ISSN: 2249 - 7862
Aureole, Vol. VII, December 2015 PP 33-41

PROBLEMS FACED BY THE ACCREDITED SOCIAL HEALTH ACTIVISTS (ASHAS) IN THE DELIVERY OF PRIMARY HEALTH CARE SERVICES IN SELECTED DISTRICTS OF KERALA.

*** Ancy Joseph**

Abstract

This paper seeks to study the problems faced by Accredited Social Health Activist (ASHAs) in the delivery of primary health services in the community. A cross sectional study was done on 405 ASHAs selected from three districts of Kerala. The study finds that the effectiveness of ASHA workers largely depends on the training and support from both the health system and the community. Challenges faced by the ASHA are workload, inadequate and delayed payment, lack of follow up after initial training, lack of recognition or priority treatment of patients referred by ASHA, no fixed salary, dissatisfaction with honorarium, health insecurity, inadequate transport allowances, increased drop out of ASHAs, large population to serve and irregular maintenance of drug kit

Keywords **:** *ASHA, Primary health services, National Rural Health Mission, Immunisation*

**Research Scholar, School of Gandian thought and development studies, MG University,Kottayam*

Introduction

The National Rural Health Mission (NRHM) was launched in the year 2005 to enhance the effectiveness of public health care system especially in rural areas. The mission has completed seven years of implementation and the second phase was initiated in the year 2013. Over the seven year period, the ASHA programme has emerged as the largest community health worker programme in the world, and is considered a critical contributor to enabling people's participation in health.1 The main aim of NRHM is to provide accessible, accountable, affordable, effective and reliable primary health care, especially to the poor and vulnerable sections of the population.2, 3 The Mission adopts a synergistic approach by relating health to determinants of good health viz. segments of nutrition, sanitation, hygiene and safe drinking water.4

One of the key components of the mission is creating a band of female health volunteers, appropriately named "Accredited Social Health Activist" (ASHA) in each village within the identified States. These village level community health workers would act as a 'bridge' or an interface between the rural people and health service outlets and would play a central role, in achieving national health and population policy goals.5, 6 Framework of the NRHM underlines ASHA as a health activist in the community.6 She is expected to provide primary medical care with her kit, Control of diseases by information, education, sanitation and surveillance, antenatal, natal & postnatal services to women, counseling in family planning, safe abortion, child Immunization and Vitamin A supplementations, change in behavior in breast feeding, birth spacing, sex discrimination, child marriage, girls education, care of the child especially newborn, household survey, collaborating with health functionaries, working with community for disease control, to create awareness on health and its determinants, mobilize the community towards local health planning, and increase the utilization of the existing health services.7, 8 ASHA will undergo series of training to be completed in 23 days spread over a period of 12 months to acquire efficiency in counseling, identifying health related problems and necessary actions to tackle the situations 9.

To a large extent, the actualization of the goal of NRHM depends on the functional efficacy of the ASHA as the grass root health activist. ASHAs being the grass root level workers, the success of NRHM depends on their awareness and perception about their roles and responsibilities in health care provision. But studies show that they are facing a lot of difficulties in implementing these activities regularly. This will affect the functioning of ASHA workers. Therefore the present study has been planned to identify the various problems faced by ASHAs in relation to the playing of their defined roles effectively and to further suggest measure for optimization of their working.

Objective

To study the problems faced by ASHAs in the delivery of primary health care services in the community in relation to their assigned job responsibilities.

Methodology

Research design

Considering the nature of the study and to accomplish the objectives, the investigator adopted a descriptive cross sectional survey design with selective employment of qualitative method to achieve the objectives of the study.

