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Original Research Article

Evaluation of awareness of job responsibilities and incentives of accredited social health activist in the delivery of health care services

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ABSTRACT

Background: Accredited social health activist (ASHA) workers are the female health volunteers of the community who takes steps to generate awareness and provide information to the community on determinants of health such as nutrition, hygiene practices and basic sanitation, healthy living condition. Our aim was to evaluate the level of awareness of job responsibilities of ASHA workers, to assess about their awareness about the different incentives in the delivery of health care services and to recommend for improvement on the functioning of the ASHA workers.
Methods: A cross sectional study was conducted in Khordha district of Odisha from March 2018 to July 2018. 3 blocks were selected purposively i.e. Bhubaneswar under urban block, Bolagarh under rural block and Banapur a tribal block. Working in the 3 selected blocks, 331 ASHA's participated in the study.
Results: 37% were between 34-39 years and 30% were in the age group of 34-39 years in the rural block and about 40% ASHA workers belonged to 25-29 years of age. For full immunization in the 1st year of life per beneficiary an amount of Rs. 100 is given to an ASHA worker. However, 67 (68.4%) in urban block, 79 (63.2%) in rural block and 83 (76.8%) ASHAs in tribal block were aware about this incentive.
Conclusions: The role of ASHAs should be well defined and accordingly with supportive supervision, the ASHAs should be monitored to efficiently & effectively play their roles and discharge duties.

Keywords: ASHA, Worker, Responsibilities, Incentives

INTRODUCTION

The Govt. of India launched "National Rural Health Mission" (NRHM) on 12th April 2005 for an initial period of 7 years (2005-2012) and then extended with naming as NHM now. The main aim is to improve rural health care delivery system besides strengthening the urban health care. It became operational in the whole country with special focus on 8 Empowered Action Group states, out of which Odisha in one.[1]

The main aim of NRHM is to provide accessible, affordable accountable, effective and reliable primary health care and bridging the gap in rural health care through creation of cadre of Accredited Social Health Activist (ASHA).[2] Now the urban and rural areas are integrated and under the flagship of NHM (National Health Mission) the major initiative of ASHA's in every village / ward is represented to serve the population in a better way.[3]

ASHA worker must be a resident of the village and a woman (married / widow / divorced) preferably in age group of 25 to 45 yrs with formal education up to eight class, having leadership qualities and communication skills to address the public. For selection the general norm followed is 1 ASHA per 1000 population. However, this could be relaxed in hilly & tribal areas as per the habitation.[4]

ASHA will be a health activist in the community who will create awareness on health. ASHA is to take steps to generate awareness and provide information to the community on determinants of health such as nutrition, hygiene practices and basic sanitation, healthy living condition. She is to provide information on existing health services, timely utilization of health and family welfare services.

She is to counsel women on birth preparedness, highlights on safe delivery, importance of exclusive breast feeding, complementary feeding, immunization, contraception and prevention of common infections including RTI/STI and care of the young children. She is also to mobilize the community and facilitate them to access health and health related services.

She is required to work with the village health and sanitation committee of the GP (Gram Panchayat) to develop a comprehensive village health plan. As part of their responsibility they are to escort pregnant women & children requiring referral to the nearest health care facility.

Objectives

- To evaluate the level of awareness of job responsibilities of ASHA workers.
- To assess their awareness about different incentives in the delivery of health care services.
- To recommend for improvement of the functioning of the ASHA workers.

METHODS

Type of study

Cross sectional

Place of the study

Khordha district of Odisha.

Period of study

March 2018 to July 2018.

Out of 10 blocks in Khordha district in eastern Odisha 3 blocks were selected purposively i.e. Bhubaneswar under urban block, Bolgarh under rural block and Banapur a tribal block. The ASHAs working under these 3 blocks were enrolled in the study and a predesigned, pretested questionnaire validated earlier by the experts of Community Medicine was implemented after taking their written consent. Urban block was designated as block1, rural block as block 2 and tribal block as block 3. Out of total 99 no. of ASHA's in urban block, 98 were enrolled in the study. Similarly in block 2 (rural block) out of 128 ASHAs, 125 agreed to give their opinion and views in the study. Out of total 111 ASHAs in block 3 (tribal block) 108 decided to participate in on study. So, out of total 338, ASHA's working in the 3 selected blocks, 331 ASHA's participated in the study.

The level of awareness of the ASHAs residing in the 3 blocks, was assessed regarding the incentives and their job responsibilities and accordingly a comparative analysis was done.

