Summer Training at
UNICEF, Jaipur
(April - June, 2013)

PERCEPTION OF AHSA SAHYOGINIS AND BENEFICIARIES BEFORE AND AFTER USING TAB UNDER PILOT STUDY E-ASHA

By
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Under the guidance of
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Post Graduate Diploma in Hospital and Health Management
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CERTIFICATE

This is to certify that Dr.Mayure Gupta, student of Post Graduate Diploma in Hospital and Health Management (PGDHM) from Institute of Health Management Research, Jaipur, Batch 17th has undergone summer training in United Nations International Children's Emergency Fund (UNICEF), Jaipur and has done study on:

- Perception of ASHA SAHYOGINIS and beneficiaries before and after using tab under pilot study e-asha.

The candidate has successfully carried out the mentioned study assigned to her during her summer training from 8th April 2013 to 8th June 2013 and her approach to the analysis has been sincere, scientific and analytical.

I wish her success in all her future endeavors.

Jagjeet Prasad Singh

Dr. J P Singh
Assistant Professor
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IIHMR, Jaipur

Dr. Ashok Kaushik
Dean, Academic and Student Affairs
IIHMR, Jaipur

PREFACE

The summer training of two months at the end of 1st year is an integral part of the PGDHM curriculum. As a part of this, I had a privilege to do my summer training at UNICEF Rajasthan. We were given few aims by our college in order to have clear view about the summer training, I prepared my study plan and tried to observe and building my information as per task assigned to me by UNICEF Rajasthan.

My objectives as per our institute were:

1 .To understand and learn day to day operational management of a Hospital / Health Care Organization and its service centers.
2. To study identified issues/ problems associated with some specific operational area or program.
3. To observe and study each service department functioning of the organization.
4. To assist in their daily operational / programme management.
5. Work on the specific issue/ project work assigned by the organization.

Task: When I joined my summer training, I was expected to train and supervise ASHA Sahyoginis to operate tab under e-asha tab a pilot project started by UNICEF Rajasthan during the field work I got an opportunity to understand the workings of public health system at grass root level. This project is started with a focus on real time data entry as well as counseling for benefeciaries.Although state is struggling from so many years to improve health of mother and child during ANC, PNC and neonatal care but still a lag is there .So UNICEF Rajasthan has started a pilot project to introduce tab which will help in real time data entry and can be used for counseling of people and also a way to update knowledge of ASHA Sahyoginis about their work. The report deals with the change in perception of ASHA and beneficiaries before and after the introduction of tab, with the assessment of knowledge gaps in ASHA regarding their work and also problems associated while working on tab in field. I hope this will help to identify the bottle necks which need corrective measures.

MAYURE GUPTA

(IIHMR 17TH BATCH)

ACKNOWLEDGEMENT

This is a two month summer training report from 8th April 2013 to 8th June 2013 in UNICEF Rajasthan. This training wouldn't have been completed without a substantial support of great number of people. Although it is not possible to acknowledge each and every person individually, I would like to thank all those who contributed their time and efforts. At the onset of the report I would like to acknowledge my sincere thanks to our institute, Institute of Health Management and Research, Jaipur, for providing us a platform to gain knowledge and skills in different aspects of health management. With profound gratitude and gratefulness, I express my deep indebtness to Colonel Ashok Kaushik, Dean Academics IIHMR, placement coordinator Mr.Dalbir for arranging our internship at UNICEF Rajasthan and their guidance and support during this training.

I would like to thank the officials at the UNICEF, Rajasthan, for giving me this opportunity of endless learning there for two months. I would like to acknowledge the immense support given to me Dr Anil Agarwal (UNICEF), Dr Apoorva chaturvedi, Dr Manisha, Dr Kapil Agarwal.I would like to thank all other staff members at UNICEF Rajasthan for being so helpful all the time and making this summer training project an unforgettable experience who despite their preoccupations and busy schedule were there to guide me on my project.

I would like to give my sincere gratitude to Dr Suresh Joshi, Dr J P Singh for their rational criticism, keen interest and valuable expert suggestion. Finally I also extend our heartfelt gratitude to The Director of IIHMR, Dr S D Gupta for giving us a platform and opportunities in health care sector. Last but not the least, I wish to thank the people whose insights and experience have shaped the content of this study.

THANKING YOU

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ABBREVIATIONS

1	PGDHM	Post Graduate Diploma In Hospital And Health Management
2	ASHA	Accredited Social Health Activist
3	NRHM	National Rural Health Mission
4	UNICEF	United Nations International Children's Emergency Fund
5	ANM	Auxiliary Nurse Midwife
6	DWCD	Department Of Women And Child Development
7	DMHS	Directorate Of Medical And Health Services
8	RTI	Reproductive Tract Infection
9	STI	Sexually Transmitted Infections
10	DOTS	Directly Observed Therapy Short Course
11	ORS	Oral Rehydration Solution
12	IFA	Iron Folic Acid
13	ANC	Antenatal Care
14	PNC	Post Natal Care
15	CHC	Community Health Centers
16	PHC	Primary Health Centre
17	JSY	Janani Suraksha Yojana
18	GSM	Global System For Mobile Communications
19	ID	Individual Data
20	IEC	Information Education And Communication
21	PC	Personal Computer
22	ICT	Information And Computer Technology
23	PDA	Personal Digital Assistant

UNITED NATIONS INTERRNATIONAL CHILDREN'S EMERGENCY FUND (UNICEF)

UNICEF has been working in India since 1949. The largest UN organization in the country, UNICEF is fully committed to working with the Government of India to ensure that each child born in this vast and complex country gets the best start in life, thrives and develops to his or her full potential.

