Qualitative Assessment of Accredited Social Health Activists (ASHA) Regarding Their Roles and Responsibilities and Factors Influencing Their Performance in Selected Villages of Wardha

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Abstract

Background: The National Rural Health Mission has introduced village-level female community health worker, accredited social health activist (ASHA) who acts as an interface between the community and the public health system. The study was conducted to assess the awareness and perceptions of ASHA regarding their roles and responsibilities in health-care system and factors affecting their performance in delivering health-care services. Methodology: A qualitative study was conducted in seven selected villages under Talegaon Primary Health Centers, Wardha district, Maharashtra, which is also field practice area of a medical college. Nonprobability sampling (purposive sampling) was done. In-depth interviews were conducted on ASHAs (n = 7) of those selected villages till saturation of data. Data were analyzed using the thematic framework approach. Results: ASHAs perception regarding their job responsibilities appeared to be incomplete. They had good awareness regarding their roles and responsibilities as a link worker. They were found to be mostly interested in higher incentive performances. ASHAs clarity regarding their roles and responsibilities as facilitator, social activist, and service provider was found to be somewhat compromised. They were ignorant about their roles and responsibilities under various newly launched national programs. The positive factors influencing ASHAs performances were regular supervision of their performances and appraisal by higher authority and support from community, family, and good relations with coworkers and staff. Challenges faced by most of the ASHAs were more workload, poor orientation to program, lack of quality training, and inadequate and delayed monetary incentives. Conclusion: Good quality training with regular refresher training sessions and regularization of incentives are required to motivate them ASHAs.

Keywords: Accredited social health activist, National Rural Health Mission, nutrition and sanitation committee, village health, village health and nutrition day

Introduction

Under the National Rural Health Mission (NRHM), the concept of trained female community health activist or accredited social health activist (ASHA) has been introduced to all villages of the country who acts as an interface between the community and the public health system. They are selected from the village itself (one for 1000 population), preferably in the age group of 25–45 years with minimum formal education of 8 years. NRHM has envisaged capacity building of ASHAs through training, and for motivating them, there is a provision of performance-based incentive system. They are trained to provide primary medical care, health education on sanitation, hygiene, antenatal and postnatal care (PNC), escorting expectant mothers to the hospital for safe delivery, and immunization of children, etc. ASHAs responsibilities range from health education to detection of diseased cases and referral to higher health facilities [Figure 1].

ASHA guidelines were formulated by the Ministry of Health and Family Welfare, Government of India, where roles and responsibilities of ASHA, their working arrangements, capacity building, and performance-based incentives, etc., have...
Roles and responsibilities of ASHAs regarding their role and position in the community and health facilities, but they are mostly focused on providing primary health care. This qualitative study was conducted in seven selected villages of Talegaon Primary Health Center (PHC), Wardha district, Maharashtra, which is under field practice area of a medical college. Nonprobability sampling (purposive sampling) was done. In-depth interviews were conducted on ASHAs (n = 7) of those seven selected villages till saturation of data was achieved. The study was conducted in February 2016.

**Results**

**Awareness and perceptions about roles and responsibilities of accredited social health activist**

Almost all of the ASHAs were well aware that they bear a major role as link workers among the community and health system. According to them, “Dawakhana aani gawati pokhri bharun kadhnachi kaam ami karlo.”

“We are the linker between the community and hospitals.”

One ASHA stated that “We are linkers between the community and hospitals. As doctors and nurses cannot visit to all the places always during need, so we accompany pregnant women to hospitals for their checkup and delivery.”

Majority of them mentioned that activities involved by them were antenatal and PNC, escorting pregnant women for checkup and institutional delivery, newborn care and referral, detection of danger signs of pregnancy and child illnesses, and health education during home visits.

However, very few mentioned about their roles in facilitating breastfeeding and complementary feeding, use of contraceptives, and promotion of building household toilets. During interview, ASHA_3 told that “Sanitary latrine to Satya Sai Sanstha ghar ghar me bana ke de rahe hai aur Gram Panchayat se bhi sahaya milta hai, isliye iss bare me hum nehi batate.”

