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RESEARCH ARTICLE

A PRE EXPERIMENTAL STUDY TO ASSESS THE EFFECTIVENESS OF STRUCTURED TEACHING PROGRAMME REGARDING KNOWLEDGE ON AYUSHMAN BHARAT HEALTH ACCOUNT (ABHA) AMONG PEOPLE RESIDING IN SELECTED AREAS OF DEHRADUN DISTRICT, UTTRAKHAND

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Abstract

Ayushman Bharat Health Account (ABHA): Empowering Individuals for Better Healthcare "Ayushman Bharat Health Account is a government initiative launched in 2018 with the aim of providing financial protection to families for secondary and tertiary care hospitalization. The present research project is, “A pre experimental study to assess the effectiveness of structured teaching programme regarding Ayushman Bharat Health Account (ABHA) among people residing in selected areas of Dehradun District, Uttarakhand.” The objective of the study was to assess the knowledge regarding ABHA among people, To evaluate the effectiveness of structured teaching programme on knowledge regarding ABHA among people and also to associate the pre-test knowledge regarding ABHA among people with their selected demographic variables.

Methodology: A quantitative evaluative research approach with a pre-experimental (one group pretest- posttest) design was adopted, the setting of the study was people nearby Nehru gram PHC, Dehradun. The sample size was 60, who were selected by random sampling technique. A Structured Self- administered questionnaire which consist of 30 objective type questions was used to assess the knowledge of the people. The investigator involved the people on Structured Teaching Programme regarding ABHA by using a Power-point slide presentation followed with pre-test. On same day, the post test was conducted. The collected data were analyzed by using both descriptive and inferential statistical methods, and interpretations were made based on the objectives of the study.

Findings: The study findings revealed that during Pre-test, most of the people 52 (86.66 %) had inadequate knowledge, whereas 06 (10 %) people have moderately adequate knowledge and very few 02 (3.34 %) of them had adequate knowledge regarding ABHA. During posttest, most of the people numbering 57 (95.00 %) were having adequate knowledge, whereas 03 (05.00 %) people have Moderately adequate knowledge and none of them had inadequate knowledge regarding ABHA. The mean score during pre-test was 6.383 ± 2.88 and the mean score during posttest was 25.97 ± 3.05. The paired‘t’ value was 39.09

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which was significant at $p \leq 0.05$ level. Thus it shows that the structured teaching programme was effective in improving knowledge regarding ABHA among people. The study concluded that the structured teaching programme was effective.

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Introduction:-

Healthcare is a fundamental pillar of human well-being, transcending geographical boundaries and societal divides. In the pursuit of optimal health outcomes, nations across the globe have embarked on transformative journeys, seeking to expand access, improve affordability, and enhance the quality of healthcare services for their citizens. Within this landscape of innovation and reform, India has emerged as a beacon of hope, spearheading initiatives aimed at realizing the vision of universal health coverage and equitable healthcare access for all. In recent years, one such initiative has captured the attention of policymakers, healthcare practitioners, and citizens alike – the AYUSHMAN BHARAT HEALTH ACCOUNT (ABHA). Envisioned as cornerstone of India's healthcare ecosystem, ABHA represents a paradigm shift in healthcare financing, offering financial assistance to individuals and families for a wide range of medical expenses. Rooted in the principle of inclusivity and equity, ABHA seeks to alleviate financial burden of healthcare costs, particularly for vulnerable and marginalized populations. The Dehradun district of Uttarakhand nested amidst the tranquil Himalayas, embodies both the serenity and the challenges of healthcare accessibility. Within this picturesque landscape lies the focal point of our enquiry- the efficacy of structured educational interventions in enhancing awareness about ABHA among the residents of selected areas.

Material and Methods:-

Research Approach:

The Quantitative evaluative research approach was adopted in this study. It was used to find out the understanding of the people about ABHA. The main goal was to find out the awareness about ABHA on various scheme parameters.

Research Design:

For the research on ABHA following design procedure was opted Pre experimental research design – design and development of Pretest questionnaire

Structured teaching and awareness program –

After pretest a structured teaching and awareness program was conducted for the community and ABHA scheme was discussed in detail.

Post experimental research design –

The same questionnaire (Pretest) which was circulated for collecting information was used to collect information after teaching and awareness program and was used as posttest to find out the increase in knowledge after the teaching and awareness program conducted for the said group of community.

