

ASSESSMENT OF ACCREDITED SOCIAL HEALTH ACTIVIST'S KNOWLEDGE AND SERVICES IN DISTRICT LUDHIANA, PUNJAB (INDIA)

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Abstract: Introduction: The role of Accredited Social Health Activist (ASHA), which is an important part of the National Rural Health Mission (NRHM) has been considered as an effective link to address the poor utilization of health and maternal & child health (MCH) services by rural community. Her knowledge about health problems and services is crucial for identification of health problems and facilitation of adequate antenatal, natal and postnatal care of the pregnant women. **Objectives:** The purpose of the study was to assess the knowledge of Accredited Social Health Activist (ASHA) regarding health problems prevailing in her area and to assess the services being provided by her to the needy pregnant women. **Material and Methods:** A descriptive cross sectional study was conducted on randomly selected 170 ASHA, 10 AWWs, 10 ANMs and 10 PRIs in the 5 out of 10 blocks of District Ludhiana, Punjab. **Results:** Maximum number of ASHAs 31.76% were in the age group of 30-35 years, 65.23% were matriculate, 58.47% were from BPL family and 58.87 % had experience in the range of 0-5 years, 57.1% of ASHAs had good level of knowledge regarding health problems prevailing in her area, and, 40% and 2.9% of ASHA had average and poor level of knowledge regarding health problems prevailing in their area respectively. Age, education and experience had no association with level of knowledge of ASHA regarding health problems prevailing in her community but economic level of ASHA had significant association with level of knowledge regarding health problems prevailing in her community ($p=0.016$). **Conclusion:** ASHAs have multifaceted duties to perform related with intricate health issues. Her knowledge and functioning have serious implication on meeting the objectives of NRHM programme. ASHA with not good enough medical knowledge, qualification and training, face problems in rendering the proper services to her community. Further, her qualification, training, honorarium and incentive, all, appeared low and need improvement.

Keywords: Accredited Social Health Activist (ASHA), NRHM, Ludhiana, Public Health Services.

INTRODUCTION

Accredited Social Health Activist (ASHA) in NRHM serves as a crucial link among the village community and Primary Health Care system (Bajpai and Dholakia, 2011).¹ These activists create awareness on health and its social determinants and mobilize the community towards local health planning and increased utilization of the health services. ASHA is a resident married/widow/divorced woman of the village with formal education at least up to the 8th standard selected by Panchayat of the village as a functionary of NRHM (Anonymous, 2005).² Presently, over eight lack sixty three thousands (863,506) ASHA are working in India, out of which Seventeen thousand twenty nine (17029) are working in Punjab (Henry, et al. 2014).³

ASHA provides primary medical care, advise the villagers on sanitation, hygiene, antenatal & postnatal care and escorts expectant mothers to hospital for safe

child delivery (Bhatt, 2012).⁴ As an honorary volunteer ASHA receives performance-based compensation for promoting variety of primary health care services in general and reproductive and child health services such as universal immunization, referral and escort services for institutional deliveries, construction of household toilets, and other healthcare interventions, in particular (Uttekar, et al., 2007).⁵ It is worthwhile that her services could also be utilized for alleviating suffering of people with disabilities as they lack access to transportation facilities to reach health facilities (Thakur, 2013).⁶

The whole programme is formulated and implemented by the Ministry of Health and Family Welfare (MOHFW), Government of India (Anonymous; 2011).⁷ To meet the health needs of the people at grass-root and peripheral levels, therefore it is reasonably imperative to assess the knowledge of ASHA

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regarding health problems prevailing in the community as each one is acting as a bridge between the Health Centre and the community (Nair and Iyengar, 2008).⁸

MATERIAL AND METHODS

A descriptive cross sectional study was conducted in five selected health blocks of District Ludhiana, Punjab from December 2013 to May 2014. The study was conducted on randomly selected 170 ASHA, 10 *Angan-Wadi Workers* (AWW), 10 Auxiliary Nurse Midwife (ANM) and 10 *Panchayati Raj Institution* (PRI) representatives in the 5 out of 10 blocks of Ludhiana to evaluate the knowledge of AHA by herself and AWWs, ANMs and PRIs for the services rendered by her to the community. A structured interview schedule and a questionnaire were used to collect responses of the participants to evaluate the knowledge and functioning of the ASHA on the basis of literature review and validation by subject experts. The collected data was analyzed using descriptive and inferential statistics. The knowledge of ASHA was assessed in terms of poor, average and good and on the basis of a test key assigning '1' score to the right answer and '0' for wrong response by the ASHA. Chi-square non-parametric statistical testing was used to find the association between the level of knowledge and selected socio-demographic variables

