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*Aswani Patchala*
*Samson S. R. Nallapu*
*T.S.R.Sai*

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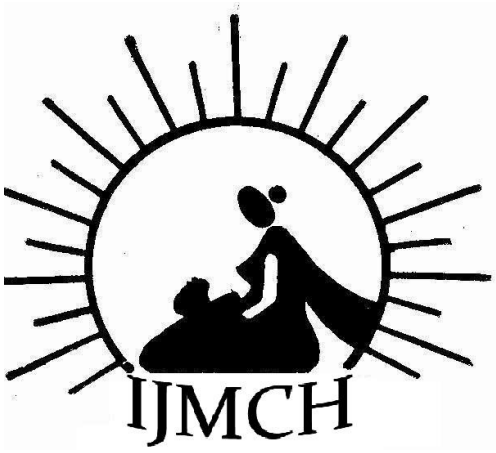


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The Accredited Social Health Activist (ASHA) is the key facilitator under the National Rural Health Mission. This study is to evaluate the role of ASHA in Maternal & Child Health (MCH) activities, factors influencing her function and the community's perception of her.

# Evaluation of MCH Activities of ASHA in a PHC in Guntur District

**Aswani Patchala*, Samson S. R. Nallapu**, T.S.R.Sai*****
***Post Graduate Registrar, **Associate Professor, ***Professor& Head**
**Dept. of Community Medicine, NRI Medical College, Chinakakani, Guntur(AP)**

**Correspondence:** Dr. Aswani Patchala

**ABSTRACT**

**Background:** The Accredited Social Health Activist (ASHA) is the key facilitator under the National Rural Health Mission. This study is to evaluate the role of ASHA in Maternal & Child Health (MCH) activities, factors influencing her function and the community's perception of her.

**Methods:** Information was obtained through pretested questionnaires and discussions with all the ASHAs in Thullur Primary Health Center (PHC) of Guntur District, other staff and beneficiaries.

**Results:** Most ASHAs retained only the elementary knowledge necessary for obtaining incentives and their involvement in people's health care is not marked. Delay in incentives and regularization of job are their main concerns. The influence of caste was apparent in rural peoples' utilization of the ASHAs' services among other issues.

**Conclusion:** Though certain competencies have been built up among ASHAs, her role as an activist is unclear. ASHAs need to be stimulated by the PHC team they are working with.

***KEY WORDS: ASHA, knowledge, qualitative, incentives, performance***

## INTRODUCTION

Consumption of health services by rural families is poor in spite of Governmental efforts to provide essential services to their doorsteps. While immunization services are being availed reasonably well, other Maternal & Child Health (MCH) services of the Primary Health Center (PHC) are underutilized. Though the contribution of the private health sector in MCH is considerable, it is beyond the reach of the masses. Worldwide, community health worker programs have emerged as one of the most effective strategies to address human resources for health shortages while improving access to and quality of primary healthcare [1].

The National Rural Health Mission (2005 -2012) was formulated to provide comprehensive integrated health care to the rural people, especially the vulnerable sections of the society, women and children [2]. The Accredited Social Health Activist (ASHA) was introduced as a link between the community and the health system to motivate and help vulnerable sections to improve their accessibility to basic health services. The ASHA is envisioned as a key health facilitator under the NRHM. The ASHA's role is considered extremely important in terms of motivating pregnant women for utilization of the antenatal care from the PHC. ASHAs would reinforce community action for universal immunization, safe delivery, newborn care, and prevention of water-borne and other communicable diseases, nutrition and sanitation [3]. Regular evaluation of the ASHA's contribution towards improved utilization of health services by the community is vital.

The Government of India has set up certain MCH process, outcome and impact indicators for monitoring the ASHA. Some of these indicators are; number of ASHAs selected and trained, ASHAs attending review meetings, newborns weighed, families counseled, deliveries with skilled assistance, institutional deliveries, completely immunized children, unmet need for spacing contraception [4].

Some factors critical to the success of ASHA include selection of ASHA by prescribed process, referral linkage with nearest functional facility for services, priority and recognition of cases referred by ASHA to MO / ANM, monthly meeting of ASHA at PHC, timely payment of incentives to ASHA etc.

This study is set to provide an insight into the working of ASHA'S in the community by evaluating her role in the MCH services provided by the PHC system. An attempt is being made to evaluate the knowledge of the ASHA, the problems faced by her in performing health care activities and community awareness about the ASHA workers in MCH care.

