A STUDY ON THE EFFECTIVENESS OF ASHA WORKERS AMONG PUBLIC WITH SPECIAL REFERENCE TO ALANGHAD PANCHAYAT

Project Report

Submitted by

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Under the guidance of

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In partial fulfilment of requirements for the award of the post graduate degree of

Master of Commerce and Management

ST. TERESA'S COLLEGE (AUTONOMOUS), ERNAKULAM

COLLEGE WITH POTENTIAL FOR EXCELLENCE

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ST. TERESA'S COLLEGE (AUTONOMOUS), ERNAKULAM

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CERTIFICATE

This is to Certify that the project report titled **" A STUDY ON THE EFFECTIVENESS OF ASHA WORKERS AMONG PUBLIC WITH SPECIAL REFERENCE TO ALANGHAD PANCHAYAT"** submitted by **ANJANA P S** towards partial fulfilment of the requirements for the award of post graduate degree of **Master of Commerce and Management** is a record of Bonafide work carried out during the academic year 2024-25.

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DECLARATION

I, **ANJANA P S** hereby declare that this dissertation titled, **" A STUDY ON THE EFFECTIVETNESS OF ASHA WORKERS AMONG PUBLIC WITH SPECIAL REFERENCE TO ALANGHAD PANCHAYAT"** has been prepared by me under the guidance of **Ms. Elizabeth Rini K F**, Assistant Professor, Department of Commerce, St.Teresa's College, Ernakulam.

I also declare that this dissertation has not been submitted by me fully or partly for the award of any Degree, Diploma, Title or Recognition before.

Place: Ernakulam **ANJANA P S**

Date: 31.03.2025

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I wish to acknowledge all those who helped us to complete this study. I thank God almighty for helping me and guiding me in the right path and who made all things possible.

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1.1 INTRODUCTION

In the landscape of India's healthcare system, Accredited Social Health Activists (ASHAs) have emerged as pivotal figures, particularly in rural and underserved communities. Established by the National Rural Health Mission in 2005, ASHA workers represent a grassroots initiative aimed at improving access to healthcare services, promoting health education, and empowering communities to adopt healthier lifestyles. Their role spans a wide spectrum of responsibilities, from maternal and child health to communicable disease control and sanitation advocacy. This study focuses on evaluating the effectiveness of ASHA workers in fulfilling these roles and their impact on health outcomes among the public.

ASHA workers serve as a critical link between the formal health system and the community, functioning as frontline health educators and facilitators of primary healthcare services. Through their close integration within local communities, ASHA workers play a crucial role in increasing awareness about preventive healthcare measures, facilitating timely referrals to healthcare facilities, and encouraging adherence to treatment protocols. This study seeks to assess the extent to which ASHA workers contribute to improving health-seeking behaviors and health outcomes among community members, thereby addressing healthcare disparities and promoting health equity.

Understanding the effectiveness of ASHA workers requires a comprehensive examination of their training, capabilities, and the challenges they encounter in performing their duties effectively. While ASHA workers have been instrumental in extending the reach of healthcare services to marginalized populations, their effectiveness can vary significantly based on factors such as training adequacy, community engagement strategies, and support from the healthcare system. By exploring these dimensions, this study aims to provide insights into enhancing the effectiveness of ASHA workers and optimizing their role within India's broader public health framework.

Through a mixed-methods approach encompassing qualitative interviews, quantitative surveys, and analysis of health indicators, this research endeavours to

generate evidence based recommendations for policymakers, healthcare providers, and stakeholders. These recommendations are intended to inform strategies for strengthening primary healthcare delivery, improving health outcomes, and fostering sustainable community health initiatives across diverse socio-economic contexts in India.

1.2 STATEMENT OF THE PROBLEM

The problem of this study aims to address is the lack of comprehensive data and analysis on the effectiveness of ASHA workers in Alanghad Panchayat, which hinders the ability to make informed decisions for policy and practice improvements. This study seeks to fill this gap by systematically evaluating the performance and impact of ASHA workers in this specific region, thereby contributing to the broader understanding of their role in public health.

1.3 SIGNIFICANCE OF THE STUDY

The significance of the study lies in its comprehensive evaluation of ASHA workers' effectiveness in improving health outcomes Alanghad in Panchayat. It assesses their impact on maternal and child health, and the effectiveness of their education on hygiene, sanitation, and nutrition in enhancing public health practices. Additionally, the study examines community perceptions and experiences with ASHA services. The insights gained will help policymakers and healthcare administrators understand the program's strengths and weaknesses, guiding improvements and resource allocation to enhance healthcare delivery and outcomes at the community level.

1.4 SCOPE OF THE STUDY

This study focuses on evaluating the effectiveness of Accredited Social Health Activist (ASHA) workers specifically within Alanghad Panchayat. It aims to assess their impact on improving maternal and child health outcomes, particularly through their initiatives in health education on topics such as hygiene, sanitation, and nutrition. The study also investigates public perceptions and experiences with ASHA services to gauge community trust and satisfaction levels. Geographically, the scope is limited to

Alanghad Panchayat, providing a localized perspective on the implementation and outcomes of the ASHA program in this rural area. The findings aim to offer insights that can guide policy decisions and enhance healthcare delivery at the grassroots level, contributing to broader efforts to improve public health initiatives in rural India.

OBJECTIVES

- To analyse effectiveness of activities of the ASHA workers.
- To evaluate community satisfaction with the service of ASHA Workers.
- To evaluate the effectiveness of health education provided by ASHA workers.
- To understand challenges faced by public in accessing the services of ASHA workers.

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1.5 HYPOTHESES

H0: There is no significant relationship between challenges faced by public and services provided by ASHA workers.

H1: There is a significant relationship between challenges faced by public and services provided by ASHA workers.

1.6 METHODOLOGY OF STUDY

1.6.1 RESEARCH DESIGN

This research is descriptive and analytical in nature. Descriptively, it describes more about the effectiveness of asha workers among the public. In analytical in nature because in evaluates the performance and impact of asha workers in Alanghad panchayat.

1.7.2 COLLECTION OF DATA

The data can originate from various sources depending on its intended use and context. The source of data can be classified into primary data and secondary data.

- **Primary data**: Primary source is also called original source. It is directly collected from first hand experience. Throughout adopting the questionnaire method for data collection.

- **Secondary data:** Secondary data that has already been collected, processed and made available by others. In this study secondary information are collected from research articles, journals, google etc..

1.7.3 DATA ANALYSIS TOOLS

The collected data was analysed using SPSS (Statistical Package for the Social Sciences) and Microsoft Excel. The following statistical techniques were employed:

- Percentage chart
- Line chart
- Bar chart
- Diagram
- Table
- One way ANOVA

1.7.4 SAMPLING DESIGN

- **Sampling Technique**

  In this study the researcher use convenience sampling technique for data collection.

- **Population**

  The population of the study in from different people in Alanghad panchayat.

- **Sample Size**

  The sample size of this study is 75. It consists of 75 different Ashaworkers in Alanghad Panchayat.

1.8 LIMITATIONS OF THE STUDY

Participants may not accurately remember or report past interactions with ASHA workers.

Due to small size of sample some respondents might have given biased answer.

A single time frame may not capture long term effectiveness.

Lack of access to or familiarity with technology for data collection and communication in some areas.

1.9 CHAPTERIZATION

Chapter 1- Introduction: This chapter covers the introduction, statement of the problem, significance of the study, scope of the study, objectives, hypotheses, research methodology, and limitations of the study.

Chapter 2- Review of Literature: This chapter consists of summaries of the prevailing literature on financial literacy, stock market participation and digital financial education.

Chapter 3- Theoretical Framework: This chapter includes the effectiveness of ASHA workers in Alangad Panchayat, Kerala**,** focusing on their role in health awareness, accessibility, and service utilization. Based on the Health Belief Model and Community Participation Model**,** it explores how ASHA workers influence public health behaviors and community engagement. Key indicators include maternal and child health services, disease prevention, and community satisfaction**.** The study also considers the impact of government policies, training, and support in enhancing ASHA workers' efficiency in delivering healthcare services.

Chapter 4- Data analysis and interpretation: The data collected from various sources are sorted and analysed to evaluate the effectiveness of the ASHA workers in Alanghad Panchayt.

Chapter 5- Findings, Suggestions, and Conclusion: Findings, recommendations, and conclusions on the effectiveness of ASHA workers on Alanghad Panchayat are included in the final chapter.

2.1 LITERATURE REVIEW

The chapter provide foundation of knowledge on topic. The review of related literature is an important aspect of every work. The purpose is to find out the research topic to study the role of ASHA Workers and their contribution to the health care system. Some of the review of literature are given below.

Nambiar (2024): The CHWs in Kerala play care reforms and COVID-19 management. Despite their strong work ethic and close relationship with local self- government, low and irregular wages remain the biggest challenge.

Poonam S Kalne, Pooja S Kalne, Ashok M Mehendale k2022): In underserved communities, the community health worker (CHW) concept has been employed to improve health and lessen unfavorable health consequences. In India's rural healthcare delivery system, auxiliary nurse midwives (ANMs), accredited social health activists (ASHA workers), and Anganwadi workers (AWWs) are the primary field-level frontline officials who come into direct contact with the population. They bear a large portion of the burden of carrying out health services. This review investigated the various contributions made by these CHWs, ANMs, ASHA workers, and AWWs to the advancement of basic healthcare in Indian rural areas. The goal of reviewing this paper was to learn more about what CHWs do to provide the target demographic with high quality healthcare. A thorough literature search was conducted using crucial databases including PubMed, Google, and Google Scholar. Recent studies were examined to determine how well CHWs perform essential healthcare services in low and middle income nations. Numerous studies demonstrate how their work has a good effect on society. The length of time CHWs spend at work each day and how well they perform as a whole depends on several variables. This review study showed that, globally, there is a growing interest in CHWs' performance. In terms of incentives, pay, and training expenses, CHWs are thought to be a more affordable option than other types of health workers. They are recognized as the main factors in providing promotive, preventive, curative and rehabilitative healthcare services, achieving enhanced neonatal and maternal health and the development of children and adolescents. The current review also examined previous studies on the work done by CHWs and their potential benefits for enhancing primary healthcare in rural India. It focused on the routine work done by

these health workers to increase service accessibility and access to high-quality healthcare, particularly for individuals living in rural areas. Hence, it is necessary to evaluate the functions and general status of community health workers (CHWs), as well as recognize their role, to improve their efficiency in providing basic healthcare services to society and make necessary changes in the future.

Houweling, Shajy Isac, John Anthony, Audrey Prost (2021): The study found that ASHAs built relationships, counselled and supported many pregnant women of lower socio-economic positions. Ongoing inequities in health facility births and perinatal mortality were perpetuated by overlapping contextual issues beyond the ASHAs' purview. Supporting ASHAs' integration with community organizations and health system strategies more broadly is needed to address these issues and optimize pathways between equity in intervention coverage, processes and perinatal health outcomes.

Pranay Nadella, SV Subramanian, Andres Roman-Urrestarazu (2021): Receiving ANC from ASHAs and AWWs is associated with improved ANC utilization, ANC quality, early initiation of breastfeeding and the key outcome of reduced infant mortalitBhanupriya Pande (2020): ASHA is trusted person for most of services but when it comes to seeking solutions for health problems people are very apprehensive. It will be hurdle for community mobilization for health improvement. Hence it is need to be addressed on urgent basis by imparting some medical knowledge to ASHA and giving some certifications.

