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Research Article

A STUDY ON THE KNOWLEDGE PRACTICE GAP OF ASHAS ABOUT HER WORK PROFILE FROM NORTHERN INDIA

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ABSTRACT

Objective: The objective of the study was to study the knowledge practice gap of Accredited Social Health Activist (ASHAs) about her work profile from northern India.

Methods: The study was carried out between June 2021 and November 2021. The study comprised all 97 local ASHA employees, who were all questioned using a self-made semi-structured questionnaire.

Results: Data were collected from 94 ASHA workers. 91 (96.8%) of ASHA workers completed 8th standard or more of schooling. 92 (97.87%) of ASHA workers completed training before working as ASHA. Almost all the study subjects had knowledge about immunization activities, accompanying delivery cases, and participation in family planning activities. Very few ASHAs knew that active participation in village health planning, providing counseling to the residents on various health issues and addressing adolescence health issues with residents of the village were part of her work profile. Drug kit stock register, format for individual birth preparedness plans, format for first examination of the new born, and home visit form for high risk baby were relatively deficient with respect to their maintenance and completeness.

Conclusion: ASHAs do offer a variety of services and have the ability to contribute to the provision of primary healthcare, but they must still put their knowledge to use when offering services and/or advise to negotiate access to healthcare for underprivileged women and children.

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INTRODUCTION

The Government of India sent off the National Rural Health Mission (NRHM) on April 12, 2005, to offer reasonable fundamental clinical types of assistance, especially to destitute individuals and more fragile part of the population [1,2]. The Mission embraces a synergistic procedure by relating prosperity to determinants of well-being, namely, sustenance, sterilization, neatness, and safe drinking water [3]. One of the essential pieces of the mission is making a band of female prosperity volunteers, appropriately named "Certify Accredited Social Health Activist" (ASHA) in each town. These town level prosperity laborers would go probably as a "range" or an association point between the nation people and prosperity organization outlets and would expect a central part, in achieving public prosperity and people procedure goals [4,5].

Arrangement of the NRHM underlines ASHA as a prosperity specialist in the community [5]. She should give essential medical care at the doorstep. The bundle of administrations incorporate each age gathering of life cycle, alongside all sort of administrations fundamentally zeroing in on preventive, promotive and rehabilitative care [6,7]. ASHA lobbyist structure principal mainstay of local area cooperation. She is supposed to serve a similar local area from where she comes, among which she live.

The current study has been intended to study the knowledge practice gap of ASHAs about her work profile from northern India. This study was embraced to figure out the knowledge practice gap of ASHA workers about her work profile.

METHODS

Study setting
Community based study.

Study setting design
This was a cross-sectional study.

Study duration
The study duration was from June 2021 to November 2021.

This cross-sectional review was arranged and completed in the country field practice region serving under the aegis of the branch of local area medication of a tertiary consideration showing foundation situated at northern India. The insights concerning ASHAs working in each town and the rundown of blocks, subcenters and subtleties of each and every town were accessible at the workplace of region well-being authority. Significant subtleties were acquired from that point.

Inclusion and exclusion criteria
The field practice region covered a sum of 97 ASHA laborers. All ASHA laborers in the space were remembered for the review. Nonetheless, the people who could not be reached notwithstanding three visits were barred. At long last information gathered from 94 ASHA laborers was remembered for the review. The medical officials accountable for the individual PHC's were met and the times of the gathering with ASHA laborers were discovered.

Study strategy
The ASHAs were welcomed for interview endless supply of the month to month meeting utilizing a self-planned semi-organized survey. They

were informed about this review and were mentioned to partake. The inquiries were outlined in English at first and later deciphered in Hindi and were retranslated to English to check legitimacy of inquiries contained. A definite pro forma to record socio-segment profile of ASHA laborers, their insight and works on with respect to things to be finished for antenatal cases, potential inconveniences during pregnancy, moves expected to be initiated in the event that ASHA predicts an entanglement, potential difficulties during conveyance, information and works on in regards to vaccination, information and practices about broad obligations, information, and practices about record keeping and other pertinent information and so on was ready to fill perceptions of the current review.

Ethical approval

The study begun after obtaining ethical approval from the ethical committee of the medical college.

Data analysis

The collected data were entered into Microsoft Excel. Coding of the variables was done. SPSS version 20 was used for analysis. Interpretation of the collected data was done using appropriate statistical methods such as percentage and proportions.

RESULTS

Baseline characteristics of ASHA functionaries

Data of 94 ASHA functionaries were analyzed and presented here. Mean age of ASHA workers was 29.16 (SD 4.4) years. 43 (45.7%) of the ASHA workers were in the age group of 20–29 years. Religion wise majority 88 (93.6%) of the ASHA workers were Hindus. Most 91 (96.8%) of ASHA workers completed 8th standard or more of schooling. Married ASHA functionaries outnumbered unmarried ones. 92 (97.87%) of ASHA workers completed training before working as ASHA.

