

**STATUS OF TRAINING OF ASHA (ACCREDITED SOCIAL HEALTH ACTIVIST)
WORKERS IN A RURAL BLOCK OF HARYANA.**Meely Panda^{1*}, Neelam Kumar² and Jagbir Singh Malik³¹MD, Senior Resident, Department of Community Medicine, Jamia Hamdard Institute of Medical Science and Research, New Delhi, 110062.²MD, Professor, Department of Community Medicine, Pandit Bhagwat Dayal Sharma Post Graduate Institute of Medical Sciences, Rohtak, Haryana, 124001, India.³MD, Senior Professor, Pandit Bhagwat Dayal Sharma Post Graduate Institute of Medical Sciences, Rohtak, Haryana, 124001, India.**Corresponding Author: Dr. Meely Panda**

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ABSTRACT

Objective: Objective of this study was to assess the status of training of ASHA workers and to evaluate factors affecting their performance. **Methods:** Study was done from October 2012 till May 2013 in a rural block of Haryana. There were a total of 28 ASHA workers, 23 AWWs (Anganwadi Workers), 6 ANMs (Auxiliary Nurse Midwife) and 5 Sarpanch. A list of all the ASHA workers (28 in number) along with their phone numbers were collected from the LHV (Lady Health Visitor). A semi-structured questionnaire was handed over to them and status of training and details related to their level of satisfaction and difficulty in work process was assessed. The other health functionaries were also questioned and results were entered into excel sheet for analysis. **Result:** It was observed that 32% of ASHA workers were not trained at all, 60% were incompletely trained i.e. less than 23 days of training and only the rest 7% were completely trained. About 80% of ASHA workers were satisfied with their career options but 75% found difficulty in the process of working. It was observed that those ASHAs who were satisfied with their career options were helped by the health functionaries and this relation had statistical significance. **Conclusion:** Training status of ASHA workers significantly affects the other activities taken up by her. She is required to work in collaboration with the other health workers which in turn affects the working conditions, satisfaction and difficulties in the work processes if any.

KEYWORDS: ASHA workers, Health functionaries, Training.**INTRODUCTION**

The National Rural Health Mission (NRHM) is a flagship scheme of the central government launched in April 2005.^[1] It aimed to improve the access and provision of basic healthcare facilities in rural India by undertaking an architectural correction in the existing healthcare delivery system.^[2-4]

A new band of community based functionaries, named as Accredited Social Health Activist (ASHA) was proposed to work as grass root level workers.^[2] ASHA will be the first port of call for any health related demands of deprived sections of the population, especially women and children, who find it difficult to access health services.^[5-7] They are the most cost effective way of reaching underserved and inaccessible population.^[8]

AIMS AND OBJECTIVES

Objective of this study was to assess the status of training of ASHA workers and to evaluate factors affecting their performance.

MATERIALS AND METHODS

Study population included health care providers like ASHA workers serving in the respective subcentres, Anganwadi workers, MPHWF (F) – Multipurpose health worker female, PRI representatives.

From among the three PHCs (Samargopalpur, Chiri, Lakhanmajra) under CHC Chiri, PHC Chiri was randomly chosen. All the 5 subcentres under the PHC i.e. Subcentre Chiri, Subcentre Gharonthi, Subcentre Khranti, Subcentre Indergarh and Subcentre Chandi were considered for the study ranging from October 2012 till May 2013. There were a total of 28 ASHA workers, 23 AWWs, 6 ANMs and 5 Sarpanch. A list of all the ASHA workers (28 in number) along with their phone numbers were collected from the LHV (Lady Health Visitor). A day before the visit to the respective subcentre, they were informed over phone or personally.

Institute's review board approval was taken for the study. All the study subjects were fully informed about the

purpose of the study. Informed consent was obtained before the assessment. Anybody unwilling to participate was excluded from the study. The questionnaire was pretested and semi structured blending both qualitative and quantitative data. Consolidated criteria for reporting qualitative research (COREQ) guidelines were followed. There were separate sheets of questions for ASHA, AWW, ANM and PRI representatives. All of them were interviewed one by one and various aspects of the working process of the ASHA were studied. The contents for the questionnaire were chosen after going through the modules which are distributed to the ASHA workers and from which they are imparted training. Besides, there are criterias which have been depicted in the NRHM (National Rural Health mission) mission document and the schedule was constructed so as to observe whether they were at par with those standards or not. Data collection was done at a time convenient to them.