Ethical Consideration

Sanction to conduct the research study was obtained from the Institutional Ethics Committee of the University. Informed consent was obtained from participants on the basis of inclusion criteria & willingness to participate in the study. Anonymity and confidentiality were maintained throughout the study. Data was collected after getting approval from the CMO of the district Ludhiana. Thus, ethical principle of self-determination was maintained and participants were treated as autonomous sources by informing them about the study and allowing them to voluntarily choose to participate.

RESULTS

This study was undertaken with the aim to evaluate the knowledge and functioning of ASHA in terms of their own assessment as well as by the ANMs, AWWs, and PRIs in district Ludhiana.

Socio-Demographic Profile

Maximum number of ASHA 31.76% were in the age group of 30-35 years, 65.23% were matriculate, 58.47% were from BPL family and 58.87% had experience in the range of 0-5 years (Table-1).

Table-1. Socio-Demographic Profile of the sample

Age	Frequency(N)	Percentage
21-25 years	7	4.10%
25-30 years	36	21.20%
30-35 years	54	31.80%
35-40 years	41	24.10%
Above 40 years	32	18.80%
Education level		
Primary	31	18.20%
Matriculation	111	65.30%
Secondary	28	16.50%
Marital status		
married	157	92.40%
single	2	1.20%
widow	11	6.50%
Economic status		
BPL	99	58.20%
Non BPL	71	41.80%
Monthly incentives		
Less than 1000	117	68.80%
1000-2000	40	23.50%
2000-3000	8	4.70%
3000-4000	4	2.40%
above 4000	1	0.60%
Type of family		
nuclear	83	48.80%
joint	86	50.60%
extended	1	0.60%
Experience		
0-5 years	100	58.80%
5-10 years	66	38.80%
10-15 years	4	2.40%

Association of Socio-Demographic factors with the Knowledge of ASHA:

Majority of ASHA, 99.4% had correct knowledge that hospital delivery was the first priority for safe delivery, 97.6% regarding chemical used in water purification, 95.9 % about symptoms of malaria, 91.8% about diarrhea, 91.2 % about measles as a viral disease, 92.9% about pneumonia as lung infection, 80.6% regarding importance of immunization, 80% about symptoms of dehydration in children, 79.4% regarding primary control strategy for the prevention of communicable diseases, 77.6% regarding minimum antenatal visit for pregnant women, 68.8% regarding warning signs of high risk pregnancy, whereas, only 12.9% had correct knowledge regarding dosage of iron tablets for pregnant women, 12.9% regarding preparation of ORS at home and 24.1% regarding first preference after delivery, 31.2% knowledge about DOTS, 37.6% regarding family planning, 57.1% regarding prevention of RTI/STD and 61.8% ASHAs had knowledge regarding red alerts in newborn assessment (Table-2).

Fifty seven percent of ASHAs had good level of knowledge regarding health problems prevailing in their

area, 40% and 2.9% of ASHAs had average and poor level of knowledge regarding health problems prevailing in their area respectively. Age, education and experience had no association with level of knowledge of ASHA regarding health problems prevailing in her community but economic level of ASHA had significant association with level of knowledge regarding health problems prevailing in her community ($p=0.016$) (**Table-3**).

Self-Assessment of the Services delivered by ASHA

More than 95% of ASHAs had adequate training or had been imparted induction training, motivated the

couple for family planning and 92.9% ASHAs created community awareness on determinants of health.

