

## Original Research Article

# Evaluating the performance of ASHA workers in rural and tribal areas in Kurnool division of Kurnool district, Andhra Pradesh

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**Received:** 08 May 2019

**Accepted:** 03 July 2019

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### ABSTRACT

**Background:** ASHA is a health activist in the communities who creates awareness on health and its social determinants and mobilizes the community towards local health planning and increased utilization and accountability of the existing health services. This study was conducted with the aim of evaluating the work performance of ASHAs in tribal and remote rural areas in Kurnool division of Kurnool district.

**Methods:** This is a community based observational and cross sectional study carried out from July 2014 to July 2015. Six PHCs of Atmakur CHNC namely Kottalcheruvu, Bairlutu, Kothapally, Yerramattam, Gokavaram, Pamulapadu were selected for the study by using multistage random sampling technique. 65 ASHAs from 20 SCs of these six PHCs had participated in the study for evaluation of their performance in the field.

**Results:** Majority of ASHAs had average level of the performance in counselling of antenatal cases, escorting postnatal cases, motivating cases for family planning adoption, escorting family planning cases whereas the performance level was found to be good among majority of ASHAs with regard to escorting antenatal cases, counselling of postnatal cases and getting children immunized. Majority of ASHAs were not performing activities regarding creating awareness on social determinants of health, providing primary medical care for minor ailments, informing births and deaths to SC/PHC, distributing ORS, IFA and chloroquine.

**Conclusions:** Regular on job training as well as review training for ASHAs every 6 months helps them to increase their participation in various activities with a rejuvenated enthusiasm. The incentives for ASHA must be raised and paid promptly to them to improve their performance.

**Keywords:** ASHA, Performance, Antenatal, Postnatal, Incentive

### INTRODUCTION

For any society to be healthy, they need to be aware regarding creation of a healthy environment through hygiene maintenance, safe drinking water, sanitation and being motivated to seek preventive and curative health. ASHA is playing that crucial role of generating the much desired awareness and acting as a link between the rural communities and the health infrastructure thus empowering people to have the biggest asset "health" in their stride, which ultimately would be helpful in community empowerment at large and bring revolutionary change at the local level and also helping

socio-economic development in the rural areas of the country.<sup>1</sup>

ASHAs were very active and effective in promoting safe delivery and immunization and to some extent access to sterilisation, because the support system was geared to promoting exclusively these aspects. The ASHAs were therefore less functional and effective in tasks related to community level counselling, care provision and in mobilisation work and the lesser effectiveness is correlated to the inadequate emphasis on skills in the training module and lack of support systems for ongoing mentoring, support and supervision.<sup>2</sup>

The present study was conducted to evaluate the work performance of ASHA workers in tribal and remote rural areas in Kurnool division of Kurnool district.

**Objectives**

- To study the socio-demographic profile of ASHAs.
- To assess the performance of ASHAs in the field.

**METHODS**

This study was an observational and cross sectional study. Multistage random sampling technique had been used to select study area. In Kurnool district, Kurnool division was selected by simple random sampling. From CHNCs of Kurnool division, Atmakur CHNC was selected by simple random sampling. All the six PHCs of Atmakur CHNC namely Kottalcheruvu, Bairlutu, Kothapally, Yerramattam, Gokavaram, Pamulapadu were selected for the study. From the sub centres of six PHCs of Atmakur CHNC, 20 SCs were selected randomly. These 20 SCs were visited constantly on VHNDs to monitor the work performance of ASHAs and correct them if there is any deviation. 65 ASHAs from these 20 SCs had participated in the study for evaluation of their performance in the field. Each time, the performance was analyzed during the last three months. The selection of Kurnool division, Atmakur CHNC and finally ASHAs working in villages formed different stages of the sampling technique. The study was conducted for a period of one year starting from July 2014 to July 2015. A pre-designed instrument for evaluation of work performance has been developed and pre tested before using for this study. Some modifications have been made in this instrument after pre testing in the field on some ASHAs. The data was collected from the ASHAs in the field along with their respective female health workers and Anganwadi workers for finding out the level of true participation. The data was analyzed using SPSS 17 version.