STATISTICAL ANALYSIS

Collected data was coded and analyzed using SPSS 20 and online Graph Pad software version 5.01. Categorical data was presented as percentage (%). Pearson's chi square test was used to evaluate differences between groups for categorized variables. Normally distributed data were presented as means and standard deviation with 95% confidence intervals (CI). All tests were performed at a 5% level significance, and thus the value less than 0.05 (p value < 0.05) was taken as significant association.

Status of training: Training of a total period of 23 days has been accepted as the norm for complete training. It includes initial training of 7 days and continuous training of four rounds of four days each. Any period of training less than this has been categorized as incompletely trained and any person who hasn't even received the first step of 7 day induction training has been put into the untrained category. The training up to module five has been taken into consideration for all practical purposes of assessment.

OBSERVATIONS

The **Figure 1** depicts the socio-demographic details of 28 ASHA workers. Categorization of age shows that most of the subjects (82%) belonged to the age group 25 – 35 years followed by 11% and 7% who were more than 35 years and less than 25 years respectively. Education status found approximately half of the ASHAs to have completed class ten. Caste wise details show that general caste including Jats constituted about 60%, whereas, schedule and backward castes constituted 25% and 15% respectively. Approximately 57% of study subjects had a household income of less than Rs.5000 per month. Except for one ASHA out of 28 (4%) who was a widow, rest all (96%) of them were married. Cent percent of the ASHAs were Hindu and cent percent resided in the same village they served for.

Training details of ASHA workers (**Figure 2**) revealed that approximately 32% of ASHA workers were not trained at all, 60% were incompletely trained i.e. less than 23 days of training and only the rest 7% were completely trained. Based on the capability to understand, it was found that from among those who attended training, about 58% of them could understand what was being taught, and 5% did not understand it at all. Effectiveness of the training in terms of how far they could apply the knowledge on-field denoted that 42% felt it was good, 53% could fairly approve it and rest 5% felt that the theory knowledge was not effective at all for practical application. About 65% said that either the ANM/LHV/MO gave them on-job training, 21% felt that no one had ever given them any such type of training and still 14% said they had never heard about any such type of thing. Considering the rounds of training attended, approximately 32% were not trained at all, 39% and 29% attended 2-3 and 4-5 rounds respectively. All the ASHAs who were trained had been facilitated with food, accommodation and honorarium.

The mean total population coverage per ASHA was 1070 ± 236.6 SD although ANOVA test showed no significance (**Table 1**). The mean total household visits per week were found to be 19 ± 8.8 Standard Deviation (SD) (**Table 1, Figure 3**).

About 80% of ASHA workers were satisfied with their career options but 75% found difficulty in the process of working (**Figure 4**). All the other functionaries felt that ASHA was necessary in their area, but felt that they were less incentivized (**Table 2**). Cent percent of ANMs felt that they provided them on-job training and 83% felt that ASHAs were a part of the village health plan. It was observed that those ASHAs who were satisfied with their career options were helped by the health functionaries and this relation had statistical significance (**Table 3**). It was observed that those ASHAs who had some or other difficulties in their working process were less helped by the health functionaries and this relation however, had no statistical significance (**Table 4**). But those helped by their Panchayats faced less difficulties and this had statistical significance.

