



# AN EXPLORATORY ANALYSIS OF KNOWLEDGE AND PRACTICE, JOB-RELATED DIFFICULTIES AND DISSATISFACTION OF ASHAS IN RURAL INDIA

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## ABSTRACT

**Background:** Accredited Social Health Activist (ASHA), a voluntary worker operating under National Rural Health Mission (NRHM), was launched with the intention of improving the reproductive and child health (RCH) services in rural India.

**Objectives:** This study aimed to assess the knowledge and practice of ASHAs in rural Bengal, find out the predictors of poor performance, and search for causes of dissatisfaction and difficulties faced during work.

**Methods:** This cross-sectional study was conducted for a period of three months on 56 ASHAs, working in a particular service area. Mixed methods were employed.

**Results:** Out of 56 ASHAs participating in the study, working as ASHA was the only source of income in 76.79%. Majority received inadequate modular trainings (73.21%), and 39.29% lacked job satisfaction. 44.64% ASHAs had poor performance. Predictors of poor performance were age > 35 years, education less than graduate, and lack of job satisfaction. Focused Group Discussion (FGD) revealed that they were dissatisfied with inadequate remuneration and troubled by lack of essential medicine supply.

**Conclusion:** Urgent and effective measures should be taken for betterment of the performance of ASHAs, and to redress their grievances.

**Key Words:** ASHA, NRHM, RCH, knowledge, Practice, Job satisfaction

## INTRODUCTION

The Millennium Development Goals (MDGs) aim towards improvement of the physical health as well as quality of life of the people, but their achievement is limited by resource constraints, mainly dearth of health manpower.<sup>1</sup> There is a growing concern about shortage of medical personnel and health workers worldwide as the population continues to rise.<sup>2</sup> This shortage is far more prominent in the developing countries. Moreover, there is clustering of health workers in urban regions, along with resultant paucity of manpower in rural and remote areas.<sup>3,4,5</sup> At this point of time, the gradually increasing role of community health workers (CHWs) is being recognized, as they are indispensable for achievement of the MDGs.<sup>6</sup> In general, CHWs workers are healthcare providers who belong to a particular community, are selected from and

trained in the same community, work for the same community and are acceptable to that community.<sup>7</sup> CHWs is a generalized term which includes nurse-midwives, home-based care givers, salaried personnel and volunteers.<sup>6</sup> The Accredited Social Health Activist (ASHA) is a voluntary worker, operating in the rural health system of India, introduced as the main task-force of National Rural Health Mission (NRHM). The NRHM, launched by the Government of India on April 2005 was an initiative towards achievement of the MDGs in India.<sup>8</sup> The aim of NRHM is comprehensive healthcare, focused mainly on the rural women and children, thereby improving the reproductive and Child Health (RCH) services. ASHAs represent the cornerstone of the NRHM. The actualization of the goals of NRHM depends on the proper functioning of ASHAs. ASHAs are trained according to modules, and expected to act as a link worker between the rural popu-

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lation and the health infrastructure.<sup>8</sup> The present study aimed to assess the knowledge and practice of ASHAs in rural West Bengal, and find out the predictors of poor performance, along with exploratory analysis of various difficulties and causes of dissatisfaction among the ASHAs.

## METHODOLOGY

This cross-sectional study was conducted in the service area of Rural Health Unit and Training Centre, Singur, Hooghly district, West Bengal, under the purview of All India Institute of Hygiene and Public Health (AIHH & PH), for a period of 3 months, starting from July 2012 to September 2012. Mixed methods, i.e. combination of a quantitative survey and qualitative technique consisting of focused group discussions (FGDs) were employed in this study. The study population comprised all ASHAs working in the said service area, and giving informed consent for inclusion in the study. For the quantitative survey, a pre-designed, pretested semi-structured questionnaire was used. The questionnaire included information regarding socio-demographic variables, a schedule for interview regarding the knowledge about the service area as well as responsibilities & practice of different services provided, job related difficulties, time allocation, and a checklist regarding training & recruitment norms. Content and face validity was ensured and translation from English to Bengali was done with care for semantic equivalence. The Cronbach-Alpha for reliability was 0.85. The knowledge and performance were scored, with each correct response fetching '1' mark, and every wrong/unanswered response fetching '0' marks respectively. The cumulative score was calculated. Median score was calculated, and ASHAs scoring less than median score were considered to have scored poorly. Finally, 56 ASHAs operating in the service area were included.

