Evaluation of role of mobilizers (ASHA & AWW) on village health and nutrition day (VHND) – Mamta day of study district

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ABSTRACT

Introduction and Aim: Mamta Abhiyaan is one of the major approaches towards reaching the MDGs of reduction of MMR from present 178 to 100 and IMR from present 42 to 30 in India. Mamta Day is celebrated as an outreach services provision to each single beneficiary at grassroots level. Functionaries of Mamta day are FHW, ASHA, and AWW mainly. ASHA & AWW acts as community personnel which helps in counselling and mobilization for all services provided on Mamta day. The aim of the study was to evaluate the role of ASHA and AWW on VHND (Village health and nutrition day) i.e., Mamta day of study district.

Materials and Methods: Quantitative and qualitative research method, cross sectional study was conducted in rural areas of western Gujarat covering 40 Mamta days. Every participant was clearly explained the purpose of study and their consent was taken. It was an anonymous study using pre structured proforma from available literature.

Results: At 82.5% sites, AWW was present whereas 77.5% sites ASHA workers were present. At 10 session sites ASHA did not have a due list of any beneficiary. Most sessions were conducted at Anganwadi and sub centre. At all 31 session sites, ASHA was mobilizing beneficiaries to the site; and at 6 (15%) session sites, there was not any mobiliser available. At 30 out of 31 session sites, ASHA was reminding beneficiaries for the next visit. AWW was involved in various services which varied from one session to another.

Conclusion: The presence of all three frontline workers (AWW, ASHA, and ANM) is essential for comprehensive VHND services, but there are notable challenges, including incomplete beneficiary lists and inadequate tracking of left-out children, hampering effective growth monitoring.

Keywords: Mamta day; ASHA worker; Anganwadi worker.

INTRODUCTION

The Mamta Abhiyaan, a collaborative initiative launched in 2006 by the Government of Gujarat with support from UNICEF, plays a pivotal role in enhancing comprehensive reproductive and child health (RCH) services within the framework of the National Rural Health Mission. This initiative is strategically designed to deliver a range of preventive, promotive, and curative healthcare services while fostering integration with the Integrated Child Development Services (ICDS) program and encouraging community participation (1).

Mamta Abhiyaan assumes a critical role in India's relentless pursuit of achieving crucial Millennium Development Goals (MDGs), including reducing the Maternal Mortality Ratio (MMR) from 178 to 100 and the Infant Mortality Rate (IMR) from 42 to 30, highlighting its significant impact on the nation's healthcare landscape (2, 3). Simultaneously, India's unwavering commitment to achieving comprehensive healthcare and addressing nutritional challenges in rural areas finds embodiment in the Village Health and Nutrition Day (VHND) program. This initiative, instrumental in providing vital healthcare and nutrition services to marginalized communities, heavily depends on the pivotal roles fulfilled by Accredited Social Health Activists (ASHAs) and Anganwadi Workers (AWWs). The Mamta day study district, nestled within India's multifaceted healthcare landscape, offers a compelling setting to assess the influence and effectiveness of these Mobilizers in successfully executing VHND (4).

The transformation of healthcare delivery in rural India in recent years is nothing short of remarkable. ASHAs and AWWs play pivotal roles in facilitating VHND activities, embodying the principles of community participation, education, and service provision. The assessment of their contributions in the Mamta day context is not only relevant to local health outcomes but also aligns with broader national and global health agendas (5).

The program is orchestrated as a monthly endeavor in each village, conducted at established Anganwadi Centers, Sub Centers, Primary Health Centers, or

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Community Health Centers. It relies on the collaborative efforts of a diverse team of healthcare workers, ICDS personnel, Kishori Shakti Yojna (KSY) girls, representatives from Mahila Swasthya Sangh, and non-government organization representatives. Advanced scheduling of program dates ensures widespread awareness among service providers and the community (1, 6).

The regular and effective organization of VHND has the potential to instigate crucial behavioral changes within communities, fostering a culture of health-seeking behavior and, consequently, leading to improved health outcomes. Given the significance of VHND, it is imperative that the prescribed services are consistently met, monitored, and evaluated, with clearly defined roles for ASHAs and AWWs.

MATERIALS AND METHODS

To conduct the present assessment study, a mixed-methods research approach was employed to gather data from the Mamta day initiative. The study was carried out within the rural areas of the designated study district, utilizing a cross-sectional design spanning one year. Ensuring representation, a random sampling technique, specifically the lottery method, was employed to select one Primary Health Center (PHC) from each of the seven blocks within the study district. The schedule for Mamta Day (VHND) was sourced from the Chief District Health Office, facilitating the evaluation of all Sub Centers associated with the selected seven PHCs, resulting in the assessment of 40 Mamta days (VHNDs).

