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Performance Assessment of Accredited Social Health Activists in Eastern India: A Cross Sectional Study

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Abstract: ***Introduction: The GOI launched the National Rural Health Mission in 2005, under which many innovations have been introduced in the states to deliver healthcare services in an effective manner to provide accessible, accountable, affordable, effective and reliable primary health care, especially to the poor and vulnerable sections of the population. The actualization of the goal of NRHM depends on the functional efficacy of the ASHA as the grassroots health activist. The study was conducted to access the performance of ASHA workers in one of the selected blocks of eastern India. Methods: The study was carried out in 4 PHCs which were randomly selected from one of the blocks of Odisha. The ASHA workers were contacted in their respective PHCs during their monthly review meetings. Results: A total of 75 ASHA workers gave consent for the study.63 (84%) ASHAs had completed up to matriculation education and 42 (56%) were working for more than 3 years. Out of these 75 ASHAs, 59 (78.67%) received training within 6 months of the interview, while rest 16 (21.33%) were beyond 6 months.21.33% ASHA ranked very well in performance. Time - lapse since the last training was found to be significantly related to the performance of ASHAs (P = 0.000). Conclusion: The overall performance of ASHA's was found to be satisfactory. As time since the last training received was found significant to the overall performance, regular training of ASHAs should be emphasized to further improve their performance.***

Keywords: Accredited social health activist, performance

1. Introduction

The Government of India launched the National Rural Health Mission (NRHM) in 2005, under which many innovations have been introduced in the states to deliver healthcare services in an effective manner to provide accessible, accountable, affordable, effective and reliable primary health care, especially to the poor and vulnerable sections of the population. (2)

One of the core strategies proposed in this mission was to create a village level social activist, designated as ASHA for every village. To a large extent, the actualization of the goal of NRHM depends on the functional efficacy of the ASHA as the grassroots health activist. One of the core strategies proposed in this mission was to create a village level social activist, designated as ASHA for every village with a 1, 000 population. This was aimed to provide primary medical care, advice the villagers on sanitation, hygiene, antenatal and postnatal care, escorting expectant mothers to hospital for safe delivery etc. To perform her activity in a proper manner, the NRHM has envisaged capacity - building of the ASHA through training and motivating them through a performance - based compensation. It was suggested that ASHA would be chosen by and accountable to the Panchayat. She would act as an interface between the community and the public health system. As an honorary volunteer ASHA would receive performance - based compensation for promoting variety of primary health care services in general and reproductive and child health services in particular, such as universal immunization, referral and escort services for institutional deliveries, construction of household toilets, and other healthcare interventions. (3 - 4) With this background, the study was conducted to access the performance of ASHA workers in one of the selected blocks of Odisha, India.

Objective

To access the performance of ASHA workers in one of the selected blocks of eastern India.

2. Materials and Methods

Out of 6 Primary health centres (PHC) in one of the blocks; 4 PHC's were randomly selected for the study, the study was conducted. The ASHA workers were contacted in their respective PHC during their monthly review meetings. All with an experience of more than 1 years were included for the study. After explaining the purpose of the study and obtaining oral consent, the study was conducted using interview technique. Information was collected in a pretested proforma. For checking the authenticity of their given information, the data collected was cross verified from the records of respective PHC.

The study was conducted from July 2019 to October 2019. Every month one PHC was visited and information was collected from the ASHA. Out of 106 ASHA workers selected from the 4 PHC 's only 75 ASHA workers could be contacted during their monthly meeting.

The performance was assessed based on 11 indicators namely, 1. Home visits 2. Registration of pregnant mothers 3. Ante natal care 4. Post - natal care 5. Janani Suraksha Yojana 6. Immunization coverage 7. Village Health Nutrition and Sanitation Committee 8. Help ANM for immunisation 9. Distribution of DOTS 10. Family Planning 11. Preparing Blood Smear for fever cases. Each component carried a total score of 3. If the score was less than 25%, score was 0, 25 - 49% - 1, 50 - 75% - 2, more than 75% - 3. Only Post - natal care had two sub components and hence carried a score of 6. The total score was 36.

The performance was graded as very poor, poor, good and very good. A score of less than 9 was very poor, 9 - 17 was poor, 18 - 26 was average and 27 and above was graded as good.

Data collected was entered in excel sheet and analysed using SPSS V21.

3. Results

A total of 75 ASHA workers gave consent for the study, out of which majority of ASHAs were 64 (85.33%) in the age group of 25–35 years.64 (85.33%) ASHAs belonged to other backward class (OBC), and 68 (90.67%) were married. Moreover, 63 (84%) ASHAs had completed up to matriculation education and 42 (56%) were working for more than 3 years. All ASHAs, had received modular training. Out of these 75 ASHAs, 59 (78.67%) received it within 6 months of the interview, while rest 16 (21.33%) beyond 6 months. Regarding performance assessment, none of the ASHA ranked very poor, while 10.66% of ASHAs ranked poor, 68% of ASHA ranked good and 21.33% ASHA ranked very good in performance. Only time lapse since the last training was found to be significantly related to the performance of ASHAs (P = 0.000).

