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CONSTRAINTS FACED BY ACCREDITED SOCIAL HEALTH ACTIVISTS IN PROVIDING MATERNAL AND CHILD HEALTH CARE SERVICES

Community Medicine

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ABSTRACT

Background: Successful outcome of the National Rural Health Mission (NRHM) depends to great extent on the performance of an Accredited Social Health Activist (ASHA). The objective of this study was to find out the feedback on the performance of ASHAs as well as constraints faced by them in providing MCH care. **Methods:** A cross-sectional study was conducted among 400 ASHAs by using a pretested, semi structured questionnaire for socio-demographic profile, feedback on their performance as well as constraints faced by them in providing MCH care. Performance of an ASHA was assessed into 4 categories, namely; 1-Very good (≥76%); 2- Good (51-75%); 3- Average (26-50%) and 4- Poor (0-25%). Descriptive data are presented as proportions and percentages. **Results:** Majority (81.2%) of the ASHAs were graded into average category followed by 62.5% and 53.2% of the ASHAs were awarded into good and very good category of performance, by their respective MO, ANM and beneficiaries, respectively. They were facing various constraints such as; not getting financial incentive total & timely, poor transport facility, inadequate facilities for stay at night at delivery centre, inappropriate behaviours of the health staffs, no full social support etc. **Conclusion:** In this study, none and some (12.5%) of the ASHAs were performing into very good category of performance as per their respective MO and ANM, respectively that would be due to many constraints were faced by them.

KEYWORDS

ASHA, ANM, MCH, NRHM, Constraints

INTRODUCTION:

Government of India took steps to strengthen the maternal and child health (MCH) care services as early as the first and second five-year plans (1951-56 and 1956-61). The National Rural Health Mission (NRHM) was launched in the year 2005 to enhance the effectiveness of MCH care services, especially in rural areas with aims of providing accessible, accountable, affordable, effective and reliable primary health care, especially to the poor and vulnerable sections of the society.[1]

Community health workers are the lifeline of Indian health care system. It is stated that health worker motivation is the main determinant of health worker retention and health sector performance (Peters et.al. 2010).[2]

The performance of an Accredited Social Health Activist (ASHA) is crucial for achieving the aims and objectives of NRHM. Perceptions about the performance of ASHAs' from their respective MO, ANM, and beneficiaries have not been evaluated yet through most of the research studies. This study aims to describe the factors affecting the function of ASHAs in MCH care, with a special focus on their service delivery evaluation from various community stakeholders' perspective. Thus, it was planned to find out the feedback on the performance of the ASHAs as well as various constraints faced by them under the department of Community Medicine, KGMU, Lucknow, U.P., India.

Aims And Objectives:

1. To assess the performance of ASHAs on the basis of feedback given by stakeholders
2. To find out various constraints faced by them in providing MCH care services.

MATERIAL AND METHODS:

A community-based cross-sectional study was conducted among 400 ASHAs in district Lucknow, Uttar Pradesh, India. By using formula $4pq/l^2$ where average prevalence of performance (p) of an ASHA was assumed to be 50% and expecting 10% of no response, the interview was targeted to conduct on 440 ASHAs who were trained and working in the field from ≥ 6 months. Multistage random sampling technique was used to select required sample size. In first stage, out of 8 rural blocks/ Community Health Centres (CHCs), 4 rural blocks / CHCs such as; Bakshi-ka-Talab, Kakori, Chinhat, and Sarojni Nagar were selected randomly. Further from each CHC, 4 PHCs were selected randomly. Thus, total of 16 PHCs were selected and from each PHC, 25 ASHAs were selected randomly to get required sample size of 400 ASHAs.

The studied ASHAs were assured of maintaining anonymity and confidentiality of collected data and they were informed that despite having given consent they would have right to withdraw from the study at any time. A pretested, semi structured questionnaire was used to get the information regarding demographic characteristics, feedback on work performance of ASHAs from health care providers & beneficiaries as well as **about constraints f**aced by them in providing MCH care services. The investigator personally contacted to the ASHA's coordinator/ Medical Officer and ANM of the concerned PHCs and took permission to conduct the study among the ASHAs. The tentative date/time of data collection was mutually decided and ASHAs workers were contacted in their respective PHCs during their monthly review meetings.

