Original Article

Factors influencing the work performance of ASHA under NRHM –A cross sectional study from eastern Uttar Pradesh.

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Abstract:

Research question: What are the factors influencing the work performance of ASHA?

Objectives: To study the factors influencing the work performance of ASHA in community.

Study Design: Descriptive cross sectional study.

Setting: The present study was conducted in the field practice area of Rural Health & Training Centre of Institute of Medical Sciences, Banaras Hindu University, Varanasi.

Participants: One hundred and thirty five ASHAs were included in the present study.

Material and Methods: A cross sectional study was conducted based on a sample of 135 ASHAs working in different areas of Chiraigaon Block of Varanasi district in eastern Uttar Pradesh (UP). ASHAs were interviewed for their functioning and their outcome was correlated. Chi-square test was used to analyze the data.

Results: The study revealed that only 16.3% ASHAs knew about motivating the community for toilet construction. Twenty three percent ASHAs were aware that they should also give medical care for minor ailments. Their less knowledge for content of responsibility significantly affected their practices in community. The practices of the more knowledgeable group were found better than the ignorant one.

Conclusion: Less knowledge of the content of job responsibility, caste, incentive oriented practices and delayed and inadequate payment of incentives for ASHAs influences the work performance.

Key words: ASHA, job responsibility, incentive oriented practices, caste, incentive.

Introduction :

Under National Rural Health Mission a new cadre of community health worker i.e. Accredited Social Health Activist (ASHA) has been created who acts as a health activist in the community. Expected activities from her include creating awareness on health and its determinants, mobilize the community towards local health planning, and increase the utilization of the existing health services etc. Guidelines for selection of ASHA have been issued to the States by the Government of India to ensure that women with required capacity may only be appointed as ASHA. A training of twenty three days divided into four phases has been proposed to enhance the knowledge and skills of ladies identified to work as ASHAs in the community. Curriculum has been developed by the GoI to train her for seven days initially after selection to make her functional in an appropriate manner[1]. As she receives a fixed honorarium as compensation money for the activities performed by her, the timely flow of this money is of great importance for her commitment and motivation and to remain active in the community.

Achievement of the goals envisioned in NRHM to a large extent depends upon the functional efficacy of ASHA as grass root health activist. Her efficacy depends on several factors such as her own cognitive competency (including capacity building), aptitude and attitude, effective relationship with other key health functionaries like Anganwadi Workers, Auxillary Nurse Midwives and staff of the Primary Health Centre, her relationship with functionaries of Panchyat Raj Institution of her area and with the community.

The ASHA scheme was launched in Uttar Pradesh in 2005. With this background, in the present study all the possible factors have been traced out which are either hampering or decelerating the functioning of ASHA.

Methodology:

Study settings: The present cross sectional study was conducted in Chiraigaon Community Development Block of Varanasi, which is the field practice area of Rural Health and Training Center, Department of Community

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Medicine, Institute of Medical Sciences, Banaras Hindu University. Study was conducted between October 2008 to October 2009.

Sample size: Sample size for the proposed study was calculated on the basis of following formula (Sukhatmne, 1997):

$$n = \frac{qz^2 / pd^2}{1 + \frac{1}{N}\left[\frac{qz^2}{pd^2} - 1\right]}$$

Where,

p is prevalence of characteristic under study, q = 1-p, z denote the value of(N) ordinate at specified level of significance. N is population size and d is permissible margin of error in the estimated value .

There were 240 ASHAs in the study area, hence N= 240. Since, the study subjects/population were recently implemented under NRHM, no prior information was available on the prevalence of the characteristic under study, so the probable value of the p is taken as 50. The permissible margin of error in the estimated value was taken as 10% with degree of assurance discussed as 95%. After putting all these values in the above mentioned formula the required sample size came out to be 127.