For the qualitative part, 5 FGDs were conducted for 43 ASHAs, with 7-9 different participants in each, with assurance of confidentiality, anonymity and choice of dropping out at any point of time. Each FGD was about 45 minutes long, and interviews were carried on until saturation of data was achieved. The interviews were conducted in the local language, Bengali. Topics like causes of dissatisfaction about work, difficulties faced during performing their duties and attitudes of the rural people towards the ASHAs were covered. They were also asked to discuss about possible solutions to the problems they face.

Written informed consent was obtained from each participant, and participation was completely voluntary. The study received clearance from the Institutional Ethics Committee of AIHH & PH. The quantitative data was entered and analyzed in IBM SPSS version 20.0. A p value

less than 0.05 was considered as statistically significant. The qualitative data analysis was done after verbatim transcription and methodical and meticulous collection, collation and coding of the items into the following themes: Relevant themes were classified as individual, community, and health system. The qualitative findings were corroborated with the quantitative data appropriate to the conceptual framework of the study.

## RESULTS

The background parameters of the study population is shown in Table 1. Most of the ASHAs belonged to the age group of 31-35 years (41.07%), completed graduation (33.9%), were married (94.6%), and had a low family income (55.36%). Most of them were working as ASHA for 2 years or more (82.14%). Working as ASHA was the only source of income in 76.79%. Majority received less than/equal to five modular trainings (73.21%). Nearly 39.29% reported to be not satisfied with their job as ASHA. All of them were not satisfied with their remuneration and role clarity (not shown in the table).

On assessment of the knowledge regarding responsibilities and performance of ASHAs, it was observed that only 51.79% had correct knowledge about their service area and the population served. Knowledge regarding various do-s and don't-s for maintaining optimum maternal and child health was present in 69.64% and 78.57% respectively. Regarding choice, availability and timing of contraception and family planning, only 35.71% had correct knowledge, whereas, regarding the other miscellaneous activities like community mobilization, counselling and organizing activities on nutrition and sanitation, and role as drug-depot holder was present in only 32.14% ASHA. (Table 2) Satisfactory performance in the area of maternal health, family planning, child health were present among 57.14%, 21.43% and 62.5% respectively. (Table 2) Regarding escorting the mothers and child for perinatal visits, immunizations and during minor ailments, along with staying with them when required was rather neglected (42.86%). The ASHAs facilitated institutional deliveries in only 36 (64.29%) cases (not shown in table). Other miscellaneous activities were satisfactorily performed by only 30.36% ASHAs.

The median knowledge score was 6 [Inter-quartile range (IQR) 5-10; Range 1-14], and median performance score was 14 [IQR 12-17; Range 7-27]. When cumulative scores were calculated by summing up both the scores, median was 20 [IQR 18-26; Range 9-41]. Scores less than median were taken as poor cumulative scores. Twenty five (44.64%) ASHAs had a poor cumulative score. On multivariate analysis, covariates of poor cumulative scores were age more than 35 years, education less than graduation, and absence of job satisfaction. (Table 3)

FGDs revealed several sensitive, confidential and hidden societal aspects regarding the grievances, and commonly faced difficulties. One middle-aged ASHA said: "We are not able to carry out our duty properly most of the time, as we have to deal with inadequate and irregular medicine supply." Another ASHA opined: "People treat us harshly, and some consider us as unwanted. I remember, one day I was not allowed to enter the premises of a house to weigh a newborn, as I belong to a backward class. In this scenario, it is impossible for us to carry out our work." Lack of co-operation and avoidant attitude on the part of villagers was also pointed out by some ASHAs.

All the ASHAs were dissatisfied with remuneration. A young ASHA commented: "I will rather pursue some clerical job in an office than continue this job. There is no fixed salary, and the remuneration is also insignificant." Most of the ASHAs were of the opinion that the remuneration was too little for too much work: "We want to serve the villagers. But if we are paid this less, how can we continue this job? We have dependent family members." Last year, some of the ASHAs had to leave their job because of the inadequate and inconsistent remuneration, they said. Nobody could definitely point out any possible solution, except one ASHA who asked: "Why doesn't the government do something for us, like a fixed payment along with job-based incentives?" All the others agreed. The findings of the FGD are summarized in figure 1.

