**Original Article**

# AN EVALUATION OF ASHA WORKER'S AWARENESS AND PRACTICE OF THEIR RESPONSIBILITIES IN RURAL HARYANA

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## ABSTRACT

**Introduction-** Currently Government of India is providing comprehensive integrated health care to the rural people under the umbrella of National Rural Health Mission (NRHM). A village level community health worker "Accredited Social Health Activist" (ASHA)' acts as an interface between the community and the public health system. Therefore present study was conducted to access the socio-demographic profile of ASHA workers and to assess the knowledge, awareness and practice of their responsibilities.

**Methodology-** The study was conducted in the rural field practice area of the department of community medicine, MMIMSR, Mullana. All 105 ASHA workers in the area were included in the study and were interviewed using a self designed semi-structured questionnaire. Data was analyzed using SPSS and valid conclusions were drawn.

**Results-** Majority of ASHA workers were aware about helping in immunization, accompanying clients for delivery, providing ANC and family planning services as a part of responsibility. Only 17-19% of ASHAs knew about registration of births and deaths, assisting Auxiliary Nurse Midwife (ANM) in village health planning, creating awareness on basic sanitation and personal hygiene.

**Conclusion-** ASHAs do provide constellation of services and play a potential role in providing primary health care but still they need to put into practice their knowledge about while providing services and/or advice to negotiate health care for poor women and children.

**Key words-** ASHA, Awareness, Responsibility, Practice

## INTRODUCTION

The Government of India launched the National Rural Health Mission (NRHM) on 12th April 2005, to provide accessible, accountable, affordable, effective and reliable primary health care, especially to the poor and vulnerable sections of the population.[1,2] The Mission adopts a synergistic approach by relating health to determinants of good health viz. segments of nutrition, sanitation, hygiene and safe drinking water.[3] One of the key components of the mission is creating a band of female health volunteers, appropriately named "Accredited Social Health Activist" (ASHA) in each village within the identified States. These village level community health workers would act as a 'bridge' or an interface between the rural people

and health service outlets and would play a central role, in achieving national health and population policy goals.[4,5]

Framework of the NRHM underlines ASHA as a health activist in the community.[5] She is expected to Provide primary medical care with her kit, Control of diseases by information, education, sanitation and surveillance, antenatal, natal & postnatal services to women , counselling on family planning, safe abortion, child Immunization and Vitamin A supplementations, change in behaviour in breast feeding, birth spacing, sex discrimination, child marriage, girls education, care of the child especially newborn, household survey, collaborating with health functionaries, working with community for disease control, to create awareness on health and its determinants, mobilize the community towards local health planning, and increase the utilization of the existing health services.[6,7]

The current study has been designed for ascertaining how efficient the ASHAs are to play their defined roles effectively. They can play an important role in identifying problems at the earliest and help in improving community health status. Therefore the present study was undertaken to understand the functioning of the ASHAs in the community. Objectives of the study were to assess the socio-demographic profile of ASHA workers and to study their knowledge, awareness and practice of their responsibilities.

## MATERIALS AND METHODS

The present cross sectional study was carried out in the rural field practice area of the department of community medicine, Maharishi Markandeshwar Institute of Medical Sciences And Research (MMIMSR), Mullana (Ambala) during the period of June 2010 to May 2011. The Field practice area covers 95 villages covering population of 135000 and has a total of 105 ASHA workers. All ASHA workers in the area were included in the study. However, those who could not be contacted despite three visits were excluded. Finally data collected from 105 ASHA workers was included in the study. The Medical officers In charge of the respective PHC's were met and the days of the meeting with ASHA workers were ascertained. Ethical committee approved the study. Informed consent was obtained from the study participants.