“Satya Sai Sanstha (NGO) is building sanitary latrines in household and Gram Panchayat is also helping, so we do not talk of that.”

From the findings, it is clear that the participants had good awareness regarding their role as link workers between the community and health facilities, but they are mostly focused toward maternal and child health (MCH) services, and it may...
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**Table 1: Coding framework**

| Higher-order themes | Second-order themes | First-order themes |
|---------------------|---------------------|-------------------|
| Awareness and perceptions of ASHA regarding their role and responsibilities | Link workers and facilitators | Home visits |
|                     |                     | Institutional delivery |
|                     |                     | Antenatal and postnatal care |
|                     |                     | Newborn care |
|                     |                     | Immunization |
|                     |                     | Referral to higher center |
| Health educator     | Counseling          | |
|                     | Nutritional counseling | |
|                     | Antenatal and postnatal counseling | |
|                     | Danger signs of newborn | |
|                     | Menstrual hygiene | |
|                     | Availability of health facilities | |
| Service provider    | Treatment of minor ailments | |
|                     | Dressing of minor wounds | |
|                     | Assisting pregnant ladies | |
|                     | Home visits | |
|                     | Counseling | |
|                     | Referral | |
|                     | VHND | |
| Activist            | Arrange VHNSC meetings | |
|                     | Immunization coverage | |
|                     | Target of institutional delivery | |
| Factors affecting their performance in delivering health-care services | Positive factors | Appraisal and recognition |
|                     | Family support | |
|                     | Community support | |
| Professional        | Cooperative coworkers and PHC staffs | |
|                     | Good supervision | |
| Organizational      | Poor monetary incentives | |
| Negative factors    | Delayed incentives | |
|                     | Limited income | |
|                     | Excessive workload | |
|                     | Vast coverage | |
|                     | Poor transportation facility | |
|                     | Lack of quality training and refresher training | |
|                     | Inadequate supply of drugs and equipment | |
|                     | Lack of infrastructure | |
|                     | Irregular monitoring | |

ASHA=Accredited social health activist, VHND=Village health and nutrition day, PHC=Primary health centers, VHNSC=Village health, nutrition and sanitation committee

be because incentives to these services are more compared to other services. Role as facilitator was also found to be compromised, reason may be lack of clarity regarding their responsibilities as facilitators.

**Accredited social health activist as health educator**

Majority of ASHAs mentioned that they disseminate health information during home visits and Village Health and Nutrition Day (VHND) regarding antenatal care (ANC), child care, institutional delivery, menstrual hygiene, nutrition of pregnant mother and children, and sanitation mostly. They also provide awareness regarding the health-care delivery systems and the availability of various services.

ASHA_6 highlighted that

“Gao wale mujhe puchte hai apne bimari ki bareme aur kaha SE chikitsha lena hai wo bhi puchte hai.”

“Villagers ask me regarding their illnesses and from where to seek health care.”

Most of the ASHAs mentioned that they provide health education during VHNDs and home delivery to antenatal/postnatal and lactating women for about 10–15 min per visit. Although they have some awareness regarding their roles as health educators, it seems that they were giving very less time in health education because they were overburdened by other activities and had to maintain various registers as stated by most of the ASHAs.

**Accredited social health activist as service provider**

Most of the ASHAs stated that they can treat minor ailments such as acute respiratory infections, worm infestations, and dressing of minor wounds by the drug kit provided to them, and they refer patients to higher center if danger signs are present or if there are no signs of improvement.

None of the ASHAs explained about detection of tuberculosis, leprosy, and malaria cases in the community. All the ASHAs were unaware about programs for noncommunicable diseases and had very less knowledge regarding noncommunicable diseases. None of them measured blood pressure of patients; on asking, one ASHA said that,

“Sikhaya tha par mujhe aata nei, haar VHND me ANM BP naapte hai pregnant mahilao ki.”

“We were taught but I do not know how to measure BP now, but during every VHND auxillary nurse midwife (ANM) measures blood pressure of pregnant women.”