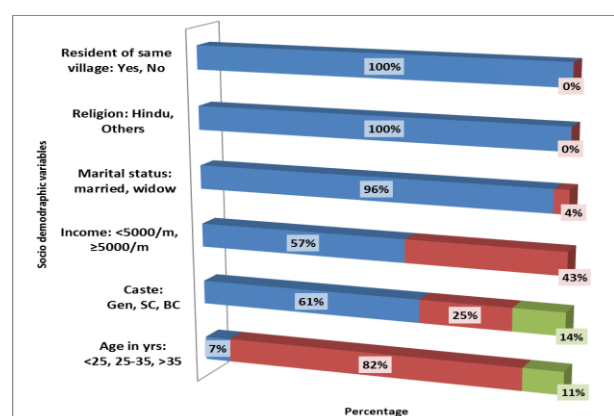


Figure 1: Socio-demographic variables of ASHA workers

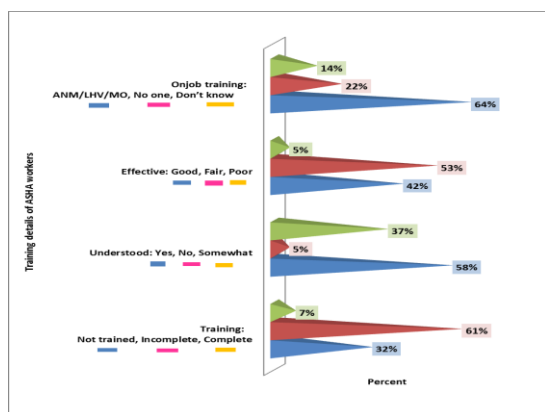


Figure 2: Training details of ASHA workers

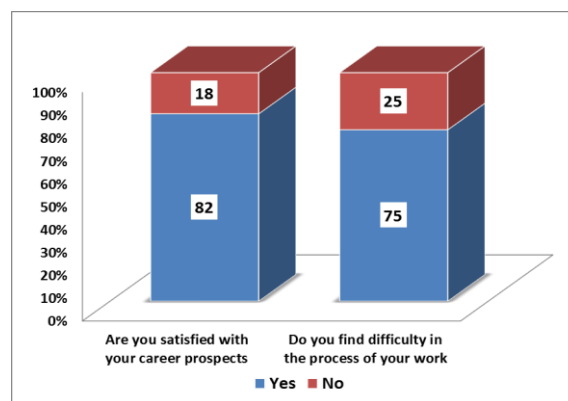


Figure 4: Satisfaction about career options of ASHA workers

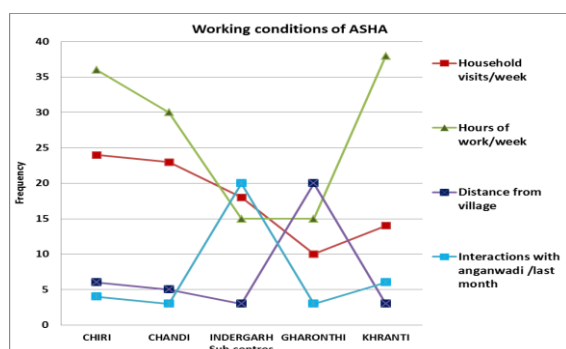


Figure 3: Difficulty in the working process of ASHA workers

Table 1: Variables associated with the working conditions of ASHA

	Name of Village	Mean	Standard Deviation	Significance (ANOVA)
Population Served	Chiri	1054	234.9	0.166
	Chandi	1283	76.4	
	Indergarh	1325	35.4	
	Gharonthi	1000	0.0	
	Khranti	967	326.5	
	Total	1070	236.6	
Household Visits / Week	Chiri	24	9.5	0.010*
	Chandi	23	2.9	
	Indergarh	18	3.5	
	Gharonthi	10	0.8	
	Khranti	14	5.8	
	Total	19	8.8	
Working hours per week	Chiri	36	12.3	0.000*
	Chandi	30	0.0	
	Indergarh	15	0.0	
	Gharonthi	15	0.0	
	Khranti	38	2.7	
	Total	31	12.3	
Distance of institutional place of delivery from village in km	Chiri	6	0.9	0.000*
	Chandi	5	0.0	
	Indergarh	3	0.0	
	Gharonthi	20	0.0	
	Khranti	3	0.0	
	Total	8	6.1	
No. of interactions	Chiri	4	1.9	
	Chandi	3	5.8	
	Indergarh	20	0.0	

with anganwadi workers last month	Gharonthi	3	0.0	0.000*
	Khranti	6	1.9	
	Total	5	4.9	

Table 2: Opinion of functionaries about the ASHA workers

Question		Options	Frequency	Percentage
Is ASHA necessary in your area	MPHW(F) n=6	Yes	6	100
		No	0	0
	AWW n=23	Yes	23	100
		No	0	0
	PRI n=5	Yes	5	100
		No	0	0
Do you feel ASHAs are less incentivized	MPHW(F) n=6	Yes	4	66.6
		No	2	33.4
	AWW n=23	Yes	12	52.2
		No	11	47.8
	PRI n=5	Yes	3	60.0
		No	2	40.0
Do they ever come up to you with their problems	MPHW(F) n=6	Yes	5	83.3
		No	1	16.7
	AWW n=23	Yes	10	43.5
		No	13	56.5
	PRI n=5	Yes	1	20.0
		No	4	80.0
Do you participate in their selection process	MPHW(F) n=6	Yes	4	66.7
		No	2	33.3
	AWW n=23	Yes	6	26.1
		No	17	73.9
	PRI n=5	Yes	1	20.0
		No	4	80.0
Have you ever provided them any training	MPHW(F) n=6	Yes	6	100
		No	0	0
	AWW n=23	Yes	18	78.3
		No	5	21.7
	PRI n=5	Yes	0	0
		No	5	100
Do ASHAs participate in making of the village health plan	MPHW(F) n=6	Yes	5	83.3
		No	1	16.7
	AWW n=23	Yes	0	0
		No	23	100
	PRI n=5	Yes	0	0
		No	5	100

