

Role of Accredited Social Health Activists (ASHAs) in the Improvement of Health Status of Villagers under NRHM in Kolhapur District, Maharashtra

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Abstract

Context of Study: India's primary healthcare system is based on the Primary Health Centre (PHC) and these PHCs provide treatment free of cost. It is also found that despite significant improvements made in the past few decades, the public health challenges are not only so huge but are also growing and shifting at an unprecedented rate in India. Therefore the Indian government launched the National Rural Health Mission (NRHM) in 2005 to "address infirmities and problems across primary health care and bring about improvement in the health system and the health status of those who live in the rural areas. One of the core strategies proposed in this mission was to create a village level social activist, designated as ASHA for every village and she is expected to create awareness on health and its determinants, mobilize the community towards local health planning and increase utilization of the existing health services. During 2008 this scheme is implemented in the all districts of Maharashtra State. There are total 2773 ASHA are working in the Kolhapur district. To provide medical care to villagers their role is very important. Hence present study made an attempt to study the role of ASHAs in the improvement of health status of villagers in Kolhapur.

Objectives: The objectives of present study are to know socio-economic characteristics of ASHAs, to study the work done by ASHAs in the selected villages and to study the improvements in the rural health due to ASHA scheme.

Methodology: The study is based on primary and secondary source. Keeping in view the resources available in terms of time, money and the objectives of study, for the present study, out 2773 of 107 ASHAs were selected by using accidental / convenience sampling technique from total four villages of two talukas of Kolhapur district.

Conclusion: Due this scheme rate of institutional deliveries increase with the skillful help of ASHAs, malnutrition decreases and infant mortality also increases.

Keywords: Social health activists; India; Primary healthcare system; Primary health centre

Introduction

Provision for health should be considered a fundamental human right, and attainment of highest level of health is a most important social goal. National Rural Health Mission (2005-12) was launched in April 2005 by GOI [1]. Mission, seeks to provide effective healthcare to rural population, especially the vulnerable sections of the society through Inter-sectoral Convergence. Under National Rural Health Mission (NRHM) many innovations have been introduced in the states to deliver healthcare services in an effective manner. One of the core strategies proposed in this mission was to create a village level social activist, designated as ASHA for every village and she is expected to create awareness on health and its determinants, mobilize the community towards local health planning and increase utilization of the existing health services. To a large extent, the actualisation of the goal of NRHM depends on the functional efficiency of the ASHA as the grassroot health activist [2]. ASHA is trained community based link worker and acts as bridge between the Government functionaries and Tribal and Non-tribal population who find it difficult to access the

health services. ASHA is a first port of call for any health related demands of the community. ASHA is a health activist and she creates health awareness in community. ASHA is promoter of good health practices. Initially ASHA scheme is implemented in fifteen tribal dominated districts in Maharashtra State. During 2008 this scheme is implemented in the all districts of Maharashtra State. In Maharashtra State ASHAs are working in 15 Tribal and 31 Non-tribal districts. Compensation to ASHA is linked with her performance. Under NRHM 1419525 ASHAs were selected and 8242 were trained in Maharashtra.

In Kolhapur district there are total 73 Primary Health Centres, 413 sub-centres, 18 Rural Hospitals and 2 Sub-district Hospitals. To strengthen primary health centre and improve the health status of villagers under NRHM district health mission was implemented in Kolhapur district. Each village and each primary health centre of Kolhapur district has ASHAs. ASHA is the cornerstone of NRHM. District Health Mission is successfully implementing the ASHA scheme. Major improvements in the health status of villagers occurred due to ASHA. There are total 2773 ASHA are working in the Kolhapur district. To provide medical care to villagers their role is very important. Hence present study made an attempt to study the role of

ASHAs in improvement of health status of villagers in Kolhapur district.

The Objectives of the Study

The following are the specific objectives of the present study

- To know socio-economic characteristics of ASHAs.
- To study the work done by ASHAs in the selected villages.
- To study the improvements in the rural health due to ASHA scheme.

Methodology

The present study examines socio-economic characteristics of ASHAs, the work done by ASHAs in the selected villages and the improvements in the rural health due to ASHA scheme. The present study has been carried out only in four villages of two talukas i.e. Karveer and Bhudhargad of Kolhapur district in Maharashtra State to study the improvements in the rural health status due to ASHA scheme. Explorative cum descriptive type of research design was used for present research. The present study was based on the primary as well as secondary data. Universe of the present study was the total ASHAs in Kolhapur district and there were 2773 ASHAs working when study was conducted.

Sampling design

Selection of the villages:

ASHAs are working in the every village of Kolhapur district. List of talukas and villages were made available from Zilla Parisad. Kolhapur district has twelve talukas and total PHCs are 73 and total 2773 ASHAs are working in the district. Out of ten talukas, two talukas were purposefully selected. One is Karveer which one is developed and near to the city and other one is Bhudhargad which is far away from the city and socio-economically backward. From each talukas four villages were selected. From Karveer taluka Shirolu Dhumal and Uchagav, villages were selected and from taluka Madilage Budhruk and Minche Krudha were purposefully.