Abhishek Magotra (2020): Accredited Social Health Activist (ASHA) program has been accepted, and the services utilization has been increased among many Indian communities since its inception in 2005 under National Rural Health Mission (NRHM). ASHA worker's knowledge is important for the success of this program. ASHA will be the first port of call for any health relate demands of deprived sections of the population, especially women and children, who find it difficult to access health services. Selected from the community itself and accountable to it, the ASHA will be trained to work as an interface between the community and the public health system. The ASHA scheme is presently in place in 33 states (except Goa, Chandigarh & Puducherry).[1] ASHA plays an important role in in the community for providing health care and even in MCH care also it plays in important role.

Hannah J Koehn, Shenglin Zheng, Corey O'Hara, Beatrice Lorge Rogers (2020): ASHAs' home visit not more strongly associated with the health outcomes for which they were paid than outcomes for which they were paid. AWWs home visit were positively associated with awareness of NHDs, and associations varied for other recommended health behaviors. Further research could elucidate the causes for successes and failures of CHW programs in different states of India.

Smisha Agarwal, Sian L Curtis, Gustavo Angeles, Ilene S Speizer, Kavita Singh, James C Thomas (2019): Our results suggest that the ASHA program is successfully connecting marginalized communities to maternity health services. Given the potential of the ASHA in impacting service utilization, we emphasize the need to strengthen strategies to recruit, train, incentivize, and retain ASHAs.

A Mishra, K Mishra (2018): Government of India, has been launched since 12 years which it aims to deliver effective health care to the rural disadvantage population. Accredited Social Health Activist (ASHA) being the community health mobilizer is the main driving force of their area to the health system under NHM. This study aims to describe and relate factors affecting function of ASHA in her area, with a special focus on their service evaluation from various community stakeholders' perspective. Aim of the Study: To describe various factors affecting performance of ASHA. Material and Method: Community based cross sectional study design at Jagatsinghpur district in between July, 2012 to June, 2013 (12months). Convenient sampling procedure is being followed and total numbers of study respondents are 117. Predesigned pretested questionnaire is used for data collection.

Kerry Scott, Asha S George, Rajani R Ved (2017): Published work on ASHAs highlights a range of small-scale innovations, but also showcases the challenges faced by a program at massive scale, situated in the broader health system. As the program continues to evolve, critical comparative research that constructively feeds back into program reforms is needed, particularly related to governance, intersect oral linkages, ASHA solidarity, and community capacity to provide support and oversight.

Sangeeta Kori, Manohar Bhatia, Ashok Mishra (2015): There is a need to revise and update the knowledge of ASHA workers from time to time. On the job trainings of the

ASHAs should be in process to develop necessary knowledge and skills with recent updates. The block level meetings should be utilized for the feedback, enhancing knowledge & solving the problem faced by the ASHAs.

Lipekho Saprii, Esther Richards, Puni Kokho, Sally Theobald (2015): ASHAs are valued for their contribution towards maternal health education and for their ability to provide basic biomedical care, but their role as social activists is much less visible as envisioned in the ASHA operational guideline. Access by ASHAs to fair monetary incentives commensurate with effort coupled with the poor functionality of the health system are critical elements limiting the role of ASHAs both within the health system and within communities in rural Manipur.

Kavita Bhatia (2014): This article presents a historical review of national community health worker (CHW) programs in India using a gender- and rights-based lens. The aim is to derive relevant policy implications to stem attrition and enable sustenance of largescale CHW programs. For the literature review, relevant government policies, minutes of meetings, reports, newspaper articles and statistics were accessed through official websites and a hand search was conducted for studies on the rights-based aspects of large-scale CHW programs. The analysis shows that the CHWs in three successive Indian national CHW programs have consistently asked for reforms in their service conditions, including increased remuneration. Despite an evolution I" stakeholder perspectives regarding the rights of CHWs, service reforms are slow. Performance based payments do not provide the financial security expected by CHWs as demonstrated in the recent Accredited Social Health Activist (ASHA) program. In most countries, CHWs, who are largely women, have never been integrated into the established, salaried team of health system workers. The two hallmark characteristics of CHWs, namely, their volunteer status and the flexibility of their tasks and timings, impeded their rights. The consequences of initiating or neglecting standardization should be considered by all countries with large-scale CHW programs like the ASHA program.

Reetu Sharma, Premila Webster, Sanghita Bhattacharyya (2014): In order to improve the performance of ASHAs, apart from taking corrective actions at the professional and organizational front on a priority basis, it is equally essential to promote cordial work relationships amongst ASHAs and other community-level

workers from the two departments. This will also have a positive impact on community health.

Ghan Shyam Karol, BK Pattanaik (2014): Community health worker (CHW) programs are essential for expanding health services to many areas of the world and improving uptake of recommended behaviour's.. One of these programs, called Accredited Social Health Activists (ASHA), was initiated by the government of India in 2005 and now has a workforce of about 1 million. ASHAs primarily focus on improving maternal and child health but also support other health initiatives. Evaluations of ASHA efficacy have found a range of results, from negative, to mixed, to positive. Clarity in forming a general impression of ASHA efficacy is hindered by the use of a wide range of evaluation criteria across studies, a lack of comparison to other sources of behavioral influence, and a focus on a small number of behaviors per study. We analyse survey data for 1,166 mothers from Bihar, India, to assess the influence of ASHAs and eight other health influencers on the uptake of 12 perinatal health behaviors. We find that ASHAs are highly effective at increasing the probability that women self-report having practiced biomedically recommended behaviors. The ASHA's overall positive effect is larger than any of the nine health influencer categories in our study (covering public, private, and community sources), but their reach needs to be more widely extended to mothers who lack sufficient contact with ASHAs. We conclude that interactions between ASHAs and mothers positively impact the uptake of recommended perinatal health behaviors. ASHA training and program evaluation need to distinguish between individual-level and program-level factors in seeking ways to remove barriers that affect the reach of ASHA services.

Saji Saraswathy Gopalan, Satyanarayan Mohanty, Ashis Das (2012): The CHW programme could motivate and empower local lay women on community health largely. The desire to gain social recognition, a sense of social responsibility and self-efficacy motivated them to perform. The healthcare delivery system improvements might further motivate and enable them to gain the community trust. The CHW management needs amendments to ensure adequate supportive supervision, skill and knowledge enhancement and enabling working modalities.

Santosh Kumar, Amit Kaushik, Sangeeta Kansal (2012): Less knowledge of the content of job responsibility, caste, incentive oriented practices and delayed and inadequate payment of incentives for ASHAs influences the work performance.

Kerry Scott, Shobhit Shanker (2010): The study found that ASHAs built relationships, counselled and supported many pregnant women of lower socioeconomic positions. Ongoing inequities in health facility births and perinatal mortality were perpetuated by overlapping contextual issues beyond the ASHAs' purview. Supporting ASHAs' integration with community organizations and health system strategies more broadly is needed to address these issues and optimize pathways between equity in intervention coverage, processes and perinatal health.

3.1 THEORETICAL FRAMEWORK

The Accredited Social Health Activist (ASHA) program, launched under India's National Rural Health Mission (NRHM) in 2005, represents a landmark initiative aimed at strengthening the country's healthcare system at the grassroots level. ASHA workers are community health volunteers, primarily women, who serve as the critical link between the healthcare system and rural communities. Their primary responsibility is to ensure that the most marginalized populations have access to basic health services, information, and resources. The program's inception was driven by the need to address significant disparities in health outcomes across India, particularly in rural and remote areas where access to healthcare facilities is limited.

ASHA workers play a multifaceted role that extends beyond mere facilitation of health services. They are instrumental in promoting health awareness and education on key issues such as hygiene, sanitation, family planning, and nutrition. Additionally, they provide essential services such as immunization, antenatal and postnatal care, and disease prevention measures. ASHA workers are often the first point of contact for pregnant women, guiding them through the healthcare system to ensure safe deliveries and healthy postnatal periods. Their efforts contribute significantly to improving maternal and child health outcomes, which are critical indicators of a nation's overall health status.

The impact of ASHA workers on public health has been profound, yet their contributions are often underappreciated. Studies have shown that areas with active ASHA programs have seen substantial improvements in health indicators such as reduced infant mortality rates, increased immunization coverage, and better management of communicable diseases. By empowering local communities with knowledge and access to healthcare, ASHA workers help to create a more resilient and responsive health system. Their work not only addresses immediate health needs but also fosters long-term health literacy and self-reliance among community members.

Despite their significant contributions, ASHA workers face numerous challenges. These include inadequate training, insufficient remuneration, and logistical difficulties in reaching remote areas. Moreover, they often operate in challenging socio-cultural environments where health interventions may face resistance. Addressing these challenges is essential to enhance the effectiveness of ASHA workers and ensure the sustainability of their impact on the healthcare system. This study delves into the crucial

role of ASHA workers, exploring their contributions, the challenges they encounter, and the strategies needed to support and optimize their work within India's healthcare framework.

3.2 Duties of ASHA Workers

ASHA workers (Accredited Social Health Activists) perform a wide range of duties aimed at improving public health and bridging the gap between the healthcare system and rural communities. Their responsibilities include:

1. Health Education and Promotion:

- ✦ Educating the community about hygiene, sanitation, and preventive healthcare.
- ✦ Promoting awareness on family planning, reproductive health, and safe sex practices.
- ✦ Conducting health awareness campaigns on communicable and noncommunicable diseases.

2. Maternal and Child Health:

- ✦ Identifying pregnant women and encouraging antenatal and postnatal care visits.
- ✦ Assisting with immunizations and promoting institutional deliveries.
- ✦ Monitoring child growth and development, ensuring children receive necessary vaccinations.

3. Healthcare Facilitation:

- ✦ Acting as a liaison between the community and primary health centres.

Guiding patients to appropriate healthcare facilities for various treatments and services.

- ✦ Distributing basic medications and contraceptives provided by the government.

4. Community Surveys and Data Collection:

- ✦ Conducting household surveys to gather health-related data.
- ✦ Maintaining records of births, deaths, and health status within the community.
- ✦ Reporting health issues and disease outbreaks to higher health authorities.

5. Disease Prevention and Management:

- ✦ Identifying and referring cases of tuberculosis, malaria, leprosy, and other diseases.
- ✦ Promoting and facilitating the treatment adherence for chronic diseases.
- ✦ Engaging in community-level health initiatives and campaigns.

6. Support and Counselling:

- ✦ Providing counselling on nutrition, breastfeeding, and child care.
- ✦ Offering support to families in managing chronic illnesses and disabilities.
- ✦ Helping women and families cope with social and health issues such as domestic violence and mental health concerns.

7. Emergency Care and First Aid:

- ✦ Offering basic first aid and emergency care.
- ✦ Assisting in transportation arrangements for patients in critical conditions.

8. Mobilization and Community Involvement:

- Organizing health camps and community meetings.

Mobilizing the community for collective action on health-related issues.

- Encouraging community participation in health programs and initiatives.

ASHA workers are integral to the rural healthcare system, providing essential services and fostering community health improvements through their dedicated efforts.

