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Role perception and job performance of Accredited Social Health Activists (ASHAs) in Vijayapura district, Karnataka: a cross-sectional study

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ABSTRACT

Background

Accredited Social Health Activists (ASHA) play an important role in the implementation of Government of India health programmes such as Janani Suraksha Yojana (JSY), a conditional cash transfer scheme to incentivize women to give birth in a health facility. ASHAs work closely with other frontline health workers such as Auxiliary Nurse Midwives (ANMs) and Anganawadi Workers (AWWs), who work in community childcare centres, to provide community-level healthcare. This study evaluates ASHA role perception and job performance.

Methods

A cross-sectional study was carried out that surveyed 617 ASHAs. A pre-designed, semi-structured questionnaire was prepared in accordance with the study objectives. The questionnaire was prepared in English and interviews were conducted in local Kannada language using verbal translation.

Results

603 (97.7%) ASHAs had a positive attitude towards their role in mobilizing the community to access health services. This included 602 (97.5%) with a positive attitude towards antenatal care (ANC), 599 (97.08%) for institutional childbirth delivery, 597 (96.7%) for birth preparedness, 601 (97.4%) for newborn care and 600 (97.2%) towards exclusive breast feeding in the first six months of life. Nearly two-thirds of the ASHAs (405, 65.6%) reported being actively involved in distributing iron and folic acid supplements to pregnant women. The study found that ASHA job performance was significantly associated with age, days of training provided and duration of service as an ASHA.

Conclusion

Perception and performance in the study population was found to be good, however, refresher training regarding assigned duties, at definitive intervals, might yield even better results.

Keywords: Accredited Social Care Activists (ASHA), Child health, Maternal health, Community health

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INTRODUCTION

The Government of India's flagship National Rural Health Mission (NRHM) aims to provide accessible, affordable and effective primary healthcare, especially to poor and vulnerable sections of the population, in order to address the deficit in rural healthcare.[1] NRHM has created a cadre of trained female community health activists called Accredited Social Health Activists (ASHAs) to mobilize the community toward increased utilization of existing health services.[2] ASHAs are selected from within local villages (one per 1,000 population), preferably from the 25–45 year age group and from people with a minimum of eight years formal education. NRHM envisages capacity building ASHAs through training, and there is a provision for a performance-based incentive system. ASHAs are trained to provide

primary medical care; health education on sanitation and hygiene; antenatal (ANC) and postnatal care (PNC); to escort expectant mothers to local hospitals for safe delivery; and to encourage the immunization of mothers and children, amongst other roles. ASHAs' responsibilities range from health education to the detection of diseases and conditions that might need referral to higher-level health facilities.[3]

ASHAs play an important part in the successful rollout of Government of India health programmes such as Janani Suraksha Yojana (JSY), a conditional cash transfer scheme to incentivize women to give birth in a health facility. ASHAs work closely with other frontline healthworkers including Auxiliary Nurse Midwives (ANMs) and Anganawadi Workers (AWWs), who run local childcare centres, to conduct community-level activities.[4]

ASHAs also act as health activists in the community, creating awareness on health and its determinants and counselling mothers on key healthy behaviours. They can mobilize the community towards local health planning and the increased utilization and accountability of existing health services.[5]

Previous studies on ASHA workers in India have shown that the majority of ASHAs (73-78%) are either middle- or high school educated, which is in adherence with the preferred selection criteria for ASHAs.[6,7] However, the majority of ASHAs (69–72%) are often unable to specify all their job responsibilities.

Many ASHAs (81–93%) report working approximately 25 hours a week[8,9] and a large percentage (91–95.5%) serve populations above 1,000 in number. The majority of ASHAs (74.65%) receive only 12 days of training or less against a recommendation of 23 days of training.[10]

The Asha programme in Vijayapur District

The implementation of the ASHA programme began in the Indian State of Karnataka in 2005 and in Vijayapur District in 2008.[3] Of 1,410 ASHA posts sanctioned for Vijayapur District, 1,394 had been filled as of May 2019, just before our study began. All of the appointees had undergone training. During our study period (June 2019 to June 2020), 1,093 ASHAs were working in Vijayapur District. The study was undertaken over a period of 12 months to assess Knowledge, Attitude and Practice (KAP) of ASHAs in delivering their assigned healthcare services.

Aims and objectives

1) To describe the sociodemographic profile of ASHAs working in Vijayapur District.
2) To evaluate these ASHAs' role perception and job performance.