Selection of the respondents for the study:

There are 73 Primary Health Centres and total 2773 ASHAs are working in Kolhapur district. Due to time constrained only ASHAs linked with PHC of four villages from two talukas of Kolhapur district were selected. Keeping in view the resources available in terms of time, money and the objectives of study, for the present study, out 2773 of 107 ASHAs were selected by using accidental / convenience sampling technique. Shirolu Dhumal/Mayachi PHC has 41 ASHAs and Uchagaon has 53 PHC from Karveer taluka. From these two PHCs 39 and 19 ASHAs were selected. Minche PHC has 43 ASHAs and Madilege PHC has 30 ASHAs from Bhudhargad taluka. From these two PHCs 26 and 24 ASHAs were selected. Hence total number of selected respondents is 107. Care was taken that respondents should be ASHAs and they are belonging to Kolhapur district only. It is also taken into the consideration that all these ASHAs are presently working and linked with respective PHC. It was decided to conduct personal interviews of ASHAs only available at the time of the visit to their houses and in work place. Besides these respondents key informants such as the medical officers, staff members of PHC and villagers were also selected for getting relevant information by

conducting informal interviews. To study the role of ASHAs in the improvement in the health status of villagers the opinions of ASHAs were taken and they were put in the tables.

Data Analysis and Interpretation

In this present study data has been analyzed and interpreted and presents some of the findings regarding with work done and improvement in health status of villagers.

Section-I: Respondents socio-economic background

This section discussed the socio-economic background of selected samples. The socio-economic background of respondents is studied in terms of name of village, name of primary health centre where ASHAs are currently working, age, marital status, religion, caste, education, type of family, members of family, poverty, and annual income of family, monthly earnings of ASHAs, source of earnings and member of local organisations.

Name of village and primary health centrer: ASHA scheme is particularly implemented under NRHM to improve the health status of villagers particularly women and children and provide health care facilities of primary health centre to the villagers. Primary Health Centres are the corner stone of rural primary health care in India. These are the important workplace of social health activists. While studying the role of ASHAs in the improvement of health status of villagers it is essential to know the village and PHC of each ASHA (Table 1).

Village	Primary Health Centre	Frequency	Percent
Shirolu Dumala	Shirolu Dumala/Mayachi	38	35.5
Unchgao	Unchgao	19	17.8
Madilage Budruk	Madilge Budruk	24	22.4
Minche Khurd	Minche Khurd	26	24.3
Total		107	100.0

Table 1: Distribution of respondents by village and PHC.

Table 1 represents distribution of respondents by Village and PHC. By observing this it shows that out of total respondents majority of respondents i.e.38 (35%) are from primary health centre of Shirolu Dhumal.

Age: Age is one of the biological factors and plays an important role in the career of the individual (Table 2).

Age	Frequency	Percent
20 to 25 years	17	15.9
26 to 30 years	49	45.8
31 to 35 years	28	26.2
36 to 40 years	12	11.2
41 and above	1	0.9
Total	107	100.0

Table 2: Distribution of respondents by age.

Table 2 represents age-wise distribution of the respondents. By observing this shows that out of 107 respondents 17 (15.9%) belong to the age group of 20-25, 49(28%) belong to the age group of 26-30, 28(26.2%) belong to the age group 31-35, 12(11.20%) belong to the age group, 36-40 and 1(0.9%) belong to the age group 61 above. Majority of women are belonging to the age group of 26-40. This is because of NRHM guidelines and majority women prefer to work after marriage and children.

Marriage: Marriage is one of the basic institutions of Indian social life (Table 3).

Marital Status	Frequency	Percentage
Married	99	92.5
Unmarried	1	0.9
Widow	6	5.6
Divorcee	1	0.9
Total	107	100.0

Table 3: Distribution of respondents by marital status.

Table 3 represent distribution of the respondents by marital status. This table shows that out of 107 respondents 99 (92.5%) respondents are married and others are unmarried, widow and divorcee. We can conclude that majority of ASHAs are married.

Religion

Religion	Frequency	Percent
Hindu	102	95.5
Jain	1	0.9
Muslim	1	0.9
Buddha	3	2.7
Total	107	100.0

Table 4: Distribution of respondents by religion.

Table 4 represents religion-wise distribution of the respondents. This table shows that out of 107 respondents, 102 (95.5%) are Hindu, 1(.9%) are Jain, 1(.9%) is Muslim and 3(2.7%) is Buddha.

Caste: Caste is one of important trait of social stratification in Indian social system. In traditional Indian society occupation was based on caste. Particular caste can do particular business.

For example Brahmans teach only and Shudharas can do manual work only. But caste system is undergoing the tremendous changes.

