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ASSESSMENT OF ACCREDITED SOCIAL HEALTH ACTIVISTS: WITH SPECIAL REFERENCE TO KOLHAPUR DISTRICT

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ABSTRACT :

Maternal Health is a major public health issue and an important indicator showing the level of social development and women status in the society. To achieve the Millennium Development goals especially with the of improvement of maternal and child health, India is launching many national health programmes. National Rural Health Mission is one of them and it made significant strides in improving the maternal and child healthcare coverage through ASHAs community health workers over a last decade. The ASHA programme is a critical component of the National Rural Health Mission (NRHM) and is one of several processes which aim to actively engage communities in improving health status. Present research paper made an attempt to assess the self reported work done of ASHAs in concern with maternal and child health. This paper concluded that the ASHAs workers are playing very important role in the promoting and improving the maternal and child health.

KEYWORDS : *Maternal Health, Child Health, Community Health workers, NRHM and Accredited Social Health Activists.*

1. INTRODUCTION:

India has witnessed several phases of the community health worker (CHW) programme since Independence. The Accredited Social Health Activist (ASHA) is the one of important community health worker under the National Rural Health Mission (NRHM) and it is successfully working and operational throughout the country. Selected from the village itself and accountable to it and ASHA will be trained to work in community.

The ASHA programme is a critical component of the National Rural Health Mission (NRHM) and is one of several processes which aim to actively engage communities in improving health status. The ASHA is a woman selected by the community, resident in the community, who is trained and supported to function in her village to improve the health status of the community through securing people's access to health care services, through improved health care practices and behaviours; and through health care provision as is essential and feasible at the community level. There are about 846,309 ASHAs in the country and approximately one ASHA per 1000 population in the rural areas. The ASHA facilitator is expected to be a mentor, guide, and counsellor to the ASHA. She/He is also expected to provide support, supervise, build capacity of the ASHA and monitor the progress of the individual ASHA in their given area. The general norm is to appoint one facilitator for every 20 ASHA. Thus one ASHA facilitator would work with about 20 ASHAs in a population of about 20,000. To make efficient use of this human resource, they could also

be deployed for supporting the VHSNC and similar community health processes.

Maternal Health is a major public health issue and an important indicator showing the level of social development and women status in the society. The concept of maternal health recognises that women have special health needs before, during and just after the childbearing. Promotion of institutional delivery and coverage of immunisation are very important strategy to reduce maternal and child mortality (Santhi Nakkeeran,Deepak Saxena, Dileep Mavalankar:2016). To achieve the Millennium Development goals especially with the of improvement of maternal and child health, India is launching many national health programmes. National Rural Health Mission is one of them and it made significant strides in improving the maternal and child healthcare coverage through ASHAs community health workers over a last decade. Then question comes who is and the answer is that ASHA is a trained woman from village who is interface between community and the public health.

ASHAs are playing very important role to promote institutional delivery and to cover immunisation. Due to ASHA scheme under NRHM maternal and child mortality has decreased and utilisation of primary health care facilities has also increased. Hence present research paper made an attempt to assess the self reported work done of ASHAs in concern with maternal and child health.

2. REVIEW OF LITERATURE:

Many studies conducted in concern with selection procedure of ASHAs and many of them are also conducted in concern with ASHAs the community health workers and these studies deal with roles, responsibilities, functions, incentives of ASHA. But few number of studies deal with assessment of work and improvement occurred to this scheme. Therefore for the present research paper some studies are taken for review.

Eble Alex's paper on ***'Incentives, women and children: How the ASHA program can reduce child mortality in rural India and how it might fail'*** made an attempt to the role of ASHA in preventing the child mortality. The National Rural Health Mission (NRHM) drew on this literature in designing its own village health worker scheme. In this scheme, an accredited social health activist (ASHA), the equivalent of a VHW, is placed in each of India's villages in an attempt to scale-up these methods to address a set of highly prevalent and highly preventable diseases causing child mortality. This study also argues that the ASHA system is the best hope India has for reducing child mortality in rural areas, but there are several serious threats which could seriously compromise its potential. This paper suggests that if proper incentives are not paid to the ASHA and the health status of villagers will not improve.

