



RESEARCH ARTICLE

ASSESSMENT OF KNOWLEDGE OF ASHA WORKERS OF NRHM REGARDING THE HEALTH OF WOMEN AND CHILDREN

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ABSTRACT

The present study was conducted to assess the existing knowledge of ASHA workers of NRHM regarding health of women and children along with some socio-personal characteristics. One hundred and fifty-five ASHA workers from three Block Primary Health Centres of Jorhat district, Assam were selected as the respondents for the present study. A structured interview schedule was prepared to study the socio-personal profile of the respondents, and knowledge of the respondents on women and children's health. Findings revealed that 45.16 per cent respondents belonged to age group of 31-40 years. A large majority of the respondents (76.77%) were married followed by unmarried with 12.90 per cent and widow 10.32 per cent. Only 2.22 per cent respondent from Kakojan BPHC was Graduate. A large majority of the respondents that is 70.32 per cent belonged to nuclear family. Majority of the respondents that is 41.29 per cent were from small family (upto 4 members). Regarding mass media exposure high percentage of respondents (65.81%) had medium level of exposure to mass media. Majority of the respondents (54.84%) covered population below 1000. A large majority of the respondents that is 83.23 per cent had medium level of knowledge on women's health and 80.00 per cent respondents had medium level of knowledge on children's health. There was positive significant relationship between level of knowledge on women's health with selected independent variables such as size of the family and mass media exposure. There was highly positive significant relationship between level of knowledge on children's health with educational qualification.

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INTRODUCTION

Health is the measure of our body's efficiency and overall well being. It is now universally accepted that health status of women in reproductive age has an impact on health of their children, the family, the community and the nation. Woman's health is the bulwark of her family; it is the foundation of community and social progress (Anand, 2005). The high levels of maternal mortality are highly distressing because the majority of these deaths could be prevented if women had availed adequate health services, in the form of either proper prenatal care or referral to appropriate health care facilities (Saha *et al.*, 2010). Therefore recognizing the importance of health in the process of economic and social development and improving the quality of life of our citizens, the Government of India has launched the National Rural Health Mission to carry out necessary architectural correction in the basic health care

delivery system. The National Rural Health Mission (NRHM) was launched by the Honourable Prime Minister Shri Manmohan Singh on 1st April 2005, to provide accessible, affordable and accountable quality health services to the poorest households in the remotest rural regions. Accredited Social Health Activists (ASHAs) are community health workers instituted by the Government of India's Ministry of Health and Family Welfare (MoHFW) as part of the National Rural Health Mission (NRHM). ASHAs are local women trained to act as health educators and promoters in their communities. The Indian MoHFW describes them as: health activist in the community who will 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. ASHA act as a key link to public health services in India. And as it is a known fact that ASHAs are local women trained to act as health educators and promoters in their communities. Therefore, their knowledge on health for women and children is a key element of their work. The ASHA worker must have adequate knowledge on health, so that she could render adequate

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services to the beneficiaries i.e., to women and children. If the ASHA workers do not have adequate knowledge on women and children's health then she will not be able to provide good health services to her beneficiaries.

Objective

The study was conducted to assess the existing knowledge of respondents regarding health of women and children in Jorhat district of Assam, along with some socio-personal characteristics.

MATERIALS AND METHODS

In the year 2015 the study was done. Jorhat district of Assam was selected purposively for the present study. Three Block Primary Health Centres (BPHCs) of Jorhat district of Assam i.e. Baghchung BPHC, Kakojan BPHC, and Titabar BPHC were selected purposively. From the selected BPHCs total 31 sub-centres were selected and all 5 ASHA workers from each sub-centre were the respondents of the present study. The respondents were administered by an interview schedule comprising of questions associated with the socio-personal characteristics of the respondents and knowledge on women and children health. Frequency and percentage were calculated to find out the socio-personal information of the respondents. Mean, standard deviation, correlation co-efficient and t-test were used to find out the knowledge of respondents on women and children's health and relationship between level of knowledge on women and children's health with selected independent variables.

