Research Article

A study to assess the health-seeking behavior of the accredited social health activists (ASHAs)—a cross-sectional study

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Abstract

Background: Accredited social health activist (ASHA) is a key link to public health services in villages in India. ASHA plays an important role at the grass root level by motivating people to utilize the health services. Unless ASHAs are healthy, it will be difficult for them to work for the benefit of the community. They play an essential role in the health-care system; yet, little is known about what ASHAs do to stay healthy. Hence, this study was done to find the health-seeking behavior of the ASHAs.

Objective: To assess the sociodemographic, socioeconomic profile, and health-seeking behavior of the ASHAs and their families.

Materials and Methods: It is a cross-sectional study on ASHAs working in the rural areas of Sakwar, Khadavli, and Pise-Padgha. All the ASHAs working in the rural areas of Sakwar, Khadavli, and Pise-Padgha were given a printed questionnaire to answer with prior consent taken. A total of 110 ASHAs were included in the study.

Result: All the ASHAs had experienced some illness in last 1 year, of which upper respiratory tract infection (URTI) was the most common morbidity. About 51.57% of ASHAs had experienced URTI. About 33.60% used homemade remedies, 79.46% went to primary health center for the treatment if not cured at home, and 65.15% of ASHAs decided their own mode of treatment.

Conclusion: The ASHAs showed a positive health-seeking behavior, wherein they mostly preferred the private hospital for chronic illnesses.

KEY WORDS: ASHA, health-seeking behavior, rural, health services

Introduction

The National Rural Health Mission (NRHM) is an initiative undertaken by the Government of India to address the health needs of underserved rural areas. Founded in April 2005 by Indian Prime Minister Manmohan Singh, the NRHM was initially tasked with addressing the health needs of the states that had been identified as having weak public health indicators. Under NRHM, a new cadre of workforce known as accredited social health activist (ASHA) was started.

ASHA is a key link to public health services in the villages in India. ASHA plays an important role at the grass root level by motivating the people to utilize the health services. Unless ASHAs are healthy, it will be difficult for them to work for the benefit of the community. They play an essential role in the health-care system; yet, little is known about what ASHAs do to stay healthy.

A health-promoting lifestyle has been defined as a "multidimensional pattern of self-initiated actions and perceptions that serve to maintain or enhance the level of wellness, self-actualization, and fulfillment of the individual." Health behavior reflects a person's health beliefs. Some common

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health behaviors are exercising regularly, eating a balanced diet, and obtaining necessary inoculations. Health-seeking behavior analyzes concepts of origin and management of illness, provides insights into utilization of available traditional and/or modern health services, and, finally, allows a deeper understanding of community perceptions regarding health care in particular settings.

Health-care seeking behavior is the seeking and acceptance by patients of health services. Access and utilization of health services is multifaceted, influenced by cultural, behavioral, and financial factors. There are several models determining health-seeking behavior. One such model, the revised and updated versions of the Andersen and Newman Behavioral Model of Health services utilization, first published in 1973, are still frequently used.

This study was done to find out the health-seeking behavior among the ASHAs, what they do as first-line of treatment and where do they seek treatment in case if not cured by first-line treatment.

The objectives were to assess demographic and socio-economic profile of ASHAs and assess the health-seeking behavior of the ASHAs and her family.

Materials and Methods

This cross-sectional study was done in ASHAs working in the rural areas of Sakwar, Khadavli, and Pise-Padgha. Universal sampling method was used; so, all the ASHAs working in these rural areas were included. The total sample size was 110. Those who did not wish to take part in the study were excluded. The study was done during the posting of 4 months and 15 days in these rural areas.

Consent was taken before filling the questionnaire. All the ASHAs were given a printed questionnaire to answer. The questionnaire included their sociodemographic and socioeconomic information of the ASHAs. It also included information regarding the health-seeking behavior of the ASHAs and their family. The questionnaire was filled by the ASHAs during their monthly meeting at the primary health center (PHC). Data were entered in Microsoft Excel 2007 software and analyzed by using SPSS software, version 16.0.

Result

The average age of ASHA working in these rural areas was 30 years. The average years of working as ASHA were 4 years. The average numbers of family members of ASHAs were five with maximum ASHAs having a nuclear type of family. The average total family income was about Rs. 3,405.7 [Tables 1 and 2].

All the ASHAs showed some illness in last 1 year, of which 51.57% showed URTI [Table 3].About 33.60% used home-made remedies and 79.46% went to PHC for the treatment if not cured at home. About 12.73% showed chronic illnesses, for which maximum preferred government hospitals. Home remedy was mostly taken for URTI. Self-remedy was taken for fever and URTI by most of the ASHAs. Many ASHAs preferred private hospital, especially for chronic illnesses [Table 4].

Table 1: Sociodemographic data

Characteristics	Frequency (%)
Age (years)	
20–30	66 (60)
31–40	36 (32.73)
>40	8 (7.27)
Years of working as ASHA	
<2	5 (4.55)
2–5	94 (85.45)
>5	11 (10)
Type of family	
Joint	32 (29.09)
Nuclear	59 (53.64)
Extended nuclear	10 (9.09)
Three generations	9 (8.18)
Total family members	
2–5	69 (62.73)
6–10	35 (31.82)
>10	6 (5.45)

Discussion

The study conducted on ASHAs in rural area revealed that they showed positive health-seeking behavior. ASHAs preferred to seek treatment in government and private institutions, especially for chronic illness.

