ORIGINAL RESEARCH ARTICLE
pISSN 0976 3325 | eISSN 2229 6816
Open Access Article
www.njcmindia.org

Assessment of Functionality of ASHAs with Respect to Health Services in Bharatpur, Rajasthan, 2016

Latika Nath Sinha[1], Vinod Goyal[2]

Financial Support: None declared
Conflict of Interest: None declared

How to cite this article:
Sinha LN, Goyal V. Assessment of Functionality of ASHAs with Respect to Health Services in Bharatpur, Rajasthan, 2016. Natl J Community Med 2019;10(2):96-100.

Author's Affiliation:
[1]Assistant Professor, Dept of Community Medicine, Pali Medical College, Pali; [2]Scholar, EMS, IIPS, Mumbai

Correspondence
Dr. Vinod Goyal
vinodgoyal99@gmail.com

Date of Submission: 11-11-18
Date of Acceptance: 30-01-19
Date of Publication: 28-02-19

ABSTRACT

Introduction: National Rural Health Mission (NRHM) since 2013 adopted the strategies of Reproductive, Maternal, Newborn, Child and Adolescent health (RMNCH+A), under which Accredited Social Health Activist (ASHA) programme has emerged as the largest community health programme in the world.

Methods: A cross sectional community based study was conducted to assess the functionality of ASHA in providing health services in rural areas of Bharatpur, Rajasthan and to check her awareness on job responsibilities, provisions available. It was conducted by randomly selecting one PHC from each block. All ASHA of that PHC were interviewed using a Questionnaire given in the book "Handbook for ASHA facilitator".

Results: In Bharatpur district 96% ASHAs were found functional on 6/10 tasks as per criteria lay down by ministry. 7.6% ASHA of Kaman & 8.3 % ASHA of Bhusawar, 7.2% of Nagar, 6.2% of Kumher block were non-functional. Block Bayana, Deeg and Nadbai were better in terms of ASHA functionality.

Conclusion: Specific strategy needs to be drawn to train the non-functional ASHAs to manage childhood illness. For effective conduction of VHSNC, the refreshment cost of Rs. 70 /- for 15 members to be revised. Robust supervisory system should be adhered to ensure 100% nutritional counseling during home visits.

Key words: RMNCH+A, ASHA functionality, district, supervision

BACKGROUND

National Rural Health Mission (NRHM) launched in the year 2005, is aimed at reducing maternal and childhood morbidity and mortality through engagement of ASHA at village level.[1] ASHA is considered a critical contributor to enable people's participation in health.[2]

In Rajasthan ASHA emerged out through convergence of Department of Women and Child Development and NRHM.[3] 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, preschool education. Decision was taken at State level, that there will be only one worker with Anganwadi, who will work with DWCD and Department of Medical and Health Services (DMHS). This worker is called as 'ASHA Sahyogini', selected by the community through Gram Panchayat and accountable to the community [3, 4].

ASHA fulfills her role through five activities [2] i.e. a) Home Visits b) Attending the Village Health and Nutrition Day (VHND) c) Visits to the health facility d) Holding village level meeting e) Maintain records

Fund-Flow Mechanism and Compensation Package to ASHA in Rajasthan: Under NRHM ASHA

Sahyogini is a voluntary worker who will get performance based incentives for different health programmes. ASHA gets fixed Rs. 1600 monthly from DWCD and incentive [5] based on activities undertaken is being given by DMHS under the overall supervision of MOs/ANMs. The mechanism adopted is through Online ASHA soft **(**The Online Payment and Monitoring System) [6] to ensure payment of incentives to ASHA directly in her bank account.

Drug Kit for ASHA Sahyogini - The drug Kit is provided to ASHA Sahyogini to provide primary Health care to the community for minor ailments like fever, pain, minor trauma etc. The replenishment of medicines is made from PHC /Sub center.

Operational Status in Bharatpur District[7]: 1853 ASHA workers were sanctioned, 1609 were in place. In Rajasthan Supervisory cadre at PHC i.e. PHC ASHA supervisor is recruited as a contractual candidate and are supposed to monitor all activities of ASHA programmes.

OBJECTIVE OF THE STUDY

Since no previous study had been conducted in Bharatpur to understand the functionality of ASHA on the health services provided by her. This study was conducted to serve as baseline so that further studies may be conducted for improving the functionality of ASHAs and sharing the findings with all stakeholders. The objectives of this study were to assess the functionality of ASHA on the health services provided by her and to check her awareness on job responsibilities, provisions available. Further, the study focuses to grade all the blocks of the district as per functionality.