Setting

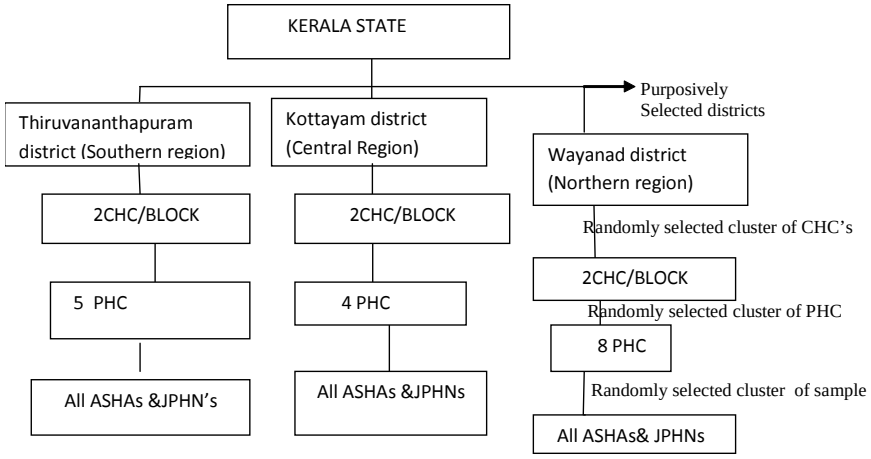
Keeping in view the different geographical regions, the investigator purposively selected three districts , namely Northern, central, and Southern, to represent the entire state of Kerala. Thus Wayanad from Northern, Thiruvananthapuram from southern and Kottayam from central region were selected. The investigator obtained written permission from the Kerala State NRHM Director, Trivandrum, and District Programme Managers (DPM) of Kottayam, Wayanad and Trivandrum respectively to conduct the study.

Sample and Sampling

Considering the setting of the study, a cluster sampling technique was used to select the sample,ie.ASHAs & JPHNs from each of the selected Primary Health Centers(PHCs). In cluster sampling there is a successive random sampling of units. It is otherwise called multistage sampling. The resulting design can be described in terms of the number of stages.4

At the first stage from each district two CHCs were selected using lottery method. In second stage from the selected CHCs of each district the PHCs were selected randomly (lottery method) till the

researcher obtained the required sample size of ASHAs (135/district) and JPHN's(80-135) .In each of the selected PHCs, the entire ASHAs and JPHNs who were present on the day of data collection were selected. Thus a total of 405 ASHAs and 73 JPHNs were selected for the study. Schematic representation of sampling design is given below.



Schematic Representation of the Sampling Design

Tools and Technique

Keeping in view the different geographical regions, the investigator purposively selected three districts , namely Northern, central, and Southern, to represent the entire state of Kerala. Thus Wayanad from Northern, Thiruvananthapuram from southern and Kottayam from central region were selected. The investigator obtained written permission from the Kerala State NRHM Director, Trivandrum, and District Programme Managers (DPM) of Kottayam, Wayanad and Trivandrum respectively to conduct the study.

The researcher reviewed ASHAs training modules and consulted with the experts in the field for the development of the tools. In order to generate qualitative information for the present study, the investigator developed focus group discussion guide to conduct the discussions with ASHAs and JPHNs. The purpose of focus group discussion with ASHAs was to elicit information about the problems faced by the ASHA workers in the delivery of primary health services.

To ensure the content validity, the tool was given to experts from different fields which includes, 4 from community health nursing, 3 from community medicine, 2 from medical surgical, 1 from obstetrics and gynaecology and one statistician. Based on their valuable suggestions focus group discussion guide was finalised.

Reliability of the tool was assured by

- Triangulation of information obtained from two data collection tools (Focus Group Discussion with ASHAs , JPHNs and ASHA Coordinator)
- Inter-rater reliability during the analysis phase with a peer de-briefer

Procedure for Data Collection

The data were collected over a period of six months from April to September 2015. The investigator personally contacted the ASHA Coordinators and Medical Officers of the concerned PHCs and took permission to conduct the study among the ASHA workers. The tentative date and time of data collection was mutually decided. The ASHA workers were contacted in their respective PHCs during their monthly review meetings

Focus group discussions (FGD) were conducted using a Focus group interview guideline, with ASHAs and JPHNs separately and two CHCs were randomly selected from each district. Six sessions were conducted with ASHAs and there were eight to twelve members in each session, who were randomly selected proportionally from the subcentres of each PHC. The investigator took the help of a facilitator in order to record the details of focus group discussion. The purpose of the FDG was explained and discussions were tape recorded with their consent. Assurance was made to the respondents on the confidentiality of the information. They were also promised that the information would be used for study purpose only. Focus group Discussions among ASHAs were based on the various problems faced by the ASHA workers in relation to the delivery of primary health care services such as maternal health, Child health, Family Planning, communicable and non-communicable diseases. ASHAs actively participated in the discussion and brought out many issues .Each session took around 45 minutes to one hour.