The challenge is enormous but UNICEF is well placed to meet it. The organization uses quality research and data to understand issues, implements new and innovative interventions that address the situation of children, and works with partners to bring those innovations to fruitition.

UNICEF uses its community-level knowledge to develop innovative interventions to ensure that women and children are able to access basic services such as clean water, health visitors and educational facilities, and that these services are of high quality. At the same time, UNICEF reaches out directly to families to help them to understand what they must do to ensure their children thrive.UNICEF also wants them to feel a sense of ownership of these services. That same knowledge and interface with communities enables the organization to tackle issues that would otherwise be difficult to address: the complex factors that result in children working, or the growing threat that HIV/AIDS poses to children. UNICEF knows that key to addressing these challenges are its partnerships with sister UN agencies, voluntary organizations active at the community level, women's groups and donors.

The organization also works with an array of celebrities, including members of the Indian cricket team and leading actors from the Indian film industry, as well as hundreds of thousands of unnamed volunteers who tirelessly give their time and influence to ensure that, together, they are able to help every child realize his or her full potential.

THE MISSION OF UNICEF

UNICEF is mandated by the United Nations General Assembly to advocate for the protection of children's rights, to help meet their basic needs and to expand their opportunities to reach their full potential.

UNICEF is guided by the Convention on the Rights of the Child and strives to establish children's rights as enduring ethical principles and international standards of behavior towards children.

UNICEF insists that the survival, protection and development of children are universal development imperatives that are integral to human progress.

UNICEF mobilizes political will and material resources to help countries, particularly developing countries, ensure a "first call for children" and to build their capacity to form appropriate policies and deliver services for children and their families.

UNICEF is committed to ensuring special protection for the most disadvantaged children - victims of war, disasters, extreme poverty, all forms of violence and exploitation and those with disabilities.

UNICEF responds in emergencies to protect the rights of children. In coordination with United Nations partners and humanitarian agencies, UNICEF makes its unique facilities for rapid response available to its partners to relieve the suffering of children and those who provide their care.

UNICEF is non-partisan and its cooperation is free of discrimination. In everything it does, the most disadvantaged children and the countries in greatest need have priority.

UNICEF aims, through its country programmes, to promote the equal rights of women and girls and to support their full participation in the political, social, and economic development of their communities.

UNICEF works with all its partners towards the attainment of the sustainable human development goals adopted by the world community and the realization of the vision of peace and social progress enshrined in the Charter of the United Nations.

INTRODUCTION

The government of India and government of Rajasthan have launched NRHM in 2005 to address the health needs of rural population, especially the vulnerable sections of the society. The mission envisaged providing access to equitable, affordable, accountable and effective primary healthcare to rural people, especially poor women and children with greater emphasis on 18 high focus states covering 2.5 lakh villages. It also addressed the effective integration of health concerns with the determinants of health like sanitation and hygiene, nutrition, and safe drinking water. The sub center is the most peripheral level of contact with the community under the public health infrastructure which caters the population of 3000-5000. The worker in sub center is an ANM who is directly involved in all the health issues of this population which is spread over the wide area of many kilometers and covering 5 to 8 villages. Many a times the villages are not connected by public or private transport system making her more difficult to achieve the objectives and goals of providing quality health care. So the new band of community based functionaries named as Accredited social health activist (ASHA) is proposed in the NRHM who will serve the population of 1000 and 500 in hilly and desert terrene.

ASHA is the first port of call for any health related demands of deprived sections of the population, especially women, children, old aged, sick and disabled people. She is the link between the community and the health care provider.

ASHA *SAHYOGINI*- CONVERGENCE OF DWCD & NRHM

In each *Anganwadi* Center apart from *Anganwadi* Worker and *Sahayika* one additional worker named '*Sahyogini*' is envisaged to provide door to door information and services of Nutrition, Health, and preschool education. Her role is quite similar to the role of ASHA under NRHM. So to avoid duplication of workers providing same types of services in the same area, the decision was taken at State level, that there will be only one worker coterminous with Anganwadi, who will work with DWCD and DMHS. This worker is called as 'ASHA *SAHYOGINI*', selected by the community through *Gram Panchayat* and responsible to the community.

Criteria for selection:

-One ASHA Sahyogini for each *Anganwadi* center.

-Woman resident of that area, Married /widow /divorcee.

-Age between 21 to 45 years.

-ASHA *Sahyogini* should have effective communication skills, leadership qualities and be able to reach out to the community.