Research Study Setting:

The study was conducted in village Nehrugram nearby PHC, Raipur Dehardun. This PHC covers about 40,000 populations. The said PHC is 7km away from CIMS college of Nursing.

Population:

Population is the set of people or entities to which the results of a research are to be generalized. The study population was the community residing nearby 1 km of PHC Nehrugram and patient visiting PHC OPD the total number of population sample for study was 60 numbers.

Sampling:

Sampling is the process of selecting a representative segment of the population under study. (Denise F. Polit and Beck, 2011). In the current study 60 people were selected using random sampling methodology so as to have random assessment about ABHA.

Sample:
The samples comprised of the People between 18-65 years and who fulfilled the inclusion criteria and who were attending the OPD at the PHC Nehru gram.

Sample Size:
The total sample size of present study comprised of 60 samples came after calculation. Z=1.96 p = 97% d = 5% assumed error α1 = α2 = 1.92

It was estimated by using formula, n=(σ1-σ2)2(Z1-α/2+Z1-β)2(m1-m2)2

Sampling Technique:
A random sampling technique was adopted for selecting the samples for the study. The totalnumber of people who visit the PHC every day is approximately 100. The sample size was 60.The samples were selected based on the availability and interest shown in the government programs.

Criteria For Sample Selection:
Inclusion Criteria –
The following was the basic criteria for selection of the sample for the study
Those who were in the age group of 18 to 65 residing in the selected area.
Those who were available at the time of data collection.
Both male and female willing to participate in the study.
Person who can read and write Hindi or English.

Exclusion Criteria –
The people who had already been exposed to any teaching on ABHA were excluded,

Result:-

Section–A
Distributionofpeopleaccordingtotheirdemographic variables.Variables.n=60

Sr.no	Personalvariables	Frequency(f)	Percentage(%)
1	**Age**		
	25–34years	29	48.34 %
	35– 44years	19	31.66 %
	45– 54years	09	15.00 %
	55– 64years	03	05.00 %
2	**Sex** Male		
	Female	24	40.00 %
		36	60.00 %
3	**TypeofFamily** Joint		
	Family NuclearFamily	22	36.66 %
		38	63.34 %
4	**MaritalStatus**		
	Unmarried	05	08.34 %
	MarriedWidow	54	90.00 %
	Divorced	01	01.66 %
		00	00.00 %
5	**Place** Rural		
	Urban	54	90.00 %
		06	10.00 %
6	**Religion** Hindu		
	Christian	47	78.33 %
	Muslim	03	05.00 %
	Others	08	13.33 %
		02	03.34 %

7	**Education**		
	NoformalEducation Primary Education Higher Education	00	00.00 %
		05	08.34 %
	Graduate	35	58.33 %
	MastersDegree	12	20.00 %
		08	13.33 %
8	**Occupation**		
	Unemployed	24	40.00 %
	SelfEmployed	09	15.00 %
	PrivateEmployee	24	40.00 %
	GovernmentEmployee	03	05.00 %
9	**MonthlyIncome(INR)**		
	Lessthan 10,000	12	20.00 %
	10,000– 15,000	29	48.33 %
	15,000– 30,000	12	20.00 %
	30,000– 45,000	7	11.67%
	45,000or more	00	00.00 %

Table 1:- Frequencyandpercentagedistributionofpeoplewithrespecttodemographic variables.

Age:
Table 1 shows that 29 people (48.34 %) belongs to the age group between 25-34 years, 19 people (31.66 %) belongs to the age group between 35-44 years, 09 people (15.00 %) belongs to the age group between 45-54 years and 03 people (05.00 %) belongs to the age group between 55-64 years

Gender:
Total 24 people (40%) were male and 36 people (60%) were female

Type Of Family:
Total 22 people (36.66 %) people belonged to Joint Family and 38 people (63.34 %) representation was from the nuclear family

Marital Status:
Total 05 people (08.34 %) were unmarried, 54 people (90.00 %) were married where as 01 person (01.66 %) was widow and no person was having divorce in the overall sample

Place:
Total 54 people (90.00 %) were from the rural area whereas 06 people (10.00 %) were from the urban area

Relegion:
Total 47 people (78.33 %) were Hindu, 03 people (05.00 %) were Cristian, 08 people (13.33 %) were Muslim and 02 people (03.34 %) belonged to other category

Education:
No one was illiterate in the overall sample, 05 people (08.34 %) were having primpary education, 35 people (58.33 %) were having higher education, 12 people (20.00 %) were graduate and 08 people (13.33 %) were post graduate and above.

