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Research Article

Upgradation of Healthcare Services at Doorstep Due to ASHA's Presence

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ABSTRACT

This study focuses on healthcare services in rural areas in India, which is a first of its kind on healthcare programme that has been launched, such as the National Rural Health Mission (NRHM) in rural setting. Through these massive healthcare programmes, healthcare services are provided at doorstep through Accredited Social Health Activists (ASHAs) in rural areas. In this study, random sampling was used and the sample size was 60 ASHAs and 10 Auxiliary Nurse Midwives (ANMs). This study tries to explore the benefits of ASHAs and ANMs.

Keywords: National Rural Health Mission, Accredited Social Health Activist, Mission programme

INTRODUCTION

The Accredited Social Health Activist (ASHA) represents the pivotal part in the whole design and strategy of the National Rural Health Mission (NRHM), which, in turn, is a critical initiative of the central government to fulfil its promise on inclusive growth. The performance of ASHAs is, therefore, crucial for the success of NRHM and hence of the inclusive growth strategy of the Indian government. In the primary healthcare sector, NRHM is the principal programme of the government to achieve the health-related millennium development goals such as reducing infant mortality rate (IMR) and maternal mortality rate (MMR), control specific diseases and improve the nutrition status of children and mothers. NRHM was introduced in 2005 in the 18 high-focus states in India and has been expanding in its coverage ever since. Several mid-term appraisals of NRHM have been carried out, the last one having been carried out by the present team (2009). The present study is devoted to identifying and suggesting ways in the short to medium term to improve the performance of ASHAs under NRHM in India (Bajpai, 2011).

The Government of India has launched NHRM to address the healthcare needs of the rural population, especially the vulnerable sections of the society. The sub-centre is the most peripheral level of the contact with the community under the public health infrastructure. This caters to the population norms of 3000–5000. The worker is the sub-centre in an ANM, who is involved directly in all the health issues of this population, spread over the wide area of many kilometres and covering 5–8 villages. Often villagers are not connected by public or private transport systems, thereby making it more difficult to achieve the objectives and goals of providing quality healthcare for the poor and deprived sections of the society.

Hence, the new band of community-based functionaries, named as ASHA, is proposed in the NRHM, who will serve populations of 1000 and 500 in hilly and desert terrains, respectively.

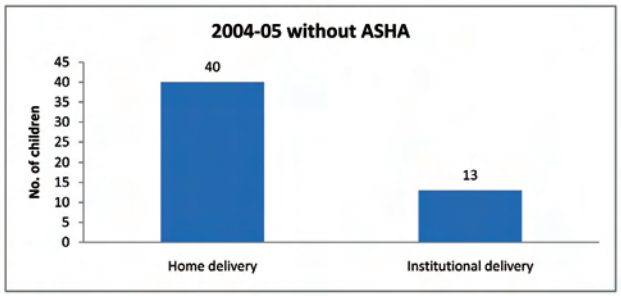
ASHAs are the first port of call for any health-related demands of the deprived sections of the population, especially women, children, aged, sick and disabled people; they are the link between the community and the healthcare provider (*mohfw.nic.in/NRHM/stakeholders.htm*). Health activists in the community create awareness on health and its social determinants and mobilise the community towards local health planning and increased utilisation and accountability of the existing healthcare services. They are the promoters of good health practices, provide a minimum package of curative care as appropriate and feasible for that level and make timely referrals. They arrange for essential provisions, like Oral Rehydration Therapy (ORS), iron folic acid (IFA) tablet, chloroquine, disposable delivery kit (DDK), oral pills and condoms, to be made available to all inhabitants. ASHAs take steps to create awareness and provide information to the community on determinants of health such as nutrition, basic sanitation and hygiene practices, healthy living condition for working conditions, information on existing health services and timely utilisation of health and family welfare services. They counsel women on birth preparedness, importance of safe delivery, breastfeeding & complementary feeding, immunisation, contraception and prevention of common infections including RTI/STI and care of young child. ASHAs mobilise the community, facilitate them in accessing health and its related services available at the Anganwadi/sub-centre/primary health centres, assist the village health and sanitation committee of the gram panchayat to develop a comprehensive village health plan, and escort/accompany pregnant women and children requiring treatment/admission to the nearest pre-identified health facility (i.e. PHC/CHC/FRU). They provide primary medical care for minor ailments such as diarrhoea, fever and first aid for minor injuries, work as the provider of DOTS under RNTCP and act as depot holder for essential provisions that will be made available to every habitation. They inform about the births and deaths in their village and any unusual health problems/disease outbreaks in the community to the sub-centre/primary health centre. Besides, they also promote the construction of household toilets under the Total Sanitation Campaign (http://www.nrhmorissa.gov.in/component_asha2.html).

METHOD

This was a longitudinal study conducted in Atrauli block in Aligarh district. Around 150 participants were included from three different periods, (i.e. 50 participants each from 2004–2005, 2008–2009 and 2010–2011), with a 2-year gap period. In three different years, data researchers tried to find out the effect of healthcare services before and after the inception of ASHA in rural settings.