RESEARCH FINDINGS AND DISCUSSION

The results of the study showed that 45.16 per cent of total respondents belonged to age group of 31-40 years (Table 1). It is revealed from the Table 1 that 76.77 per cent respondents were married. Further it is found that 70.32 per cent respondents were HSLC passed and it is interesting to note that only 2.22 per cent respondent from Kakojan BPHC was Graduate. It is revealed from Table 1 that the majority of the respondents that is 70.32 per cent were from nuclear family whereas 27.10 per cent respondents were from joint family. A few respondents (2.58%) were from extended family. The Table.1 further indicated that 41.29 per cent of respondents belonged to small family; followed by 30.32 per cent medium and 28.39 per cent respondents belonged to large family. Majority of the respondents that is 65.81 per cent had medium level of mass media exposure followed by 18.06 per cent high and 16.13 per cent had low level of mass media exposure (Fig. 1). It is revealed from the Table 2 that a large majority of the respondents that is 83.23 per cent respondents had medium level of knowledge on women's health. A very few respondents (7.74 %) had low level of knowledge on women's health. It is evident from the table that the highest percentage of respondents (83.23%) possesses medium level of knowledge on women's health. It might be due to the fact that the respondents might get enough scope to collect information on women's health from different mass media sources which might help them to possess a medium level of knowledge on women's health or because of receiving trainings from NRHM might also have helped them to have enough knowledge.

Table 1. Distribution of respondents according to their socio-personal characteristics

Characteristics	Baghchung BPHC (n=60)		Kakojan BPHC (n=45)		Titabar BPHC (n=50)		Total (n=155)	
	f	%	f	%	f	%	f	%
1. Age (in years)								
20-30	10	16.67	2	4.44	12	24.00	24	15.48
31-40	30	50.00	24	53.33	16	32.00	70	45.16
41-50	20	33.33	19	42.22	22	44.00	61	39.35
2. Marital status								
Married	43	71.67	27	60.00	49	98.00	119	76.77
Unmarried	4	6.66	15	33.33	1	2.00	20	12.90
Widow	13	21.67	3	6.67	-	-	16	10.32
3. Educational qualification								
Up to HSLC	9	15.00	5	11.11	8	16.00	22	14.19
HSLC passed	46	76.67	29	64.44	34	68.00	109	70.32
HS passed	5	8.33	10	22.22	8	16.00	23	14.84
Graduate	-	-	1	2.22	-	-	1	0.65
4. Family type								
Nuclear	37	61.67	34	75.56	38	76.00	109	70.32
Joint	19	31.67	11	24.44	12	24.00	42	27.10
Extended	4	6.66	-	-	-	-	4	2.58
5. Family size								
Small	26	43.33	17	37.78	21	42.00	64	41.29
Medium	12	20.00	16	35.55	19	38.00	47	30.32
Large	22	36.67	12	26.67	10	20.00	44	28.39

Table 2. Distribution of respondents according to their level of knowledge on women's health

Knowledge level	Baghchung BPHC (n=60)		Kakojan BPHC (n=45)		Titabar BPHC (n=50)		Total (n=155)	
	f	%	f	%	f	%	f	%
Low	2	3.33	4	8.89	6	12.00	12	7.74
Medium	52	86.67	38	84.44	39	78.00	129	83.23
High	6	10.00	3	6.67	5	10.00	14	9.03

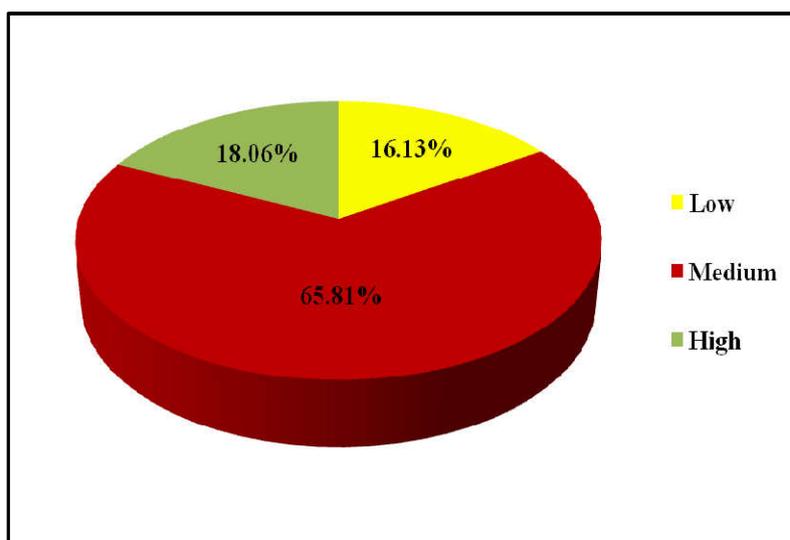


Fig. 1. Distribution of respondents according to their exposure to mass media

Table 3. Distribution of respondents according to their knowledge on women's health