**METHODS AND MATERIALS**

Thullur Primary Health Center in Guntur District of Andhra Pradesh was selected for this study as it comes under the service area of the NRI Medical College. The duration of the study was for 2 months from 1st week of November to end of December, 2012. A questionnaire was prepared for evaluating the knowledge of the ASHAs, general profile and problems faced by them in pursuing their work. It included questions from their training manual on various MCH activities. The questionnaire was pretested locally. All 27 ASHAs who attended the ASHA day on the first Tuesday of November 2012 were noted and subsequently administered the questionnaire. The performance of each ASHA for the last four months from the date of survey was noted from her record book and verified with the records of the Nodal Officer (LHV). Key informant interviews were done with the Nodal Officer and the NRHM District Manager. Two group discussions were conducted with groups of the above ASHAs. In-depth interviews were also done with some of the ASHAs. A total of 70 beneficiaries were randomly selected from their villages and visited over the following days and interviewed with the help of another pretested questionnaire. Two group discussions were conducted with beneficiaries from the community (Antenatal mothers, Post natal mothers and mothers of under 5 children). Consent of the ASHA workers and families was obtained using a standard consent form in the local language i.e. Telugu.

The data obtained from the questionnaires was analyzed using WHO Epi Info statistical package for percentages. Transcribed data from the discussions and interviews were assessed for emerging issues and themes.

**OBSERVATIONS & DISCUSSION:**

In this study most of the ASHAs (49%) were between the ages of 20 to 30 years of age. This concurs with Deoki Nandan et al's study which showed that more than half (53.3%) of ASHAs were in the age group 20-29 years. It was suggested that this may be strength for the programme as they are energetic and enthusiastic and may deliver better service with proper motivation and capacity building [2].

**Table 1: General profile of ASHAs, knowledge and performance variables (n=27)**

| Indicators | Below average | Average | Good |
|---|---|---|---|
| Educational status | 15% (Primary) | 74% (secondary) | 11% (Inter & Diploma) |
| Training status | 7% (3 days) | | 93% (Full) |
| Work experience | | 33% (2 to 5 years) | 67% (>5 years) |
| General MCH based knowledge | 59% (<40%) | 41% (40% to 60%) | 0 (>60%) |
| Incentive based MCH knowledge | 15% (<80%) | 37% (81 – 90%) | 48% (>90%) |
| Remuneration | 18.5% (<500 Rs) | 26% (500 - 1000Rs) | 55.5% (1001 -1500 Rs) |
| Performance | 44% (<40%) | 30% (40% to 60%) | 26% (>60%) |

Regarding level of education, many ASHAs in this study had secondary education status (Table 1). Deoki Nandan.et.al found that 40% of the ASHA'S from rural block has studied up to the higher secondary [2].The present study also shows that 70.4% of ASHA belong to schedule caste (SC) and schedule tribe (ST) communities and all are residents of the villages they were working in. The work experience is more than five years for two thirds of the ASHA workers. An UNFPA study mentions that 42 to 68 per cent of ASHAs belong to Backward Caste and they were living in the same village for the last 14 years [5].

Impact on Family planning: Of the 57 eligible beneficiaries, only 12 (21%) have been given counseling regarding Family planning. Of the above only 7 (58.3%) agreed for tubectomy and got it done. The remaining beneficiaries did not follow any other contraceptive methods. Out of 57 home visits ASHA gave advice regarding nutrition to only 13 (22.8%) families. Neera Jain et.al in their study mention that of the 40% who were counseled for acceptance of any method of family planning by ASHA, only 6% turned up as acceptor of tubectomy [6].

Work performance evaluation showed that only a quarter of ASHAs was above average. Almost a third of the ASHAs were receiving remuneration above 1500 rupees per month. Impact assessment shows that though there were more than 90% institutional deliveries, the ASHAs had no role in them. Parul Sharma et al found that of the women who delivered in Govt. Hospital 74.2% women were registered with ASHA and only 13.4% belonged to rural areas while the rest (83.6%) belonged to urban slums [7].

The study shows that many ASHAs had a poor overall knowledge of MCH (Table 1). Inspite of their training there are still lacunae left in their knowledge as also noted by Dharshan KM et al [8]. Most ASHAs retained only the rudimentary working knowledge necessary for obtaining incentives. They did not have sufficient knowledge to counsel the beneficiaries. Neera Jain et.al in their study felt that quality of training should be enhanced and refresher training should be planned regularly [6]. Nirupama Bajpai suggests that without a clear understanding of one‘s own responsibilities as an ASHA, performance and effectiveness cannot be improved [9].

Qualitative Study Findings (some issues and themes from the discussions)

*"There is not much extra use of ASHA. She is only doing now what the ANM was doing before*." *"These women get good daily wages for farm work. Why will they come for meetings? They only get 50 rupees for attending a full day meeting."* Key informant interview, Nodal Officer (Lady Health Visitor) about 50 years of age working with ASHAs for last 2 years.

