A STUDY OF ASHA WORKERS ACHIEVEMENT WITH RESPECT TO FAMILY PLANNING

Dr. Dhananjay Mankar
Assistant Professor
Tata Institute of Social Sciences, Mumbai, India
Email: dhananjay.mankar@tiss.edu

Nishant Sagar
Ph.D Research Scholar
IIHMR Jaipur, India
Email: nishantsagar85@gmail.com

ABSTRACT
ASHA workers tasks include motivating women to give birth in hospitals, bringing children to immunization clinics, encouraging family planning (e.g., surgical sterilization), treating basic illness and injury with first aid, keeping demographic records, and improving village sanitation. ASHAs are also meant to serve as a key communication mechanism between the healthcare system and rural populations. ASHA play important role in generating demand and awareness among the community. The awareness about the nutrition, sanitation, hygiene, immunization, and population stabilization have yet not reached the community in the effective manner. The selection of ASHA is from various socio cultural backgrounds. There is also wide disparity among the ASHA in economic status and literacy level. Objectives of the study are: To assess the socio demographic, economic profile of ASHA in Bahariya block, Siwan, Bihar, To assess the health system difficulties in respect to incentives , behaviour and others difficulties during the work in Bahariya block , Siwan, Bihar, To assess the association between different socioeconomic - Demographic conditions, health system difficulties and Family planning (Surgical Sterilization ).A analytical cross sectional study where the correspondent was interviewed face to face with questionnaire and used secondary data available at PHC in respect to FP achievement. 100 ASHA of barhariya block of siwan have been taken. Done the uni-variate and Bi-variate analysis.Chi-square (p-value) which gives association between the variables. p-value less than 0.10 tells that there is significant association between two variables. Major findings of study are - SC caste ASHA, less educated, and with family income less than 2 lakhs are doing more FP. This may be due in order to receive higher incentive to support their family. Even Annual family income of ASHA is found to be significantly associated with the number of FP done.

Keywords: ASHA , Socio economy , Demography , Family planning

INTRODUCTION
The millennium development goal emphasizes on “reduction in Infant mortality rate and reduction in maternal mortality ratio” This is also re-emphasized in the mission document of the National Rural Health Mission (NRHM) along with “Universal access to public health service, such as woman’s health, child health, water, sanitation & hygiene, immunization, nutrition, and population stabilization, gender and demographic balance. In 2005 National Rural Health Mission was launched to achieve these goals and one of the core strategies to achieve these goals was selection of ASHA on the population of 1000 in rural area. The Indian MoHFW describes them as - “Health activist(s) in the
community who will create awareness on health and its social determinants and mobilize the community towards local health planning and increased utilization and accountability of the existing health services”. Their tasks include motivating women to give birth in hospitals, bringing children to immunization clinics, encouraging family planning (e.g., surgical sterilization), treating basic illness and injury with first aid, keeping demographic records, and improving village sanitation. ASHAs are also meant to serve as a key communication mechanism between the healthcare system and rural populations.

Following are the tasks of ASHA workers:

1. Knowing our village people
2. Village Health Plan
3. Communication for health behaviour change
4. Linkages with AWW, TBA, ANM, MPW
5. Escorting patients to a hospital
6. Primary medical care
7. Act as Depot Holders
8. Records and registration

Their work is to create awareness among the community about government health schemes and mobilize them to the community health centres. They act as first link between the community and health centre. ASHAs are also termed as the backbone of preventive health care system. Bihar is the third most population state in India with population of 10.38 crore with 90 percent living in rural area as per census 2011. The young age population is very high with 18 percent of children age between 0 to 6 years as per census 2011. The state is one among several states in the country, where Infant Mortality rate and Maternal Mortality Rate is 42/1000 live birth and 218/100000 live birth respectively. The total fertility rate is 3.3 which is very high as compared to India. As per census 2011 the literacy rate is 64 percent. The undr5 mortality rate of Bihar is 72 per 1000 live birth in 2012 as per PIP 2012-13. There is wide disparity among state. The under5 mortality rate in Siwan is 53 and Sitamarhi is 106 per 1000 live birth as per AHS.

