and roles and responsibility effectively.

Variables in Equation (Education Status) in Roles and Responsibilities Factor:

Step	Significant	EXP (Opt Ratio)
Education 1	.111	4.833
Education 2	.094	5.833
Education 3	.500	2.000
Education 4	.361	3.000
Constant	.657	1.500

The table no 9 above reflects that education 1(8^{th} pass or below) are 4.833 times more likely interested to perform their roles and responsibilities. The education 2 (High school) are 5.833 times more likely interested to perform their task and roles and responsibilities. The education 3

(Intermediate) are more likely 2.000 times interested to perform their roles and responsibilities. The education 4 (graduate) are 3.000 times more likely interested to perform their roles and responsibilities and the constant is 1.500.

Variables in Equation (Population Size) in Roles and Responsibilities Factor:

Table:

Step	Significant	EXP (Opt Ratio)
Population 1	.276	6.379
Population 2	.593	2.811
Population 3	.632	1.000
Constant	.578	2.113

The above table reflects that population 1 which is the population size of below 500, Asha working 6.379 times more likely in respective areas. The population 2 which are population size 500 to 1000, ASHA are working 2.811 times more likely in respective areas of their roles and responsibilities. The population 3 which is the population size of above 1000, where the significant is .632 And ASHA are working more likely to 1.000 in thair respective areas of roles and responsibilities.

SECTION 8 - SUMMARY OF FINDINGS & KEY LESSONS LEARNED:

- Most of the ASHAs are serving to a population of more than the specify norm of 1,000. Interior population in Bilpank block of Ratlam district is distributed over large areas and divided by hills. These natural barriers are the reason behind the ASHAs failed to visit these areas and group of the population remained unserved and unreachable.
- The ASHAs are partial in few of their duties which includes: registration of the pregnant women, ANC/ PNC, full immunization, but the ignored areas are mobilizing community for construction of toilets, participation in VHSNC, Family Planning and development of integrated village health plan etc. The activities which are linked to monetary incentives they do with priority and rest activities are done with lesser importance by the ASHA.
- There are 36 type of incentive made for ASHA worker, but most of the ASHAs were not aware about the incentive which are made for them even they shows lack of interest to check their bank account to check the payment is done or not.
- Few of the ASHAs notified that they have and received kits and supplies which were incomplete in many regards. Else other was not having proper kits and supplies, some of the kits were expiry dated. The majority of respondent having lack knowledge of proper use of drugs and use of supplies.
- Another operational problem is Anti natal care and post natal care, ASHA only focus on registration of the pregnant women and institutional delivery because she get incentive for it. In ANC visit and PNC visit ASHA shows lack of interest.
- Major finding is that around quarter of ASHAs are not able to conduct monthly meeting in the community because they are not motivate the people in many reasons and the monthly meeting done by ASHA sahyogi was not done in some of the villages which can affect to capacity building of the ASHA.
- On family planning component, as it is a sensitive health aspect, it is important to convince community to adopt family planning method and routine follow up on regular basis but it is not done by the ASHA. Also they use to feel shy communicating familplanning method in front of the mass. Majority says that they only convince to female usually.

SECTION 9 – RECOMMENDATIONS:

- There should an examination of the population served by each ASHA strongly be made at the Primary Health Center, sub-centre level under the guidance of block office and devidation of population of should be made among the ASHAs accordingly so that it could follow population norms limited to 1000 or less as per guideline. In hilly/desert, the norm should be laid back and new ASHA should be selected in that area where there is no ASHA.

- For effective health outcome and efficient work there is need of proper capacity building of ASHA worker, there should be proper monitoring to check ASHA training and for those who have completed all the trainings and module there should be a half yearly refresher training on running basis.

- The ignored areas of ASHAs functioning are to work with VHSNC which are either non - existing or non functioning in most of the cases. The VHSNC should be restructured and ASHAs should be mobilize to make inclusive health plan for month wise. The possibility of incentives provision for this purpose should be find out.

- ASHAs must be directed to give importance to the job of motivating for Health services and family planning measures.

- The compensation which is given to the ASHAs must be accordingly increased. Payment should be done at the end of month without fail. Further enhancement of compensation will motivate her to work more enthusiastically.

- The unregularity in the area of supply and kits should be investigated and edequate action should be taken. The ASHAs must get kits and supplies complete regularly from the respective block and district offices.

SECTION 10 - ETHICAL CONSIDERATION:

In this research study "Knowledge assessment of ASHA worker regarding their Roles and responsibility and health services', these points are kept in mind;

1. Respondent would not be subjected to impairment in any specification.
2. Respect for the dignity of research participants should be taken with priority.
3. Full consent would be obtained from the participants prior to the study.
4. The protection of the privacy of respondent will be ensured.
5. Equal level of confidentiality of the research data should be ensured.
6. The use of offensive, discriminatory, or other unacceptable language needs to be avoided in the formulation of Questionnaire/Interview/Focus group questions.