**RESULTS**

Majority of the study subjects belonged to age group of 30-34 years (30.8%) followed by 25-29 years (23.1%) and predominantly to scheduled castes (55.3%), having secondary level educational status (60%), and lower socio-economic status (66.2%). 100% of the study subjects were married (Table 1).

An analysis of the work performance revealed that the performance level with regard to antenatal counselling was found to be 50-75% in 58.5% ASHAs whereas in escorting of antenatal cases, it was 75-100% in 64.6% ASHAs. With regard to counselling postnatal cases, the level of performance was found to be 75-100% in majority of the ASHAs (60.0%) while that with regard to escorting postnatal cases, the performance was found to be 50-75% in majority of ASHAs (63.1%).

**Table 1: Socio demographic characteristics of study group (n=65).**

Characteristics	Frequency	Percentage (%)
<b>Age group (years)</b>		
20–24	7	10.7
25–29	15	23.1
30–34	20	30.8
35–39	13	20
40 and above	10	15.4
<b>Educational status</b>		
Illiterate	3	4.6
Primary	8	12.3
Upper primary	13	20
Secondary	39	60
Hr. Secondary and above	2	3.1
<b>Social status</b>		
Other castes	7	10.8
Backward caste	15	23.1
Scheduled caste	36	55.3
Scheduled tribe	7	10.8
<b>Socio- economic status</b>		
Lower middle	10	15.4
Upper lower	12	18.4
Lower	43	66.2
<b>Social position</b>		
Daughter- in-law	53	81.5
Daughter	12	18.5

With respect to helping in immunization of children, it was found that the performance was 75-100% in 75.4% ASHAs. The performance with regard to motivating family planning cases was found to be 50-75% in 66.2% ASHAs while with regard to escorting family planning cases, the majority (56.9%) showed 50-75% performance (Table 2).

Less than 50% of the ASHAs were performing activities regarding creating awareness on social determinants of health (32.3%), providing primary medical care for minor ailments (38.5%), informing births and deaths to SC/PHC (35.4%), distributing ORS (41.5%), IFA (43.1%) and chloroquine (46.2%) (Table 3).

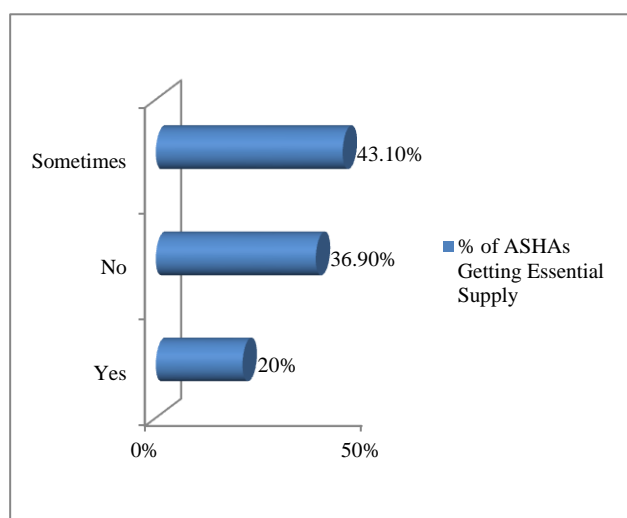
Majority of the ASHAs reported that they get essential supply sometimes (43.1%) (Figure 1). Whereas motivating factor for being an ASHA was earning money (56.9%) followed by absorption in Government job (21.5%) (Figure 2). While expectation for better work was stated as better pay (63.1%) and availability of more medicines (20%) by majority of them (Figure 3). Whereas main problem faced by ASHAs was reported as lack of literacy in community (41.6%) by majority of them followed by lack of timely availability of medicines (32.3%) (Figure 4).

