Role of Accredited Social Health Activist (ASHA) in Promoting Health awareness in India

Nikunj P Trivedi

Associate professor, Department of English, School of Science, Jain (Deemed to be University), JC Road, Bangalore-560027

Email Id- t.nikunj@jainuniversity.ac.in

Dr. M.Sulagna Mohanty

Assistant Professor, School of Humanities & Social sciences, Block-II, Jain (Deemed-to-be) University, Jayanagar 9th Block, Bangalore

Email Id- m.sulagna@jainuniversity.ac.in

ABSTRACT: ***A flagship program was started by the Indian government in the year 2005 and this program is the accredited social Health worker activist (ASHA), under the umbrella of the national health rural mission (NHRM). More than 10 lakhs of the ASHA worker have been working in the different state of the India. Later, ASHA has emerged as the one of the most important initiative of the NHRM. A Woman in a community selected as the ASHA worker and trained accordingly to look after the improvement in the health status of the people in her own locality. Indian government focused on the institutionalisation of the delivery of the new born through the ASHA worker and introduce the ASHA activist as the key factor in the improvising the maternal health of the women. ASHAs work with the anganwadi workers some time to promote the health issues and motivate the people especially female about their common problems.***

KEYWORDS: Community health worker (CHW), Accredited social health activist (ASHA), Roles and responsibilities, Child birth.

INTRODUCTION

The identification of primary care as core factor for enhancing communal health has become popular among Community Health Workers (CHWs). CHWs are defined by the World Health Organizations as members of community, chosen by besides accountable to community for which they work, in addition to funded by the healthcare system, but less preparation than skilled health workers. While these features describe fundamental relations influencing the position of a CHW, depending on the program purpose, in terms of functions and obligations, recruitment, training and rewards, they vary within and throughout countries. The literature conceptualizes the CHW program through two distinct discussion sets: as program extension personnel and as community activists.

CHWs are integrated into the healthcare system as support extension staff to support physicians and nurses with tasks such as immunization and promotion of health. In this sense, because they are good at providing facilities to underserved communities, they are regarded 'another pair of hands' and they enhance the health system's ability to address financial in addition to human commodity famines in a poor environment. CHWs have conceptualized to strengthen the functionality between the current health community and the public as social and cultural middlemen. In this sense, their position should promote the participation of the community and involve taking the necessary steps to tackle the sociocultural obstacles that lead to negative health.

Health workers working in wealthy countries' close to zero communities or poor countries' community members show evidence of the contribution of CHWs to preventing serious disease risk, increasing immunization uptake, and encouraging good breast feeding practises. Epidemiological studies report that CHWs have indicated the ability to improve the use of antenatal, postnatal and postpartum services and to help stop prenatal and maternal deaths through earlier detection and referral of difficult pregnancy complications in low-income countries like Bangladesh, Brazil as well as Nepal) [1]. The deployment of CHWs has become a popular approach for the liberation of primary health care at the people stage due to these successes and growing acknowledgment of emergency in possessions for good health.

Many Southeast Asian Countries and Africa, particularly India, are preparing and introducing the CHW program to improve primary health care systems on a national scale. The perceptions of population health workers have been affected by many factors, including form in addition to consistency of management, degree of interactions with health systems, the availability of medications, the clarity of roles, funding trends and the quality of program organization. Educations have also shown that within these groups, CHWs who originate from the communities they represent higher levels of receipt [2]. Personality qualities and strengths such as interaction, inspiration, leadership and willingness to attract members of the group are also essential factors influencing CHWs' effectiveness.

As a significant driving factor for the continued involvement in the program, sufficient and suitable reimbursement for CHWs has emerged. In a production remuneration scheme, in order to obtain benefits, CHWs must facilitate the use of health facilities. However, negative group interactions with healthcare services may deter the use of medical care; it may restrict the motivation of CHWs to receive their rewards. There is an increasing form of literature focusing on practical aspects of practice of CHW program, such as capacity building, and positive monitoring and opportunities grounded on success. There are however, knowledge gaps as to the degree to which CHWs may be wellbeing advocates or managers of transformation, fostering community engagement and mobilization, which are critical features of health improvement and success.

This paper also presents a review in the North Indian state of the Government of India's Community Health Worker (CHW) program, the Certified Social Health Activist (ASHA) program, exploring the impact of institutional constraints on the progress of the CHW program. CHWs are lay people who, across a variety of initiatives, encourage wellbeing among their peers, from expanding healthcare services to mobilizing at-risk people or all members of the group to pursue preventive activities. At the 1978 World Health Assembly in Alma Ata, the CHW program earned recognition as a central component of the primary care agenda in the 30 years because (WHO) promoted greater community participation in health. These programs, however, it have had mixed outcomes and much continues to be learned about how effective CHW programs can be planned and managed.