BOX 1: Roles and responsibilities of ASHAs[1-5]

1) An ASHA will be the first port of call for any health-related demands and requirements.
2) An ASHA will take steps to create awareness and provide information to the community on the Social Determinants of Health (SDH).
3) An ASHA will mobilize the community and facilitate community members in accessing health and health-related services available at the village, sub-centre and primary health centre levels.
4) She will work with the Village Health, Sanitation and Nutrition Committee (VHSNC) of the Gram Panchayat to develop a comprehensive village health plan.
5) An ASHA will provide primary medical care for minor ailments such as diarrhoea and fever, and will administer first aid for minor injuries.
6) ASHAs should reinforce community action for institutional delivery, newborn care, universal immunization and prevention of communicable diseases.
7) She will also help the villagers in adopting promotive and preventive health behaviour by educating them on nutrition, safe drinking water, sanitation and utilization of health services.
8) She will promote construction of household toilets among villagers under the Total Sanitation Campaign.

METHOD AND MATERIALS

The current study was carried out in Karnataka state, India. We conducted a cross-sectional study in Vijayapur District between June 2019 and June 2020.

The sample frame

The sample frame was all the ASHAs working in three taluks (administrative districts comprising a number of villages) of Vijayapur District: Vijayapur, Basavana Bagewadi and Muddebihal. Inclusion criteria were all ASHAs who had been in post for more than six months and who had undergone some training for the role. Exclusion criteria were newly recruited ASHAs who had been in post for less than six months, and those who did not wish to participate.

Official permission to conduct the study was obtained from the District Heath Officer, Vijayapur. Details of ASHAs working in the three selected taluks were obtained from the District Health Office, Vijayapur. Information about ASHA facilitators and the details of all Medical Officers and Public Health Centres (PHCs) in the study area were obtained.

This provided a sample size of 248 ASHAs working under 15 PHCs in Vijayapur taluk; 223 ASHAs working under 14 PHCs in Basavana Bagewadi taluk; and 186 ASHAs working under 10 PHCs in Muddebihal taluk. This gave a total of 617 ASHAs who were included in the study.

Data collection tool

A pre-designed, semi-structured questionnaire was prepared in accordance with the study objectives. The questionnaire was prepared in English and the interviews were conducted in the local Kannada language by translating questions verbally one at a time. A date for data collection was designated with the prior permission of the Medical Officer. After obtaining permission, the ASHA facilitators were informed and asked to mobilize ASHAs from 4–5 nearby PHCs to a central PHC chosen to be the centre for data collection.

A preliminary self-introduction to the subject, an orientation to the study, and an explanation of the purpose of the study and manner in which it was to be carried out was provided. Data was collected through a questionnaire-based oral interview conducted by the investigator after study subjects gave verbal consent at the PHC. Face-to-face interviews were carried out in Kannada, explaining each question in detail and making sure the ASHAs fully understood. Once the ASHA had finished answering one question, the interviewer moved onto the next question. Responses were tabulated by the investigator using Microsoft Excel 2007 software. Data was analyzed by using SPSS software version 21. Statistics calculated included mean values, proportions, percentages and Chi-square tests.

RESULTS

Table 1 represents the sociodemographic profile of ASHAs who participated in the study. Out of 617 study participants, 52.4% were from the age group 30–39 years, and 47% were aged 20–29 years; and four (0.6%) participants were 40 years old or over. The mean age was 30.67±4.65 years. Just over two-thirds of the ASHAs were married (68.6%) and the remaining 32% were either separated or widowed.

Most of the ASHAs (78.1%) lived in a nuclear family and work in the village where they live (80.1%); 95.8% ASHAs were Hindus. Most (86.5%) of the ASHAs were High School educated and nearly three-quarters (74.4%) were paid a monthly wage of less than 5000 Indian rupees (approx. US$70).

Table 2 shows ASHAs' role perception (attitude). It shows the percentage of ASHAs who gave positive and negative responses. Out of 617 ASHAs, all felt that it is necessary to provide information about existing health services to the community and to create awareness on health, hygiene and nutrition amongst local people. 603 (97.7%) had a positive attitude towards mobilizing the community for accessing health services, including antennal care (602/97.5%), institutional childbirth delivery (599/97.08%), birth preparedness (597/96.7%), newborn care (601/97.4%) exclusive breast feeding for the first six months of life (600/97.2%), mother's immunization (596/96.5%), infant immunization (602/97.5%) and family planning advice (599/97.08%).