Three FGDs were also conducted with the JPHNs of each district. Six or more members were present for the session. Purpose of the FGD was explained and consent was obtained to tape record the information. Discussion was based on the functioning of ASHA workers in the delivery of primary health care services in the community. JPHNs actively participated in the discussion and shared their opinion and observations made on ASHAs in their capacity as supervisory staff. Each session took around 30 to 45 minutes.

Results

Majority (64.9%) of the ASHAs were in the age group of above 40 years. Three hundred and forty six (85.47%) of them are married and 233 (57.5%) are Hindu by religion. 394 (97.3%) of ASHAs had formal education till 8th standard as recommended in NRHM with sizeable number (180;44.4%) of them had education up to higher secondary level. When distributed according to income level 308(76%) ASHAs belongs to an income of <5000/month.Majority209 (51.6%) of them were looking after a population between 1000-1500. 377(93.1%) were satisfied as ASHAs and 402 (99.3%) of them continue to work in the same position.

Problems: analysis of the findings

1. In some areas, the ASHAs position has remained vacant and no additional re cruitments have taken place. Some of them have a population ranging between 2000-3000 (where the norm is one ASHA for a population of 1000). Hence they are not able to deliver service properly due to the over burden of work.
2. Population in some of the villages in the Wayanad district is spread over large areas and intercepted by hills and rivers. ASHAs in such places will have to walk long distances to reach the home of tribals. Due to these natural barriers, the ASHAs even failed to visit certain areas and certain sections of the population remained un-served and un-reached.
3. The activities linked to financial incentives are getting priority and other activi ties are given less importance by the ASHAs. The ASHAs are very keen on some of their job responsibilities like registration of pregnant women, ANC/ PNC, immunization, but they neglect areas such as adolescent education, motivating pregnant women for nutritious diet, identification of patients with TB, leprosy, mobilization for cataract surgery etc
4. The entire compensation received by ASHAs per month is quite inadequate for their sustenance. The members in the community and JPHNs have indicated the inadequacy of the compensation to the ASHAs.
5. Majority of the ASHAs are not getting incentives in time. This is a negative mo tivational factor which needs to be tackled. Most of the ASHAs in all the three districts voice dissatisfaction with the incentive. The main reason that came out of the study was that they have to work hard, their expenses are more and ince ntives come late. The dissatisfaction was observed more among ASHAs work ing in the tribal areas in Wayanad. More expenses are the commonest cause of dissatisfaction among tribal ASHAs.
6. As lot of communication is needed with the people in the community, ASHAs demand some monthly payment towards telephone charges.
7. Transportation of expectant mothers is a major problem. In the villages of Way anad , the transport services are not available specially at night time. The charges for transportation of expectant mothers are also much higher than the sanc tioned 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.
8. 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 pro vided to her under the JSY scheme.
9. When they take delivery cases to Government hospitals, they are given very harsh and indifferent treatment by the hospital staff, especially when the tribals of Waynad district are the beneficiaries.