Increasing our awareness of this program is especially relevant in view of the recent WHO recommendation that poor countries raise their CHW program numbers as part of an attempt to resolve the global shortage of health workers in developing countries. This shortage greatly impedes progress towards many health reforms, including the fight against HIV/AIDS in particular. Experience with the ASHA program will provide insights into how to generally help the CHW program, including those explicitly based on HIV. Usually, CHW programs are conceptualized in two ways. Second, in the current conventional biomedical health system, CHWs are seen as service extenders, assisting doctors and nurses with tasks such as measuring infants, operating immunization camps and disseminating expert-developed health messages..

This strategy values the CHW program for its potential to expand health care to underserved zones by filling employee deficiencies with relatively low-paying employees who are unlikely to move out of the country. Second, by acting as national intermediaries between current health system including indigenous residents and by functioning as agents of change, CHWs could be as playing a wider role in enlightening the health of a group. Cultural intermediaries are members of a system that promotes communication between lay people and healthcare providers in communities. This mediation aims to help close the divide between neighborhoods in addition to biomedical facilities that often struggle to address needs of marginalized individuals.

By empowering healthcare consumers to share opinions about the programs provided and by promoting ways to align medical care with conventional values and practices, CHWs could play a larger role as community mediators. As part of the reform, CHWs can be as essential to promoting the engagement, critical reflection as well as action required to recognize or work towards addressing challenges that contribute to inadequate health for people in the community. CHWs are also seen as fostering change through serving in community as an empowerment prototypical for others, mainly females, who constitute majority of CHWs.

DISCUSSION

1. *Contextual on India's Asha program*

ASHA program is a necessary element of aggressive National Rural Health Mission (NRHM) of the Government of India. A substantial upsurge in government spending on health, from 0.8% as GDP to 20.3%, is sponsored by the NRHM. The goal of the NRHM is to create an ASHA per 1,000 populations, and quarters a million of these healthcare professionals have already been educated [3]. The government defines the role of ASHA in different ways: ASHAs have to a main role to achieve objectives of national populace health policy. This position aligns with the earlier discussed service extension or other pair of hands conceptual framework. Second, they are seen as a bridge between citizens as well as health care outlets to nation. Third, they have to behave as part of the reform.

ASHA will be a public health activist who will raise knowledge of safety and its socioeconomic factors and mobilize the society to plan local function and enhance the use and responsibility of existing healthcare services. These two positions align with the second conceptual framework of CHWs as cultural intermediaries and wider agents of revolutionary reform discussed earlier. Whether actual fact lives up to this rhetoric by allowing ASHAs to perform the role of arbitration and advocacy instead of simply completing narrow, government-dictated duties will be essential to our evaluation of the achievement of the organization.

ASHAs are proposed to encourage females to catalogue childbirth and local health centers, companion people to principal health centre (PHC) as required, bring offspring to inoculation clinics, promote family development, particularly medical sterilization, first aid treatment of basic diseases and injuries, maintain demographic documents and improve neighborhood sanitation. ASHAs are intended to grasp knowledge meetings besides increase consciousness of the problem such as maternal issues, disease, wellbeing, nutrition as well as sanitation socioeconomic factors, as well as early adolescence and female reproductive health counselors.

2. *Roles and accountabilities of Asha worker*

ASHA will a public health leader who will raise knowledge of safety and its socioeconomic factors and organize the community to prepare for local health and to improve the use and transparency of current health facilities [4]. She will be a champion of good performs for wellbeing. She will have, as necessary and feasible for that class, a minimum therapeutic care package and made appropriate references. Her tasks and duties will be as follows:

- ASHA will undertake steps to raise knowledge as well as provide public information about health predictors such as education, clean water and hygienic practises, safe working circumstances, knowledge on current health facilities and need for family and personal care services to be used in a timely manner.
- She will advise mothers on antenatal care, the value of healthy delivery, nursing and supportive feeding, immunization, contraceptives and avoidance of severe diseases, including Genital Tract Infection/Sexually Transmission Disease and adolescent child care.
- ASHA will organise and enable the community to access education in addition health-related facilities available at township health centres, such as Vaccination, Ante Natal Check-up (ANC), ICDS, hygiene and government-supplied services.
- ASHA worker need to work in coordination with gram panchayat to work for the comprehensive health plan for the people of the village.
- ASHA worker work as an escort to pregnant women for the required treatment at nearest public health facilities.
- ASHA worker train to take care of the people with minor ailment like diarrhoea, fever etc and also provide the first aid to the needy people.

