Socio-economic condition of ASHA workers in Karnataka

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Abstract

The research paper primarily focuses on the socio-economic profile of the ASHA workers who are actively participating and creating the health awareness in rural areas of karnataka State. The study aims to awareness of health its effect of asha workers. For the purpose of the study purposive sampling is used to approach 50 Respondents. Further it's also covers the issues like age profile, educational level, nature of occupational, income level, sexual harassment issues, double work load, domestic violence, outside domestic violence, and community composition of asha worker in covid-19 periods. I am using Semi structured in-depth interviews were conducted to collect the data and having a focused group discussion with them. Thematic analysis was done through all transcribed data of interviews. The findings showed that most of the respondents also had faced different types of violence, and health issues, Finding are the contributing source in community awareness programs.

KEYWORDS: Objectives, health issues, covid19.

1. Introduction:

Accredited social health activists (ASHAs) are community instituted by the government of india. Ministry of Health and Family Welfare (MoHFW) as a part of the National Rural Health Mission (NRHM). The mission began in 2005 full implementation was targeted for 2012.The National Rural Health Mission is to provide every village in the country with a trained female community health activist ASHA or Accredited Social Health Activist. Selected from the village itself and accountable to it, The ASHA will be trained to work as an interface between the community and the public health system. ASHA must primarily be a woman resident of the village married/ widowed/ divorced, preferably in the age group of 20 to 45 years. She should be a literate woman with due preference in selection to those who are qualified up to 10 standard wherever they are interested and available in good numbers.ASHA will be chosen through a rigorous process of selection involving various community groups, self-help groups, Anganwadi Institutions, The Block nodal officer, District nodal officer, The village Health Committee and The Gram Sabha.The main task of the ASHA is to create awareness on health and its social determinants and mobilize the community towards local health planning and increased utilization and accountability of the existing health services (P K Hota 2005). Socio economic profile of ASHA workers include information about their age, marital status, educational level, family occupation, social category, family income, health issues,violence. The study, further, analysed the workload of the ASHA workers.

2. Objectives of the study:

- To Study of Internal and External Background of the Accredited social Health Activists (ASHAs).
- To Study of the Problems of Accredited Social Health Activists (ASHAs) Workers.
- To Analyze the Violence against Women at Work place (Govt Hospitals).
- To Study of the Socio-Economic conditions of ASHA Workers.

3. Method of the study:

This study is based on secondary data. The researcher has selected 50 respondents (ASHAs) workers women for research study. I have used purposive sampling method for my particular study. This research uses the descriptive and qualitative technique for presenting research data. For this Researcher has conducting interview schedule for collection of data and as well as having a focused on group discussion. I was selecting chikabalapura and sidlaghatta 2 Taluk in Chikabalapura district for research purpose.

Data Analysis

Table-1 Age group of the respondents

Details of age	Frequency	Percentage (%)
18 to 20	08	16
21 to 30	21	42
31 to 40	13	26
40 above	08	16
Total	50	100

The above table shows 16 % of the respondents between age group of 18-20 years, 42% of between 21-30years, 26% of between 31-40 years & 16% of above 40years.

Table-2 Marital Status of the Respondent:

Details of Marital	Frequency	Percentage (%)
Married	42	84
Widows	06	12
Divorced,	02	4
Total	50	100

In the following table majority women 84% of the respondents are married, 12% of the respondents are widows, & 4% of the respondents are divorced.

Table-3 Education Level:

Education	Frequency	Percentage(%)
Sslc	44	88
Puc	05	10
Degree	01	02
Total	50	100

The above table shows 88 % were sslc level, 10 % were Pre-university level, and 02% were Graduation level education.

Table-4 Type of family:

Type of family	Frequency	Percentage(%)
Nuclear family	31	62
Joint family	14	28
Single family	05	10
Total	50	100

The above table shows 62% of the respondents are to Nuclear family & 28% from joint family. Only 10% of the respondents are belonging to the single family. In this study 77% of the families are patriarchal, only 23% of female headed families.

Table-5 Family income

Family income	Frequency	Percentage(%)
Low income	23	46
Medium income	17	34
High income	10	20
Total	50	100

Presented accordingly in the study. On the basis of income level the highest percentage (10%) of the respondents are from middle income group followed by 34% and 20% from low income group respective.

Table-6 occupation

Occupation	Frequency	Percentage (%)
Labourer	19	38
Agriculture	16	32
Business	10	20

Service	**05**	**10**
Total	**50**	**100**

It is evident from the data that majority of the respondents 38% were laborer, 20% respondents are engaged in business, followed by 32% engaged in agriculture and a small percent of respondents (10%) is from service.