- ASHA *Sahyogini* should be literate woman with formal education up to eighth class. In tribal and desert areas the educational qualification may be relaxed if the 8th pass candidate is not available. This is permitted only after the approval of State level Committee.

- Adequate representation from disadvantaged population groups.

Roles and Responsibilities of ASHA Sahayogini

- **Create awareness**

Health, Nutrition, basic sanitation, hygienic practices, healthy living and working conditions, information on existing health services and need for timely utilization of health, nutrition and family welfare services.

-Counseling

Birth preparedness, importance of safe and institutional delivery, breast-feeding, immunization, contraception, prevention of RTI/STI. Nutrition and other health issues.

- Mobilization

Facilitate to access and avail the health services available in the public health system at Anganwadi Centers, Sub Center, PHC, CHC and district hospitals.

- Village health plan

Work with the village Health and sanitation Committee to develop the village health plan

- Escorts/ Accompany

Escorts the needy patients to the institution for care and treatment. She will accompany the woman in labor to the institution and promote institutional delivery.

-Provision of Primary Medical Health Care

Minor ailments such as fever, first aid for minor injuries, diarrhea. A drug kit will be provided to ASHA

- Provider for DOTS

-Depot Holder ORS, IFA, DDK, chloroquine, oral pills and condoms

-Care of new born and management of a range of common ailments

- Inform births, deaths and unusual health problem or disease out break

- Promote construction of household toilets

Training

Capacity building of ASHA is critical in enhancing her effectiveness. It has been envisaged that training will help to equip her with necessary knowledge and skills. Training of ASHA Sahyogini is a continuous process. Considering her range of functions and task to be performed, her induction training is planned for 23 days in four rounds (10+4+4+5 days). The trainings are planned in cascade model. The nongovernmental organizations are involved in the training of ASHA *Sahyoginis* at grass root level.

mHealth (also written as m-health or mobile health) a term used for the practice of medicine and public health, supported by mobile devices. The term is most commonly used in reference to using mobile communication devices, such as mobile phones, tablet computers and PDAs, for health services and information, but also to affect emotional states. The mHealth field has emerged as a sub-segment of e-health, the use of information and communication technology (ICT), such as computers, mobile phones, communications, satellite, patient monitors, etc., for health services and information. mHealth applications include the use of mobile devices in collecting community and clinical health data, delivery of healthcare information to practitioners, researchers, and patients, real-time monitoring of patient vital signs, and direct provision of care (via mobile telemedicine).

Mobile technologies are increasingly growing in developing countries like India. There have been several new researches and developments in this space. Nowadays mobile is becoming an important ICT tool not only in urban regions but also in remote and rural areas. The rapid advancement in the technologies, ease of use and the falling costs of devices, make the mobile an appropriate and adaptable tool to bridge the digital divide. Mobile phone ownership in India is growing rapidly, six million new mobile subscriptions are added each month and one in five Indian's will own a phone by the end of 2007. By the end of 2008, three quarters of India's population will be covered by a mobile network. Many of these new "mobile citizens" live in poorer and more rural areas with scarce infrastructure and facilities, high illiteracy levels, low PC and internet penetration.

The availability of low cost mobile phones and the already broad coverage of GSM networks in India is a huge opportunity to provide services that would trigger development and improve people's lives.

Looking at the success of using mobile a step has been taken to improve the maternal and neonatal health with the introduction of tablet in rural areas used by ASHA *Sahyoginis* to record the ANC, PNC and neonatal cases and to do the counseling also .

UNICEF (Rajasthan) has started a pilot project on e-asha tab for real time data entry in Jasol village, Balotra(block),Barmer (district) .Under this project among 25 ASHA *Sahyoginis* 20 tablets were distributed. Tablet has a software system in which details of ASHA and area covered by them will appear on typing the phone number of ASHA.After that ASHA will select ANC, PNC and neonatal folder for data entry. The information will be saved and uploaded directly on server in Jodhpur through internet pack provided in sim inserted in tab. An Id will be sent to beneficiaries mobile number and ASHA *Sahyoginis* mobile number on which messages will be sent time to time regarding ANC, PNC and neonatal care. The project is in initial phase of implementation.

RESEARCH QUESTIONS

1. Whether current knowledge of ASHA at grass root level is sufficient to counsel beneficiaries?

2. Are there any gaps in the knowledge of ASHA regarding their responsibilities?

3. Whether introduction of tablet will help to update ASHA knowledge and how much they have been able to internalize tablet after one month of training?

STUDY OBJECTIVE

1. To identify gap in ASHA'S knowledge

2. To access the development of skills of ASHA in operating tablet

3. To find out the problems associated while operating tab by ASHA

METHODOLOGY

This section briefs about the methodology selected for conducting the monitoring. Using the descriptive research design, continuous monitoring to assess the performance of ASHA *Sahayoginis* in delivering services, identify the gaps in her knowledge and skills with reference to her roles and functions under NRHM, to access the development of skills of ASHA in operating tablet.