ASHAs are involved in different programs for which a fixed amount of incentive is paid based on the programs. In order to increase the efficiency of their work regular capacity building programs are conducted at PHC level. ASHA day is conducted on every Thursday and ASHA have been trained in module I, II, III, IV, V, VI & VII as a part of capacity building program. The grand total number of ASHAs in India was reported in July 2013 to be 870,089. Despite some improvement in the infant mortality indicator in the country, the stated goals have not been fully achieved. The under 5 child mortality of India is 61 per 1000 live birth in 2011 as per World Bank. Efforts made by Government of India in striving towards its goals are further strengthened by various international and national agencies joining hands in this initiative.

ASHA play important role in generating demand and awareness among the community. The awareness about the nutrition, sanitation, hygiene, immunization, and population stabilization have yet not reached the community in the effective manner. The selection of ASHA is from various socio cultural backgrounds. There is also wide disparity among the ASHA in economic status and literacy level.

**SELECTION CRITERIA OF ASHA**

1. ASHA must be a woman and resident of the village.
2. The minimum education required for the selection of ASHA is 8th pass.
3. On the day of selection, age of ASHA should be minimum 25 year and maximum 45 years. She should have a valid document for her age proof.

4. ASHA must be a daughter in law/widow of the village. In any case unmarried girls /lady cannot be selected as ASHA.

5. ASHA cannot be selected if she is daughter in law/daughter/wife of public representative, owner of public distribution shop, people working in government service.

6. ASHA has to be physically fit and mentally sound.

WORK OF ASHA

1. Communicate with the community for the improvement in health related behaviour.
2. Assist in preparation of village health action plan and implement them.
3. Co-ordinate with Aganwadi worker, trained birth attendant, ANM and multipurpose worker.
4. Counsel the community on health related programme.
5. Assist and help the beneficiary to reach hospital.
6. Act as depot holder.
7. Maintain the record registration

STATE PROFILE OF BIHAR

Bihar has a population of 10.38 million with a decadal growth rate of 25.07% as compared to the national growth rate of 17.64%. The population density per square km is 1102 as against the national average of 382. The sex ratio is 916 per 1000 males and the literacy rate is 63.82%.

LITERATURE REVIEW

According to study published in Indian journal of humanities and social, Vol. 4, No. 9; July 2014 by Ghan Shyam Karol and Dr. BK Pattanaik on evaluations study on knowledge and motivation of ASHA worker in Rajasthan, ASHAs knowledge on reproductive and child health care have been assessed with the help of standardized knowledge test which depict that they have scored 90.5, 86.7, and 86.62 percent in general reproductive awareness, maternal health care and child health care respectively. However, their knowledge score in family planning and HIV/AIDS is lower (64.16%) as compared to maternal and child health care. Findings also tells that out of the total number of cases those have adopted ANC(Antenatal Care), conducted deliveries in health institutions, received PNC(Postnatal Care), availed child immunization care facilities and number of eligible couples adopting various family planning methods in ASHA’s operational area, 67.33,72.28,74.97 , 80.78 and 30.49 percent of cases respectively have been motivated by the ASHAs. As the study finding shows that their capacity is low in motivating family planning cases for restricting high fertility in rural areas.

According to study published in Indian journal of community medicine, 2010; july 35(3): 414-419 by Manish K singh and JV singh on factor influencing utilization of ASHA services under NRHM in relation to maternal health in rural Lucknow, Utilization of ASHA services for early registration was significantly associated with age and religion of RDW (Recently Delivered Woman). Young, educated and socio-economic class III RDW utilized ASHA services the maximum for early registration. Utilization of ASHA services for adequate ANC or antenatal care (100 iron and folic acid tablets, 2 tetanus toxoid injection and ≥3 antenatal visits) was also inversely associated with age of RDW. Young, Hindu, scheduled caste, middle school pass, Class III RDW and those with birth order one had high odds for utilization of ASHA services for adequate ANC. With regard to postnatal check-up, again young RDW with birth order one, Hindu RDW in reference to Muslim and RDW in socio-economic class III had higher likelihood for utilization of ASHA services. Caste-wise Scheduled caste (SC) and other backward caste (OBC) RDW had higher odds for utilization of ASHA services.
Educated RDW and those with educated husband had higher odds for utilization of ASHA services for postnatal check-up.

