'ASHA scheme'- Benefits and Drawbacks with Special Reference to Golaghat District ,Assam

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Abstract:
The health of a nation's population determines it`s social development. ASHA works at lower level through decentralization .Financial constraints are one of the major barriers to healthcare for marginalized section of the society, including parturient women in many low income and middle income countries like India. Regardless of socioeconomic, demographic, or obstetric differences, women received more antenatal care, skilled delivery, and postnatal care from ASHA scheme. The fee-free policy benefits the economically disadvantaged population in particular, as it has been shown to increase their access to skilled care during pregnancy and delivery. ASHA workers may play an important role in promoting prenatal care, increasing the link between ANC contacts and institutional delivery. In the present study, ASHA was found to be the major facilitator for receipt of ANC services like early registration, three or more ANC visits, two TT injections and natal care by Recently Delivered Women .The study shows that frontline health workers need further technical training to provide integrated counseling on all aspects of postnatal care.

Keywords: ASHA, Facility base delivery, postnatal, Antenatal care, Education, Employment.
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Introduction:

The health of a nation's population determines it`s social development. Maternal morbidity and mortality have been major public health concerns around the world, particularly in developing countries. Millennium Development Goals give focused on reduction of global maternal mortality Ratio by 75% between 1990-2015[1]. The renewed commitment to reduce maternal and infant mortality rates under the Sustainable Development Goals (SDG) and the amount of resources the government of India is investing to improve maternal and child health outcomes underscore the need to understand the dynamics of maternal and child health care utilization beyond simply focusing on institutional births. In 2005, as a key component of efforts to expand access to health services in underserved areas, India's National Rural Health Mission (NRHM) introduced Accredited Social Health Activist (ASHA), a community based health worker (CHW).[2] The introduction of the Accredited Social Health Activist (ASHA) workers by the Ministry of Health and Family Welfare Department in 2005 was to improve the accessibility, availability and acceptability of the existing health facilities particularly in rural areas. The ASHA is a female volunteer selected

by the community for every 1000 populations, deployed in her own locality after a short training on community health. Through ASHA, one of the core strategies of NRHM was to promote access to improved health care at the household level. ASHA as centerpiece of National Health Mission creates awareness and provides information to the community, counsel's mothers on birth preparation, safe delivery, feeding practices, and family planning, and accompanies pregnant women and children to health facilities, act as depot holder for ORS, IFA, and DDK, etc. ASHA (Accredited Social Health Activist) is a vital link to public health services in India's villages. ASHA have a thorough understanding of the expected work and are the primary source of information and support for pregnancy-related services[3]. The NRHM's ASHA workers made significant contributions to expanding access to healthcare in rural and poor communities across India[4]. Financial constraints are one of the major barriers to healthcare for marginalized section of the society, including parturient women in many low income and middle income countries like India. Regardless of socioeconomic, demographic, or obstetric differences, women received more antenatal care, skilled delivery, and postnatal care from ASHA scheme. The fee-free policy benefits the economically disadvantaged population in particular, as it has been shown to increase their access to skilled care during pregnancy and delivery[5]. A cross-sectional research at PHC Sarojini Nagar in Lucknow discovered that 54.2% of newly born women assisted by ASHAs had three or more ANC visits Overall coverage for two TT injections was 98.8%[6]. A study conducted in three Karnataka districts found that ASHA were very functional in terms of providing prenatal and intranatal care services such as counselling assistance and escort service .At least 60% of women who reported an institutional delivery attributed it to ASHA motivation in their community[7]. Assam was one of the 18 states that launched the ASHA programme in 2006 to strengthen decentralized village and district-level health planning. Assam is making steady progress towards achieving the goals and objectives shared by the National Rural Mission, National Production Policy, and Millennium Development Goals. Assam has achieved 100% selection of ASHA against the target both in rural and urban area. Assam also achieved 100% training of ASHA against target. ASHA workers may play an important role in promoting prenatal care, increasing the link between ANC contacts and institutional delivery.

Objective

We conducted this study to ascertain the effectiveness of ASHA scheme to improve maternal healthcare. The main objectives of the study are to assess the knowledge of ASHA workers and evaluate their role in motivation of eligible couples for acceptance various Maternal and Child Health care services. Three outcomes on the use of maternal healthcare service were used to access the effect of maternal health status after introduction of ASHA scheme: Antenatal care, Facility based delivery and postnatal care. Antenatal care was defined as care that women obtained from their healthcare providers during pregnancy. Antenatal care was measured using two main variables: Antenatal visit and Antenatal prevention. Antenatal visit was classified into two categories: those who had four or more antenatal visit and those who had less than four. Antenatal prevention care was defined by two other variables: Receiving folic acid and receiving tetanus injection. Facility based delivery was coded as place of delivery - Government hospital, Private nursing home and Home. Again identify the use of cord care and skin to skin care to accelerate the adoption of healthy postnatal care practices.