- ASHA worker also act as a supervisor for a depot holder with availability of the essential medication as oral rehydration therapy, iron tablets, chloroquine, oral pills etc.
- ASHA Worker also responsible for inform the authority for birth and death in the village apart from any usual outbreak of the diseases. ASHA worker also responsible for spread the awareness about construction of the toilets in the village for proper sanitation.

3. Integration of the Asha worker with Anganwadi worker

Anganwadi worker (AWW) and ASHA worker come together to organize the health day, where the local resident of a particular region such as adolescent girls, women and children motivate to mobilized toward the venue of the health day and get aware about the health related issues. The people have been given lecture on the topic such as nutrition importance, care of the pregnant women, personal hygiene, procedure and importance of the antenatal procedure, delivery of babies, and domestic remedies for the minor disease and way and duration of the immunizations [5].AWW worker helps to ASHA workers and also guide them to organize the health day at anganwadi centers, where the both the worker act as a catalyst to educate, and guide the people for the related issues.

Health activities can be carried out on these occasions through the showing of banners, traditional dance, etc to raise awareness of wellness issues among beneficiaries. The Anganwadi employee will be the drug kit depot holder and will issue it to ASHA. The substitution of the drugs absorbed can achieved through AWW. With the support of ASHA, AWW will review the number of qualified couples as well as the children under a year of maturity in the village. ASHA will help the AWW in mobilizing dietary supplementation for pregnant women and children. She will also take initiative to carry the village residents to Anganwadi Centers on particular days of immunization, health checks/health days, etc.

4. Limitation of the Asha worker

4.1.Limited based payment structure:

The compensation got by the government to the ASHA worker is a strong motivation factor for success of the initiative taken under the ASHA scheme. Many ASHA workers have this only way to earn the money as they don't have the other alternative to earn the extra income. The ASHA worker paid for bringing the people to the health center and helping them in the treatment. Unfortunately, a ASHA worker con not earn money for motivating the people about the health issues and even they are not paid for conducting the meeting with the people for various issues assigned to them as social changes etc. All the work to be assigned them is being discussed in the training sessions under NRHM policy.

The prevalence tradition in a village and the medical intervention in various diseases have a critical difference as the villagers have believed in the traditional way to fight disease and other thing like the delivery of a baby. ASHA worker has to do a lot of hard work in promoting the government supported scheme and facilitate the birth control as motivate the people for sterilization after two children and also motivate the people to come health center for delivery of their offspring as this is the only way to earn money. Otherwise, an ASHA worker has to perform his duty at net loss as they get only Rs 150/- as a compensation for completely immunization of female and they have paid out Rs 500 /- in transportation and all as expenditure.

4.2.Limited by poor institutional support:

A noticeable barrier in the services of the ASHA worker has seen in the form of the poor facilities provided at the level of the institution. Inadequate numbers of the staff create the problem in the procedure of the medical intervention as sometimes staff is not available to attend the patients [6]. The one more problem is associated with the non-availability of well-equipped instrument at public health center. The current facilities are not properly scattered within the locality and a needed person need to travel a lot for availing the facilities at the health center, moreover, these health center even does not have the basic medical procedure equipment such as blood test and transfusion ,even these health center does not have the proper delivery room and toilets. Transportation problem is also a main problem in the rural area for commutation of the patients.

ASHAs, maintain staff jobs besides earn remuneration, must strive to persuade people to be using local health center. They have a tough condition because it is not theoretically prepared to switch demands of the market for most amenities particularly deliveries including diseases needing something beyond most medications. Only after the health centre provides facilities superior to home treatment (i.e. when the centre is accessible and properly supplied with medication) does the statement that getting patients into the local clinic increases health product results hold true. The usefulness of captivating time, money in addition to liveliness to come to centre is nevertheless, all too often doubtful.

It has been observing that the poor facilities at the public health center keep away the people from availing the facilities. It is well known that the hospital is the system for the facilitate the people but what happen with the people if these health center does not equipped with the necessary equipment and basic medical testing kit [7]. These are the reason due to which people feel much safer at home rather than at hospital. In rural area , transportation is also a major problem because of the poor road and dedicated vehicle services attached with each health center and no one can guess that by the time vehicle would arrived at the point of need, the patient would survive or not. There are many occasion that a people got o public health center upon the advice of the ASHA worker and he does not find anything accept the shortage of the medical kit and medicine and even non availability of the staff.

