RESEARCH ARTICLE

Knowledge of rural women regarding activities of accredited social health activist in three different villages of District Amritsar: A cross-sectional study

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ABSTRACT

Background: Accredited Social Health Activist (ASHA) is the grass root level worker and hence plays a prime role in making primary healthcare accessible to rural areas. She creates awareness on health and persuading the community toward local health planning and hence plays major role in increasing utilization of health services. The knowledge of the people about the availability of ASHA in their area and about the activities performed by her also play important role in utilization of services given by ASHA. Hence, keeping this in view the present study was conducted. 

Aim and Objectives: (1) The aim of the study was to assess the knowledge of the rural women about the availability of ASHA in their area and (2) to assess the knowledge of the rural women about the activities performed by ASHA.

Materials and Methods: The study was conducted in rural field practice area of Government Medical College, Amritsar, Punjab. The study was a cross-sectional type and the adult decision maker female of the family was interviewed using a pre-designed and semi-structured pro forma after approval from Institutional Ethics committee. A total of 1521 females were interviewed.

Results: The present study revealed that majority (52.3%) of the respondents were in the age group of 24–45 years, 41.7% illiterate and 54.6% in the upper lower class. It was found that 45.8% respondents were visited by ASHA and out of these, majority of the respondents (78.2%) were visited for Maternal and child health services followed by health awareness (20.7%) and minor illnesses (9.9%).

Conclusion: The visits by ASHA were irregular and majority of the respondents were visited by ASHA for maternal and child health services in all the three villages and hence knowledge regarding these activities was seen to be more among the respondents. However, overall less knowledge was seen among the villagers about other activities being performed by ASHA worker.

KEY WORDS: Accredited Social Health Activist; MCH services; Rural

INTRODUCTION

The success of National Rural Health in India depends on the performance of Accredited Social Health Activist (ASHA) as she works at the grass-root level. ASHA plays key role in making primary healthcare accessible to rural community by creating awareness on health, hence community is persuaded toward local health planning, which results in increased utilization of maternal and child health services. As a link between community and the health-care system, she plays major role in motivating people to use accessible health-care services. Her collaboration with local self-governments is important to address the health needs of the community. ASHAs being an essential part of social life of people in the rural areas, they have become backbone of National Rural Health Mission. ASHAs fill the gap in human resources for...
providing primary healthcare, thereby complement the health system in the country.[3]

The quality of service can be improved by increasing the awareness level of the users as reported by Reproductive and child Health survey in 2004. As per the report, the users should have access to any information on health and other issues which increases the accountability of the service provider beside improving service quality.[4] Hence, ASHA can play an important role in creating awareness about the available health services and for this she has to make home visits. Along with this, knowledge of the people about the availability of ASHA worker in their area and about the activities performed by her also play role in utilizing services given by ASHA. So keeping this in view the present study was conducted to study the knowledge of the rural people about the availability of ASHA in their area and the activities performed by her.

MATERIALS AND METHODS

A community based cross-sectional study was conducted among the adult decision maker female of the households in the rural field practice area of Department of Community Medicine, Government Medical College, Amritsar after approval from Institutional Ethics committee. The study was conducted in three villages which were selected accordingly:

1. Village Naagkalan with Subsidiary Health Centre as Public health facility
2. Village Pakharpura with Sub center as Public health facility
3. Village Pandher without any Public health facility.

Sample size included 1521 respondents; out of which 766 respondents were from Naagkalan, 423 from Pakharpura and 332 from Pandher as per probability proportional to size sampling. The purpose of the study was explained and written informed consent was obtained from the respondent. The respondent was informed to answer the questions on the basis of her experience. The questions were asked in the vernacular language. The information from the decision maker adult female was obtained by face to face interview. The questionnaire was filled on pre-tested and pre-designed and validated Pro forma for the study. Anonymity and confidentiality was maintained.

Modified Kuppuswamy Scale based on Education, Occupation of the head of the family and total family income was applied as criteria for socio-economic status.