Shrivastava S R, Shrivastava P S 2012) paper titled with ***'Evaluation of trained Accredited Social Health Activist (ASHA)***' workers regarding their knowledge, attitude and practice was made an attempt to evaluate knowledge, attitudes and practices of ASHA workers in relation to child health. A cross-sectional study was conducted at Palghar Taluka in the Thane district of Maharashtra for a period of 3 months from January 2011 to March 2011, inclusive, with the study participants all being trained ASHA workers working in the various primary health centres of Palghar Taluka. A total of 150 ASHA workers were working in the area, of which four workers were untrained and thus excluded from the study. The study argues that despite the training given to ASHAs, lacunae still exists in their knowledge regarding various aspects of child health and morbidity. In the future training sessions, more emphasis should be given to high risk cases requiring prompt referral.

Mony Prem and Raju Mohan's essay (2012) on ***'Evaluation of ASHA programme in Karnataka under the National Rural Health Mission***' explores the diversity within the ASHA programmes in different districts and overall within Karnataka. The sampling design adopted for the study was a multi-stage sampling design proposed by the National Health Systems Resources Centre (NHSRC) for all states across India in order to enable comparisons. The major findings of this study are the ASHA workers perform tasks mostly as link workers and community health workers and to only a small extent as social activists. Within the domain of their link worker role, through their home visits to the households of community members they have contributed to improvements in the basic antenatal care and also in increasing the number of institutional

deliveries and immunisation. We also found that there is inadequate coverage of marginalized households within villages and hamlets in rural and peri-urban Karnataka.

Farah N.Fatima, Mohan Raju, Kiruba S. Varadharajan, Adit Krishnamurthy, S.R, Annathkumar and Prem K.Mony titled with '***Assessment of Accredited Social Health Activists'-A National Community Health Volunteer Scheme in Karnataka State***, India assess the performance of ASHAs in general and maternal and child health in particular. The objective of this study was to assess adherence to selection criteria in the recruitment of ASHAs Assessment of: This study shows that by and large, functionality of ASHAs in terms of carrying out tasks was reasonably high. Further improvements will require continuous capacity-building to improve knowledge and skills of ASHAs through basic and refresher training as well as mentoring by the taluka and district team. In addition health system strengthing through provision of drugs and moral support, special skill building in individual and group motivation for behaviour change targeted to both 'unfinished agenda' of communicable diseases, maternal and nutritional disorders and other.

Lipekho Saprii's study titled with "***Community Health Workers in Rural India: Analysing the opportunities and challenges Accredited Social Health Activists (ASHAs)*** face in realising their multiple roles. This study highlights challenges faced by ASHAs such as selection of ASHA which is influenced by power structures and poor community sensation of the ASHA programme presents a major risk to success and sustainability. Small and irregular monetary incentives discourage ASHAs. Finally ASHAs has very limited knowledge about their role as an activist and they are the6mselves treating as health service providers. The ASHA programme in India is an ambitious CHW scheme that offers an opportunity for the state government and policy makers and practitioners to improve health. There is need to better understanding of the opportunities and challenges faced by ASHAs in diverse Indian contexts and this study has highlighted the challenges and realities of this work in rural Manipur. ASHAs were valued for their contribution and promoting opportunities to support maternal health education and biomedical care, although role as social activist was considered less substantial.

Concurrent Evaluation of National Rural Health Mission by International Institute for Population Sciences and complies Ministry and Family Welfare Government of India with ***Third Common Review Mission Report(2009)*** shows the profile of ASHA that represents socio-economic and service rel66ated characteristics of ASHAs., medical items/kits available with ASHA and whether thos6e items/kits were used by ASHA, activities performed by ASHA, ASHA's awareness about breastfeeding, diarrhoea, acute respiratory infections and major features of NRHM, incentives received, difficulties faced and support required to effectively implement NRHM For present ASHAs were selected from eight, SHA districts of Maharashtra State. One of striking finding of the study is that all of the ASHAs had never worked as 'Dai's ASHAs awareness about breast feeding, diarrhoea, acute respiratory infections and major features of NRHM, incentives received, difficulties faced and support required to effectively implement NRHM. This report also emphasis that the ASHA will receive performance-based incentives for promoting universal immunisation, referral and escort services, ASHAs has received any training on use of Nischay Pregency test. All districts medical items/kits are not available with ASHA and various activities performed by ASHAs such as accompanying women for delivery and visiting households total end ANC/immunisation session reported by almost every surved ASHA.