Thereafter the collected data was analyzed in SPSS 21 and interpreted after appropriate statistical tools were applied.

RESULTS

Table 1 depicts the profile of ASHA worker in the 3 sample blocks. A comparative analysis was done between the 3 blocks which showed that out of 98 ASHA workers in urban block, 37% were between 34-39 years and 30% were in the age group of 34-39 years in the rural block and about 40% ASHA workers belonged to 25-29 years of age. Regarding educational qualification 45 (45.9%) ASHA's were educated till middle class in urban block and in rural block 65 (52%) and in tribal blocks 37 (34%) were educated till primary level. Majority of the ASHA worker were married in all the 3 blocks.

Table 2 reveals the population covered by ASHA workers. 50(51%) of ASHA workers covered <1000 population in urban block and 58 (46.4%) in rural block. In the tribal block 39(36.1%) ASHA workers covered 1000 to 1500 population.

Table 3 shows the ASHA workers' knowledge across 3 blocks regarding incentives given for immunization. According to this table based on the block wise analysis of ASHA workers awareness on the different incentives for different job responsibilities, it was found that in urban area out of 98 ASHAs about 78 (79.6%) whereas about 98 (78.4%) in rural area and 101 (93.5%) in tribal area were aware about the incentives given for mobilization of children.

Table 4 projects the ASHA workers knowledge regarding incentive on reproductive health.

About 88 (89.7%) of ASHA worker in urban block, 98 (78.4%) in rural block and 100 (92.6%) in tribal block were aware about PPIUCD insertion and about the incentives. The other incentives based on job responsibilities include promoting spacing of births, for which incentive of Rs. 500 is given. In urban block 83 (84.7%) ASHA's, in rural block 97 (77.6%) and in tribal block 90 (83.3%) were aware of promoting spacing of births and for which the incentives given is Rs. 500. An amount of Rs. 300 is given for motivation of males for sterilization at hospitals. It is found that 82 (83.7%) in urban block, 102 (81.6%) in rural and 90 (83.3%) in tribal block are aware of this particular method of contraception. An amount of Rs. 200 is given for

motivation of females for sterilization of females in hospitals. In the urban block 83 (84.7%), in rural block 110 (88%) and in tribal block 99 (91.7%) ASHA's are aware regarding motivation for female sterilization for which they are paid an incentive of Rs. 200.

Table 1: Profile of ASHA's in the sample blocks.

Profile	Urban block-1		Rural block-2		Tribal block-3	
	No.	%	No.	%	No.	%
Age group (in years)						
25-29	29	29.6	14	11.2	43	39.8
30-34	31	31.6	41	32.8	37	34.3
35-39	36	36.7	37	29.6	22	20.3
40-44	2	2.1	33	26.4	6	5.6
Education						
Primary	19	19.4	65	52	36	33.3
Middle	45	45.9	25	20	37	34.3
Secondary	28	28.6	9	7.2	30	27.8
Higher Secondary	4	4.08	16	12.8	5	4.6
+3(Graduate)	2	2.02	0	0	0	0
Marital status						
Married	75	76.5	69	55.2	93	86.1
Unmarried	11	11.2	14	11.2	10	9.3
Divorced	12	12.3	15	33.6	5	4.4

Table 2: Population covered by ASHA's in the 3 blocks.

Population	Urban block-1		Rural block-2		Tribal block-3	
	No.	%	No.	%	No.	%
<1000	50	51	58	46.4	34	31.5
1001 to 1500	19	20.4	43	34.4	39	36.1
>1500	29	29.6	24	19.2	35	32.4

Table 3: Comparison of ASHA workers' knowledge across 3 blocks regarding incentives for immunization.

Incentives for different job responsibilities	Block wise ASHA worker awareness					
	Block-1		Block-2		Block-3	
	No	%	No	%	No	%
Mobilization of children through ASHA (per session Rs.150/-)	78	79.6	98	78.4	101	93.5
For full immunization in 1st year of life (per beneficiary Rs. 100/-)	67	68.4	79	63.2	83	76.8
For complete immunization up to 2nd year of age Pulse polio immunization / day Rs. 75/- as volunteer	56	57.1	63	50.4	68	62.9

*Multiple responses.

Table 5 shows a comparative analysis of ASHA workers knowledge regarding the incentives for maternal health. The different activities undertaken is as follows like Rs. 300/- for ANC package in rural areas, facilitating institutional delivery is Rs. 300/- in rural areas. However in urban areas per antenatal case, the total package for ANC is Rs. 200/- so, a total of Rs. 400/- is the dedicated incentive for urban area ANC. For confirmation of maternal death the AHSA's are given Rs. 150/- per case.