Occupation:
Total 24 people (40.00 %) were unemployed, 09 people (15.00 %) were self employed, 24 people (40.00 %) were private employee and 03 people (05.00 %) were Government employee

Monthly Income:
12 people (20.00 %) were having monthly income less than 10,000 where as 29 people (48.33%) were having monthly income between 10,000- 15,000, 12 people (20.00 %) were having monthly income between 15,000 –

30,000 Where as 07 people (11.67 %) were having income in the range of 30,000 – 45,000 per month where as no people in the sample were having income more than 45000 per month

Section-B:

Distribution Of People According To Their Pre-Test Score On Knowledge Regarding ABHA

The assessment of the knowledge was done on the basis of the evaluation of pretest questionnaire. The sample population of the studywas initially briefed about the objective of the study and the pretest questionnaire was circulated to take their view points about ABHA. There were 30 questions in the pretest. Each correct answer was given the score of 1 and each wrong answer wasgiven the scoreof 0.Belowisthe table showingthe assessment of knowledge during pretest.

BasedonPretest(withoutteaching/education)

Category	Score	Noofpeople	Percentage
Adequateknowledge	23-30	2	3.34 %
Moderatelyadequateknowledge	10-22	6	10 %
Inadequateknowledge	0-9	52	86.66 %

Table 2:- Scoringkeyforknowledgeassessment-Pretestbeforeteaching/education.

From table no. 2 it is clear that during pre-test, most of the people numbering 52 (86.66 %) have inadequate knowledge, whereas06 (10 %) people have moderately adequate knowledge and very few 02 (3.34 %) of them have adequate knowledge regarding ABHA. Further, during the analysis of the pretest questionnaire it was revealed that very few of the people were onlyable to answer the generalized questions like have you heard about ABHA, How you know about it, about understanding of ABHA, eligibility, registration etc. But by and large the people were not adequately aware about ABHA.

Section-C:

Distribution Of People According To Their Post Test Score On Knowledge On ABHA

The assessment of the knowledge was done on the basis of the evaluation of posttest questionnaire. The sample population of the studywas initially briefed about the objective of the studyandthe pretestwhichwas carried out.Theywereprovide ateachingcum educationsession of around 45 minutes followed by an open session of question and answer so as to have clarityon ABHA. Afterthisactivityposttest questionnaire wascirculated totaketheirviewpointsabout ABHA. The post test was same as that of pretest and also consisted the same were 30 questions. Each correct answer was given the score of 1 and each wrong answer was given the score of 0. Below is the table showing the assessment of knowledge after posttest.

