

Role of ASHA (Accredited Social Health Activist) Worker in Screening for Low Vision at the Grass Root Level

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Research Article

Abstract: Aim: To evaluate the usefulness of ASHA worker in detecting patient with low vision at village level. **Methodology:** Government of India launched National Rural Health Mission (NRHM) to address the health needs of the rural population and introduced a band of community based functionaries, Accredited Social Health Activist (ASHA). Under the Swarnim Gujarat Project (18-02-2010 to 30-03-2010), 40 selected ASHA were trained in Ranpur taluka (population-87914), Ahmedabad district, Gujarat. They detected patients with vision < 6/60. These patients were evaluated and diagnosed by ophthalmic assistants and referred to higher center, if required. **Observation:** 40 trained ASHA workers screened 80610 (91.69%) people out of the total population (87914) of Ranpur, which indicates good coverage. 434 patients had vision < 6/60 (prevalence of blindness-5.38 per thousand). **Conclusion:** ASHA is a fountainhead of community participation. Better penetration of health services armed with ASHA project can go long way in decreasing the prevalence of blindness in the nation as a whole. The major cause of low vision in India is still cataract which, luckily, is a preventable cause of blindness. However, better participation by the locals and monetary benefits to ASHA can help in better achievement of schemes objectives.

Keywords: ASHA, Low vision, Ophthalmic assistant.

Introduction

The Government of India launched National Rural Health Mission (NRHM) to address health needs of the rural population. For this, a new band of community based functionaries, named as ASHA (Accredited Social Health Activist) has been introduced. They are selected from the village itself and are trained to work as an interface between the community and the public health system.

Methodology

This project was conducted from 18th February to 30th March 2010 to study the efficacy of ASHA worker in screening for low vision. Under the guidance of District development officer (Ahmedabad district, Gujarat , India), a total of 1175 ASHA workers were selected out of the total population of 14,55,200 of Ahmedabad district. The criteria for selection were strictly followed.

One thousand and three ASHA workers completed the training. Out of these 1003 ASHA workers, 40 were of Ranpur Taluka (population of 87,914), a part of Ahmedabad district. ASHA workers screened the population and selected patients having vision, less than 6/60. They were then referred to the ophthalmic assistant for a diagnosis. When in doubt, the patients were referred to the higher center for confirmation of diagnosis.

Results and Discussion

ASHA serve as a bridge between poor and primary care services. The population 87,914 of Ranpur was screened by 40 ASHA workers. This accounts for a lack of 48 ASHA workers in Ranpur itself, as the required number of ASHA in the area is 88, given the norm of one ASHA per 1000 population. This could be due to lack of awareness and initiative by the locals. Of the total population, 80610 (91.69%) people could be screened, which indicates a good coverage of the area. The rest 7304 persons were either outstation, migrated, sick or dead (Fig 1). With the knowledge and equipments provided to them, the ASHA workers could identify 434 patients with vision less than 6/60 which means prevalence of blindness in the area is 5.38 per thousand populations. This included 159 (36.63%) males and the rest 275 (63.36%) females; this could be due to ignorance on the part of females. The affected population range between 55 years and 90 years. The ASHA workers then referred these 434 patients to the ophthalmic assistants where complete evaluation of the patients was carried out and a provisional diagnosis was made. Out of these 434 patients, 400 patients were detected to have cataract, 14 had corneal opacity, 5 patients had phthysical eye and 15 had other causes like retinal detachment, pseudophakic bullous keretopathy, squint, glaucoma, amblyopia (Fig 2). The diagnosis was confirmed by higher center when required.

Selection of Asha

- General norm is “One ASHA per 1000 population”
- ASHA must primarily be a literate woman resident of the village – married/widowed/divorced, preferably in the age group of 25 to 45 years.
- She should have good communication skills.

Training Programmes

ASHA undergo a series of training episodes (induction training and periodic trainings) to acquire the necessary knowledge and skills. Training programs are a combination of in-service training and module based training.

Roles and Responsibilities

ASHA makes a sample survey of the residents of villages. They create awareness, promote good health practices, and provide information to the community. They identify eye problems (including cataract) and refer patients. They also provide primary medical care for minor ailments.

Incentives

ASHA is an honorary volunteer and does not receive any salary. They receive performance based non monetary incentives which include awards, exposure visits, hazard allowance, educational benefits, eligibility for civil service, preferential access to housing loans etc. They are compensated for travelling allowance and daily allowance. They are given an incentive of Rs 175 per operated cataract patient.

Conclusion

ASHA is a fountainhead of community participation in public health in her village. Her active and enthusiastic involvement in the project can ensure better delivery of health service and can also decrease workload on the existing health resources. ASHA cannot function without adequate institutional support. For the success of ASHA scheme it is necessary that institutional structures take prompt action on the referrals made by her. The ASHA project could help us in detecting ocular diseases in rural population. The major cause of low vision in developing countries, like India is still cataract which luckily is a preventable cause of blindness. Hence better penetration of health services armed with ASHA project can go a long way in decreasing the prevalence of blindness in the nation as a whole. The major drawbacks that we observed included lack of monetary benefits for ASHA workers,

less initiation by the locals to volunteer as ASHA worker. The health system and ASHA scheme should work hand in hand to make this scheme a complete success.

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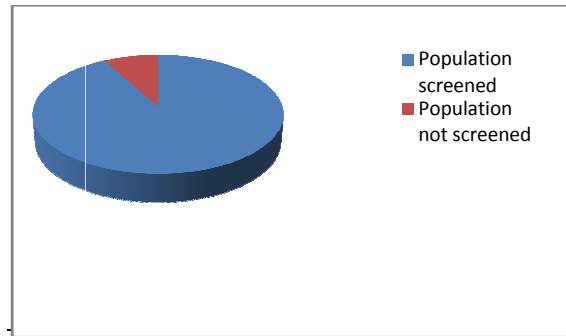


Figure 1: Extent of Penetration of Asha

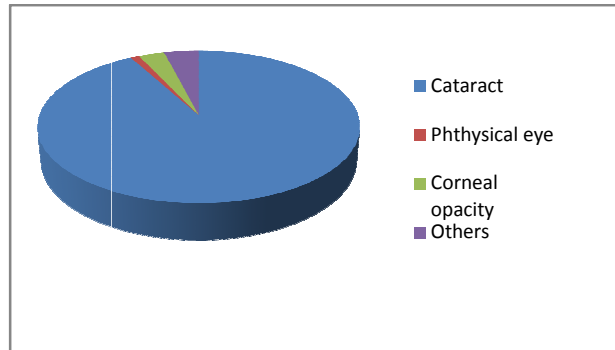


Figure 2: Cause of Low Vision

Other causes-retinal detachment, PBK, squint, glaucoma, amblyopia