

CHAPTER- 10
MAJOR FINDINGS

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The analysis of the collected data has been presented in the chapter 6, 7, 8, 9 and the findings discussed accordingly. However to reflect the importance of the findings in a more orderly manner, the major findings of the study are provided in the following sections.

10.1 Job Profile of ASHA workers

10.1.1 The study of job profile of ASHAs was not satisfactory. More than half (55.6%) of ASHAs were selected on the basis of recommendation which was often influenced by personal biases of members of Gram Panchayat, and the stated criteria and qualification as per NRHM guideline were often overlooked while recommending ASHAs for appointment.

10.1.2 Majority of ASHAs (99.3%) accompanied pregnant women for antenatal checkup, 97.2% ASHAs navigated their clients and organized awareness camps. Only 60.4% of ASHAs took part in village health sanitation programme. Whereas formation of Village Health Sanitation Committee in the village and work related to construction of toilet, arrangement of clean and safe drinking water are also mandatory works for ASHAs as per NRHM guideline. Findings revealed that all the villages did not have VHNC and some villages only had existence of VHSC but it was not functioning properly. Hence ASHAs were not performing their assigned responsibilities regarding sanitation and hygiene.

10.1.3 All the ASHAs (100%) dealt with maternal health and child health where as 27.8% ASHAs dealt with adolescence health and only 18.8% of ASHAs worked to improve health literacy. Findings indicated that mostly ASHAs involved themselves in incentives-based activities. They worked more for monetary benefits and other assigned task remains ignored.

10.1.4 Majority of ASHAs (70%) responded that they were not getting their payment on time thus they are dissatisfied regarding their payment for work.

10.1.2 Socio Economic Status of ASHAs

10.2.1 Socio economic status of ASHAs in the study area reveals that 75.6% ASHAs lie in lower middle class, 13.3 lie in lower class, and remaining 11.1% lie in middle class group.

The socio economic status of ASHAs in the study area was studied with reference to different demographic variables such as age, educational qualification, marital status, caste, occupation, landholding, family structure, material possession and organizational involvement. The analysis of data reveals that majority of the ASHAs (73%) belonged to the 15-25 years age category, 95.7% were married, and 47% were from middle income group. 97% ASHAs had formal education and were capable of acquiring technical information easily. Further 3% of ASHAs were identified as illiterate but NRHM guideline recommends that ASHA should be literate with formal education up to class VIII. Thus it indicated a gap in selection of ASHA workers.

10.3 Association of ASHA workers socio economic status with their demographic profile.

It was tried to find out whether SES of respondent is dependent on their demographic profile. The result of one way ANOVA indicate that with the increase of age, SES of respondents also increases. Similarly with the increase of educational level and organizational involvement SES scores of ASHAs also increases. It may be assumed that higher qualification helps ASHAs to understand health issues in a scientific and a broader prospect and they would be able to transmit health related messages more confidently in a very convincing manner. Further organizational involvement provides exposure to the ASHA workers and they got opportunity to interact and share their views with people in groups.

10.4 Socio economic status of beneficiaries dealt by ASHA workers

Similarly socioeconomic status of beneficiaries dealt by ASHAs was studied. The findings reveal that majority of beneficiaries (42%) belonged to lower middle class, 27% belonged to lower class where as 22.4% were middle class. Remaining 18.6 belonged to upper middle class. Findings indicated that majority of respondents living in the villages were not aware about the role of health workers, health facilities and other related aspects. Due to their lack of awareness they mostly could not avail required treatment even at the time of emergency..

10.5 Approaches and interventions used by ASHA workers to fulfill their objectives.

Home visit, counseling, meetings, organizing awareness camp, vaccination camp, nutrition day, village health and sanitation day, distribution of leaflet and folder, street play, skits and drama are considered as institutional approaches being instructed to ASHAs in order to transmit health messages to their target segment.