Vandana K. et al suggest that Government health workers (Nurse Midwives & Child development workers), village leaders and other community stakeholders had a limited understanding regarding the roles of the ASHAs [10]. Haider S. et al mention that CMOs & MO I/Cs felt that good coordination between ANM & ASHA had not been observed. In their opinion ANMs may not know ASHA even of their respective villages [11].

*"Other than MCH duties the ASHA does not do any other work". "According to our project, an ASHA should get a maximum of Rs. 600 per month. Some of these women are even getting 2000 rupees! Are they really doing that much work?"* Key informant interview, NRHM Project Manager, working for 3 years.

"*What work do I have? Only once a week I have to go and inform about immunization. That is all! Rest of the time I can work in the field"*. In-depth interview, ASHA.

Vandana Kanth et al showed that only 22 % of ASHA's in their study had some understanding of their role as given under the NRHM ASHA guidelines. The remaining had little to no knowledge about what their roles were [10]. The mentoring group for ASHA in fact commented in 2006 that there was lack of clarity about the role of ASHA as to whether she was an activist or a Government health functionary [12].

Neera Jain et al found that 59% BCG vaccination for new borns was facilitated by ASHA. They also mention that ASHAs support in ANC services and immunization was significantly high in comparison to other services [6]. Deoki Nandan et al's study also mentioned that these were the most important activities performed by the ASHAs [2].

*If we get paid regularly we will be more interested in the work! In the beginning people, especially OC (Forward caste) families never accepted us. Now after 5 years, they greet me on the road and also ask when the immunization is."* FGD, ASHAs.

Bella Patel Uttekar et al remarked that ASHAs expressed that they were unsatisfied or indifferent with the cash assistance as it was 'too much of work and too little money' or money was not available timely [13]. Neera Jain et al also felt that to avoid the delays in compensation money, mechanism developed by the state must be strictly followed [6]. Untimely performance based cash payments to ASHAs emerged as a serious concern, because in the absence of remuneration, it would be difficult to sustain interest of ASHAs for long [13].

*"We don't know of any ASHA. An ayah accompanies the ANM when she visits our houses". "Yes. Yes. They do come around with the nurse and tell us. However we don't go. We prefer private doctor."* Focus Group Discussion with beneficiaries.

**Table 2: Beneficiaries' perception on ASHA (n=70)**

| | |
|---|---|
| Do not know ASHA | 18.5% |
| Know ASHA but use her services occasionally | 54.4% |
| Know ASHA and also use her services frequently | 27.1% |
| ASHA visited home for antenatal visits and TT immunization | 28% |
| ASHA visited home to inform about post natal visits | 3.7% |
| ASHA visited home to inform about immunization of under 5 children | 47.3% |
| ASHA visited home to counsel regarding family planning | 21% |

Neera Jain et al. mention that communication strategy needs to be designed to create awareness on ASHA scheme at community level for better acceptance of ASHAs [6]. A few families reported that they do not know of any ASHA. 75% of the families report that ASHA did come around to their houses to inform about MCH and immunisation services (Table 2).

In the present study it is found that many beneficiaries are going for Antenatal care and immunization on their own. However credit for this is being given to the ASHA workers by their ANMs and Nodal officer. This has a direct effect on the remuneration to ASHAs. Some of them are receiving even upto 3000 rupees a month.

There seems to be a caste based differentiation in the utilization of the ASHA's services. The OC & BC groups are using her services for getting information about immunization only. However the SC / ST group are utilizing her well. As she is usually from the same community, she is known to them and they accept her advice. In some interior villages where other health facilities are not available, all the caste groups are utilizing the ASHA's services regarding immunization. According to Saraswati Swain et al, the issue of upper caste families ignoring the ASHA's if belonging to lower caste needs to be tackled. She also suggests that rich families also do not call upon the ASHA's for services [14].

The study reveals that the ASHA is serving as a messenger from the Sub center to inform about the immunization dates. She is not doing much counseling or health education work. Deoki Nandan also suggests that most of the ASHAs preferred helping in delivery and immunization. However many other jobs like promotion of awareness on hygiene and sanitation, counseling on family planning etc. were drawing lesser attention probably due to lack of incentives [2].

Many people feel that the ASHA is an Ayah / helper of the VHN. While she feels the need for the ANM in visiting upper class houses, she goes on her own to the SC/ST houses. Haider et al state from their study that almost all ANMs agreed that they got help from ASHA in immunization, identifying pregnant women and advice Antenatal care. In some areas ANM take assistance of ASHAs in home visits, health education and health programmes [11].

