Original Article
ASHAS' AWARENESS & PERCEPTIONS ABOUT THEIR ROLES & RESPONSIBILITIES : A STUDY FROM RURAL WARDHA

SV GOSAVI*, AV RAUT**, PR DESHMUKH***, AM MEHENDALE****, BS GARG*****

ABSTRACT

Introduction : The National Rural Health Mission (NRHM) was launched on 12th April 2005; one of the key components of the NRHM is to provide every village in the country with a trained female community health activist - 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.

Objective : to study the awareness and perceptions of ASHA regarding their role in health care provision & to study the problems faced by ASHA.

Study Area & Methodology : The study was undertaken in selected villages of Primary Health Centre, Anji, district Wardha in Maharashtra. Purposive sampling method was adopted. 7 in-depth interviews carried out before saturation of responses observed. Study period : 1 Nov 2009 to 31 Dec 2009.

Results : Most of the ASHA were aware about their responsibility regarding ANC, immunization, tuberculosis, leprosy, malaria, high risk pregnancy but none of the ASHA were having specific information on schedule of immunization, how to detect TB & leprosy cases. Almost all were aware that they would be getting performance based incentive but none of them were aware about how much incentives they will exactly get while doing that particular work. Challenges faced by most of the ASHA were lack of support from PHC staff, the lack of good training, unclear reimbursement policy & poor clarity in how to collaborate work with the ANM and Anganwadi worker.

Conclusion : Though the NRHM focuses on reducing the maternal & child mortality & morbidity, creation of functional infrastructures & up gradation of services. We found out that the public health machinery is not successful in generating awareness and creating a cadre of functional frontline workers in the form of ASHA. ANC services at the village level were affected because of lack of participation of ASHA in village health & nutrition day (VHND) & because of lack of clarity in their roles in health care provision.

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Introduction:

Since the role of the community health worker was re-emphasized during the Alma Ata conference in 1978, there have been several variations and definitions of this term. Globally, they are called by a variety of names including Health Auxiliaries, Barefoot Doctors, Health Agents, Health Promoters, Family Welfare Educators, Health Volunteers, Village Health Workers, Community Health Aides, Community Health Volunteers and Community Health Workers. With the varying demands and differing levels of health within countries, regions, districts, and villages, each community has its own version of the community health worker.

According to WHO, "CHWs are men and women chosen by the community, and trained to deal with the health problems of individuals and the community, and to work in close relationship with the health services. They should have had a level of primary education that enables to read, write and do simple mathematical calculations" (WHO 1990).  

Witmer et al (1995) define community health workers as “Community members who work almost exclusively in community settings and who serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked access to adequate care. By identifying community problems, developing innovative solutions, and translating them into practice, community health workers can respond creatively to local needs”.  

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. The ASHA is expected to be an interface between the community and the public health system. NRHM is envisaged as a horizontal program with emphasis on initiatives and planning at local level. ASHA being the grass root level worker the success of NRHM depends on how efficiently is ASHA able to perform but the efficiency of ASHA or efficiency of performance of ASHA depends on their awareness & perception about their roles & responsibilities in health care provision. Hence, this study was conducted with following objective.
Objective:
1. To study the awareness and perceptions of ASHA regarding their role in health care provision
2. To study the problems faced by ASHA

Methodology:
Study area: The study was undertaken in selected villages of Primary Health Centre, Anji of district Wardha in Maharashtra. There are 28 villages under the Primary Health Centre, Anji. Based on the population of the respective villages and the norm of selecting an ASHA for approximately 1000 population, 67 ASHA have been selected in these 28 villages. Some of these ASHA had undergone the initial induction training of 7 days while the others were due for the training from the District health system. Information on this was sought from the primary health centre Anji and only those villages. Wherein the ASHA had undergone the induction training was purposively selected for the study purpose.

Methodology and sample size:
Purposive sampling method was adopted. We carried out in-depth interviews among such purposively selected ASHA till redundancy in responses started creeping up. In all, 7 in-depth interviews were carried out before saturation of responses was observed.