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APPENDICES

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A STUDY TO EVALUATE KNOWLEDGE ASSESMENT OF ASHA WORKERS REGARDING THEIR ROLES AND RESPONSIBILITIES AND HEALTH SERVICES

Questionnaire

(Respondent should not be subjected to harm in any ways whatsoever and confidentiality of the data will be ensured.)

Date of interview: _____ **Place: _____**

Interviewer Name: _____

Personal Information:

1. Name of ASHA: _____ 2. Age: _____
3. Marital Status:
   a) Unmarried c) Widowed
   b) Married d) Divorced
   c) Separated
4. Education status:
   a) Below 8th c) Intermediate
   b) High school d) Graduate
   c) Post graduation
5. Do you work for same village you stays : YES/NO
6. Your month and year of joining ASHA programme: _____
7. Total training attended: _____
8. What population size do you serve: _____

Roles and responsibilities of ASHA workers:

9. Do you provide information about existing health services?
   a. Yes (0)
   b. No (1)
   c. Rarely (2)
10. Do you aware community regarding heath, hygiene and nutrition?
    a. Yes (0)
    b. No (1)
    c. Rarely (2)
11. Do you mobilize the community for obtain the health services?
    a. Yes (0)
    b. No (1)
    c. Rarely (2)

12. Do you lead village level monthly VHSNC meeting?
    a. Yes (0)
    b. No (1)
    c. Rarely (2)
13. Do you inform the Sub-centre/PHC/CHC about births and deaths in the village?
    a. Yes (0)
    b. No (1)
    c. Not required (2)
14. Do you inform Outbreak of health problem/disease?
    a. Yes (0)
    b. No (1)
    c. Not required (2)
15. Promoting construction of household toilets is your duty?
    a. Yes (0)
    b. No (1)
    c. Don't know (2)
16. Do you promote hand washing after toilet and before food handling to community?
    a. Yes (0)
    b. No (1)
    c. Not required (2)

Knowledge of ASHA workers on antenatal care:

17. Should pregnant women consume more food during pregnancy?
    a. Yes (0)
    b. No (1)
    c. Not required (2)
18. Iron and calcium tablets should be consumed during pregnancy?
    a. Yes (0)
    b. No (1)
    c. Not required (2)
19. TT injection to be taken by the pregnant mothers?
    a. Yes (0)
    b. No (1)
    c. Not required (2)
20. Is it necessary to do Minimum of 4 ANC visits for every pregnancy?
    a. Yes (0)
    b. No (1)
    c. Not required (2)
21. Is swelling of legs is Danger signs of pregnancy in following?

a. Yes (0)
b. No (1)
c. Not required (2)

Knowledge of ASHA workers on postnatal care:

22. Is Prelacteal feeds should to be given for new born?
    1. Yes (0)
    2. No (1)
    3. Don't know (2)
23. Colostrums should be given?
    1. Yes (0)
    2. No (1)
    3. Don't know (2)
24. Umbilical cord is applied with turmeric?
    1. Yes (0)
    2. No (1)
    3. Don't know (2)
25. Is it essential to covering the child in warm cloth?
    1. Yes (0)
    2. No (1)
    3. Don't know (2)
26. 4 times Post natal visits to be conducted?
    1. Yes (0)
    2. No (1)
    3. Don't know (2)
27. 6 month duration is exclusive time of breastfeeding?
    1. Yes (0)
    2. No (1)
    3. Don't know (2)
28. More than 24 months mother should give breastfeeding?
    1. Yes (0)
    2. No (1)
    3. Don't know (2)

Knowledge of ASHA workers on general health:

29. In sexually transmitted Infection, it is necessary to treat the partner
    1. Yes (0)
    2. No (1)
    3. Don't know (2)
30. Is Mental illness can be cured by superstitious.?
    1. Yes (0)
    2. No (1)

3. Don’t know (2)

31. BCG vaccine act protection against Tuberculosis while given at birth time?
    1. Yes (0)
    2. No (1)
    3. Don’t know (2)
32. Do you know the 4 reason of HIV/AIDS spreads by: (if yes specify)
    1. Yes (0)
    2. No (1)
    3. Don’t know (2)
33. Are all the drugs/ supplies sufficiently available in yourASHA kit? (list is given below)
    1. Yes (0)
    2. No (1)
    3. Rarely (2)

Knowledge of ASHA workers on Family Planning:

35. While reastfeeding the child, mother can use Oral contraceptives?
    4. Yes (0)
    5. No (1)
    6. Don’t know (2)
34. Always new condom is to be used for each sexual encounter?
    1. Yes (0)
    2. No (1)
    3. Don’t know (2)
35. Is emergency contraceptive pills can be takene after 1 week of unprotected sex?
    1. Yes (0)
    2. No (1)
    3. Don’t know (2)
36. The chances of fertility are maximum at mid of menstruation cycle
    1. Yes (0)
    2. No (1)
    3. Don’t know (2)
37. Does Use of condom is necessary 3 months after vasectomy time ?
    1. Yes (0)
    2. No (1)
    3. Don’t know (2)
38. Using regular abortion as family planning measurement is good.
    1. Yes (0)
    2. No (1)
    3. Don’t know (2)

Sign of Interviewee _____ Signature of Interviewer _____