The respective MO/In-charge, ANM and a beneficiary were asked to grade an ASHA's performance by giving marks in out of 100. Thus, an ASHA was graded into one of the 4 categories of performance i.e., **1-Very good (≥76%), 2- Good (51-75%), 3- Average (26-50%), and 4-Poor (0-25%).**

Further, ASHAs were asked about various constraints that were faced by them. Out of total 4 kind of social supports (family & community) i.e. 1. emotional, 2. instrumental, 3. informational and 4. appraisal supports, an ASHA having ≥3 supports was considered as fully supported while an ASHA who had only 1 or 2 kinds of supports was considered as having 'somewhat' supports. Collected information was tabulated and analysed by Microsoft excel. Descriptive data was presented as proportions and percentages.

RESULTS:

Table-1 shows that majority of the ASHAs i.e. 76%, 97.2%, 59.8%, 58% and 69.5% were belonged to the age group of < 35 years, Hindu by religion, nuclear family, middle school passed and IV category of socioeconomic classification, respectively. Majority of the ASHAs (i.e. 81.2%, 62.5% and 53.2%) were graded into average, good and very good categories of performance, by MO, ANM and beneficiaries, respectively **(table-2).** As per the study, majority of the ASHAs were facing various constraints for providing MCH care services **(table-3).**

DISCUSSION:

In present study, out of 400 ASHAs, majority (76.0%) of them were from the age group of less than 35 years which is similar to studies done by Gopalan SS et al.[3] (2012) and Meena S et al.[4] (2020) who also reported that majority of ASHA's i.e., 78.2% and 67% were in the age group of 25-35 years, respectively. Most (97.2%) of the ASHAs were Hindu and rest were Muslims by religion that is nearly similar to the findings of studies done by Patil S et al.[5] (2023) and Shashank K et al.[6]

(2013) who reported that majority of the ASHAs workers i.e. 94% and 87.1% were Hindus, respectively. Majority (59.8%) of the ASHAs had nuclear family that is little less than the finding of study done by Patil S et al.[5] who reported that 81% of the ASHAs had nuclear family. As far as educational qualification of the ASHAs is concerned, majority (58%) of them had formal education only up to 8th standard as recommended in NRHM that is similar to the finding of study done by Joseph A (2015) who reported that 52.8% ASHAs had formal education till 8th standard.[7] As per Udai Pareek's socio-economic classification, 5.5% of ASHAs were belonged to class V which is similar to finding of study done by Meena S et al.[4] at Jaipur Rajasthan who reported that of 7.4 percent.

In this study health care providers and beneficiaries had different perceptions and gave their feedback on the performance of the ASHAs. As per medical officers/In-charge, they didn't grade even a single ASHA into 'very good category' rather majority (81.2%) of them were graded into 'average category' of performance whereas about two third (62.5%) of the ASHAs were graded into the category of 'good performance' by their respective ANM. Contrary to feedback given by MO & ANM, majority of beneficiaries said that the ASHAs are working hard and have helping & supportive nature therefore, more than half (53.2%) of them were awarded into 'very good category' of performance that is similar to another study, 'evaluation of ASHA scheme under NRHM in Uttar Pradesh (2013)' where majority of the eligible women said that an ASHA is co-operative and easily accessible to them in the hours of need and they also said that an ASHA shares a cordial relationship with them.[8]

Feedback on the performance of ASHAs from the MOs, shows that majority of ASHAs were performing below the set level, assumed average performance prevalence of 50%. In this study, none and some (12.5%) of the ASHAs were graded into 'very good category' of performance by their respective MO and ANM, respectively and they said that majority of ASHAs gave works preference which had financial incentive rest of otherwise. Thus, activities linked to financial incentives were getting priority and other activities were given less importance by the ASHAs that is similar to the report of another study done by JosephA (2015).[7]

