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AWARENESS, PERFORMANCE AND PROBLEMS OF ASHAS (ACCREDITED SOCIAL HEALTH ACTIVISTS) IN PROVIDING MATERNAL HEALTH SERVICES IN THE TRIBAL AREAS OF WAYANAD DISTRICT, KERALA

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ABSTRACT

In order to meet the basic primary health care needs of the rural population of the country, Government of India introduced the National Rural Health Mission (NRHM) in 2005. ASHAs (Accredited Social Health Activists) are recruited under NRHM as a change agent who are expected to bring the reforms in improving the health status of oppressed community. The success of NRHM depends on how efficiently ASHAs are able to perform their duties to reach out to the rural deprived communities. The present study aims to assess the knowledge of ASHAs regarding maternal health services and their performance in the delivery of these services and to trace the problems faced by them in providing maternal health services in tribal areas. This descriptive study was conducted among a sample of 100 ASHAs working in the tribal areas of Wayanad district. Data on knowledge and problems were collected using a questionnaire and a rating scale was used to assess their performance. The results of the study depicts that ASHAs have very good knowledge in maternal health and their performance is rated at a moderate level by their supervisors. ASHAs face a number of problems in rendering maternal health services in tribal areas effectively. The main problems include poor and irregular remuneration, remoteness of the tribal hamlets and lack of transportation facility, hesitation of tribal women to avail the services and more responsibilities in other areas of health. ASHAs' performance is found to be affected by increasing number of problems that they face. ASHAs' performance in providing maternal health services to tribal women may be improved by taking appropriate steps in solving their grievances.

KEYWORDS : ASHA, tribal women, knowledge, performance, problems

Introduction

Health status of the under privileged and marginalized population in many parts of India is very poor. Health care facilities are mainly concentrated in urban areas depriving the majority of rural people of even minimum basic health services (Park, 2015).

Government of India launched the National Rural Health Mission (NRHM) in 2005 to provide basic primary health services to the entire rural population of the country. The goal of the Mission is to provide accessible, affordable, accountable, effective and reliable primary health care to people residing in rural areas, with special emphasis to the poor, women and children.

The fulcrum of NRHM is Accredited Social Health Activist (ASHA) at the village level, who are local women trained to act as a link between their own community and the health system. ASHA will counsel women on various aspects of mother and child care, mobilize mothers and facilitate them in accessing various services available at Anganwadies, subcentres and primary health centers (Ministry of H & F W,GoI, 2006).

In Kerala NRHM was launched in 2006 with the goal of improving availability and access to quality health care to people especially in rural and under privileged areas. Even though Kerala has achieved first place in human development index among the Indian states, certain marginal groups like dalits, fisher folk and tribal people lagged behind in the development process (Kerala Economic Review, 2008). The rate of institutional deliveries is high in Kerala as compared to other Indian states. Wayanad district is having the lowest rate of institutional deliveries (95.4%) among the fourteen districts in the state (DLHS 2007-8). Tribal population is vulnerable to various health problems that scale up maternal mortality, infant mortality and communicable diseases.

The NRHM programme is covering the tribal areas as well. ASHA are recruited in these areas also for serving the tribal population. The present study aimed at making an analysis of the expertise and performance of ASHA in relation to maternal health services in tribal areas. The objectives of the study were

- to assess the knowledge of ASHA regarding maternal health services
- to assess the performance of ASHAs in the delivery of these services
- to trace the problems faced by ASHAs in providing maternal health services in tribal areas.

The following hypotheses were set for the study

1. The performance of ASHAs is positively correlated to their knowledge on maternal health services.
2. The problems faced by ASHAs affect their performance negatively in the delivery of maternal health services to tribal women.

Methodology:

Study design: The present study is descriptive in nature which seeks to assess the knowledge and performance of ASHAs in maternal health services and the problems faced by ASHAs in providing maternal health services in tribal areas.

Population: The study population consists of ASHAs working in the tribal areas of Wayanad district.

Sample and Sampling Technique: Based on the density of tribal population, one health block was purposively selected for collecting primary data for the study. A sample of 100 ASHAs was selected proportionately from 6 PHCs under this health block.

Data collection methods and tools:

A structured questionnaire was used to collect the information pertaining to the ASHAs' knowledge on maternal health services and the problems faced by them in providing maternal health services to tribal women. A rating scale was used to rate the performance of ASHAs in relation to provision of maternal health services in tribal areas. ASHAs' performance was rated by their immediate supervisors namely Junior Public Health Nurses.

The data were analysed by descriptive statistical methods such as frequency and percentage. Chi square test was used to find out association between problems and performance.