Study area and sample selection

The study area comprises of a district Barmer block Balotra village Jasol of Rajasthan, covering only one PHC. Fifteen ASHA from different educational background and of 15 areas were selected. Purposive sampling method was followed. Also beneficiaries 5ANC & 5PNC (of 42 days) respectively catered by ASHA i.e., total 38 under different areas catered by 15 ASHA were selected.

TOOLS FOR ASSESMENT

For assessment and collecting information pertaining to the performance of ASHA *Sahayoginis* following research instruments were used

A. INTERVIEW SCHEDULE FOR ASHA – An interview schedule was prepared for ASHA *Sahayogini*. It required her to give detailed information on various aspects as, her roles and responsibilities, trainings received, supplies available with her, services delivered. A part of the schedule also dealt with assessing her level of knowledge and skills. Also it deals with skills developed to operate tablet after a month's training, problems associated while learning tablet and while operating tablet.

B.INTERVIEW SCHEDULE FOR BENEFICIARIES-An interview schedule was prepared for ANC and PNC (42 days only) for beneficiaries required to give detailed information on various aspects about ANC PNC visits their knowledge and also knowledge provided to them by ASHA.

Questionnaire designed is a qualitative and quantitative one.

Data has been recorded on excel sheets for further analysis.

Analysis has been done by taking out frequency out of total number of sample taken.

OBSERVATION AND FINDINGS

Data collected after interviewing ASHA and beneficiaries the following findings were derived as shown in table no.1

Table.1 No of ASHA Sahyogini based on Educational Background and Population Covered and Experience

BACKGROUND CHARACTERISTICS	NO OF ASHA SAHYOGINIS
EDUCATIONAL BACKGROUNDS	
5th standard	1
Up to 8th standard	7
Up to 10th standard	2
Up to 12th standard	3
Graduation	2
Total	15
POPULATION COVERED	
500-1500	12
1500-3000	2
Above 3000	1
Total	15
EXPERIENCE BACKGROUND	
1 month-1 year	3
1 year-2 year	3
2 year-4 year	1
4 year-6 year	2
6year-8 year	6
TOTAL	15

There was also a norm that ASHA should have received education at least till 8th standard. This criterion can be relaxed if no suitable person with this qualification is available. The

finding was encouraging as it was found that nearly all the ASHA, who were interviewed, had 8 or more years of schooling. Apart the following educational backgrounds of ASHA were found for 5th standard or below, 8th, 10th, 12th and graduation.

By norm, an ASHA *Sahayogini* will serve a village with a population of 1000 in the plains and 500 in hilly and dessert terrain but it was found that ASHA is catering population of 500-1500, 1500-3000 and more than 3000.

Experience criterion is 1 month-1 year, 1-2 year, 2-4 year, and 4-6 year.6-8 years.

ASSESING KNOWLEDGE OF ASHA BEFORE USING TAB

To know about their roles and responsibilities and to check their knowledge gaps regarding ANC and PNC the following criteria were taken

1) **ANC visit** scoring is done as complete, partial and incomplete those who respond as 4 visits and less respectively.

2) **Danger signs before pregnancy** scoring are done those who out of five respond four or five correctly as complete, three as partial and less than three as incomplete.

3) **PNC visit** scoring is done as four complete and less as incomplete.

4) **Danger signs after delivery** scored as complete, partial and incomplete with 7-5, 4-2 and less than one as correct responses respectively.

5) **Neonatal knowledge** scoring is done as complete those who responded correctly about disease, signs and treatment ,partial those who responded about any two and incomplete as those who knows about any one or none.

6) ***Janani suraksha yojna*** **knowledge** scoring is done as complete for those who correctly responded three or four information as complete, partial with 2 and incomplete with 1 or none.

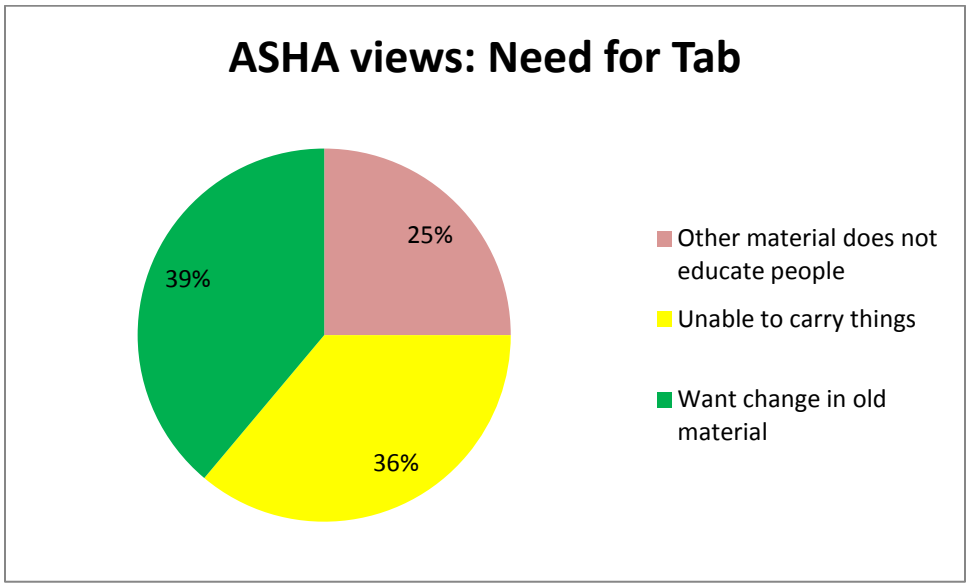
7) **Tests done on pregnant women** scored as complete who responded six or five, partial with four or three and incomplete with two or less.

