ROLE OF ASHAS [ACCREDITED SOCIAL HEALTH ACTIVISTS] IN HEALTH CARE PRACTICES IN CHAKA BLOCK OF ALLAHABAD DISTRICT

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ABSTRACT

In order to provide effective health care to rural population, the National Rural Health Mission (NRHM) by government of India proposed introduction of female health workers at village level. These workers are called Accredited Social Health Activists (ASHAs) and their role is to act as an interface between the community and the government healthcare services. The ASHAs are trained to advise village about sanitation, hygiene, contraceptives, and immunization to provide primary medical care for diarrhoea, minor injuries, fevers and to escort patient to medical centres. The main role of ASHAs includes control of specific diseases and improvement of nutrition status of children and mothers. The study was undertaken with a view to ascertain the role of ASHAs on health care practices. The study was conducted in Chaka Block of Allahabad district. Fifty ASHAs and fifty beneficiaries (villagers) were selected by random sampling technique who were approached personally by investigation for collection of relevant data and facts. It is concluded from the study that ASHAs belonged to low socio economic status and they had knowledge regarding delivery of women but had less knowledge about child care. They had got training regarding their duties and responsibilities like innovative health care services and also attend meetings at block level monthly. Majority of the respondents were maintaining their common activity records, distributing drugs and providing counseling to villagers effectively. They also delivered "Directly Observed Treatment Shot" (DOTS) course for tuberculosis and oral rehydration solution, distribution of folic acid tablets and chloroquine to patients and alert authorities during unusual outbreaks. They face problems in their work like, lack of public awareness regarding the health services and hindrances in getting honorarium.

Key words : *ASHAs (50 SHAs and 50 beneficiaries), health care practices*

INTRODUCTION

Health is the level of functional or metabolic efficiency of a living being. In humans, it is the general condition of a person's mind and body, usually meaning to be free from illness, injury or pain (as in "good health" or "healthy"). The World Health Organization (WHO) defined health in its broader sense in 1946 as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. Systematic activities to prevent or cure health problems and to promote good health in humans are undertaken by health care providers. The term "healthy" is also widely used in the context of many types of non-living organizations and their impacts for the benefit of humans, such as in the sense of healthy communities, healthy cities or healthy environments. In addition to health care interventions and a person's surroundings, a number of other factors are known to influence the health status of individuals, including their background, lifestyle, and economic and social conditions; these are referred to as "determinants of health" **(World Health Organization, 2003)**. Health is an important determinant of a person's quality of life. So it is a subjective as well as an objective evaluation of the physical, mental and social status. Each year, millions of children and mothers could be saved through improved access to basic health interventions. Those who most desperately need them the rural poor live in remote villages where the cost of reaching them could be five times greater than urban areas. India lives in villages. Development of India depends heavily on transformation of rural areas. Since the dawn of independence, rapid strides have been made in the improvement of the quality and out of reach of health care services to the people. Therefore, improving quality of life of the rural people was taken up as a major task in various five year plans. There have been spectacular successes such as eradication of small pox, control of plague and a significant decline in the morbidity and mortality due to control of malaria, cholera, TB and several other communicable diseases. The continued efforts to this end have delivered goods significantly, yet the task ahead is upheaval and challenging. Health is the fundamental human right. State has the responsibility for the health of its citizens. Department of Health and Family Welfare is striving for the attainment of health for people through wide network of the government health care delivery system. Health care is more than 'medical care'. It embraces a multitude of the services provided to the individual or community by health personnel aiming at promotion, protection and restoration of the health. State is providing the integrated health services to its people through its primary health care network. Because of the existence of wide gap of health, presently health care is focused greatly on the rural areas.

METHOD AND MATERIALS

2.1 SELECTION OF THE LOCALE

Chaka block of Allahabad district was selected purposively due to nearness for the researcher to conduct her study as well as presence of good number of ASHA workers in the area.

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2.2 SAMPLING PROCEDURE

Research design : Descriptive research design was adopted for the study.

Selection of sample : Chaka block comprises of 49 villages. There were 160 ASHAs. The names of the ASHAs were arranged alphabetically then 50 ASHAs were selected through random sampling method, fifty beneficiaries (villagers) also were selected on first come first served basis. Therefore a total of hundred respondents (fifty ASHAs and fifty villagers) were selected for the present study. The respondents were selected on the basis of the following criteria:

- They should be residents of Allahabad only.
- They should be between the ages of 25-45 years.

2.3 Tools for Data Collection: For data collection, two pre-structured interview schedules were specially prepared keeping in view the objectives of the study. The interview schedule for respondents (ASHAs) contained closed and open ended questions. The interview schedule for the beneficiaries (villagers) contained only closed ended questions. Interview schedules were prepared in English and translated into Hindi to the respondents which were used to secure information systematically from the respondents. The schedule consisted of two parts-

1. Interview schedule (ASHAs) PART I- It was developed for collection of information about the socio-economic status of women which included respondent's (ASHA's) name, age, family size, family type, caste, religion, educational status, occupation, monthly family income, types of house, land holding, material possession, farm power, social participation of the respondents. For assessing Socio-economic status of the respondents modified scale developed by **Trivedi and Udai Pareek's (1964)** was used. PART II- It was designed to identify duties and responsibilities of respondents during the work. This part also included the problems faced by ASHAs in performing their duties.
2. Interview schedule (Villagers) PART I - It was developed for collection of information about the socio-economic status of women which included beneficiaries name, age, family size, family type, caste, religion, educational status, occupation, monthly family income, marital status. PART II- It was deigned to get specific information regarding beneficiaries.