Materials and Method

Women of reproductive age group were interviewed through a pre-tested questionnaire tool specially designed for this study. The

interview schedule had both quantitative and qualitative data which are close-ended. Household questionnaires were administered to 202 women of the reproductive age group. To reduce entry errors, data were entered into Microsoft Excel 2007 and exported to IBM Statistical Package for Social Sciences (SPSS) V.22. Binary logistic regression run to see how education, place of residence, employment affect follow ASHA instruction by pregnant women. The present study was conducted in Golaghat district (in 10 wards) in the State of Assam, India. The study primarily follows the descriptive research method.

Data Collection and Instruments

We designed a household questionnaire which was pretested. This was to ensure validity and reliability and to check ambiguities. With the pretest feedback, we reworded the questions to carry the intended meaning to ensure that they could be translated directly into the local language. We also arranged the questions orderly. The pretesting revealed weaknesses in the questionnaire, which were subsequently addressed before its application on the field. It also helped to reduce biases. Women were interviewed using a questionnaire comprising three main sections: The first section consists of demographic characteristics (age, education, employment and Place of residence). The second set of questions probed into whether they follow instruction given by ASHA, whereas the third section asked questions about access to and use of antenatal care service, place of delivery as well as postnatal care service.

Results

The use of ASHA services as a source of information and motivation for registration, as well as receiving free medicines from ASHAs, was significantly higher among women.

Table 1

Varriable	Frequency N=202(%)	Follow ASHA instruction N=113(%)	Donot follow ASHA instruction N=89(%)
Age			
15-23	64(31.7)	45(40)	19(21.3)
24-32	88(43.6)	56(50)	32(36)
33-49	50(24.8)	12(10.6)	38(43)
Place of residence			
Urban	95(47)	40(35.4)	55(62)
Rural	107(52.9)	73(64.6)	34(38.2)
Employment Status			
Unemployed	77(38.1)	51(45.1)	26(29.2)
Manual job	69(34.2)	47(41.5)	22(25)
Skilled job	47(23.3)	6(5.3)	41(46)
Education			
Primary	88(43.6)	76(67.3)	12(13.4)
Secondary	62(31)	27(24)	35(39.3)
Tertiary	52(25.7)	10(8.8)	42(47.2)

General characteristics of the population are shown in Table 1. About 202 women of reproductive age group (15–49) years were interviewed .More than 40% of the women are of age group 24-32. Out of the 202 women 56% women prefer to follow instruction provided by ASHA. Out of them 35% and 65% women reside in urban and rural area respectively .Most of them are unemployed and 47% frequently engaged in manual job, more often completed

primary and secondary education .On the other hand 43% women donot prefer to follow ASHA instruction. Most of them are highly educated and engaged in skilled job.

Table 2 : Logistic regression of Place of residence, education, employment versus following ASHA instruction.

Binary logistic regression

		B	S.E.	Wald	df	Sig.	Exp(B)	95% C.I.for EXP(B) Lower	Upper
Step 1[a]	Place of residence (rural vs urban)	-.952	.396	5.780	1	.016	.386	.178	.839
	Primary			35.911	2	<.001			
	Secondary	-3.011	.581	26.908	1	<.001	.049	.016	.154
	Tertiary	-3.938	.701	31.583	1	<.001	.019	.005	.077
	skilled			8.561	2	.014			
	Unemployed	1.210	.600	4.058	1	.044	.298	.092	.968
	Manual job	.397	.593	.448	1	.503	1.488	.465	4.758
	Constant	3.613	.751	23.169	1	<.001	37.082		

Table 2 shows the results of the binary logistic regression that examined the association between following ASHA instruction and place of residence, Education and Employment status. Women reside in urban area 0.386 times less likely to follow ASHA instruction .Again with the increase in education level preference for following ASHA instruction decline. Women who have completed tertiary education 0.019 times less likely to follow ASHA instruction .On the other hand unemployed women 0.289 times more likely to follow instruction provided by ASHA.

Reward is an inducement which stimulate one to act in a desired direction. ASHAs will be benefited with Incentive for motivating the Pregnant Women and facilitating Institutional Deliveries in the Govt. Health Institutions. Incentive will be up to Rs. 600 per case for Rural Institutional delivery and up to Rs. 400 per case for Urban Institutional delivery.

