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A study on perception of training quality and problems faced by Ashas of Vijyapura district, Karnataka

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Abstract
Introduction: One of the key components of the NRHM is to provide every village in the country with a trained female community health activist i.e. Accredited Social Health Activist (ASHA). ASHA is a health activist in the community, who will create awareness on health and its determinants and mobilize the community towards local health planning and increased utilization and accountability of the existing health services.
Objectives: To assess the training details of the ASHAs working in Vijayapur District and to know problems faced by them in carrying out their roles and responsibilities.
Methods: A cross-sectional study on 617 ASHAs of Vijayapur district. 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 collection was done 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 were delay in their payments (32%), followed by their Expenses incurred is more than the incentives (26%) that they get.

Keywords: ASHAs, role perceptions, difficulties

Introduction
The National Rural Health Mission (NRHM) was launched on 12th April 2005 with an objective to provide effective health care to the rural population with emphasis on poor women & children. One of the key components of the NRHM is to provide every village in the country with a trained female community health activist i.e. Accredited Social Health Activist (ASHA). ASHA is a health activist in the community, who will create awareness on health and its determinants and mobilize the community towards local health planning and increased utilization and accountability of the existing health services.

ASHA is expected to fulfil her role through 5 major activities in the community [1, 4].

1. **Home visits:** For up to 2 hrs every day, for at least four or five 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, new born and child health interventions, but also for non-communicable diseases, disability, mental health and also schemes and programmes relating to them. The ASHA should prioritize homes where there is a pregnant woman, new born, child below two years of age, or a malnourished child. Home visits to these households should take place at least once in a month. Where there is a new born in the house, a series of six visits or more becomes essential.
2. **Attending village health and nutrition day (VHND):** The ASHA should promote attendance at the monthly Village Health and Nutrition Day by those who need Anganawadi or Auxiliary Nurse Midwife (ANM) services and help with counselling, health education and access to services.

3. **Visits to the health facility:** This usually involves accompanying a pregnant woman, sick child, or some member of the community needing facility-based care. ASHA is expected to attend the monthly review meeting held at the PHC.
4. **Holding village level meeting:** 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.
5. **Maintain records:** Maintaining 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 healthcare, the fourth aimed is mobilization and fifth is supportive of other roles.

Training of ASHAs [1, 3, 5].

The Ministry of Health & Family Welfare (MOHFW), Government of India has developed a 23-day basic training schedule to provide the necessary knowledge & skills to ASHAs. Periodic re-training is to be held for about two 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, trouble shoot problems they are facing, monitor their work and also for keeping up motivation and interest.

Performance based incentives to ASHAs [1, 3, 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/bi- monthly training.
- Wherever compensation has been provided for under different national programmes for undertaking specific health or other social sector programmes 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 programmes, 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 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 [4].

The implementation of ASHA programme was started in 2005 in Karnataka state and it was implemented in 2008 in Vijayapur District [3].

Out of 1410 ASHA posts sanctioned for Vijayapur district, 1394 have been filled. All of the appointees have undergone training. During our study period, 1093 ASHA's 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.

Aims and Objectives

1. To assess the training details of the ASHAs working in Vijayapur District.
2. To know problems faced by them in carrying out their roles and responsibilities

Materials and Methods

The current study was carried out in Karnataka state, India.

Study design: Cross sectional study

Study area: Vijayapur District

Total study period: 12 months

Study subjects: All the ASHAs of 3 taluks' (Vijayapur, Basavana Bagewadi and Muddebihal) of Vijayapur district.

Inclusion criteria

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

Exclusion criteria

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

Official permission was obtained from District Heath Officer, Vijayapur. Details of ASHA's working in the above three taluks were obtained from District Health Office, Vijayapur. Along with that, information of ASHA facilitator and the details of all the Medical Officers and their PHC's of the study area were obtained. 248 ASHA's are working under 15 PHC's in Vijayapur taluk, 223 ASHA's are working under 14 PHC's in Basavana Bagewadi taluk and 186 ASHAs are working under 10PHCs in Muddebihal taluk. So, a total of 617 ASHA's 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 mobilise the ASHAs from nearby 4-5 surrounding PHCs to a PHC which was decided as the centre 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 was 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.

All responses were tabulated by the investigator using Microsoft Excel 2007 software. Graphical representations were made wherever necessary. Data was analysed by using SPSS software version 21. Statistical used are Mean, Proportions and percentages and Chi- square test

Results

Table 1: Socio-demographic profile of ASHA

		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%

Above table represents socio-demographic profile of ASHAs who were studied. Out of 617 study subjects, maximum number of them were from the age group 30-39 (52.4%), followed by the age group 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. 95.8% ASHAs were Hindus, with monthly income less than 5000 (74.4%). Most of the ASHAs (78.1%) revealed that they come from nuclear family and work for the same village in which they were residing (80.1%).

Table 2: Training duration, perception of quality of training

		Frequency	Percent
Days of training	17	86	13.9
	23	531	86.1
Do you think it was over crowded?	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

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. Majority of ASHAs 79.1% told that they got adequate facilities for accommodation and food during training and 17.8% of ASHAs told that they did not receive any compensation for attending the training.