On asking, a few ASHAs mentioned that they were very satisfied after providing basic services such as treating ailments of people, but majority mentioned regarding unavailability or inadequate supply of drugs and equipment to them from the government.

ASHA_1 stated that

“Chikitshya karke lagta hai ke hum khud doctor ban gaye.”

“After treating it feels like I have become a doctor.”

It was found that awareness regarding their roles and responsibility as service provider was incomplete and they were found to be less interested, may be because of lack of quality training and inadequate supply of drugs and equipment to them.
Accredited social health activist as activist
Interviewing ASHAs regarding their role as activists highlighted that most of them were completely unaware of what being an activist means. A few of them stated that they mostly focus on fulfilling the target of immunization coverage, institutional delivery, and organizing VHNDs as supervisors and medical officers of PHC instruct them. A few mentioned that they help Anganwadi worker to arrange Village Health, Nutrition and Sanitation Committee (VHNSC) meetings monthly where village problems regarding health, sanitation, and nutrition are discussed and measures are taken. Hence, the awareness regarding their role as activist was found to be deficient; lack of training can be the reason.

Factors influencing accredited social health activists’ performance
The various factors such as the facilitating and inhibiting ASHAs performance in delivering health-care services are described as follows:

Personal
Poor monetary incentives
Almost all of the participants said that the incentives provided to them were not adequate for their livelihood, and a few told that the monetary incentives provided to them were delayed. On asking, none of the ASHAs can correctly mention the amount of incentives allocated for specific services.

On probing, ASHA_2 told that

“ANC/PNC, immunization, delivery karke hume bohot kaam time milti hai aur iske liye Janani surakshya scheme bhi lagu hai, pregnant aurat ko v thoda bohot paisa milti hai aur hume bhi.”

“We get very less time after attending ANC/PNC, immunization and delivery and Janani Suraksha scheme is also applicable because of which the pregnant lady gets some money and so do we.”

ASHA_7 said that “Mera gaon bohot chota hai, kuch hi pregnant cases milti hai mujhe, mera utna income hota nehi.”

“My village is very small and I get few pregnant cases so my income is very less.”

Findings suggest that they are mostly focused toward higher incentive-based services, and it may be because the low monetary incentives for other services could not attract their interest as they had very limited income, and because of their workload, they preferred to do higher incentive-based services.

Excessive workload
All the ASHAs said that the workload was excessive and paperwork mostly maintaining various registers was very hectic. One of the ASHAs narrated,

“I hardly get time for my family members, have to do paperwork at home also and receive phone calls from patients anytime. My husband scolds me sometimes saying that what is the point of working for others when I cannot even give time to my own family.”

Vast coverage area and poor transportation
A few ASHAs said that their village is very vast with no proper transportation facility. Hence, they find it difficult to attend and refer patients mainly during night hours.

Family and community support
Most of the ASHAs said that they get family support. ASHA_4 mentioned that she gets extreme support from her family mainly husband, even he helps her in her works. All of the ASHAs mentioned that community members support them and follow their advice seriously. ASHA_3 mentioned that “Logo ke liye kaam karke aacha lagta hai wo log doctor SE fyada humpe viswas rakhte hai.”

“We feel good after doing something for people; they trust us more than doctors.”

Professional
Quality training
Most of the ASHAs said that they had received training in the initial phase of their service and no refresher trainings were provided. A few said that trainings they received were effective, but revision trainings are required. Furthermore, a few said that trainings are necessary as they have poor orientation to various national programs.

Cooperation of coworkers and others
Almost all ASHAs mentioned that Anganwadi workers and auxiliary nurse midwives (ANM) cooperate with them mainly in VHNDs. Medical officers also help them. A few said sometimes Gram Panchayat and VHNSC also cooperates with them.

Organizational
Supervision
According to the study participants, supervisors instruct them, but regularization of meetings with supervisors was lacking, so they sometimes are not able to clarify their doubts which affects their performance.