Statistical Analysis

The collected data were entered into MS Excel and analyzed using Epi info software version 7. Descriptive statistics were presented in frequency and percentages and Chi-square test applied to assess the statistical association.

RESULTS

A total 1521 respondents were interviewed in the three villages during the study. In all the three villages, majority of the respondents, that is, 580 (75.5%) in Naagkalan, 301 (71.2%) in Pakharpura, and 240 (72.3%) in Pandher were in the age group of 25–55 years. Out of total illiterate respondents, 46.8%, 36.9%, and 36.4% were observed in Naagkalan, Pakharpura, and Pandher, respectively. More than half (54.6%) respondents belonged to the upper lower socio-economic status [Table 1].

It was observed that more proportion of respondents (24.6%) were ever visited by ASHA in Naagkalan, followed by 20.8% in Pakharpura and 20.5% in Pandher whereas monthly visits were seen to be in more proportion in Pakharpura (29.8%), followed by 11.7% in Pandher and 8.6% in Naagkalan [Table 2].

Table 3 shows that out of 687 respondents visited by ASHA, 537 (78.2%) respondents were visited by ASHA for Maternal and Child health services while 142 (20.7%) and 68 (9.9%) respondents reported that ASHA visited them for health issues which increases the accountability of the service provider beside improving service quality.
awareness and treatment of minor illness respectively. The visits for health awareness were seen to be in more proportion (30.4%) in Pakharpura, followed by 20.7% in Pandher and 11.3% in Naagkalan and this difference in distribution was found to be statistically significant.

Table 4 shows that when asked about the activities performed by ASHA, out of 1521 respondents, 663 (43.6%) respondents were aware of the Maternal and Child health services while 188 (12.4%) and 107 (7%) were aware of health awareness and treatment of minor illness respectively being performed by ASHA. On the other side, more than half (50.9%) did not know about any of the activities performed by ASHA. About 64.4% respondents in Naagkalan, 25.1% in Pakharpura, and 52.7% in Pandher did not know about any of the activities performed by ASHA. This difference in distribution was highly significant.

DISCUSSION

The study was carried out in three villages of Threawal Block of district Amritsar, which is Government Medical College, Amritsar’s field practice area. The three villages were selected with the criteria one with Subsidiary Health Centre, second with Sub center and third without any public health facility. The decision-making females of the household were interviewed by house to house survey so as to study the availability and utilization of health services at their place. Majority of respondents belonged to the age group 25–35 years, with 89.5% in village with Subsidiary Health center, 88.2% in village with sub center, and 83.7% in village without any health facility. The present study revealed that 41.7% respondents were illiterate. It was found that more proportion of families in Pandher and Pakharpura belonged to the lower middle and upper middle socio-economic status as compared to Naagkalan. It was inferred that less proportion of respondents in village with SHC were aware about the health workers in their area as compared to village with sub center and village without health facility. The respondents in village with sub center had better visits by the ASHA than the other villages. In all the three villages in the present study, the visits by ASHA were seen to be irregular. Majority of the respondents were visited by ASHA for maternal and child health services in all the three villages and hence knowledge regarding these activities was seen to be more among the respondents. The visit for health awareness was reported in more proportion in village with sub center followed by village without any health facility and village with Subsidiary Health center. The knowledge of the respondents about the activities performed by ASHA was seen to be more in Pakharpura which might be due to more visits by ASHA in the village. But overall less knowledge was seen among the villagers about the activities being performed by ASHA.

According to 68th round of National Sample Survey Organization (2011-12), there were 102 (20–24 years), 166 (25–34 years), 137, (35–44 years), 99 (45–54 years), and 133 (above 55 years) females per 1000 persons which is not in concordance with the present study. The reason might be that all females of the household were not included in the present study and only decision maker female of the household was included.