10.5.1 Institutional approaches adopted by ASHAs

Home visit method was most commonly used by ASHA workers of the three districts. Majority of ASHAs of the study areas always conducted vaccination camps and provided counseling. 80% ASHAs from Sonitpur district and 89% ASHAs from Sivsagar district conducted meetings very often, whereas ASHAs of Nagaon districts rarely conducted meetings. Village health sanitation day was arranged sometimes by ASHAs in the study area.

10.5.2 Unique approaches adopted by ASHAs at the district level

ASHAs of Sonitpur and Sivsagar districts used group discussion method very often whereas ASHAs of Nagaon district were not using group discussion method. This approach provides opportunity to ASHAs to know satisfaction and dissatisfaction and expectation of beneficiaries. On the other the community becomes aware of constraints faced by ASHAs in conducting their job.

To make ASHAs' visits to their clients more effective ASHAs of Sivsagar and Nagaon districts conducted visits in the work place of their target segments to monitor their self-care behaviour, medication and for a better follow up. This method was introduced to ASHAs of Nagaon and Sivsagar districts by their health officials. This intervention helped ASHAs to provide social support, give their care to the families and enabled ASHAs to maintain frequent contacts with their clients.

10.5.3 Unique Approaches adopted by ASHAs at the block level

At Jakhlabondha block ASHAs arranged demonstration education and counseling for mothers on clinical nutrition and infant care with the support of health officials at primary health centres. It helped ASHAs to further advocate and clarify good care practices to the beneficiaries.

Biswanath Charali and Pithakhuwa health development of Sonitpur district conducted baby shows with the help of ASHA workers. Children from 0-5 years of age are considered for the shows and they are grouped into two categories on the basis of their age. Children were measured height and weight. The judges of the show check their vaccination cards and discuss with parents about rearing of children in a healthy environment. On the basis of children health and hygienic state they are ranked, and the best are awarded prizes. This approach helps parents to understand the importance of complete immunization and motivate them to take best care of their children.

10.5.4 Unique approaches adopted by ASHAs at the Village level

ASHAs of Puronigudam grampanchayat under Samuguri health development block of Nagaon district developed songs and poems on health issues which helped them to create awareness among illiterate people and children. It also enhanced, ASHAs creativity and communication skills. ASHA workers used this method to express their knowledge that they had gained about health to teach and inform members of their community in an informal and entertaining manner.

ASHAs of Amlapati Gram Panchayat of Gaurisagar health development block of Sivsagar district arranged games and drawing competition with the support of School authority among the children during school vacations on topics like good health, sanitation and small family concept, healthy environment etc. They also discussed about different health issues and benefits of Yoga in day to day life which created awareness among children about healthy practices and motivated them towards healthy adolescence.

10.6 knowledge of ASHAs in different aspects of health related issues

Knowledge of ASHAs was assessed considering five different aspects of health issues such as their knowledge of the community, maternal health, children health, sanitation and hygiene and food and nutrition.

As per NRHM guideline ASHAs must have high level of knowledge in the above mentioned aspects. The study found that ASHA workers of the study area had high level of knowledge regarding their community and maternal health. They had medium level of

knowledge in the aspects of child health, sanitation and hygiene and in the aspects of food and nutrition. Findings indicated that ASHA workers' knowledge of different aspects of health is less than what is desirable for carrying out their work.

10.7 Significant difference in knowledge of ASHAs on different aspects of health issues and selected demographic variables

One way ANOVA results shows that there was a significant difference between mean scores of ASHAs' knowledge and mean scores of their age, educational level and organizational involvement. It implies that knowledge level is increasing with the increase of age of ASHAs.

10.8 Core skills needed by ASHA to perform their task effectively

Communication skill, interpersonal skill, organization skill, advocacy skill, coordination skill, teaching skill was studied in order to find out effectiveness of ASHAs in performing their task. The study found that ASHAs had complete mastery over communication skills, interpersonal skills and organizational skills. They had some skills in coordination but had very little skills in advocacy and teaching their community. Regarding overall skills of ASHAs it was found that majority (49.9%) had some skills, they are not masters in all the skills which are needed by them to perform their task effectively. The lacuna in their skills may be due to the inappropriate and incomplete training provided to them.

