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Research article

ARE ACCREDITED SOCIAL HEALTH ACTIVIST WORKERS AWARE OF THEIR ROLES AND RESPONSIBILITIES

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ABSTRACT

Introduction: The role of Accredited Social Health Activist (ASHA) workers is vital in public health delivery system in India. The study was planned with objective to assess the socio-demographic profile of ASHA workers, awareness and practices of their roles and responsibilities and difficulties faced while working in north-east district of Delhi, India. **Materials and methods:** A descriptive cross sectional study was conducted in north east district of Delhi among 55 ASHA workers after taking written informed consent. Data was collected using a pre tested semi-structured questionnaire consisted of items on socio-demographic profile of ASHA workers, knowledge and practices about their roles and responsibilities and difficulties faced in community. The data was analyzed by using SPSS software version 17. Qualitative data was expressed in percentages and quantitative data was expressed in mean ± SD. **Results:** Mean age (±SD) of ASHAs was 31.84 ± 7.2 years. Most of them were married (96.4%), Hindu (85.5%) and were catering to a population of 1000-2000 (87.3%). Most of the ASHA workers were aware of their work of maternal and child health services. However lesser numbers were aware of their role in registration of births and deaths and to treat minor ailments. 96.4% reported that they maintain family planning register, only 51 (92.7%) reported that they maintain antenatal register. 10 (18.2%) ASHAs reported that they face problems in coordination with Auxiliary Nurse Midwife (ANMs). **Conclusion:** ASHAs performance is impacted by their limited orientation towards their roles and responsibilities. Training should provide complete knowledge about the same.

Key words: Community health workers, Roles, ASHA, Delhi

INTRODUCTION

The role of community health workers (CHWs) in healthcare delivery system is widening as they are considered inevitable to meet the universal healthcare provision and the millennium development goals.[1] The CHWs enable access to and utilization of health services and inculcate health promotive behaviours among the people in the community. They are deployed to cater to the demand of underutilized services, unmet health behaviours and underserved populations.[2] The National Rural Health Mission (NRHM) was launched by the Government of India in 2005 to strengthen the healthcare delivery system and to provide comprehensive integrated health care services to people in rural area and recently urban area also included. One of core strategies was to recruit and train female Accredited Social Health Activist (ASHA) workers in each village to act as interface between community and public health system. They are given the task of providing basic preventive and curative services, promoting use of existing health services and encouraging dialogue on social health issues.[3] ASHA is a female volunteer honorary worker selected by the community, deployed in her own village (one in every 1000

population) after a short training on community health. She is preferred to be between 25 and 45 years old, with a minimum formal education of 8 years and demonstrable leadership qualities. They are provided with performance based incentives for their services.[4] There are presently a total of 866726 ASHAs selected across the country. The proposed total is 908281, of which 95.42% have been selected. Most ASHAs have completed the first four rounds of training and in states that had initiated this, the fifth round of training as well.[5] Since the success of NRHM depends hugely on performance of ASHA workers, it is important to assess their perception regarding the tasks that they have to perform in the community and difficulties faced by them while working. The rationale of such research is to contribute to the literature on design and support to ASHA program to maximize their impact to improve the health indicators. Keeping in view the above aspect, this study was planned with objective to assess the socio-demographic profile of ASHA workers, awareness and practices of their roles and responsibilities and difficulties faced while working in north-east district of Delhi, India.

MATERIALS AND METHODS

Study design: A descriptive cross sectional study was carried out on ASHA workers recruited under NRHM, Delhi covering a population of approximately 1, 10,000. Study area was chosen by using convenience sampling method.

The study was conducted over a period of three months from October to December 2014. Written informed consent was taken from the study subjects. Ethical clearance was taken from department before start of study. The option to opt out of the study was kept open without any clause. The data was kept confidential and was used for research purpose only.

Inclusion criteria: A total of 55 ASHA workers who provide services to Gokalpuri, Chandu Nagar and adjoining areas constituted the study population. ASHA workers who gave consent for the study were included in the study. There were no specific exclusion criteria for study. All ASHA workers in the study area were approached for participation in the study voluntarily.

Methodology

Data was collected using a self designed pre-tested semi-structured questionnaire prepared in English and translated in local language. Questionnaire consisted of items on socio-economic and demographic profile of ASHA workers like age, educations status, income, religion etc. Questions on knowledge and practices about roles and responsibilities of ASHA worker's like maternal health, child health, control of common communicable diseases etc. were included. Perception of ASHAs about their training and working conditions was also assessed. The questionnaire was pilot tested before start of study for its reliability and validity. Cronbach's alpha which is coefficient of reliability was calculated to be 0.81. The content validity of the tool was established by giving it to experts in the relevant field. Most of the experts agreed on most of the items and necessary modifications were made as per their suggestions.