Knowledge (awareness) of her responsibilities

Almost all the study subjects had knowledge about immunization activities, accompanying delivery cases and participation in family planning activities. Very few ASHAs knew that active participation in village health planning, providing counseling to the residents on various health issues, and addressing adolescence health issues with residents of the village were part of her work profile (Table 1).

Practice of ASHAs in the form of record keeping:

Village health register and delivery forms were primarily available registers and formats. Drug kit stock register, format for individual birth preparedness plans, format for first examination of the new born, and home visit form for high risk baby were relatively deficient with respect to their maintenance and completeness. Similarly reports regarding VHND (beneficiaries given services and participation of VHSNC members) were poorly maintained by study subjects (Table 2).

Table 1: Knowledge (awareness) of ASHAs about her work profile

Knowledge about areas of ASHAs work profile	n=94	Percentage
Assist in immunization activities	94	100
Accompanying delivery cases	94	100
Family Planning activities	91	96.8
Maintaining records and registers	85	90.4
Accompanying pregnant women in ANC cases for any danger sign	80	85.1
Take part in basic sanitation and hygiene related activities	77	81.9
Reproductive and sexual health services	73	77.6
Provide basic curative services	70	74.5
HBNC care delivery	65	69.1
Provide TB medicines (DOTS)	60	63.8
Take part in disease prevention activities	58	61.7
Good health practices	54	57.4
Basic sanitation and hygiene	50	53.2
Child health issues	50	53.2
Mobilization of community	46	48.9
Community Advocacy	41	43.6
Registration of births and deaths	41	43.6
Advice to mother about breast feeding	33	35.1
Village health planning	25	26.6
Counseling	18	19.1
Adolescence health issues	15	15.9
Multiple responses permitted		

Table 2: Practice of ASHAs in the form of record keeping *(registers and reporting formats)*

Record keeping by ASHAs	n=94	Percentage
Registers and formats		
Village health register	90	95.7
Delivery forms	83	88.3
Home visit form	72	76.6
ASHA diary	26	27.6
Drug kit stock register	14	14.9
Format for individual birth preparedness plans	7	7.4
Format for first examination of the new born	4	4.3
Home visit form for high risk baby	2	2.1
Reports		
Children: Immunization and feeding practices	84	89.4
Pregnant women – numbers, registered, ANC, danger signs	80	85.1
Deliveries: numbers, institutional and home deliveries, danger signs	80	85.1
Newborn care: Numbers, feeding practices	62	65.9
Home visits: Birth preparedness plan	62	65.9
Deaths: Mothers, newborns, infants and children	58	61.7
VHND: beneficiaries given services, participation of VHSNC members	15	15.9

DISCUSSION

The Indian government laid out the NRHM on April 12, 2005, determined to convey essential medical services to the local area's most powerless and oppressed individuals. The Ministry of Health and Family Welfare Department presented the ASHA work force in 2005 fully intent on improving the ease of use, accessibility, and agreeableness of the ongoing wellbeing offices, especially in provincial regions. The super driving component behind action at the grassroots level was another framework of local area level well-being experts who were either female wellbeing volunteers, well-being administration advertisers, or ASHA representatives. The ASHA worker is depicted by NRHM as a local area acknowledged well-being dissident who overcomes any barrier between the local area and the medical services framework.

Most of ASHA representatives (45.7%, n=43) were between the ages of 20 and 29. Others revealed noticed comparable outcome [4,8]. Subsequently, most of ASHAs might be considered energetic, which might be a strength for the program since they are enthusiastic and invigorated and may offer better support with the right sort of inspiration and limit building. With respect to, most of ASHA workers had basically an eighth-grade training, however three ASHAs (3.19%) had less. As per another review, up to 32.8% of ASHAs have instructive levels underneath the eighth grade [2]. This can be made sense of by the choice necessities, which are eighth class in certain spots and fifth class in others [8]. Others also reached comparative conclusions [2,9].

Just 19.7% of ASHAs in Rajasthan who were assessed for the ASHA and JSY demonstrated that pregnant ladies are probably going to vomit [10].

Conversely, that's what our examination shows >80% of ASHAs agreed. Our discoveries highlight deficient degrees of information, especially concerning direct obstetric issues after conveyance and the quick post pregnancy time frame. ASHAs neglected to feature delayed work as a complexity, despite the fact that it very well may be deadly in the event that not managed rapidly.

Records are dissected to make reports, which are then shipped off higher program the executives levels reports stayed up with the latest by ASHAs. The general reaction from ASHA about how they might interpret inoculation, especially with respect to lockjaw vaccination, was inadmissible. Most ASHAs got a kick out of the chance to help with labor and immunizations. Monetary impetuses are likewise connected to these exercises. Notwithstanding, numerous different positions drew less consideration, reasonable because of an absence of motivations, for example, bringing issues to light of disinfection and cleanliness, giving family arranging guiding, and so on. Furthermore, they had little information on their capability in the enrollment of births and passing's. These may be the spots that should be reoriented.