Caste	Frequency	Percent
Mahar	12	11.2
Shimpi	1	0.9
Maratha	65	60.7
Sutar	3	2.8
Virshiav Lingayat	1	0.9

Gurav	6	5.6
Teli	1	0.9
Kumbhar	2	1.9
Bhat	2	1.9
Nathpanthi Davri Gosavi	1	0.9
Muslim	1	0.9
Lingayat Mali	1	0.9
Dhangar	1	0.9
Khatik	2	1.9
Nhavi	2	1.9
Mang	1	0.9
Parit	1	0.9
Nav-Bouddha	4	3.7
Total	107	100.0

Table 5: Distribution of respondents by caste.

Table 5 shows the caste-wise distribution of the respondents. Out of 107 respondents, 65(60%) are Marathas, 12(11.2%) are Mahar and remaining others are Lingayat, Simpi, Gurav, Teli, Muslim, Nhavi, Khatik, Parit, Kumbhar, Shimpi, Mang, Sutar and Dhangar.

By observing Table 5 that out of majority ASHAs are belonging to Maratha Castes. This is because Kolhapur district is dominated by Maratha Castes.

Caste-category:

Caste-Category	Frequency	Percent
Open	67	62.61
OBC	19	17.75
SC/ST	17	15.88
NT/DNT/VNT	04	3.7
Total	107	100

Table 6: Distribution of respondents by caste-category.

The caste-category wise distribution of the respondents is given in the Table 6. This table shows that out of 107 respondents, 67(62.61%) respondents are from open category, 19(17.75%) are from OBC category, 17(15.88%) respondents are from SC/ST category and four respondents i.e. 1(2%) is from NT community.

Education of respondents: Table 7 represents the distribution of respondents by education.

Out of 107 respondents, 49(45.8%) have education upto 10+2, 43(40.2%) have education upto secondary, 3(2.8%) have education upto post graduation, 11(10.3%) have education upto graduation and 1(.9%) have education upto primary.

Education	Frequency	Percent
Primary	1	0.9
Secondary	43	40.2
Higher Secondary 11th To 12th	49	45.8
Graduate	11	10.3
Post- Graduate	3	2.8
Total	107	100.0

Table 7: Distribution of respondents by education.

Respondents' monthly income:

Table 8 represent the monthly income-wise distribution of the respondents. Out of 107 respondents, 95(88.8%) are from the income group of 0-500, 10(9.3%) are from the income group of 501-1000, 1(0.9%) are from the income group of 1001-1500 and 1(0.9%) are from the income group of 1500 above.

Monthly Income	Frequency	Percent
0-500/-	95	88.8
501-1000/-	10	9.3

Annual Income	Frequency	Percent
Below 10,000/-RS.	5	4.7
10,000/- to 20,000/-	61	57.0
21,000/- to 30,000/-	26	24.3
31,000/- to 40,000/-	4	3.7
41,000/- to 50,000/-	4	3.7
51,000/- to 60,000/-	1	0.9
Above 60,000/-	6	5.6
Total	107	100.0

Table 10: Distribution of respondents by annual income.

Table 10 represents the annual income-wise distribution of the respondents. Out of 107 respondents, 61(57%) are from the income group of 10,000 to 20000, 26(24.3%) are from the income group of 21,000/- to 30,000/- and only one respondent is from the income group of 51,000/- to 60,000/.

Family: The importance of family as a social institution is widely known and perfectly established from the point of view of its content, structure as well as functions in all social systems. It plays an important role and influences the whole extent of social organization and culture (Waster Mark, 1939, pp: 19).

Family is the most basic and universal social institution. It is the foundation of the larger social structure. All other institutions depend on its contribution. Type of the family and number of family is given.

1001-1500/-	1	0.9
1500 above	1	0.9
Total	107	100.0

Table 8: Distribution of respondents by monthly income.

Source of Income:

Source of income	Frequency	Percent
Incentives given to ASHA	94	87.9
Any other	13	12.1
Total	107	100.0

Table 9: Distribution of respondents by source of income.

Table 9 represents the source of income. Out of 107 respondents, majority of respondents i.e. 94(87.9%) have only incentives given to ASHA as source of income.

Annual income of respondents:

Type of family: There are two types of families, one is joint family and another is nuclear family. Because of many factors joint families are disintegrating.

Type of Family	Frequency	Percent
Nuclear	62	57.9
Joint Family	45	42.1
Total	107	100.0

Table 11: Distribution of the respondents by the type of family.

Table 11 show the distribution of the respondents by the type of family. Out of 107 respondents, 62(57.9%) respondents have nuclear family, whereas 45(42.1%) have joint families.

Size of family: Table 12 show the distribution of the respondents by size of family. Out of 107 respondents, 53(49.5%) have 2 to 4 members

in their family, 17(34%) have 5 to 7 members in their family and 17 respondents have above 7 members in their family.