METHODOLOGY

Data for the present research was selected from a cross-sectional community based Study during the period August – December, 2016. One PHC was selected randomly using lottery method from each of 9 blocks which equals to total 9 PHCs. From selected PHC, all the currently working ASHA workers who were present in sector meeting were taken for interview and group discussion to recall their functions. A total of 182 ASHAs participated in the study from the selected PHCs. The ASHAs who were absent in monthly sector meeting were not included in the study.

Data collection was done by using a pre designed, pre tested questionnaire and individual interview in monthly meeting of ASHA by asking the questions in Hindi with ASHA by the investigator.

Format I "To record functionality of ASHA under each facilitator" given in MOHFW (NRHM) book "Handbook for ASHA facilitator" (Eng version) Page no. 25[8] was used. Questions used in this study were same as given in this book and same criteria of functionality used.

Focused group discussion was done to cull out the quality aspect of services, job responsibilities, provisions available and problems faced by ASHAs in discharging their responsibilities. FGD was conducted among 8-10 participants.

Data analysis was done by using Microsoft excel version 16 using frequencies, percentage and means to evaluate the performance of ASHA. Analysis of FGD done on basis of notes of discussion held and major findings of recordings available with Principal invigilator. Feedback of ASHA supervisors at end of FGD were also taken into consideration for analysis.

Ethical Considerations: The ethical clearance was taken by the Institutional Ethical committee of IIPS, Mumbai Permission for study taken from Chief medical and health officer Bharatpur. Written consent was taken from each ASHA before taking part in the interview. Recording of all FGD's was also done after consent.

RESULTS

Sixty three percent of ASHA found functional on management of childhood illness. ASHA identified the case and referred to hospital for further treatment after providing basic drugs like ORS for diarrhoea as shown in figure 1. Approximately 97.3% ASHA found functional on set of home visits for newborn care as specified in HBNC guidelines, attending VHNDs/promoting immunization, supporting institutional delivery (figure 2). 97.3 % ASHA attended VHNDs, but weight monitoring on growth chart needs strengthening as weight is plotted on growth chart of MAMTA card by only 40-60% ASHAs at Roopwas, Nadbai, Bayana only. Weighing machine was not functional at AWCs of Bhusawar and Nagar blocks. Also, 1.6 % ASHA is non functional on attending VHND. 1.1 % ASHA comes as 'not applicable' category in VHND/ immunization indicator which shows that session not held. It was found that 15% ASHAs were non-functional on VHSNC meeting which shows that VHSNC were to be strengthened and meetings be held regularly. Notes of discussion and feedback of ASHA facilitators during FGD further reiterates that VHSNC funds were not available with ASHAs of Roopwas, Kaman, Nagar. One point observed was that VHNSC funds were released from district to blocks early in financial year but it was not fur-

ther released to sub centre/ASHA level till end of financial year.

Table 3 shows the frequency distribution of ASHA functioning in Successful referral of the IUD, female sterilization or male sterilization cases and/or providing OCPs/Condoms. Also 95% ASHA were functional on family planning programme. But major portion of functionality is due to distribution of contraceptives as sterilization however IUD is seen very less in this time period. 21 % ASHA in Nagar block is not functional on Family planning. The percentage distribution of ASHA functional on 6/10* task is presented in table 4. Bayana is on the top for highest (100%) ASHA being functional. District average of functional ASHA was 95.60%. Sewar, Kumher, Nagar, Kaman, Bhusawar had 4.7, 6.2, 7.1, 7.6, 8.3 percent of nonfunctional ASHA respectively.

Table 1- Frequency Distribution of ASHA functioning in Management of childhood illness – especially diarrhoea and pneumonia

Indicator	ASHA Worker (%)
Functional	115 (63.2)
Non- Functional	24 (13.2)
Not Applicable	43 (23.6)
Total	182 (100)

Table 2- Frequency Distribution of ASHA functioning in (a) Set of home visits for newborn care under HBNC (b) Attending VHND/promoting Immunization (c) Supporting Institutional Delivery

	Home visits under HBNC (a) (%)	Attending VHND/promoting Immunization (b) (%)	Supporting Institutional Delivery (c) (%)
Functional	177 (97.3)	177 (97.3)	177 (97.3)
Non- Functional	2 (1.1)	3 (1.6)	4 (2.2)
Not applicable	3 (1.6)	2 (1.1)	1 (0.5)
Total	182 (100)	182 (100)	182 (100)

Table 3- Frequency Distribution of ASHA functioning in (a) Holding or attending village/VHSNC meeting (b) Successful referral of the IUD, female sterilization or male sterilization cases and/or providing OCPs/Condoms