The following observations were obtained following the above mentioned criteria of scoring in table no .2

Table 2 Assessment of Knowledge of ASHA Sahyoginis Before and After Using Tablet

Variables	BEFORE			AFTER		
	Complete	Partial	Incomplete	Complete	Partial	Incomplete
ANC VISIT	0	0	15	15	0	0
DANGER SIGNS KNOWLEDGE BEFORE DELIVERY	0	1	14	10	5	0
PNC VISIT	0	0	15	14	0	1
DANGER SIGNS KNOWLEDGE AFTER DELIVERY	0	8	7	14	0	1
NEONAT KNOWLEDGE	3	5	7	10	2	3
JSY	2	4	9	10	3	2
TESTS DONE ON PREGNANT WOMEN	0	7	8	6	9	0

NEED FOR TAB DUE TO



During the field work ASHA'S view for tablet to be introduced was taken and they gave the following reasons:

-IEC material available to them is not enough to educate people (36 percent)

-Want change in old material (39 percent)

- Unable to carry things to beneficiaries house door to door

IMPROVEMENT IN SKILLS AND KNOWLEDGE OF TAB AFTER 1 MONTH OF TRAINING

To assess the skills and knowledge about tablet after one month of training on tablet ASHA Sahyoginis were asked to respond about

1) Starting of tablet

2) First written messages flashed on tab screen

3) Knowledge about video on ANC

4) Knowledge about contents of video

5) Knowledge about video on immunization

6) Knowledge about neonatal care video

7) Knowledge about saving data

This is assessed by number of correct answers given by ASHA Sahyogini for each question by yes or no before and after one month of training and is shown in table no.3

Table No .3 Improvement in Skills and Knowledge for Tab in ASHA Sahyogini

Questions asked	Before	After
Response given correctly for starting tab	11	15
First written message flashed on tab screen	0	5
Knowledge about *Leela bai* video (ANC)	6	10
Knowledge about contents of video	6	10
Knowledge about *Mona's* video (immunization)	4	12
Knowledge about neonatal video	5	9
Knowledge about saving data (color)	9	11
Knowledge about saving data(message)	12	13

PERFORMANCE ASSESMENT OF ASHA SAHYOGINI ABOUT ABILITY TO OPERATE TABLET AFTER ONE MONTH OF TRAINING

To assess the performance and knowledge about tablet ASHA Sahyogini responses are categorized as good, fair and poor.

1) Time taken to learn to operate tab categorized as good for two days, fair for three days and poor for five days or more.

2)**Time taken to open a file** is categorized as good for one minute ,fair for two or three minutes and poor for more than five minutes.

3) **Written messages knowledge** categorized as good if all responses were given ,fair for two or more and poor for less than two.

4) **Video knowledge** categorized as good if all responses were given, fair for two or more and poor for less than two.

5) **Excellence in number of data saved** categorized as good if more than five data are saved in day, fair more than two and poor if less than two.

Table no.4 shows the findings of ability to learn to operate tab by ASHA *Sahyogini*

Table No.4 Performance Assessment of ASHA *Sahyogini* About Ability To Operate Tablet After One Month Of Training

CHARACTERISTICS	PERFORMANCE CATEGORY		
	GOOD	FAIR	POOR
	(No. of ASHA *Sahyoginis*)		
Time taken to learn tab	7	8	0
Time to open file	10	5	0
Written messages knowledge	7	4	4
Video knowledge	9	4	2
Excellence in no of data saved	6	9	0

CHANGE IN PERCEPTION AFTER USING TAB

Change in perception is assessed by benefits and advantages assessed by ASHA *Sahyoginis* after using tablet for a month. It is categorized as good, fair and poor according to number of responses given by ASHA *Sahyoginis* and following this criteria the findings are given in table no.5

1) **Ease in ASHA work** good if four or three benefits responded by ASHA, fair if two and poor if less than one.
2) **Benefits** good if six or five responses, fair if four or three and poor if less than two.
3) **Drawbacks** good if no comments or one, fair if two and poor if three.
4) **Changes seen in people** good if five or four changes seen by ASHA, fair if three or two and poor if less than one.
5) **New knowledge attained for ANC** good if 7 or 6, fair if 5-3and poor if 2 or less.
6) **New knowledge attained for PNC** good if 4 or 3, fair if 2 and poor if less than 1.
7) **New knowledge attained for neonatal care** good if 5 or 4 ,fair for 3 -2 and poor if less than 1.