Table 3: Association of satisfaction of ASHA workers with help received by functionaries

Variables		Are you satisfied with your career option as an ASHA			Significance
Are you helped by the following in your work		No	Yes	Total	
MPHW (F)	Yes	3	23	26	$\chi^2 = 9.91$ df = 1 p = 0.002*
		60.0%	100.0%	92.9%	
	No	2	0	2	
		40.0%	0.0%	7.1%	
		5	23	28	

	Total	100.0%	100.0%	100.0%	
AWW	Yes	1	22	23	$\chi^2 = 16.03$ df = 1 p = 0.001*
		20.0%	95.7%	82.1%	
	No	4	1	5	
		80.0%	4.3%	17.9%	
Total	5	23	28		
		100.0%	100.0%	100.0%	
PRI representative	Yes	1	5	6	$\chi^2 = 0.007$ df = 1 p = 0.9
		20.0%	21.7%	21.4%	
	No	4	18	22	
		80.0%	78.3%	78.6%	
Total	5	23	28		
		100.0%	100.0%	100.0%	

Table 4: Association of difficulty in the work process with help received by functionaries

Variables		Do you find any difficulty while working as an ASHA			Significance
Are you helped by the following in your work		Yes	No	Total	
MPHW (F)	No	2	0	2	$\chi^2 = 0.72$ df = 1 p = 0.39
		9.5%	0.0%	7.1%	
	Yes	19	7	26	
		90.5%	100.0%	92.9%	
Total	21	7	28		
		100%	100%	100%	
AWW	No	4	1	5	$\chi^2 = 0.08$ df = 1 p = 0.78
		19.0%	14.3%	17.9%	
	Yes	17	6	23	
		81.0%	85.7%	82.1%	
Total	21	7	28		
		100%	100%	100%	
PRI representative	No	19	3	22	$\chi^2 = 7.07$ df = 1 p = 0.008*
		90.5%	42.9%	78.6%	
	Yes	2	4	6	
		9.5%	57.1%	21.4%	
Total	21	7	28		
		100%	100%	100%	

DISCUSSION

Categorization of age shows that most of the subjects (82%) belonged to the age group 25 – 35 years. Approximately half of the ASHAs had completed class ten. Caste wise details show that general caste including Jats constituted the major chunk. Approximately 57% of study subjects had a household income of less than Rs.5000 per month, 96% of them were married, cent percent of them were Hindu and cent percent resided in the same village they served for.

Shasank et al.^[9] in his study done in Karnataka also found similar details related to demography; the average age being 31 years, 98% married, 90% Hindus residing in the same village they belonged to and 60% of workers up to 10th standard educated. Study under directorship of Baishya et al.^[10] in Nagaland, found the average household income per month to be > Rs.5000 in about 35% of cases and < Rs.5000 in the rest 65% of cases. The slight dis-similarity from our study could be due to the fact that Haryana as such is a prosperous state with per capita income per person much higher than the north-

eastern states. Garg PK.^[11] and Bajpai et al.^[12] also reported similar details relating to their selection but analysis by Bajpai et al was incoherent with that of ours, denoting the fact that several criteria prescribed for selecting ASHAs might have been sacrificed in practice in his study done in the low performing states. Santhya et al.^[13] had similar socio-demographic details with mean age of 29 years, 98% residing in the same village and 98% married.

Training details found that 32% were not trained at all and 7% were completely trained. About 58% could understand what was being taught, 42% felt that it was effective as well and 65% of them felt that they were provided on job training.

