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ORIGINAL ARTICLE

A Study on Perception of Training Quality and Problems faced by Accredited Social Health Activist of Vijayapura District, Karnataka

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ABSTRACT

Introduction: Accredited Social Health Activist (ASHA) is the most important cadre in the health sector of India. They serve as the first point contact between the population and health facility. Hence, proper training of ASHAs is an absolute necessary factor for carrying out their assigned activities efficiently. It should also be acknowledged that ASHAs are facing a lot of problems in carrying out their roles and responsibilities. Addressing those problems and providing suitable solutions to them are the need of the hour. **Objectives:** The objectives of the study were to assess the training details of the ASHAs working in Vijayapura district and to know problems faced by them in carrying out their roles and responsibilities. **Methods:** A Cross sectional study was conducted with inclusion of 617 ASHAs. A pre-designed, semi-structured questionnaire was prepared in accordance with the study objectives. The questionnaire was prepared in English and the interview was conducted in Kannada language by explaining them questions one by one. Data were collected by interview technique. **Results:** Details of the training session showed that majority (86.1%) of ASHAs had 23 days of training with (5.2%) of ASHAs opined that the training session was over crowded. About 84.6% of ASHAs said that the teacher was able to explain clearly; with 72.8% of ASHAs informed that content of training was appropriate and 18.5% replied that there was a need of refresher training. The main problem faced by ASHAs was delay in their payments (32%), followed by their expenses incurred are more than the incentives (26%) that they get.

Key words: Accredited Social Health Activists, problems, training quality

INTRODUCTION

The National Rural Health Mission (NRHM) was launched on April 12, 2005, with an objective to provide effective health care to the rural population with emphasis on poor women and children. One of the key components of the NRHM is to provide every village in the country with a trained female community health activist, that is, Accredited Social Health Activist (ASHA).

ASHA is expected to fulfill her role through some major activities in the community.[1-3]

She should conduct house visits for up to 2 h every day, for at least 4 or 5 days a week. ASHA should visit the families living in her allotted area, with first priority being accorded to marginalized families. Home visits are intended for health promotion and preventive care. They are important not only for the services that ASHA provides for reproductive, maternal, newborn, and child health interventions but also for non-communicable diseases, disability, mental health, and also schemes and programs relating to them. Home visits to these households should take place at least once in a month.

She is also expected to accompany a pregnant woman, sick child, or some member of the community needing facility-based care.

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As a member or member secretary of the Village Health, Sanitation and Nutrition Committee (VHSNC), ASHA is expected to help convene the monthly meeting of the VHSNC and provide leadership and guidance to its functioning with the help of elected member of Gram Panchayat, who leads the committee.

ASHAs are required to maintain records which help her in organizing her work and help her to plan better for the health of the people.

The above first three activities relate to facilitation or provision of health care, the fourth aimed at support of other roles.

Training of ASHAs[1,4,5]

The Ministry of Health and Family Welfare, Government of India, has developed a 23-day basic training schedule to provide the necessary knowledge and skills to ASHAs. Periodic retraining is to be held for about 2 days, once in every alternate month at district level for all ASHAs. During this training, interactive sessions are held to help refresh and upgrade their knowledge and skills, troubleshoot problems they are facing, monitor their work and also for keeping up motivation and interest.

Performance-Based Incentives to ASHAs[1,4,5]

ASHA has been instituted as an honorary volunteer and do not receive any salary or honorarium. Her work is so tailored that it does not interfere with her normal livelihood. However, ASHAs are compensated –

- For the duration of her training both in terms of travel allowance and daily allowance
- For participating in the monthly/bimonthly training
- Wherever compensation has been provided for under different national programs for undertaking specific health or other social sector programs with measurable outputs, such tasks should be assigned to ASHAs on priority (i.e., before it is offered to other village volunteers) wherever they are in position
- Other than the above specific programs, a number of key health-related activities and service outcomes are aimed within a village, for example, if she registers pregnant woman, accompanies pregnant woman during delivery to reach institutions, getting the children immunized, etc.

There also provision for non-monetary compensation in the form of recognition, in the local area and awards given at state level meetings for best ASHA worker.

In studies regarding the above the topic, it was shown that many ASHAs (62.5–70%) lack the essential knowledge to perform their jobs to the best of their ability. Not many ASHAs (69–71%) received refresher trainings. Studies showed that majority of ASHAs (85.5–93%) were dissatisfied by their incentives. Many ASHAs (63–69%) in majority states were not actually receiving these minimum amounts in practice.

Results from different studies have shown that activities such as sanitation improvement and new born/child health are often not compensated for. These are received as least importance by ASHAs, whereas, they spend most of their time on and receive most of their incentives from activities related to ANC and delivery. Several ASHAs (57–71%) also reported spending out of their own pockets for travel and related items, especially in rural areas.[3]

Hence, to address the above-mentioned concerns and to throw the light on the current scenario, the study was carried out under two main objectives. Those being,

- To assess the training details of the ASHAs working in Vijayapura district
- To know problems faced by them in carrying out their roles and responsibilities.