Table 6 shows a comparative analysis of ASHA workers' knowledge regarding incentives for child health. As per the block wise analysis of ASHA workers, regarding the incentive for home based newborn care programme, for which ASHA worker gets Rs. 250/- per newborn, in urban block out of 98 only 52(53.1%) of ASHA workers, in rural block out of 125 only 67 (53.6%) and in tribal block 44(40.7%) were aware about it. Lack of proper training, capacity building and reorientation, in service training at frequent intervals for up gradation of their level of knowledge that already exists.

As per the Table 7 the knowledge of ASHA workers regarding incentives for RNTCP is provided. As a community DOTs provider for giving treatment support in category I TB patients a sum of Rs. 1000 is provided to

ASHA workers. In the urban block out of 98, 43(43.9%) of ASHA workers, in rural block, out of 125 ASHA workers 65 (52%) and in tribal block 35 (32.4%) were aware of it. Similarly, as a community DOT provider, for providing treatment support to Category II TB patients the ASHA's are provided @ Rs. 1500/-. In urban block, out of 98 ASHA workers 45 (45.9%), in rural block out of 125 ASHA workers 66 (52.8%) and in tribal block out of 108, 40(37%) ASHA workers had appropriate knowledge.

Table 4: Comparison of ASHA worker knowledge across 3 blocks regarding incentives for reproductive health.

Incentives based on job responsibilities	Block wise ASHA workers awareness					
	Block-1 (n=98)		Block-2 (n=125)		Block-3 (n=108)	
	No.	%	No.	%	No.	%
Incentive for accompanying the client for PPIUCD insertion Rs. 150/-	88	89.7	98	78.4	100	92.6
Under ESB scheme for promoting spacing of births @ Rs. 500/-	83	84.7	97	77.6	90	83.3
Promoting adoption of limiting methods up to 2 children @ Rs. 1000/-	85	86.7	98	78.4	89	82.4
Motivation of male sterilization at hospitals @Rs. 300/-	82	83.7	102	81.6	90	83.3
Motivation for female sterilization @ Rs. 200	83	84.7	110	88	99	91.7

Table 5: Comparative Analysis of ASHA workers knowledge regarding incentive for maternal health.

Maternal health	Block wise ASHA worker awareness					
	Block-1		Block-2		Block-3	
	No.	%	No.	%	No.	%
Rural areas per case total package for ANC = Rs. 300. Facilitating initial delivery = Rs. 300. Total Rs. 600/-	75	76.5	89	71.2	77	71.3
Urban area per case Total package for ANC=300 Facilitating institutional delivery = Rs. 200 Total Rs. 400/-	78	79.6	42	33.6	32	29.6
Confirmation of maternal death @ Rs. 150/-	35	35.7	42	33.6	22	20.4
Mobilization of beneficiary to VHND session per ASHA per quarter	37	37.8	55	44	54	50
Mobilize and accompany suspected high risk pregnant women to ICTC or FICT – Rs. 100/- per case	29	29.6	26	20.8	28	25.9
Incentive for accompanying a abortion case@ Rs. 100/-	15	15.3	18	14.4	14	12.9

*Multiple responses.

Table 6: Comparative analysis of ASHA worker knowledge regarding incentives for child health.

Job responsibilities	Block wise ASHA worker awareness					
	Block-1		Block-2		Block-3	
	No.	%	No.	%	No.	%
Incentive for home based newborn care programme Rs. 250/- per newborn	52	53.1	67	53.6	44	40.7
Incentive for follow up of LBW babies Rs. 50/month/case	42	42.9	55	44	41	37.6
Incentive to ASHA for follow up of SNCU discharge babies Rs. 50/case / month	43	43.8	52	41.6	37	34.2
Incentive of ASH for IDCF Rs. 200 Mobilizing children 6 months to 60 months Rs. 3/child/qtr	44	44.9	49	39.2	23	21.3

Table 7: Comparison of ASHA worker knowledge regarding incentive for RNTCP.

Sl. No.	Incentive based on responsibilities	Block wise ASHA worker Awareness					
		Block – 1		Block -2		Block – 3	
		No.	%	No.	%	No.	%
1.	As community DOT provider providing treatment support to category I TB patient @ Rs. 1000	43	43.9	65	52	35	32.4
2.	As a community DOT provider providing treatment support to category II TB patients @ Rs. 1500	42	45.9	66	52.8	40	37
3.	As a community DOT provider providing treatment support to drug resistant TB patients @ Rs. 5000	46	46.9	72	57.6	34	31.5
4.	For sputum sample transport in tribal and difficult areas @ Rs. 25/- sample	42	42.9	75	60	50	46.3
5.	Injection prick @ Rs. 25/- injection	45	45.9	70	56	42	38.9

*Multiple responses.