3.3 Honorarium

ASHA workers receive an honorarium as a form of compensation for their services, though it is often not a fixed salary but rather performance-based incentives tied to specific health activities and targets. The honorarium structure includes the following components:

1. Fixed Monthly Payment:

    - In some states, ASHA workers receive a fixed monthly payment to cover basic expenses. This amount varies across states and is intended to provide a minimal level of financial support.

2. Incentive-Based Payments: ASHA workers earn additional incentives based on the completion of specific health-related tasks and achieving set targets. These incentives are provided for activities such as:

    - Ensuring institutional deliveries.
    - Promoting and ensuring full immunization for children.
    - Registering pregnant women and ensuring they receive antenatal and postnatal care.
    - Conducting community-level health education sessions.

Identifying and referring cases of tuberculosis, leprosy, and other communicable diseases.

- Promoting family planning and distributing contraceptives.
- Ensuring regular follow-ups for patients with chronic diseases.

3. National Health Programs:

- Incentives are also provided for participation in various national health programs, such as:
- National Immunization Days (NID) for polio.
- Campaigns for maternal and child health, tuberculosis, malaria, and other health initiatives.

4. State-Specific Schemes:

- Some states have additional schemes and programs that provide extra incentives to ASHA workers for activities specific to the health priorities of that region.

The honorarium system, while providing some financial support, is often criticized for being insufficient, leading to financial insecurity for many ASHA workers. Efforts to improve their compensation, such as increasing the fixed monthly payment and revising the incentive structure, are ongoing to ensure fair remuneration for their crucial role in the healthcare.

3.4 Training program

ASHA workers undergo extensive training to equip them with the knowledge and skills needed to perform their duties effectively. The training program is structured to cover a wide range of health-related topics and practical skills, and it is conducted in phases to ensure comprehensive learning. Key components of ASHA training include:

1. Induction Training:

Orientation: Introduction to the role and responsibilities of an ASHA worker, the healthcare system, and the community.

- Basic Health Knowledge: Fundamentals of maternal and child health, family planning, immunization, nutrition, and common diseases.

2. Module-Based Training:

- Module I (Understanding the Role): Detailed understanding of ASHA's roles, responsibilities, and the health needs of the community.
- Module II (Maternal and Child Health): Focused training on antenatal care, safe delivery practices, postnatal care, and newborn care.
- Module III (Child Health and Nutrition): Training on growth monitoring, breastfeeding, complementary feeding, and managing common childhood illnesses.
- Module IV (Communicable Diseases): Identification, prevention, and management of tuberculosis, malaria, leprosy, and other infectious diseases.
- Module V (Non-Communicable Diseases): Awareness and management of diabetes, hypertension, and other chronic conditions.
- Module VI (Community Mobilization): Skills in community engagement, health education, and behaviour change communication.

3. On-the-Job Training:

- Practical Sessions: Hands-on training in health centres and community settings, guided by healthcare professionals.
- Field Visits: Regular field visits to households for practical experience in health promotion and service delivery.

4. Specialized Training:

- First Aid and Basic Life Support: Training in emergency care, first aid, and handling common medical emergencies.

- Reproductive and Child Health: Specialized sessions on contraceptive methods, reproductive health counselling, and adolescent health.

  Disease-Specific Programs: Focused training for national health programs like the Integrated Child Development Services (ICDS) and the Revised National Tuberculosis Control Program (RNTCP).

5. Refresher Training:

- Periodic refresher courses to update ASHA workers on new health guidelines, practices, and emerging health issues.

6. Use of Health Technology:

- Training on the use of digital tools and mobile applications for health data collection, reporting, and communication.

These training programs are designed to ensure that ASHA workers are well prepared to address the diverse health needs of their communities, provide accurate health information, and offer essential services.

3.5 Community programs

ASHA workers play a crucial role in implementing various community programs aimed at improving public health. These programs are designed to address a broad spectrum of health issues and ensure that essential health services reach even the most remote and underserved populations. Key community programs involving ASHA workers include:

1. Maternal and Child Health Programs:

- Janani Suraksha Yojana (JSY): Encouraging institutional deliveries by providing financial incentives to pregnant women and ensuring they receive adequate antenatal and postnatal care.

- Janani Shishu Suraksha Karyakram (JSSK): Ensuring free and cashless services for pregnant women, including delivery, caesarean section, and neonatal care.

- Home-Based Newborn Care (HBNC): Regular home visits to monitor the health and development of newborns and provide essential newborn care.

2. Immunization Programs:

- Mission Indradhanush: Ensuring full immunization coverage for children and pregnant women by conducting immunization drives and raising awareness about vaccine-preventable diseases.
- National Immunization Days (NID): Mobilizing communities for polio vaccination and other national immunization campaigns.

3. Family Planning Programs:

- Promotion of Contraceptive Use: Educating couples about various contraceptive methods and distributing contraceptives like condoms, oral contraceptive pills, and emergency contraception.
- Sterilization Camps: Encouraging and facilitating access to sterilization services for eligible couples.

4. Nutrition Programs:

- Poshan Abhiyaan (National Nutrition Mission): Addressing malnutrition among children, adolescents, pregnant women, and lactating mothers through community-level interventions and nutritional education.
- Supplementary Nutrition Program (SNP): Ensuring the distribution of nutritious food to children under six years, pregnant women, and lactating mothers.

5. Disease Control Programs:

- Revised National Tuberculosis Control Program (RNTCP): Identifying and referring suspected tuberculosis cases, ensuring treatment adherence, and providing support to patients.

  National Vector Borne Disease Control Program (NVBDCP): Educating communities about the prevention and control of malaria, dengue, chikungunya, and other vector-borne diseases.
- Leprosy Eradication Program: Identifying and referring suspected leprosy cases, promoting awareness, and reducing stigma.

6. Non-Communicable Disease Programs:

- National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases, and Stroke (NPCDCS): Conducting community screenings and raising awareness about lifestyle modifications to prevent and manage non-communicable diseases.

7. Adolescent Health Programs:

- Rashtriya Kishor Swasthya Karyakram (RKSK): Addressing the health and development needs of adolescents through education on nutrition, reproductive health, mental health, and substance abuse prevention.

8. Sanitation and Hygiene Programs:

- Swachh Bharat Abhiyan: Promoting cleanliness, hygiene, and the use of toilets to prevent open defecation and improve community sanitation.

9. Community-Based Health Insurance Programs:

- ✦ Pradhan Mantri Jan Arogya Yojana (PMJAY): Educating and assisting families in enrolling for health insurance schemes to ensure access to secondary and tertiary healthcare services.

Through these community programs, ASHA workers play a pivotal role in enhancing public health, reducing health disparities, and ensuring that critical health services are accessible to all segments of the population.

3.6 Leave provisions

ASHA workers, as community health volunteers, often face challenging work conditions and require adequate leave provisions to manage their personal and professional lives effectively. While the specifics of leave provisions can vary across different states and regions, the following are general guidelines and entitlements typically available to ASHA workers:

1. Maternity Leave:

- ✦ ASHA workers are generally entitled to maternity leave, allowing them to take time off during the later stages of pregnancy and after childbirth. The duration of maternity leave varies but is usually around 6 to 12 weeks.

2. Sick Leave:

- ✦ Provision for sick leave is essential for ASHA workers to ensure they can take time off to recover from illnesses without compromising their health. The exact number of sick leave days can vary based on state policies.

3. Casual Leave:

- ASHA workers are often granted casual leave for attending to personal matters or unforeseen circumstances. The number of casual leave days typically ranges from 10 to 12 days per year.

4. Earned Leave:

- Some states provide earned leave to ASHA workers, which accumulates based on the number of days worked. This leave can be used for longer periods off work, such as vacations or extended personal matters.

5. Special Leave:

Special leave provisions may be available for ASHA workers to attend training programs, health camps, or other official duties. This ensures they can participate in capacity-building activities without losing their regular income.

6. Compensatory Leave:

- In cases where ASHA workers are required to work on public holidays or weekends, compensatory leave may be provided to ensure they receive adequate rest and work-life balance.

7. Bereavement Leave:

- ASHA workers are generally allowed bereavement leave to cope with the loss of a family member. This leave period can vary depending on the state's policies.

It is important to note that the implementation and adherence to these leave provisions can vary significantly across different regions, and advocacy for standardized and consistent leave policies for ASHA workers is ongoing. Ensuring that ASHA workers

have access to adequate leave is crucial for their well-being and effectiveness in delivering community health services.

3.7 Review meeting

Review meetings for ASHA workers are crucial for evaluating their performance, addressing challenges, and providing continuous support and training. These meetings are typically organized at various administrative levels, such as village, block, and district levels, and serve multiple purposes. Here are some key aspects of ASHA review meetings:

1. Frequency and Organization:

Monthly Meetings: Most commonly, ASHA workers participate in monthly review meetings. These are usually held at the primary health center (PHC) or block level and are attended by ASHA workers, their supervisors (ASHA facilitators), and health officials.

- Quarterly and Annual Meetings: In addition to monthly meetings, quarterly and annual review meetings may be organized to conduct more comprehensive evaluations and plan for the upcoming periods.

2. Objectives:

- Performance Evaluation: Assessing the performance of ASHA workers against set targets and health indicators, such as immunization coverage, antenatal care visits, and disease surveillance.
- Problem Solving: Identifying and addressing challenges faced by ASHA workers in the field, such as supply shortages, community resistance, or logistical issues.
- Capacity Building: Providing ongoing training and updates on new health guidelines, protocols, and programs. This ensures ASHA workers are equipped with the latest knowledge and skills.

- Data Review: Reviewing health data collected by ASHA workers, ensuring accuracy, and discussing trends and patterns to inform health planning and interventions.

3. Agenda and Activities:

- Reporting: ASHA workers present reports on their activities, achievements, and challenges encountered during the previous month.
- Feedback and Guidance: Supervisors provide feedback on

  performance, offer guidance on improving service delivery, and address any concerns raised by ASHA workers.
- Training Sessions: Conducting refresher training sessions on various health topics, new initiatives, and best practices.
- Case Discussions: Discussing specific cases or incidents encountered in the community to learn from experiences and develop solutions.

  Planning: Setting targets and action plans for the upcoming month, including specific health campaigns, community outreach activities, and coordination with other health programs.

4. Documentation and Follow-Up:

- Minutes of Meetings: Detailed minutes of each meeting are recorded, highlighting key discussions, decisions, and action points. This documentation is essential for accountability and tracking progress.
- Action Plans: Developing and distributing action plans based on the outcomes of the review meetings, ensuring that ASHA workers have clear guidelines and objectives.
- Follow-Up: Regular follow-up on action points and issues raised in previous meetings to ensure they are addressed effectively and promptly.

5. Support and Motivation:

- ✦ Recognition: Acknowledging and rewarding outstanding performance to motivate ASHA workers and encourage best practices.
- ✦ Support Systems: Strengthening support systems, such as peer groups and mentorship programs, to provide ASHA workers with additional resources and assistance.

Review meetings are vital for maintaining the effectiveness of ASHA workers, enhancing their skills, and ensuring that community health programs are implemented efficiently and effectively. These meetings foster a collaborative environment where ASHA workers can share experiences, learn from each other, and continuously improve their service delivery.