The implementation of ASHA program was started in 2005 in Karnataka state and it was implemented in 2008 in Vijayapura district.[4]

Out of 1410 ASHA posts sanctioned for Vijayapura district, 1394 have been filled. All of the appointees have undergone training. During our study period, 1093 ASHAs were working. This study was done for a period of 11 months to assess the details about the training of the ASHAs and to know problems faced by them in carrying out their roles and responsibilities.

METHODS

The current study was carried out prospectively in Karnataka state, India, in the year 2019.

An analytical cross-sectional study was conducted in Vijayapura district for a period of 12 months from January to December 2019. All the ASHAs of three talukas' (Vijayapura, Basavana Bagewadi, and Muddebihal) of Vijayapura district were included for the study.

Inclusion Criteria

The following criteria were included in the study:

1. All the ASHAs working for more than 6 months
2. ASHAs who have undergone training.

Exclusion Criteria

The following criteria were excluded from the study:

1. Newly recruited ASHAs (<6 months)
2. ASHAs who do not give their consent.

Official permission was obtained from District Heath Officer, Vijayapura. Details of ASHAs working in the above three

taluks were obtained from District Health Office, Vijayapura. Along with that, information of ASHA facilitator and the details of all the medical officers and their PHCs of the study area were obtained. Two hundred and forty-eight ASHAs are working under 15 PHCs in Vijayapura taluk, 223 ASHAs are working under 14 PHCs in Basavana Bagewadi taluk, and 186 ASHAs are working under 10 PHCs in Muddebihal taluk. Hence, a total of 617 ASHAs were included in the study.

A pre-designed, semi-structured questionnaire was prepared in accordance with the study objectives. The questionnaire was prepared in English and the interview was conducted in Kannada language by explaining them questions one by one.

A pre-set date was designated with the prior permission of the medical officer. After obtaining his/her permission, ASHA facilitator was informed to mobilize the ASHAs from nearby 4 to 5 surrounding PHCs to a PHC which was decided as the center for data collection. A preliminary self-introduction to every subject, orientation about the study, purpose of the study, and manner in which it will be carried out was explained to them.

Data collection was done by interview technique. It included a questionnaire-based oral interview. The interview was conducted by the investigator after taking oral consent of the study subjects at the PHC. Face-to-face interviews were carried out in Kannada, explaining them each question in detail and making sure they understand every bit of it. Once, all the ASHAs finished the question, and then, the next question was taken up in the interview.

Graphical representations were made wherever necessary. Data were analyzed using SPSS software version 21. Statistical used is mean, proportions and percentages, and Chi-square test.

RESULTS

Table 1 represents sociodemographic profile of ASHAs who were studied. Out of 617 study subjects, maximum number of them were from the age group 30 to 39 (52.4%) followed by the age group of 20–29 (47%). The mean age of the study subjects in the given study was 30.67 ± 4.65. Majority of ASHAs were married (68.6%) and nearly 32% were either separated or widowed. About 86.5% of ASHAs were high school educated. About 95.8% ASHAs were Hindus, with monthly income <5000 (74.4%).

Details of the training session showed that majority (86.1%) of ASHAs had 23 days of training with (5.2%) of ASHAs opined that the training session was over crowded. About 84.6% of ASHAs said that the teacher was able to explain clearly; with 72.8% of ASHAs informed that content of

Table 1: Sociodemographic profile of ASHA

Variables	Frequency	Percent
Age profile of ASHAs mean age – 30.67 S.D: ±4.65		
20–29	290	47.0
30–39	323	52.4
40–49	4	0.6
Marital status of ASHAs		
Married	423	68.6
Widowed	76	12.3
Separated	118	19.1
Educational status		
High school	534	86.5
College	83	13.5
Religion		
Hindu	591	95.8
Muslim	18	2.9
Others	8	1.3
Monthly income		
<5000	459	74.4
≈5000.00	107	17.3
>5000	51	8.3
Husbands occupation		
Farmer	308	72.8
Daily wage worker	73	17.2
Unemployed	42	10
Family type		
Nuclear	482	78.1
Joint	135	21.9
Does the ASHA work for same village		
Yes	494	80.1
No	123	19.9
Duration of service		
<5 years	257	41.6
>5 years	360	58.4

ASHA: Accredited Social Health Activist

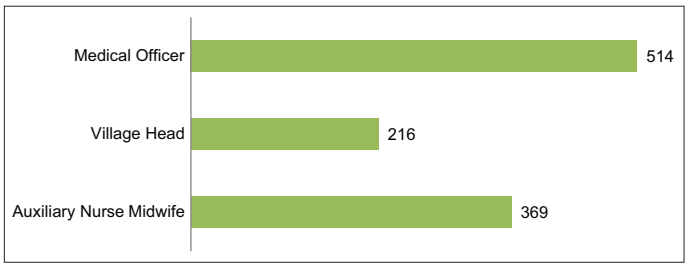

Figure 1: Person to whom Accredited Social Health Activists report their delay in payments?