All the ASHAs found themselves useful to community. They registered all cases of pregnant mother. The hospital staff gave due priority to them when they accompanied the cases (99.4%). Almost all ASHAs counseled pregnant women on ANC, PNC, safe delivery, breastfeeding, immunization, contraception and prevention of RTI and STI and mobilized community to access health services and for training. About 87.6 % ASHAs had second training after 1st training, 87.1% informed AWWs/ANMs on birth and death in their area

Table-2. Assessment of the Knowledge of ASHA (N-170)

Sr. No	Questions	Correct responses	
		Frequency	Percentage
1	Knowledge Regarding Diarrhea	156	91.8%
2	Knowledge Regarding Measles	155	91.2%
3	Knowledge Regarding Pneumonia	158	92.9%
4	Knowledge Regarding Family Planning	64	37.6%
5	Knowledge Regarding DOTS	53	31.2%
6	Knowledge Regarding Symptoms of Dehydration in Children	136	80%
7	Knowledge Regarding Symptoms of Malaria	163	95.9%
8	Knowledge Regarding Dose of Iron Tablet for Pregnant Women	22	12.9%
9	Knowledge Regarding Warning Signs of High Risk Pregnancy	117	68.8%
10	Knowledge Regarding Minimum Antenatal Visit to Pregnant Women	132	77.6%
11	Knowledge Regarding Priority for Safe Delivery	169	99.4%
12	Knowledge Regarding First Preference after Delivery	41	24.1%
13	Knowledge Regarding Red Alert in Newborn Assessment	97	57.1%
14	Knowledge Regarding Importance of Immunization	137	80.6%
15	Knowledge Regarding Preparation of ORS At Home	22	12.9%
16	Knowledge Regarding Chemical used in Water Purification	166	97.6%
17	Knowledge Regarding Prevention of RTI/STD	105	61.8%
18	Knowledge Regarding Primary Control Strategy for Prevention of Communicable Disease	135	79.4%

Table-3. Association of Socio-Demographic Variables with Level of Knowledge (N-170)

Variables	Category	Level of Knowledge			Total	p-value
		Poor	Average	Good		
Age	21-25 years	1 (14.2%)	3 (42.9%)	3 (42.9%)	7	0.487
	25-30 years	2 (5.6%)	12 (33.3%)	22 (61.1%)	36	
	30-35 years	2 (3.7%)	21 (38.8%)	31 (57.4%)	54	
	35-40 years	0 (0%)	19 (46.3%)	22 (53.7%)	41	
	Above 40 years	0 (0%)	13 (40.6%)	19 (59.3%)	32	
	Total	5(3%)	68(40%)	97(57%)	170	
Educational-Qualification	Primary	0 (0%)	12 (38.7%)	19 (61.3%)	31	0.241
	Matriculation	4 (3.6%)	40 (36%)	67 (60.4%)	111	
	Secondary	1 (3.5%)	16 (57.1%)	11 (39.3%)	28	
	Total	5 (2.9%)	68 (40%)	97 (57.1%)	170	
Economic level	BPL	0 (0%)	44 (44.4%)	55 (55.6%)	99	0.016*
	Non BPL	5 (7%)	24 (33.8%)	42 (59.2%)	71	
	Total	5 (2.9%)	68 (40%)	97 (57.1%)	170	
Experience	0-5 years	5 (5%)	43 (43%)	52 (52%)	100	0.115
	5-10 years	0 (0%)	25 (37.9%)	41 (62.1%)	66	
	> 10 years	0 (0%)	0 (0%)	4 (100%)	4	
	Total	5 (2.9%)	68 (40%)	97 (57.1%)	170	