4.3.Limited by rigid hierarchical construction of health system:

In the healthcare system, analysis and interviews exposed a hierarchy that reduces opportunities for effective contact through status, seniority and income brackets. The software has detrimental effects on this tensional stiffness and top-down control and knowledge flow. Sadly, much of it remains untapped because, because of the bureaucratic system through which they work, they are unable to relay useful knowledge to healthcare workers. For example, ASHAs has a complex understanding of why women chose not to fall pregnant in the hospital than many health practitioners, considering the offer of Rs. 1400 for health facilities to women.

The problems at the public health center are very much known by the people as they believe that there will be no benefit in going there as these public health centers are facing the problem of shortage of the medicine, and staff. A number of mothers-in law have decided that their daughters-in law will give birth to their baby at home as they feel home more safer than the public health facilities. Even many believe that conditions are not as hygienic at hospital in rural area as they can avail at their own house. Villagers have been still believed that local traditional birth attendant lady (dais) can handle the deliveries of the baby with more efficiently. If medical practitioner accesses these understandings they could build up protected birth surroundings that meet the requirements of women in addition to their family and address the substantial sensible concerns of the narrowed people. Sarcastically, these points go untouched since health practitioner limit the connections with ASHAs to guide them.

4.4.Limited by lack of participation at community level:

According to guideline of the National Rural Health Mission (NRHM), ASHA worker are continuously engaging in the task of the motivation of the people to avail the facilities at the public health centers and other scheme relating to the social planning [8]. The scope of the work has broadened up to the improvement of the village health. Many immunization camps organized in the rural area to motivate the people regarding personal health and social issues.

CONCLUSION

In meeting some economic objectives, the ASHA program has shown early success. Structural aspects of the program however have restricted ASHAs' ability to bridge gap for biomedical programs and communal needs and act as agents of change. In essence, this has decreased the ability of ASHAs to dramatically increase program priorities that are odds with municipal expectations. Poor health transport system can lead to disheartening care for those that are trying to participate in the healthcare system, leading to ASHA mistrust. In order to facilitate progressive reform, the compensation system does not provision cultural arbitration or

reward ASHA efforts. Instead of modifying and developing programs to make them attractive, the healthcare organization focuses on encouragement rural citizens to take up biomedical therapies, mostly by providing financial benefits. For time being, it seems improbable that NRHM will be intelligent to accomplish its objectives of introducing a CHW program that expands services to inhabitants while at the same time promoting greater community engagement and more generally, broad revolutionary reform.

REFERENCES

[1] A. Nyamathi, B. E. Salem, V. Meyer, K. K. Ganguly, S. Sinha, and P. Ramakrishnan, "Impact of an ASHA intervention on depressive symptoms among rural women living with AIDS in India: Comparison of the ASHA-Life and usual care program," *AIDS Education and Prevention*, 2012, doi: 10.1521/aeap.2012.24.3.280.

[2] A. Karasz, S. Raghavan, V. Patel, M. Zaman, L. Akhter, and M. Kabita, "ASHA: Using participatory methods to develop an asset-building mental health intervention for Bangladeshi immigrant women," *Progress in Community Health Partnerships: Research, Education, and Action*, 2015, doi: 10.1353/cpr.2015.0080.

[3] N. Bajpai and R. Dholakia, "Improving the Performance of Accredited Social Health Activist in India," *Working Papers Series*, 2011.

[4] A. Shrivastava and A. Srivastava, "Measuring communication competence and effectiveness of ASHAs (accredited social health activist) in their leadership role at rural settings of Uttar Pradesh (India)," *Leadership in Health Services*, 2016, doi: 10.1108/LHS-12-2014-0079.

[5] K. Scott and S. Shanker, "Tying their hands? Institutional obstacles to the success of the ASHA community health worker programme in rural north India," *AIDS Care - Psychological and Socio-Medical Aspects of AIDS/HIV*, 2010, doi: 10.1080/09540121.2010.507751.

[6] V. N. R. Das *et al.*, "Impact of ASHA Training on Active Case Detection of Visceral Leishmaniasis in Bihar, India," *PLoS Neglected Tropical Diseases*, 2014, doi: 10.1371/journal.pntd.0002774.

[7] A. Nyamathi, M. Ekstrand, B. E. Salem, S. Sinha, K. K. Ganguly, and B. Leake, "Impact of Asha Intervention on Stigma Among Rural Indian Women With AIDS," *Western Journal of Nursing Research*, 2013, doi: 10.1177/0193945913482050.

[8] K. J. Shashank, M. M. Angadi, K. A. Masali, P. Wajantri, S. Bhat, and A. P. Jose, "A study to evaluate working Profile of accredited social Health activist (ASHA) and to Assess their knowledge about Infant health care," *International Journal of Current Research and Review*, 2013.