Research Article

Assessment of the work profile of Accredited Social Health Activist workers in Kathua district of Jammu and Kashmir, India: A cross-sectional study

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ABSTRACT

Background: Accredited Social Health Activist (ASHA) workers and their activity are considered as one of the key components of National Health Mission (NHM). ASHA workers serve as an important link between community and health facilities. **Objectives:** The objectives of the study were to assess the work profile of ASHA workers in Kathua district of Jammu and Kashmir. **Materials and Methods:** The present prospective cross-sectional study was conducted in Parole Block of district Kathua in Jammu and Kashmir from February 2019 to May 2019. A total of 176 rural ASHA workers were interviewed using a predesigned, pretested questionnaire after seeking informed consent. **Results:** About 52.2% catered to a population of 500–1000. About 34% of the workers were educated up to 10th standard and 10.7% up to 12th standard. About 64.2% of the ASHA workers are active in supporting institutional deliveries and 88% of the ASHAs made household visits for nutrition counseling. **Conclusions:** ASHA acts as a first link between the community and health-care services. Thus, it is necessary to strengthen the role of ASHA on promotive and preventive health care services through regular joint training of ASHAs.

KEY WORDS: Accredited Social Health Activist Workers; Health Care Services; National Health Mission

INTRODUCTION

In the year 2005, the Government of India launched National Rural Health Mission, now called National Health Mission (NHM), to improve the conditions of public health of rural areas and Accredited Social Health Activist (ASHA) was one of the core strategy proposed by NHM.[1] ASHA refers to the women health workers of village-level who work to improve the condition of health at grass root level of mothers, infants, old aged, sick, and disabled people. Each ASHA is set up over 1000 population.[2] Each ASHA worker is given 2000 as remuneration for the mandatory and ensured services which she provides to the community. Besides this, work-based incentive is given based on their performanceintroduction of the ASHA worker improved the accessibility, availability, and acceptability of the existing health facilities, particularly in rural areas.[3] ASHA acts as a link between a community and the health provider. The basic training module has been developed by the Ministry of Health and Family Welfare to provide the necessary knowledge and skills to women identified as ASHAs, and regular re-orientation training programs are organized at the district levels.[4,5] Until date, 700,000 ASHA workers have been trained and deployed across the country. It is necessary to keep the ASHA workers motivated so that they can effectively and efficiently carry out their responsibilities. Thus, this study aimed at assessing work profile of ASHA so as to address the issues faced by them.

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MATERIALS AND METHODS

The present prospective cross-sectional study was conducted in Parole Block of district Kathua in Jammu and Kashmir

from February 2019 to May 2019 after seeking ethical clearance. The entire district caters to a population of 209,984, according to 2011 Census. There is total of 166 revenue villages and about 470 Anganwadi Centers in this block. The total number of rural ASHAs working in this block is 183. After seeking permission from the health department, all the ASHA workers of the block Parole who have completed 1 year of service were enrolled in the study. However, 176 were finally included in the study as four workers did not fit the inclusion criteria and three could not be contacted. The medical officer in charge of the respective areas was informed about the study and days of the monthly block level meeting of ASHA workers were ascertained. A predesigned, pretested questionnaire was implemented to the ASHA worker after obtaining informed written consent. ASHA facilitators were also contacted for coordination with the ASHA workers.

The collected data were entered into Microsoft Excel, coding of the variables was done and thereby, interpretation and analysis of the collected data were done using appropriate statistical methods.

RESULTS

A total of 176 ASHA workers were interviewed. The majority of the ASHA workers (92) catered to a population of 500–1000. Other than this 15 of the ASHA worker was having more than 1500 population [Table 1]. The majority of the ASHA workers were covering single village. About 34% of the workers were educated up to 10th standard and 10.7% up to 12th standard [Table 2].

Most of the ASHA workers (62.5%) belonged to scheduled caste and only 1 belonged to the scheduled tribe [Table 3]. About 97.7% of the ASHAs were insured under Pradhan Mantri Jeevan Jyoti Bima Yojana and Pradhan Mantri Suraksha Bima Yojana [Table 4].

About 64.2% of the ASHA workers are active supporting institutional (86.3%) in promoting immunization and 90.3% in providing oral contraceptive pills (OCPs)/condoms and successful referral of intrauterine devices (IUDs)/female sterilization/male sterilization. About 88% of the ASHAs made household visits for nutrition counseling. About 72.7% of the ASHA were involved in early management of childhood illness – especially diarrhea and pneumonia [Table 5].