Table 8: Comparison of ASHA worker across 3 blocks regarding knowledge on job responsibilities & incentives in various disease control programme.

Sl. No.	Job responsibilities	Block wise ASHA worker Awareness					
		Block – 1		Block -2		Block – 3	
		No.	%	No.	%	No.	%
1.	Blood sample collection, report and treatment in NVBDCP @ Rs. 15/- for & Rs. 75/- for complete treatment.	55	56.1	75	60	50	46.3
2.	Line listing of lymphoedema and hydrocele cases @ Rs. 200/-	54	55.1	65	52	43	39.8
3.	Incentive to ASHA NLEP PB=400 MB=600	65	66.3	70	56	60	55.6
4.	Identification regaining motivating and transporting the case for cataract operation @ Rs.250/- case	60	61.2	68	54.4	47	43.5
5.	Under NIDDCP salt testing @Rs. 25/- per 50 tests	45	45.9	46	36.8	26	24.1

Table 9: Comparison of ASHA worker across 3 blocks knowledge regarding other job responsibilities and incentives.

Sl. No.	Job responsibilities	Block wise ASHA worker awareness					
		Block – 1		Block -2		Block – 3	
		No.	%	No.	%	No.	%
1.	Organizing GKS meeting (monthly) @ Rs. 1500/- month	89	90.8	10	80	86	79.6
2.	Attending monthly sector meeting @ Rs. 150/-meeting	90	91.8	112	89.6	85	78.7
3.	To support ANM in updating RCH register per quarter / 300	85	86.7	80	64	78	72.2

Table 10: Comparative Analysis of Block wise on Information on Training of ASHA workers.

Sl. No.	No. of ASHAs trained	Block wise ASHA worker Awareness					
		Block – 1		Block -2		Block – 3	
		No	%	No	%	No	%
1.	Training Module 1 to 5	90	91.8	125	100	88	81.5
2.	Round 1 : Module 6 & 7	90	91.8	122	97.6	85	78.7
3.	Round 2 : Module 6 & 7	88	89.8	122	97.6	71	65.7
4.	Round 3 : Module 6 & 7	84	85.7	122	97.6	70	64.8
5.	Round 4 : Module 6 & 7	84	85.7	122	97.6	13	12
6.	First AID Training	90	91.8	125	100	100	92.6
7.	FTD / Malaria	86	87.8	125	100	99	91.7
8.	DOTs Training	86	87.8	125	100	100	92.6
9.	NLEP	86	87.8	125	100	95	88

*Multiple response.

Table 8 shows the comparison of ASHA workers knowledge on job responsibilities & incentives in various disease control programmes across 3 blocks. Certain job responsibilities are as follows like blood sample collection, report and treatment in NVBDCP @ Rs. 15 for testing and Rs. 75/- for complete treatment. Out of 98 ASHA workers in urban area 55 (56.1%) were aware about it in urban block, whereas in rural block 75 (60%) and in tribal block 50 (46.3%) were aware about it.

Table 9 shows the ASHA workers knowledge on other job responsibilities & incentives like organizing GKS meeting (monthly) i.e., Gaon Kalyan Samiti for which they are given Rs. 150/- per month. It was concluded that 89 (90.8%) ASHA's in urban area, 100 (80%) in rural area, 86 (79.6%) in tribal area were aware about GKS meeting and the incentive regarding it. A good number of ASHAs' involvement was there in making the GKS meeting successful. Monthly sector meeting @ Rs. 150/- (for which they were given incentive) was attended regularly by 90 (91.8%) of ASHA's in urban area, 112 (89.6%) of ASHA's in rural area and 85 (78.7%) of ASHA's working in tribal area

Table 10 shows the comparative analysis among ASHA workers in the 3 blocks. The training module (1 to 5) for ASHAs was undertaken by 90 (91.8%) in urban block, 125 (100%) in rural block & 88 (81.5%) in tribal block. Regarding 6&7, Round 1 training 90 (91.8%) of ASHA's in urban block, 122 (97.6%) in rural and 85 (78.7%) in tribal block had under gone training. Module 6&7, Round 2 training was undertaken by 88 (89.8%) ASHA's in urban block, 122(97.6%) in rural block and 71 (65.7%) in tribal block.