The ASHA workers were interviewed by post graduate student of Department of Community Medicine after the meetings using a self designed semi-structured questionnaire. The questionnaire was pilot tested on 10 subjects and amended for clarity with the addition of some answer options and was modified accordingly. The questionnaire was designed in English initially and later translated in Hindi and back translated to English to check validity of translated questionnaire contained. A detailed proforma for the purpose of recording socio-demographic profile of ASHA workers, their knowledge and practices regarding things to be done for antenatal cases, possible complications during pregnancy, actions supposed to be taken if ASHA foresees a complication, possible complications during delivery, knowledge and practices regarding immunization, knowledge and practices about general responsibilities, knowledge and practices about record keeping and other relevant data etc was prepared for the purpose of filling observations of the present study. The collected data was entered in Microsoft Excel. Coding of the variables was done. SPSS version 11.5 was used for analysis. Interpretation of the collected data was done by using appropriate statistical methods like percentage and proportions.

## RESULTS

### Socio-demographic profile of ASHA functionaries

Data of 105 ASHA workers was included and analysed in the study. Majority 41 (39.05%) of the ASHA workers were in the age group of 20-29 years. Mean age of ASHA workers was 31.36 years. Most 89 (84.76%) of the ASHA workers were Hindus. Most 101 (96.19%) of ASHA workers completed 8th std or more of schooling. Of the 105 ASHAs interviewed 93 were married accounting for 88.57% of the subjects. 102 (97.14%) of ASHA workers completed training before working as ASHA. In general ASHA workers were satisfied and happy with their training.

### Knowledge and awareness of her responsibilities-

A large proportion of the ASHAs commonly cited vomiting (80.95 %) and swelling of hands and feet (69.52 %) as pregnancy complications that women are likely to experience.

**Table -1: ASHAs' knowledge about complications during pregnancy & delivery and its' management**

| Study Variable | Number (%) |
|---|---|
| **Complications women can experience during pregnancy*** | |
| Vomiting | 85 (80.95) |
| Swelling of hands and feet | 73 (69.52) |
| Paleness/Anaemia | 27 (25.71) |
| Abdominal pain | 25 (23.80) |
| Excessive bleeding | 22 (20.95) |
| Weak or no movement of foetus | 18 (17.14) |
| Abnormal position of foetus | 11 (10.47) |
| Visual disturbance | 11 (10.47) |
| Others | 3 (2.85) |
| **Actions supposed to be taken, if ASHA recognize signs of complication in a pregnant woman*** | |
| Take her to the nearest functional FRU | 75 (71.42) |
| Ask her to consult the ANM next day | 33 (31.42) |
| Immediately refer her to the nearest functional FRU | 48 (45.71) |
| Refer her to government hospital | 50 (47.61) |
| Refer her to private accredited hospital | 30 (28.57) |
| Others | |
| **Complications during delivery *** | |
| Excessive bleeding | 82 (78.09) |
| Abnormal position of foetus | 59 (56.19) |
| Convulsions/fit | 21 (20.00) |
| Foetus die in mother's womb | 10 (9.52) |
| Placenta problem | 15 (14.28) |
| Others | 11 (10.47) |
| Do not know | 3 (2.85) |

* Multiple responses

On the other hand, it was surprising to hear that 31.42% of the ASHAs said that they would ask the pregnant woman to consult the ANM the next day. (Table 1)

In order to ascertain knowledge of ASHA workers about immunization questions were asked about when and how many doses to be given? Where to take the child? And booster doses to be given. (Table 2)

**Table -2: Response of ASHAs regarding their knowledge about immunization**

| Vaccine | Response (%) | | No response |
|---|---|---|---|
| | Satisfactory | Not satisfactory | |
| BCG | 63 (60.00) | 36 (34.28) | 6 (5.72) |
| DPT | 66 (62.85) | 31 (29.53) | 8 (7.62) |
| Polio | 85 (80.95) | 20 (19.05) | 0 (0.00) |
| Measles | 80 (76.19) | 18 (17.14) | 7 (6.67) |
| Tetanus | 32 (30.47) | 64 (60.95) | 9 (8.58) |

Regarding newborn care, majority of ASHAs rightly said that newborns are most likely to die soon after birth (67.62%), followed by a quarter of ASHAs reporting deaths in first week of life.