3.8 Community Outreach

Community outreach is a critical component of ASHA workers' roles, aiming to ensure that health services reach every individual in the community, especially the most vulnerable. Here are some strategies to enhance community outreach for ASHA workers:

1. Organize Health Camps and Clinics:

   - ✦ Regular Health Camps: Schedule regular health camps in different localities within the panchayat to provide basic health services, screenings, and vaccinations.
   - ✦ Mobile Clinics: Implement mobile clinics that can travel to remote or underserved areas to ensure that all community members have access to healthcare services.

2. Leverage Local Institutions and Networks:

   - ✦ Schools and Anganwadis: Partner with schools and Anganwadi centers to conduct health education sessions and check-ups for children and their families.

- ✦ Community Centers: Utilize community centers as hubs for health information, distribution of health materials, and conducting healthrelated activities.

3. Develop and Distribute Educational Materials:

   - ✦ Pamphlets and Brochures: Create easy-to-understand pamphlets and brochures on various health topics and distribute them door-to-door and at public gatherings.
   - ✦ Visual Aids: Use posters, charts, and visual aids to educate community members about important health issues and practices.

4. Engage with Community Leaders and Influencers:

   - ✦ Local Leaders: Involve local leaders, religious heads, and respected elders in health promotion activities to gain their support and influence within the community.
   - ✦ Youth Volunteers: Recruit and train local youth as health ambassadors to assist ASHA workers in spreading health messages and organizing activities.

5. Utilize Technology and Media:

   - ✦ Mobile Messaging: Use SMS, WhatsApp, and other mobile messaging platforms to send health tips, reminders for vaccinations, and information about upcoming health camps.
   - ✦ Community Radio: Collaborate with local radio stations to broadcast health programs, interviews with healthcare professionals, and success stories from the community.

6. Conduct Door-to-Door Visits:

   - ✦ Regular Home Visits: Ensure ASHA workers conduct regular home visits to check on the health status of families, especially pregnant women, infants, and the elderly.

- ✦ Health Surveys: Carry out health surveys during visits to identify health needs, provide advice, and refer individuals to appropriate healthcare facilities.

7. Organize Group Activities:

- ✦ Health Education Sessions: Arrange group health education sessions focusing on topics like hygiene, nutrition, maternal and child health, and chronic disease prevention.

- ✦ Support Groups: Form support groups for individuals with specific health conditions (e.g., diabetes, hypertension) to share experiences, provide mutual support, and receive guidance from ASHA workers.

8. Strengthen Referral Systems:

- ✦ Referral Networks: Establish a strong referral network with local healthcare facilities to ensure that community members can access specialized care when needed.
- ✦ Follow-Up: Implement follow-up mechanisms to ensure that referred individuals receive the necessary care and support

9. Celebrate Health Days:

   - ✦ Health Awareness Days: Celebrate national and international health days (e.g., World Health Day, World AIDS Day) with community events, rallies, and educational activities to raise awareness and promote healthy behaviours.

10. Provide Continuous Training and Support:

    - ✦ Skill Development: Offer regular training sessions for ASHA workers to update their knowledge and skills in community outreach and health education.
    - ✦ Supervision and Mentorship: Provide ongoing supervision and mentorship to ASHA workers to ensure they are supported and motivated in their outreach efforts.

By implementing these strategies, ASHA workers can enhance their community outreach efforts, ensuring that health services are accessible, comprehensive, and effective for all community members.

3.9 Preventive care

Preventive care is a crucial aspect of ASHA workers' responsibilities, aiming to prevent illnesses and promote healthy lifestyles within the community. Here are several strategies for ASHA workers to enhance their role in preventive care:

1. Health Education and Awareness

   - ✦ Workshops and Sessions: Conduct regular workshops and educational sessions on preventive health topics such as hygiene, nutrition, vaccination, and chronic disease management.

- School Programs: Collaborate with schools to educate children on hygiene practices, balanced diet, and the importance of physical activity. ▪ Community Events: Organize community events on special health days to raise awareness about various health issues and preventive measures.

2. Immunization Drives

- Routine Immunization: Ensure that all children in the community receive their routine immunizations as per the national immunization schedule.
- Awareness Campaigns: Conduct awareness campaigns to educate parents about the importance of vaccines in preventing diseases like measles, polio, and tuberculosis.
- Tracking and Follow-up: Maintain records of immunizations and follow up with families to ensure that children receive all necessary doses.

3. Maternal and Child Health

- Antenatal and Postnatal Care: Provide regular antenatal check-ups for pregnant women, educating them about proper nutrition, hygiene, and recognizing danger signs during pregnancy.
- Breastfeeding Promotion: Promote exclusive breastfeeding for the first six months and continued breastfeeding along with appropriate complementary feeding thereafter.
- Growth Monitoring: Regularly monitor the growth and development of infants and young children to identify and address malnutrition early.

4. Disease Prevention and Control

- ✦ Vector Control: Educate the community about vector-borne diseases like malaria and dengue, and promote measures such as using mosquito nets and eliminating stagnant water.
- ✦ Sanitation and Hygiene: Promote good sanitation practices, including proper handwashing techniques, safe drinking water, and proper waste disposal.
- ✦ Screening Programs: Organize screening programs for common diseases like hypertension, diabetes, and tuberculosis, and refer suspected cases for further evaluation.

5. Nutrition and Lifestyle Promotion

- ✦ Balanced Diet: Educate families about the importance of a balanced diet rich in fruits, vegetables, and whole grains, and the risks of consuming processed and junk foods.
- ✦ Physical Activity: Encourage regular physical activity, especially among children and adolescents, to prevent obesity and related health issues.
- ✦ Substance Abuse Prevention: Raise awareness about the harmful effects of tobacco, alcohol, and other substances, and support community members in quitting these habits.

6. Family Planning and Reproductive Health

- ✦ Contraceptive Awareness: Provide information on various contraceptive methods, their benefits, and availability to promote informed family planning choices.
- ✦ Safe Practices: Educate about safe sexual practices to prevent sexually transmitted infections (STIs) and promote reproductive health.

7. Elderly Care

- ✦ Health Check-ups: Conduct regular health check-ups for the elderly to monitor and manage chronic conditions like hypertension and diabetes
- ✦ Support Groups: Form support groups for the elderly to provide emotional support, social interaction, and health education.

8. Mental Health

- ✦ Stress Management: Educate the community about the importance of mental health and provide tips on managing stress and anxiety.
- ✦ Referral Services: Identify individuals with mental health issues and refer them to appropriate mental health services for further evaluation and treatment.

9. Environmental Health

- ✦ Clean Environment: Promote activities aimed at maintaining a clean and safe environment, such as community clean-up drives and proper waste management.
- ✦ Air Quality: Raise awareness about the importance of indoor and outdoor air quality and how to minimize exposure to pollutants.

10. Documentation and Reporting

- ✦ Record Keeping: Maintain accurate records of all preventive care activities, health education sessions, immunizations, and screenings.
- ✦ Feedback Mechanism: Establish a feedback mechanism to continually assess the effectiveness of preventive care activities and make necessary adjustments.

By focusing on these areas, ASHA workers can significantly contribute to the prevention of diseases and the promotion of a healthy community.

4.1 DATAANALYSIS AND INTERPRETATION

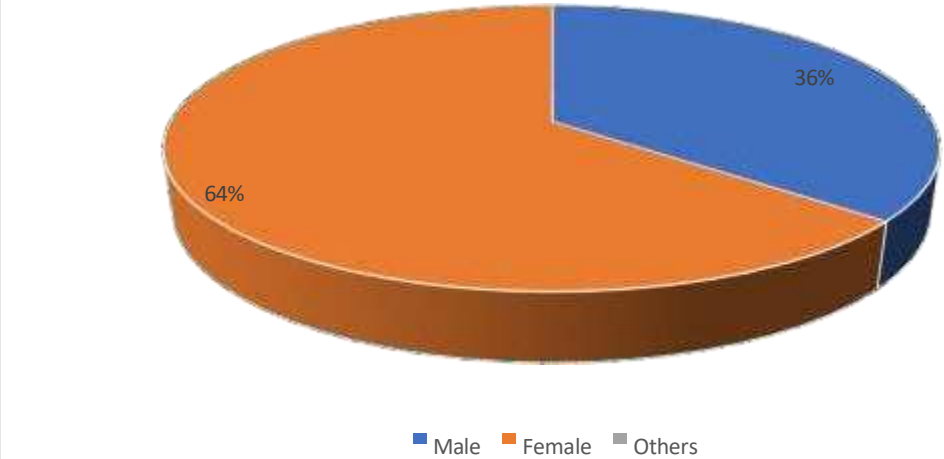
Table No.4.1

Gender wise Classification of respondents

Gender	No. of Respondents	Percentage
Male	27	36
Female	48	64
Others	0	0
Total	**75**	**100**

Figure 4.1

Gender wise Classification of respondents



From the above table show the gender wise classification of 75 respondents. Here 64% of respondents are female and remaining 36% are male.

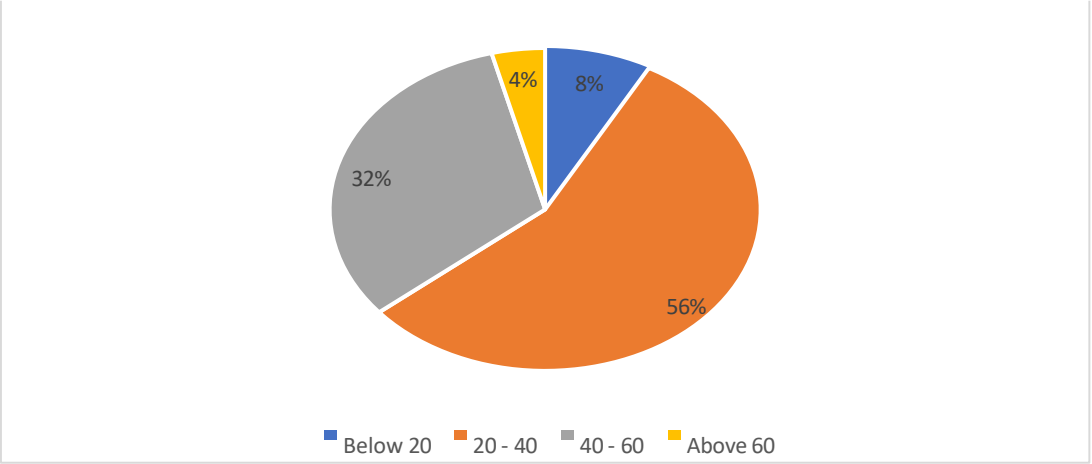
Table No.4.2

Age Wise Classification of Respondents

Age Group	No. of Respondents	Percentage
Below 20	6	8
20 – 40	42	56
40 – 60	24	32
60 Above	3	4
Total	**75**	**100**

Figure.4.2

Age Wise Classification of Respondents



The above table shows that 56% of respondents are 20 – 40 age group, 32% of respondents are 40 – 60 age group, 8% of respondents are below 20 and 4% of respondents are above 60.

