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STATUS, CHALLENGES, AND OPPORTUNITIES AMONG ASHA'S IN PAURI DISTRICT IN UTTARAKHAND

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Abstract
ASHA, the grass root level specialist is an extension among populace and wellbeing (Healthcare system). The objective of this work is to determine the difficulties and obstacles looked by ASHA during their hands on work in rustic area of region Pauri district in Uttarakhand. The cross-sectional study took place in the Bahadarbad block of Haridwar district. ASHA workers with more than six months of active field experience prior to the survey start date were included. Interviews were conducted in person using a pre-structured, pretested checklist. Verbal assent was collected both from ASHA's and recipients. At the hour of the review of every one of the 133 ASHA's were enlisted in the block Bahadarbad block and subsequent to applying consideration and prohibition rules, 28 ASHA's were seen as qualified for the review. Data resulted that many ASHA's are dissatisfied by their incentives and were interested in learning more skills in the health field.50% of the ASHA's in our study sample scored under 48 % in their understanding evaluation. Different bury related factors influences work execution of ASHA's in field. Monetary impetuses, self-identity and working for society were inspiration for joining this calling. In any case, deferred and deficient instalment, overburden of work, unfortunate vehicle, and struggle among ICDS and Wellbeing staff were normal difficulties. Additionally, the fundamental information to play out their responsibilities actually requires more hands-on training with regular Monitoring and supervision.
Key words: ASHA, Challenges, Work Performance, Fieldwork, Health Workers.

INTRODUCTION

The Key objective for strengthening the healthcare delivery system with a focus on the needs of the impoverished and sensitive rural populations is the goal of the National Rural Health Mission (NRHM). Finding one ASHA (Accredited Social Health Activist) every 1000/500 people in rural areas is one of the mission's primary beliefs in order to help the community get access to public health services. She is intended to boost use of the current health services, raise community understanding of local health planning, and raise awareness of health and its determinants. "In order to address the Millennium Development Goals (MDG) on health-related indicators, the NRHM's approach is built around the ASHA's (Welfare MoHF 2022). In India, a significant number of family members receive advice from Female Health Workers (FHWs), who are also tasked with treating specific disorders. To enhance India's chances of achieving these objectives through the NRHM, it is crucial to research ways to increase ASHA performance, particularly through the procedure of hiring, training, monitoring, giving out rewards, and expanding into bigger responsibilities.[1,2,3]

The Alma Ata Declaration of 1978 emphasised the value of Primary Health Care and the crucial role Community Health Workers (CHWs) play in connecting communities to the health system.[4] The idea of using local residents to provide some basic health services to their communities has been around for at least 50 years. Numerous projects, from large-scale, national programmes to community-based initiatives, have had experiences around the world.[5] We now understand that CHWs may play a significant part in expanding access to cover the healthcare services in rural regions and can adopt initiatives that result in better health. CHW projects require thorough planning, reliable funding, strong government leadership, and community participation to be effective on a big scale. CHWs require consistent training, oversight, and trustworthy logistical support to complete their responsibilities successfully. The potential of community health workers (CHWs) to provide basic healthcare to marginalised populations must be fully realised.[6]

The National Rural Health Mission (NRHM), which is a crucial project of the federal government to carry out its promise of inclusive growth, is at its core because of the Accredited Social Health Activist (ASHA) model.[2] Therefore, the effectiveness of ASHA's is essential to the success of NRHM and, by extension, the inclusive growth policy of the Indian government. The government's main initiative for achieving the millennium development goals for health, such as reducing the infant and maternal mortality rates, controlling certain diseases, and improving children's and mothers' nutritional condition, is known as NRHM. Since its introduction in 2005 in India's 18 high-focus states, NRHM has been enlarging its geographic reach.[7,8] There have been several mid-term evaluations of NRHM, with the most recent one being completed by the current staff (2009). The purpose of this article is to identify and recommend low- to average-term improvements to ASHA performance in India under NRHM.[9,16]