Results and discussion

Socio personal information about ASHAs

Table -1 Distribution of ASHAs by age

Sl.No	Age Group (in years)	No. of respondents	Percentage
1	25 - 34	12	12
2	35- 44	60	60
3	45-54	28	28
	Total	100	100

Data from table-1 indicate that 72 percent of ASHAs are aged between 25 and 45 years, which is the preferred age group for ASHA as per NRHM guidelines (Operational Guidelines for ASHA under NRHM,G o I).

Table-2 Distribution of ASHAs by marital status

Sl.No	Marital status	No. of respondents	Percentage
1	Married	95	95
2	Widowed	4	4
3	Divorced	1	1
	Total	100	100

The selection criteria of ASHAs shows preference to married widowed or divorced women over unmarried women because in Indian culture, a woman after her marriage will leave her own village and migrate to her husband's village (Operational Guidelines for ASHA under NRHM,G o I).Table-2 depicts that ninety five percent of ASHAs are married, four of them are widowed and one ASHA is divorced.

Table-3 Distribution of ASHAs by education

Sl.No	Education	No. of respondents	Percentage
1	Up to SSLC	68	68
2	Higher secondary/ PDC	23	23
3	Degree	5	5
4	Technical	4	4
	Total	100	100

Data from table-3 indicate that 68% of ASHAs studied up to SSLC and 23% of them up to higher secondary level. Five of them are graduates and four ASHAs have technical qualification. All of them have reached more than the required educational qualification (8th std) specified for ASHA under NRHM guideline (Operational Guidelines for ASHA under NRHM, G o I).

Table-4 Distribution of ASHAs by caste

Sl.No	Caste	No. of respondents	Percentage
1	General	36	36
2	OBC	35	35
3	SC	17	17
4	ST	12	12
	Total	100	100

Table -4 illustrates that 36% of ASHAs belong to general caste and 35% from Other Backward Caste(OBC). Among the remaining ASHAs17% are from Scheduled Caste(SC) and12% are from Scheduled Tribe(ST) groups. The caste status of ASHAs shows how the inclusive principle was adhered to in selection process of ASHAs at the grassroots level, giving due representation to different caste and community groups.

Table- 5 Distribution of ASHAs by type of family

Sl.No	Type of family	No. of respondents	Percentage
1	Nuclear	84	84
2	Joint	11	11
3	Three generation	5	5
	Total	100	100

Data from table –5 indicate that eighty four ASHAs (84%) come from nuclear family which may be attributed to the changing family pattern in Kerala from large families to small nuclear families.

Table – 6 Distribution of ASHAs by monthly family income

Sl.No	Monthly family Income in rupees	No. of respondents	Percentage
1	<= 2000	70	70
2	2001-5000	19	19
3	5001-8000	9	9
4	> 8000	2	2
	Total	100	100

Data from table -6 indicate that seventy ASHAs (70%) reported that their monthly family income is less than or equal to rupees two thousand only and nineteen percent of them have monthly income between Rs.2001 and Rs.5000.

Table – 7 Distribution of ASHAs by duration of experience as ASHA

Sl.No	Duration of experience as ASHA	No. of respondents	Percentage
1	Up to 5 years	21	21
2	6-10 years	62	62
3	11-15 years	17	17
	Total	100	100

Table -7 depicts that 62 ASHAs have the experience of working as ASHA for five to eight years and seventeen of them have more than eight years of experience.

Knowledge of ASHAs regarding maternal health services

ASHAs are categorised into three categories based on the score obtained for knowledge and the details are given below.

Table -8 Distribution of ASHAs by level of knowledge regarding maternal health services

Sl. No.	Knowledge score	Category	No. of respondents	Percentage
1	1-10	Poor	0	0
2	11- 20	Good	38	38
3	21-30	Very good	62	62
	Total		100	100%

Data from table -8 depicts the level of knowledge of ASHAs regarding provision of maternal health services. The mean knowledge score is 21.09. Sixty two percent of ASHAs have very good knowledge and the remaining of them have good knowledge on maternal health services. This finding has been substantiated by the study of Karol G S and Pattanaik B K (2014) in which it was found that ASHAs have very good knowledge about maternal and child health services.

Performance of ASHAs in Providing Maternal Health Services

ASHAs are categorised into three categories based on the score obtained for performance and the details are given below.

Table-9 Distribution of ASHAs by level of performance in providing maternal health services

Sl. No.	Performance score	Category	No. of respondents	Percentage
1	Up to 20	Low	8	8
2	21-40	Moderate	70	70
3	41-60	High	22	22
	Total		100	100%

Data from table -9 indicate that seventy ASHAs (70%) show moderate performance in providing maternal health services to tribal women as reported by their immediate supervisors (JPHNs). The level of performance of twenty two percent of ASHAs is high. Performance of the remaining eight percent of ASHAs is reported to be low. The finding of the present study is supported by the study of

Babu S (2009) which indicates good performance among majority of ASHAs in the provision of primary health services in general.