This study by Sujay R Joshi, Mathew George, ***"Healthcare through Community Participation Role of ASHAs"*** focuses on the operation of the Accredited Social Health Activist programme of the National Rural Health Mission in one of the tribal blocks of Thane district in Maharashtra finds that incentives given to ASHAs generate a bias in their work activities and shift the attention of these community health workers from the community to the health services system. Moreover, ASHAs have the poor socio-economic background. The ASHA's role in the community is more important compared to ANMs as they belong to the community and work to address the health needs of the community on various fronts. ASHAs make them depend on the incentives offered since this is their main source of income. Additionally, due to the excessive focus of ASHAs on curative care, the community considers them more an extended arm of the health service system, not as change agents as envisaged in the programme.

Update on the ASHA Programme, (National Rural Health Mission, Ministry of Health and Family Welfare, Government of New Delhi,Janaury:2012). This report indicates that the ASHA programme has also been subject to intense scrutiny through studies, evaluations and reviews, ever since the time of its inception. This is the fifth in the series of bi-annual ASHA updates produced by the national Health Systems Resource Centre(NHSRC) for training Division, Ministry of Health and Family Welfare. The objective of these biannual updates is to report on the progress of the ASHA and community processes programme in the states While the promotion of institutional delivery and immunization are the two key tasks that continue to be seen as her most important responsibilities the ASHA is active on a range of tasks including malaria surveillance, nutrition, Dots, home based newborn care, motivation for family planning and contraceptive counselling. The linkage of the ASHA with the Village Health, Sanitation and nutrition committees (VHSNC)) is peripheral and needs to be strengthened. ASHA as agents of social marketing is being introduced for contraceptives and oral pills and sanitary napkins. But these programmes are in too early a phase for comment improves mechanisms of performance based timely payments and urgently put in place the payments for newborn visits. For the ASHA programme to impact on maternal and child survival the ASHA must be taught the skills for counselling pregnant women and families with children on nutrition and improved health care practices as well as community level care for the newborn and sick child.

III) RESEARCH METHODOLOGY:

THE STATEMENT OF PROBLEM

The present study has been made an attempt to assess the self reported work done of ASHAs in the promoting of maternal and child health in rural areas.

THE OBJECTIVES OF THE STUDY

The following were the specific objectives of the present study

1. To know the selection criteria and roles/functions of ASHA.
2. To assess the self reported work done of ASHAs in promoting Child and Maternal health.

THE STUDY AREA

The present study has been carried out only in all primary health centres of six talukas i.e. district in Maharashtra State.

SAMPLING DESIGN

(a) Selection of the district and PHCs:

Kolhapur district is well-known for its socio-cultural and historical background. It is also famous for production of jaggary and Kolhapuri Chappals. National Rural Health Mission is also implemented in Maharashtra also. Initially ASHA scheme is implemented fifteen tribal dominated districts in Maharashtra State. During 2008 this scheme is implemented in the all districts of Maharashtra State. ASHAs are working in the every PHCs of every village of Kolhapur district. Kolhapur district has twelve talukas and total PHCs 73 Total 273 ASHAs are working in the district. Out of ten talukas, six talukas were purposefully selected. One is Karveer Taluka were selection was made on the basis of is development and distance from city. Three talukas Karveer, Hatkanagale and Panhal were near to the city and where Bhudhargad, Radhanaagri and Ajara which were far away from the city and socio-economically backward. From each talukas all PHCs were selected purposefully.

(b) Selection of the respondents for the study.

ASHAs are work6ing in the every village of Kolhapur city. There are fifty Primary Health Centres and tota6l 2773 ASHAs are working in Kolhapur district. Total 1635 ASHAs are working in thirty five PHCs in six talukas. Out 1635 ASHAs of selected PHCs 62% ASHAs were selected it covers 1005 ASHAs. Care was taken that respondents should be ASHAs and they are belonging to Kolhapur district only. It is also taken into the consideration that all these ASHAs are presently working and linked with respective PHC. It was decided to conduct personal interviews of ASHAS only available at the time of the visit to their houses and in work

place. Besides these respondents key informant such as the medical officers, staff members of PHC and villagers were also selected for getting relevant information by conducting informal interviews.

