SUMMER TRAINING PROJECT

BY

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ABBREVIATIONS

NRHM	National Mission for Rural Health
ASHA	Accredited Social Health Activist
MoHFW	Ministry of Health & Family Welfare
CHW	Community Health Workers
VHW	Village Health Office
SEARCH	Society for Education, Action, and Research
LBW	Low Birth Weight
ICDS	Integrated Child Development Services
IMR	Infant Mortality Rate
MMR	Maternal Mortality Rate

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PART 1

LITERATURE REVIEW

IMPACT OF ASHA ON POSTNATAL SERVICES IN RURAL INDIA AND THE GROUND LEVEL CHALLENGES

INTRODUCTION

The Government of India on 12th of April launched the National Mission for Rural Health (NRHM), primarily targeted at disadvantaged groups of people in society, was initiated to tackle rural India's health needs. The diverse core components of NRHM consist of presenting a trained woman within the community or Accredited Social Health Activist (ASHA) from the same village in every villager within the country. The position of the ASHA includes three styles of work-organizer, interconnect worker or mediator and healthcare worker at the grassroots level.

According to Hashima-e-Nasreen, Ahmed Syed Masud, Housne Ara Begum (2007), NRHM and ASHA have as significant an impact as individual ASHAs hired in health facilities for the provision of awareness of safe health conduct amongst their population. To maintain and disseminate awareness in ASHAs through their local members, primary recruiting parameters are highly significant, for instance, literacy level and local area representation.

In order to employee women known as ASHA the knowledge & expertise needed, the Ministry of Health & Family Welfare (MoHFW) has set up a training program of 23-days. The analysis shows, however, that the amount and consistency of the preparation must be modified to increase results of ASHAs.

The 1978 Alma Ata declaration underlined that primary health care and the crucial role of Community Health Workers (CHW) in linking communities to the system of health care were important. The usage of members of the community in their neighbourhoods for delivering basic health care is a practice that has been around for at least 50 years. There have been many encounters globally of projects that vary from large-scale, regional schemes to community-based initiatives.

CHWs have a major role to play in expanding rural ingress to and supply of healthcare and can take action that will improve the health outcomes, particularly in the field of child welfare, but not exclusively. For CHW projects to be effective on a broad scale, we need strategic preparation, stable funding and strong policy participation and community involvement. CHWs need ongoing supervision, training, and credible logistical

support to carry out their duties successfully. CHWs are major health instrument, the possibility of which should be explored fully to broaden the universal health coverage to underprivileged communities.

CHW programs are extensively been recorded in the literature of health; three foreign perspectives on broad CHW programs, and reasonably accessible research on the perspectives of the Indian CHW, are discussed in this context section.

INTERNATIONAL CHW UPDATE

We are looking at 3 very powerful CHW systems from Nepal, China and Iran for the purpose of this report. Although these programs are different in several programs than the ASHA, and in several ways are relevant. (a) Fast-expanding economies with large populations of India and China; (b) Bordering on India by Bangladesh and faced with similar economic and health issues as many neighbouring states in India, especially Bihar and West Bengal; and (c) A significant scapegoat programme has been established by Iran.

In general, CHW initiatives rely primarily on primary care facilities, such as child and maternal welfare, education, immunization, family planning, water and sanitation, the essential curative treatment of specific infectious diseases and communicable disease prevention. Most CHW programs enrol women in healthcare workers because of their large significance for mothers' and children's health but notable programmatic examples of men in Egypt, Iran, Bhutan, Thailand and Bolivia also exist (Catalyst 2005, 2007; Brown 2006).

The deciding criteria, in particular qualification, are broadly varied among programs; in SEARCH India women with a largely small education are employed, whereas a Class 11 pass is required for Iran's national program. The nature of the preparation and assistance the CHWs provide in the sector are the basis for their performance and success. However, attrition is due both to the absence of sufficiently educated candidates and to the infeasibility of overqualified candidates. There is a wide variety of benefits, including income growth and social recognition systems. The latest and biggest ASHA initiative is the CHW of India implementing. Although a country's CHW scheme failed to launch in 1977 (UNICEF 2004), there were a number of non-governmental organizations and state-run initiatives across the world.