Table no.5 Change in Perception of ASHA after Using Tab for One Month

	GOOD	FAIR	POOR
EASE IN ASHA WORK	8	5	2
BENEFITS	2	9	4
DRAWBACKS	9	4	2
CHANGES IN PEOPLE SEEN	4	9	2
KNOWLEDGE ATTAINED IN ANC	2	9	4
PNC	4	7	4
NEONAT	3	11	1

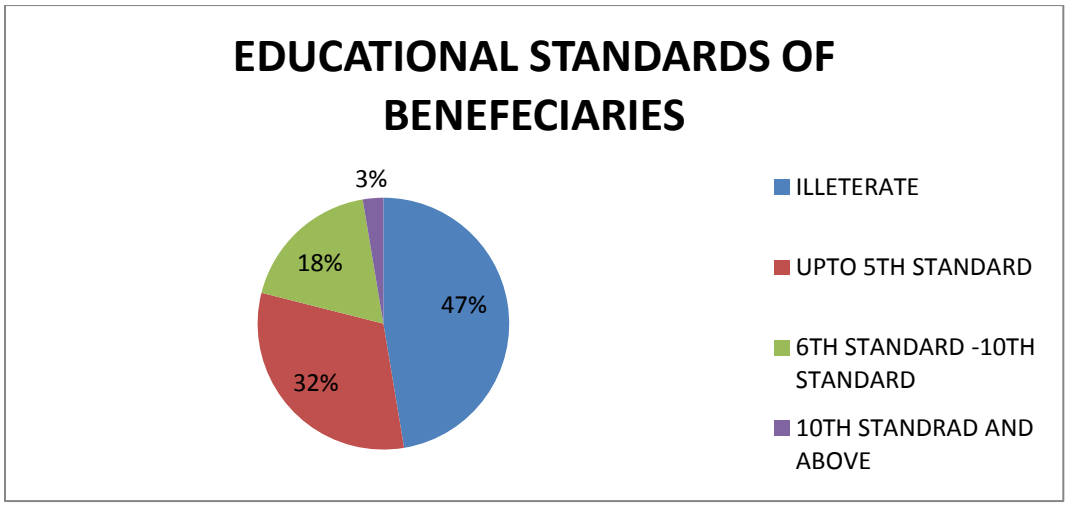
KNOWLEDGE OF BENEFECIARIES

Knowledge of beneficiaries was also assessed by asking questions related to ASHA visiting them during ANC and PNC also knowledge and counseling given by ASHA.Benefeciaries views about ASHA work and after been counseled on tab by ASHA were recorded.

BACKGROUND CHARACTERISTICS OF 38 SELECTED BENEFECIARIES

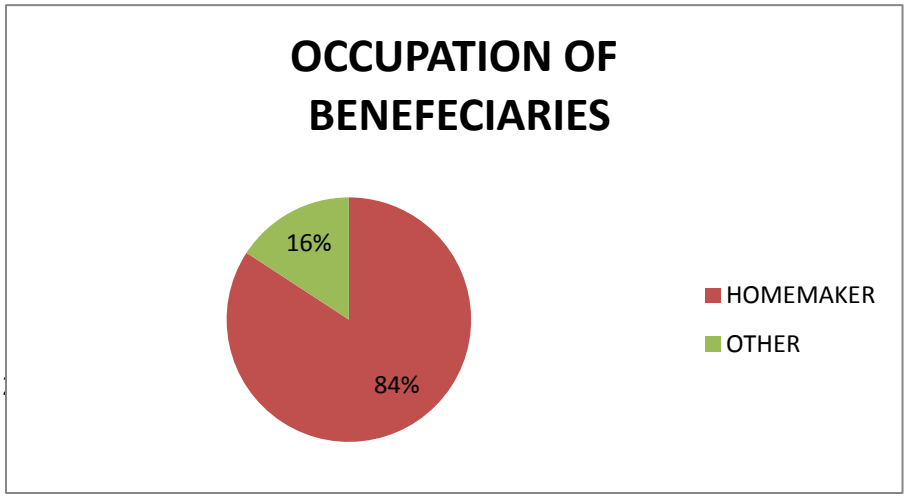
EDUCATION

Out of 38 selected beneficiaries 47percent were illiterate, 32percent were educated up to 5th standard, 18percent were educated from 6th to 10th standard and only 3 percent were above 10th standard educated.