Table 1 socio-demographic profile of ASHAs

Characteristics		Frequency	Percent
Age profile of ASHAs (Mean age: 30.67 S.D:±4.65)	20-29	290	47.0 %
	30-39	323	52.4%
	40-49	4	0.6%
Marital status of ASHAs	Married	423	68.6%
	Widowed	76	12.3%
	Separated	118	19.1%
Educational status	High school	534	86.5%
	College	83	13.5%
Religion	Hindu	591	95.8%
	Muslim	18	2.9%
	Others	8	1.3%
Monthly income (Indian rupees)	<5000	459	74.4%
	≈5000.00	107	17.3%
	>5000	51	8.3%
Husband's occupation	Farmer	308	72.8%
	Daily wage worker	73	17.2%
	Unemployed	42	10%
Family type	Nuclear	482	78.1%
	Joint	135	21.9%
Does the ASHA work in her home village?	Yes	494	80.1%
	No	123	19.9%
Duration of service	<5 years	257	41.6%
	> 5 years	360	58.4%

Table 2 Details regarding role perception of ASHA (n=617)

Roles	Answered Yes (n)	Percent (%)
Does the ASHA feel it is necessary to provide information about existing health services?	617	100%
Does the ASHA feel it is necessary to create awareness on health, hygiene and nutrition?	617	100%
Does the ASHA feel it is required to mobilize the community for accessing health services such as:		
Antenatal care (ANC)	603	97.7%
Postnatal care (PNC)	602	97.5%
Institutional delivery	599	97.08%
Illness/ fever	597	96.7%
Birth preparedness	597	96.7%
Newborn care	601	97.4%
Exclusive breast feeding	600	97.2%
Immunization of mother	596	96.5%
Immunization of infants	602	97.5%
Use of family planning methods	599	97.08%

Furthermore, Table 2 represents the major activities carried out by ASHAs in their practice area. Within the study sample, 317 (51.3%) ASHAs reported that the population they serve is less than or equal to 1,000 people. Just under half (284/46%) of the ASHAs reported that they work a minimum of 10 hours per week. Nearly two-thirds (405/65.6%) are actively involved in distributing iron and folic acid tablets to pregnant women and 597 (96.7%) educate mothers about exclusive breast feeding for the first six months of life; 471 (76.3%) say that they encourage mothers to continue breastfeeding when the child is suffering from diarrhoea. The majority of ASHAs (535/86.7%) assist their ANM colleagues on immunization days and 568 (92%) assist AWWs in mobilization. 101 (16.3%) ASHAs report that they also work as a Directly Observed Treatment (DOTS) agent, to check patients take prescribed treatments appropriately.

Nearly all (604/97.8%) ASHAs reported that they provide information about birth and death in their village to the appropriate Primary Health Centre/Sub-Centre and (566/91.7%) reported active involvement in Panchayat Raj Institutions or Village Health Sanitation and Nutrition Committee in their village. We found that an ASHA's job performance is significantly associated with her age, days of training undertaken and duration of service as an ASHA.