It was found that 60% of the ASHAs belonged to the age group of 20–30 years, and the average number of years working as ASHA was found to be 3 years. In a study by Fathima et al.,[1] the mean age of ASHAs was 30.3 ± 5.0 years. Persai et al.[2] revealed that ASHAs linked tobacco usage to diseases such as respiratory problems, lung cancer, tuberculosis, and oral disease. Only one-third of ASHAs reported informing all patients about the harmful health effects of tobacco, whereas more than half of them reported providing information only to patients experiencing specific illness. No such reporting was seen in our study. It was revealed that most of the ASHAs resorted to hospitals for the chronic illnesses. Shashank et al.[3] showed that the effectiveness of ASHA worker largely depends on the training and support from both the health system and the community. Moreover, in a study by Sharma et al.,[4] it was shown that in order to improve the performance of ASHAs, apart from taking corrective actions at the professional and organizational front on a priority basis, it is equally essential to promote cordial work relationships among ASHAs and other community-level workers.

Table 2: Socioeconomic data

Characteristics	Frequency (%)
ASHAs education	
Secondary	93 (84.54)
Higher secondary	15 (13.64)
Graduation and above	2 (1.82)
Husband's education	
Primary	10 (9.09)
Secondary	82 (74.54)
Higher secondary	13 (11.83)
Graduation and above	5 (4.54)
Husband's occupation	
Farmer	75 (68.18)
Business	14 (12.73)
Government job	17 (15.45)
Private sector	4 (3.64)
Total earning members in family	
1–2	97 (88.18)
3–4	10 (9.09)
5–6	1 (0.91)
7–8	2 (1.82)
Total family income	
1,000–5,000	77 (70)
5,001–10,000	20 (18.18)
10,001–15,000	9 (8.18)
15,001–30,000	3 (3.64)
Per capita income	
200–700	91 (82.73)
701–1500	17 (15.45)
1,501–3,000	1 (0.91)
3,001–5,000	1 (0.91)
Ration card	
Yellow	79 (71.82)
Orange	31 (28.18)
White	0 (0)

Table 3: Illness history

Illness history	Frequency (%)
Illness in last 1 year	
Yes	110 (100)
No	0 (0)
Type of illness: (*n* = 190)	
Cough, cold, and fever (URTI)	98 (51.57)
GI symptoms	62 (32.63)
MSK	21 (11.05)
Surgeries	6 (3.16)
Others	3 (1.59)
Chronic illness	
Yes	14 (12.73)
No	96 (87.27)
Type of chronic illness	
HT	6 (5.46)
Diabetes mellitus	0 (0)
Kidney disorder	2 (1.82)
Thyroid disorder	1 (0.91)
Others	5 (4.54)
None	96 (87.27)

Table 4: Health-seeking behavior

Behavior	Frequency (%)
First treatment taken at home for any illness (*n* = 122)	
Homemade remedy	41 (33.60)
Self-medication	30 (24.59)
Local healer	1 (0.82)
Family or neighbors advice	2 (1.64)
Others	48 (39.34)
Was it cured by home remedy?	
1 = yes	0 (0)
2 = no	110 (100)
Days waited before taking second step for illness	
Less than 1 week	105 (95.45)
1 week–1 month	4 (3.64)
1–3 months	0 (0)
More than 3 months	1 (0.91)
If not treated at home then where was treatment taken? (*n* = 112)	
PHC	89 (79.46)
Local private practitioner	14 (12.5)
Government hospital	5 (4.46)
Private hospital	4 (3.57)
Treatment for chronic illness (*n* = 119)	
PHC	3 (2.52)
Local private practitioner	2 (1.68)
Government hospital	11 (9.24)

No study has been done so far to find out the health-seeking behavior of the ASHAs, this being the strength of this study. The limitations of the study were that it was carried out only in three rural settings; so, the reasons for health-seeking behavior may not be generalized for all the ASHAs.

The study, thus, concluded that the ASHAs showed a positive health-seeking behavior.

Conclusion

The ASHAs showed a positive health-seeking behavior wherein they mostly preferred the private hospital for chronic illnesses.

Private hospital	9 (7.57)
None	94 (78.99)
Decision of treatment is taken by (*n* = 132)	
Father-in-law	6 (4.55)
Mother-in-law	7 (5.30)
Husband	33 (25)
Self	86 (65.15)
Others	0 (0)
Home remedy for (*n* = 277)	
URTI	108 (38.99)
Fever	104 (37.54)
GI symptoms	47 (16.97)
MSK/injuries	12 (4.33)
Headache	6 (2.17)
Others	0 (0)
Drugs taken without consulting doctor (*n* = 277)	
Pain killers/PCM	107 (38.62)
ORS	98 (35.38)
Multivitamins and iron tablets	56 (20.22)
Cough syrup	16 (5.78)
Others	0 (0)
Self-remedy for (*n* = 290)	
URTI	102 (35.17)
Fever	105 (36.21)
GI symptoms	59 (20.34)
MSK/injuries	22 (7.59)
Headache	2 (0.69)
Others	0 (0)
Home remedies used (*n* = 322)	
Homemade syrup	89 (27.64)
Medicinal plants	103 (31.99)
Steam inhalation	76 (23.60)
Cold towels for fever	52 (16.15)
Others	0 (0.62)
Preference for government hospital (*n* = 291)	
Minor illnesses	64 (21.99)
Chronic illnesses	100 (34.36)
Emergencies	78 (26.80)
Deliveries	42 (14.43)
Surgeries	7 (2.42)
Preference for private hospital (*n* = 314)	
Minor illnesses	83 (26.43)
Chronic illnesses	103 (32.80)
Emergencies	80 (25.48)
Deliveries	45 (14.33)
Surgeries	3 (0.96)

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