In preparation for the study, all Auxiliary Nurse Midwives (ANMs) were adequately informed about the upcoming supervision. Data collection was carried out through a pretested semi-structured questionnaire, meticulously designed to assess the contributions of Mobilizers, Accredited Social Health Activists (ASHAs), and Anganwadi Workers (AWWs). The research process was underpinned by ethical considerations, with permissions sought from relevant authorities, including the Medical Officer in charge of the respective PHC, Block Health Officer, and Chief District Health Officer.

Each participant received a comprehensive explanation of the study's purpose, and their informed consent was diligently obtained. It was emphasized that the study findings would hold no bearing on their employment status. To facilitate data analysis, a coding system for qualitative responses was established prior to data entry. Subsequently, data were meticulously entered into a computerized database using MS Excel and subjected to thorough analysis.

Ethical approval, a paramount prerequisite, was obtained from the ethical committee of the relevant institution before the study's commencement. Following data collection, on-site corrections were diligently performed as needed to ensure data accuracy and completeness.

RESULTS

Table 1: Locations where Village Health and Nutrition Day (VHND) was observed (n=40)

<table>
<thead>
<tr>
<th>Session site</th>
<th>Frequency (percentage)</th>
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<tbody>
<tr>
<td>Anganwadi</td>
<td>15 (37.5%)</td>
</tr>
<tr>
<td>Sub centre</td>
<td>9 (22.5%)</td>
</tr>
<tr>
<td>House on rent</td>
<td>6 (15%)</td>
</tr>
<tr>
<td>PHC</td>
<td>5 (12.5%)</td>
</tr>
<tr>
<td>School</td>
<td>3 (7.5%)</td>
</tr>
<tr>
<td>Community hall</td>
<td>2 (5%)</td>
</tr>
</tbody>
</table>

Mamta day is celebrated every Wednesday, ensuring comprehensive coverage of each village under the Primary Health Center (PHC). This organized schedule of Mamta day is referred to as the Mamta calendar, designating specific weeks' Wednesdays for dedicated activities. Typically, the venue for Mamta day celebrations is the local Anganwadi center, aligned with the coverage area of the respective sub center.

During the study, Village Health and Nutrition Days (VHNDs) were observed at various locations, with the distribution as follows: Anganwadi centers (37.5%), sub centers (22.5%), rented houses (15%), PHC premises (12.5%), schools (7.5%), and community halls (5%). This diverse range of venues reflects the adaptability and flexibility of the program in reaching communities where they are most accessible.

Table 2: Personnel presence at session sites (n=40)

<table>
<thead>
<tr>
<th>Session site</th>
<th>Frequency (percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FHW</td>
<td>40 (100%)</td>
</tr>
<tr>
<td>AWW</td>
<td>33 (82.5%)</td>
</tr>
<tr>
<td>ASHA</td>
<td>31 (77.5%)</td>
</tr>
<tr>
<td>Helper</td>
<td>21 (52.5%)</td>
</tr>
<tr>
<td>MPW</td>
<td>11 (27.5%)</td>
</tr>
</tbody>
</table>

For conducting VHND effectively, staff members required are FHW, AWW, ASHA, Helper and MPW. Above table showing, FHW, AWW, ASHA, Helper and MPW were present at 100%, 82.5%, 77.5%, 52.5% and 27.5% session sites respectively. Thus, a qualitative portion of study was conducted among 33 AWW & 31ASHA workers.

FHW, ASHA and MPW were filling Mamta cards at 35 (87.5%), 3 (7.5%) and 1 (2.5%) session sites respectively; and at one site no one was feeling Mamata cards. In study district, incentives given to AWW, Helper and ASHA for providing services on
One VHND were 50, 50 and 25 rupees respectively, which should be given at the end of the session. In present study, at 18 (45%) session sites, disbursement of money to AWW, ASHA and Helper were done immediately after session.

During the observed sessions, ASHA was present at 31 sites, constituting 77.5% of the total. However, ASHA workers were notably absent at 5 session sites, and they were not recruited at 4 session sites. Out of the 31 sites where ASHA was present, 10 session sites did not have a due list of any beneficiaries.

Table 3 reveals the availability of due lists with ASHA, indicating that she had due lists for various beneficiary categories, including pregnant women, women in need of first-time or subsequent antenatal care (ANC), pregnant women requiring TT injections, postnatal women, infants in need of immunization, and adolescent girls. The percentages for due lists in these categories were 67.74%, 54.84%, 54.84%, 61.29%, 64.52%, and 48.39% of session sites, respectively. These due lists serve a crucial role in identifying and addressing left-outs and dropouts. Mobilizers, namely AWWs and ASHA workers, are responsible for preparing the due lists one day before Mamta day. From these lists, they can identify individuals who have been left out or dropped out and provide essential counseling, which is essential for overcoming community resistance and other barriers.

Left-outs are individuals, both children and women, who do not utilize immunization services due to reasons such as lack of knowledge, mistrust in immunization services, geographic constraints, or other factors. Dropouts, on the other hand, are children who receive one or more vaccinations but do not return for subsequent doses. During the study, left-out children were identified at 8 session sites (20%), primarily due to difficulties in convincing their caretakers for vaccination. Dropouts were found at 13 session sites (32.5%), and this was attributed to the caretakers being laborers who frequently migrated for work.