Members of Family	Frequency	Percent
2-4 Members	53	49.5
5-7 Members	37	34.6
Above 7 Members	17	15.9
Total	107	100.0

Table 12: Distribution of respondents by number of family members.

Poverty:

Poverty	Frequency	Percent
Below Poverty Line	49	45.8
Above Poverty Line	58	54.2
Total	107	100.0

Table 13: Distribution of respondents by poverty.

Table 13 shows the distribution of the respondents by poverty. Majority of respondents are from APL.

Membership of local oraganisation:

Member of Local oraganisation	Frequency	Percent
YES	5	4.7
NO	102	95.3
Total	107	100.0

Table 14: Distribution of respondents by membership of local oraganisation.

Table 14 shows the distribution of the respondents by membership of local organization. Majority of respondents i.e. (102(95.3%)) are not members of any local organization.

Name of organization:

Name of Oraganisation	Frequency	Percent
Not Applicable	102	95.3
Shivaji Nagari Path Sanstha	1	0.9
Shivneri Bhachat Gat Arye	1	0.9
Bhachat Gat Arye	1	0.9
Gurumauli Mahila Bhachat Gat	1	0.9
Bhairavnath High School	1	0.9
Total	107	100.0

Table 15: Name of organization.

Table 15 represents the names of local organizations and distribution of the respondents by membership of local organization. Majority of respondents i.e. 102(95.3%) are not members of any local organization and only four respondents are members of local organizations such as Self-Help-Groups, Co-operatives, High School etc. In this section the socio-economic characteristics of respondents are discussed. The socio-economic characteristics such as age, income, education, family type, poverty level and membership of local organizations are very important in defining the overall development of respondents. The socio-economic data concern with performance with performance of ASHAs was age, incentives given to them and residence of the ASHAs. ASHA is a promoter of good health practices. She is village level social activist.

Majority of ASHAs belongs to the age group of 26-40 and this age group ASHAs gave good performance. ASHAs' work is not salary based it is incentive based. If they have not shown any performance the incentives will not given to them in the form of cash. So they should show the performance every time. All the ASHAs were from their own villages either they daughters or daughter-in-laws. So they have their own towards their native. This will also its own effect on the performance.

Section-II: Work done by ASHAs

Work done by ASHA and Improvement health status of villagers for year 2011-12	Frequency	Percent
% of weighted new born baby and awareness programmes for Mother-Children		
No idea	74	69.2
1 TO 50%	13	12.1
51 TO 100%	20	18.7
% diarrhea children and ORS supply		
No idea	85	79.4
1 TO 50%	16	15.0
51 TO 100%	6	5.6
No of Institutional deliveries with the help of ASHAs		
No idea	39	36.4
1 TO 10	40	37.4
11 TO 20	17	15.9

21 TO 30	6	5.6
41 TO 50	1	0.9
51 TO ABOVE	4	3.7
% institutional deliveries		
No idea	25	23.4
1 TO 50%	16	15.0
51 TO 100%	66	61.7
% of immunized children age group of 12-23 months		
No idea	4	3.7
1 TO 10	4	3.7
11 TO 20	99	92.5
Supply of Contraceptive to BPL families		
No idea	29	27.1
1 TO 10	50	46.7
11 TO 20	8	7.5
21 TO 30	2	1.9
31 TO 40	1	0.9
51 TO ABOVE	17	15.9
Supply of Chloroquen to Malaria affected areas		
NO idea	95	88.8
1 TO 50%	5	4.7
51 TO 100%	7	6.5
Infant mortality rate		
Increased	1	0.9
Decreases	106	99.1
Malnutrition		
Decreased	107	100.0
Record of Leprosy and T.B. patients as compared to early year		
No idea	64	59.8
1 TO 10	42	39.3
41 TO 50	1	0.9

Table 16: Work done by ASHA and Improvement health status of villagers for year 2011-12.

Table 16 shows the work done and improvements in the health status of villagers. It is observed from the table that out of 107 respondents, 66 respondents from selected villages told that in selected four villages institutional deliveries increases from 51-100%, institutional deliveries also increased with skillful help of ASHAs, 99.1% of infant mortality decreases, 100% malnutrition decreases and immunization was done.

ASHAs are not well aware about the other roles and improvements were brought in this case.

Section-III: Improvement in health status of villagers

In this section particularly improvement in health status of villagers was assessed by taking some indicators such as rate of institutional delivery, infant mortality rate, health awareness programmes, rate of malnutrition, availability of health care facilities etc. Opinions of ASHAs from selected villages were taken and put in the form of following table and assessed.

	Frequency	Percent	No of Programmes	Frequency	Percent
YES	90	84.1	1 To 3 Programmes	60	56.1
NO	17	15.9	4 To 6	43	40.2
Total	107	100.0	7 and above	4	3.7

Table 17: Meetings/programmes related to health awareness conducted for villagers by ASHA.