Sl. No.	Statements	Percentage	
		% Known by respondents	%Unknown by respondents
1.	Menstruation period naturally lasts for 3-6 days	100.00	-
2.	A mother is not to be stopped breastfeeding completely after the age of 6 months of her baby	100.00	-
3.	Health check-up is very much essential as soon a woman conceives	99.35	0.65
4.	One time health check-up is not enough during pregnancy	99.35	0.65
5.	First secretion of breast milk which is thick and yellow in color is known as colostrums	99.35	0.65
6.	Fasting during pregnancy never helps in smooth delivery	98.06	1.94
7.	A pregnant woman is to consume a balanced diet	97.42	2.58
8.	Anaemia can be prevented by taking iron supplements	96.77	3.23
9.	Feeding of colostrums is must for the baby	94.84	5.16
10.	Nutrition for lactating mother has same importance as that for a pregnant lady	93.55	6.45
11.	Requirement of iron is same in both pregnancy and lactating period	93.55	6.45
12.	Obesity never helps for smooth delivery of a child	92.90	7.10
13.	Generally, average age of menopause is 45-55 years	92.26	7.74
14.	Only mother is not responsible for determination of sex of her baby in the womb	89.68	10.32
15.	First 28 days is more crucial for a baby born with complications	87.74	12.26
16.	Extra amount of calcium is required during pregnancy	87.10	12.90
17.	Women gains about 11-12 kg weight during pregnancy	76.77	23.23
18.	Registration of pregnancy can be made at the beginning of pregnancy	75.48	24.52
19.	Tetanus toxoid injection is necessary for a pregnant women not because she gets cut in her body	65.81	34.19
20.	Anaemia is a common problem during pregnancy	63.87	36.13
21.	The daily nutritional requirements of women differ from that of men	55.48	44.52
22.	Baby is to be feed with one breast only at a time	0.65	99.35

N=155

Table 4. Distribution of respondents according to their level of knowledge on children's health

Knowledge level	Baghchung BPHC (n=60)		Kakojan BPHC (n=45)		Titabar BPHC (n=50)		Total (n= 155)	
	f	%	f	%	f	%	f	%
Low	5	8.33	9	20.00	2	4.00	16	10.32
Medium	42	70.00	34	75.56	48	96.00	124	80.00
High	13	21.67	2	4.44	-	-	15	9.68

Table 5. Distribution of respondents according to their knowledge on children's health

S.No.	Statements	Percentage	
		% Known by respondents	%Unknown by respondents
1.	A child is to be feed with yellow fruits such as ripe papaya, ripe mango etc. to protect him from Vitamin A deficiency	100.00	-
2.	Vaccination has an important role to protect a child from different diseases	99.35	0.65
3.	Anaemia (less percentage of Hb in blood) in childhood can be prevented by inclusion of gradual weaning of egg yolk, green leafy vegetables, meat & cereals	98.71	1.29
4.	The first and main symptoms of a child, suffering from protein-energy malnutrition is loss of weight according to his age	98.06	1.94

N=155

Continue.....

5.	The colour of a newborn baby is not pale	97.42	2.58
6.	If a child is suffering from diarrhea, breast feeding is not to be stopped	96.13	3.87
7.	After birth the infant should be covered with sterilized cloth	95.48	4.52
8.	Breastfeeding should be started within 1 hour of delivery	93.55	6.45
9.	Child is to be breast feed as long as possible	92.26	7.74
10.	A healthy newborn baby always cry as soon as he is born	90.32	9.68
11.	Child should be feed as soon as the food is ready	85.81	14.19
12.	Anaemia reduces the child's resistance to infections	83.87	16.13
13.	The mother is not to be stopped breast feeding as soon as baby starts weaning	83.23	16.77
14.	Use of powder harms the baby	80.00	20.00
15.	A newborn baby generally sleeps for most part of the day	76.13	23.87
16.	A child is to be weaned when he is 4-6 months old	75.48	24.52
17.	Protein Energy Malnutrition is not caused due to inadequate water intake	73.55	26.45
18.	A child is to be feed diluted cow's milk (mixed with water) if he does not get mother's milk	56.13	43.87
19.	The normal body temperature of a newborn baby is 98 ⁰ to 99 ⁰ F	55.48	44.52
20.	Child should not be forced if he refuses to eat meal	53.55	46.45
21.	Infancy includes the time from birth to one year of age	43.23	56.77
22.	Newborn baby's heart rate is about 180 per minute	36.77	63.23
23.	'Not able to see in the dim light' is the symptom of Vitamin A deficiency	22.58	77.42
24.	The child gets energy if the jaggery or sugar is mixed in his diet	13.55	86.45