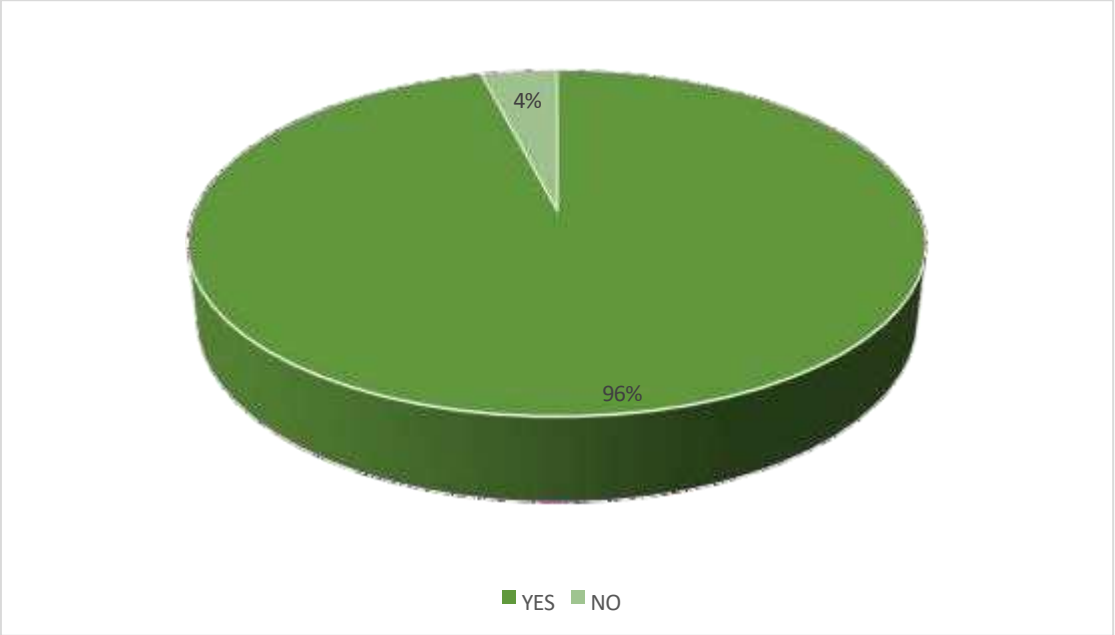
Table No.4.3

Awareness about ASHA Workers

Options	NO. of respondents	Percentage
Yes	72	96
No	3	4
Total	**75**	**100**

Figure:4.3

Awareness about ASHA Workers



The above table shows that 96% of respondents are aware of ASHA Workers, while only 4% are not.

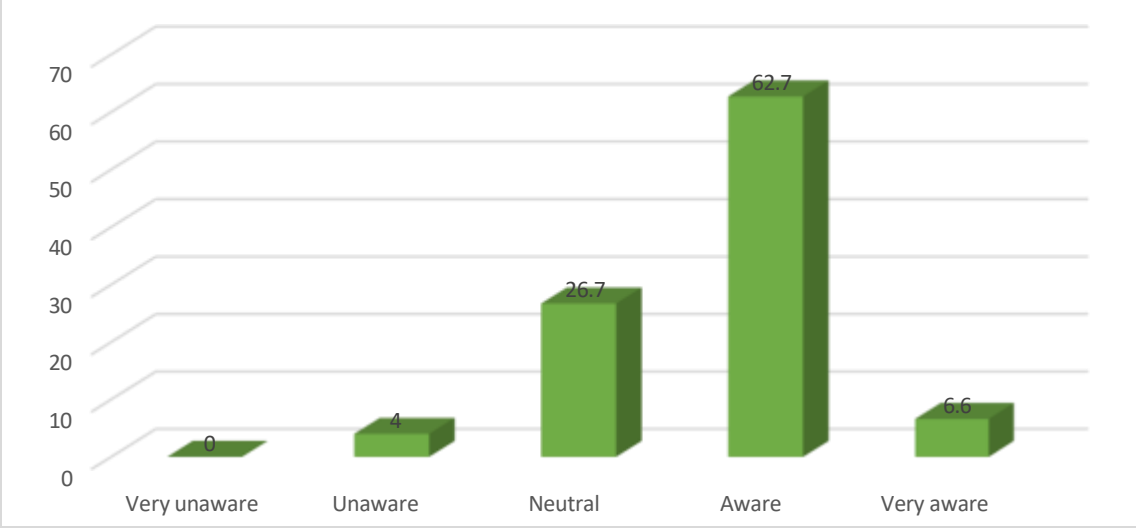
Table No:4.4

Awareness level

Awareness level	No. of Respondents	Percentage
Very unaware	0	0
Unaware	3	4
Neutral	20	26.7
Aware	47	62.7
Very aware	5	6.6
Total	**75**	**100**

Figure.4.4

Awareness level



The above table shows that 62.7% of respondents are aware of service provided by ASHA workers, while 26.7% hold a neutral position. A smaller percentage, 6.6% are very aware and only 4% are unaware, with 0% being very unaware.

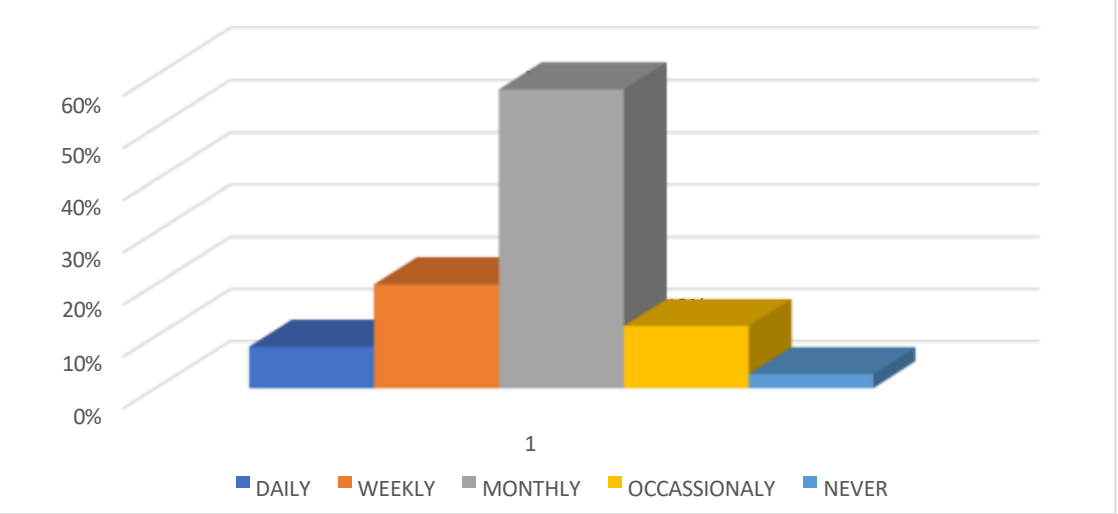
Table No.4.5

Frequency of ASHA Workers visits to the community

Options	No of respondents	Percentage
Daily	6	8
Weekly	15	20
Monthly	43	57.3
Occasionally	9	12
Never	2	2.7
Total	**75**	**100**

Figure.4.5

Frequency of ASHA Workers visits to the community



The above table shows that 57.3% of the community receives monthly visits, while 20% benefit from weekly visits. About 12% report occasional visits, and 8% experience daily visits. However, 2.7% of respondents never see ASHA workers.

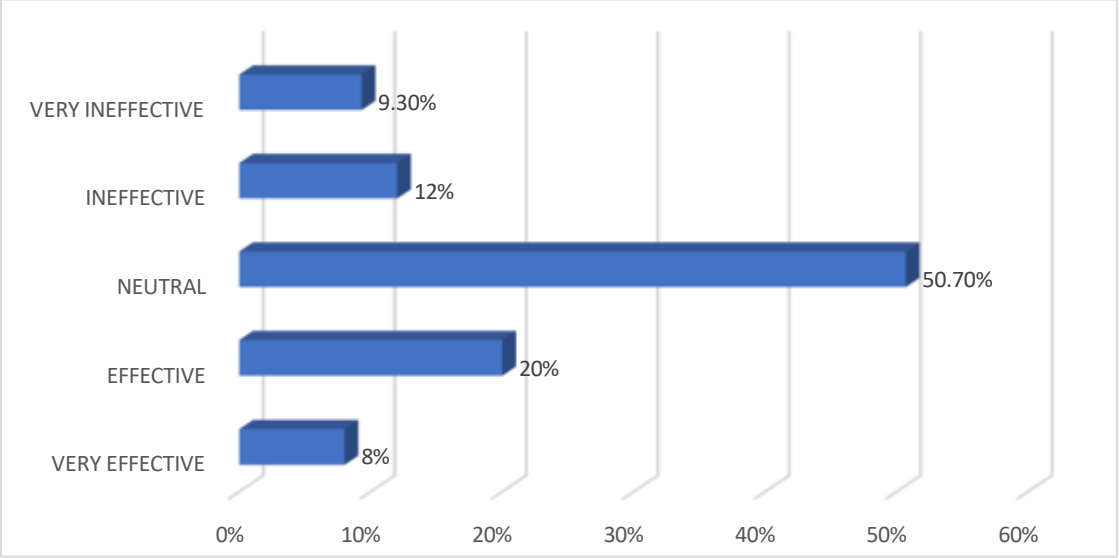
Table No.4.6

Effectiveness of healthcare services provided by ASHA Workers

Options	No. of respondents	Percentage
Very effective	6	8
Effective	15	20
Neutral	38	50.7
Ineffective	9	12
Very ineffective	7	9.3
Total	**75**	**100**

Figure.4.6

Effectiveness of healthcare services provided by ASHA Workers



The table shows that the majority view these services neutrally (50.7%), Positive feedback totals 28%, with 20% finding them effective and 8% very effective. 21.3% perceive them as ineffective or very ineffective (12% and 9.3% respectively).

Relationship between challenges faced by public and services provided by ASHA workers.

H0: There is no significant relationship between challenges faced by public and services provided by ASHA workers.

H1: There is a significant relationship between challenges faced by public and services provided by ASHA workers.

Table No.4.7

Services Provided by ASHA Workers

Services	Strongly agree	Agree	Neutrally agree	Disagree	Strongly disagree	TOTAL
Basic medical care	9	18	42	6	0	75
Maternal and child health	10	16	37	8	4	75
Nutrition and hygiene	28	22	19	4	2	75
Disease prevention	5	10	32	19	9	75
Helping pandemic situations	10	15	32	12	6	75
Health education	9	16	23	19	8	75

Table No.4.7

Challenges Faced by public

Activities	Strongly agree	Agree	Neutrally agree	Disagree	Strongly disagree	TOTAL
Proper services	30	19	16	4	6	75
Lack of awareness	18	20	27	7	3	75
Proper visit	16	22	30	3	4	75
Lack of Communication	22	19	23	8	3	75
Lack of availability	13	21	31	7	3	75

Table No.4.7

Relationship between challenges faced by public and services provided by ASHA workers.

	Sum of Square	**df**	**Mean Square**	**F**	**Sig.**
Between Groups	1.054	3	.351	.629	.599
Within Groups	39.666	71	.559		
Total	40.720				

Here we test the two variables services provided by ASHA Workers and challenges faced by public. The result of the test shows the significant level of ANOVA is greater than 0.05 that is **.599** hence the test accept the null hypothesis **(**H0: There is no significant relationship between challenges faced by public and services provided by ASHA workers.) and reject the alternative hypothesis **(**H1: There is a significant relationship between challenges faced by public and services provided by ASHA workers).