Table 3

Antenatal care visit	
1. > 4 visit	98 (86%)
2. < 4 visit	15 (13%)
3. Folic acid	110 (97%)
4. Tetanus	107 (94%)
Institutional Delivery	
1. Government Hospital	79 (69%)
2. Private Nursing Home	24 (21%)
3. Home	10(9%)

Introduction of ASHA scheme had made a dramatical improvement in maternal health care service in our study area. ASHA works at lower level through decentralization. They provide health education through household visits and community outreach activities, and are engaged in health promotion activities in their localities. As a result among the pregnant women who had followed ASHA instruction, antenatal visit stood up to 86%. The aim of antenatal care (ANC) is to identify and manage obstetric complications. Other services such as tetanus toxoid immunization and intermittent preventative treatment for malaria during pregnancy (IPTp) are administered during ANC visits .WHO guidelines on maternal and neonatal care suggested that pregnant women should receive at least four antenatal care (ANC) visits prior to delivery[8]. ANC also presents with the opportunity to promote institutional delivery and healthy practices such as breastfeeding, early postnatal care and birth spacing. ASHA also plays a pivotal role to increase institutional delivery upto 79% in government hospital and 24% in private hospital. Only a negligible (9%) portion of birth attain in home.

Post natal care

1**.** Cord care

Only 17 percent of all women reported that they did not apply anything on cord most of them are highly educated. Rest apply oil, mainly mustard oil on cord for faster healing irrespective of place of residence and place of delivery. One woman mentioned:

"We applied mustard oil on the cord stump to prevent infection ...if no mustard oil is put then the cord stump could get infected".

2. Skin-to-skin care (STSC)

The vast majority (91 percent) of all women (N=185) were not aware of STSC. Even when the STSC technique was explained to them, they said they were not aware of the method. The World Health Organization has recommended thermal control as one of the essential components of newborn care[9]. While thermal care is important for all newborns, it is especially critical for low birth-weight (LBW) or preterm infants as they are at risk of acquiring hypothermia, a potentially fatal condition where the newborn's normal body temperature falls below 36.5° C. Studies indicate that in home deliveries, the incidence of hypothermia is particularly high, ranging between 39- 49 percent[10, 11].

Women who did not go for postnatal checkup her husband, mother in law , even women herself argued that after birth baby and mother donot face any complications.

Conclusion

A socio-cultural preference for home-based childbirth and viewing childbirth as a natural

occurrence not needing professional assistance has been prevalent in India. This attitude was change after introduction of ASHA scheme. Literature supports that institutional birth rates, had sharply increased from 38% in 2005 to 74% in 2013 [12,13]. In the present study, ASHA was found to be the major facilitator for receipt of ANC services like early registration, three or more ANC visits, two TT injections and natal care by Recently Delivered Women.

The study shows that frontline health workers need further technical training to provide integrated counseling on all aspects of postnatal care .The most vulnerable period of a newborn`s life is the period during birth and the first week of life[17]. Some barriers to the adoption of healthy postnatal care practices are embedded in the cultural practices and the perception of impurity. Changing such behaviors is not only difficult, but also demands an understanding of the cultural context. ASHA also need training in counseling skills and should be provided counseling aids to make their counseling effective.

ASHAs have optimal knowledge of expected work and are the major source of information and support for pregnancy-related services. But still they fail to grasp the attention of the highly educated women so proper training is essential to enhance their efficiency.

Recommendation

Some of the suggestions which would effectively promote the participation of ASHAs in the reproductive health care at the community level are:

(i) ASHAs need to be given orientation training progamme from time to time and an integrated training programme of ASHAs along with other grassroots level health functionaries such as elected representatives of panchayati raj institutions and members of Community Based Organizations like Youth Clubs and Mahila Mandals will promote greater cooperation between ASHAs and the rural community at large.

(ii) Area based and community specific specialized training on need and importance of various family planning methods and HIV/AIDS is required for ASHAs.

(iii) Timely payment of remuneration will motivate them to put their effort regularly and sincerely in community services.

(iv) The grassroots level health functionaries i.e. Health Worker (male)and Health Workers (Female) need to consider ASHAs as their co-worker not as a temporary low paid village health volunteers and should give hands on training to ASHAs in various areas of maternal and child health care.

(v) Last not the least, there must be an activity mapping of various grassroots level functionaries i.e. Anganwadi workers, ANMs (Auxiliary Nurse and Midwife) and similar other grassroots level workers deployed by the government, private and nongovernmental agencies dealing with health care delivery services at the grass roots level, so that there would not be any replication of effort leading to wastage of resources.

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