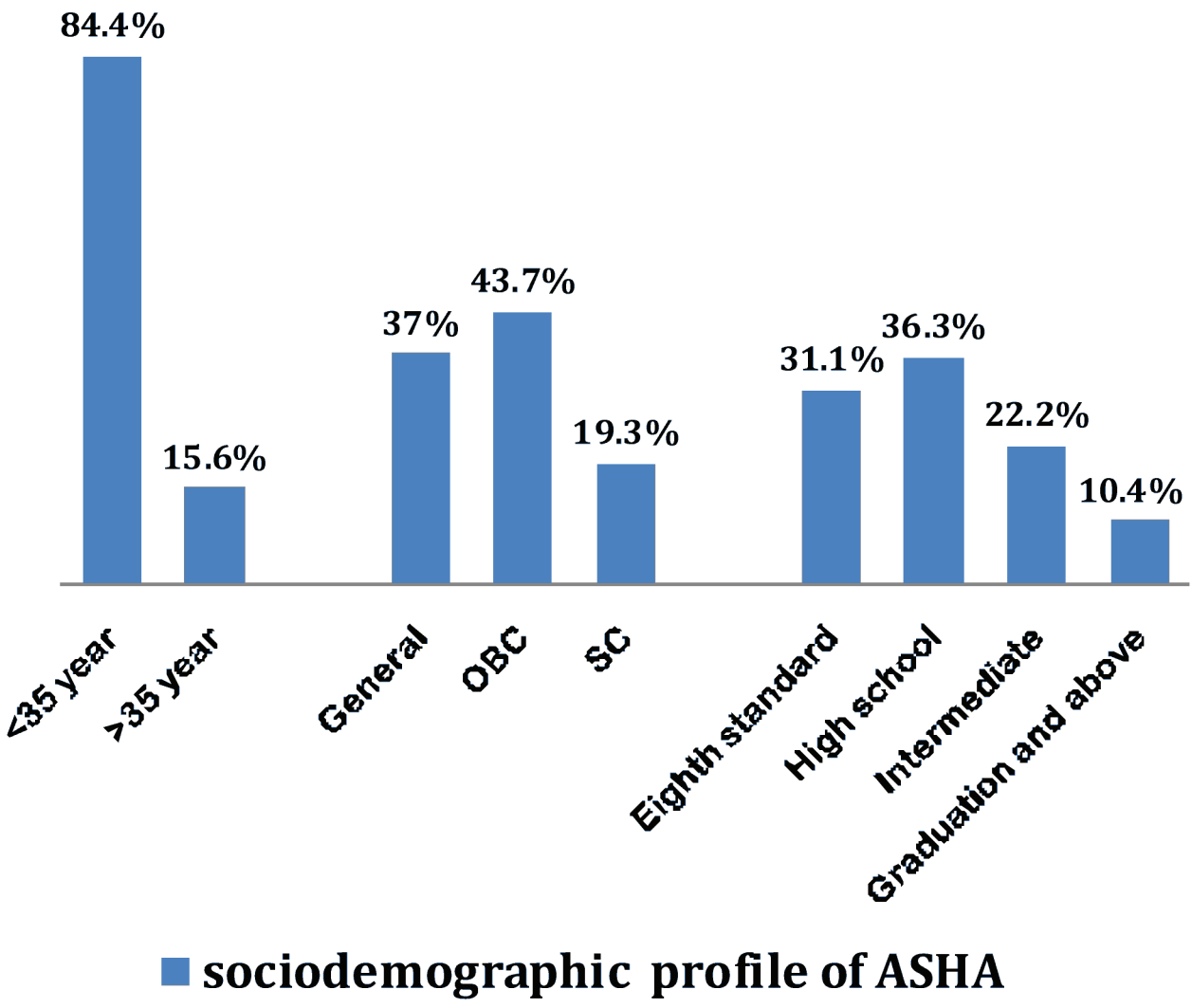
Sampling: Sample area selection comprised of Block Nyayapanchayats with above study subjects. Out of total 14 Nyaya Panchayats in the Block eight were selected randomly for the required sample size. All ASHAs working in these Nyaya Panchayats were selected and the final number came out to be 135. Our analysis is based on this sample size.