## DISCUSSION

Our study revealed poor knowledge and performance in 44.64% of the ASHAs in this service area. We also found out a few predictors of poor knowledge and performance, in the form of increased age, low education and lack of job satisfaction. FGD revealed that inadequate medicine supply and harsh behaviour towards ASHAs were the main barriers to their proper functioning, and all of them were displeased regarding remuneration.

The utilization of ASHA services in different scenarios and for various purposes was assessed by some authors. ASHAs have been called as a link worker, who bridges the gap between the facilities and the beneficiaries.<sup>9</sup> However, the proper functioning of ASHAs as well as proper utilization of their services is always not possible.<sup>6</sup> ASHA's capacity in influencing the pregnant women to deliver in public institutions as a part of Janani Suraksha Yojana (JSY) appeared limited in a study in Ujjain district.<sup>10</sup> On the other hand, Stalin et al have commented that ASHAs can be effectively involved in the newborn care, provided they are trained adequately.<sup>11</sup> Studies from other parts of the country have aimed at exploring the performance of ASHAs and finding factors on which poor performance depends. Kansal et al have found that low education was

a predisposing factor for poor performance, when it comes to keeping records in village health registers. He also found that performance was satisfactory in the areas of antenatal care and child care.<sup>12</sup> Swain et al, Haider et al and Malini et al have expressed similar views.<sup>13,14,15</sup> In our study, we observed that increasing age of ASHAs was an important predictor of poor scores in knowledge regarding responsibilities, and performance. In the present study, mean age was 33.06 years, similar to Kansal et al and Jain et al.<sup>12, 16</sup> However, no other study has thrown any light on the effect of age on knowledge or performance. Surprisingly, in a study by Shrivastava et al, it was discovered that many of the ASHAs were below 25 years of age, which is against the rule. This, the authors explain, was due to paucity of candidates who could serve as ASHAs.<sup>17</sup> While we found lacunae in the fields of contraception, nutrition, sanitation and imparting health education, Shrivastava et al have found deficits in the field of childhood illness recognition and referral. Jain et al have found that 70% of the institutional deliveries were facilitated by ASHA, a finding similar to our study.<sup>16</sup> A sharp contrast is the study by Shrivastava et al. who found that ASHA facilitated institutional delivery in about 100% cases. Qualitative research in the form of focused group discussion revealed that ASHAs preferred greater hours of training and less hours of meeting.<sup>6</sup> No other study mentions adequately about job satisfaction of ASHAs, and their grievances.

## CONCLUSION

The present study, in spite of having a small sample size and cross-sectional nature, hints at probable factors which might influence proper functioning of ASHAs. However, to formulate effective measures to improve the performance of ASHAs as well as facilitate the adequate utilization of ASHA services by the beneficiaries, large-scale longitudinal and interventional studies are required. To our belief, this study might carve the path for future research regarding improper functioning of ASHAs.

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**Table 1: Background characteristics of the ASHAs (n=56).**

Characteristics	Number (%)
Age (in completed years) Mean, SD	33.06, 5.94
≤30	9(16.07)
31-35	23(41.07)
36-40	19(33.93)
≥41	5(8.93)
Education (completed till)	
Secondary:	17(30.4)
Higher secondary:	18(32.1)
Graduation:	19(33.9)
Post-graduation:	2(3.6)
Marital status	
Married	53(94.6)
Widowed	3(5.4)
Caste	
Scheduled caste	6(10.71)
Schedule tribe	4(7.14)
OBC	4(7.14)
General	42(75)

Monthly household income (INR)	
<2000	31(55.36)
≥2000	25(44.64)
Number of modular trainings received	
≤5	50(89.29)
>5	6(10.71)
Whether satisfied with job	
Yes	34(60.71)
No	22(39.29)
Years of experience as ASHA	
< 2 years	10(17.86)
2-5 years	46(82.14)
Source/s of income	
Only as ASHA	43(76.79)
Other sources along with ASHA	13(23.21)