10.9 Significance difference in skills of ASHAs with their knowledge and previous work experience

The result of the test revealed that there is no significant difference between skills and knowledge of ASHAs, and skills with their previous work experiences.

10.10 Attitude of ASHAs towards their work and their relation with selected demographic variable.

Majority of ASHAs (78.6%) had positive attitude towards their work. Further one way ANOVA result shows that there is no significant difference in the attitude of ASHAs across the age groups, educational level, organizational membership and their social category.

10.11 Institutional training imparted to ASHA workers

The guideline of NRHM recommended orientation training, on the job training and off the job training for ASHA workers at least for 23 days on the areas like- preventive health and record keeping, maternal health, child health, adolescence health and awareness, referral and first aid, food and nutrition and sanitation and hygiene etc. .The guideline also recommend refreshers training for every year.

Study found that only 32.6% ASHAs received 23 days training and majority of ASHAs received training less than the required amount. It implies that all ASHAs in the study area received inappropriate and incomplete training. Refreshers trainings rarely happen. Training are mainly provided in the area of maternal and child health. Other areas remain overlooked. Hence it is difficult to expect their performance to be optimal and it impacts their competency. Study found a gap regarding the training of ASHAs.

10.12 Significant difference between training of ASHAs with their knowledge, skills and attitude

A one way ANOVA result shows that there is a significant difference in the mean scores of knowledge and attitude of ASHAs across the duration of training. It implies that training enhances the knowledge and attitude of ASHAs but training was found significantly not related with skills. This may be due to the inadequate and incomplete training provided to them. Therefore reorientation training should be conducted to understand the problems they are facing and to improve their competency in order to get effective outcomes.

10.13 Motivational levels of ASHA workers

Majority of ASHAs feel that their work is challenging but they enjoy doing it to a large extent. Positive health outcomes of their community and the recognition they are getting for their work motivated them to a large extent to continue their work. Regarding satisfaction of ASHAs with intrinsic and extrinsic rewards, the study found that they are not satisfied with the extrinsic rewards provided to them like accessories, certificate and felicitation and with the honarium provided to them for their performance. They will be more satisfied if they are provided with a

fixed remuneration and better incentives. It indicated that ASHA workers are self-motivated and want to continue their work for their community.

10.14 Problems faced by ASHAs during their work

The study highlighted the most important problem faced by ASHA workers in the study area was non availability of funds due to which they cannot assist the beneficiaries in getting access to the financial provisions under different schemes. Secondly they are heavily work loaded. They have to take care of many health issues due to which their performance suffers. Thirdly the most common problem that they faced is the lack of adequate training. They mentioned about their need for the training. They sometimes faced transportation problems especially for taking the expectant mothers to the hospital at night and they have to take the patient to hospital at their own expenses.

10.15 Feedback on ASHAs performance

Beneficiaries, community representative and institutional feedback were considered in order to find effectiveness of ASHAs performance.

10.15.1 Beneficiaries feedback

88% beneficiaries in the study area heard about NRHM or they knew about ASHA workers. 55% beneficiaries knew that ASHA provides medicine free of cost. 52% beneficiaries were aware of ASHAs holding discussion about hand washing and only 38.2% beneficiaries had information on ASHAs discussion about construction of household toilets. Majority of the beneficiaries (87.8%) had no idea about village health and sanitation committee and they never heard about it. Regarding institutional delivery 93% beneficiaries were aware about its benefits and they were informed about Janani Suraksha Yojana (JSY) in details. All the beneficiaries admitted that ASHAs always accompanied pregnant women for ANC/PNC. The findings indicated that ASHAs are fully engaged in providing all the information regarding the JSY schemes to their clients but majority of the beneficiaries were not informed about sanitation and hygiene and about village health and sanitation committee. It led many of the beneficiaries to think that ASHAs are mainly dealing with the activities related to maternal and child health.

