



Full Length Research Article

ASSESSMENT OF KNOWLEDGE OF ACCREDITED SOCIAL HEALTH ACTIVISTS (ASHA) REGARDING THEIR ROLES AND RESPONSIBILITIES UNDER NRHM IN RURAL KARNATAKA

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ABSTRACT

Introduction: A new initiative in the Indian health care system by introducing Accredited Social Health Activist (ASHA) workers under the National Rural Health Mission (NRHM) made a remarkable impact in utilization of healthcare services at the peripheral level. This study was conducted with the objective to assess the knowledge of ASHA workers on their roles and responsibilities as an ASHA worker.

Methods: A cross-sectional study was conducted between April and July 2014 at Mysore district, Karnataka. Using Multistage random sampling technique, 216 ASHA workers in three Taluks were included in the study and their knowledge was assessed using a self-administered pre tested structured questionnaire translated in the regional language (Kannada).

Results: Among 216 ASHA workers who participated in the study 115(53.2%) were in the age group of 31 to 40 years and majority 167(77.3%) had studied up-to high school. Among the study participants majority, 94.9 % had a knowledge about diarrhoea, few 38.8% had knowledge on neonatal care, 176(81.5%) had a good knowledge on their roles and responsibilities as an ASHA worker

Conclusion: Despite the training given to ASHAs, lacunae still exists in their knowledge about their roles and responsibilities under NRHM. Monthly meeting and frequent refresher training can be used as an effective tool to improve their knowledge.

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INTRODUCTION

The Government of India launched the National Rural Health Mission (NRHM) on 12th April 2005, to provide accessible, accountable, affordable, effective and reliable primary health care, especially to the poor and vulnerable sections of the population (http://www.mohfw.nic.in/NRHM/Documents/Mission_Document.pdf and www.cortindia.com/RP/RP-2007-0301.pdf). One of the main core strategy suggested under the NRHM was the creation of the much touted Accredited Social Health Activists (ASHA) to strengthen the decentralized village and district level health planning and management and to promote access to improved health care at household level through ASHA (http://www.mohfw.nic.in/NRHM/Documents/Mission_Document.pdf). The Ministry of Health & Family Welfare (MOHFW) has developed a basic training schedule to provide the necessary knowledge and skills to women identified as ASHAs and there are also regular re-orientation trainings organized at the district levels. Separate curriculum and the modules are made available in providing training to the ASHAs (ASHA, 2005).

The induction training and the regular orientation trainings are required to enhance her knowledge and practical skills regarding her job responsibilities. Thus, an assessment of the information that ASHA workers have retained from the training must be performed to know the needs for further training and reorientation.

Objectives

1. To assess the knowledge of ASHA workers on their roles and responsibilities.
2. To describe the factors influencing the knowledge of ASHA workers on their roles and responsibilities.

MATERIALS AND METHODS

A cross-sectional study was carried out at 20 Primary Health Centres in Mysore district during 2014 (April-July) among ASHA workers. The ASHA workers trained and working under NRHM for more than one year and consenting to participate in the study were the study participants. Assuming the average performance of ASHA as 50%, (i.e. ASHA having the positive character) (Government of India, 2005). The sample size was calculated by using the following formula, $n = Z^2 pq / L^2$ Where, Z= Standard normal variate for 95% confidence interval=1.96, p = Percentage of ASHAs having the positive character =0.5, q = (1-p) = 1-0.5 = 0.5, L = Allowable error,

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considering an allowable error of 10% (i.e. 0.1), $n \approx 100$. A design effect of 2 and 10% cases as non-respondents were taken. Thereby, a total sample size of 220 was calculated. Multistage random sampling technique was used. In Mysore District out of seven taluks, three taluks were selected by simple random sampling. Complete remuneration of the number of ASHAs in the selected taluks was obtained from the district health authority (District ASHA Mentor). From a strength of 225, 191 and 162 ASHA workers in Nanjanagud, K.R. Nagara and Periyapatna, 96, 67 and 57 were included respectively in the study using probability proportionate to size sampling method. Then, the complete list of PHC's in the area were obtained from the District health and family welfare office and the PHC's were selected by simple random sampling. All ASHA workers were included from the selected PHC's until saturation was attained. Out of 225 ASHA workers selected for study, nine of them declined to participate in the study, thereby 216 ASHA workers participated in the study. The purpose of the study was explained and written consent obtained from the participants. The data was collected regarding their Socio demographic profile and the knowledge of ASHA workers on their roles and responsibilities using a self-administered pretested structured questionnaire translated in the regional language (Kannada). Ten questions to assess the knowledge of ASHA worker were given and each correct answer was awarded a score of one and a zero for every wrong answer. Then, the sum of all the scores were taken for a total of 10 and they were arbitrarily classified as good for a score more than 6, fair between 4 to 6 and as poor when less than 4.