**Table 2: Field performance of ASHA workers.**

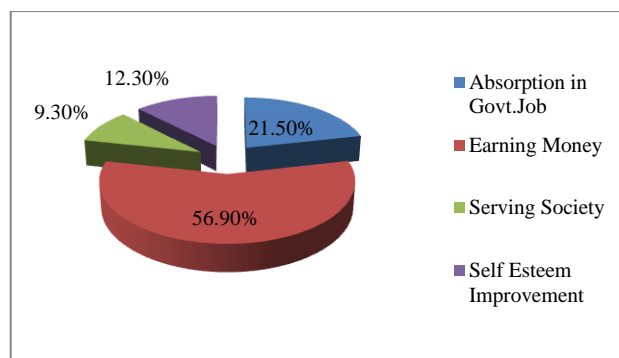
Activities of ASHAs	Performance level of ASHAs (50-75%)	Performance level of ASHAs (75-100%)
Counselling antenatal cases	38 (58.5)	27 (41.5)
Escorting antenatal cases	23 (35.4)	42 (64.6)
Counselling postnatal cases	26 (40)	39 (60)
Escorting postnatal cases	41 (63.1)	24 (36.9)
Immunization of children	16 (24.6)	49 (75.4)
Motivating family planning cases	43 (66.2)	22 (33.8)
Escorting family planning cases	37 (56.9)	28 (43.1)

**Table 3: Performance of ASHAs regarding other job responsibilities.**

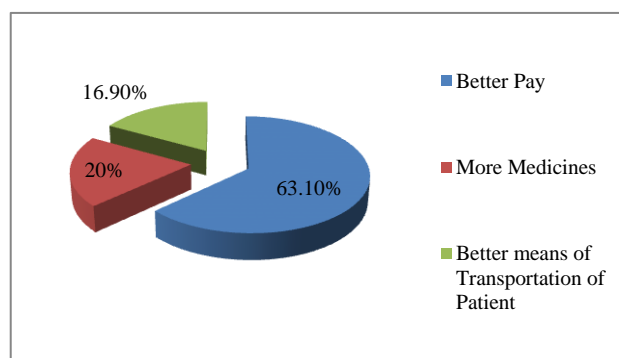
Activities of ASHAs	Number of ASHAs	Percentage (%)
Creating awareness on social determinants of health	21	32.3
Providing primary medical care for minor ailments	25	38.5
Informing births and deaths to SC/PHC	23	35.4
Distribution of ORS	27	41.5
Distribution of Chloroquine	30	46.2
Distribution of IFA	28	43.1



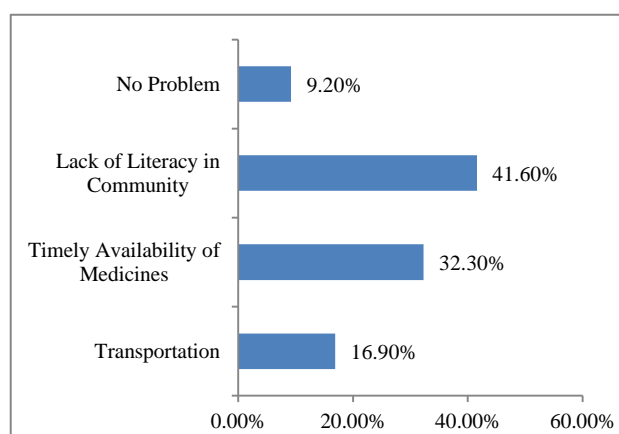
**Figure 1: Regular replacement of essential supply.**



**Figure 2: Motivating factors for ASHAs.**



**Figure 3: Expectation by ASHAs for better work.**



**Figure 4: Expectation by ASHAs for better work.**

**DISCUSSION**

Majority of ASHAs belong to 30-34 years (30.8%) followed by 25-29 years (23.1%). Similarly in a study by Darshan et al it was found that majority of ASHAs were between 25-34 (53.1%) years of age.<sup>3</sup> While Saxena et al noticed that maximum (42%) ASHAs were in 26-30 years of age group.<sup>4</sup> Similarly Kansal et al found that majority of the ASHAs (84%) were equal to or less than 35 years of age with most being in the age group of 25-30 years.<sup>5</sup>