Tools of study: For study purpose semi-structured and pre-tested interview schedule was used. The interview schedule consisted of three parts. First part consisted of questions regarding socio-demographic profile of the study subjects like age, caste, educational status and marital status of respondents etc. Second part consisted of questions regarding knowledge of the study subjects about their duties like creating community awareness on determinants of health, counseling pregnant lady on safe delivery, ANC, breastfeeding, contraception etc, working with Village Health and Sanitation Committee to develop a village health plan, mobilizing community to access health services at different facilities, providing Directly Observed Treatment Short course chemotherapy, informing AWW/ ANM about birth and death, visiting new born, accompanying pregnant mother to hospital, promoting for toilet construction in the working area. Third part consisted questions regarding practice of their duties in their respective service areas.

Data collection: Data was collected using a pretested, semi structured interview schedule. Verbal Consent was taken from the subjects before starting the interview by the researchers. Information pertaining to their knowledge regarding various components of their work performance was taken. Chi-square test was used for statistical analysis to find out the association between variables.

Results and discussion: Majority of the ASHAs (84%) were d" 35 of age with most being in the age group of 25-30 years. The mean age was found to be 30.14 years. This finding holds unanimity with the study conducted by Srivastava DK et al[2] (2009) in which more than half of the ASHAs were in the younger age group i.e., between 20-29 years age.

Figure 1



One might presume that the work performance of the ASHA could be affected by her marital status, at least to some extent. However, no question could rise on this issue because all the ASHAs in present study were already married. Srivastava et al[2] and Neeraj Jain et al[3] have also revealed in their study that more than 90 % of the ASHAs were married. According to the distribution of caste majority of the study subjects belonged to the OBC category (43.75) while 37% were from the General category. Only 19.3% were from the SC category. Similar caste composition were studied by Neeraj Jain et al[3] (2008) in UP.

Table: 1

Knowledge affecting the practices of ASHAs (n=135)

Knowledge		Practices			Test of significance
		Yes	No.	Total	
Create community awareness on determinants of health	Yes	29 (61.7)	18 (38.3)	47 (34.8)	χ^2 = 11.2* * *
	No	28 (31.80)	60 (68.20)	88 (65.2)	
Counsel pregnant lady on safe delivery, ANC, breastfeeding, contraception etc.	Yes	92 (92.2)	10 (9.8)	102 (75.6)	χ^2 = 12.8* * *
	No	21 (63.6)	12 (36.40)	33 (24.4)	
Work with VHSC to develop a village health plan	Yes	34 (66.7)	17 (33.3)	51 (37.7)	χ^2 = 10.36* *
	No	32 (38.1)	52 (61.9)	84 (62.3)	
Mobilize community to access health services at different facilities.	Yes	66 (73.3)	24 (26.7)	90 (66.7)	χ^2 = 4.3*
	No	25 (55.6)	20 (44.4)	45 (33.3)	
Directly Observed treatment short course chemotherapy	Yes	85 (78)	24 (22)	109 (80.7)	χ^2 = 4.5*
	No	15 (57.7)	11 (42.3)	26 (19.3)	
Inform AWW/ANM about birth and death	Yes	72 (90)	8 (10)	80 (59.3)	χ^2 = 13.7* * *
	No	33 (63.6)	20 (36.4)	55 (40.7)	
Visiting new born	Yes	68 (81)	16 (19)	84 (62.2)	χ^2 = 0.66
	No	44 (86.3)	7 (13.7)	51 (37.8)	
Accompany pregnant mother to hospital	Yes	130 (98.5)	2 (1.5)	132 (97.8)	Fisher's exact test P=1.00
	No	3 (100)	0 (0)	3 (2.2)	
Promotion for toilet construction	Yes	13 (59.1)	9 (40.9)	22 (16.3)	χ^2 = 20.6* *
	No	17 (15)	96 (85)	113 (83.7)	

Figures in parentheses indicate the percentage (* = Significant (P<0.05), * * = Highly significant (P< 0.01), * * * = Very highly significant (P<0.001) P value is obtained applying Fisher's exact test.