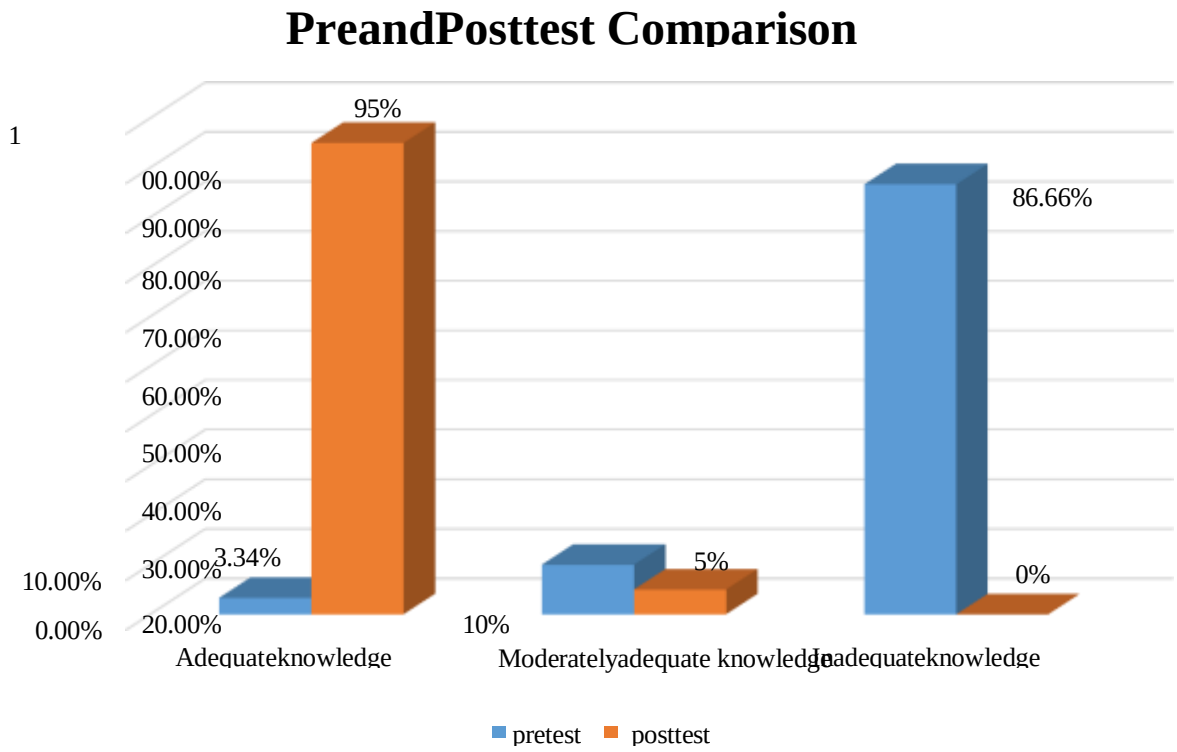
BasedonPosttest(afterteaching/education)

Category	Score	Noofpeople	Percentage
Adequateknowledge	23-30	57	95 %
Moderatelyadequateknowledge	10-22	03	5 %
Inadequateknowledge	0-9	0	0 %

Table 3:- Scoringkeyfor knowledge assessmentafter posttest-on teaching/education.

From table no. 3 it is clear that after posttest, most of the people numbering57 (95.00 %) were having adequate knowledge, whereas03 (05.00 %) people have moderately adequateknowledge and none of them had inadequate knowledge regarding ABHA. The above trend showsthat asmallteachingcum orientation program aboutABHAhad createdawareness among subjectpeople. Further,duringtheanalysisofthe posttestquestionnaireit wasrevealedthatmost of the people were able to answer most of the questions related to ABHA.

Comparison Between The Pretest And Post Test Scores On Knowledge Of ABHA Among People.



FigureNo.1:- Comparisonbetweenpretestandposttest.

The above figure shows a comparison between pretest and posttest. From the figure it is clearthat during the pre test 86.66 % of people were having inadequate knowledge and only 3.34 % were having adequate knowledge. But just after teaching and educating and making them aware aboutABHAitwasfoundthatthelevelofadequateknowledgehasdrasticallyincreasedfrom 3.34 % during pre test to 95.00 % after post test. Thus their has been a remarkable boost in the level of knowledge after post test.

Table4:- DescriptiveStatisticsofPretestKnowledgeScoreRegardingABHAamongpeople. N = 60

Mean	SD	Md	Range
6.38	2.889	3.8	22

NB:SD=Standarddeviation Md=Median

Table 4 provide descriptive statistics for the pretest knowledge scores among peopleregardingABHA. Themeanknowledgescorewas6.38,with astandarddeviation(SD)of 2.889,indicatingamoderatelevelofvariationinknowledgelevelswithinthesample.Themedian (Md) knowledge score was 3.8. These statistics provide a comprehensive overview of the distribution and central tendencies of pretest knowledge scores among the people, which canhelp researchers and policy makers, understand the initial knowledge levels and plan targeted interventions accordingly.

Table5:- DescriptiveStatisticsofPosttestKnowledgeScoreRegardingABHAamongpeople.**N=60**

Mean	SD	Md	Range
25.97	3.0567	19.3	22

NB:SD=Standarddeviation Md=Median,

Table 5 depict descriptive statistics for the knowledge scores among people regarding ABHA after educational and awareness program intervention (post test). The mean knowledge score increased to 25.97 from the pretest score, indicating drastic improvement in knowledge levels. The standard deviation (SD) increased to 2.307, suggesting a increase in the variation of knowledge scores within the sample compared to the pretest. The median (Md) knowledge

score increased remarkably to 19.3. These statistics highlight the positive impact of awareness andeducationinterventionsaboutABHA, withanincreasedmeanscoreand increased variability, underscoring the effectiveness of the implemented strategies in improving awareness about ABHA.