Statistical Analysis: The data was entered in MS-Excel and analyzed by using SPSS software version 17. Qualitative data was expressed in percentages and quantitative data was expressed in mean $\pm$ SD.

RESULTS

Socio demographic profile

Table 1 shows socio demographic profile of ASHA workers. Mean age ($\pm$SD) of ASHAs was 31.84 $\pm$ 7.2 years. Maximum 31 (56.4%) belonged to age group of 25-35 years. 47 (85.5%) were Hindu and 8 (14.5%) ASHAs were from Muslim community. Majority (61.8%) of ASHAs were educated up to or above senior secondary school and most of them were married (96.4%). 16 (29.1%) belonged to scheduled caste (SC), 16 (29.1%) to other backward classes (OBC) and 21 (38.2%) to general category. Majority (87.3%) were catering to a population of 1000-2000. Mean ($\pm$SD) population catered was 1891.85 ($\pm$384.27).

All ASHAs (100%) were provided with ASHA diary. All were aware about the incentives they were entitled to for their work. 53 (96.4%) ASHAs reported that they did not get any money in advance for providing services in emergency. Only 24 (43.6%) reported that they receive their incentives on time. Monthly income ($\pm$SD) of ASHAs was Rs. 2117.39 $\pm$ 796.95. When inquired about the last ASHA training session attended, 37 (67.3%) reported that they attended 0-3 months back, 8 (14.5%) attended 3-6 months back and 10 (18.2%) 6 months – 1 year back.

Table 1: Socio-demographic profile of ASHA workers

Characteristic		Frequency	%(N= 55)
Age(in years)	<25 yrs	8	14.5
	25-35 yrs	31	56.4
	35-45 yrs	16	29.1
Religion	Hindu	47	85.5
	Muslim	8	14.5
Education	Middle	5	9.1
	Secondary	16	29.1
	Senior secondary and above	34	61.8
Marital status	Unmarried	2	3.6
	Married	53	96.4
Caste	Scheduled casts (SC)	16	29.0
	Scheduled tribe (ST)	2	3.6
	Other backward Classes (OBC)	16	29.1
	General	21	38.2
Population served	<1000	4	7.3
	1000-2000	48	87.3
	>2000	3	5.5

Table 2: Awareness of ASHAs about their roles and responsibilities

Responsibility	Positive response	% (N= 55)
Mobilize children for immunization	54	98.2
Provide counseling for family planning	53	96.4
Bring pregnant women for check up to health centre	52	94.5
Accompany pregnant women to hospital during delivery or complications	49	89.1
Distribute Iron folic acid (IFA) tablets to pregnant women	47	85.5
Counsel the mother regarding child nutrition	43	78.2
Registration of births and deaths in the area	29	52.7
Can act as DOTS provider	43	78.2
Give treatment for minor ailments	16	29.1

Table 3: Perception regarding training of ASHAs

Training aspect	Complete (%)	Incomplete (%)	Need to be repeated (%)	Too much information being given
Pregnancy and child birth	33(60.0)	5 (9.1)	11 (20.0)	6 (10.9)
Newborn care	36 65.5)	5 (9.1)	4 (7.3)	10 (18.2)
Child health	33 60.0)	7 (12.7)	9 (16.4)	6 (10.9)
Family planning	43 78.2)	8 (14.5)	1 (1.8)	3 (5.4)
Common diseases	36 65.5)	9 (16.4)	7 (12.7)	3 (5.4)
Nutrition	37 67.3)	8 (14.5)	6 (10.9)	4 (7.3)
Use of medicines	35 63.6)	10 (18.2)	6 (10.9)	4 (7.3)
Roles and responsibilities of ASHA	37 67.3)	10 (18.2)	4 (7.3)	4 (7.3)