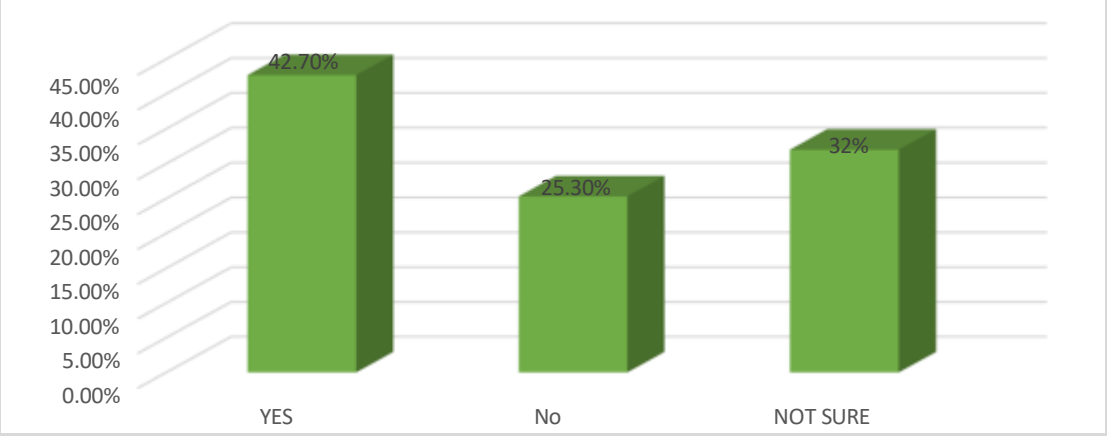
Table N.4.8

Improvement in health outcomes

Options	No. of respondents	Percentage
Yes	32	42.7
No	19	25.3
Not sure	24	32
Total	**75**	**100**

Figure.4.8

Improvement in health outcomes



42.2% of respondents believe there has been an improvement in health outcomes,23.3% of respondents do not believe there has been an improvement and, 32% not sure.

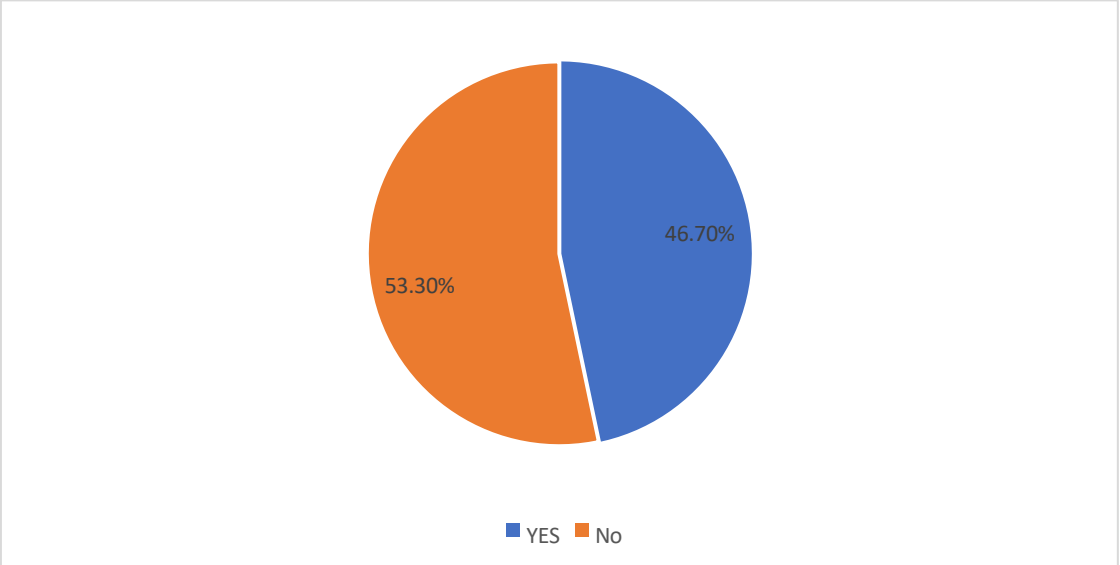
Table No:4.9

Health Education classes

Options	No. of respondents	Percentage
Yes	35	46.7
No	40	53.3
Total	**75**	**100**

Figure.4.9

Health Education classes



53.3% of respondents says that ASHA workers do not conduct health education classes and the remaining 46.7% 0f respondents says that ASHA workers do conduct health education classes.

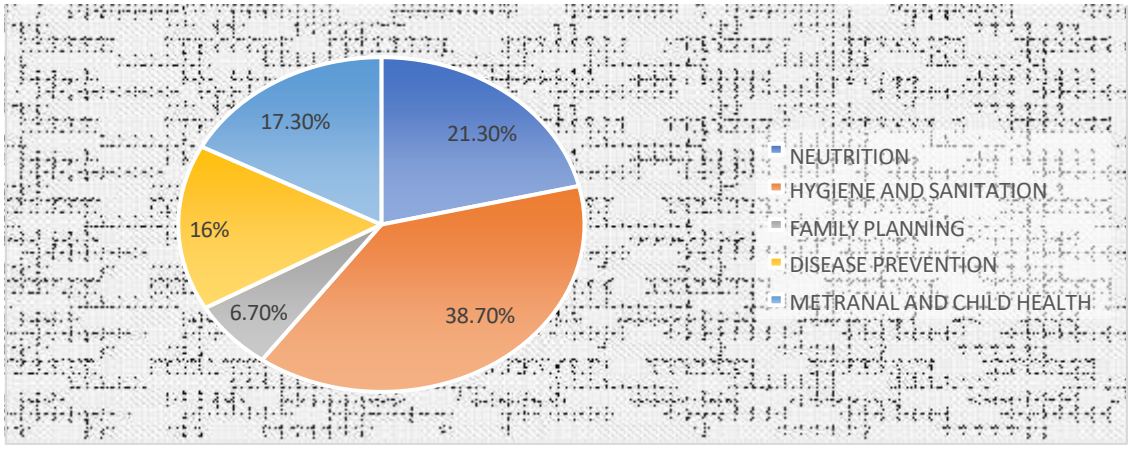
Table No.4.10

Topics Covered in Health Education Session

Topics	No. of respondents	Percentage
Nutrition	16	21.3
Hygiene and sanitation	29	38.7
Family planning	5	6.7
Disease prevention	12	16
Maternal and child health	13	17.3
TOTAL	**75**	**100**

Figure.4.10

Topics Covered in Health Education Session



The table shows that the topics covered in health education classes by ASHA workers indicates a strong emphasis on hygiene and sanitation (38.7%).21.3%, reflecting efforts to promote nutrition. Maternal and child health and disease prevention are also significant areas of focus, comprising 17.3% and 16% of the classes respectively, Family planning is covered to a lesser extent at 6.7%

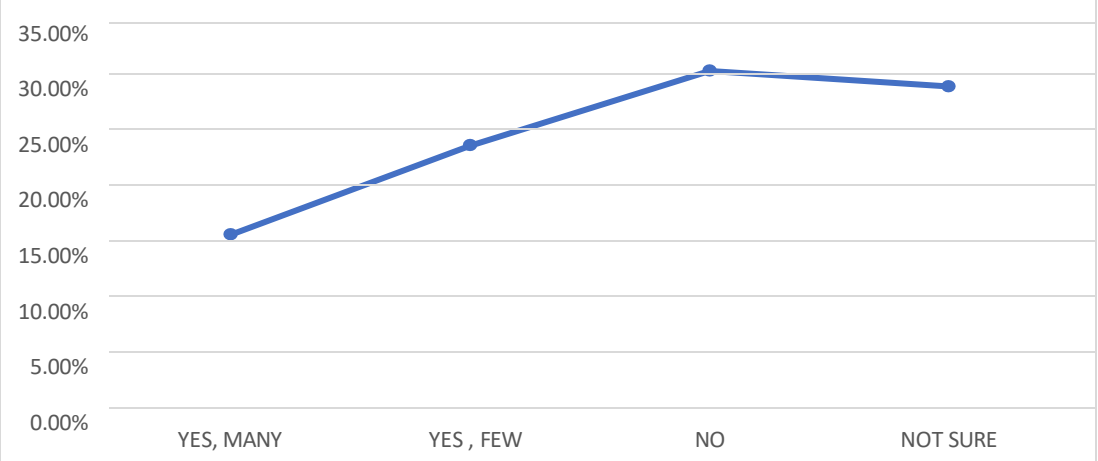
Table No.4.11

Health Practices Implemented Based on ASHA Workers Suggestions

Options	No. of respondents	Percentage
Yes, many	12	16
Yes, few	18	24
No	23	30.7
Not sure	22	29.3
Total	**75**	**100**

Figure.4.11

Health Practices Implemented Based on ASHA Workers Suggestions



The table shows that the health practices implemented by public based on ASHA workers' suggestions. 30.7% explicitly stating they have not implemented any and 29.3% unsure if they have. On the positive side, 24% of individuals have incorporated a few of the suggested health practices, while 16% have adopted many.

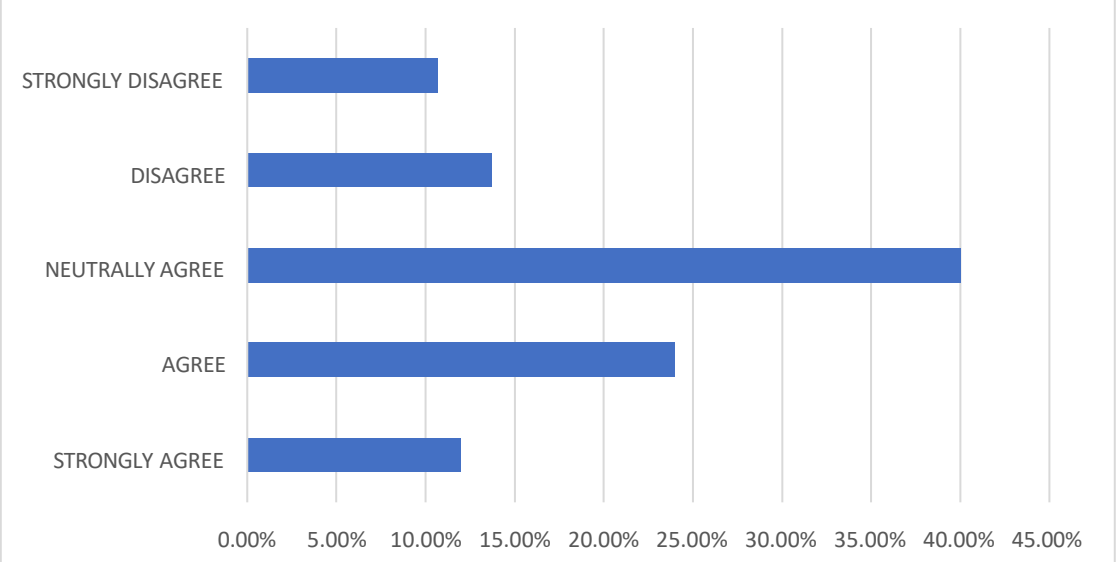
Table No.4.12

Impact of ASHA Workers Educational Efforts

Option	No. of respondents	Percentage
Strongly agree	9	12
Agree	18	24
Neutrally agree	30	40
Disagree	10	13
Strongly disagree	8	10
TOTAL	**75**	**100**

Figure.4.12

Impact of ASHA Workers Educational Efforts



The above table shows that 38% of respondents either strongly agree (12%) or agree (24%) with the impact of ASHA workers' education initiatives, indicating a positive reception among a significant portion of the population. However, 27% of respondents either disagree (13%) or strongly disagree (14%).