The study explored ASHAs familiarity with their tasks. Very few ASHAs mentioned assisting ANM in village health planning, creating awareness on basic sanitation & personal hygiene and registration of births & deaths as their responsibilities. (Figure 1)

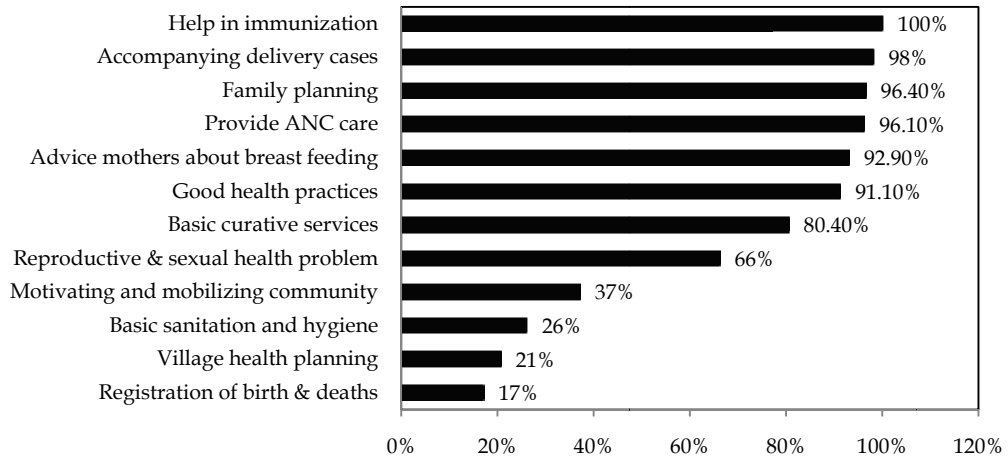


**Figure 1 : ASHAs' awareness about her responsibilities**

Out of total 105, 60 (57.14%) said that they were provided drug kits at the end of training. Another 27% ASHAs received drug kit much later after their training and the remaining were yet to receive it. Only 30 (28.57%) ASHA workers agreed that they have ever used this kit.

Record keeping practice by ASHAs was satisfactory except birth & death registration records which were relatively deficient with respect to their maintenance and completeness. The people primarily inspiring them to work as

ASHA were Gram Pradhan (70.47%) and family members (52.38%). (Table 3)

**Table 3: Practice of ASHAs regarding record keeping and their views about inspirational force behind them**

| Study Variable | Number (%) |
|---|---|
| **Various record keeping by ASHA workers *** | |
| ANC records | 101 (96.19) |
| Immunization records | 98 (93.33) |
| Delivery records | 96 (91.43) |
| Family planning records | 90 (85.71) |
| Birth & death registration records | 73 (69.52) |
| Household survey records | 83 (79.05) |
| **Inspirational Force Behind ASHA workers *** | |
| Gram Pradhan | 74 (70.47) |
| family members | 55 (52.38) |
| ANMs | 48 (45.71) |
| Others | 25 (23.81) |

* Multiple responses

**Table 4: Distribution of ASHAs according to motivational factors to become ASHA, cash remuneration received and expectations for better work by them**

| Study Variable | Number (%) |
|---|---|
| **Motivational factors for ASHA workers*** | |
| To provide health services | 54 (51.43) |
| To earn money | 85 (80.95) |
| Doing work gives satisfaction | 58 (55.24) |
| To do something (pass time) | 32 (30.48) |
| Serving/helping the community | 65 (61.90) |
| Hoping for absorption in government job | 21 (20.00) |
| **Amount of monthly cash remuneration received (in Rupees)** | |
| <200 | 22 (20.95) |
| 200-500 | 35 (33.33) |
| 500-800 | 28 (26.67) |
| >800 | 20 (19.05) |
| **Expectations by ASHA for better work*** | |
| Better Incentives | 89 (84.76) |
| Fixed regular monthly payment | 98 (93.33) |
| Better means of transportation of patients | 27 (25.71) |
| Incentive for more work | 35 (33.33) |
| More medicines | 14 (13.33) |
| Others | 7 (6.67) |