Socio demographic details		Number of subjects (n) (N=75)	Percentage (%)
Age	25 - 35	64	85.33
	36 - 45	11	14.67
Marital Status	Unmarried	7	9.33
	Married	68	90.67
Caste	OBC	64	85.33
	General	9	12.00
	SC / ST	2	2.67
Education status	Not completed matriculation	12	16.00
	Completed Matriculation	63	84.00
Work experience	<3 years	33	44.00
	>3 years	42	56.00
Time lapsed since last training	<6 months	59	78.67
	>6 months	16	21.33

Table 1: Socio Demographic details of studied ASHA workers

Variable		Performance Rank			Total	χ^2 (p)
		Poor	Good	Very Good		
Age	25 - 35	1	47	16	64 (85.33)	38.555 (0.000)
	36 - 45	7	4	0	11 (14.67)	
Marital Status	Unmarried	0	3	4	7 (9.33)	6.182 (0.045)
	Married	8	48	12	68 (90.67)	
Caste	OBC	7	45	12	64 (85.33)	2.148 (0.709)
	General	1	5	3	9 (12)	
	SC / ST	0	1	1	2 (2.67)	
Education status	Not completed matriculation	2	6	4	12 (16)	2.127 (0.345)
	Completed Matriculation	6	45	12	63 (84)	
Work experience	<3 years	1	26	6	33 (44)	4.504 (0.105)
	>3 years	7	25	10	42 (56)	
Time elapsed since last training	<6 months	0	43	16	59 (78.67)	34.808 (0.000)
	>6 months	8	8	0	16 (21.33)	

4. Discussion

The study assesses the performance of ASHAs from a block of Eastern India for their work performance. Work performance as dependent variables were correlated with a number of different independent demographic variables.

As per the guidelines of NRHM for ASHA, she should be primarily a woman resident of the village, preferably in the age group of 25–45 years. In our study, 64 (85.33%) ASHAs were in age group of25–35 years. Bhanderi et al. Evaluation of accredited social health activists Gujarat, showed that 32 (40%) ASHAs were in age group of 25–35 years. [1] An eight states study by the national health systems resource centre (NHSRC) showed that in all states, about 60% of ASHAs were in 24–35 years age group, except in Kerala where only 35% belonged to this age group. [5]

In our study, the majority of ASHAs (85.33%) were from OBC and only 12% belonged to general category While 2.67% ASHAs were from scheduled caste (SC). In the study of Bhanderi et al. Evaluation of accredited social health activists in Anand District of Gujarat, ASHAs (68%) were from OBC and only 10% belonged to general category While 16% ASHAs were from scheduled castes (SC). [1] The, SIHFW study it was found that as much as 35% ASHAs came from general category, 40% from OBC, 23% from SC. [6] A study conducted in Cuttack, Orissa, the caste composition revealed that the ASHAs from SC and ST together constitute more than half of the total sample, while those belonging to general castes and OBC were 26% and 21%, respectively. [7]

In our study, 90.67% ASHAs were married, while rest were unmarried. However, in Gujarat study, 96% ASHAs were married, while rest were either widow or divorcee. [1] In Nagaland study, as high as 82.3% ASHAs were married. [8]

The performance ranks were not associated with caste, education status of the ASHAs [Table 2]. Study done in Varanasi noted a significant association of caste, education as well as the size of service population with performance scores of ASHAs. [9] However, in this study, performance ranks were found to be significantly associated with time lapse since the last training received [Table 2]. This emphasizes the importance of periodic refresher training of ASHAs for improving their performance. Mony and Raju

also felt the need of training of ASHAs in their study done in Karnataka to fulfil the objectives of the program. [10] In our study, correlation was observed between age, marital status, work experience and time elapsed since last training achieved by ASHAs, as depicted in Table 2.

5. Conclusion

The overall performance of ASHA's was found to be satisfactory. As time since last training received was found significant with the overall performance, regular training of ASHAs should be emphasized to further improve their performance.

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Conflict of Interest
There are no conflict of interest

References

[1] Bhanderi DJ, Varun AR, Sharma DB. Evaluation of accredited social health activists in Anand District of Gujarat. Journal of Family Medicine and Primary Care.2018 May; 7 (3): 571.
[2] Shashank K J, M M Angadi. Assessment of Roles and Responsibilities of ASHA workers in Bijapur taluk of Karnataka. Indian J. Pharm. Biol. Res.2015; 3 (2): 78 - 80.
[3] Government of India, National Rural Health Mission ASHA (2005). Module Guidelines, Ministry of Health and Family Welfare, New Delhi, India.
[4] Guidelines on Accredited Social Health Activists (ASHA). Available at https: //nhm. gov. in/images/pdf/communitisation/task - group - reports/guidelines - on - asha. pdf
[5] National Health Systems Resource Centre. ASHA - Which Way Forward? Evaluation of ASHA Programme. New Delhi: National Institute of Health and Family Welfare; 2010 - 2011. Available from: http: //www.nhsrcindia. org/index.
[6] State Institute of Health & Family Welfare. Assessment of the functioning of ASHA under NRHM in Uttar Pradesh. Lucknow, Uttar Pradesh State Institute of Health & Family Welfare; 2007 - 2008. Available from: http: //www.nihfw. org/doc/RAHI - I%20Reports/Lucknow/LUKNOW. pdf. [Last accessed on 2017 May 04].
[7] National Institute of Applied Human Research and Development, Cuttack, Orissa. Rapid Appraisal of Functioning of ASHA under NRHM in Cuttack, Orrisa; 2007 - 2008. Available from: http: //www.nihfw. org/doc/ RAHI - I%20Reports/Cuttack/CUTTACK. pdf. [Last accessed on 2017 May 04].
[8] ASHA evaluation in Nagaland available at https: //nhsrcindia. org/sites/default/files/202103/ASHA%20Evaluation%20Nagaland%20Report. pdf
[9] Mohapatra A, Mohapatra SC. Intraorganizational human resource auditing of ASHAs in Harahua block of Varanasi. J Public Health Epidemiol 2013; 5: 237 - 42.
[10] Mony P, Raju M. Evaluation of ASHA programme in Karnataka under the national Rural health mission. BMC Proc 2012; 6 Suppl 5: 12.