* Significant at .05 level of significance

Table-4. Self-evaluation of Services delivered by ASHA

Sr. No	Question	Correct Response	
		Frequency	Percentage
1	Do the people feel you are useful?	170	100%
2	Does the hospital staff give priority to your referral when you accompany?	169	99.4%
3	Are you satisfied with the honorarium you get every month?	37	21.8%
4	Have you been imparted the induction training?	163	95.9%
5	Was other training given to you after 1st training?	149	87.6%
6	Was training adequate?	166	97.6%
7	Was training beneficial to you?	169	99.4%
8	Do you register the cases of pregnant mother?	170	100%
9	Do you counsel on ANC, PNC, and safe delivery?	167	98.2%
10	Do you accompany pregnant mother to hospital?	168	98.8%
11	Do you distribute IFA, Oral pills, ORS etc.?	139	81.8%
12	Do you distribute DOTS?	106	62.4%
13	Do you inform AWW/ANM on birth and death?	148	87.1%
14	Do you help AWW in supplementary nutrition feeding?	98	57.6%
15	Do you motivate community people for construction of latrines?	80	47.1%
16	Do you help ANM for immunization?	148	87.1%
17	Do you educate to adolescent regarding health?	122	71.8%
18	Do you motivate the couple for family planning?	162	95.3%
19	Do you create community awareness on determinants of health?	158	92.9%
20	Do you counsel community on safe delivery, NC/PNC, breastfeeding, immunization, contraception and prevention of RTI and STI?	164	96.5%
21	Do you mobilize community to access health services at different facilities?	166	97.6%
22.	Do you act as depot holder for essential provisions like ORS, iron folic acid tablet, oral pills and condoms?	136	80%

and 87.1% helped ANMs for immunization. 81.8% ASHAs distributed supplementary nutrition and ORS, 62.4% distributed DOTS, 80% distributed oral pills, 80% acted as depot holder for essential provisions like ORS, iron folic acid tablets, 71.8% ASHAs educated adolescents regarding health. 47.1% ASHAs motivated community for construction of latrines but only 21.8% were satisfied from the honorarium they received (**Table-4**).

Evaluation of ASHA by ANM, AWW and PRI

All ANM were satisfied with training and number of ASHA in the Sub-Centre and their community's perception of ASHA but all felt that the salary of ASHA was not sufficient. All ANM revealed, that they motivated the ASHA towards her work and helped ASHA when she faced problems. 90% ANM viewed ASHAs as beneficial to villagers and 80% ANMs said that ASHA fulfilled her job responsibility.

All AWWs reported that ASHA met them monthly or weekly and opined that the health facilities had improved because of ASHA and that people were satisfied with the working of ASHA, 80% AWW were satisfied with the way the ASHA work. 100% PRI motivated the ASHA towards her work and viewed that the community is satisfied with her. 80% PRIs informed that ASHA shared her problems with them (**Table-5**).

DISCUSSION

Level of ASHA's knowledge about health problems

In the present study, majority of ASHAs, 91.8% knew about diarrhea, 91.2% had knowledge about measles, 80% ASHAs knew about dehydration, these findings are similar to the study done by **Darshan et al., 2011**)⁹ who found that 83.07% of ASHAs had knowledge about diarrhea, but differed with 31.54% and 8.5% having correct knowledge about measles and dehydration. Here 92.9% ASHAs knew about pneumonia, whereas (**Waskel et al., 2014**)¹⁰ reported it to be 80%. We found, 95.9% ASHAs knew signs of malaria, which is higher than the study done by (**Darshan et al., 2011**)⁹ wherein 80.7% were stated to know about malaria. Our finding that 68.8% knew the warning signs of high risk pregnancy is in contrast to the finding of the study by (**Smitha, 2011**)¹¹ which reported it to be 7.2%. In the present study, 80.6% ASHAs, knew about immunization which is slightly more than the 73.3% reported by (**Shrivastava, 2009**)¹² and less than the 98% reported by (**Garg, 2013**).¹³

Assessment of the services delivered by ASHA to her community

Most of the ASHAs, 87.6% got 2nd training after induction training which is similar to the study done by

Table-5. Opinion of ANM, AWW and PRI about ASHA

Sr. No	Question	Response	
		Frequency	Percentage
ASHAs as per the Opinion of ANMs			
1.	Are they (ASHA) adequate in number under you in this sub center?	10	100%
2.	Is population covered by ASHA adequate in your area?	6	60%
3.	Are they fulfilling their job responsibility?	8	80%
4.	Do you feel that working of ASHA is benefitting the villagers?	9	90%
5.	Was training imparted to them?	10	100%
6.	Do you feel the training is adequate?	9	90%
7.	Do you feel the community is satisfied with ASHA?	10	100%
8.	Are they getting sufficient salary?	0	0.0%
9.	Do you motivate the ASHA towards work?	10	100%
10.	Do ASHAs report to you as and when they face problem?	10	100%
ASHAs as per the Opinion of AWW			
1.	Do you know about the ASHA under the NRHM?	10	100%
2.	Do you work/ meet together monthly or weekly?	10	100%
3.	Do you know how are ASHA selected in your area?	0	0.0%
4.	Do you think that the health facilities have improved because of ASHA?	10	100%
5.	Are you satisfied the way ASHA work?	8	80%
6.	Do you think that people are satisfied with the working of ASHA?	10	100%
ASHAs as per the opinion of PRI			
1.	Are they involved in the NRHM?	10	100%
2.	Were you involved in selection of ASHA?	2	20%
3.	Do you feel the community is satisfied with the ASHA?	10	100%
4.	Do you motivate the ASHA towards work?	10	100%
5.	Does ASHA report to you if any problems she face?	8	80%