Table 17 represents the meetings and programmes related to health awareness conducted for villagers by ASHA. Majority of ASHAs told that they conducted nearly 1 to 3 the meetings and programmes for villagers.

Table 18 shows various subjects of meeting and programmes. Out of 90 respondents 24 respondents told that they have idea. But other gave various subjects of meetings and programmes. Those who told that they have no idea about subject they also participate in the meetings passively.

Subjects	Frequency	Percent
Not applicable	17	15.9
No idea	24	22.42
Breast feeding, information about pregnancy, diet of malnourished children	3	2.8
Stribruhunhatya(female feticide)	3	2.8
About HIV	2	1.9
About Pulse Polio	17	15.9
Health problems of Teen agers and solutions	14	13.1
Meeting with girls(adult)	3	2.8
Pregnancy related issues	6	5.6
Meeting with of newly married women	2	1.9
Cleanliness of children	2	1.9
Rashtriya Sabha and Pulse Polio	3	2.8
About Save Girl Child	3	2.8
Health Programmes on National days- 15th August and 26th January	8	7.5
Total	107	100.0

Table 18: The subjects of meetings and programmes.

Type of medicines	Frequency	Percent
Not applicable	6	5.6
Paracetamol	13	12.1
Sepron	12	11.2
O.R.S	15	14.0
Fura	6	5.6
Nichaya kit	3	2.8
Unicough syrup	4	3.7
Cough syrup	2	1.9
Cold syrup	2	1.9
Dysentery	10	9.3
Albediazol	2	1.9
Contraceptives	1	0.9
Iron tabs	4	3.7
Acidity	1	0.9

Hemoglobin	3	2.8
Folic-acid	1	0.9
Vitamin- A	5	4.7
Coloroqueen	1	0.9
Worm killer	6	5.6
Vaccination to pregnant women	1	0.9
Citron	2	1.9
Mala D	3	2.8
Medicines to T.B.	4	3.7
Total	107	100.0

Table 19: Type of medicines provided by ASHAs to the villagers.

Table 19 shows type of medicines provided by ASHAs to the villagers. Mainly ASHAs provide general medicine, medicine to pregnant women and children, medicines of dangerous communicable diseases such as T.B., Malaria and immunization of children.

Village	Do you feel there is improvement in health of villagers?		Total
	YES	NO	
Shiroli Dhumal	36	2	38
	94.7%	5.3%	100.0%
	35.0%	50.0%	35.5%
	33.6%	1.9%	35.5%
Unchgao	19	0	19
	100.0%	0%	100.0%
	18.4%	0%	17.8%
	17.8%	0%	17.8%
Madilage Budruk	24	0	24
	100.0%	0%	100.0%
	23.3%	0%	22.4%
	22.4%	0%	22.4%
Minche Khurd	24	2	26
	92.3%	7.7%	100.0%
	23.3%	50.0%	24.3%
	23.3%	50.0%	24.3%
	22.4%	1.9%	24.3%
Total	103	4	107
	96.3%	3.7%	100.0%

	100.0%	100.0%	100.0%
	96.3%	3.7%	100.0%

Table 20: Opinion of ASHAs about improvement in health status of villagers

Table 20 represents the opinion of the ASHAs about the improvement in the health status of villagers of four selected villages. Out of 107 respondents 96% of respondents told that improvement in the health status of villagers occurred due to implementation of this scheme in the four selected villages. All ASHAs from Uchagao and Madilege Kurd told that improvement occurred in the health status of villagers due this scheme.

This improvement is mainly related the maternal and child health. From village Minche Khurd and Uchagao rate of institutional deliveries increased and from the village Shirolu Dhumal and Madilage Bhudhruk rate of malnutrition decreased. Overall in all villages

increase in keeping cleanliness and awareness about sanitation which is major preventive measure of diseases is increased.

This section deals improvements in the health status of villagers due to implementation of ASHA scheme. Majority of respondents told that improvement in the health status of villagers in-terms of maternal and child health was achieved through this scheme.

Table 21 shows the improvements in the health status of villagers. Major improvements are decrease in malnutrition, increase in institutional delivery, decrease in infant mortality rate and increase in the awareness about sanitation.