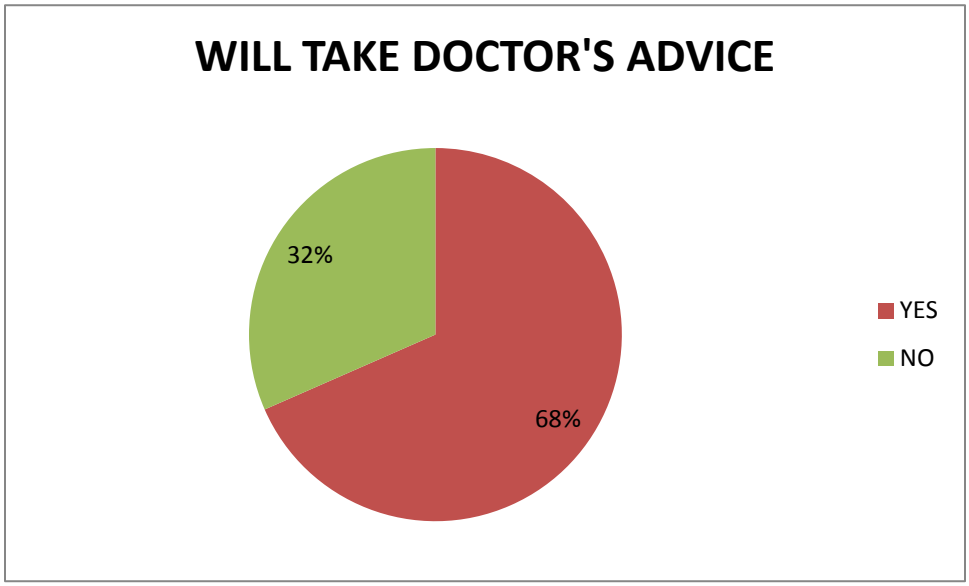


OCCUPATION

Out of 38 selected women 84percent were homemaker while 16percent are involved in other occupations as tailor, labor, cook etc.

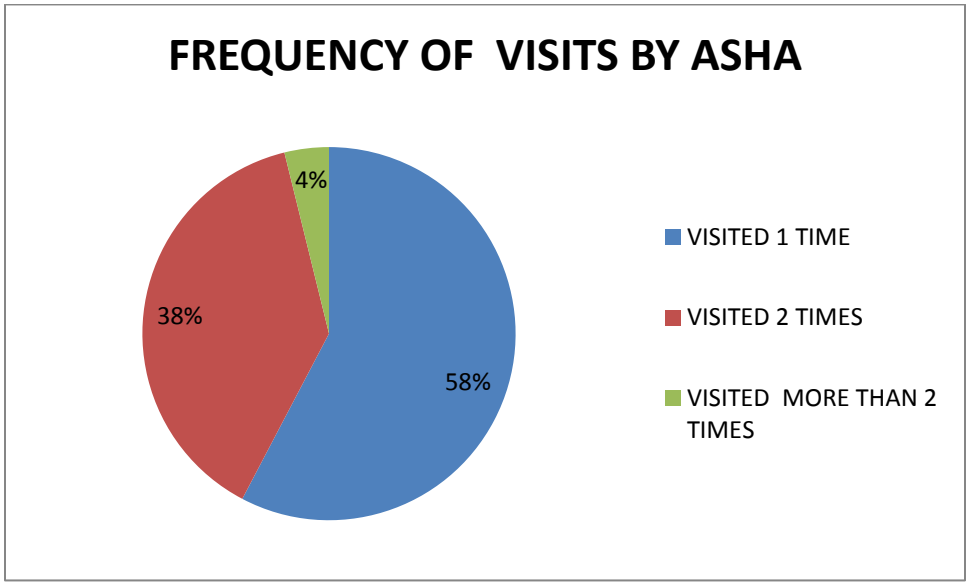


On asking whether they will take any advice of doctor in case of complications 32percent were negative.



Out of 38, 68percent were visited by ASHA rest 32 percent were left unvisited and left without counseling.

26 BENEFECIARIES VISITED BY ASHA -26 beneficiaries visited by ASHA were asked about the total number of visits during ANC or PNC by ASHA results were 58percent were visited by ASHA only one time ,38percent 2 times and only 4percent were visited by ASHA more than 2 times.



VIEWS OF BENEFECIARIES REGARDING ASHA'S WORK

Various questions were asked to beneficiaries regarding ASHA work and following observations were obtained as shown in table no.6

Table No.6views of Beneficiaries Regarding Job Performed By ASHA

VIEWS OF BENEFECIARIES REGARDING ASHA'S JOB PERFORMED	
QUESTIONS ASKED	POSITIVE RESPONSE (%) (no of benefeciaries,n=26)
WHETHER FULL INFORMATION RECEIVED BY ASHA	31
FOLLOWS ASHA'S ADVICE	39
WHETHER ASHA WRITES INFORMATION IN REGISTER OR NOT	46
SATISFIED WITH ASHA'S WORK	58

KNOWLEDGE OF BENEFECIARIES REGARDING MATERNAL AND NEONATAL HEALTH CARE

1) **Knowledge given by ASHA understood** is rated as complete if response is understood fully, partial if understood most and somewhat while incomplete if response is not understood.

2) **ANC message knowledge** rated as complete if 2 responses are given partial if one response is given and incomplete if no response given.

3) **Neonatal knowledge** is complete if 5 or 4 responses were given, partial if 3 or 2 responses were given and incomplete if 1 or no response were given.

4) **JSY knowledge** is complete if 3 responses were given, partial if 2 responses were given and incomplete if 1 or no response were given.

5) **After using tablet knowledge** is complete if responses given were 5 or 4, partial if 3 or 2 responses were given and incomplete if 1 or no response were given.