* Multiple responses

Major motivating factor for ASHAs were either financial gain (80.95%) or serving/helping the community (61.90%). About one-fifth of ASHAs were earning more than Rs.800 per month whereas one-fifth were earning less than Rs. 200 per month, showing the varying capability of ASHAs. Majority of the ASHAs (71.66%) were not satisfied with their incentives. There was a general demand from all stakeholders for a regular monthly payment to each ASHA besides the job related incentives. For betterment of work around 84.76% expect better pay. (Table 4)

## DISCUSSION

Majority (39.05%) of the ASHA workers were in the age group of 20-29 years. Similar result was observed by others.[4,8] Thus majority of the ASHAs may be considered young and this may be strength for programme as they are energetic and enthusiastic and may deliver better service with proper motivation and capacity building. ASHA envisage a total period of 23 days training in five episodes. It is said that ASHA training is a continuous one and that she develops the necessary skills & expertise through continuous on the job training.[9] Regarding level of education, most of ASHA workers had completed minimum 8th std but a few i.e. 4 ASHAs (3.80%) had education less than 8th std. Another report shows percentage of ASHAs educated below 8th std as high as 32.8%.[2] This can be explained by the fact that selection criteria are 8th Class and at some places it has been reduced to 5 th Class.[8] Similar findings were obtained by others.[2,10]

Report on assessment of ASHA and Janani Suraksha Yojana (JSY) in Rajasthan shows that only 19.7% of ASHAs cited that pregnant women are likely to experience vomiting.[11] This is in contrast to our finding which shows > 80% of ASHAs said so. Our findings indicate low knowledge levels with special reference to direct Obstetric complications during delivery and post partum period (Table 1). Prolonged labour as a complication was not mentioned by ASHAs and this could be life threatening if not managed in time.

As far as ASHAs knowledge about immunization was concerned, their overall response was not satisfactory specifically regarding tetanus immunization. Most of the ASHAs preferred helping in delivery and immunization. These activities are also associated with financial incentives. But many other jobs like promotion of awareness on hygiene and sanitation, counselling on family planning etc. were drawing lesser attention probably due to lack of incentives. They were

also not very much aware about their role in birth and death registration. These could be areas requiring reorientation.

The study revealed that only 57.14% of the ASHAs received drug kit, immediately after training. Non-availability of drug kits is a matter of concern. Not surprisingly, finding of our study mimics the finding presented by 'Rapid appraisal of functioning of ASHA in Orissa'.[8] Availability of drug kit helps ASHAs in not only attending some primary medical care needs, but also builds confidence of community in ASHAs as someone available in " hour of need".

The present study revealed that the most important motivational factor for the ASHAs were the financial gain. Others studies have observed similar result.[4,6,8] ASHA workers received incentive of Rs. 25/- per ANC for a maximum of 03 ANC visits for a particular pregnant woman, Rs. 200/- for facilitating pregnant women per institutional delivery, Rs. 100/- per case for complete immunization of children other than routine immunization coverage, Rs. 50/- per case for birth & death registration.[12]

Hope of being absorbed in government job was least important motivational factor in our study whereas this factor was ranked second most important motivational factor in another study conducted in Uttar Pradesh in 2008.[10] This study contradicts our observation on this aspect. Initially they had immense hope from government but hope got blunted with the passage of time, could be a possible explanation for the same.

## CONCLUSION

In general ASHAs are satisfied and happy with the training. But their perception about the in job responsibilities appeared to be incomplete and improper. Many of them were not aware about their role in assisting ANM in village health planning, creating awareness on basic sanitation & personal hygiene. They were also not very much aware about their role in birth and death registration. Incentives in monitory terms and capacity building in the weak areas of training can act as driving force in delivering better health services. ASHAs do provide constellation of services and play a potential role in providing primary health care but still they need to put into practice their knowledge about while providing services and/or advice to negotiate health care for poor women and children.

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