According to census 2011, the female illiteracy rate of India was 34.5% and that of Punjab was 28.66% which is not in concordance with the present study. The reason might be...
that in census, the females of both rural and urban areas were included while in the present study, the females from only rural area were included in the study. The difference in socio-economic status in the villages may be due to the reason that more proportion of head of the families were literate in Pandher and Pakharpura as compared to Naagkalan in which 41.5% head of the families were illiterate. On evaluation of ASHA scheme under NRHM in 15 districts of Uttarak Pradesh, it was reported that 100% respondents were aware of ASHA worker working in their village.[7] ASHA being the grass root level worker plays an important role in providing primary healthcare to rural areas. The performance of ASHA has direct effect on success of National Rural Health Mission in India. She plays an essential role in motivating people to use accessible health-care services and hence in increased utilization of MCH services. The difference in visits by the ASHA in the villages might be due to the reason that it depends on worker to worker how she does her job. The ASHA in village with sub center may be a good worker or the supervision of ASHAs might be good. The possible justification for fewer visits by the workers in Naagkalan could be that as more than 50% respondents depended on daily wages for their livelihood due to unskilled labor and left home in the early morning and returned late, in the evening, hence visit by health workers went unnoticed. According to a study conducted by Kaur et al. in Amritsar District (2015), it was observed that 50.2% respondents were paid home visits by the ASHA.[9] The reason for irregular visits by ASHA may be that one of the motivating factors for ASHAs is the financial incentives and they do not get incentives for every service provided by them. According to a study conducted in rural Haryana by Garg et al. in 2013, financial gain (80.95%) and serving/helping the community (61.90%) were the major motivating factors for ASHAs.[9] According to a study conducted in Deganga Block of West Bengal, Focused group discussion (FGD) with ASHAs revealed their dissatisfaction with the job due to disproportion between their work and incentives.[10] In a study conducted by Bhatt H regarding the functioning of ASHAs in Bageshwar and Nainital districts of Uttarakhand (2012), the FGD among community members revealed that ASHA was mainly involved on the promotion of institutional delivery and immunization. Most important factor motivating ASHAs for the job was to earn some money, reported by them in the study. All the ASHAs had knowledge about the MCH services to be provided by them whereas nearly 50% knew about the services other than MCH to be provided by them.[11] According to a study conducted in rural Haryana by Garg et al. in 2013, it was reported that most of the ASHAs preferred helping in delivery and immunization.[9] In a study conducted by Gundbowdi et al. among recently delivered mothers in Belagavi District of Karnataka, 55.3% reported that ASHA escorted them during delivery.[12] The results in the present study may also be due to the reason that MCH services are associated with financial incentives, so these are becoming the areas of primary interest for the ASHA. On the other hand, many other activities such as counseling on family planning, awareness on hygiene, and sanitation etc. gained lesser attention probably due to lack of incentives. However, visit for health awareness was seen to be more in Pakharpura which may be due to more number of visits by ASHA in Pakharpura. Being the ones who directly communicate with the community that they belong to, ASHA plays significant role in achieving various health related goals such as infant mortality rate and maternal mortality rate and also improvement of nutritional status of mothers and children.

The major strength of the study was that it was community based with the limitation that there could be recall bias as the respondents had to answer on the basis of past 1 year experience. Another limitation was not including all the aspects of maternal and child health services in detail as these are the main services provided by ASHA.

CONCLUSION

It is concluded that there is statistical difference in distribution of knowledge about the ASHA and visits by the ASHA in the three villages. The visit by ASHA has positive impact on the knowledge of the respondents about activities being performed by her. The financial incentives are the major motivating factors in performing duties. So apart from Maternal and child health services, there is a need to associate other activities with financial incentives also to make Primary health-care available and accessible at the grass root level. ASHAs need regular assessment to know whether they are efficient and trained; and also able to fulfill their role and responsibility for which they were introduced in the existing public health system.

REFERENCES

Kaur et al. Knowledge of rural women regarding activities of ASHA


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