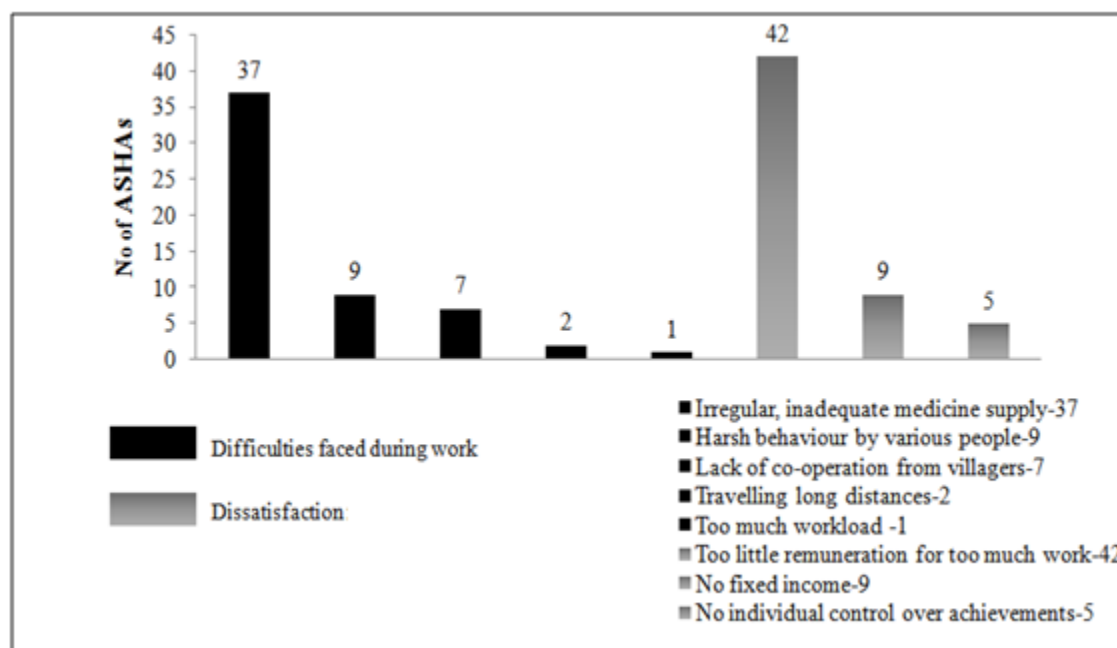
**Table 2: Knowledge regarding responsibilities and performance of ASHAs (n=56)**

	No (%) of ASHAs with correct knowledge
Knowledge regarding:	
Service area	29 (51.79)
Maternal health	39 (69.64)
Child health	44 (78.57)
Contraception & family planning	20 (35.71)
Nutrition, sanitation, drug-depot holder, community mobilization and counseling etc.	18 (32.14)
Performance regarding:	
	No (%) of ASHAs who performed satisfactorily
Maternal Health	32(57.14)
Contraception & family planning	12(21.43)
Child health	35(62.5)
Escorting and/or staying with mothers for maternal and child health related activities	24(42.86)
Nutrition, sanitation, drug-depot holder, community mobilization and counseling etc.	17(30.36)

**Table 3: Covariates of poor cumulative score of ASHAs(n=56)**

Variables	ASHAs with poor cumulative scores(25/56)	Odd's ratio (95%C.I.)	Adjusted O.R. (95%C.I.)
Age in complete years	≤ 35years (8/32)	1	1
	> 35years (17/24)	7.286 (2.217-23.938)	3.974 (1.337-8.381)
Marital status	Married (23/53)	1	-----
	Widow (2/3)	2.609 (0.223-30.57)	-----
Caste	General (19/42)	1.101 (0.325-3.733)	-----
	Others (6/14)	1	-----
Education	≤ HS (20/35)	4 (1.204-13.284)	2.332 (1.003-7.725)
	> HS (5/21)	1	1
Monthly household income (INR)	< 2000 INR(18/31)	3.56 (1.153-10.994)	1.558 (0.893-5.297)
	≥ 2000 INR(7/25)	1	1
Years of experience as ASHA	2-5 years (20/46)	0.769 (0.195-3.027)	
	< 2 years (5/10)	1	
Source/s of income	Other sources along with ASHA (9/13)	3.797(1.004-14.360)	1.328(0.243- 3.996)
	Only as ASHA(16/43)	1	1
Training received	≤5 (21/41)	2.89(0.788-10.573)	
	>5 (4/15)		
Job satisfaction	Absent (17/22)	11.05 (3.09-39.492)	5.564 (1.058-12.802)
	Present (8/34)	1	1

Hosmer Lemeshow goodness of fit for the model was good  $p > .04(.059)$ ; Nagelkerke R square value was 0.624



**Figure 1:** Bar diagram showing difficulties faced during work and causes of dissatisfaction among study population(N=56)