	Holding or attending village/ VHSNC meeting (a) (%)	Successful referral for/providing contraceptive services (b) (%)
Functional	154 (84.6)	172 (94.5)
Non- functional	27 (14.8)	9 (4.9)
Not applicable	1 (0.5)	1 (0.5)
Total	182 (100)	182 (100)

*Successful referral of the IUD, female sterilization or male sterilization cases and/or providing OCPs/Condoms

Table 4- Percentage Distribution of ASHA functional on 6/10* task

Block	% of ASHA functional on 6/10* task
Bhusawar	91.67
Kaman	92.31
Nagar	92.86
Kumher	93.75
Sewar	95.24
Nadbai	96.30
Roopwas	96.77
Deeg	96.88
Bayana	100.00
Total	**95.24**

The total number of tasks out of which ASHAs are scored will also depend on the availability of potential cases or beneficiaries in her area during the period of last one month. e.g. - If there were no TB and Malaria cases in ASHA's area then Facilitator should write NA in the respective cells and mention this in the remarks. This would reduce the total no. of tasks from 10 to 8 and affect the scoring of ASHAs also. In case of total 8 tasks she should be functional on at least 5/8 tasks and in case of 7 tasks it should be at least 4/7. These scores can then be considered equivalent to the scores of other ASHAs who are scored out of 10.

Though 97% ASHA were functional on HBNC Visits, but due to issues of entry of HBNC in ASHA software, she didn't get same amount as claimed. Also quality of HBNC visits needs to be strengthened. Most ASHAs complained that card is lengthy. One good point observed in Bharatpur was that mostly blocks have supply of IFA syrup at AWC. IFA syrup was being given to clients as per guidelines in all blocks by most of ASHAs.[15] Mostly ASHAs know the usage of IFA syrup (1 ml twice in a week, not to give with milk etc.) as they got training of this under HBNC PLUS programme and implementing since 2014.

DISCUSSION

Though many diarrhoea cases were in the notice of ASHA and management done promptly, but Pneumonia cases were either not found or not identified in the area. ASHA of blocks Kaman (54%), Bhusawar (58%), Sewar (14%), Kumher (13%) were not able to keep track of Pneumonia and Diarrhoea cases.

Home delivery not found in the last month in the area of 74% ASHA, which shows the success of Janani Suraksha Yojna and Janani Shishu Suraksha Karyakaram programmes in NRHM since its inception. This was similar to the study in Uttar Pradesh[9]. Quality of HBNC visits needs to be strengthened. Around 8% ASHA in Bhusawar block had not visited on post delivery Day 1. A similar study in Mewat district, Haryana showed that documentation and quality of visit as per checklist was done adequately by only 19% of ASHAs.[10]

In Nagar block 14% ASHA not functional on VHND due to session not held/health issues of ASHA worker. ASHA of block Roopwas (39%), Kaman (23%), Kumher (19%), Nagar (14%), didn't attend/held VHSNC due to any reasons. VHSNC funds were released from district to blocks early in financial year but it was not further released to sub centre/ASHA level till end of financial year. This observation was similar to the one made in Jharkhand wherein these funds were not transferred to VHSNC or Sarpanch/ASHA account from block level [11,12,13]. As per her mandate of visiting 10 households per day, ASHA is visiting household for nutrition counselling. Also she kept track of children by weighing the child at AWC with help of AWW and doing visits under HBNC and HBNC PLUS. ASHA of block bhusawar (42%), Kaman (31%), Sewar (19%), Kumher (19%), Nadbai (19%), Nagar (14%) is not visiting for nutrition counselling. As stated in the NHM update of 2015, ASHAs need to further improve by enhancing usage of IFA syrup, promoting complementary feeding, identification of malnourished children through growth monitoring and Shakir's tape.[13,14] . Non-availability of functional weighing machine at AWC of Bhusawar and Nagar further validate the non-functionality of ASHAs in these blocks.

HBNC PLUS implemented in Bharatpur with support of NIPI (Norway India partnership Initiative) be continued and strengthened further as it targets significant components of infant survival. [16]

CONCLUSIONS

Blocks where ASHAs were visiting the household for nutrition counselling were found more functional on management of diarrhoea and Pneumonia. Notes of discussion and feedback of ASHA facilitators during FGD further reiterates that most of ASHA functional on support of institutional delivery was also functional on FP referral/contraceptive use. Good performing blocks has achieved good due to better VHSNC, regular VHND, regular home visits for nutrition counselling, follow up of DOTS cases. It was seen that ASHAs who visited for birth plan of pregnant women also visited for HBNC and mobilized the children for immunization. So a continum of care (ANC-Delivery-PNC) as stated in RMNCH+A was observed. District average of functional ASHA was 95.60% as per functionality criteria of 6/10. Bayana is on the top for highest (100%) ASHAs were being functional. Block Bayana, Deeg and Nadbai were better in terms of ASHA functionality.