Regarding relationship of beneficiaries with ASHAs, findings indicated that majority of beneficiaries (54 %) have positive relationship with ASHAs to a large extent. 57% responded that they are friendly and disciplined to a large extent. 58% beneficiaries were satisfied with the activities and outcomes of ASHA's work. It indicated that 46% beneficiaries expected more service and improvement in their performance.

10.15.2 Community representative feedback

Community representative of the study area reported that they were aware of ASHAs availability and working in the community. 92% community representatives were aware of the benefits extended to the women who registered under JSY scheme. Majority of the respondents (54%) were not involved in conducting village health planning and only 58.8% responded in the affirmative regarding existence of village health sanitation committee. It showed that ASHAs in every village of all the districts are not supported by the members of GP in terms of participation and engagement of community. Further, they are not involved in supervising the ASHAs activities. Moreover, the community representatives expressed about non-availability of funds on time which effect functioning of ASHAs activities and performance.

10.15.3 Health official's feedback

Findings show that health officials have good relation with ASHAs. 53% health officials stated that ASHAs do home visits to some extent but is not regular. Health officials also revealed their satisfaction to some extent on ASHAs' performance. On the ground of monetary benefits ASHAs made all the efforts to take pregnant women to health institution for deliveries and increased immunization coverage, but other activities were being ignored.

9.15.4 Comparative analysis

To find out the performance of ASHA workers and the outcomes of their activities in the three districts, a comparative analysis was carried out among the ASHAs. Comparative analysis was done in regards to ASHAs knowledge, skills, attitude, motivation, satisfaction and training imparted, and changes in the health outcomes in the three districts.

Finding shows that ASHA workers of Sivsagar district had high level of knowledge whereas the ASHAs of Sonitpur and Nagaon district had medium level of knowledge. In regards

to their attitude ASHAs in the study areas had positive attitude towards their work. Regarding skills ASHAs of Sivsagar district were more skilled in carrying out their roles and responsibilities and were more capable of convincing their communities to adapt healthy practices as compared to ASHAs of Nagaon and Sonitpur districts.

Study reveals that 35% of ASHAs in Sivsagar district, 41% in Nagaon district and 37% in Sonitpur district were receiving less than the prescribed 23 days training. As a result ASHAs were not receiving required knowledge and skills needed to perform their task effectively. With regards to their motivation 75% ASHAs from Sivsagar district, 72% from Sonitpur district and 68% from Nagaon district felt their work is challenging as well as novel to a large extent. 88% ASHAs from Sivsagar district, 87% from Sonitpur and 83% from Nagaon district enjoyed their work as ASHA to a large extent. Findings indicated that ASHAs of Sivsagar district was more motivated followed by ASHAs of Sonitpur district and Sivsagar district respectively. With regards to their satisfaction it was found that ASHA workers of the three districts were satisfied with the intrinsic reward whereas dissatisfied with extrinsic rewards that they were getting for their work. ASHAs of three districts expressed that the financial incentives which they were receiving for their work was very nominal. They demanded that the monthly payment for their work should be made timely as the payment was always delayed. A positive outcome in the health indicators is observed under those areas in which ASHAs are mainly performed task.

Conclusion

Feedbacks of beneficiaries, community representative and health officials have been discussed in this chapter. The findings clearly show that the beneficiaries, community representatives and health officials are satisfied with the work of ASHA. But the involvement and monitoring of ASHAs performance by Village Health Committee is not regular and the VHSC is not formed in many villages. Further a comparative analysis of ASHAs competency, training imparted, motivational level and outcomes of the activities dealt by ASHAs among the three districts carried out. The findings indicated that ASHAs of Sivsagar district is more competent as compared to other two districts, followed by ASHAs of Sonitpur district and Nagaon district respectively.

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