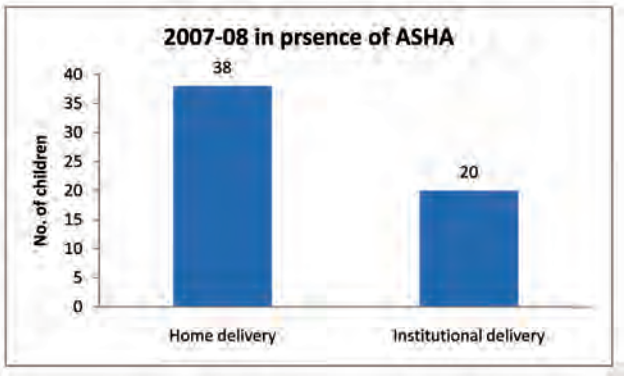
RESULT AND DISCUSSION

This longitudinal study was carried out in the Atrauli block, Aligarh district. In this study, data were taken from fifty families with whom ASHA was not in field as a frontline worker. Moreover, in this study, we will also observe the effect of the CCSP project, which is run by the Department of Sociology and Social work, Aligarh Muslim University (AMU), Aligarh. Three points will be considered for data – delivery, routine immunisation and traditional practices. This is explained in the graph in Figure 1.



Note: Data collected in 2011–2012.

For the year 2004–2005, the above graph shows that institutional delivery was very low and home delivery was very high at the CSE level. At that time, ASHAs were not present in the field.



In Figure 2, in 2007–2008, institutional delivery increased and home delivery gradually decreased due to the presence of ASHAs in the field.

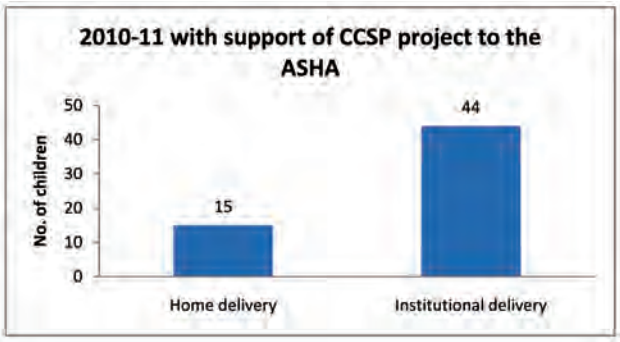
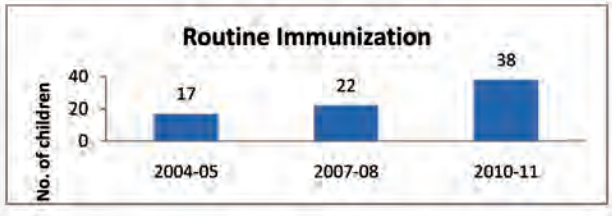
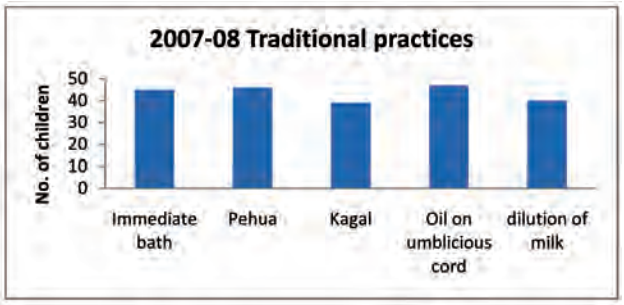


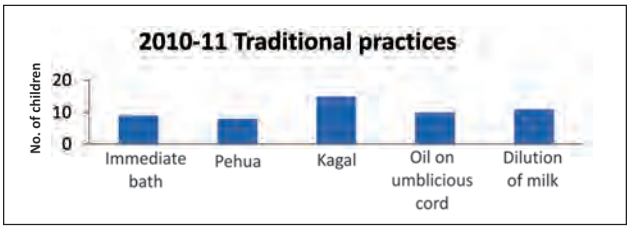
Figure 3 shows that in 2010–2011 with the help of the CCSP project, institutional delivery increased drastically and home delivery reciprocally decreased because block supervisor helped ASHAs in counselling and in home visits.



In 2004–2005 when ASHAs were not present, routine immunisation was very low (see Figure 4); however, in 2007–2008 when ASHAs were involved in field routine immunisation, it increased slightly. As seen in the figure, in 2010–2011 with the help of the CCSP project, routine immunisation increased significantly up to 38%.



In 2007–2008, before the commencing of the CCSP project, harmful traditional practices were very high in the rural community (see Figure 5).



In 2010–2011 when the CCSP project was started with the help of block supervisors to the ASHAs, all five indicators of harmful traditional practices saw a drastic decline (see Figure 6).

CONCLUSION

This study has shown the importance of ASHAs for healthcare services. In all three time periods, it is seen that without ASHAs healthcare services were not available at the doorstep for the vulnerable and marginalised sections of the society in rural settings. However, ASHA made it possible. In addition, it there was a major impact in the health of newborns.

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