In the 1980s, the SEARCH NGO (Society for Education, Action, and Research) spearheaded in tribal districts across Maharashtra was a pioneer in neonatal home treatment. Antenatal and postnatal diagnosis, birth participation, and developmental follow up were conducted by the Village Health Office (VHW), and study results led to a reduction in neonatal mortality by up to 20 per cent relative to the target community (e.g. Bang et al 2005). The interventions of diet therapy have contributed to a substantial decline in birth of low birth weights, while other approaches have resulted enhanced mortality (60% decrease in preterm infants; 70% decrease in LBW children) and a major decline in co-morbidity events such as sepsis, asphyxia, hypothermia and food issues.

On top of it, the system shed light on diagnoses of neonatal and paediatric pneumonia and their treatment within time at the neighbourhood level. SEARCH introduced a way to count breaths and identify fast breathing which resulted in a 44% reduction in neonatal death caused by pneumonia.

Mitanin, Chhattisgarh: In 2002, in collaboration with civil society, the government of Chhattisgarh initiated the Mitanin Initiative; it was an ASHA project model. Mitanins were encouraged and trained on the spread of households, including basic neonatal care, nutrition consultations, childhood and rights-based case management practices (e.g. ingress to essential Public, empowering women and ICDS services and midday meal mobilization). A Mitanin is not charged; rather, they are charged a piece of land, depending upon the decision of the villagers, for cultivation or from other ways. Currently, greater than sixty thousand Mitanins are present in over seventy thousand hamlets, with three thousand women assisted as middle-level supervisors.

Mitanin is commonly known to have increased IMR from 85 in 2002 (country's second highest) to 65 in 2005. Simultaneously, the share of children that are underweight has dropped from 61% to 52% in the state, with full immunizations from 22% to 49% in the 12-24-month period.

IMPORTANCE OF POSTNATAL SERVICES

The postnatal care services are very crucial for healthier development of the baby and also the mother's health. ASHA's are trained by the government of India to work in rural areas, especially their communities, educators, basic services providers, and health activist. The goal of the ASHAs is to connect the marginalized communities with access to a better and improved healthcare system. Some of the roles of these health activists include identifying and register new pregnancies, deaths, and births. ASHAs deliver maternal and new-born healthcare services through home visits, immunization, and first aid (Sharma et al., 2018).

The health of the community in the management of healthcare data, management, and also participate in planning community health levels. ASHAs educate mothers about breastfeeding, skills in birth attendance disease prevention, and how to take care of their babies. They provide education to the community regarding the prevention of malaria, risk of malaria to new-borns, and provide drugs for malaria, diarrhoea, and tuberculosis. They mobilize the community to demand health services from the authority so that to reduce neonatal deaths and to encourage the people to adhere to antiretroviral medications, especially to the HIV-positive women. Effective postnatal care is crucial where the recovery after birth deviates from normal expectations. Nurses and ASHAs in the community have the duty to evaluate and provide appropriate interventions to the mothers and the babies on time. This helps to reduce the risk of death of the baby and improves the adverse outcomes of the mother and positively affects the development of the child (Dixit, Dwivedi, and Gupta, 2017).

ASHA'S ROLE AFFECT THE STATISTIC OF INFANT MORTALITY RATE (IMR), AND MATERNITY MORTALITY RATE (MMR)

The roles that the ASHAs play in the community are of great benefit for the reduction and maintenance of the IMR and MMR in India. Their counselling strategies, educating pregnant mothers and those who have recently delivered, and practices are involved in ensuring that the targeted group acquires the most appropriate care. ASHAs records and retains the information on the births that have occurred in the community. In doing so, they are able to prioritize and come up with strategies to reduce the maternity and infant mortality rate. These social health activists, through their education and training of women both those who have given birth recently, the pregnant women, and all the women in the community, are indirectly involved in reducing the statistics of IMR and MMR (Valiveti et al., 2017).

The ASHA program in India was ranked to meet the objectives of connecting the poor and marginalized people with healthcare services. The IMR and MMR result after the implementation of the ASHAs program by the government of India showed positive significance and success. Through the influence of the ASHAs in the community between the year 2005 and 2012 after the launch of the program demonstrated that there was at least 74 to 84% rise in antenatal care. The use of skilled attendants during birth increased from 53 to 75% while giving births through the health facilities increased from 43 to 66% (Shet, Sumit, and Phadnis, 2018).