Villages	If Yes Which Improvements				Total
	Decrease in Malnutrition	Increase in Safe Deliveries in Institutions	Decrease in infant mortality rate	Increase the awareness about sanitation	
Shirolu Dumala	4	5	9	20	38
	10.5%	13.2%	23.7%	52.6%	100.0%
	19.0%	17.9%	45.0%	52.6%	35.5%
	3.7%	4.7%	8.4%	18.7%	35.5%
Unchagao	5	9	2	3	19
	26.3%	47.4%	10.5%	15.8%	100.0%
	23.8%	32.1%	10.0%	7.9%	17.8%
	4.7%	8.4%	1.9%	2.8%	17.8%
Madilge Budruk	6	5	6	7	24
	25.0%	20.8%	25.0%	29.2%	100.0%
	28.6%	17.9%	30.0%	18.4%	22.4%
	5.6%	4.7%	5.6%	6.5%	22.4%
Minche Khurd	6	9	3	8	26
	23.1%	34.6%	11.5%	30.8%	100.0%
	28.6%	32.1%	15.0%	21.1%	24.3%
	5.6%	8.4%	2.8%	7.5%	24.3%
Total	21	28	20	38	107
	19.6%	26.2%	18.7%	35.5%	100.0%
	100.0%	100.0%	100.0%	100.0%	100.0%
	19.6%	26.2%	18.7%	35.5%	100.0%

Table 21: Improvements.

Meetings and Programmes regarding malnutrition, health of pregnant women, infant mortality rate and sanitation awareness were

conducted by ASHAs. This section could conclude that due this scheme rate of institutional deliveries increase with the skillful help of

ASHAs. From all four selected villages villagers told to the ASHAs that due this scheme public health care facilities increases in rural areas where poverty is more and this only possible by the ASHAs.

Performance of ASHAs and improvement of health status of villagers is assessed by taking opinion of ASHAs. But by informal discussion with villagers, doctors and other staff of primary health centres. A doctor from sub-centre of primary health centre from Minche-Khurd a small village with 3000-4000 population and remote village told that due ASHAs recruitment and performance institutional level deliveries increases. Villagers were encouraged and co-operation was provided at all the levels by ASHAs.

Rural Health Mission aims at all improvements of Primary health centres. Because India has nearly 70% of rural population. To create awareness, to encourage the villagers to utilize the primary health services there is one communicator between primary health centre and villagers is need. So NRHM add the component of Accredited Social Health Activist. Rather than other components of NRHM, ASHA component works efficiently to achieve the goal of NRHM rather than socio-economic background of ASHAs.

Review of Literature

Many studies are also conducted in this case and these studies deal with roles, responsibilities, functions, incentives and assessment of ASHA scheme. Therefore some studies are taken for review for the present study in this concern.

Nirupam et al. working paper titled with 'Improving the Performance of Accredited Social Health Activists in India' addresses concerning issues around recruitment, responsibilities, training, incentives, and supervision of the ASHAs in Bihar, Chhattisgarh, Rajasthan, and UP and Assam [3]. The ASHAs represent the cornerstone of NRHM's strategy to address the millennium development goals (MDG) on health related indicators. As a result, this paper presents findings from data collected through written questionnaires and the selected states are regionally representative and are among the poorest and most populous states in the country. This study focuses on the importance of ASHAs performance and in order to maximize India's potential to achieve these goals through the NRHM, it is essential to investigate methods to improve ASHA performance, specifically through the processes of recruitment, training, supervision, provision of incentives and expansion to greater roles. This paper had also concluded that the ASHAs play a critical and effective role in bridging the gap between NRHM and the communities therefore it's important to keep the ASHA motivated to perform her duties efficiently and address issues related to provision of quality services to their communities.

Zakir paper title with 'Health of the National Rural Health Mission' is based on the findings of evaluation studies undertaken by the Planning Commission, the Ministry of Health and independent authorities [4]. These studies indicate that the situation in terms of quantitative goals and quality of service in many states leaves much to be desired. This study also has concluded that however, within this limited period, the NRHM has succeeded in putting back the issue of public health at the top of the government agenda. This has put the pressure on the state governments to divert resources to the health sector, thereby substantially strengthening the public health system, including its workforce. Although these achievements have fallen short of what was originally conceptualized, the investment has had a positive impact on several health indicators like immunization,

institutional deliveries and antenatal care. The review of this study also reveals that the service delivery capacity of the public health system had increased at each level. Outdoor patient visits had increased at all three levels (SC, PHC and CHC). The maximum improvement was found at the PHC level (129%) followed by an almost similar increase at the district and CHC level (86%). The main beneficiaries of indoor services at each level were invariably women followed by children and men, respectively. This study also reveals that NRHM did not adequately take into account the complexities of Indian rural societies, characterised by gender disparities, and divided on the lines of caste, micro-politics and economic class and the NRHM did not pay sufficient attention to the socio-cultural context in which the health system is situated and which ultimately determines the success of policies and measures, including decentralisation. This is perhaps the most important factor limiting the success of the NRHM.

Saraswathy et al. research paper title with 'Assessing Community Health Workers' Performance Motivation': a mixed-methods approach on India's Accredited Social Health Activists (ASHA) programme [5]. This study examined the performance motivation of community health workers and its determinants on India's Accredited Social Health Activist (ASHA) programme. This study is conducted in the state of Orissa and 386 CHWs were selected for the study. The major findings of the study is the CHWs are more motivated on the individual and community level factors than the health system determinants and the inadequate healthcare delivery status and certain working modalities reduced their motivation.