Statistical analysis

Data was entered in to Microsoft Excel sheet and analyzed using SPSS-22.0. Socio demographic characteristics and knowledge were analyzed using descriptive statistics like proportions and percentages. The factors influencing the knowledge and awareness of ASHA workers on their roles and responsibilities were analyzed by using chi-square test. The level of significance was fixed at 0.05.

RESULTS

Among 216 ASHA workers who participated in the study 115(53.2%) were in the age group of 31 to 40 years, with a mean age of 33 years and majority 167(77.3%) had studied up-to high school and few 21(9.7%) had studied up-to middle school. Among the study participants, 161(74.5%) were housewives, 135(62.5%) belonged to nuclear family, 196(90.7%) were married and a few 19(8.8%) were widows. Majority 210(97.2%) were Hindu by religion belonged to OBC caste 114(52.8%) and a few 8 (3.7%) belonged to ST caste. According to the modified B.G. Prasad socio economic classification, majority 196(90.7%) belonged to class V socio economic status (Table 1). Among the study participants majority 94.9 %, 91.1% and 91.1% had a knowledge about diarrhoea, HIV/AIDS and Health insurance and only 38.8% and 58.8 % had a knowledge on neonatal care and breast feeding respectively (Figure 1). Among the study participant majority 176(81.5%) had a good knowledge of their roles and responsibilities as an ASHA worker and only 2(0.9%) had a poor knowledge regarding the same (Table 2). Among the variables studied for the association of factors influencing the knowledge of ASHA workers taluk, refresher training, performance based on post-natal visits, participation in village health and nutrition day and participation in village health and sanitation committee meeting were found to be significantly associated ($p < 0.05$) (Table 3).

DISCUSSION

In this study 176(81.5%) had a good knowledge of their roles and responsibilities as an ASHA worker and only few 2(0.9%) had a poor knowledge regarding the same. A study from Bhagwan Waskel *et al.* (2014) in Madhya Pradesh observed that, a large proportion of

Table 1. Distribution of ASHA workers based on their socio-demographic profile (n=216)

Variables	Frequency	Percentage
Age group in years		
<30	81	37.5
31-40	115	53.2
41-50	20	9.3
Total	216	100
Education		
Middle School	21	9.7
High School	167	77.3
Pre University	26	12
Degree	2	0.9
Total	216	100
Occupation		
House wife	161	74.5
Coolie	26	12
Agriculture	13	6
Tailor	10	4.6
Social work	6	2.8
Total	216	100
Type of family		
Nuclear	135	62.5
Joint	27	12.5
Three generation	54	25
Total	216	100
Marital status		
Married	196	90.7
Divorced	1	0.5
Widow	19	8.8
Total	216	100
Religion		
Hindu	210	97.2
Muslim	6	2.8
Total	216	100
Caste		
OBC	114	52.8
SC	94	43.5
ST	8	3.7
Total	216	100
Socio economic status		
Category III	1	0.5
Category IV	19	8.8
Category V	196	90.7
Total	216	100

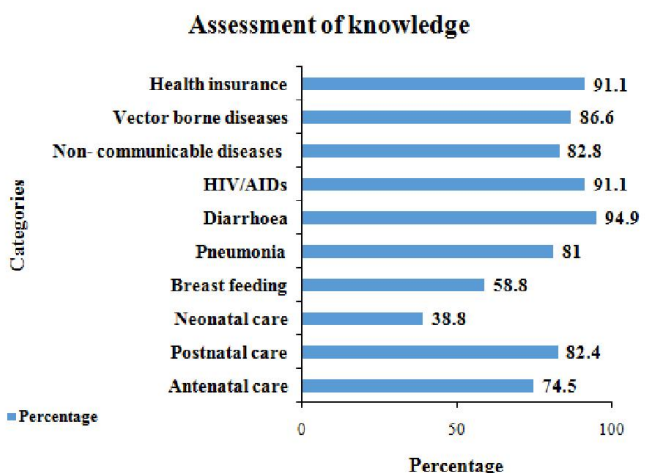


Figure 1. Distribution of ASHA workers based on their knowledge of their roles and responsibilities (n=216)