Table.6:- EffectivenessofeducationalinterventionregardingknowledgeaboutABHA. N=60

S.No.	Knowledgescore	Mean	SD	MD	t value	Df	Tablevalue
1.	Pretest	6.383	2.889	19.592	39.09	58	3.460
2.	Posttest	25.975	3.057				

NB:SD=Standarddeviation,MD=Meandifference,df=degreeoffreedom,S=significantat 0.05level

Table 6 shows the effectiveness of the educational intervention in improving knowledge about ABHA among sample people at PHC, Nehrugram. The pretest knowledgescorehad a mean of 6.383 ± 2.88 and a standard deviation (SD) of 2.889, while the posttest knowledge score hada meanof25.97±3.05anda increasedSDof3.057.The paired't'test value is39.09which is significantlyhigher than the table value of 3.460 at $p \leq 0.05$level. Hence hypothesis H_1 is retained. Thus it becomes evident that the structured-teaching programme is effective in improving the knowledge regarding ABHA among people indicating that the educational intervention had a significant positive impact on enhancing understanding about ABHA among the sample people. This finding underscores the effectiveness of the implemented educational and awareness strategies in improving knowledge levels among the study participants and highlights the importance of such interventions for promoting maximumbenefits about ABHA.

Table7:- AssociationBetweenthe Level ofKnowledgeRegardingAyushmanBharathHealth account (ABHA) among people with their selected demographic variables.

S.No.	Socio-DemographicData	Inadequate knowledge	Moderately Adequate knowledge	Adequate Knowledge	$\chi 2$ value	pvalue	Degree of freedom	Remark
1.	**Age**							
	25–34 years	00	02	27				
	35–44 years	01	02	16				
	45–54 years	00	01	08	21.546	0.0014	6	S
	55– 64 years	01	01	01				
2.	**Gender**							
	Male	01	04	19	2.120	0.3463	2	NS
	Female	01	02	33				
3.	**TypeofFamily**							
	Jointfamily							
	Nuclearfamily	O1	03	18	0.7066	0.7023	2	NS
		01	03	34				
4.	**Maritalstatus**							
	Unmarried							
	Married	01	02	02				
	Widow	00	03	50	31.618	0.0000	4	S
	Divorced	01	01	00				
5.	**Place**							
	Rural Urban	01 01	04 02	49 03	4.4654	0.1072	2	NS

6.	**Religion**							
	Yes	00	02	45				
	No	01	01	01	34.474	0.0000	6	S
	Muslim	01	01	06				
	Other	00	02	00				
7.	**Education**							
	No Formal			03				
	education	01	01					
	Primary			31				
	education	01	03					
	Higher			11	4.042	0.670	6	NS
	education	00	01					
	Graduate			07				
	MasterDegree	00	01					
				00				
		00	00					
8.	**Occupation**							
	Unemployed	00	01	23				
	Self employed	01	02	06	27.425	0.0001	6	S
	Private	00	01	23	2			
	employee	01	02	00				
	Government							
	employee							
9.	**Monthly**							
	Income							
	<10,000	01	01	10				
	10,000-15,000	01	02	26	2.5704	0.8605	6	NS
	15,000-30,000	00	02	10				
	30,000-45,000	00	01	06				
	45,000 or	00	00	00				
	more							

Variables considered include age,gender,place,educational status ,occupation,type of family ,marital status,monthly income,

The Chi-square ($\chi 2$) test was used to determine the association between these variables and the pretest knowledge levels.

Regarding age, the analysis revealed no statistically significant association between age groups (<20, 25- 34, 34-44, 45-54,55-64 years) and pretest knowledge levels ($\chi 2 = 21.456$, df = 6, p = 0.0014), indicating that age very little significantly influence initial knowledge about the ABHA .

Also about the Gender(male,female) analysis shows no significance association ($\chi 2 = 2.120$, df = 2, p = 0.3463).