In present study various constraints were faced by the ASHAs in providing MCH care services. It was found that majority (84.5%) of the ASHAs were not getting financial incentive total & timely that is similar to other studies where majority of the ASHAs were not getting financial incentive regularly, timely and the entire compensation received by them per month was quite inadequate for their sustenance.[4&7] In another study, most of the ASHAs said, there is less incentives and no provision of fixed salary.[8] In a study done by Sharma R et al. (2014) reported that the ASHA's incentives from both departments were said to be inadequate, irregular, delayed and paid separately rather than, as ASHAs would prefer, a consolidated amount.[9] In a study done by Shet S et al. (2018) reported that activity based incentive was the main challenge faced by ASHA worker where majority (95%) of the ASHA workers agreed that they are getting only monthly incentives according to their activity but not the monthly salary.[10] Bhatia K (2014) reported that ASHAs were discouraged from working by family members because of low payments and delay in receiving incentives.[11] A study, done by Guha I et al.[12] (2018) revealed that the incentive provided to all of the ASHAs was not adequate for their livelihood, and they also said that the monitory incentives provided to them were delayed.

More than half of the ASHAs (55.0%) said that they were facing transport problems to go to delivery centre with expectant mother, especially at night. A study done by Meena S et al.[4] who reported that 23% of the ASHAs were also facing transport problems. In the district Waynad, Kerala, same problem was also faced by majority of the ASHAs where they said that transportation of expectant mothers was a major problem. The charges for transportation of expectant mothers are also much higher than the sanctioned amount. Since ASHA is a link between community and health service, any delay in transportation may lower her credibility in the community which may decrease her effectiveness.[7] As far as different social supports are concerned, only about two fifth (40.8%) of the ASHAs were getting full community supports which is contrary to another study[12] where all of the ASHAs mentioned that community members support them and follow their advice seriously. As far as family support is concerned, majority of the ASHAs (85.2%) were getting full family supports from her husband and other family members similar to a study which revealed that most of the ASHAs were getting extreme support from her family, mainly from her husband.[10]

Majority (64.8%) of the ASHAs said about staying problems for them at delivery centres especially at night because of lacking of facilities such as; adequate sitting arrangement, safe drinking water, hygienic toilets, clean rooms & galleries from dust & dirt, regular supply of electricity, etc., that's why they have to spend a lot of money. Similarly in a study, it was also found that while accompanying the expectant mothers to the institutions and staying there the ASHA has to incur more expenditure on food, stay etc., than the sum provided to her under the JSY scheme [7]. As far as facilities for institutional delivery is concerned, half of the ASHAs (50%) said that there were no adequate facilities at delivery centres as well as more than half of ASHAs (54.5%) told that there were avoidable referral of pri-gravida and other cases that's similar to another study which reported that poor infrastructure is one of the major reasons why people do not prefer to conduct delivery at government health facilities and also revealed that referral cases brought by ASHA are not given due importance and she feels neglected.[8]

More than half of the ASHAs (50.2%) said that they were facing inappropriate behaviours of the health staffs with them at delivery centres. Same problems were also reported in a study, when ASHAs take delivery cases to Government hospitals, they are given very harsh and indifferent treatment by the hospital staffs.[7] As far as availability of ASHA kit & drugs knowledge is concerned, majority (70.5%) of the ASHAs had incomplete drugs (ASHA) kit and drug knowledge which is similar to a study where majority of ASHAs lack knowledge on proper doses of drugs and the drugs which they receive also were closer to expiry date.[7] As far as self-health security is concerned, only about one fourth (26.5%) of the ASHAs were getting some self-health security measures like masks, globes etc. A study done by Joseph A (2015) also revealed that the ASHAs expressed concern over their health security as there is no protective measures like mask, protective immunization etc., available to them who are caring for patients with communicable diseases like TB, Leprosy etc.[7]

More than half of the ASHAs (51.2%) said that after getting initial training there was no further trainings were arranged which is accordance to another study where it was found that, though ASHAs have undergone 23 days training, yet need is felt to reorient them on various health related issues and on accounts keeping.[8] Furthermore, in another study majority of the ASHAs said that, trainings are necessary as they have poor orientation to various national health programs[12]. About one third i.e., 31% and 27.5% of the ASHAs said that there were no regular monthly meetings held by AWW/ANM and MO/ In-charge, respectively. Therefore, they requested that revised trainings, monthly meetings as well as supportive supervision should be continued regularly to be update.