Data collection:
A written informed consent was taken from the ASHA; average time required for each in-depth interview was approximately 1 hour & 45 min, data collection was done by investigator himself. A semi-structured schedule with open ended questions was used for data collection process.

Study period: 1 Nov 2009 to 31 Dec 2009

Results:
1. AWARENESS
2. PERCEIVED ROLES OR RESPONSIBILITIES
3. CHALLENGES FACED BY ASHA:
1. AWARENESS:

Table 1. AWARENESS OF ASHA ABOUT THEIR ROLE & RESPONSIBILITIES

<table>
<thead>
<tr>
<th>AWARENESS</th>
<th>ASHA 1</th>
<th>ASHA 2</th>
<th>ASHA 3</th>
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<th>ASHA 5</th>
<th>ASHA 6</th>
<th>ASHA 7</th>
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<tbody>
<tr>
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<tr>
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<tr>
<td>INTEGRATED COUNSELING &amp; TESTING CENTRE (ICTC)</td>
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Most of the ASHA's were not aware about Village Health Nutrition and Sanitation Committee (VHNSC), some had heard about it but they also did not know regarding the composition, functions of VHNSC and what exact role the VHNSC was expected to play in making the Village health plan, also all the ASHA were not able to explain their role in making such a Village health plan which is amongst one of the key functions of ASHA.

Almost all were aware that they would be getting performance based incentive but none of them were aware about how much incentives they will exactly get while doing that particular work. After probing on this most of ASHA told that-

"vkhflud e/; sekukcnny foqljysv1 rkvi6jykl ka.; kr vlysylhdle djkutkrki Ski Skudkd: "

Most of the ASHA said that they repeatedly asked about their incentives in their training but trainer told that, first you do your work & don’t focus on only money.

Some ASHA told that

"eh elcly vl0j yk ekukcnny [li nk foqljysi k Rlah ljk eyk Qoflyr ekgrfnyhuigla

Some ASHA told that, they had asked to Medical Officer repeatedly about their incentives but Medical Officer did not give detailed and proper information regarding incentives.
Most of the ASHA were aware about their responsibility regarding immunization but none of them explain what are the signs of high risk pregnancy & none of the ASHA were explained how to detect case of tuberculosis, leprosy, malaria.

Most of the ASHA were aware about the HIV/AIDS & how it is transmitted but none of the ASHA knew about the integrated counseling & testing centre (ICTC).

2. **PERCEIVED ROLES OR RESPONSIBILITIES:**

*Most of the ASHA’s perceive their duties to include:*

- Assisting women for Immunization & supplementary nutrition,
- Counseling her on eating nutritious food, maintaining cleanliness
- Some gave information on provide escort to pregnant women for delivery in hospital
- Referred TB, Leprosy, malaria to PHC

But the primary role of registration & encouraging the women for availing institutional delivery was largely missed by the ASHA.

3. **CHALLENGES FACED BY ASHA:**

Challenges faced by most of the ASHA were lack of support from PHC staff, no compensation for services other than institutional delivery, unclear reimbursement policy-delayed payments, poor confidence in their own ability to carry out the desired work which reflected on the lack of good training & poor clarity in how to collaborate work with the ANM and Anganwadi worker. Medical officer, ANM considered ASHA as their subordinate and did not understand the problems faced by ASHA, they also failed to give them proper guidance and mutual respect and love. The ASHA complained regarding the lack of recognition and priority treatment of cases referred by them to MO / ANM.

**Discussion:**

**WHAT DO WE ALREADY KNOW ABOUT VILLAGE HEALTH WORKER IN INDIA?**

Following reports of successful experiments in the non-governmental sector with the community health workers (CHWs), the Indian government introduced a CHW Scheme across the country in 1977 envisaging "provision of health services at the doorsteps of villager" (Chatterjee 1993, Maru 1983).

However, the names of the worker and the scheme changed over time - from CHW in 1977 to Community Health Volunteer in 1980 and Village Health Guides in 1981.