DISCUSSION

In a study conducted by Gopalan SS et al revealed that majority of ASHA's were in age group of (31-35) years and (2-5) years was the year of experience in 82.90% of ASHA worker.[6] In the same study the no. of trainings the ASHA workers had undergone was <5 in 232 (73.06%).[5] Desai et al in a study amongst ASHAs in Kolhapur district, Maharashtra for improvement of health status of villages showed that 49(46%) of ASHA's were in (26 to 30) yrs of age. In the same study regarding work done by ASHAs 40 (37.4%) ASHAs rendered help for institutional delivery. In the same area it was observed that 100% malnutrition was decreased and immunization was done. Majority of the ASHAs conducted meetings and programmes for villages and only24 respondents told that they had no idea about the subject but participated in the meeting passively. For full immunization in the 1st year of life per beneficiary an amount of Rs. 100 is to be given to ASHA worker. However, 67 (68.4%) in urban block, 79 (63.2%) in rural block and 83 (76.8%) in tribal block were aware about this incentive. For complete immunization up to 2nd year of life and Pulse Polio Immunization incentive of Rs. 75/-day, 56 (57.1%) in urban block, 63 (50.4%) and 68 (62.96%) in rural block and a tribal block respectively had adequate knowledge. ASHA's work is multi tasking. Alex in his study on incentives, women and children: how the ASHA programme can reduce the child mortality in India argued that the ASHA system in the best ray of hope for reducing child mortality in rural areas.[7] This paper also suggested that if proper incentives are not paid well then the health status of villages will not improve. Deoki et al in study of interface of ASHA with the community and service providers in UP had pertinent findings as follows.[8] All the ASHA's were given 7 days induction training for which they were satisfied. However, there perception about their job responsibilities looked improper. Majority were not aware about their roles in the changing behavior about their roles in different infant feeding practices, hand washing technique, basic sanitation. They were not aware about birth & death registration. An ASHA worker gets Rs. 100 as an incentive to accompany an abortion case. Out of 98 ASHAs in urban block, 15 (15.3%) were accompanying an abortion case and 14 (14.4%) in rural block & 14 (12.9%) in the tribal block were actually accompanying an abortion case. In a study conducted by Kanth et al in Champavan district, Bihar (State) of India, the findings shows that the ASHA's understanding about the role and responsibilities was limited, similar to our study.[9] The training, ongoing support is inadequate for them to play a comprehensive pivotal role in the community. Regarding the incentive for follow up of LBW babies for which they are to be paid Rs. 50/month/case, in urban block about 42 (43%) and rural block 55 (44%) and in tribal block 41 (37.6%) of ASHA's were only aware of this job responsibility and about the incentives. The incentive to ASHA for follow up of SNCU discharge babies is Rs. 50/case/month. However as per the opinion of the ASHA workers in urban block 43 (43.8%), in rural block 52 (41.6%) and in tribal block 37(34.2%) were aware about it. Wang et al in India conducted a vistaar project in 2012 on PBP for ASHA's in India (performance based incentive) indicated that delay in payment, lack of data on how incentives affect outcomes, lack of transparency and adequate governance were all factors in the ASHA PBP scheme which could have negative impact on ASHA model effectiveness.[10] Module 6 & 7 Round 3 training was undertaken by 84 (85.7%) of ASHAs in urban block, 122 (97.6%) in rural block and 70 (64.8%) in tribal block. Module 6 and 7 Round 4 training was undertaken by 84 (85.7%) of ASHAs in urban block, 122 (97.6%) in rural block and 13 (12%) in tribal block. Training of the ASHAs in tribal block was diminished drastically from Round 2 to Round 4 of 6 and 7 module. This shows that their job proficiency may be hampered due to lack of training. Money et al in his study in Karnataka explored the diversity within the different ASHA programme in different districts.[11] The major findings of his study showed that ASHA worker perform tasks as link worker and community health workers, very less as social activists. Shrivastava et al in a cross sectional study at Palghar Taluka in the Thane district of Maharastra provide information that in spite of training given to

ASHAs their still exists lacunas in the level of knowledge on morbidity patterns on child health.[12]

CONCLUSION

The role of ASHA as conceived by NHM must be acknowledged by other stake holders like ANM, AWW, village Mukhya /panchayat. The relationship between the ASHAs and the community need to be strengthened by payment to be done through Panchayat / VHSC (village health & sanitation committee). Educating ASHA's about their role vis-à-vis other health workers and increased cooperation & training between them would serve their community health needs especially in regard to their service.

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