When the depth and accuracy of knowledge and extent of retention after training was checked it was found only 10% of the documented content could have been revived by the respondents without probing during interview. The knowledge of the content of her job responsibility was found very less i.e only (47) 34.8% of the ASHAs knew regarding the component creating community awareness about various health determinants as a part of their job responsibilities and out of these only 29 (61.7%) were creating awareness in the community on the determinants of health. Saraswati Swain et al[4] (2008) have reported this to be 48% in their study. Among the study subjects maximum 132 (97.8%) were aware that they should accompany the pregnant mother to the health facility and even the prevalence of practice was also found to be maximum regarding this component. Knowledge regarding other components like providing DOTS, counseling pregnant lady, mobilizing community to access the health services available at different facilities was revealed to be 80.7%, 75.5%, 66.7% respectively. Least level of knowledge among study subjects was found to be regarding promotion for toilet construction; as much as 113 (83.7%) were not aware about this component. 16.3% ASHAs know about

motivating the community for toilet construction. Similar study conducted by Saraswati Swain et al[4] (2008) where 48% of ASHAs admitted motivation of community for construction of toilets. If the knowledge and comprehension of the component of her job responsibility would be less it's obvious that it will certainly affect the practice. Throughout the process it has been seen that ASHAs didn't have knowledge were practicing but it might be interpreted as malpractice which could not be assessed during the study.

Observations in table (1) are statistically significant ($p<0.001$). Thus, the practices of the knowledgeable group were better than the ignorant one indicating that better knowledge of duties and responsibilities aides in rendering more services. Haider et al[5] (2008) who had documented that only 16.1% of ASHAs were creating awareness on health related issue which is less than that reported in our study.

Table: 2
Practices according to the caste of ASHA (n=135)

Practices		Caste			Test of significance
		Gen (n=50)	OBC (n=59)	SC (n=26)	
Creating community awareness on determinant of health	Yes	24 (48)	23(38.9)	10(38.5)	$\chi^2 = 1.08$
Counseling pregnant lady on safe delivery, ANC, breastfeeding, contraception etc.	Yes	49 (98.00)	49 (83.05)	15 (57.69)	†$\chi^2 = 11.8^{***}$ df=1
Working with VHSC to develop a village health plan	Yes	32 (64.00)	27 (45.76)	7 (26.92)	$\chi^2 = 9.2^{**}$.
Mobilizing community to access health services at different facilities.	Yes	40 (80.00)	41 (69.49)	10 (38.46)	$\chi^2 = 13.6^{**}$
Distributing DOTS	Yes	37 (74.00)	43 (72.88)	20 (76.92)	$\chi^2 = 0.15$
Informing AWW/ANM about birth and death	Yes	44 (88.00)	48 (81.36)	15 (57.69)	$\chi^2 = 9.8^{**}$
Visiting new born	Yes	40 (80.00)	52 (88.14)	20 (76.92)	†$\chi^2 = 1.9$ df=1
Escorting/Accompanying pregnant mother to hospital	Yes	50 (100.00)	57 (96.61)	26 (100.00)	‡Fisher exact P=0.18
Mobilizing cataract patient for operation and post operative care	Yes	25 (50.00)	24 (40.68)	8 (30.77)	$\chi^2 = 2.69$
Promoting toilet construction	Yes	12 (24.00)	15 (25.42)	3 (11.54)	$\chi^2 = 2.35$

Figures in parentheses indicates the percentage ‡ =Fisher's exact test is applied between general and other(OBC and scheduled caste), †= χ^2 test is calculated after clubbing Scheduled caste and OBC, * * = Highly significant (P< 0.01), * * * = Very highly significant (P<0.001)

Table 2 shows that the practices were better in case of ASHAs from the general category followed by OBCs and then SCs. This was found to be statistically significant for their duties of mobilizing the community to access health services (p<0.001), working with the VHSC to develop a village health plan (p<0.007), informing the AWW/ANM about births and deaths in the community (p<0.007), and counseling pregnant ladies for safe delivery (p <0.001).