In Uttarakhand, the ASHA program under the National Health Mission[8] has been implemented through the State and the District ASHA Resource Centres across the State (SARC &

DARC). Rural Development Institute lead the overall program as State ASHA Resource Centre and provided continuous support to all 13 DRACs for ensuring quality and timely delivery of complete training programs to all 11000 ASHA's across the state. From 2007-2013, RDI developed a core group of trainers at the district level which has conducted all training at sub-block, block, and district levels under the leadership of District ASHA Resource Centres in their respective districts. All the resource materials and state trainers were trained by National Health Resource Centre (NHRC).[3] The state trainers were group of professionals and officials from the government, SARC, and other NGOs.

The various evaluations and feedback indicated that it was a unique style of project where everyone received appreciation at all levels for the implementation of a large-scale project very effectively. However, there are certain concerns, issues, and challenges that affect the expected outcomes from the project across the state.[7] The study was focused on the current status of knowledge, adaptation of new skills, and changes in community practices. It also looks at the broader framework of implementation processes and analyze the satisfaction level of both grassroots providers and clients.[10,11,12] The observation study also evaluated the level of coordination and networking within the project and with other departments outside the project. This investigation's goal is to explore and assess alternatives, not to call into doubt the use of ASHA's in rural settings. We feel that focusing on enhancing ASHA performance is not only smart but also the most realistic and useful course of action given the current situation. Thus, the present article analyses the entire issue in terms of the provisions that are currently in place and those that might be implemented in Uttarakhand for the retention, education, and performance of ASHA's[13,14,15,16].

MATERIAL AND METHODS

This cross-sectional study took place in the Bahadarbad Block of Haridwar district. ASHA workers with at least six months of prior field experience were included. Face-to-face interviews were conducted utilizing a pre-structured, pretested checklist. Verbal consent was obtained from both ASHA workers and beneficiaries. Initially, all 133 ASHA workers registered in the Bahadarbad block were considered. Following the application of inclusion and exclusion criteria, 28 ASHA workers were identified as eligible participants for the study.

Various tools will be employed as instruments for data collection in the research endeavor. To comprehend the issues at hand, data collection will be concentrated on two main sources of information. Primary data will be gathered through semi-structured interviews with selected stakeholders, including ASHA workers, ANMs, AWWs, PRI members, and community members. Additionally, a literature review will serve as the secondary source of information. Focus group discussions with community members will also be conducted to gain insight into their perspectives.

The data collected from ASHA workers, ANMs, AWWs, PRI members, and community members has been thoroughly evaluated. Responses have been categorized into various sections according to the report's structure and further divided into subsections as necessary. These responses were interpreted for analysis within the report. The following five questions were the primary emphasis of the paper.

1. Are the roles and responsibilities allocated to ASHAs deemed acceptable and easily comprehensible? Is there an expectation of additional duties for ASHAs in the future?

2. Is the ASHAs' training sufficient, suitable for knowledge retention, and of a strong standard?

3. Are the incentives and compensation plans in place at ASHA consistent with and sufficient for them to meet the demands of NRHM?

4. Do the rural areas' current supervisory mechanisms properly monitor and track ASHA performance and are they sufficiently detailed?

5. Are the ASHAs happy with their reputation and job? What was the main justification for keeping ASHA'S?

RESULT

Role & responsibility

The site visits and qualitative data supported the claim that the majority of the ASHAs who took part in the study understood their tasks and responsibilities. Many of the ASHAs we spoke with were unable to list all of their duties. The fact that ASHAs currently claim to work 3–4 hours each day also gives the possibility of increasing her responsibilities, which would also raise her incentives. According to our research findings, numerous ASHAs express discontent with their incentives, suggesting potential benefits from improvement. Moreover, qualitative research highlights ASHAs' motivation to enhance their medical knowledge.