DISCUSSION

In this cross-sectional study, 176 ASHA workers were interviewed over a period of 4 months. The majority of the ASHA workers were covering single village. About 34% of the workers were educated up to 10th standard and 10.7% up to 12th standard. About 64.2% of the ASHA workers are active supporting institutional deliveries, 86.3% in promoting immunization, and 90.3% in providing OCPs/condoms and successful referral of IUDs/female sterilization/male sterilization regarding ASHAs education selection criteria are 8th class but in certain circumstances, it is reduced due to non-availability. About 29 ASHAs had education qualification <8th standard which were are also seen by a study done by Jain *et al*.[6]

The majority of the ASHAs have completed their secondary school of education which was also supported by study conducted by Garg *et al*. and Fathima *et al*.[7,8] Each ASHA is supposed to cover a population of 1000. In our study, there was variation in the population size catered by the ASHAs. About 52.7% ASHA workers covered a population size of 500–1000 whereas 8.52% covered more than 1500 population. Shet *et al*., in a study at Karnataka revealed that 69% of ASHA workers covered a population size of 1000–1500 and 94% of them were covering a single village. Shet *et al*., in a study at Karnataka revealed that 69% of ASHA workers covered a population size of 1000–1500 and 94% of them were covering

Table 1: Population status of ASHAs

Population covered	Number of ASHA	Percentage
<200	2	1.13
200–500	33	18.7
500–1000	92	52.2
1000–1500	34	19.3
>1500	15	8.5

ASHA: Accredited Social Health Activist

Table 2: Educational status of ASHAs

Educational status	Number of ASHA	Percentage
<8th standard	29	16.4
Up to 8th standard	68	38.6
Up to 10th standard	60	34
Up to 12th standard	19	10.7

ASHA: Accredited Social Health Activist

Table 3: Social status of ASHAs

Social caste	Number of ASHA	Percentage
Others	65	36.9
Scheduled caste	110	62.5
Scheduled tribe	1	0.5

ASHA: Accredited Social Health Activist

Table 4: Status of social security schemes

Social caste	Number of ASHA	Percentage
Pradhan Mantri Jeevan Jyoti Bima Yojana	172	97.7
Pradhan Mantri Suraksha Bima Yojana	172	97.7
Pradhan Mantri Shram Yogi Maandhan Yojana	49	27.8

ASHA: Accredited Social Health Activist

Table 5: ASHA functionality

Performance indicators	Number of ASHA (*n*)	Percentage
Newborn visits on the 1st day of birth in case of home deliveries	13	7.3
Home visits for newborn care as specified in the home-based newborn care guidelines (six visits in case of Institutional delivery and seven in case of a home delivery)	76	43.1
Attending VHNDs/promoting immunization	152	86.3
Supporting institutional delivery	113	64.2
Management of childhood illness – especially diarrhea and pneumonia	128	72.7
Household visits with nutrition counseling	155	88
Referring fever cases seen/making malaria slides in malaria endemic area	130	73.8
Directly observed treatment short course provider	2	1.13
Holding or attending village/village health sanitation and nutrition committee meeting	149	84.6
Successful referral of intrauterine device/female sterilization/male sterilization cases and/or providing oral contraceptive pills/condoms	159	90.3

ASHA: Accredited Social Health Activist

a single village.[9] In our study, 64.2% ASHAs accompanied pregnant females for institutional delivery and 72.7% were involved in the management of childhood illness, particularly diarrhea. In a study by Kumar *et al*., 130 (98.5%) actually accompanied the pregnant women to hospital, 85 (78.%) gave directly observed treatment short (DOTS) course therapy, and 66 (73.3%) mobilized community to access health services at different facilities.[10] About 72% of volunteers were present with the mothers at the time of delivery in Nepal.[11] Furthermore, Swain *et al*. reported that only 48% of ASHA's were aware of various health determinants as a part of the job responsibility,[12] whereas only 2 ASHAs were working as DOTS provider which needs to be increased.

Strengths and Limitations

The main focus of the current study was to assess the services provided by ASHAs in rural area. The limitation of this study was that only rural ASHAs were covered as urban ASHAs were very less in number (only 10).

CONCLUSIONS

In the current study, it was found that ASHA act as a first link between the community and health care services. Thus, it is necessary to strengthen the role of ASHA on promotive and preventive health care services through regular joint training of ASHA and ICDS workers. Political will and health systems support for the ASHA program, a key component of the NHM, will go a long way in making a significant change to the lives people, particularly in rural areas.

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