According to the USAID ASSIST India Project, will have an influence on our community-based improvement work. ASHAs became more self-confident after they started engaging in ASHA work. Positive changes at the household level and recognition in the community helped shape ASHAs’ agency, which, in turn, allowed them to address challenges in their work environment in promoting health behaviours in the community. One ASHA told us, “After I became an ASHA people from the village come to me; they call me and they respect me. Everyone asks me how to do this, how to do that, what not to do so everything has changed after I became an ASHA.” However, since the ASHAs worked within bounded socio-cultural, gender and religious contexts, they were constantly challenged by norms existing within these contexts. Within the family, because of the ASHA’s extra income and social prestige brought with her job, we found that family support increased related to the distribution of domestic chores among family members including husbands. There was also an increase in direct support in an ASHA’s work such as her husband accompanying her to distant villages for conducting surveys or handing out condoms to male community members. Yet ASHAs were found to be also limited in their movements. An ASHA needed a male member to accompany her for night deliveries and had to negotiate for going out and performing her duty at night.

One ASHA reported, “In the beginning when I was going alone at night I felt that he (husband) was not feeling good about it. Then I thought rather than messing up my family life, I told him to come with me when I had to go out at night. Then he understood. Now, he gives full co-operation to me.” Since ASHAs’ work is incentivized, it played a role in the husbards’ help and support. Yet the same was also a source of conflict. As one ASHA reported, “The problem is that when I go for deliveries at night my husband taunts me saying ‘You have no substantial salary and still you step out at night to get deliveries done, don’t you have any respect’.” The ASHA navigated this challenge by assuring her husband that she would get a regular salary in the future. But this creates false expectations and in the event that salaries are not regularized, which is likely, the ASHAs may face more difficulties in negotiating their work and personal lives.

In the community, challenges were found to include low decision-making power and mobility of women in the community that precludes them from accessing health care. Furthermore, while the ASHA recognized the importance of male involvement, they were unable to directly engage with male partners and family members. As one ASHA reported, “Women come to get information regarding family planning. Males do not come. Even I feel a hesitation in explaining to them (males). Males sometimes get information from my husband.” ASHAs also faced challenges at the health system level. The disrespect shown by hospital staff and lack of access to essential medicines and pregnancy testing kits led to the loss of credibility among ASHAs, which affected their work performance.

OBJECTIVES OF THE STUDY

1. To assess the socio demographic ,economic profile of ASHA in Bahariya block , Siwan, Bihar.
2. To assess the health system difficulties in respect to incentives , behaviour and others difficulties during the work in Bahariya block , Siwan, Bihar.
3. To assess the association between different socioeconomic - Demographic conditions, health system difficulties and Family planning (Surgical Sterilization ).

RESEARCH QUESTION

Is there any association in achievement of ASHA'S with respect to Family planning (Surgical sterilization ) and different socioeconomic - Demographic and health system difficulties ?
HYPOTHESIS

A. Null hypothesis
No association between High literacy of ASHA, high literacy of ASHA husband, low economical conditions, Short distance from PHC, Joint family and low age and high performance of ASHA in respect of surgical family planning.

B. Alternative hypothesis
High literacy of ASHA, high literacy of ASHA husband, low economical conditions, Short distance from PHC, Joint family and low age is responsible for high performance in respect of surgical family planning.

RESEARCH METHODOLOGY

The study design is analytical cross sectional study where the correspondent was interviewed face to face with questionnaire. The Sample size taken was 100 in number and total 100 ASHAs were interviewed with the help of semi structured questionnaire. The questions asked were on the socio and demographic profile of ASHA. Some of the questions were related to their economic profile. They were interviewed about their age, caste, literacy, type of family, husband education, distance of PHC from their house, annual income of family, time taken in travel and health institution level problem. Secondary data (one year) was collected from PHC in respect of FP (surgical sterilisation) motivated by ASHA.