(Bajpai and Dholakia, 2011)¹ where it was 83.2%. 99.4% ASHAs revealed that patients referred by them got priority in hospital which is close to 95% reported by (Shrivastava, 2009).¹² 99.4% ASHAs found training useful for them, which is higher than the study by (Parsot *et al*, 2009)¹⁴ who found it to be 75%. 96.5% ASHAs counseled pregnant women on safe delivery, natal care & post natal care, breastfeeding, immunization, contraception and prevention of respiratory tract infection and sexually transmitted disease in the present study which is similar to Shrivastava, 2009¹² which reported it to be 100%.

Maximum of ASHAs 98.8% accompanied delivery cases in contrast to 16% reported by (Saxena, 2008).¹⁵ 62.4% ASHAs distributed DOTS which is less than the study of Kumar (2011)¹⁶ that found it to be 73.5%. The finding that 87.1% ASHAs informed AWW/ANM about birth and death is in contrast to the study made by (Garg, 2013)¹³ where it was found to be only 17%. Our finding that 95.2 % ASHA motivated the couples for family planning, is supported by a similar study by Bajpai and Dholakia, 2011¹ which found it to be 92%.

Association of socio-demographic variables and level of knowledge

The findings of our study that the educational status of ASHA and level of knowledge was not statistically significant ($p=0.241$) is similar to the study conducted by (Darshan *et al.*, 2011) ($p=0.2932$).⁹ however the study by (Knasal, 2012)¹⁶ reported significant association ($p<0.01$). The association between the age of ASHA with the level of knowledge was not found statistically significant ($p=0.487$) in the present study, whereas the study done by (Parost *et al.*, 2009)¹⁴ found it to be statistically significant ($p<0.05$).

CONCLUSION

ASHA is an important part of NRHM in meeting 'The Millennium Development Goals' by 2015. As a health worker, she provides outreach services to help out rural people in their health matters at the point of care, often in the patient's home. It is imperative from this study that she is knowledgeable to an extent and is displaying responsibility in this direction. But as her role is multifaceted involving knowledge and practice in the

fast changing health scenario and society, it is necessary that ASHA should have adequate knowledge, aptitude, leadership skills and a say in village health matters.

Therefore, she must be more qualified, given compulsory longer hands-on induction training and subsequent periodical reorientation as a regular feature of the scheme. Her present meager honorarium which affects her motivation, morale and initiative, needs genuine consideration. Thus, ASHA should get reasonable fixed salary and performance driven reasonable benefits. The program should be expanded and implemented in urban areas as well. Despite facing, all these odds, ASHAs are providing good services to her community.

Limitations

The sample size, 170 ASHAs, 10 AWWs, 10 ANMs and 10 PRIs, and the area covered, though appeared small in this study, but it involved a good time to approach, administer and elicit their complete responses and was completed within 6 months' time. Thus, the findings emerged are only indicative and cannot be generalized. Therefore, future studies should include large sample over large area over a long duration, to reasonably generalize the results.

RECOMMENDATIONS

Some ASHAs were not clear about their role and they faced difficulty in understanding some of the tasks for them. This may be because of their lower qualification/ training deficits or poor motivation. Therefore, they must be at least higher secondary level educated and appropriately trained with more practice opportunities under supervisor to fulfill the needs of changing society. In addition they must be provided genuine salary and incentive for their work. ASHA forms NRHM's service at the grassroots level hence, regular training as well as regular supply of materials must be ensured to them.

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