SOURCES OF DATA: The present study was based on the primary as well as secondary data.

TECHNIQUES USED FOR DATA COLLECTION:

The personal observations during the visits to the selected village and PHC, interviews with the sampled with the help of interview schedules and informal interviews with key information such as director, staff members and villagers were the techniques of data collection.

DATA COLLE6CTION:

Subseque6nt fieldwork visits to selected villages, PHCs and residential areas of sampled ASHAs f6or collecting the primary data were planned and executed during 2016-17. The secondary data were collected from the office of the Zilla Parishad, Gram Panchayat and selected PHCs of villages and relevant reference materials have been collected from various Govt. Circulars, Reports, Books and Journals and Websites.

DATA PROCESSIN6G:

The quantifiable data were coded and codebooks were prepared. The coded data were entered into the computer and have been processed with the help of SPSS software, made available under the6 UGC-DRS-SAP-phase-III programme, in the Department of Sociology. The computer generated out-put is used for tabulation, analysis and interpretation.

IV) ABOUT ACCREDITED SOCIAL HEALTH ACTIVISTS (ASHASS):

ASHA is the first port of call for any health related demands of deprived sections of the population, especially women, children, and old aged, sick and disabled people. She is the link between the com6munity and the health care provider.

Roles and Responsibilities of ASHA:

• ASHA should pr6imarily be a lady occupant of the town wedded/bereaved/separated from 6preferably in the age gathering of 25 to 45 years.

• She ought to be a litera6te lady with formal instruction up to class eight. This might be loosened up just if no suit6able individual with this capability is accessible.

• ASHA will be picked through a thorough procedure of choice including different local gatherings, self improvement gatherings, Anganwadi Institutions, the Block Nodal officer, District Nodal officer, the town Health Committee and the Gram Sabha.

• Capacity working of ASHA is being viewed as a consistent procedure. ASHA will have not under-go arrangement of train6ing scenes to procure the vital information, aptitudes and certainty for playing out her spelled out jobs.

• The ASHAs will get execution based motivators for advancing widespread inoculation, referral and es6cort administrations for Reproductive and Child Health (RCH) and other medicinal services projects, and development of family toilets.

• Empowered with learning and a medication pack to convey first-contact social insurance, each ASHA is relied upon to partake in general wellbeing programs in her town.

• ASHA will be the principal port of require any wellbeing related requests of denied segments of the populace, particularly ladies and kids, who think that its hard to get to wellbeing administrations.

• ASHA will be a wellbeing extremist in the network who will make mindfulness on wellbeing and its social determinants and prepare the network towards neighborhood wellbeing arranging and expanded use and responsibility of the current wellbeing administrations.

• She would be an advertiser of good wellbeing rehearses and will likewise give a base bundle of remedial consideration as proper and plausible for that dimension and make opportune referrals.

• ASHA will give data to the network on determinants of wellbeing, for example, sustenance, essential sanitation and sterile practices, sound living and working conditions, info6rmation on existing wellbeing administrations and the requirement for auspicious use of wellbeing and family welfare administrations.
• She will advise w6omen on birth readiness, significance of safe conveyance, bosom nourishing and comple6mentary bolstering, vaccination, contraception and anticipation of basic contaminations including Reproductive Tract Infection/Sexually Transmitted Infections (RTIs/STIs) and care of the youthful youngster.
• ASHA will assemble the network and encourage them in getting to wellbeing and wellbeing related administrations accessible at the Anganwadi/sub-focus/essential wellbeing focuses, for example, inoculation, Ante Nat6al Check-up (ANC), Post Natal Check-up advantageous nourishment, sanitation and ot6her administrations being given by the legislature.
• She will go about as a stop olde6r for basic arrangements being made accessible to all homes like Oral Rehydration Therapy (ORS), Iron Folic Acid Tablet(IFA), chloroquine, Disposable Delivery Kits (DDK), Oral Pills and Condoms, and so on.
• At the town level it is perceived that ASHA can't work without sufficient institutional help. Ladies' boards of trustees (such as self improvement gatherings or ladies' wellbeing advisory groups), Village Health and Sanitation Committee of the Gram Panchayat, fringe wellbeing laborers particularly ANMs and Anganwadi specialists, and the mentors of ASHA and in-benefit intermittent preparing would be a noteworthy wellspring of help to ASHA.