ASHAS RESPONSIBILITIES AND CHALLENGES FACED FROM FAMILIES

Families with cold behaviour in terms of unwelcome attitude have difficulties in expressing themselves because they are deeply hurt inside such that sometimes not sure about their conditions. These people might be either having trust issues with the healthcare system, or they may be having mood swings and thus try to suppress their anger for some reason (Desai, 2016). Other reasons may not be viewed as needing to seek rehabilitation treatment, conventional borders on rehabilitation, for people who may have to seek care and are limited to their capacity to do so, alarming assessments of medical attention, where people can consider care as necessary and affordable, though not desirable, choices. ASHA play essential roles in families with cold behaviour regarding the healthcare system. They act as counsellors to those people. Some people in the community are very reluctant to seek health care services as they are influenced by the traditions, myths, and cultural norms of the society. Such people in the community are characterized by cold behaviour and attitude towards the healthcare system (Desai, 2016).

ASHAs face several challenges in trying to understand the cultural practices and beliefs of the community as they try to provide postnatal services within the community (Chaturvedi, Sharma, and Kakkar, 2017). For occasion, a few challenges within the determination of ASHAs have also been compromised by control systems and lack of community knowledge of the ASHA system presents a significant danger to progress and sustainability. The main wellness centres linked to ASHAs are poorly equipped. Hence, ASHAs encounter

unfavourable results in their capacity to inspire trust and validity within the community. Little and sporadic money related motivating forces to demotivate ASHAs. ASHAs provide support, education, mobilization, and counselling to the community members to seek and demand healthcare services. The social health activists are involved in the identification, management, and referral of emerging cases of illnesses of the new-born babies within the community. ASHAs assist and lead the community in demanding healthcare services such as maternal services. ASHAs have to establish a partnership with the key elders (gatekeepers) of the community and demonstrate to them the importance of delivering postnatal services so that they can help them identify the pregnant women, new mothers, and the babies in the community. It is not that easy to convince such culture-oriented elders on something outside their traditions. These are among those people in the community with significant influence and have a cold behaviour towards the healthcare system (Chaturvedi, Sharma, and Kakkar, 2017).

CHALLENGES FACED BY ASHA

A thorough study of existing research aids us in setting up the context for investigation in ASHA's performance in India. A study of healthcare providers from community workers (CHWs, Shasthya Sebika) in Bangladesh in 1972. The research was being conducted via a rural improved health project. It was showed how financial incentives played a major role and increased drop-out rates were resultant of dissatisfaction with pay levels in comparison to hours invested. Although China adopted the concept of community workers at the beginning of the 1950s, structural reforms led to an uneducated and poorly trained health workforce in 1978. This resulted in poor healthcare quality in the once-thriving health workers' community system. Iran has shown that extensive planning in CHWs is related to beneficial health effects including decreased motherhood and improved life expectancy. Two years of extensive training have allowed CHWs to handle responsibilities more efficiently while recognizing high expectations of quality in Iran. Overall, earlier work reveals that the best possible CHW outcomes require rigorous preparation, consistent control systems and improved returns. This framework explores how ASHA efficiency in India can be enhanced. As a result of administrative problems, payments to ASHA are sometimes delayed (e.g. non-transfers of funds).

ASHAs had trouble to overcome inaccessible and scattered families and natural boundaries like forests, pooches and forlorn streets. Walking is the only mode of transportation for benefit conveyance. The impact of preparing, characteristics of ASHAs, topographical highlights, family characteristics and community state of mind. The disregard appeared by clinic staff and need to get to fundamental solutions and pregnancy testing units are driven to the misfortune of validity among ASHAs, which influenced their work execution. ASHA may not be paid for their services in some areas, and this influences their performance. Studies carried out at state district levels in India indicated that ASHAs are not well motivated in enhancing their roles as a result of poor financial compensation (Cherian, Kanth, and George, 2017).

Poor mentoring structures and sustaining supervision hinder ASHA's activities in some districts and states. There are inadequate training and recruitment of new ASHAs, which is vital to promote investments in ensuring the available ASHAs receive education and institutional support required to offer the necessary services. The investment in ensuring the effective services there is a need to establish robustly and evaluated extensive scale programs of services such as mobile academics in the training of new ASHAs (Bhowmick, Darbar, and Sorathia, 2018). Further research is still required to understand the implementation of the different approaches, support structures, and incentives systems that have been adopted in several states that have affected the functioning and uptake of the ASHA program. Several analytical improvements are required to explore in facilitating ASHA's roles of respectful maternity care (George et al., 2018).