Majority of the study subjects had secondary level of educational status (60%). Similarly in a study by Darshan

et al it was reported that about 70% of ASHAs had received secondary level of education.<sup>3</sup> While Jain et al found that 53.3% of the ASHAs had schooling up to Junior High School, 31.7% High School and 5% intermediate, and 10% were graduates.<sup>6</sup>

The study subjects belonged predominantly to scheduled caste (55.3%) followed by backward caste (23.1%). Whereas in a study by Kansal et al it was reported that majority belonged to the OBC category (43.75%) while 37% were from the General category followed by 19.3% belonged to SC category.<sup>5</sup> While Srivastava et al noticed that the caste composition of ASHA showed roughly equal distribution between SC (38.33%), OBC (35%) and General (26.67%).<sup>7</sup> Jain et al found that 35% ASHAs came from general category while 40% of them were BC, 25% from SC (23%), and ST (2%).<sup>6</sup>

Majority of the study subjects belonged to lower socio-economic status as per modified BG Prasad's classification (66.2%). Similarly in a study by Srivastava et al it was reported that more than half (61.67%) of ASHAs belonged to below poverty line.<sup>7</sup> Whereas Saxena et al noticed that most of them belong to upper middle class (41.3%) followed by lower middle class (27.3%) and upper class (18%).<sup>4</sup>

The social position of 81.5% study subjects was daughter-in-law. 100% of the ASHAs were married. Similarly in a study by Kansal et al it was noticed that all the ASHAs were found married.<sup>5</sup> Whereas Mahyavanshi et al noticed that 89.2% ASHA workers were married while 9.2% and 1.5% unmarried and widows respectively.<sup>3</sup> Srivastava et al found that almost all the ASHAs were married except two, out of whom one was widow and other one separated.<sup>7</sup> In a study by Jain et al it was reported that 91.7% ASHA were married.<sup>6</sup> Only 1.7% were unmarried.

In present study about 100% ASHAs involved in counselling and escorting of antenatal cases, counselling and escorting of post-natal cases, in motivating and escorting family planning cases, helping in immunization of children. Similarly in a study by Alagarajan et al it was found that accompanying women for delivery, accompanying ANM to attend immunization session were reported by 94-99% ASHA.<sup>8</sup> Swain S et al found that 92.5% ASHAs were accompanying the pregnant women to the hospital, 84% ASHAs were counselling the mothers on PNC and safe delivery, 80% were mobilizing the children for immunization.<sup>9</sup> Whereas in a study by Kanth et al it was noticed that 34% ASHAs involved in facilitating the immunisation of children, 30% accompanied mothers for institutional delivery, 22% in mobilising women for antenatal care.<sup>10</sup>

The performance level in terms of antenatal counselling was found to be 50-75% in 58.5% and up to a level of 75-100% in 41.5% ASHAs whereas in escorting of antenatal cases, it was 75-100% in 64.6% and up to a level of 50-75% in 35.4% of ASHAs. The level of performance was

75-100% in around 60% of the ASHAs in counselling of post-natal cases while in 40% of the ASHAs it was 50-75%. In escorting postnatal cases, the performance was found to be 50-75% in around 63.1% ASHAs while in 36.9% of the ASHAs it was 75-100%.

The performance level of the ASHAs was found to be 75-100% in 75.4% ASHAs and 50-75% in 24.6% ASHAs towards helping in immunization of children. The level of performance was found to be around 50-75% in 66.2% ASHAs while 33.8% ASHAs were having a 75-100% level of performance in motivating cases for family planning services. In escorting family planning cases, 56.9% showed 50-75% level of performance while in 43.1% of the ASHAs it was 75-100%.

