Original Article

ACCREDITED SOCIAL HEALTH ACTIVISTS IN HEALTH CARE DELIVERY SYSTEM: RECRUITMENT, ROLE AND PERCEIVED REASONS FOR JOINING SERVICES

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ABSTRACT

Background: As per National Rural Health Mission (NRHM), India launched ASHA programme in the year 2006, to bridge the gap between health services and the underserved population of community. We conducted a study in Murshidabad district of West Bengal to describe socio-demographic profile, recruitment process and perceived reason for joining the health services. **Methods:** We conducted a cross sectional study among 237 ASHAs and the result was analysed in Epi info. **Results –** Of the total 237 ASHAs interviewed, one third (n=79) ASHAs were Muslims in that district where two third of the population belonged to the same religious community and one third were not local residents of their areas. More than 90% of the ASHAs were recruited by village pradhan and or village panchayat. Majority (44%) joined for financial benefits. Majority (67%) of the ASHA had to serve more than 1000 populations and only 10% of the ASHA were trained in module 6 & 7. **Conclusion:** Recruitment process of ASHA was not in line with the prescribed guideline and reasons for joining the services as perceived by ASHAs was not matching with the programme objective.

Key words: ASHA, Perceived reasons, recruitment, NRHM, Murshidabad

Introduction :

Accredited Social Health Activist (ASHA) is the key component of National Rural Health Mission 2005[1,2] . Scheme of ASHA was initiated to bridge the gap between health services and targeted underserved population of community[3]. Programme first started in Chhattisgarh[4]. The Mitanins were women health workers whose role was defined as a mix of community level care provision, facilitators and activists. This programme was the precursor of the Accredited Social Health Activists (ASHA) programme started in 2006 under the National Rural Health Mission (NRHM). The NRHM was

launched in 2005 with an objective to provide effective health care to the rural population[5,6]. The ASHAs are the link agents between the community and the health care delivery system.

As per NRHM guidelines, every village / large habitat of 1000 population should have an ASHA chosen by and accountable to the Panchayat[5]. ASHA must be primarily a woman resident of the village and she must be married/widow/divorced/ separated and preferably in the age group of 25-45 years. She should be a literate woman with formal education of up to 8th class with communication and leadership qualities[5,7]. ASHAs are chosen through a rigorous process of selection involving various community groups, self-help groups, Anganwadi Institutions, the Block Nodal Officer, District Nodal Officer, the Village Health Committee and the Gram sabha[1,4]. Accredited Social Health Activists have to undergo a series of modular training programs at the district hospitals / Block Primary Health Centres (PHCs) by the trained taluka medical officer / district health officer.

ASHA's are trained to advise village populations about sanitation, hygiene, contraception, and immunization; to provide primary medical care for diarrhea, minor injuries, and fevers; and to escort patients to medical centers[6]. She must be trained in five to seven modules for ASHA and has to do her job about 3-4 hours per day for which she gets performance based incentives on monthly basis[7-9]. Qualified, trained and motivated human resource is key to success of any programme. Present study was conducted to study the profile, recruitment process and reasons for joining the services as perceived by ASHAs.

Objectives: Objectives of the study were as follows-

1. To study socio-demographic profile of ASHAs working in Murshidabad district.
2. To study the process of recruitment and role of ASHAs working in Murshidabad district.
3. To study the reasons for joining the health services as perceived by ASHAs.

Material and Methods:

Study area: Present study was conducted in Murshidabad district of West Bengal. Murshidabad has a total population of 7,102,430 as per 2011 census. Twenty percent of the population is women of child bearing age (15-45 years) and 21% population are children of 0-6 years.

Study population: Study population was ASHAs working in the district for more than one year.

Study design: A cross sectional study among ASHAs working in Murshidabad district.

Sampling and Sample size: A sample size of 237 was calculated within 95% confidence limit, power of 80%, absolute precision of 5%, non response rate of 10% and reported prevalence of 82% of ASHAs completing household visits[10]. A line list of all 4270 ASHAs working in the district was created. The sample sizes of 237 ASHAs were selected from this line list by using simple random sampling.

Data collection: Data collection was done by interviewing ASHAs using a pre-tested questionnaire developed by the National Health Systems Resource Centre, New Delhi for the multi-state evaluation of ASHAs[11, 12]. The instrument was translated in local Bengali language. Information on socio-demographic characteristics, recruitment process and perceived reasons for joining the services was collected. Data collection was done by trained field workers and supervisors. Data collection was done from January to March 2012.

Data Analysis: Data was entered and analyzed using Epi-Info (3.5.1 version, CDC Atlanta, USA). Means and proportions were calculated to describe the socio-demographic and job related characteristics of ASHA.

Human subject protection: The respondents provided written informed consent in local Bengali Language. The study was approved by the ethics committee of the National Institute of Epidemiology (ICMR), Chennai.

Results:

Out of total 4270 ASHAs working in Murshidabad district 237 (5.6%) were interviewed. Out of total 237 ASHAs interviewed, 62% were above 35 years of age (age range 28 – 44 years), 96% were currently married and 63% were educated up to secondary school level.