- ASHA to act as health resource person-of-first-resort in all maternal and child health matters, and to act as link-person between the community and the service providers.
- ASHA would act as a bridge between the ANM and the village and be accountable to the Panchayat.
- The ASHAs will receive performance-based incentives for promoting universal immunization, referral and escort services for Reproductive & Child Health and other healthcare programmes, and construction of household toilets.
- She should identify all pregnant women in your village.
- Her main role is to be the first point of contact for village members seeking health services, focusing particularly on pregnant women, new mothers, and young children.
- She is trained in “first-contact health care”, which includes administering basic first aid and simple curative care, including the high impact interventions discussed above, as well as providing disposable delivery kits for simple in-home deliveries.
- She is also responsible for promoting a package of sound child health practices such as safe delivery, breastfeeding and immunization.
- She also facilitates village residents in accessing higher levels of government-provided health care such as antenatal and post-natal checkups provided by government auxiliary nurse midwives (ANMs) and institutional deliveries at government health centers.
- Maintenance of village Health Register.
- Organisation of the Village Health and Nutrition Day.
- Co-ordination with SHG Groups.
- Meeting with ANM
- Monthly meetings at PHC level.

(Ministry of Health an6d Family Welfare, Government of India: 2011)

iv) SELECTION CREITERIA6 OF ASHA:

- **Tribal Area :-**
  - One ASH6A per 1000 population.
  - ASHA is pr6imary resident of village with formal education up to class 8th in Tribal.
  - Age gro6up of 20-45 years.
  - She shou6ld be married women.

- **Selection Proced6ure:- (According to GR dated 3rd July 2007)**
  - As per gui6delines, Gramsabha or VHNSC will recommend five names of suitable candidates to Taluka Health Officer.
  - Taluka Health Officer will select one lady as ASHA amongst these shortlisted can6didates.
  - Appointment le6tter of ASHA will be issued by Taluka Health Officer.
- **Non-Tribal Area :-**
  - One ASHA pe66r 1500 population.
  - ASHA is primary6 resident of village with formal education up to class 10th in non-tribal in th6e age group of 25-45 years.
  - She should be marr6ied women

Selection Procedure:-

- VHNSC 6will recommend three names of suitable candidates to Gramsabha.
- Gramsabh6a will select one lady as ASHA amongst these shortlisted candidates.
- Appointmen6t letter of ASHA will be issued by Taluka Health Officer.

Support Mechanism of AS6HA:-

- One District C6ommunity Mobiliser for one district
- One Block Facil6itator for 10 ASHAs in tribal area
- One block facilita6tor per PHC in non-tribal area.
- 1425 Block Facilita6tor appointed in Non-Tribal area.
- State, District & Ta6luka Mentoring Committees are being constituted for supporting ASHAs.

V) ASSEMENT OF SELF REPORTED WORK DONE OF ASHAs in PROMOTING CHILD AND MATERNAL HEALTH.

Assessment of self reported work done was taken in-terms of Number of visits to married couples to promote family planning, number of registered pregnant women, total number pregnant women who completed the course of I.F.6A 100, total number of pregnant women who completed course of I.F.A 200, number of institutional deliveries at Number of Registered Deliveries by ASHAs in PHC or SUB-PHC, visit and record of new born baby, number of children who completed zero polio dose, immunisation, infant mortality and maternal mortality.

Table No: 1

Number of visits to married couples to promote family planning 6

Number of Visits	6Frequency	Percent
1 to 100 per year	615	1.5
101 to 200 per year	644	4.4
201 to 300 per year	663	6.3
301 to 400 per year	1604	10.3
401 to 500 per year	2621	22.0
501 to 600 per year	1676	17.5
601 to 700 per year	683	8.3
701 to 800 per year	660	6.0
801 to 900 per year	629	2.9
901 to 1000 per year	610	1.0
Above 1000	1606	10.5
00	61	.1
NR	9663	9.3
Total	1005	100.0

Table-No-1 represents number of ASHAs visits to married unprotected couples (who are not using the contraceptives). Majority of them told that 221(22.0%) they yearly visits yearly visits 301 to 400 per year, 17(17.5) % ASHAs visits 501 to 600 visits per year.93(9.3%) ASHAs have not responded because at time of interview some of them have not the data with them.