Less than 50% of ASHAs were performing activities regarding creating awareness on social determinants of health (32.3%), providing primary medical care for minor ailments (38.5%), informing births and deaths to SC/PHC (35.4%), distributing ORS (41.5%), IFA (43.1%), and chloroquine (46.2%). Whereas in a study by Saxena V et al it was reported that 22% ASHAs involved in health education.<sup>4</sup> Swain S et al had noticed that 87.5% ASHAs involved in distribution of IFA.<sup>9</sup> Informing AWW/ANM on birth and death assumed least priority among the ASHAs. In a study by Joshi et al it was found that 95% ASHAs were providing drugs for minor primary illnesses.<sup>11</sup> Other activities like counselling and arranging community meetings were done by only 8% and 2%, of the ASHAs respectively.

In the present study 91% of ASHAs were performing as DOTS providers. Similarly in a study by Manoj Alagarajan et al it was found that 92 percent in kurnool reported working as DOTS provider.<sup>8</sup> Whereas Santhosh S et al noticed that 48% of the ASHAs under study were DOTS providers.<sup>12</sup>

Thus one may infer that in the present study majority of ASHAs had average level of the performance with regard to certain parameters like counselling of antenatal cases, escorting postnatal cases, motivating cases for family planning adoption, escorting family planning cases whereas the performance level was found to be good among majority of ASHAs with regard to escorting antenatal cases, counselling of postnatal cases and getting children immunized.

Majority of the ASHAs reported that they get essential supply sometimes (43.1%). 36.9% of ASHAs stated that they had no regular replacement of essential supply. Whereas Srivastava DK et al had found that regular replacement of essential supply was found with 65% ASHAs.<sup>7</sup>

Motivating factor for being an ASHA was stated as earning money (56.9%) by majority of the ASHAs followed by absorption in government job (21.5%). Similarly in a study by Srivastava et al it was noticed that

major motivating factor for ASHAs were either money (81.66%) or absorption in government job (66.66%).<sup>7</sup>

Majority of the ASHAs reported that their expectation for better work was better pay (63.1%) and availability of more medicines (20%). Similarly Srivastava et al had noticed that for betterment of work around 83.33% ASHAs expect better pay, 43.33% feels more medicines should be given to them, 23.33% feels better means of transport facilities for the patients.<sup>7</sup>

Main problem faced by ASHAs was reported as lack of literacy in community (41.6%) by majority of them and lack of timely availability of medicines (32.3%) whereas 9.2% of ASHAs reported that they had no problem. Whereas Saxena et al had found that 32.7% of ASHA had no problems during routine work while 32% had transport related problems while rest of them are facing health facility related problems (15.3%) or to get honorarium at time (13.3%).<sup>4</sup>

## CONCLUSION

In the present study about 100% ASHAs involved in counselling and escorting of antenatal cases, counselling and escorting of post-natal cases, in motivating and escorting family planning cases, helping in immunization of children whereas less than 50% of ASHAs were performing other activities. Regular on job training as well as review training for ASHAs every 6 months helps them to increase their participation in various activities with a rejuvenated enthusiasm. The incentives for ASHA must be raised. Measures should be taken to ensure that the honorarium is paid promptly to ASHAs through primary health centres. The medicines in the drug kit provided to ASHAs should be replaced promptly to avoid any time delay in providing early treatment to the needy patients.

## ACKNOWLEDGEMENTS

We acknowledge all the ASHAs who had participated in the study and also the ANMs and AWWs who helped to organize and carry out this study.

*Funding: No funding sources*

*Conflict of interest: None declared*

*Ethical approval: The study was approved by the Institutional Ethics Committee*

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**Cite this article as:** Biyyala R, Moola RSR, Arepalli S. Evaluating the performance of ASHA workers in rural and tribal areas in Kurnool division of Kurnool district, Andhra Pradesh. Int J Community Med Public Health 2019;6:3418-22.