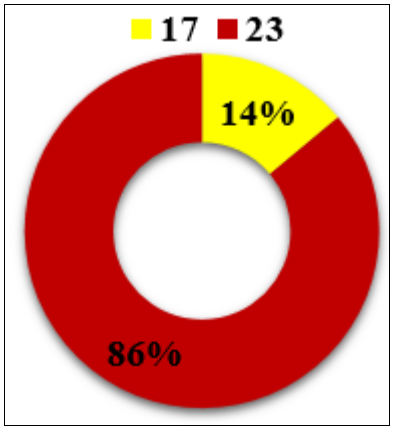

Fig 1: Day training

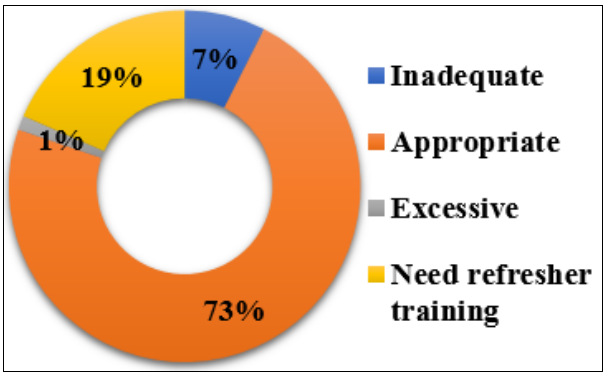

Fig 2: Content of training

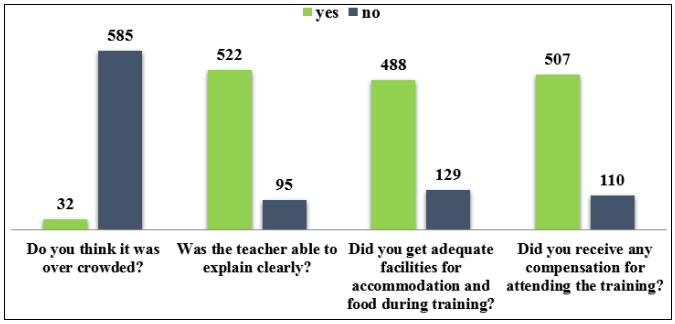

Fig 3: Perception of training

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

	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%

Regarding payments to ASHAs, 471 (67.5%) ASHAs reported delay in their incentives. 604 (97.8%) ASHAs said 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.

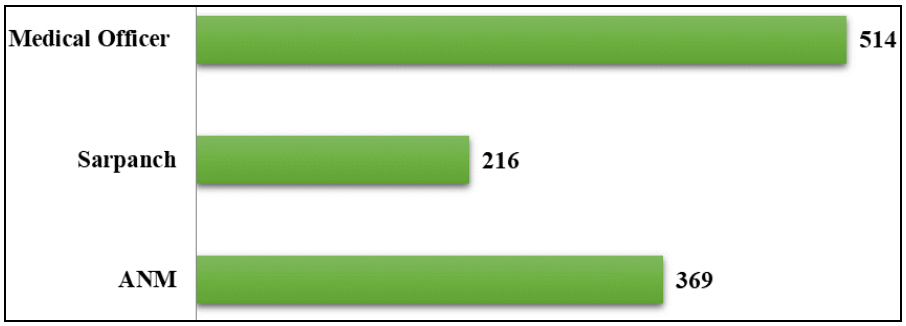

Fig 4: Person to whom ASHAs report their delay in payments?

Problems faced by ASHAs

The main problem faced by ASHAs were delay in their payments (32%), followed by their Expenses incurred is more than the incentives (26%) that they get.

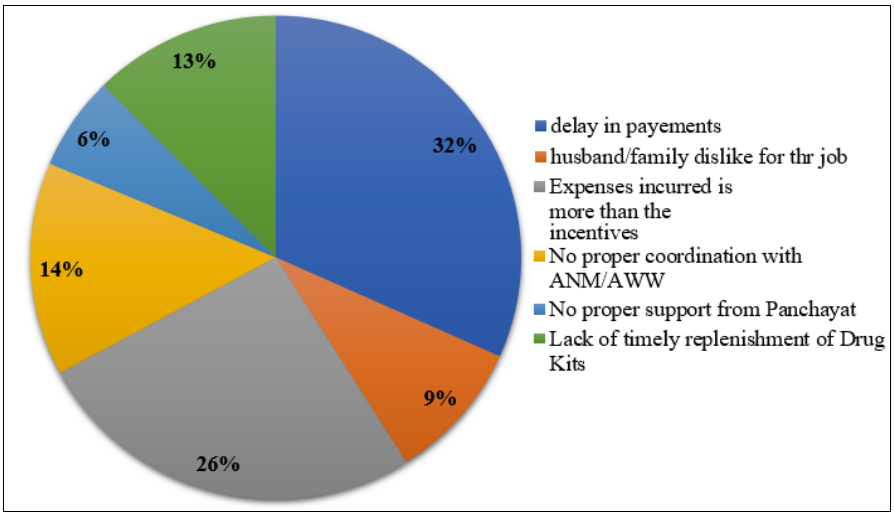

Fig 5: Problems faced by ASHAs

Discussion

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.

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 Dr Smitha P.K [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.

A study by MKCGMC [8] showed that roughly 40% of the ASHAs got payments within one 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 Dr. Sarawati Swain *et al*. [9] where an ASHA reported that the Doctor demands Rs. 200 for each delivery case that she accompanies and if she deny 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 fulfil 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. 471 (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 P.B *et al*., [11] and Mony *et al*., [12].

Conclusion

On the whole, work satisfaction amongst ASHAs was compromised. Refresher training at regular interval should be imparted at PHC, Block and district level on specific topics.

The entire compensation received by ASHAs per month is very low which is quite inadequate for their sustenance. Compensation for ASHAs should be suitably increased. Payment should be done at the work site without any delay through cheque. Possibility of making direct release of money up to PHC level should be explored by the government.

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