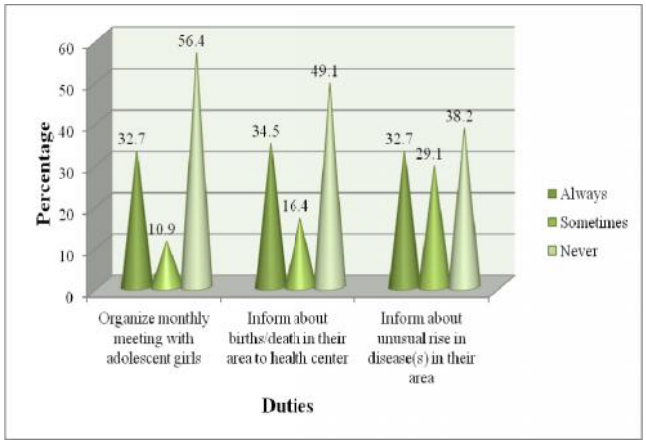

Fig 1: Duties performed by ASHAs in their respective areas

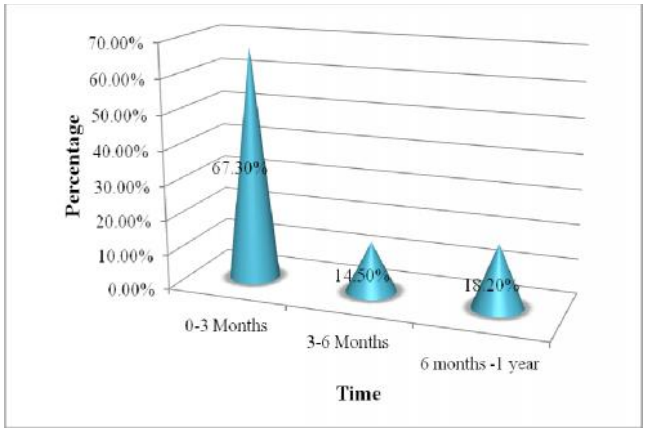

Fig 2: Time since last ASHA training received

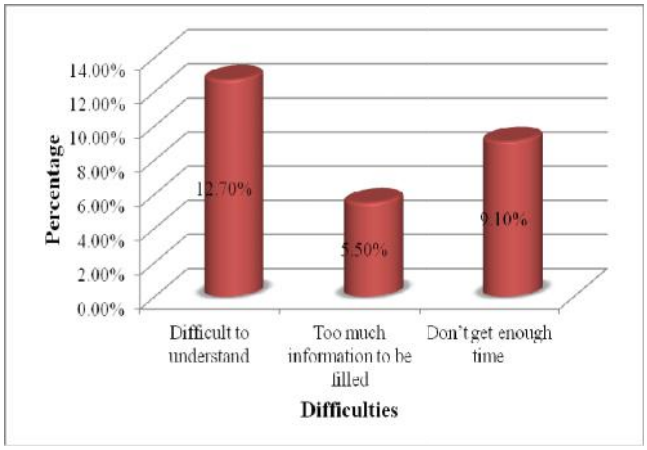

Fig 3: Problems faced by ASHAs in maintaining registers

Awareness and practices about responsibilities

ASHAs were asked if they were aware of their roles and responsibilities as shown in Table 2. Most of the ASHAs workers were aware of their work of mobilizing children for immunization, providing counseling for family planning, bringing mothers for ANC and companying them for hospital for delivery. However lesser numbers were aware of their role in distribution of tablet Iron and Folic acid, registration of births and deaths, and DOTS. Few were aware of their role to treat minor ailments.

The number of hours a day an ASHA used to work was 4.8 $\pm$ 1.4. All ASHAs reported that they were actively involved in spreading awareness about health in their areas. Only 7 (12.7%) reported that they acted as DOTS provider for any patient. Figure 1 shows duties performed by ASHAs in their respective areas. 18 (32.7%) reported that they always organize monthly meeting of adolescent girls for promoting menstrual hygiene. 19 (34.5%) reported that they always inform about the births and deaths in their area to the health centre. Only 18 (32.7%) reported that they always inform about any unusual health problems/disease outbreaks in their community to the health centre.

A majority of ASHAs (96.4%) reported that they maintain family planning register, only 51 (92.7%) reported that they maintain antenatal register, 54 (98.2%) maintain immunization register, 36 (65.5%) maintain birth and deaths register and 34 (61.8%) used to maintain household survey register. Only 40 (72.7%) ASHAs said that they knew about TB patients in their area.

Figure 2 show that 67.3% ASHAs received basic training in last 3 months. 1 (1.8%) ASHAs received training up to 4th module while 12 (21.8%) and 42 (76.4%) received up to 6th and 7th module respectively. When asked about if they were able to understand the module, 47 (85.5%) responded they always understand the module, 5 (9.1%) said that she sometimes understand the module and 3 (5.5%) said they never understand the module.

Data was collected about the problems faced by ASHAs during training. 7 (12.7%) reported that training sessions were overcrowded. ASHAs were asked about their perception regarding training aspects. The responses were collected on four aspects; training is complete, incomplete, need to be repeated or too much information is imparted. Responses are shown in Table 3. Data was collected from ASHA workers about the duties performed by them in their respective areas. 18 (32.7%) ASHA workers reported that they *always* organize monthly meeting for adolescent girls for promoting menstrual hygiene, 6 (10.9%) reported only *sometimes* and 31 (56.4%) said they *never* organize any such meetings. About their responsibility of informing births and deaths in the area to the health centre, 19 (34.5%) reported that they *always* inform the same, 9 (16.4%) said only *sometimes* while 27 (49.1%) reported they *never* inform. One of the responsibilities of ASHA workers is to inform about any unusual health problems/disease outbreaks in the community to the health centre, 18 (32.7%) ASHAs reported *always*, 16 (29.1%) sometimes while 21 (38.2%) ASHAs answered they *never* report about the same.