Table 6. Relationship between knowledge of respondents on women's health with selected independent variable

Variables	Correlation Co-efficient ('r')	't' value
Age	0.004	0.049
Marital status	0.029	0.358
Educational qualification	0.063	0.780
Type of family	0.064	0.793
Size of the family	0.182*	2.288
Mass media exposure	0.203*	2.562
Population covered	0.022	0.271

* Significant at the 0.05 level

Table 7. Relationship between knowledge of respondents on children's health with selected independent variables

Variables	Correlation Co-efficient ('r')	't' value
Age	0.063	0.786
Marital status	0.134	1.671
Educational qualification	0.247**	3.150
Type of family	0.064	0.793
Size of the family	0.055	0.681
Mass media exposure	0.031	0.383
Population covered	0.093	1.155

** Significant at the 0.01 level

It is interesting to note in the Table 3 that all the respondents under the study had knowledge on duration of menstruation period and about the continuation of breast feeding after 6 months. But some statements were not known by most of the respondents. Almost all the respondents (99.35%) had no knowledge about the fact that baby is to be fed with one breast at one feed only which is an important aspect to be known by all the mothers. It might be because of the fact that during training period these important aspects were not discussed thoroughly. Therefore an intervention programme is highly required for the respondents. It would help the respondents to render their services more effectively. It is revealed from Table 4 that a large majority of the respondents that is 80.00 per cent had medium level of knowledge on children's health. Few respondents (9.68%) had high level of knowledge on children's health. The ASHA workers might gain enough scope to collect information on children's health from different mass media like television, radio, newspaper etc. As the ASHA workers has undergone various trainings provided by NRHM which might help most of them to possess a good knowledge on children's health.

Table 5 revealed that all the respondents had knowledge about the sources of Vitamin A, but a higher percentage of respondents did not know about the symptoms of Vitamin A deficiency. It might be the fact that they had not been given full knowledge on some aspects during the training period. Therefore an intervention programme is highly required for the respondents in such items so that they can provide better services to NRHM.

It is revealed from Table 6 that there was positive significant relationship between level of knowledge on women's health and size of the family. It means that the level of nutrition knowledge of respondents increased with increase in number of family members at their home. This might be due to the fact that the respondents might get scope to know about the different information from different age group of members of the family by keeping contact with them. These might be the reason for increase in her knowledge. Further analysis shows that the level of knowledge on women's health had positive significant relationship with mass media exposure. The level of knowledge on women's health was more who had adequate

exposure to mass media. It means people with more exposure to mass media had more knowledge on women's health. As different programmes related to women's health were telecast and broadcast through television and radio frequently and different articles were also getting published on women's health time to time which might have helped the respondents to collect more information on women's health and made the respondents knowledgeable regarding women's health. It is revealed from Table 7 that there was highly and positive significant relationship between level of knowledge on children's health and educational qualification. It means that the level of knowledge of respondents increased with the increase in educational qualification. It might be due to the reason that with increase in educational level might help the respondents to gather more information's through different journals, papers on children's health and due to their educational level, they might have developed interest to go through new bulletins etc., from where they could collect more information on children's health.

Conclusion

The findings showed that the ASHA workers of Jorhat and Titabar sub division of Jorhat district had medium level of knowledge on women and children's health. A few aspects which were not known by the respondents and were very important to be known by an ASHA worker such as a 'Baby is to be fed with one breast at one feed', 'The daily nutritional requirements of women differ from that of men', 'Jaggery or sugar is to be added in baby's diet for energy', 'Not able to see in the dim light is the symptom of Vitamin A deficiency', 'Newborn baby's heart rate is about 180 per minute' etc. are to be given more emphasis during training period to improve the knowledge of respondents for better performance in rendering services to the beneficiaries.

A full knowledge on the subject would help the respondents to work whole heartedly rather than mechanically.

Recommendations

- i. Time to time refresher courses may be organized for the ASHA workers of NRHM.
- ii. Monitoring and supervision on ASHA is to be given emphasis.
- iii. Similar studies can be done for the supervisors of ASHA workers.

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