The reason for inferior practices among lower caste ASHA when traced out by interviewing them was revealed to be discrimination by upper caste people to lower caste ASHA. At beginning study was not conducted among participant, keeping the caste system in mind that it might hindrance in performance of ASHA. In middle of the study we noticed that caste was being the major factor influencing the work performance of ASHA in community. On deep enquiry it was found that all responsibilities of upper caste people used to hired by only upper caste ASHA in community. "Some ASHAs are not working. In our village ASHA does not visit every household as she is a daughter-in-law of upper caste". Statement made by the people under a study done by Dr Neeraj Jain et al[3] (2007-08) in UP. Saraswati Swain et al[4] 2008 conducted similar study revealed that upper caste do not seek their help at the time of need on the pretext of caste.

It seems that most ASHAs are doing incentive oriented practices. The most important activities enumerated by the ASHA were mobilizing the children and mother for immunization (100%), depot holder (99.3%), motivating for sterilization (100%), accompanying of pregnant lady to hospital (98.5%). The activities like motivation for construction of sanitary toilet have assured least (22.2%) priority. Though ASHAs were not given any monthly honorarium for their working, ASHA being a voluntary worker, her sustenance is dependent on incentives earned by her for her respective work. Uttar Pradesh[6] state has approved incentive scheme for ASHAs. It has been observed that ASHAs were performing completely incentive oriented practice. She was performing particular practice which gives her the maximum incentive and rest of her responsibilities remains at lower side irrespective of the importance of that component.

Table 3 Compensation package for ASHA from various practices (n=135)

Sources	Payment received	Payment not received	Payment received (incomplete &delayed)
Escort/Accompany for institutional delivery	120 (88.8)	-	15 (11.2)
Routine Immunization of mother and children	-	90 (66.6)	45 (33.3)
Motivation for sterilization	135 (100)	-	-
Mobilization for cataract operation and post operative care	-	110 (81.4)	25 (18.6)
Directly Observed treatment short course chemotherapy	-	135 (100)	-
Mobilization for vision testing	-	135 (100)	-
New born visit	-	35 (25.9)	100 (74.1)
Pulse polio round	135 (100)	-	-

Figures in parentheses indicates the percentage

The sustenance of the programme depends on motivation of the functionaries and it is well understood that adequate compensation is necessary to keep the worker motivated . Our study revealed that 66.6% of ASHAs had not received any compensation for immunization while the remaining 33.3% complained that the payment they received was less than the defined amount (incomplete) and delayed. This finding is almost similar to the findings of the study conducted by Saraswati Swain et al[4] in 2008 where 62% ASHAs complained that their incentive were delayed and irregular and 66% complained of less amount. None of the ASHAs had received any compensation for DOTS and motivation for vision test. Majority (81.8%) had not received monetary compensation for motivation for cataract operation, till the end of this study. Neeraj Jain et al[3] (2008) concluded in his study that delayed compensation lead to low morale of functionaries and adversely affect the programme. It was a general complaint of three fourth of ASHAs that they are getting the compensation money for new born care are either delayed or less then the prescribed amount. The findings of our study are supported by Saraswati Swain et al[4] where (93.8%) of the ASHAs were not satisfied with the amount of compensation they receive .When ASHAs have been asked that what motivate them to do their working?

Majority of them answered to get absorb into the government job. The findings of our study were in contrast to the study conducted by Saraswati Swain et al[4] (2007-08) where only 16% of ASHAs were motivated because of this reason. Only 30% of ASHAs knew that they are working under some programme called "NRHM" or Mission. Neeraj Jain et al[3] (2007-08) revealed that only 15% of ASHAs had orientation about programe under which they were functioning (NRHM).

Wrong motivational factor, poor knowledge and orientation for the programme may badly influence the working of ASHAs in community in future .The main goal of this study to identify the factor influencing the work performance of ASHAs in community and to project lacunae in the working system so that strategy for the improvement could be made to progress the efficiency of working among ASHAs. Better understanding of the component of her job responsibilities, community awareness regarding her function, positive attitude,capacity building and more compensation would encourage her to do the job with enthusiasm and spirit.

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