As a result, she may be considered for extra duties that fall within her realm of competence. It makes sense to expand the activist status of the ASHA to include additional duties in raising awareness because doing so can lower the cost of treating chronic diseases and enhance community health. The programme can include activities closer to service delivery or just raising awareness (as is the thought process behind the design of Modules 6 & 7 in the ASHA Training program developed by the Government of India?) . The cost of training needs to be evaluated, encompassing substantial overhead expenses such as compensation provided to trainees for the duration of training days, travel expenses for both trainees and instructors, honoraria paid to instructors, training supplies, stationary, and travel expenses for field trips during the training. The discussion surrounding ASHA's "duties and obligations" should also consider the increasing population. The rural population has unavoidably increased significantly since the establishment of NRHM in 2005, and as a result, the population covered by ASHAs has Exceeded the suggested coverage population of 1000/500 residents. Additionally, most babies born in the last 10 years are included in the population growth, which greatly increases the workload for ASHAs. The possibility of increased incentives for ASHAs is a benefit, but there is also a risk of overburdening them, which will result in subpar performance and coverage. The expanding population must therefore be more carefully taken into account while employing of new ASHA's.

Training

For ASHAs to receive the best education possible, the number, quality, and assessment of training must change. Nearly 300

pages of dense reading are required for ASHAs during their training, which is spread out over a 23-day period. However, in our study sample, ASHAs obtained a maximum average of 15 to 16 days of training. Several ASHAs also mentioned during the site inspections that the overall number of training days (15–16 days) and the daily training programme (3–4 hours) were both poorly organised. The length of the scheduled training programme was also shortened because additional programmes were frequently shared during the training session. Trainers differ from location to location and even within a block, indicating that the training received by all ASHAs is not uniform. Even though refresher training is sometimes required due to the shortcomings of first training, it is rarely done. Additionally, there are no established assessment procedures to ensure that ASHAs have retained the requisite information from training sessions and are qualified to practice. According to our findings, half of the ASHAs in our study sample had knowledge evaluation scores below 48%. As a result, ASHAs do not possess the necessary skills to do their responsibilities effectively. In the form of written and viva exams, an assessment of the knowledge retained by ASHAs from both theoretical and practical training sessions.

The upcoming deployment of Modules 6 and 7 for ASHA inductive training should also be considered. The new training modules' main benefits include a stronger emphasis on newborn care, the incorporation of graphical learning, and their suitability for audiences with lower levels of reading. However, there will be a lot of factors to consider when implementing these new training modules. First off, the addition of these new duties shifts ASHA's job closer to that of a service provider, necessitating an increased requirement for monitoring, better performance management and recording, routine refresher training, better management of drug kits, etc. Second, our findings suggest that several ASHAs have not gotten thorough training, even with just modules 1–5. They are burdened with the requirement for additional training and must come up with a practical plan to ensure that the ASHAs receive instruction in both the existing and new modules without seriously interfering with their work.

Incentives and Compensation

There are several significant problems with ASHA incentives and remuneration that, if resolved, would significantly boost ASHA performance and motivation. Activities pertaining to newborn care are not adequately incentivized (7 home visits and referral management), and there are no special rewards for treating childhood ailments. Activities connected to ANC and delivery are where ASHAs spend most of their time and receive the majority of their incentives .[10] Incentives for these extra duties must be taken into consideration because engaging in these activities will have a major positive impact on public health. Third, the majority of ASHAs—at least 75%—believe that the remuneration they received fell short of their expectations. Higher financial incentives per action can be taken into consideration to provide continued inspiration for ASHAs to succeed in their professions, given that a significant part of them is dissatisfied with their current level of compensation. The degree of incentive should ideally be much higher than it is now Since the financial incentive is not consistently tied to the level of labor involved in an activity. For instance, ASHAs only get Rs. 100 to spend on travel, food, and other necessities for a Village Health and Nutrition Day, which they plan, carry out, and recruit people for. This cash incentive is insufficient to inspire ASHAs and guarantee that they will work as efficiently as possible. Many ASHAs admitted to paying for travel and other expenses out of their own pockets, particularly in rural locations. ASHAs are less motivated to complete their responsibilities to the best of their abilities when there is a chance that their compensation will be reduced or demanded. Nearly all ASHAs now have bank accounts, however incentives are not transferred on time or on a regular basis. ASHAs stated during the group discussion that transfers typically occur every quarter or every two years. It must follow a set schedule, which is essential for the expansion and advancement of the ASHA programme. It is crucial to remember, though, that there were other considerations that motivated ASHAs to perform and perform well in addition to cash rewards. ASHAs decided to work as community health workers for the top three reasons, which also included a will to enhance the health facilities in their community and the social standing that came with the position. As a result, improvements must be considered to put ASHAs on a developing career track where the possibility of career advancement and recognition will significantly boost their motivation and, as a result, their performance. These improvements must be made in addition to a redesign of the financial compensation design and procedures .[11] The ASHA facilitator, who is also having financial difficulties, must travel across considerable distances at least four days a week to see all the ASHAs in each field, but because of insufficient travel and daily allowances, the visits do not meet the necessary standards for quality and frequency.