At all 31 session sites, ASHA was actively mobilizing beneficiaries to attend the session. However, at 6 session sites (15%), there were no Mobilizers available. Additionally, at 30 out of 31 session sites, ASHA was responsible for reminding beneficiaries about their next visit. Notably, ASHA had not prepared a list of referred beneficiaries with whom she was supposed to accompany the referral center at any site.

In terms of the role of AWW during VHND, she was absent at 7 session sites (17.5%). Out of the 33 session sites where AWW was present, 28 AWWs were conducting child weight assessments, but only 13 AWWs were accurately recording these weights on the Mamta card. Moreover, 5 AWWs were not weighing or recording weights on the Mamta card at all. Surprisingly, at 3 sites, the weight plotting for children was being done by FHW/MPW despite the presence of AWW. Notably, counseling on household water purification and sanitary latrines was absent at all session sites, and there were no demonstrations of proper hand washing conducted by health workers at any of the sites.

**DISCUSSION**

The choice of Mamta day celebration sites, primarily Anganwadi and Sub Centers, closely aligns with the findings of Kotecha et al., (7), who reported that VHND predominantly occurred at Anganwadi in 93.33% of their study sites, with only 6.67% taking place in community hall and temple premises. This consistent site selection reflects a standardized approach to VHND organization across various regions.

The presence of healthcare personnel, including Anganwadi workers and helpers, during VHND sessions was notably high, with 96.67% and 93.33% participation, respectively, in line with Kotecha et al. (7) findings. However, variations were evident in the study conducted by Dindod et al., (8), with 100% presence of FHW, 63.33% of AWWs, 93.33% of ASHAs, 50% of helpers, and 6.67% of MPWs. These disparities may reflect regional differences in healthcare infrastructure and workforce availability.

Efficient utilization of the Mamta card, a crucial tool for tracking maternal and child health, was observed at 83.3% and 92.1% of the sites, as reported by Kotecha et al. (7) and Patel et al. (9), respectively. This underscores the importance of accurate record-keeping for monitoring and enhancing healthcare outcomes.

However, notable gaps were identified in the presence and preparedness of ASHA workers. ASHAs were absent at 5 session sites and not recruited at 4 session sites, with 15% of sites lacking any mobilizer. This contrasts with the study by Patel et al. (9), which

<table>
<thead>
<tr>
<th>Due list available</th>
<th>Total no. of sites where due list is available (percentage)</th>
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<tbody>
<tr>
<td>Pregnant women</td>
<td>21 (67.74%)</td>
</tr>
<tr>
<td>Women who need ANC for first time/ subsequent</td>
<td>17 (54.84%)</td>
</tr>
<tr>
<td>time</td>
<td></td>
</tr>
<tr>
<td>Pregnant women requiring TT injection</td>
<td>17 (54.84%)</td>
</tr>
<tr>
<td>Postnatal women</td>
<td>19 (61.29%)</td>
</tr>
<tr>
<td>Infants requiring immunization</td>
<td>20 (64.52%)</td>
</tr>
<tr>
<td>Adolescent girls</td>
<td>15 (48.39%)</td>
</tr>
</tbody>
</table>
reported that one or more mobilizers were available at 89.77% of their study sites. Furthermore, a significant proportion of ASHAs did not possess due lists of beneficiaries, and no lists of referred beneficiaries were prepared by ASHAs at any site. These findings highlight potential challenges in task allocation and coordination within the ASHA workforce.

On the AWW front, although the majority of AWWs (28 out of 33) were conducting child weight assessments, only 13 AWWs were accurately recording these weights on the Mamta card. Additionally, 5 AWWs were not conducting weight assessments or recording them on the card at all. The absence of counseling on household water purification, sanitary latrines, and proper hand washing at all sites raises concerns about the comprehensiveness of health education during VHND sessions (10).

Several common challenges emerged, including insufficient logistics, the use of rented houses as Anganwadis, the absence of ASHA recruitment, transportation difficulties for vaccines and health personnel, coordination issues among coworkers, the absence of Village Health and Sanitation Committees (VHSCs), and grant unavailability. These challenges may hinder the effective execution of VHNDs and should be addressed to improve healthcare service delivery.

CONCLUSION

The presence of all three frontline workers (AWW, ASHA, and ANM) is indispensable for delivering the intended package of services during VHNDs. However, it is concerning that only half of the ASHA workers possessed all the duelists of expected beneficiaries. The identification and tracking of left-out and dropout children were insufficiently addressed, with no active tracking at any site. Additionally, growth monitoring of children was compromised at many sites due to the absence of weight assessments.

In summary, while there are notable successes in the VHND program, there are also areas that require improvement. Addressing these challenges and ensuring effective coordination, training, and resource allocation is crucial for the continued success of the program within the Mamta day study district.

CONFLICT OF INTEREST

The authors declare no conflicts of interest.

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