Table 2. Distribution of ASHA workers based on their Knowledge score

Knowledge status	Frequency	Percentage
Good	176	81.5
Fair	38	17.6
Poor	2	0.9
Total	216	100

Table 3. Association of factors influencing the knowledge of ASHA worker

	Knowledge			Chi square test	p value
	Poor	Fair	Good		
Taluk					
Nanjangud	0(0)	7(18.4)	84(47.7)	12.786	0.02*
K.R. Nagara	1(50.0)	18(47.4)	49(27.8)		
Periyapatna	1(50.0)	13(34.2)	43(24.4)		
Total	2(100)	38(100)	176(100)		
Age group in years					
<30	0(0)	10(26.3)	71(40.3)	4.412	0.358*
31-40	2(100)	24(63.2)	89(50.6)		
41-50	0(0)	4(10.5)	16(9.1)		
Total	2(100)	38(100)	176(100)		
Education					
Primary school	0(0)	8(21.1)	13(7.4)	8.922	0.157*
High school	2(100)	28(73.7)	137(77.8)		
PUC	0(0)	2(5.3)	24(13.6)		
Degree	0(0)	0(0)	2(1.1)		
Total	2(100)	38(100)	176(100)		
Refresher training					
Required	2(100)	29(76.3)	160(90.9)	6.767	0.048*
Not required	0(0)	9(23.7)	25(11.6)		
Total	2(100)	38(100)	176(100)		
Performance based on post-natal visits					
Well performing	1(50.0)	29(76.3)	99(56.3)	5.310	0.039*
Under performing	1(50.0)	9(23.7)	77(43.8)		
Total	2(100)	38(100)	176(100)		
Participation in village health and nutrition day					
Well performing	1(50.0)	14(36.8)	32(18.2)	7.338	0.016*
Under performing	1(50.0)	24(63.2)	144(81.8)		
Total	2(100)	38(100)	176(100)		
Participation in VHSC meeting					
Well performing	2(100)	28(73.7)	63(35.8)	20.969	0.001*
Under performing	0(0)	10(26.3)	113(64.2)		
Total	2(100)	38(100)	176(100)		

*Fischer's exact test

Note: Numbers in parenthesis indicate percentages

ASHAs had good knowledge about pneumonia i.e.164 (79.69%) and an average knowledge about ANC i.e. 136(66.02%). In comparison, our study shows that 81% had a knowledge about pneumonia and 74.5% about ANC care, which is slightly more compared to the above study. A study by Roy *et al.* (2013) found that, ASHA workers have adequate knowledge of their duties in the antenatal, intranatal and post-natal stages of a pregnancy. A study by Mahyavanshi *et al.* (2011) showed that 82.31% knew the importance of immediate breast feeding, within half an hour of normal delivery, nearly 86% had poor knowledge of problems regarding breast feeding and around 50% knew the causes of diarrhoea. In contrast to these, this study showed that 58.85% had a knowledge regarding breast feeding which is lesser comparatively and 94.9% had knowledge regarding diarrhoea which is higher compared to the others. Mahyavanshi *et al.* (2011) study revealed that, nearly 80% had poor knowledge regarding neonatal infection, majority 86.16% of ASHA workers had poor knowledge regarding referral condition and when and where to refer the baby. In our study 61.8% ASHA workers had a poor knowledge about neonatal care, but on HIV/AIDS (91.1%), Non-communicable diseases (82.8%) and health insurance (91.1%) they had a good knowledge. In the present study it was observed that factors like regional distribution, refresher training requirement, performance based on post-natal visits, participation in village health and nutrition day and participation in village health and sanitation committee meeting were found to be significantly associated with knowledge of ASHA worker.

Conclusion

Among the study participants majority 176(81.5%) had a good knowledge of their roles and responsibilities as an ASHA worker and only few 2(0.9%) had a poor knowledge regarding the same. Taluk, refresher training, and performance based on post-natal visits, participation in village health and nutrition day, participation in village health and sanitation committee meeting were found to be significantly associated with the knowledge of ASHA workers.

Limitations

1. Prior contamination of data cannot be assessed due to spill over of information from neighbouring study participants.
2. Hawthorne effect cannot be ruled out.

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