**CONCLUSION**

There is a need for a community/village level voluntary health functionary and this need is being met over the years through the trained Dais / Village health guides / extension workers etc. Under the NRHM, the ASHA has been envisioned not just as a health worker but an activist. This study gives insight into the limited impact of the ASHA on MCH activities in rural communities. Some issues like community acceptance, irregular incentive payment and poor understanding of her role continue to hinder the work of the ASHA. Currently the ASHA is mainly seen as a messenger to inform about immunization dates etc that too to only a segment of the population. People are using the Govt. health services as before and the impact of the ASHA in terms of improved usage is questionable. Her role as a viable link between the health system (PHC/SC) and the community is not yet apparent. The role of the ASHA as Social Activist is not being fulfilled. Perhaps at selection itself, one must identify women who have a zeal for community oriented voluntary work. It must be kept in mind that the financial remuneration is only an incentive and not a salary. Though training plays an important role, ASHAs need to be motivated and inspired through the exemplary attitudes and behaviors of the health team that they are working with i.e. the Medical Officer, the Nurses, VHNs etc.

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**REFERENCES**

1. Anne Liu, Sarah Sullivan, Mohammed Khan, Sonia Sachs, Community Health Workers in Global Health: Scale and Scalability. Mount Sinai Journal of Medicine. Volume 78, Issue 3, May/June 2011 pages 419–435.
2. Deoki Nandan, Srivastava D.K., Shiv Prakash. A Study Of Interface Of ASHA With The Community and the Service Providers In Eastern Uttar Pradesh. 2008-09, Report - National Institute of Health and Family Welfare. : http://www.nihfw.org/pdf/RAHI-II%20Reports/GORAKHPUR.pdf.
3. National Rural Health Mission, Meeting people's health needs in rural areas, Framework for Implementation, 2005-2012, Ministry of Health and Family Welfare, Government of India, Nirman Bhawan, New Delhi-110001 page 54.
4 NRHM Manual, Annex I, Guidelines On Accredited Social Health Activitists (ASHA), pg 1-11, http://mohfw.nic.in/NRHM/RCH/guidelines/ASHA_guidelines.pdf
5 Concurrent Assessment of Janani Suraksha Yojana (JSY) in Selected States Bihar, Madhya Pradesh, Orissa, Rajasthan, Uttar Pradesh United Nations Population Fund – India First published in 2009© UNFPA.
6 Neera Jain, Srivastava N.K., A. M. Khan, Neera Dhar, Vivek. A, Menon S., Nandan D., Assessment of functioning of ASHA under NRHM in Uttar Pradesh. Health and population, perspectives and issues 2007-2008., 31{2}:132-140.
7 Parul Sharma, Jayanti Semwal, Surekha Kishore, A Comparative study of utilization of Janani Suraksha Yojana (Maternity Benefit Scheme) in rural areas and urban slums. Vol. 22 No. 2, Vol. 23 No. 1, July 2010 -June 2011 Indian Journal of

Community Health, http://www.iapsmupuk.org /journal/index.php/IJCH/issue/view/2

8. Darshan. K Mahyavanshi, Mitali G. Patel, Girija Kartha, Shyamal K. Purani, Sunita S. A cross sectional study of the knowledge, attitude and practice of ASHA workers regarding child health (under five years of age) in Surendranagar district. Health line ISSN 2229-337X, The Journal Of Indian Association of Social and Preventive Medicine, Gujarat Chapter Volume 2 Issue 2 July-December 2011, page 50.
9 Nirupam Bajpai, Ravindra H. Dholakia. Improving the Performance of Accredited Social Health Activists in India . Working Paper No. 1May 2011. Working Papers Series Columbia Global Centers | South Asia, Columbia University *South Asiahttp://globalcenters.columbia.edu/content/improving-performance-accredited-social-health-activists-india*
10 Vandana Kanth, Anil Cherian, Jameela George. The contribution of Accredited Social Health Activist (ASHA) under National Rural Health Mission (NRHM) in the implementation of Comprehensive Primary Health Care in East Champaran district, Bihar (State) India. Pages: 418-419, http://www.globalhealthequity.ca/webfm_send/96
11 Haider S., Adhish S.V., Gupta S., Dhar N., Datta U. Menon S. Nandan D., Health and Population perspectives and issues – A Rapid appraisal of Sahiya (ASHA) in Jharkhand, Vol. 31,(2), 80 -89, 2008.
12. Minutes of the Mentoring group for ASHA, NIHFW, Munrika, August 1st 2006 at 9.30 AM. Chairperson – Ms.S.Jalaja, Addl.Secretary, MOHFW, GOI.
13. Bella Patel Uttekar, Sandhya Barge , Wajahat Khan , Yashwant Deshpande , Vasant Uttekar , Jashoda Sharma, Balaji Chakrawar , Shweta Shahane. Assessment of ASHA and Janani Suraksha Yojana in Rajasthan. UNFPA, New Delhi, April 2007:51.
14. Saraswati Swain, Pusphanjali Swain, Nair K.S., Neera Dhar, Sanjay Gupta , Deoki Nandan, Health and Population perspectives and issues, Vol. 31,(2), 73 -79, 2008.