Regular Monitoring and supervision

According to the study, regular supervision and monitoring were insufficient and inappropriate supports. ASHAs are not consistently meeting with a specialised supervisor, and their direct mentors—the ASHA Facilitators—do not have the best expertise and abilities to address their needs. Although ANMs provide the majority of assistance and support to ASHAs, these ANMs are not technically acknowledged as ASHAs' supervisors. Despite these instances of monitoring, the state does not have a formal evaluation process for ASHAs, and no performance data is kept. It will be challenging to raise ASHA's performance in the absence of a review of prior work and a supervisor to monitor performance. Incentives payments, not performance or record maintenance, are the main focus of the report style and information gathering procedure.

Motivation and satisfaction level

The majority of ASHA's are not satisfied with their status, the scope of work, and prescribed incentives. However, their retention percentage is very good, only 2-5% ASHA's were dropout. During the observation visit, the majority of ASHA's coated that they are continuing work because they hope one day, they will become part of the government system and get permanent employment. In remote areas of most the villages, ASHA's are not staying in the same village, and as a result of this, people are not receiving any kind of services regularly. It was observed that ASHA's were visiting their village only during activities. Most of the time, ASHA is staying in nearby urban areas and just coordinates their work from a mobile phone.

District implementation agencies

Currently, District ASHA Resource Centre (DARC) is implementing the ASHA program under the leadership of the District Health Administration across the district. They are partially involved in the planning, budgeting, and scheduling of training programs. The majority of the time, they have to follow the instruction provided by state or district administrations. Due to the lack of an annual training calendar, DARC does always not get sufficient time for the preparation of training, even, on several occasions, they did not get adequate time to inform ASHA's of training programs. Financial and other support from the state are also not effectively managed by district as well as state administration. Besides all these hindrances, it is one of the best models which has been appreciated across the country. The DARC has worked very effectively, at the same time they are easily accessible for ASHA's, and response and feedback are also adequate and very effective.

DARC require both qualitative and quantitative human resource for ensuring better outcomes. There should annually calendar of training and regular financial flow for ensuring the delivery of effective and quality training programs. The state has to help, DRAC to develop effective supervision, support, and performance assessment procedure for regular follow-ups of ASHA's and ASHA Facilitators.

CONCLUSION

The study found that there is no regular, adequate, or appropriate structure for ASHA oversight and support. ASHAs don't often consult with a designated supervisor, and their direct mentors lack the expertise needed to carry out their duties. Although ANMs provide most of the support and assistance to ASHAs, these ANMs are not officially acknowledged as ASHAs' mentors or supervisors, hence there is no clear organizational or reporting structure. Additionally, it was noted that there is no official review procedure for ASHAs, and no performance statistics are kept. It would be advantageous to evaluate the ASHA's current performance and give supervision to identify any gaps and fill them to further increase the role that ASHAs play in allowing communities to live healthier lives.

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