Table 3 Job performance of ASHAs

Variables (n= 617)	Age (%)			Days of training (%)		Education (%)		Duration of service (%)		Total (%)
	20-29	30-39	40-49	17 Days	23 Days	High School	College	<5 yrs	>5 yrs	
Serve a population ≤1,000	145 (45.7)	169 (53.3)	3 (0.94)	43 (13.5)	274 (86.4)	246 (77.6)	71 (22.3)	121 (38.1)	196 (61.9)	317 (51.3)
Work a minimum of 10 hrs/week	137 (48.2)	145 (51)	2 (0.7)	36 (12.6)	248 (87.3)	254 (89.4)	30 (10.5)	111 (39)	173 (61)	284 (46)
Distribute iron/folic acid tablets	171 (42.2)	233 (57.5)	1 (0.2)	29 (7.1)	376 (92.8)	357 88.1)	48 (11.8)	177 (43.7)	228 (56.3)	405 (65.6)
Educate mothers about exclusive breastfeeding	280 (47)	313 52.4)	4 (0.67)	76 (12.7)	521 (87.2)	524 (87.7)	73 (12.2)	219 (36.6)	378 (63.4)	597 (96.7)
Encourage mothers to breastfeed during baby's diarrhoea	221 (47)	247 (52.4)	3 (0.63)	63 (13.3)	408 (86.6)	399 (84.7)	72 (15.2)	199 (42.2)	272 (57.3)	471 (76.3)
Assist ANM on immunization days	253 (47.2)	278 (52)	4 (0.7)	72 (13.4)	463 (86.5)	459 (85.7)	76 (14.2)	201 (37.5)	334 (62.5)	535 (86.7)
Work as DOTS agent	39 (38.6)	62 (61.3)	0 (00)	11 (10.8)	90 (89.1)	94 (93)	7 (7)	35 (34.6)	66 (65.4)	101 (16.3)
Assist AWWs in mobilization	269 (47.3)	295 (52)	4 (0.7)	76 13.3)	492 (86.6)	485 (85.3)	83 (14.6)	191 (33.6)	377 (66.4)	568 (92)
Provide information on birth/death to PHC/SC	284 (47)	316 (52.3)	4 (0.66)	84 (14)	520 (86)	521 (86.2)	83 (13.7)	213 (35.2)	391 (64.8)	604 (97.8)
Actively involved with PRI/VHSNC	271 (47.8)	291 (51.4)	4 (0.7)	77 (13.6)	489 (86.3)	507 (89.5)	59 (10.4)	205 (36.2)	361 (63.8)	566 (91.7)
	X^2= 9.987 df = 18 p = <0.05			X^2= 1.881 df = 9 p = < 0.05		X^2= 3.228 df = 9 p = >0.05		X^2= 11.431 df = 9 p = <0.05		

DISCUSSION

The present study was carried out with the objective of studying the role perception and job performance of ASHAs in Vijayapur District, along with capturing information on their sociodemographic profile. This captured the perceptions of 617 ASHAs in the study. All felt it is necessary to provide information about existing health services and to promote awareness on health, hygiene and nutrition in community. This is similar to the findings of previous studies conducted by Desai PB et al [6] and Saurabh R Shrivastava et al [7]

The majority of ASHAs have a positive attitude towards their roles and responsibilities regarding ANC, PNC, institutional childbirth delivery, birth preparedness, exclusive breast feeding, newborn care, immunization of mother and infants and use of family planning. Similar results have been obtained from a multi-state survey carried out by the Indian National Institute of Public Cooperation and Child Development[24] and also from studies by Mrigen Deka et al, [8] Charu Kohli et al[9] and Shrivatsa et al[10.] Our results contrast with those from a study by H R Salve et al, [11] which found that 21.3% of ASHAs had negative and stigmatized attitudes, though this was towards mental health in particular.

Regarding the ASHAs' visits to Anganawadi centres (AWC), 40.5% of ASHAs reported that they visit more than three times a month. Most (92%) also reported assisting AWWs in maintaining records of children and pregnant women. They help to ensure pregnant and lactating women and infants access available nutrition supplements. These findings are roughly similar to a studies by Shobha Malini et al[12] and Hiader et al[13] which found that 53% and 59.5% of ASHAs respectively visited the AWC more than three times a month and assist AWWs in updating the list of eligible couples and of children >1 year of age in the village. Nearly all (92%) of ASHAs were well aware of the objectives of Village Health Sanitation Nutrition Committee (VHSNC) and were actively involved in it. This is similar to the findings of a study by Kalinga Centre for Social Development (KCDS),[14] which found that awareness of the objectives of the VHSCs was higher among the ASHAs than ANMs. Our study also found that ASHAs were well of the formation process of VHSNC, though a study by Das A et al[15] found that most ASHAs (82.5%) indicated that their villages did not have a VHS(N)C. In their study, only 14.5% of ASHAs indicated the existence of a VHS(N)C. Only 11 ASHAs had attended a meeting during the last month.

In our study, 58.9% of ASHAs reported that they received good support from members of the Panchayat Raj Institution (PRI, the village government) in regard to community mobilization and to celebrate events such as World Oral Health Day, World Breastfeeding Week and World Malaria Day. These results were roughly similar to study Dr. Shobha Malini et al. [12]

CONCLUSION

Our evaluation of the role perception and job performance of ASHAs in Vijayapur District, Karnataka suggests that the local ASHAs display good role perception and awareness of the jobs assigned to them. Their tasks often require integration with other village health programmes. This may indicate that better practice in this region and can be captured and used as a good practice example for regions that perform less well against national criteria. Refresher training for ASHAs at definitive intervals is recommended to ensure that ASHAs are fully aware of the roles and activities they are assigned to fulfil.

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