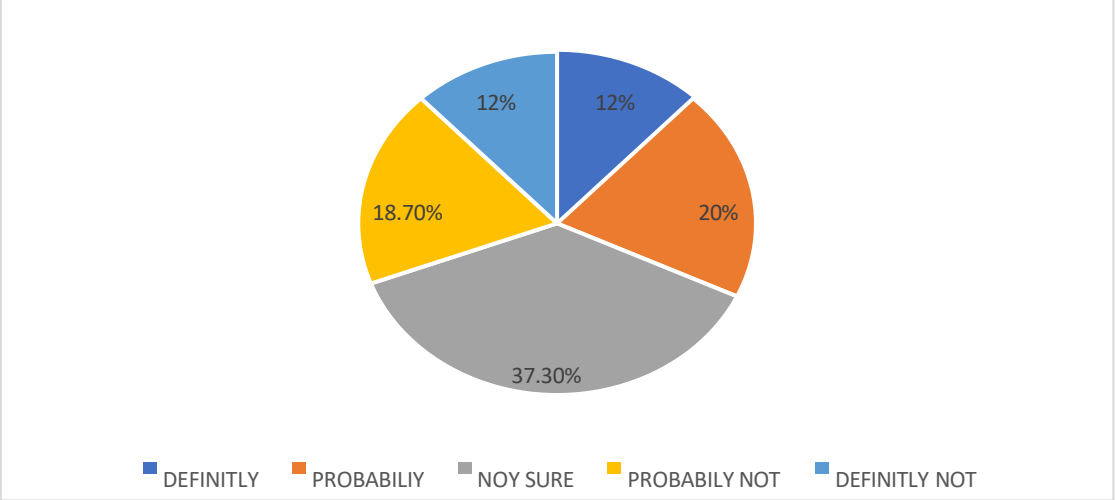
Table No.4.13

Recommendation on Contribution of ASHA Workers service

Option	No. of respondents	Percentage
Definitely	9	12
Probably	15	20
Not sure	28	37.3
Probably not	14	18.7
Definitely not	9	12
TOTAL	**75**	**100**

Figure.4.13

Recommendation on Contribution of ASHA Workers service



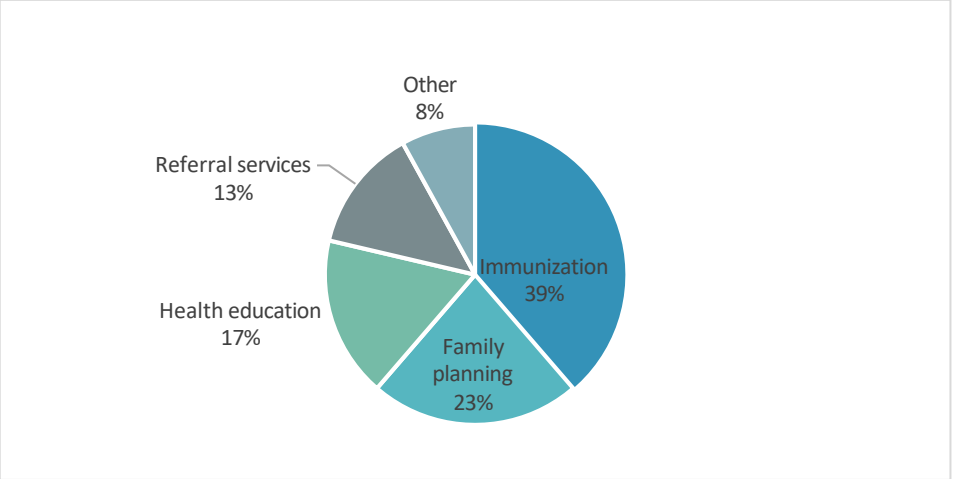
The above table shows that 37.3% of respondents expressed uncertainty, indicating a lack of clear consensus or understanding about the service's value or impact. Meanwhile, 20% of respondents leaned towards favouring its continuation. However, 18.7% were inclined towards discontinuation, 24% (12% definitely not and 12% probably not) expressed opposition.

Table No.4.14

Services utilised by Families

Services	No. of respondents	Percentage
Immunisation	29	38.7
Family planning	17	22.6
Health education	13	17.3
Referral services	10	13.4
Other	6	8
Total	75	100

Figure.4.14



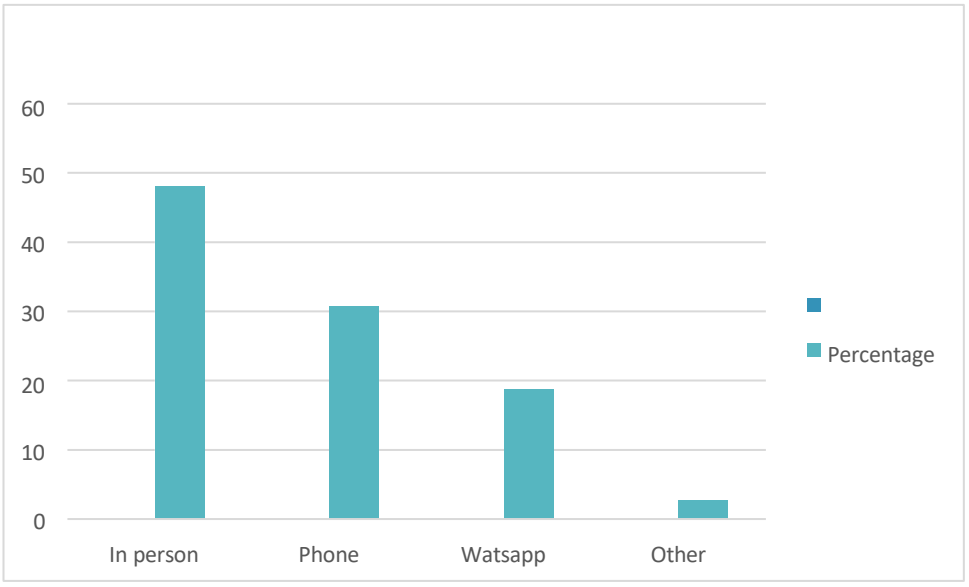
From the above table ,Immunisation was the most frequently stated service (39%) among those surveyed, suggesting that it is the most accessible or frequently utilised treatment. Strong community-based outreach and vaccination public health campaigns may be indicated by this. The prevalence of family planning reports (23%) and health education reports (17%) indicate a significant focus on reproductive health and awareness-raising initiatives. The relatively low percentage of referral services (13%) suggests that many health issues may have been handled at the original point of contact, even if some clients were sent for additional care. The Other (8%) group indicated that a small percentage of respondents received services other than basic health, such as nutrition, maternity care, or minor treatments.

Table No..15

Communication with asha workers

Option	No.of respondents	Percentage
In person	36	48
Phone	23	30.67
WhatsApp	14	18.67
Other	2	2.66
Total	75	100

Figure.4.15



The above figure indicates that 48% of the respondents prefer to face to face communication , which indicates its relevance in community health work .(31%) of respondents who cited phone calls, suggesting ease of accessibility

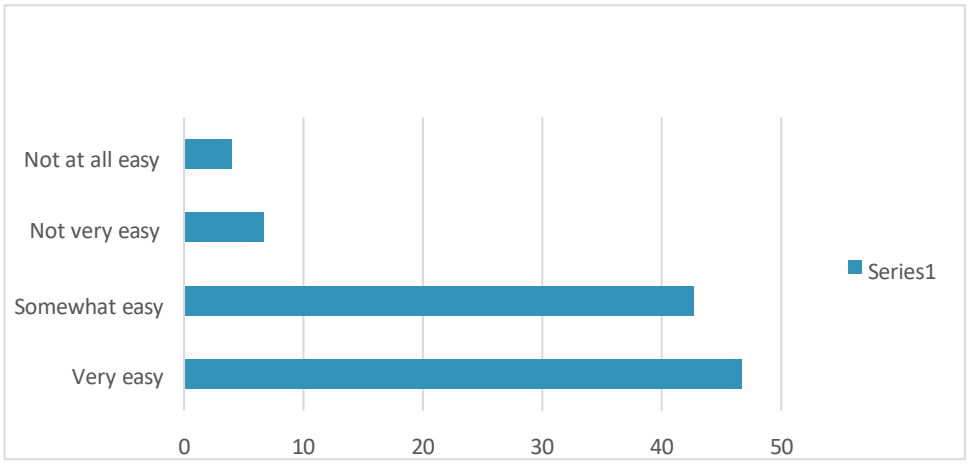
Use of digital messaging was selected by (19%) who opted for whatsapp, indicating a shift from traditional means of communication. Other options were chosen by 3% of respondents which indicates that a small fraction of people uses other means of communication.

Table No.4.16

Access to asha workers

Options	No.of respondents	Percentage
Very easy	35	46.66
Somewhat easy	32	42.67
Not very easy	5	6.67
Not at all easy	3	4
Total	75	100

Figure 4.16



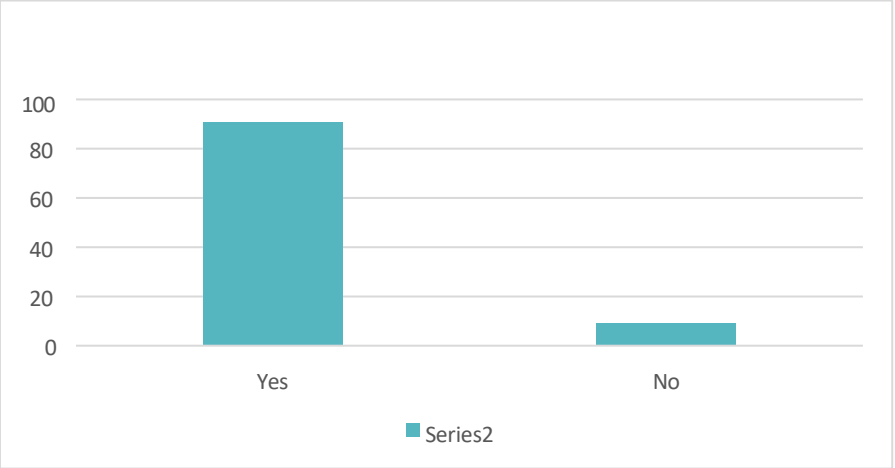
From the above figure, Most respondents seem to have easy access to ASHA workers because 47% indicated it is “Very Easy” and 43% said it is “Somewhat Easy.” On the contrary, just 6% said access is “Not Very Easy”, while an even smaller proportion, 4%, said it “Not At All Easy.” This means that 90% of respondents have some level of ease accessing ASHA workers which goes to show that they are well present and easily accessible in the community.