Table-1: Socio-demographic characteristics of ASHAs working in Murshidabad district of West Bengal (N= 237)

Particulars	Characteristics	No.	%
Age	<35 years	90	37.97
	≥35 years	147	62.03
Marital status	Married	228	96.2
	Widow, divorced & separated	9	3.8
Educational level	Up to secondary pass	150	63.3
	Higher secondary & college level	87	36.7
Occupation	Homemaker	142	59.9
	Self employed and others	95	40.1
Religion	Hindu	169	71.3
	Muslim	68	28.7
Caste	General and OBC	141	59.5
	SC, ST	96	40.5
No. of children	Up to 2	196	82.7
	More than 2	41	17.3
BPL card holder	Yes	53	22.4
Resident of service area	Yes	161	67.9
Monthly Family Income Median ±SD (Range)	Rs 4000 ± 800 (500 – 30000)		

Nearly two third of them were permanent resident of the villages where they were working and 60 % of them were homemaker. About one third of them were of Muslim religion

and 41% were belonged to scheduled caste and scheduled tribe categories. Most of them (83%) had up to 2 children. The median monthly family income was 4000 rupees (range 800 – 30,000 rupees) and 22% of them belonged to BPL families (Table 1).

Out of 237 ASHAs 90.3% were selected by village panchayat and /or village pradhan. Only 9.2% were recruited by ANM & health department while 0.5% by Village Health and Sanitation Committee (VHSC). In recruitment of more than 50% of the ASHAs village pradhan was the main person followed by village panchayat (38%) and ANMs (9.7%) respectively. Two third (67%) of ASHAs were assigned more than 1000 population and 30% served more than 250 households. About 59% of the ASHAs informed that it took them less than half an hour to reach their work area. Walking was the commonest mode (89%) to reach the workplace. More than 60% of the ASHAs reported that they worked for 3 hours or more per day. Village Panchayat or Pradhan was the main person (90.3%) in the selection process of the ASHAs (Table 2).

Table- 2: Recruitment process and role of ASHAs working in Murshidabad district of West Bengal- India (n=237)

Particulars	Characteristics	No.	%
Who selected ASHA	Village Panchayat and/ or Pradhan	214	90.3
	ANM and Health Department	22	9.2
	VHSC	1	0.5
Selection process of ASHA	Pradhan was the main person	124	52.3
	Meeting of the Panchayat	90	38.0
	ANM was the main Person	23	9.7
Population covered	Up to1000	78	32.9
	More than1000	159	67.1
Households served	Up to 250	156	65.8
	More than 250	81	34.2
Time to reach farthest household	Up to ½ hour	139	58.6
	More than½ hour	98	41.4
Mode of access to farthest house	Walking	211	89.0
	Bicycle	22	9.3
	Motorized vehicle & others	4	1.7
ASHA`s work hour per day	Up to 3 hours	92	38.8
	More than 3 hours	146	61.6

Out of 237 ASHAs interviewed for perceived reasons for joining the health services, The commonest reasons cited was financial benefits (43.9%) followed by desire to become permanent government employee (28.6%), desire to serve community (20.7%) and others (6.8%) respectively (Table 3).

Table-3: Reasons for joining the health services as perceived by ASHAs working in Murshidabad district of West Bengal- India (n=237)

Perceived Reasons for joining health services	No.	%
Due to financial benefit	104	43.9
Chance for permanent govt. employee	68	28.6
Desire to serve community	49	20.7
Others	16	6.8

Discussion:

In Murshidabad, most of the ASHAs conformed to the standard selection criteria in terms of age, marital status and education[10, 11]. However recruitment process has some gap as about one third of them were not residents of areas they served. Most of them served more than 1000 population. In Murshidabad, two third of the ASHAs served >1000 population as against the national norm of one ASHA per 1000 population. Similar findings were reported in the evaluation conducted by NHSRC in Malda and Birbhum districts of West Bengal where 70% and 60% of the ASHAs respectively covered more than 1000 population[15,17]. On an average one ASHA had served about 1500 population which might have caused overburden on them. In this context it is to be mentioned that in Jharkhand where all the ASHAs were selected as per target, one ASHA was selected for 500 populations[10, 11]. In Murshidabad district the target is about 5700 ASHAs to be appointed, so there is further need of 1430 ASHAs to be selected and appointed.

In Murshidabad, about 64% of the population is constituted by Muslim. However, only one third of the ASHAs in the district belonged to Muslim religion. This might be an important reason of facing difficulty in visiting houses as slightly more than one third of the ASHAs reported. The ASHAs have to be resident in their service area for their easy availability in the community as it is one of the basic principles of selection of any community health worker. But in Murshidabad one third of them were non-residents of the village where they were working. Village pradhan and /or village panchayat was main in recruitment of ASHAs. Commonest perceived reason for joining the services was financial benefit and chance to get absorbed in government job which was not in line with programme objective.

Conclusion:

Recruitment process of ASHA was not in line with the prescribed guideline and reasons for joining the services as perceived by ASHAs were not matching with the programme objective.

Recommendations:

1. The vacant posts of ASHAs should be filled up so that population covered and households served per ASHA remain evenly distributed to relieve them from overburdened workload. It is better that every ASHA covers 1000 or fewer population.
2. The selection of future ASHAs should be in such a way to properly represent the community they serve.
3. ASHAs should be motivated to align their personal goal with programme objective.

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