2.4 Collection of Data : Personal interview technique was used to collect data for the present study. All the respondents (ASHAs and villagers) were interviewed at district level hospital due to the researchers convenience and to get the reliable data.

RESULTS AND DISCUSSION

This chapter deals with the result of the objectives which were set for the study. The result of the present study derived through the use of required methodology have been classified, tabulated and discussed.

3.1 Distribution of ASHAs according to their specific information

Table 3.1 shows that 52 per cent respondents reported that they had created awareness on health, family welfare services, basic sanitation and healthy living, 28 per cent respondents created awareness on health. About 12 per cent respondents reported that they had to create awareness on healthy living whereas 6 per cent reported that they had created awareness about sanitation and hygiene and also 2 per cent created awareness on family welfare services, respectively.

Table 3.1 : Distribution of respondents (ASHAs) according to creating awareness about selected issues

[N=50]

S. N.	Create awareness	Frequency	Percentage
1	Health	14	28.00
2	Family welfare services	01	02.00
3	Sanitation and hygiene	03	06.00
4	Healthy living	06	12.00
5	All of them	26	52.00
	Total	**50**	**100.00**

Table 3.2 : Distribution of the respondents according to working hours

[N=50]

S.N.	Working hours	Frequency	Percentage
1	2-4 hrs.	37	74.00
2	4-6 hrs.	11	22.00
3	6-8 hrs.	02	04.00
4	8-10 hrs.	-	-
	Total	**50**	**100.00**

The above table indicates the working hours of the respondents. It is clear from the above table that a large percentage of the respondents i.e. 74 per cent were working for 2-4 hours, 22 per cent of the respondents were working for 4-6 hours and 4 per cent respondents were working for 6-8 hours.

Table 3.3 : Income wise distribution of the respondents

[N=50]

S.N	Income (in Rs.)	Frequency	Percentage
1	Upto 500	02	04.00
2	500-1000	12	24.00
3	1000-1500	21	42.00
4	1500-2000	08	16.00
5	2000-2500	07	14.00
	Total	**50**	**100.00**

Under this study the maximum number (42 %) of respondents had a monthly income of Rs. 1000-1500, 24 per cent earned between Rs. of 500-1000 followed by 16 per cent who earned between Rs. 1500-2000, about 14 per cent of the respondents had income ranging from Rs. 2000-2500, 4 per cent had a monthly income of upto Rs. 500.

To find out the association between age and counseling provided by the respondents to the villagers, the chi- square test was done.

Calculated value = 10.666

The table value at 4 degree of freedom at 5% level of significance = 9.487

Significant

The calculated value of chi-square was 10.666 which was more than the table value chi-square i.e. 9.487 at 4 degree of freedom at 5% level of significance.

There was a positive association between age of ASHAs and counselling done by them of the villagers. Hence, it can be concluded that middle age respondents (ASHAs) counselled better than ASHAs of other age groups.

Table 3.4 : Distribution of the respondents according to counseling of villagers about health

[N=50]

S.N.	Category	Counseling						Total	Cal.	Tab.
	Age in years	Fully		Partially		None				
		F	%	F	%	F	%			
1	Young (18-30)	06	12.00	06	12.00	08	16.00	40.00	10.666	9.487
2	Middle (31-43)	15	30.00	06	12.00	06	12.00	54.00		
3	Old (44-56)	03	06.00	0	00.00	0	00.00	06.00		

Table 3.5 : Distribution of the respondents according to services provided to pregnant women

[N=50]

S.N.	Services provide	Frequency	Percentage
1	Health check up (PNC)	25	50.00
2	Vaccination	06	12.00
3	Information about nutritious diet	07	14.00
4	Drugs (minerals, vitamins etc.)	12	24.00
	Total	**50**	**100.00**

Table 4.22 shows that 50 per cent respondents reported that they had provided health check up (Pre Natal Care) for pregnant women during pregnancy. It also found 24 per cent reported that they also distributed drugs (minerals, vitamins etc.) to the pregnant women because they need extra nutrients. Fourteen per cent reported that they had provided information regarding nutritious diet and 12 per cent reported that they had provided vaccination (ANC) to the pregnant women.

Table 3.6 : Distribution of the respondents according to services provided to children

[N=50]

S.N.	Services provided	Frequency	Percentage
1	Education	-	-
2	Immunization	10	20.00
3	Health check up	36	72.00
4	Information about nutritious diet	04	08.00
	Total	**50**	**100.00**

It is evident from the above table that a large percentage of the respondents i.e. 72 per cent reported that they provide health check up for children whereas 20 per cent of the respondents reported that they provide immunization (i.e BCG, DPT, Polio etc.) for children and about 8 per cent of the respondents reported that they provide information regarding nutritious diet for children.

CONCLUSION

It is concluded from the study that ASHAs belonged to low socio economic status and they had knowledge regarding delivery of women but had less knowledge about child care. They had received training regarding their duties and responsibilities like innovative health care services and also attend meetings at block level monthly. Majority of the respondents were maintaining their common activity records, distribute drugs and provide counseling to villagers effectively. They also created awareness regarding health, basic sanitation, and family planning. They also deliver "Directly Observed Treatment Shot" (DOTS) course for tuberculosis and oral rehydration solution, distribution of folic acid tablets and chloroquine to patients and alert authorities to unusual outbreaks. They face problems regarding their work like, lack of public awareness regarding the health services and hindrances in getting honorarium.

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