Infrastructure
Most of the ASHAs said that they did not always receive supply of adequate quantity of drugs (mostly iron and folic acid tablets) and equipment, so sometimes they had to face stock-outs of drugs which hamper their service delivery.

Most of the ASHAs mentioned that recognition for good performance by supervisors and medical officers and appreciation from community motivates them for better performance.

Discussion
Study findings suggest that ASHAs perception regarding their job responsibilities appeared to be incomplete. They had good awareness and were predominantly focused on being a link
worker. They were found to be mostly interested in providing MCH services as they may be influenced by higher incentive performances and supportive supervision by PHC staffs who encourage them to focus on MCH services in achieving the targets assigned particularly institutional delivery and immunization coverage. A similar association between higher incentives and ASHAs performance focusing mainly on MCH services was reported in other studies also.[5-7]

ASHAs clarity regarding their roles and responsibilities as facilitator, social activists, and service provider was found to be somewhat compromised in our study. Even most of them were unaware about the roles and responsibilities under various newly launched national programs. It may be because of lack of effective training and refresher training. Excessive workload and poor incentives as mentioned by ASHAs were also reasons to ignore low incentive-based performances and spend less time on health education though they had some knowledge regarding their role as health educator.

The facilitating and inhibiting factors affecting ASHAs performance are illustrated in Figure 2. Here, the size of the circle represents perceptions of ASHAs about the positive and negative factors influencing their performances.

Findings suggest that the positive factors influencing ASHAs performances were acknowledgment and appraisal by higher authority, support from community, family, and good relations with coworkers and PHC staff, and good supervision of their performance as these factors motivate them. Challenges faced by most of the ASHAs were excessive workload, vast coverage area, poor orientation to various programs, lack of quality training and inadequate supply of drugs and equipment to them, and lack of regular supervision. Irregular and low monetary incentives demotivate them. Awareness regarding correct amount of incentives as per services was lacking which also increases attrition rate as mentioned in the study of Khan et al. (1998) and Kumar et al. (2013). [8,9] However, the study of Gopalan et al. (2012) done in Orissa showed no association between ASHA’s level of dissatisfaction on the incentives and the extent of motivation regarding performances. Inadequate health-care delivery status and certain working modalities were reason behind their reduced motivation.[10]

Results of Gosavi et al. (2011) study conducted at Anji PHC, Wardha district, reported that awareness of ASHAs about their roles and responsibilities were not adequate due to work burden and lack of adequate training, support, and guidance from PHC staff. Unclear reimbursement policy and poor and delayed incentives were also reported by ASHAs.[4]

A study by Sharma et al. (2014) conducted at Udaipur, Rajasthan, showed that ASHAs’ motivation and performance were affected by many factors such as personal (e.g., education status), professional (e.g., job security and lack of effective training), and organizational (e.g., lack of infrastructure) and factors related to external work environment.[11]

Findings of Saprii et al. (2015) study conducted at Manipur reported that ASHAs were mostly understood as link workers and service providers. Lack of community sensitization regarding ASHA program was a lacuna toward their success and sustainability, and they had limited knowledge about their role as an “activist” which was also observed in our study. Small and irregular monetary incentives were major barriers to ASHAs’ performances.[5]

Garg et al. (2013) study at Haryana reported that ASHA’s perception about their job responsibilities appeared to be incomplete and improper. Many of them were unaware regarding their role in assisting ANM in village health planning, generating awareness on basic sanitation and personal hygiene and birth and death registration. A study recommended that fair incentives and capacity building of ASHAs by imparting trainings can be effective toward delivering better health services.[12]

This study is having a few limiting factors as it was conducted in one particular area on limited number of participants using purposive sampling; it limits generalisability of the results.

**Conclusion**

From these study findings, it is evident that ASHAs were not having clarity regarding their roles and responsibilities as per the NRHM guidelines. Hence, quality training programs and more efforts regarding sensitizing and motivating ASHAs may be helpful for improving their performance. Provision of fair monetary incentives and regularization of incentives can be effective in motivating ASHAs for participating efficiently in health-care delivery system.

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**Conflicts of interest**

There are no conflicts of interest.
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