Difficulties faced by ASHAs

When asked if they face any problems in maintain registers, 11 (20.0%) reported that they face difficulties in the same. 7 (12.7%) said that they find registers very difficult to understand, 3 (5.5%) said too much information have to be filled in the registers while 5 (9.1%) reported that they do not get enough time for completing registers. The various problems are shown in Figure 3.

10 (18.2%) ASHAs reported that they face problems in coordination with Auxiliary Nurse Midwife (ANMs). Only 30 (54.5%) ASHAs perceived that community had faith in them. 37 (67.3%) ASHAs reported that they face barriers while working in the community. The common barriers faced by ASHA workers while working in the community were language problems as reported by 9 (16.3%), religious and socio cultural barrier (7.3%) and casteism as reported by 6 (10.9%). Only 11 (20.0%) reported that they have been given ASHA kit. Out of

these 11, only 8 reported that medicines were refilled regularly in kit.

DISCUSSION

The present study showed that although most of the ASHAs belong to age group of 25-45 years, 8 (14.5%) were below 25 years of age and 2 (3.6%) was unmarried, which is contrary to guidelines of ASHA workers selection. Similarly 3 (5.5%) ASHAs were serving more than 2000 population which is more than recommended.[5] These figures are less than reported by Mahyavanshi DK et al where higher number of ASHA workers were recruited against selection criteria.[6] The positive findings were good representation of all caste of community, education status of ASHAs and the fact that all ASHA belonged to local community. Most of the ASHAs were serving a population of 1000-2000 as revealed by other studies also.[7]

Almost all ASHA workers were aware about their roles and responsibilities regarding maternal and child health services. Similar results were showed by a study conducted by Gosavi SV et al in Wardha where all ASHAs knew about their role in immunization and antenatal services.[8] Not all ASHAs were aware about their responsibility for birth and death registration in their areas and to act as DOTS provider. This is evident by the fact that only 7 (12.7%) reported that they acted as DOTS provider for any patient. This lack in knowledge for content of responsibility significantly affected their practices in community. Only 29.1% ASHAs were aware that they can give treatment for minor ailments in present study. Similar results were shown by another study where only twenty three percent ASHAs were aware that they should also give medical care for minor ailments.[9] This is an important role that should be communicated to them well during training. This shows that training session should focus on all aspects, not merely focusing on maternal and child health.

All ASHAs were aware about the incentives they are entitled to for their work. Only 24 (43.6%) reported that they receive their incentives on time. These findings are consistent with results showed by Singh M et al where payments were delayed for about a month.[10] All ASHAs reported that they are actively involved in spreading awareness about health in their areas. Family planning and immunization register was maintained by majority of ASHAs but not all reported maintaining antenatal register, birth and deaths register and household survey register. Another study by Garg PK et al also reported similar findings in which not all ASHA workers were maintaining records.[11]

Efficiency of training was assessed by asking ASHAs about their perception regarding training where 5 (9.1%) reported to have understood the module only sometimes and 3 (5.5%) said they never understand the module. On almost all the topics of training, significant percentage of ASHAs thought discussion was incomplete or needs to be repeated. Similar to our study findings, inefficient training have been reported by others authors also where ASHAs were reported to be unable to retain all the functions and responsibilities told to them. They were also not aware of compensation provided under various schemes.[12] This shows that refresher training should be integral part of ASHA workers skill building schedule.

A number of problems were reported by ASHAs in maintaining registers, coordination with ANMs, language problems etc while performing their duties. Lack of coordination among community health workers is a cause of concern for success of NRHM which heavily lay upon their role. This in-coordination leads to lack of supervision and thereby de-motivating the workers.[13] It is responsibility of ANMs to help and guide ASHA workers to maintain registers and provide supportive supervision.

CONCLUSION

The study found some gaps in knowledge and practices about the roles and responsibility among ASHA workers. Not all of them were aware of their role in areas like antenatal care and child care which are crucial for success of NRHM. Certain barriers faced by them were socio cultural, language and coordination with supervisors.

Recommendations: Guidelines should be followed strictly in recruitment and selection of ASHA workers. Present study showed that ASHAs performance is impacted by their limited orientation towards their roles and responsibilities. Training should provide complete knowledge about the same. Measures should be taken to address the problems faced by ASHA workers. **Limitations:** Major limitation of the study is small sample size. However, important issues of concern have been pointed out well.

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Conflict of Interest: Nil

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