Similar findings were shown by Baishya et al.^[10] in his study, where 96% had attended the training and all of them were given the honorarium during the period of training but unlike our study none of the sessions were residential. It might be due to the fact that in our study we had a constant venue for imparting training, which

was the CHC most of the time. Moreover, daily moving up and down might be an easier option for their study area ASHAs, taking distance and communication into account, which was not in our case. Santhya *et al.*^[13], Shukla^[14], Singh *et al.*^[15] Nandan *et al.*^[16] denoted similar findings with 90% of ASHAs who had received training. About 70% felt that training by MPHWS (F) in form of on job training was imparted to them which in our study were reported by 65%.

While it is obvious that good training is essential for health workers, the contents and duration of training could be decided only along with decision on the range and nature of services to be offered by them, and the level of education that they already possess. It has been highlighted that in general there has been a lack of performance due to inadequate capacity of training institutions and lack of capacity of trainers to understand the local community structure.^[17]

The population coverage per ASHA which had a mean of 1070 ± 236.6 SD. Household visits per week had a mean total of 19 ± 8.8 SD. Hours of work per week found the mean total hours to be 31 ± 12.3 SD. The parameter, distance of place of delivery from village had a total mean of $8 \text{ km} \pm 6.1$ SD. Number of interactions with Anganwadi workers per month had a mean total of 5 ± 4.9 SD.

Mohapatra and Mohapatra.^[18] Shasank *et al.*^[9], Srivastava *et al.*^[19] and Bajpai *et al.*^[12] also showed near similar findings.

All the health functionaries: MPHWS (F), AWW and PRI felt that ASHAs were necessary in their area. About 67%, 50% and 60% of MPHWS (F), AWWs and PRIs felt that ASHAs were less incentivized. Nearly 83%, 44% and 20% of MPHWS (F), AWWs and PRIs felt that ASHAs came up to them with their problems.

Bajpai and Dholakia^[12] observed that 22% of PRI members participated in selection process. Shasank *et al.*^[9], Shukla *et al.*^[14] and Nandan D *et al.*^[16] also reported similar findings related to participation in selection process wherein, ASHAs were conceived as an important link by their AWW, ANM and the PRI representatives.

Our study results found that nearly 82% of the ASHA workers were satisfied with their career option as an ASHA. Difficulty in the process of working was encountered by 75% of ASHA workers.

Association of level of satisfaction among ASHA workers with the help received by MPHWS (F), AWW and PRI representative as shown in Table 20 revealed that from among those ASHA workers who were satisfied with their career option as ASHA, cent percent also agreed that they were helped by their MPHWS (F) in their activities, whereas, from among those ASHAs who were not satisfied only 60% were aided by the MPHWS

(F). Similarly, 96% of satisfied ASHAs felt that they were aided by their AWWs in their activities. Both the relations with MPHWS (F) and AWW were found to be statistically significant ($p < 0.05$) denoting that, the more the ASHAs coordinated their activities with other health workers, the better was their level of satisfaction regarding their career options as an ASHA. However, findings on the association with PRI representative were not significant and so can be said not to have a bearing on the level of satisfaction of ASHA workers.

Similarly, association of difficulty in the working process of the ASHA worker with the help received by MPHWS (F), AWW and PRI representative revealed that those ASHA workers who had coordinated well with their PRI representatives (57%) were found to have less difficulty in their work process. It bore significance with $p < 0.05$.

Shasank *et al.*^[9] and Nandan *et al.*^[16] also found out ASHA workers to be satisfied with the services they rendered, but cited lack of coordination from their peer groups and less incentives as a cause of their demotivation. Shukla and Bhatnagar.^[14] reported 29% of ASHAs who did not have community support for their work.

Few of the challenges faced by most of the ASHAs in our study were lack of support from PHC staff, unclear reimbursement policies which delayed payments, lack of recognition and identity, problem in carrying the expectant lady to hospital at the mid of night, drunk drivers who created nuisances in the ambulances and lack of clarity with overlap of job allocation which fetched them incentives.

CONCLUSION AND RECOMMENDATIONS

Training status of ASHA workers significantly affects the other activities taken up by her. She is required to work in collaboration with the other health workers which in turn affects the working conditions, satisfaction and difficulties in the work processes if any. Thus:

- Trainings should provide complete knowledge to the trainees within the stipulated time.
- Quality of training should be enhanced
- Refresher trainings should be planned regularly.
- Training materials should be simple and well depictable.
- The satisfaction of ASHAs about her career perspective can be brought about by increasing new work options for her and decreasing the threat to her from other health functionaries. So a clear segregation of work responsibilities should be done where no one encroaches upon no one's work.

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