10. Due to fear of abortion, some people will not inform early about the pregnancy. Hence ASHAs are not able to do the early registration and hence lost subsequent monetary benefits.
11. Another operational problem is when ASHA provide all the approved services of ANC and immunization but fail to get the incentive if she missed the monthly meeting or if she has not immunized minimum 5 children per month or if she missed the opportunity to accompany the child to the health facility. Besides, she also loses the incentive if the client opted for delivery in private hospital or nursing home, although the ASHA may have taken care of the mother from the beginning. So there is no certainty of economic remuneration.
12. After monthly NCD clinic in the subcentres, the prescribed medicines are available to the patient only from the main PHCs .So due to this inconvenience many patients are not even going to the subcentres on NCD clinic days even for the routine checkup.
13. 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.
14. In Wayanad district, though ASHAs promote permanent family planning methods, doctors are not taking any interest; this is partly because there was a complaint that tribals are forced to do tubectomy. Still the beneficiaries will have to get a recommendation letter from the village leader. So ASHAs are hardly getting any monetary benefits out of this service.
15. It is extremely difficult to convince males for vasectomy as they have a misconception that such procedures may affect their future functioning as well as sexual capacity.
16. The sanitary pads available for the adolescent girls are of very poor in quality. So many of them returned them to the ASHAs.
17. ASHAs complained that they are not called to participate in the monthly Panchayat meetings, though it is given as part of their job responsibilities.
18. ASHAs expressed that being an ASHA they are not allowed to contest panchayat elections
19. Few of the ASHAs reported that they received medicine kits which are incomplete in many respects. The majority of ASHAs lack knowledge on proper doses of drugs and the drug which they receive also was closer to expiry date
20. All of the ASHAs in the three districts received training (6 modules) in the beginning but failed to give follow up even after many years of service.
21. As ASHAs will have to work almost every day in the PHC, they are not able to go for any other part time job to meet the livelihood of the family.

Conclusion

The actualization of the goal of NRHM depends on the functional efficacy of the ASHA as the grassroots health activist. The present study made an attempt to elicit the various problems faced by ASHAs in relation to the delivery of primary health services in the community. The ASHAs have outlined several problems and the most important operational problem is that activities linked to financial incentives are getting priority and other activities are given less importance by the ASHAs. Majority of the ASHAs are not getting incentives in time. The other Challenges are workload, inadequate and delayed payment, lack of follow up after initial training, lack of recognition or priority treatment of patients referred by ASHA, no fixed salary, dissatisfaction with honorarium, inadequate transport allowances, non availability of vehicles for transportation of expectant mothers during night time, harsh and unco-operative treatment by the hospital staff, increased drop out of ASHA, large population to serve, irregular maintenance of drug kit, non availability of protective measures & medical benefit ,non availability of doctors, and inadequate involvement during Panchayat meetings. These negative motivational factors need to be tackled, so that ASHA could function efficiently to attain the overall objective of National Health Mission and ultimately the health of the nation.

REFERENCES

1. National Rural Health Mission. Guidelines for Community Processes. Ministry of Health and Family welfare. .[cited2013].Available from:http:// tripuranrhm. gov.in /Guidlines/
2. Government of India, National Rural Health Mission (2005 -12), Mission Docu ment.Availableat:http://www.mohfw.nic.in/NRHM/Documents/Mission _Document.pdf . Accessed on November 28th, 2012.
3. Assessment of ASHA and Janani Suraksha Yojana in Madhya Pradesh. Available at:www.cortindia.com/RP/RP-2007-0301.pdf. Accessed on November 7th, 2011.
4. Namshum N., Maternal and child health. Reading Material for ASHA. Book Num ber- 1. 1st ed. New Delhi:Ministry of Health and FamilyWelfare, Government of India;2006. p8.
5. Srivastava DK, Prakash S, Adhish V, Nair KS, Gupta S, Nandan D. A study of inter face of ASHA with the community and the service providers in Eastern Uttar Pradesh. Indian J Public Health 2009; 53(3):133-6.
6. Darshan K. Mahyavanshi, Mitali G. Patel, Girija Kartha, Shyamal K. Purani, Sunita S. Nagar. A cross sectional study of the knowledge, attitude and practice of ASHA workers regarding child health (under five years of age) in Surendranagar dis trict. Healthline 2011; 2(2): 50-53.

7. Bhatnagar R, Singh K, Bir T, Datta U, Raj S, Nandan D. An assessment of perfor mance based incentive system for ASHA Sahyogini in Udaipur, Rajasthan. Indian J Public Health 2009; 53(3):166-70.
8. Factors influencing utilization of ASHA services under NRHM in relation to ma ternal health In rural Lucknow. Indian J Community Med. 2010 July; 35(3): 414-419.
9. Government of India, NRHM-ASHA (2005) Module Guidelines, Ministry of Health and Family Welfare, New Delhi.