PART 2

ONLINE COURSE REPORT

Course Name – eHealth: More than just an electronic record

Course Offered By – The University of Sydney

Course description – The course is self-paced five weeks, 3 hours a week. The overall course includes 5 modules and two tasks (one module per week). Attribute 1 weight is 40 per cent in module 2 and attributes 2 is 60 per cent in module 5.

Course Type – MOOC

Course Language – English

Course Methodology – The data was transferred via pre-recorded videos of lectures and a written lectures description. If required, additional reading material will be supplied with the module. The website offers a forum for debate, where people around the world can engage in the course.

Objective of the course

1) A multidisciplinary approach to equalize the effect on adoption of electronic health care through the global population of health professionals, teachers, executives, administrative officers and researchers.
2) Evaluate the current and evolving style of the technology application.

Outcome of the course

1) eHealth basics and where they are going.

2) What type of health information are we currently collecting and how will health care change in the future?

3) How do new technologies impact and contribute to health care for health consumers?

4) How can eHealth improve health harmonization and efficacy and what are its obstacles?

Key Concepts of the Course

Module 1:

1) Differentiate eHealth principles with healthcare practitioners and customers.
2) Identify an eHealth design which depicts how fundamental eHealth fields cross to influence upon health care.

3) Build insight into the basic eHealth principles.
4) Evaluate the recognition of eHealth in current custom.
5) Assess the prevailing and forthcoming barriers of eHealth to both health consumers and practitioners.

Module 2:

1) Understand the potential of mobile technology for the transition from healthcare to health and wellness.
2) Analyse strategies for incorporating mobile health apps in the professional system.

Module 3: What health data are we gathering currently and how can healthcare in the future be transformed?

Module 4:

1) How can eHealth enhance the coordination and effectiveness of the healthcare and what are the limitations?
2) Define a spectrum of innovative eHealth communications between consumers and healthcare professional.
3) Evaluate the benefits of technology-based eHealth services in enhancing passage and interaction in healthcare.
4) Understand the discrepancies between online and face to face health service communications.
5) Comprehend how eHealth could be useful to promote professional advancement.

Module 5: Some cases of eHealth in professional practice have been investigated.

Key Learning from The Course

1) Denmark has a consolidated database, which is now open to 98 per cent of primary care medical professionals, hospital physicians and all pharmacists.
2) The data obtained from personal devices would rapidly improve the likelihood of tracking care remotely.
3) Genome analysis adds to individual health information a new data layer.
4) In a website article published in October 2015, IMS (Integrated Management System) Healthcare stated that "over 165,000 mHealth Apps offer connectivity to sensors and wearables with a higher level of retention when physicists prescribe applications."A 2015 survey by the international consulting company Accenture found that more than 40% of patients globally either already wear or would be willing to wear technology to track fitness and vital signs.
5) Commercial legal drones are now delivering pharmaceutical goods in the United States, Australia and New Zealand.

6) Medical records are most often owned by companies, governments or service organizations in private ownership. Individual patient ownership of the medical record system has not yet been accepted as a model.
7) The Garvan Institute in Australia is currently applying a plan to support cancer research by transforming personal cell phones into supercomputers.
8) Electronic tattoos should be required for future tracking of wellbeing and paying for healthcare. According to online physio Karen Finnin, the most critical aspect for successful online treatment is to look at all self-treatment therapy options.
9) The most critical element in a telehealth diagnostic education program is, according to neurologist Dr. Jelle Demeestre, the collection and sharing of diagnostic data.

Conclusion – A comprehensive program moreover concentrates on diverse faces of e-health. Earlier, the thought process about e-health was, people, referring to the usage of computerised health recordings, and tools, normally in the acute quarter. It definitely isn't the entire picture, though. One of its rising domains of eHealth is how we can use innovation to facilitate interaction amongst providers and consumers of healthcare.

Beginning with Module 1, the aspects of lessons include how wide the concept of e-health is and how e-health can improve healthcare provision. Proceeded by Module 2 we will learn about smartphone technology boom and how this care is being transferred into the hands of the customers. One of the main approaches in this sector is how technology is advancing from the analysis and comprehension of the health effects of mobile health.

To set the wheels in motion further in module 3, We glance at health data and the complexity for connecting the broad variety of health information we have collected to both patients and healthcare professionals in an accessible and functional image.

Furthermore, in module 4, In promoting contact, we analysed the role of advanced technologies. Through the midst of far more than 100 years of technology engagement through healthcare, we have now started to integrate interaction capable of technology into modern models of treatment.

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THANK YOU