Table No: 2
Number of Registration of Pregnant Women

	Frequency	Percent
1 to 10	243	24.2
11 to 20	509	50.6
21 to 30	130	12.9
31 to 40	27	2.7
41 to 50	5	.5
51 to 60	1	.1
Above 100	2	.2
NR	88	8.8
Total	1005	100.0

Table-No-2 represents number of registration of pregnant women by ASHAs. Majority of ASHAS i.e.509 (50.6) have register 11 to 20 pregnant women per year where least number that is 1(.1) have registered 51 to 60 pregnant women for a year. Registration of pregnant women depends upon available of cases particular of that period. 88(8.8) respondents have not respondent at the time of interview they have not record with them.

Table No: 3
Number of Registration of the pregnant women's who completed 100 tablets of I.F.A. (Iron and Folic Acid Tablets)

Number	Frequency	Percent
1 to 10	423	42.1
11 to 20	371	36.9
21 to 30	59	5.9
31 to 40	7	.7
Above 100	2	.2
.00	18	1.8
NR	125	12.4
Total	1005	100.0

Table-No-3 represents number of registrations of the pregnant women who completed 100 tablets of I.F.A.(Iron and Folic Acid tablets). Majority of ASHAS i.e.423(42.1%) have register 1 to 10 pregnant women who completed 100 tablets of I.F.A.(Iron and Folic Acid tablets) for a year where least number that is 2(.2) have registered above hundred pregnant women for a year. Out of total ASHAs 87% ASHAs have register 1

to 100 and above, where as only 1.8% have registered zero percentage and 12.4 have not responded because non-availability of record well as not understanding of question also.

Table No: 4

Number of Registration of the pregnant women's who completed 200 tablets of I.F.A. (IRON AND FOLIC ACID TABLETS)

No Registration	Frequency	Percent
1 to 10	488	48.6
11 to 20	93	9.3
21 to 30	6	.6
41 to 50	1	.1
51 to 60	1	.1
91 to 100	1	.1
Above 100	1	.1
.00	263	26.2
NR	151	15.0
Total	1005	100.0

Table-No-4 represents number of registrations of the pregnant women who completed 200 tablets of I.F.A.(Iron and Folic Acid tablets). Majority of ASHAS i.e.488(48.6%) have register 1 to 10 pregnant women who completed 200 tablets of I.F.A.(Iron and Folic Acid tablets) for a year where least number that is 1(.2) have registered above hundred pregnant women for a year. Out of total ASHAs 59% ASHAs have register 1 to 100 and above, where as only 41.2% have registered zero percentage and 15.2 have not responded because non-availability of record well as not understanding of question also.

Table-5

Number of Registered Deliveries by ASHAs in PHC or Sub-PHC (Institutional Deliveries)

	Frequency	Percent
1 to 10	629	62.6
11 to 20	107	10.6
21 to 30	14	1.4
31 to 40	3	.3
41 to 50	1	.1
51 to 60	2	.2
71 to 80	1	.1
.00	132	13.1
NR	116	11.5
Total	1005	100.0

Table-No-5 represents Number of Registered Deliveries by ASHAs in PHC or Sub-PHC (Institutional Deliveries). Majority of ASHAS i.e. 629(62.6%) %) have register 1 to 10 deliveries at PHC and Sub-centre for a year where least number that is 1(.1) have registered 71 to 80 deliverers at PHC and Sub-centre for a year. Out of total ASHAs 86.4% ASHAs have register 1 to 80 and above, where as only 13.1% have registered zero

percentage and 11.5 have not responded because non-availability of record well as not understanding of question also.

Table-6
Number of Visits to Newly born Infants

Number Visits	Frequency	Percent
1 to 10	286	28.5
11 to 20	407	40.5
21 to 30	119	11.8
31 to 40	35	3.5
41 to 50	18	1.8
51 to 60	4	.4
81 to 90	1	.1
91 to 100	1	.1
Above 100	7	.7
.00	15	1.5
NR	112	11.1
Total	1005	100.0

Table-No-6 represents Number of Visits to Newly born Infants by ASHAs. Majority of ASHAS i.e. 407(40.5.%) %) have made 11 to 20 visits to the newly born infants for a year where least number that is 1(.1) have made 91 to 100 visits for a year. Out of total ASHAs 87.4% ASHAs have made visits to 1 to 100 above, where as only 1.5% have registered zero percentage and 11.1 have not responded because non-availability of record well as not understanding of question also.