Lakheem research paper titled with 'Women at Work in Health Sector: A Space of Their Own, highlights the issue of empowerment of women through ASHA scheme and their space in workplace and household [6]. This study indicates that after joining as ASHAs their purchasing power in household increases which in-terms increase the decision making power in the family. The ability to leave the home alone increased the confidence. The status and support is given by the family to each ASHA.

The National Institute of Health and Family Welfare, in collaboration with the UNFPA, undertook rapid appraisal of various health interventions with the concurrence of Government of India under the "Rapid Appraisal of Health Interventions" (RAHI) project. The title of this project was Assessment of the Functioning of ASHAs under NRHM in Uttar Pradesh and chief investigator is Professor Nandan, Director National Institute of Health and Family Welfare and his study team [6]. Period of the research is 2007-08. These studies were conducted in five low performing states, namely Madhya Pradesh, Uttar Pradesh, Orissa, Jharkhand, and Chhattisgarh to understand the process of implementation of various programmes, schemes and innovations under the NRHM. This report is based on rapid appraisal of the ASHA Scheme under the NRHM in Uttar Pradesh, where a total 129,312 ASHAs were selected against a target of 134,643 and 116,470 were trained till the start of study. To assess the recruitment and training process of the ASHAs, acceptability of the ASHAs in the community, status of payment of compensation, and eventually to furnish a set of suggestions to programme managers for making the project more effective. The important findings of these studies are: The ASHAs' support in ANC services and immunization was significantly high in comparison to other services. The role of the ASHAs in institutional deliveries was appreciable. PRI members too were appreciative of ASHAs' presence in the village indicating acceptance of ASHAs in the community.

Mahalingashetty et al. paper title with 'Work-time analysis of ANM and ASHA: A Priority for Strengthening Health Systems' is an attempt to analyze the work burden and specific activities performed ASHA and ANM [7]. An investigation into the work burden of ASHA and ANM was undertaken. The objectives of the study were firstly to describe the distribution of daily activities conducted by ASHA and ANM and secondly to evaluate time spent on provision of maternal health services in relation to other duties. Author hypothesize that ASHA and ANM spend more time in provision of other health services than maternal health services. Two rural blocks within Lucknow district of Uttar Pradesh, a NRHM high-focus state, was selected for study. These two blocks are Mohanlalgunj and Mall. The selected blocks represent the highest and lowest health performing, respectively, in the district. Only those frontline health workers, including ASHA and ANM, belonging to Mall and Mohanlalgunj blocks were included to participate in the study. The findings of the study are ANM and ASHA are working after the observed time, for both ANM and ASHA and the nature of work includes multitasking thereby allowing for double counting of specific official activities.

Chandan paper title with 'Women's Empowerment in NRHM: A Case Study of ASHA' (Accredited Social Health Activist) gave details about Mrs. Asha Singal, a most prominent ASHA is really found an activist through her work efforts, performance, ethical and social activities. She was born on 20th October 1964 and belongs to small village, Murlabisoti. In 2007 she joined Gramin Vikas Trust and further came to know about the requirement of ASHA in NRHM from newspaper and TV. As ASHA she performs her duty 24 hours and 7 days duty and she would earn approximate Rs.1067 per month. She has taken a step forward for increments in the remuneration of ASHA and gathered with many activists at CM Office Jaipur on 14 March 2011. She commented that the monthly compensation to ASHA sahyogini is not satisfactory on the ground of working. This study indicates that strong and eminent ASHA can bring the changes in the village and angle for the villagers.

Alex paper on 'Incentives, women, and children: how the ASHA program can reduce child mortality in rural India, and how it might fail' made an attempt to the role of ASHA in preventing the child mortality [8]. The National Rural Health Mission (NRHM) drew on this literature in designing its own village health worker scheme. In this scheme, an accredited social health activist (ASHA), the equivalent of a VHW, is placed in each of India's villages in an attempt to scale-up these methods to address a set of highly prevalent and highly preventable diseases causing child mortality. This study also argues that the ASHA system is the best hope India has for reducing child mortality in rural areas, but there are several serious threats which could seriously compromise its potential. This paper suggests that if proper incentives are not paid to the ASHA and the health status of villagers will not improve.

The research study was conducted by Prof. Nandan chief investigator and study team of BRD Medical College, Gorakhpur on the topic 'A Study of Interface of ASHA with the Community and the Service Providers in Eastern Uttar Pradesh' [6]. Major findings of study are almost all the ASHAs are resident of local community and so a very effective link person in the delivery of health services and good health message. All the ASHAs have been given seven days induction training and in general ASHAs are satisfied and happy with the training. But their perception about their job responsibilities appeared to be incomplete and improper. Majority of them were not aware about their role in changing the behavior about infant feeding, family planning,

child marriage, girl education, hand-washing and sanitation. They were also not very much aware about their role in birth and death registration. Most important motivational factor for the ASHAs was the financial gain and hope of being absorbed in government job. Monetary gain in majority of cases was very little and to receive even this money sometime needed extra effort. There was a general demand from all stakeholders for a regular monthly payment of Rs. one thousand to each ASHA besides the job related incentives.