The Village Health Guide (VHG) Scheme was made 100% centrally sponsored under the Family Welfare Program till April 2002.
The Village Health Guide (VHG) Scheme was made 100% centrally sponsored under the Family Welfare Program until April 2002. In 2000-2001, a very high level review committee was established to study in details the entire scheme. The review committee looked at the work done by CHWs, their abilities and honorarium and sustainability issues. Based on this study recommendation, the government of India communicated to the state governments that the national government's funding will be discontinued starting April 2002 and the states were asked to run the scheme on their own, if they could mobilize the resources. However, with this change in financing arrangements, it is reported that no states are currently running the VHG scheme (Suresh 2003).

In this study it was found that most of the ASHA were not aware about their roles & responsibilities due to so many task expected from ASHA without providing adequate training, lack of support, failed to give them proper guidance and mutual respect & love from PHC staff. No compensation for services other than institutional delivery, unclear reimbursement policy-delayed payments The ASHA complained regarding the lack of recognition and priority treatment of cases referred by them to MO / ANM.

Similar finding from large-scale programme called the mitanin programme was initiated by the government in the Indian state of Chhattisgarh in 2002. The evaluation report (2005) of SOCHARA on Mitanin programme found the following findings:

Programme was struggling at the field level on several fronts including Mitanin's demand for drugs, remuneration, training, and referral support; non payment of BRP-DRPs [block ressource person-district resource persons] for long periods; relative indifference of the health system, and

Community health workers : lack of adequate meaningful community participation at several stages. The knowledge level of Mitanins, their home visits, provision of primary medical care, referral, cooperation with ANM-AWW [auxiliary nurse midwife/Aganwadi Worker], Panchayat connection, gender-rights etc are presently at low levels.

Most of the ASHA were not aware about their exact amount of incentives, it will creates increase in attrition rate as it was shown from the study of Khan et al. In Bangladesh's BRAC programme CHWs “discontinued their work due to lack of time, lack of 'profit' & family's disapproval. The effects of the dropouts were decreased achievement of targets and a loss of money in the amount of $24 (U.S.) per dropout [CHW] for their training and supervision".

Conclusion :

Though the NRHM focuses on reducing the maternal & child- Mortality & morbidity, creation of functional infrastructures & up gradation of services.
Gratifying to note that NRHM has been partially successful in sensitizing the public health machinery towards -

- Generating awareness amongst ASHA &
- Creating a cadre of functional frontline workers in the form of ASHA

ANC services at the village level were affected because of lack of participation of ASHA in village health & nutrition day (VHND) because of lack of clarity in their roles in health care provision.

**Recommendations**:

In this study all of the ASHA had completed their induction training of seven days but none of them were aware about their prime role and responsibilities. A need-based training using participatory learning methods with more of hands on experience if used can help to build the capacity of these village level health workers and create a functional cadre of frontline workers. In this study almost all of the ASHA were not aware about the incentives provided for their work, if transparency is maintained in the policy regarding the incentives for their services, it will helpful in changing the attitude of the ASHA's towards health system. Also there is a perceived need on training of other health care providers regarding the role of ASHA and their capacity to work as health team with ASHA as one of its important member & Recognizing voluntarism & activism of ASHA, Imbibing activist culture, priority and recognition of cases referred by ASHA to MO / ANM. Identified transport for referral of cases from village to health facility, linkage with nearest functional health facility for referral, Timely payment of incentives to ASHA, timely replenishment of ASHA kit.

**Key message from this study**:

Numerous programmes have failed in the past because of unrealistic expectations, poor planning and an underestimation of the effort and input required to make them work. This has unnecessarily undermined and damaged the credibility of the CHW concept.

The programme very explicitly sees itself as continuing a tradition of CHW programmes in India, and the programme initiators took great care to study and learn from previous programmes

*(Key words : ASHA, awareness, perception)*

**Conflict of interest : None**

**References :**


3. [http://www.mohfw.nic.in/eag/accredited_social_health_activis.htm](http://www.mohfw.nic.in/eag/accredited_social_health_activis.htm)

4. [http://health.nic.in/NRHM/asha.htm](http://health.nic.in/NRHM/asha.htm)