RECOMMENDATIONS

Organized monitoring by ASHA supervisors as per their checklist needs to be improved.

VHSNC funds need to be transferred to VHSNC accounts timely. VHSNC meeting quality and involvement/participation of members in this meeting needs strengthening. Issue of Rs.70 for the refreshment of 15 members in VHSNC meeting needs revision in VHSC guidelines as members were increasing from 7 to 15 but refreshment fund is kept same as Rs.70.

Baby weighing machine at AWC needs to be repaired / purchased in many centers of Bhusawar and Nagar and few centers of other blocks.

Mechanism for replenishment of ASHA drug kit should be worked out as sanction is provided to districts from state NHM.

Growth monitoring and IFA usage needs to be strengthened through VHND.

As per mandate, ASHA should visit 10 household per day, when ASHA will visit household regularly, functionality on nutrition counselling and management and identification of diarrhea and Pneumonia will enhance automatically.

Identification of danger signs and management of diarrhoea and pneumonia should be discussed in VHSNC meeting with the community and stakeholders.

Questionnaire used in this study is circulated by MOHFW (NRHM) in book "Handbook for ASHA facilitator" - Format 1 for ASHA facilitator-"To record functionality of ASHA under each facilitator". This should by circulated and implemented by NHM Rajasthan to record/assess functionality of ASHA from every district.

Review of the scheme was done in a small rural setup which later on can be done on an extensive level to generalise the finding.

REFERENCES

1. Ministry of Health and Family Welfare. Guidelines of RCH-II under National Rural Health Mission (Mission Document), New Delhi. Government of India. 2005-2012.
2. Ministry of Health and Family Welfare. A strategic approach to reproductive, maternal and child and adolescent health in India. 2013 January.
3. Ministry of Health and Family Welfare. 12th five year plan (2012-2017), social sectors, New Delhi. Government of India. 2012. Volume III.
4. Mane AB & Khandekar SV. Strengthening primary health care in Rajasthan through ASHAs: A Novel Approach. International Journal of Humanities and Social Science. 2014. 4(9), 149.
5. Rajasthan Health Department. Asha - soft brochure NHM Rajasthan (2016) . Available from: http://www.rajswasthya.nic.in [Last accessed on 2017 July 25].
6. NRHM Rajasthan. Go ASHA-soft. *Online payment system in Rajasthan*. 2016. Available from: http://www.nrhm rajasthan.nic.in/ASHA%20Soft.html [Last accessed on 2017 July 25].
7. Rajasthan Health Department. Annual District Report (NHM) Bharatpur district. 2016. Available from: http:// www.rajswasthya.nic.in [Last accessed on 2017 July 25].
8. Ministry of Health and Family Welfare. Handbook for ASHA facilitators 2015. New Delhi. Government of India. 2015.
9. Deepthi S. Increasing institutional delivery and access to emergency obstetric care services in rural Uttar Pradesh. Journal of Family welfare. 2010; 56.
10. Karol GS, Pattanaik BK. Community Health workers and reproductive and child health care: an evaluative study on knowledge and motivation of ASHA (Accredited Social Health Activist) Workers in Rajasthan, India. International Journal of Humanities and Social Science. 2014 Jul; 4(9):137-50.
11. USAID–MCHIP. Report on RMNCH+A -Highlight Series Improving RMNCH+A interventions: Block Monitoring in Lohardaga District, Jharkhand of Monthly Village Health and Nutrition Day. Jharkhand. 2014.
12. Ministry of Health and family Welfare. *National Rural Health Mission, Guidelines for community Processes.* New Delhi. Government of India. 2013.
13. Sinha LN, Kaur P, Gupta R, Dalpath S, Goyal V, Murhekar M. Newborn care practices and home-based postnatal newborn care programme–Mewat, Haryana, India, 2013. Western Pacific surveillance and response journal: WPSAR. 2014 Jul; 5(3):22.
14. Ministry of Health and family Welfare. National Rural Health Mission, Update on ASHA programme. New Delhi. 2015 July. Government of India. 2015.
15. Ministry of Health and Family Welfare. NRHM Guidelines for Nutritional Anaemia in children- The Iron plus initiative. New Delhi. Government of India. January 2013
16. NIPI New Born Project. Resources Publications, HBNC+ and coordination unit.: Norway India partnership initiative. New Delhi. 2015. http://www.nipi.org.in/index.php/ resources/publications [Last accessed on 2017 July 25].