4. Socio-economic Condition of ASHA Workers:

Socio-economic status is an important determinant to understand the ASHA workers background which influences values and norms of behavior, their social participation, motivation for improvement and communication in a community. The study of ASHA workers Socio-economic condition is taken up in order to understand whether it has anything to do with the effectiveness of their work in facilitating health care services to the community. The average Socio economic score of ASHA workers is measure indicates that majority of the respondents belong to lower middle class. It would be interesting to check if the average Socio-economic of ASHA workers differ significantly across variables like age profile, educational level,nature of occupational, income level, sexual harassment issues, double work load, domestic violence, outside domestic violence, and community composition of ASHA worker.

The monetary incentives provided through JSY was cited as an important factor shaping both the experiences and performance of ASHAs and their relationships with communities and the health system in promoting maternal health. All the ASHAs sampled in the study explained their dependency on the JSY scheme, as it is through this that they receive an acceptable amount of compensation as other tasks are either poorly incentive or not incentivized at all. As JSY provides the largest amount of incentive for referral of pregnancy cases and escorting women for institutional delivery, ASHAs consider pregnancy cases as their main source of income.

For example:

My village is small; there are only few cases of pregnancy. I have limited income compared to villages with huge population For every successful delivery at hospital, we receive Rs. 600. We work hard to identify all pregnant women in my village, try to motivate them to complete all ANC and delivery in the hospital However, doctors and a nurse participating in the IDIs were critical of the incentive-based payment model of the ASHA programme. They perceived that incentive linked specific activities skew the programme through narrowing ASHAs' activities to those that are incentivized such as institutional delivery and immunization and leading to the neglect of other activities such as home visits, post-partum care and community mobilization. ASHAs' have a list of work to perform But since they have limited avenues to earn income, we mostly encourage them to achieve the targets like immunization, hospital delivery, organizing monthly village health nutrition day etc.…, so that they could earn some money.

5. Performance Based Incentives to ASHAs:

ASHA would be an honorary volunteer and would not receive any salary or honorarium. Her work would be so tailored that it does not interfere with her normal livelihood. However ASHA could be compensated with performance based incentives for her time in the following situations: For the duration of her training both in terms of TA and DA. so that her loss of livelihood for those days is partly compensated. For participating in the monthly/bi- monthly training, as the case may be.

Wherever compensation has been provided for under different national programmes for undertaking specific health or other social sector programmes with measurable outputs, such tasks should be assigned to ASHAs on priority wherever they are in position. For situation disbursement of compensation to ASHAs will be made as per the specific payment mechanism built into individual programmes.The specific programmes, a number of key health related activities and service outcomes are aimed within a village (For example all eligible children immunized, all newborns weighed, all pregnant women attended an antenatal clinic. ANM and the Sarpanch could be used as monetary compensation to ASHA for achieving these key processes. The exact package of processes that form the package would be determined at the State level depending on the supply-side constraints and what is feasible to achieve within the specified time period. For situation the payment to ASHAs will be made at Panchayats.

6. ASHA s five importent activities in the community health:

- The ASHA should visit the families living in her allotted area, with first priority being accorded to marginalized families. Home visits are intended for health promotion and preventive care For up to two hours every day, for at least four or five days a week. They are important not only for the services that ASHA provides for reproductive, maternal, newborn and child health interventions, but also for non-communicable diseases, disability, and mental health. The ASHA should prioritize homes where there is a pregnant woman, newborn, child below two years of age, or a malnourished child. Home visits to these households should take place at least once in a month. Where there is a new born in the house, a series of six visits or more becomes essential.
- The ASHA should promote attendance at the monthly Village Health and Nutrition Day by those who need Aganwadi or Auxiliary Nurse Midwife (ANM) services and help with counselling, health education and access to services.
- ASHAs visits to the health facility This usually involves accompanying a pregnant woman, sick child, or some member of the community needing facility based care. The ASHA is expected to attend the monthly review meet'ing held at the PHC.
- Holding village level me As a member or member secretary of the Village Health, Sanitation and Nutrition Committee (VHSNC), the ASHA is expected to help convene the monthly meeting of the VHSNC and provide leadership and guidance to its functioning. These meetings are supplemented with additional habitation level meetings if necessary, for providing health education to the community.
- Maintaining records which help her in organizing her work and help her to plan

better for the health of the people. The first three activities relate to facilitation or provision of healthcare, the fourth is mobilization and fifth is supportive of other roles.

Conclusion:

The research paper primarily focuses on the socio-economic status of the ASHA workers who are actively participating and creating the health awareness in rural areas of karnataka State. The study aims to awareness of health its effect of ASHA workers. Availability of monetary incentives, fair and commensurate to effort, is an important element for the continued participation of ASHAs. A well-equipped and functional health system can facilitate ASHAs' ability to perform their roles effectively and at the same time raise their credibility and trust in the community. The findings showed that most of the respondents also had faced different types of violence, Finding are the contributing source in community awareness programs.

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