The various findings are shown below in table no.7

Table No .7 Knowledge of Beneficiaries Regarding Maternal and Neonatal Health Care

KNOWLEDGE ATTAINED BY BENEFECIARIES			
	COMPLETE	PARTIAL	INCOMPLETE
N= 26 BENEFECIARIES VISITED BY ASHA (%)			
KNOWLEDGE GIVEN BY ASHA UNDERSTOOD	4	88	8
ANC MESSAGES	8	35	57
N=38 BENEFECIARIES WHETHER VISITED OR NOT BY ASHA (%)			
NEONAT KNOWLEDGE	3	30	67
KNOWLEDGE ABOUT JSY	13	13	74
AFTER USING TABLET KNOWLEDGE	39	39	22

PROBLEMS FACED BY ASHA WHILE WORKING ON TAB IN FIELD

While working on tab various problems were faced by ASHA Sahyoginis in field. The problems were technical as well as operational. Few of them were as follows:

-network not available at all the places in area been covered

-inability to view screen in day light

-problem in going back to data already recorded for correction

-charging problem due to lack of power supply or if ASHA forgets to charge tab before going into the field.

Apart from the above problems there are many other problems like there are certain conditions when data was not saved due to

-Network failure

-Net pack of sim is over while working in field

-Charge of tab finished while working

OTHER ISSUES

Apart from the above mentioned issues there were other issues like in coordination and no cooperation between ANM and ASHA.

In case if data not saved then it is left unsaved that causes misreporting.

CONCLUSIONS

Since ASHA is the ground level worker visiting people door to door. It is required that her knowledge should be complete and updated time to time as she deals with the health issues of pregnant women and neonate.

During the field work it was found that the educational background of 7 out of 15 ASHA Sahyoginis is up to norm. All 15 of them are covering population more than 1000 which is above the norms.

On assessing the current knowledge of ASHA Sahyogini before using tab none of them is having complete knowledge regarding ANC and PNC, number of visits, danger signs of ANC, PNC and neonatal care, JSY and tests to be done on pregnant women. After using tab there is a marked increase in number of responses of ASHA Sahyoginis which reflects that they have gained complete knowledge.

Need for tab was assessed taking views from ASHA, maximum responses were in favor of changing old IEC material and bring a new material for educating and this will also help ASHA in data entry work thus avoiding wastage of time.

Regarding the skills and knowledge about running tab, most of the ASHA showed improvement in their skills and knowledge in running tab after continuous one month of training. While learning to operate tab initially the performance was good in time taken to open the file, knowledge about written messages and video message while fair in time taken to learn to operate tab and excellence in saving number of data per day.

Perception was assessed as fair in most of the aspects like benefits perceived, changes seen by ASHA in people and knowledge attained for ANC and PNC and neonatal care. Very few drawbacks were perceived about tab.

Beneficiaries responses were assessed by taking the beneficiaries visited by ASHA. Their views about ASHA's job were assessed and 69 percent were not fully informed about ANC, PNC and neonatal care. Only 39 percent follows the advices of ASHA and 46 percent says that ASHA writes their details in register while ASHA visit them. The knowledge was partial and incomplete for most of the questions asked however after being counseled using tab knowledge was found to be complete for 39 percent beneficiaries and partial for 39 percent beneficiaries.

Thus it can be concluded that ASHA Sahyogini and beneficiaries showed gaps in their current knowledge and introduction of tab has helped to increase and update their knowledge regarding ANC, PNC and neonatal care and other related information.

This initial success of this pilot project will help to broaden the area of implementation of tab in other parts of Rajasthan.

REFERNCE

1. nrhmrajasthan.nic.in

2. www.unicef.org

3. Report on Monitoring the Performance of Asha Sahyoginis in Rajasthan by Dipti Govil, PhD Neetu Purohit, PhD Vrinda Mehra, PGDHM Rakhi Mathur, MSc

ANNEXURE

आशा से आपकी आशा

(प्रशनावली) (Questionnaire for Beneficiaries)

नाम- उम्र-

गाँव- व्यवसाय-

बच्चों की संख्या- ए.एन.सी/पी.एन.सी-

1. क्या आशा द्वारा आपकी जाँच हुई है?

अ) हाँ ब) नहीं

२. यदि हाँ तो कतनी जाचें हो चुकी हैं?

३. क्या आशा द्वारा आपको गर्भावस्था के दौरान रखे जानेवाली सावधानियों की पूर्ण जानकारी दी गयी थी?

अ) हाँ ब) नहीं

४. आशा द्वारा दी जाने वाली जानकारी आपको समझ आती है ?

अ) नहीं ब) थोड़ा बहुत

स)काफी समझ आता है द)पूरा समझ आता है

५. आपको दी गयी जानकारी आशा रजिस्टर मे लखती है?

अ) हाँ ब) नहीं

६. आशा द्वारा दिए गए सुझाव व जानकारी पर आप मानती हैं या अमल करती हैं?

अ) हाँ ब) नहीं

७. क्या आशा के काम से आप सन्तुष्ट हैं?

अ) हाँ ब) नही

८. प्रसव पूर्व आशा द्वारा दिए गए तीन संदेशों के बारे में बताये

(Questionnaire for ASHA)

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