Table-10 Correlation between knowledge and performance of ASHAs with regard to maternal health services

Variables	Samples(n)	Pearson Correlation	P value
Knwoledge - Performance	100	0.016	0.873

It is clear from table -10 that there is no significant correlation between ASHAs' performance and knowledge. This indicates that ASHAs' performance in providing maternal health services is not influenced by their knowledge in this area. Hence the hypothesis-1 namely **"the performance of ASHAs is positively correlated to their knowledge on maternal health services"** is rejected.

Problems faced by ASHAs in providing maternal health services in tribal areas

It is a challenging experience to work with the community especially in rural remote tribal areas. The main problems faced by ASHAs for providing maternal health services in tribal areas were identified from 100 ASHAs participated in the study using the questionnaire. The findings in relations to the problems faced by ASHAs are detailed below.

Table-11 Distribution of ASHA by the reported problems

n = 100

Sl.No.	Type of problems	No. of respondents	Percentage
1	Too much responsibilities in other areas of health	23	23
2	Unreachable tribal hamlets	20	20
3	Lack of cooperation from tribal mothers	12	12
4	Poor and irregular remuneration	90	90
5	Lack of support from own family	5	5
6	Communication problems	9	9
7	Own health problems	5	5
8	Lack of community acceptance	2	2
9	Inadequate time to perform household chores	15	15

Data from table – 11 illustrates the problems faced by ASHA in providing maternal health services to tribal mothers. The main problem reported by the majority of respondents is inadequate remuneration that is not regularly paid. Other major problems include too much of work in other areas of health (23%), interior location of tribal hamlets which are not reachable (20%), inadequate time to look after their own family affairs (15%). These findings are supported by the study of Roy S and Sahu B (2013) in which inadequate remuneration and its irregular payment were identified as the first problem. A similar finding was reported by Saprii L, Richards E, Kokho P,and Theobald S(2015) in which they report that small and irregular monetary incentives demotivate ASHAs.

Table-12 Distribution of ASHAs by Number of Problems Reported by Them

Sl. No.	Number of problems	No. of respondents	Percentage
1	No problem	4	4
2	One problem	43	43
3	Two problems	33	33
4	Three problems	11	11
5	Four problems	6	6
6	Five problems	3	3
	Total	100	100%

Data from table -12 indicate the number of problems faced by ASHAs. Forty three percent of ASHAs reported one problem only and thirty three of them reported two problems. Four of them did not report any problem

Table-13 Numbers of Problems vis-a-vis ASHAs' Performance

Sl. No.	No. of problems	Performance			Total	DF	Chi square	P value
		Poor	Good	Very good				
1	No problem	0 (0.0)	2 (50.0)	2 (50.0)	4 (100)	10	69.16	0.001
2	One problem	0 (0.0)	33 (76.7)	10 (23.3)	43 (100)			
3	Two problems	0 (0.0)	25 (75.8)	8 (24.2)	33 (100)			
4	Three problems	1 (9.1)	8 (72.7)	2 (18.2)	11 (100)			
5	Four problems	5 (83.3)	1 (16.7)	0 (0.0)	6 (100)			
6	Five problems	2 (66.7)	1 (33.3)	0 (0.0)	3 (100)			
	Total	8 (8)	70 (70.0)	22 (22.0)	100 (100)			

Note: Figures within parenthesis are percentages

Data from table -13 indicate that those ASHAs who have reported no problem or only one problem are found to have good or very good performance whereas, those who have reported four or five problems are found to perform poorly. As the number of problems increases, the performance level is found to be reduced.

The statistical analysis from this table shows that ASHAs' performance in the area of maternal health services is strongly associated with the number of problems faced by them. ($X^2 = 69.16$; D.F = 10; p- 0.001).

This inference leads to the conclusion that the hypothesis-2, namely **"The problems faced by ASHAs affect their performance negatively in the delivery of maternal health services to tribal women"** is accepted.

Conclusion

Analysis of the study results revealed that ASHAs working in the tribal areas of Wayanad district have very good knowledge about maternal health services and their performance is rated by their immediate supervisors (JPHNs) at a moderate level.

It has been found that ASHAs are facing a number of problems which hinder them from providing quality maternal health services to tribal women. Further analysis of the relationship of ASHAs' problems with their performance in the area of maternal health revealed that ASHAs' performance is strongly associated with the number of problems faced by them. As the number of problems increases, the performance level is found to be reduced.

Recommendations

ASHAs' problems in providing these services to the tribal people residing in the remote hamlets cannot be ignored. Time to time training and taking appropriate steps in solving their grievances is needed to strengthen the delivery of maternal and child health care services through ASHAs at the grassroots. Priority may be given in selecting ASHAs from among eligible tribal women to serve tribal population so that they will be available within the reach of remote tribal colonies and better accepted by their own community.

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