Table No.4.17

Protest of asha workers

Option	No.respondents	Percentage
Yes	68	90.66
No	7	9.34
Total	75	100

Figure.4.17



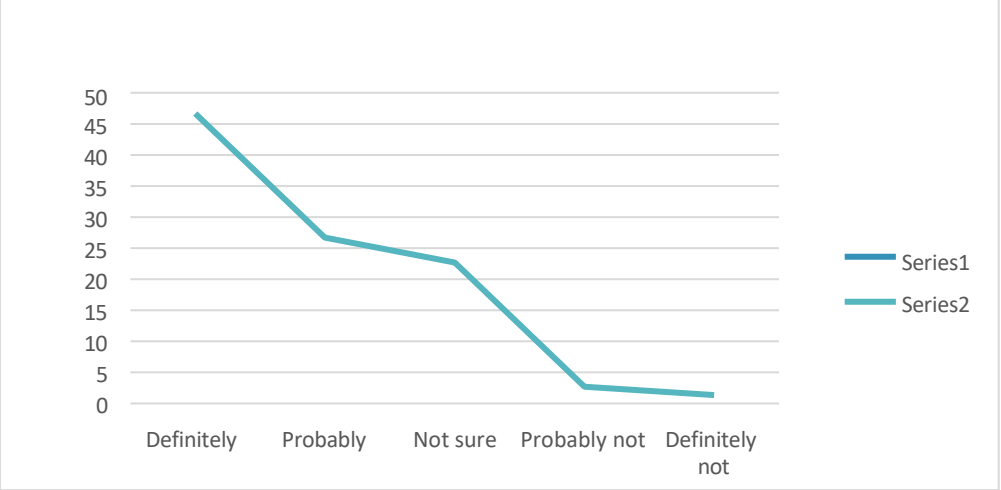
The above table shows that a majority of the people of Alanghad panchayat (90.66%)of people are aware of the protest of Asha workers . Only a 9.34% of people are not aware of the protest.

Table No.4.18

Lack of Motivation due to low wages

Option	No.of respondents	Percentage
Definitely	35	46.66
Probably	20	26.67
Not sure	17	22.66
Probably not	2	2.67
Definitely not	1	1.35
Total	75	100

Figure.4.18



In the above fig., A strong majority (35%) chose the "Definitely" option meaning that they strongly agreed with the statement that low wages negatively affect ASHA worker's motivation. (20%) chose "Probably" which still depicts a good agreement level. (17%) "Not Sure" indicates some degree of indecision or neutrality regarding the position. A very small proportion (about 3%) chose "Probably not" and even less (about 1%) opted for "Definitely not" indicating strong disagreement.

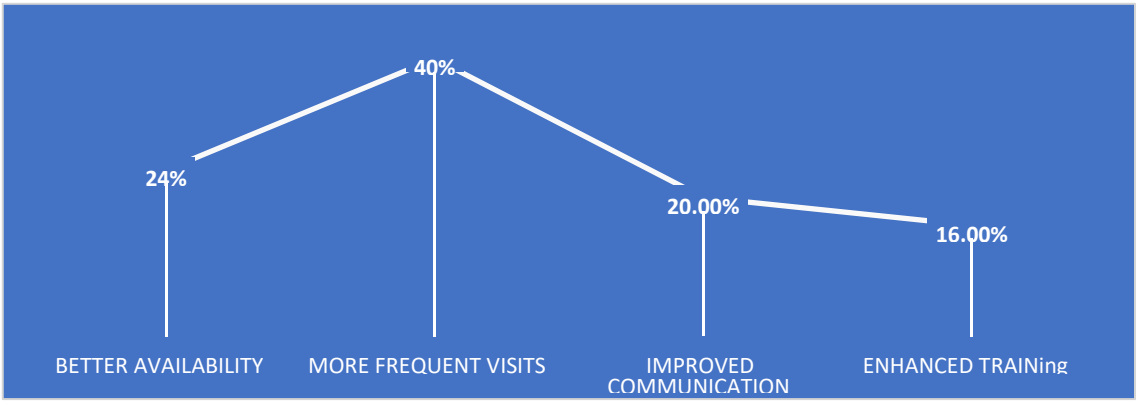
Table No.4.19

Suggestions for Improvement of ASHA Workers Services

Suggestions	No. of respondents	Percentage
Better availability	18	24
More frequent visits	30	40
Improved communication	15	20
Enhanced training	12	16
Total	**75**	**100**

Figure.4.19

Suggestions for Improvement of ASHA Workers Services



It's clear that the respondents value more frequent visits by ASHA workers the most, with a significant emphasis of 40%. Improving availability was cited as another critical area, with 24% of respondents highlighting it, followed by enhanced communication, at 20% and, a call for better training at 16%.

SUMMARY

The study found that most respondents are female, aged 20–40, and aware of ASHA workers and their services. While the majority receive monthly visits, their perception of ASHA services is neutral. An ANOVA test showed no significant relationship between public challenges and ASHA services. About 42.2% believe health outcomes have improved, but 53.3% noted a lack of health education classes, with hygiene and sanitation being the most covered topics. Opinions on the impact of ASHA workers' education efforts were mixed, with 38% having a positive view, 27% disagreeing, and 37.3% uncertain. While 20% support the continuation of ASHA services, 18.7% lean toward discontinuation, and 24% oppose it. Most respondents expressed a need for more frequent ASHA visits.

FINDINGS

- The majority of respondents are female.
- Majority of the respondents are 20 – 40 age group.
- The majority of respondents (96%) are aware of ASHA Workers.
- Majority of respondents are aware of service provided by ASHA workers.
- Most of the community receives monthly visits.
- The majority view the services provided by ASHA Workers neutrally.
- The study conducted ANOVA, the test to know whether there is any relationship between services provided by ASHA Workers and the challenges faced by public. The result of the test shows the significant level of ANOVA is greater than 0.05 that is **.599** hence the test accepted the null hypothesis. There is no significant relationship between challenges faced by public and services provided by ASHA workers.
- 42.2 percentage of respondents believe there has been an improvement in health outcomes.
- 53.3 percentage of respondents says that ASHA workers do not conduct health education classes.

- The topics covered in health education classes by ASHA workers indicates a strong emphasis on hygiene and sanitation (38.7%).
- 38 percentage of respondents either strongly agree (12%) or agree (24%) with the impact of ASHA workers' education initiatives, indicating a positive reception among a significant portion of the population.
- 37.3% of respondents expressed uncertainty, indicating a lack of clear consensus or understanding about the service's value or impact..
- 39%) among those surveyed, suggesting that it is the most accessible or frequently utilised treatment. Strong community-based outreach and vaccination public health campaigns may be indicated by this..
- 48% of the respondents prefer to face to face communication , which indicates its relevance in community health work ..
    - 47% of respondents seem to have easy access to ASHA workers .
- Majority of the people of Alanghad panchayat (90.66%)of people are aware of the protest of Asha workers .
- A strong majority (35%) chose the “Definitely” option meaning that they strongly agreed with the statement that low wages negatively affect ASHA worker’s motivation.
- It's clear that the respondents value more frequent visits by ASHA workers the most, with a significant emphasis of 40%..
- The majority of respondents value more frequent visits by ASHA workers.

SUGGESTIONS

o Develop a structural schedule to ensure more frequent visits by ASHA Workers.

o Conduct training programs that cover various aspects of healthcare, including the latest practices and technologies. o

o Establish a regular schedule for health education classes conducted by ASHA Workers. o

o Implement regular assessment to monitor the impact of ASHA Workers services. o

- Create feedback mechanisms to gather community input regularly and address their concerns regularly.
- Utilise local media, social media platforms and community leaders to spread information about ASHA workers and their activities.
- Encourage ASHA workers to build strong relationships with community members to foster trust and cooperation. o
- Provide ASHA workers with adequate resources and support, such as educational materials and health supplies, to enhance their effectiveness.
- Increase their remuneration to according to the work they take.

CONCLUSION

The study on the effectiveness of ASHA workers among the public underscores their pivotal role in enhancing community health, yet it also highlights several areas needing improvement. While a substantial portion of the population is aware of ASHA workers and their services, there is a clear demand for more frequent and consistent visits, better training, and improved communication. The findings reveal that although ASHA workers are generally known, their impact and the breadth of their services are not fully recognized by all community members. Moreover, the lack of a significant relationship between the services provided and the challenges faced by the public suggests a gap in addressing specific community needs. To bridge these gaps, implementing structured schedules for regular visits, comprehensive training programs, consistent health education classes, regular assessments, and robust feedback mechanisms are essential. These measures will not only enhance the effectiveness of ASHA workers but also ensure that their services are more responsive and tailored to the community's needs. Ultimately, by addressing these key areas, ASHA workers can significantly contribute to improved health outcomes and greater public satisfaction, solidifying their role as indispensable assets in the public healthcare system.

Table No.4.

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QUESTIONNAIRE

NAME :

GENDER :

- Male
- Female
- Others

AGE :

- Below 20
- 20 – 40
- 40 – 60
- Above 60

1. Are you aware about ASHA workers?

- YES
- NO

2. How would you rate your current awareness level of ASHA workers?

- Very unaware
- Unaware
- Neutral o Aware
- Very aware

3. How often do ASHA workers visit your place?

- Daily
- Weekly
- Monthly
- Occasionally
- Never

4. How effective do you find the ASHA Workers in providing healthcare services?

- Very effective o
- Effective
- Neutral o
- Ineffective
- Very ineffective

5. On scale 1 – 5, What specific activities by ASHA Workers have been most beneficial to your family?

Services	Strongly agree	Agree	Neutrally agree	Disagree	Strongly disagree
Basic medical care					
Maternal and child health					
Nutrition and hygiene					
Disease prevention					

Helping pandemic situations					
Health education					

6. On scale 1 -5, How satisfied are you with services provided by ASHA workers?

Services Immunization	Very satisfied	Satisfied	Neutral	Dissatisfied	Very dissatisfied
Maternal and child health					
Nutrition and hygiene					
Referral to health facilities					
Disease prevention					
Health education					
Home visit for health checkups					

7. Have ASHA Workers been helpful in improving health outcomes in your community?

- YES o NO o NOT SURE

8. Do ASHA Workers conduct health education classes?

- YES o NO

9. What topics were covered in the health education on session you attended?

- Nutrition o Hygiene and sanitation o Family planning o Disease prevention o Maternal and child health

10. Have you implement any health practices suggested by ASHA Workers?

- Yes, many o Yes, a few o No
- Not sure

11. Do you feel more knowledge about health issues due to ASHA Workers education effort?

- Strongly agree
- Agree
- Neutral
- Disagree Strongly
- disagree

12. On scale 1 -5, What are the challenges have you faced in accessing sevices provided by ASHA Workers?

Activities	Strongly agree	Agree	Neutrally agree	Disagree	Strongly disagree
Proper services					
Lack of awareness					
Proper visit					
Lack of communication					
Lack of availability					

13. Would you recommend the continuation of ASHA Workers services in your community?

- Definitely
- Probably
- Not sure
- Probably not
- Definitely not

14. Have you or any family member ever utilized the services of an Asha worker?

- Yes
- No

15. If yes, what services did you utilize?

Select all that apply:

- Immunisation
- Family planning
- Health education
- Referral services
- Other_____

16. How would you prefer to communicate with Asha workers?

- In person
- Phone
- WhatsApp

other _____

17. How easy is it for you to access Asha workers in your community?

- Very easy
- Somewhat easy
- Not very easy
- Not at all easy

18. Have you heard about the recent protest held by asha workers concerning their remuneration and workload issues?

- Yes
- No

19. .Do you believe the low wages and lack of recognition affect the motivation and effectiveness of ASHA workers in delivering healthcare services?

- Definitely
- Probably
- Not sure

- Probably not
- Definitely not

20. What improvement would you suggest for ASHA Workers services?

- Better availability
- More frequent visits
- Improved communication
- Enhanced training for ASHA Workers

21. . Do you have any additional comments or feedback about Asha workers or their services in your community?