As per the review, in the wake of preparing, about portion of the ASHAs got drug units. The absence of medication pack accessibility is a reason to worry. Obviously, the consequences of our concentrate intently look like those of "Fast examination of working of ASHA in Orissa" [8]. The accessibility of a drug unit helps ASHAs in giving some essential clinical consideration needs and increments local area trust in ASHAs as an asset for help with "long stretches of need."

The after effects of the ongoing review showed that monetary profit filled in as the ASHAs' essential wellspring of inspiration. Comparable outcomes have been seen in other research [4,6,8]. The craving to work for the public authority was positioned as the second-least spurring component in our overview, in spite of the fact that it was positioned as the most un-rousing element in one more review did in Uttar Pradesh in 2008 [9]. This study debates our discoveries in such manner. They had a great deal of trust in the organization from the start, yet as time went on, that trust faded, which could be one reason.

One more review from eastern India found that from module 1–5, medical aid and DOTs preparing was finished by around 93% of ASHA faculty. About 34% of ASHA representatives got boost preparing, while 88.4% got FTD/Malaria preparing. 1218 ASHAs, or 100%, added to vaccination. Most of them, 1199 (98.4%), aided conveyances, and 1198 (98.3%), knew about family arranging practices [11]. Others revealed seeing a comparative outcome [12-14].

CONCLUSION

ASHAs are for the most part satisfied with the preparation they got. Be that as it may, how they might interpret their day to day undertakings appeared to be off base and deficient. Furthermore, they had little information on their capability in the enrollment of births and passing's. ASHAs really do offer different administrations and can add to the arrangement of essential medical care, yet they should in any case put their insight to utilize while offering administrations as well as encourage to arrange admittance to medical care for oppressed ladies and youngsters.

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AUTHORS' CONTRIBUTION

All the authors have contributed equally.

CONFLICT OF INTEREST

The authors declare no conflicts of interest.

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REFERENCES

1. Government of India. National Rural Health Mission (2005-12). Mission Document. New Delhi: Ministry of Health and Family Welfare; 2005.
2. Assessment of ASHA and Janani Suraksha Yojana in Madhya Pradesh. Available from: http://www.cortindia.com/RP/RP-2007-0301.pdf [Last accessed on 2020 Nov 07].
3. Government of India. Reading Material for ASHA Book Number-1. New Delhi: Ministry of Health and Family Welfare, Government of India; 2005.
4. Srivastava DK, Prakash S, Adhish V, Nair KS, Gupta S, Nandan D. A study of interface of ASHA with the community and the service providers in Eastern Uttar Pradesh. Indian J Public Health 2009;53:133-6. PMID 20108875
5. Mahyavanshi DK, Patel MG, Kartha G, Purani SK, Nagar SS. A cross sectional study of the knowledge, attitude and practice of ASHA workers regarding child health (under five years of age) in Surendranagar district. Healthline 2011;72:38-55.
6. Bhatnagar R, Singh K, Bir T, Datta U, Raj S, Nandan D. An assessment of performance based incentive system for ASHA Sahyogini in Udaipur, Rajasthan. Indian J Public Health 2009;53:166-70. PMID 20108882
7. Singh MK, Singh JV, Ahmad N, Kumari R, Khanna A. Factors influencing utilization of ASHA services under NRHM in relation to maternal health in rural Lucknow. Indian J Community Med 2010;35:414-9. doi: 10.4103/0970-0218.69272, PMID 21031109
8. Assessment of ASHA and Janani Suraksha Yojana in. Available from: http://www.orissa.cortindia.com/RP%5CRP-2007-0303.pdf [Last accessed on 2021 Nov 08].
9. Jain N, Srivastava NK, Khan AM, Dhar N, Manon S, Adhish V, *et al*. Assessment of functioning of ASHA under NRHM in Uttar Pradesh. Health Popul Perspect Issues 2008;31:132-40.
10. Assessment of ASHA and Janani Suraksha Yojana. Available from: http://www.rajasthan.cortindia.com/RP/RP-2007-0302.pdf [Last accessed on 2021 Nov 08].
11. Panda M, Nanda S, Giri RC. A study on the work profile of ASHA workers in a district of Odisha in Eastern India. Int J Community Med Public Health 2019;6:675-81. doi: 10.18203/2394-6040.ijcmph20190190
12. Kori S, Bhatia M, Mishra A. A cross sectional assessment of knowledge of ASHA worker. J Krishna Instit Med Sci Univ 2015;4:25-9.
13. Saxena S, Srivastava A, Saxena A. Job satisfaction among ASHA's working in villages: A cross sectional study from district Bareilly. Int J Health Clin Res 2020;3:120-8.
14. Sharma R, Webster P, Bhattacharyya S. Factors affecting the performance of community health workers in India: A multi-stakeholder perspective. Glob Health Action 2014;7:25352. doi: 10.3402/gha.v7.25352, PMID 25319596