training was appropriate and 18.5% replied that there was a need of refresher training. Majority of ASHAs 79.1% told that they got adequate facilities for accommodation and food during training and 17.8% of ASHAs told that

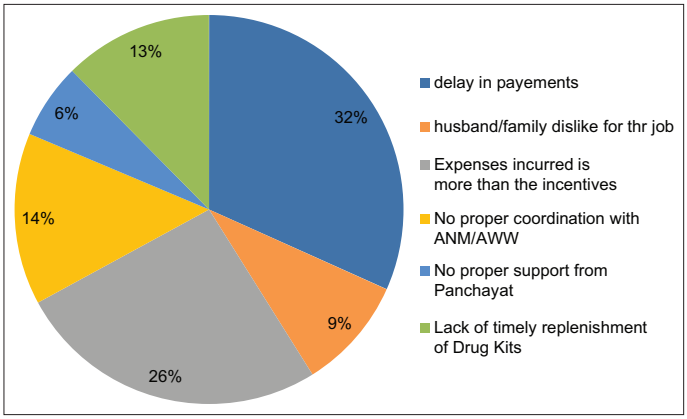

Figure 2: Problems faced by Accredited Social Health Activists

Table 2: Training duration, perception of quality of training

Variables	Frequency	Percent
Days of training		
17	86	13.9
23	531	86.1
Do you think it was overcrowded?		
Yes	32	5.2
No	585	94.8
Was the teacher able to explain clearly?		
Yes	522	84.6
No	95	15.4
Content of training		
Inadequate	46	7.5
Appropriate	449	72.8
Excessive	8	1.3
Need refresher training	114	18.5
Did you get adequate facilities for accommodation and food during training?		
Yes	488	79.1
No	129	20.9
Did you receive any compensation for attending the training?		
Yes	507	82.2
No	110	17.8

Table 3: Details regarding payments and difficulties faced by ASHAs (*n*=617)

Variables	*n*	%
ASHAs who told that there is a delay in their payments?	471	67.5
ASHAs who told that they have a bank account	604	97.8
ASHAs who opined that they are happy with their incentives?	104	16.8
ASHAs who replied that they want monthly salary?	617	100

ASHA: Accredited Social Health Activist

they did not receive any compensation for attending the training [Table 2].

Regarding payments to ASHAs, 471 (67.5%) ASHAs reported delay in their incentives. Six hundred and four (97.8%) ASHAs said that they have their own bank account. Only 104 (16.8%) of ASHAs told that they were happy with their incentives and all the ASHAs told that they would prefer monthly salary instead of performance-based incentives. Majority of ASHAs, 514 (83%) reported the delay in their payments to the medical officer of the PHC under which they serve [Figure 1].

Problems Faced by ASHAs

The main problem faced by ASHAs was delay in their payments (32%) followed by their expenses incurred are more than the incentives (26%) that they get [Figure 2].

DISCUSSION

About 83.3% of ASHAs in our study reported that were not happy and satisfied with their incentives and expressed need for fixed salary on a monthly basis. These findings were roughly similar to a study done by Mony *et al*.[6] where majority of ASHAs wanted better incentives for the services that they were giving.

About 67.5% of the ASHAs in the current study told that there is delay in their payments and most of them report to medical officer in-charge followed by ANMs. This observation was also made by Smitha[7] where nearly 70% of ASHAs reported the delay and cited as non-availability of funds from the government as the reason for the delay [Table 3].

A study by MKCGMC[8] showed that roughly 40% of the ASHAs got payments within 1 week, another 40% got it between a week and a month, and the remaining 20%, and it took over a month to avail of the cash benefit.

In the current study, 32 (5.2%) ASHAs reported that they are asked for a cut from their incentives by medical officer/ANMs. Similar findings were found in a study by Swain *et al*.[9] where an ASHA reported that the doctor demands Rs. 200 for each delivery case that she accompanies and if she denies paying, he refuses to put his signature in JSY card. Whereas another ASHA reported that Dai demands Rs. 50, ANM Rs. 100, and even the doctor demands money at the time of delivery and if it is a male child, beneficiary is forced to fulfill their demand.

These findings are of concern and to be addressed by district health administration for transparent functioning of ASHAs.

In the current study, the main problem faced by ASHAs was delay in their payments. Four hundred and seventy-one (32%) ASHAs reported the same. This finding was similar to a study done by MKCGMC *et al*.[8] and Sharma *et al*.[10]

Other problems include, expenses incurred more than incentives, non-cooperation by ANM/AWW, and no proper support from panchayat. These results were consistent in a study conducted by Kumar and Kaushik[11] and Mony *et al*.[12]

CONCLUSION

On the whole, the study depicts the findings pertaining to the difficulties faced by ASHAs on a day-to-day basis in their professional life. This domain seems to be neglected and undermined by the government.

Even though reaching out to the ASHAs in remote areas was a tedious task, extra measures were taken to complete the interview. The findings of the study were then submitted to the government for suitable consideration for improving the working conditions of the ASHAs.

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