Out of 400 ASHAs, some of them (9.2%) reported that they were serving the village which had 1500 or more population while the norm set by NRHM is one village having population about 1000. Some ASHAs (8%) also reported that there was no AWW in the village which were being served by them.

Thus, the present study revealed the issues related to supervision, job security, total & timely incentives, poor transport etc. were major constraints. Similar challenges/constraints were reported by other studies.[12-15]

CONCLUSION:

Majority of the ASHAs (81.2%) were graded into 'average category' of performance by their respective MOs, while about two third (62.5%) of the ASHAs were graded into 'good category' of performance by their respective ANM and more than half (53.2%) of the ASHAs were awarded into 'very good category' of performance by their respective beneficiaries. Majority of the ASHAs were facing several constraints such as; not getting incentives total & timely, no full social supports, lack of repeated training after initial training, non-availability of vehicles for transportation of expectant mothers during night time, harsh and un-cooperative behaviours of the hospital staffs, poor availability of self-health security measures, etc.

Recommendation:

While financial incentive is indeed powerful tool for increasing productivity and improving performance of health workers, non-

financial incentives also need to be taken into consideration. The negative motivational factors and various constraints need to be tackled, so that ASHAs could function efficiently to attain the overall objective of National Rural Health Mission (NRHM) and ultimately wellbeing of the people.

Table-1: Socio-demographic information of the ASHAs (n=400)

Characteristics		N	%
Age (yrs.)	25-35	304	(76.0)
	35-45	96	(24.0)
Religion	Hindu	389	(97.2)
	Muslims	11	(2.8)
Caste in Hindu (389)	General	68	(17.5)
	OBC	155	(39.8)
	SC/ST	166	(42.7)
Type of family	Nuclear	239	(59.8)
	Joint	161	(40.2)
Education of ASHAs	Middle school	232	(58.0)
	High school /intermediate	139	(34.8)
	Graduate & above	29	(7.2)
*Education of ASHA's Husband (372)	Illiterate	23	(6.2)
	Primary school	21	(5.6)
	Middle school	74	(19.9)
	High school /intermediate	186	(50.0)
	Graduate & above	68	(18.3)
Socio-economic class	I	0	0.0
	II	4	(1.0)
	III	96	(24.0)
	IV	278	(69.5)
	V	22	(5.5)

*Out of 400, 20 ASHAs were widows, 6 ASHAs were divorce/separated and 2 ASHAs were unmarried.

Table-2: Feedback on the performance of the ASHAs from health care providers and beneficiaries

Feedback providers	Level of Performance of ASHAs			
	Very good N (%)	Good N (%)	Average N (%)	Poor N (%)
MO	0(0.0)	75(18.8)	325(81.2)	0(0.0)
ANM	50(12.5)	250(62.5)	93(23.2)	7(1.8)
Beneficiaries	213(53.2)	165(41.3)	22(5.5)	0(0.0)

Table-3: Constraints faced by the ASHAs in providing MCH care services

S.N0.	Constraints	ASHAs	
		Yes. N (%)	No. N (%)
1.	Getting financial incentive total & timely	62(15.5)	338(84.5)
2.	Transport problems especially at night	220(55.0)	180(45.0)
3.	Full Community supports	163(40.8)	237(59.2)
4.	Full family support	341(85.2)	59(14.8)
5.	Staying problems at delivery centres	259(64.8)	141(35.2)
6.	Adequate facilities for institutional deliveries	200(50.0)	200(50.0)
7.	Avoidable referral of primi- gravida	218(54.5)	182(45.5)
8.	Inappropriate behaviours of the health staffs	201(50.2)	199(49.8)
9.	Provision of self-health security	106(26.5)	294(73.5)
10.	Availability & knowledge about complete ASHA kit	118(29.5)	282(70.5)
11.	Repeated training required	205(51.2)	195(48.8)
12.	Regular monthly meeting by ANM/AWW	276(69.0)	124(31.0)
13.	Regular monthly meeting at PHCs/CHCs	290(72.5)	110(27.5)
14.	Work burden related to serving village population	37(9.2)	363(90.8)
15.	Availability of AWW in the same village	368(92.0)	32(8.0)

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