The study was conducted by Kanth et al. on the topic 'The contribution of Accredited Social Health Activist (ASHA) under National Rural Health Mission (NRHM) in the implementation of comprehensive Primary Health Care in East Champaran district, Bihar (State) India' [9]. The study findings show that the ASHAs' understanding about their roles and responsibilities is very limited. The recruitment, training and ongoing support to the ASHAs is inadequate for them to play a comprehensive role as conceived by the NRHM. The study also brings out the fact that even the other stakeholders like the ANM, Anganwadi worker, Village Mukhiya and Panchayat have not been educated about the role of the ASHAs. Village Health and Sanitation committees have not been formed in Bihar. So we see that the ASHA is hardly supported by other stakeholders in terms of participation and engagement of the community to the overall CPHC approach. Since there were a lot of shortcomings in the whole ASHA programme.

Bhatt study 'A Rapid Appraisal of Functioning of ASHA Under NRHM in Uttarakhand, India' [2] asserted that how efficient the ASHAs are to play their defined roles effectively, what are the problems they are facing and to further suggest measure for optimization of their working. In this study it was found that at many of the places the ASHAs had to cater a population more than the norm of 1000, compensation for ASHAs should be suitably increased. The irregularity in the area of supply of medicine kits should be investigated. Also capacity building training should be imparted to the ASHAs as they are unable to conduct meeting in the community.

The Vistaar Project was conducted during 2012 on the topic 'Performance-Based Payment System for ASHAs in India' by Wang et al. [10]. The study indicates that while the ASHA PBP scheme plays a critical role in improving health indicators in the target states, the system has certain weaknesses that could have a negative impact on the effectiveness and sustainability of the ASHA model. These include: delays in payment, lack of clarity on the payment process, lack of data on how incentives affect outcomes, neglect of services that are not covered by the PBP scheme, lack of transparency and adequate governance, competition with other providers, and lack of congruity between compensation and expectations.

Shrivastava et al. paper titled with 'Evaluation of trained Accredited Social Health Activist (ASHA)' was made an attempt to evaluate knowledge, attitudes and practices of ASHA workers in relation to child health [11]. A cross-sectional study was conducted at Palghar Taluka in the Thane district of Maharashtra for a period of 3 months from January 2011 to March 2011, inclusive, with the study participants all being trained ASHA workers working in the various primary health centres of Palghar Taluka. A total of 150 ASHA workers were working in the area, of which four workers were untrained and thus excluded from the study. The study argues that despite the training given to ASHAs, lacunae still exists in their knowledge regarding various aspects of child health morbidity. In the future training sessions, more emphasis should be given to high risk cases requiring prompt referral.

Mony et al. on 'Evaluation of ASHA programme in Karnataka under the National Rural Health Mission' explores the diversity within the ASHA programmes in different districts and overall within Karnataka [12]. The sampling design we adopted was a multi-stage sampling design proposed by the National Health Systems Resources Centre (NHSRC) for all states across India in order to enable comparisons. The major findings of this study are the ASHA workers perform tasks mostly as link workers and community health workers and to only a small extent as social activists. Within the domain of their link worker role, through their home visits to the households of community members they have contributed to improvements in the basic antenatal care and also in increasing the number of institutional deliveries and immunisation. We also found that there is inadequate coverage of marginalized households within villages and hamlets in rural and peri-urban Karnataka.

The present review of literature focuses on the roles, incentives, factors affecting and improvement in the health status of villagers. Therefore the present study has made an attempt to study the role of ASHAs to improve the health status and how efficient the ASHAs are to play their defined roles effectively.

Major Findings

- Majority of women are belonging to the age group of 26-40. This is because of NRHM guidelines and majority women prefer to work after marriage and children.
- Out of 107 respondents, 49(45.8%) have education upto 10+2.
- Out of 107 respondents, majority of respondents i.e. 94(87.9%) have only incentives given to ASHA as source of income.
- ASHAs are not well aware about the other roles and improvements were brought in this case.
- From village Minche Khurd and Uchagao rate of institutional deliveries increased and from the village Shirolu Dhumal and Madilage Bhudhrak rate of malnutrition decreased.

Conclusion

Implementation of ASHA scheme in NRHM in the primary health centres of Kolhapur district play an important role in providing the

health care facilities to the villagers. Due to this scheme villagers feel the public health care facilities increased and utilization is also increased. Due this scheme rate of institutional deliveries increase with the skillful help of ASHAs, malnutrition decreases and infant mortality also increases. Overall due this scheme improvement in the health status of villagers was occurred.

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