Similarly, educational status (Informal, Up to 10th, Up to 12th, Graduation and above) showed no statistically significant association with pretest knowledge ($\chi 2 = 4.042$, df = 6, p = 0.090), suggesting that education level was not a significant determinant of initial knowledge.

Occupation did not exhibit a statistically significant association with pretest knowledge levels ($\chi 2 = 2.745$ df = 6, p = 0.001), implying that whether a employed or unemployed did not significantly affect them initial knowledge about the ABHA.

Likewise, the type of family (Nuclear, Joint) showed no statistically significant association with pretest knowledge ($\chi2 = 0.7066$, df = 2, p = 0.7023), suggesting that family structure did not play a significant role in influencing initial knowledge.

The place(Rural, Urban) exhibited no statistically significant association with pretest knowledge ($\chi2 = 4.4654$,, df = 8, p = 0.1072), indicating that the place did not impact the initial knowledge levels.

Marital status(married ,unmarried ,widow) also did not show a statistically significant association with pretest knowledge ($\chi2 = 31.618$, df = 2, p = 0.280), suggesting that the marital status did not significantly affect initial knowledge.

Religion (Hindu,christen,muslim) did not demonstrate a statistically significant association with pretest knowledge ($\chi2 = 34.474$, df = 6, p = 0.000), indicating that the number of religion did not significantly influence initial knowledge levels.

Finally the monthly income showed no statistically significant association with pretest knowledge($\chi2 = 2.5704$ df = 6, p = 0.8605) suggesting that the monthly income did not significantly impact initial knowledge.

In summary, Table 5.8 provides valuable insights into the association between various socio demographic factors and the pretest knowledge levels of people regarding the ABHA The lack of significant associations in most cases suggests that these demographic variables did not play a significant role in determining the initial knowledge levels of the study participants. This information is essential for tailoring future interventions and targeting specific groups to improve ABHA awareness and utilization

Conclusion:-

The study was conducted to assess the Effectiveness of Structured Teaching Programme on knowledge ABHA among People in a selected area Raipur, Dehradun. The study findings showed that the structured teaching programme was effective in improving their knowledge. There was no significant association found between the knowledge of ABHA and their selected demographic variables. This study intervention would help the People to get followingBenefits of ABHA.

Financial Protection:
ABHA offers financial protection by providing health insurance coverage for economically vulnerable individuals and families. It aims to reduce out-of-pocket expenses on healthcare and protect them from catastrophic health expenses.

Cashless Treatment:
Under ABHA, beneficiaries can avail cashless treatment at empaneled hospitals and healthcare providers. They can receive necessary medical care without paying upfront and can focus on their treatment without worrying about financial burdens.

Comprehensive Coverage:
ABHA covers a wide range of medical treatments, including hospitalization expenses, surgeries, diagnostics, medications, and pre- and post-hospitalization expenses. It provides coverage for both outpatient and inpatient care, ensuring beneficiaries have access to essential healthcare services.

Empaneled Healthcare Providers:
ABHA has a network of empaneled hospitals and healthcareprovidersacrossIndia.BeneficiariescanchoosefromtheseempaneledfacilitiesfortheirmedicaI treatment, ensuring quality care and access to a wide range of healthcare services

Portability:
ABHA is portable, meaning beneficiaries can avail of the scheme's benefits across India. This is particularly beneficial for individuals and families who may need to travel or relocate for medical treatment.

Technology-driven:
ABHA leverages technologyfor efficient implementation and management. It utilizes electronic health records (EHRs) and online platforms for seamless communication between beneficiaries, healthcare providers, and insurance agencies.

Preventive Healthcare:
ABHA alsoemphasizes preventive healthcare by providing coveragefor annual health check-ups and screening tests. This encourages beneficiaries to prioritize preventive measures and early detection of health conditions.

It'simporttonotethatthespecificbenefitsandcoveragedetailsmayvarydependingonthestateandthe specific implementation of the ABHA scheme.

Recommendations:-

1. Similarstudycanbeconductedascomparativestudybetweenurbanandruralpopulationindifferent settings.
2. Similarstudycanbeconducted forvarioussocioeconomicbackgrounds.
3. Similarstudycanbedonebyusingvariousteachingmethods.
4. Thestudycanbecarriedouttoassesstheusageof ABHAatdifferentagelevelandlargresizeofgroup.

Conflict of Interest:
Author declares no any conflict of interest.

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