TOOLS AND TECHNIQUES OF DATA COLLECTION

A specially designed semi structured questionnaire was prepared to carry out this study. Face to face interview was conducted with ASHA. Study Area – Block – Barhariya, District – Siwan. Study population - ASHA of this block. Sampling unit – All working asha in the barhariya block. Inclusion criteria – All ASHA of barhariya block (Total post of asha is 139 but 27 posts are vacant and 12 asha are non functional). Sample Size – 100. The Study Tools - The study tools had survey questionnaire and secondary data (one year) got by PHC in respect of FP (surgical sterilisation) motivated by ASHA.

STUDY FINDINGS

Previous study finding shows that their capacity is low in motivating family planning cases for restricting high fertility in rural areas. According to the USAID ASSIST India Project, Within the family, because of the ASHA’s extra income and social prestige brought with her job, we found that family support increased related to the distribution of domestic chores among family members including husbands. ASHAs also faced challenges at the health system level. The disrespect shown by hospital staff and lack of access to essential medicines and pregnancy testing kits led to the loss of credibility among ASHAs, which affected their work performance. In my study findings are same as SC caste ASHA, less educated, and with family income less than 2 lakhs are doing more FP. This may be due in order to receive higher incentive to support their family. Even Annual family income of ASHA is found to be significantly associated with the number of FP done. The ASHA who found the problem at facility level, other problems or delay in incentive, turns out to done less FP.

CONCLUSION

On the basis of analysis of the present study, the following conclusions were drawn – Most of the ASHA are above 40 years and most belongs to General or OBC caste. The education level among majority of the ASHA is either Matric or Inter. Around 70 percent of the ASHA are staying in Nuclear family. Around 64% of the ASHA belongs to family with income less than 2 lakhs. The husbands of the most of the ASHA are educated above Inter. It shows that this middle class ASHA’s are working to support their nuclear family. Though 40% ASHA have to travel less than 3 km to go PHC from their house but 30 percent of the ASHA have to cover atleast 9 km to reach PHC. As 45% of the ASHA
reaches within half and other 43% have to travel at least 1 hour to reach PHC. Around one-fifth of ASHA responded that there is problem or delay in incentive. Only few (3%) ASHA faced a refusal from PHC to provide services and 44% have faced some kind of problem at the facility level.

Most of the educated ASHA (8th passed and above) have to travel more distance to reach PHC. Though other demographics are not found to be associated for the current set of ASHA but they may affect at larger level. EBC caste, less educated women (up to 7th), and with husband studied up to 7th get their incentives late. This suggests that ASHA with lower socio-economic group are likely to receive incentive late as compare to other ASHA. Majority of the younger ASHA (ages less than 40 years), from EBC, educated (Matric and above), and with family income above 2 lakhs found some kind problems at the facility problem. This is obvious that educated women and upper socio-economic women wants good services for other to deliver better services. It is found that higher the age of ASHA, less number of FP done by them. Also it is noted that SC caste ASHA, were found to be less educated, and with family income less than 2 lakhs are doing more FP. This may be due in order to receive higher incentive to support their family. Even Annual family income of ASHA is found to be significantly associated with the number of FP done. Distance travelled by ASHA to reach PHC is significantly associated with FP numbers. Lesser the distance between home and PHC, number of FP done is found to be increasing. The ASHA who found the problem at facility level, other problems or delay in incentive, turns out to done less FP.

RESEARCH IMPLICATIONS

1. Incentive of ASHA should be increased.
2. Provide travelling allowance with incentive.
3. Facility of sterilisation should be available on APHC level.
4. At the time of recruitment, we should appoint the asha aged between 20 to 30 yrs.
5. We should select asha from low economic family.
6. Establish awareness programme for ASHA.
7. Performance based incentive / award should be there.

REFERENCES

3. Dalal K, Dawad S. Non Utilization of Public health care facilities: examining the reasons through a national study of women in India. ARHEN 9:1178 (Online), 2009: available in URL. http://www.rrh.org.au


10. Reading material of ASHA- Book 1


13. Indian journal of humanities and social, Vol. 4, No. 9; July 2014 by Ghan Shyam Karol and Dr. BK Pattanaik on evaluations study on knowledge and motivation of ASHA worker in Rajasthan.