Table-7
Number of Visits to Only Breast Feeding Babies

Number of Visits	Frequency	Percent
1 to 10	295	29 4
11 to 20	390	38.8
21 to 30	99	9.9
31 to 40	44	4.4
41 to 50	21	2.1
51 to 60	11	1.1
61 to 70	5	.5
71 to 80	4	.4
81 to 90	7	.7
91 to 100	2	.2
Above 100	8	.8
.00	7	.7
NR	112	11.1
Total	1005	100.0

Table-No-6 represents Number of Visits to Only Babies breast feeding babies. Majority of ASHAS i.e. 390(38.8.%) %) have made 11 to 20 visits to the breast feeding babies for a year where least number that is 1(.1%) have made 91 to 100 visits for a year. Out of total ASHAs 87.4% ASHAs have made visits to 1 to 100 above, where as only 1.5% have registered zero percentage and 11.1 have not responded because non-availability of record well as not understanding of question also.

Table-8
Number of Immunised Children

	Frequency	Percent
1 to 10	185	18.4
11 to 20	342	34.0
21 to 30	124	12.3
31 to 40	37	3.7
41 to 50	23	2.3
51 to 60	14	1.4
61 to 70	12	1.2
71 to 80	19	1.9
81 to 90	14	1.4
91 to 100	8	.8
Above 100	35	3.5
.00	7	.7
NR	185	18.4
Total	1005	100.0

Table-No-8 represents number of registration of immunised children for a year. Majority of ASHAS i.e. 342(34.0%) have registered 11 to 20 number of immunised children for a year whereas least number that is 8(.8) have registered 91 to 100 number of immunised children for a year. Out of total ASHAs 80.7% ASHAs have registered 1 to 100 above, where as only 0.7% have registered zero percentage and 18.4 have not responded because non-availability of record well as not understanding of question also.

Table-9
Number of registration of Infant deaths within 42 days

	Frequency	Percent
1 Case	53	5.3
2 Cases	6	.6
00	852	84.8
NR	94	9.4
Total	1005	100.0

Table-No-9 represents number of registration of infant deaths for a year. Majority of ASHAS i.e. 852(84.8%) %) have registered zero cases of infant deaths for a year whereas least number that is 6(.6) have registered two cases for a year.

Table-10
Number of Registration of maternal deaths

	Frequency	Percent
1 Case	15	1.5
2 Cases	4	.4
.00	893	88.9
NR	93	9.3

Table-No-10 represents number of registration of infant deaths for a year. Majority of ASHAS i.e. 852(84.8%) %) have registered zero cases of infant deaths for a year whereas least number that is 6(.6) have registered two cases for a year.

Table-11
Number of Registration of Zero Polio Doses

	Frequency	Percent
1 to 10	357	35.5
11 to 20	337	33.5
21 to 30	92	9.2
31 to 40	39	3.9
41 to 50	13	1.3
51 to 60	8	.8
61 to 70	4	.4
81 to 90	6	.6
91 to 100	6	.6
Above 100	2	.2
.00	19	1.9
NR	122	12.1
Total	1005	100.0

Table-No-11 represents number of registration of number of babies of zero polio doses for a year. Majority of ASHAS i.e. 357(35.5%) have registered 1 to 10 zero polio cases for a year whereas least number that is 2(.2%) ASHAs have above 100 for a year.

VII) FINDINGS:

Majority of ASHAs visited to married couple to promote the family planning.
Majority of ASHAs registered the pregnant women and promote institutional deliveries.
Majority of ASHAs covered the immunization and zero polio coverage.
Majority of AHASs registered zero cases of maternal and child health.

VIII) CONCLUSION:

The present study basically focused on the self reported work done by ASHAs in the selected villages of Kolhapur district in Maharashtra State. The ASHAs workers are playing very important role in the promoting and improving the maternal and child health. This paper concludes that ASHAs are performing roles very effectively in case of registration of pregnant women, immunization, ANC and PNC services, providing TT injections, birth spacing and family planning of the child.

IX) Acknowledgement:

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