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Training, opportunities and challenges of accredited social health activists for providing maternal and child health care in murshidabad district of west bengal

Abstract

Introduction: Accredited social health activists (ASHAs) are community health workers. ASHAs play an important role in identifying child morbidity at the earliest and help in improving their health status. While working in the community ASHAs face certain challenges and need specific training to work effectively and efficiently. Present study was conducted to study the training need, challenges and opportunities faced by ASHAs while working in community.

Objectives: To study the socio-demographic profile, training status, opportunity and challenges of ASHAs working in Murshidabad district of West Bengal.

Material and Methods: A cross sectional study was conducted among ASHAs in Murshidabad district of West Bengal. A total of 237 ASHAs were interviewed by using systematic random sampling. Data was collected by using pretested standard questionnaire. Data analysis was done by using Epi info.

Results: Out of 237 ASHAs, Majority (n=208, 88%) received the recommended 23 or more days of training while the rest of them received less than 23 days of training. Non availability of transport for referring pregnant women for delivery (39%, n=93), and absence of services (n=83, 35%) or staff (n=36, 15%) at health facility were the main challenges faced by ASHAs while performing their work.

Keywords: ASHAs; Training need; Job Challenges; Opportunity; Murshidabad; West Bengal

Volume 7 Issue 1 - 2017

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Received: October 20, 2016 | **Published:** May 10, 2017

Introduction

Accredited social health activists (ASHAs) is community health workers instituted by the government of India's Ministry of Health and Family Welfare (MoH & FW) as part of the National Rural Health Mission (NRHM).[1] Their tasks include motivating women to give birth in hospitals, bringing children to immunization clinics, encouraging family planning (e.g., surgical sterilization), treating basic illness and injury with first aid, keeping demographic records, and improving village sanitation. ASHAs are also meant to serve as a key communication mechanism between the healthcare system and rural populations.[2] ASHAs must primarily be female residents of the village that they have been selected to serve, who are likely to remain in that village for the foreseeable future. Married, widowed or divorced women are preferred over women who have yet to marry since Indian cultural norms dictate that upon marriage a woman leaves her village and migrates to that of her husband. ASHAs must have class eight education or higher, preferably be between the ages of 25 and 45, and are selected by and accountable to the gram panchayat (local government). If there is no suitable literate candidate, a semi-literate woman with a formal education lower than eighth standard, may be selected.[3] Although ASHAs are considered volunteers, they receive outcome-based remuneration and financial compensation for training days.[3,4]

Around 9.2 million children die every year before reaching their fifth birthday. Most of these deaths occur in developing countries in which leading causes are: acute lower respiratory infections, (mostly pneumonia: 19% of all deaths in under fives), diarrhea (17%), malaria (8%), measles (4%), HIV/AIDS (3%), neonatal deaths – mainly preterm births, birth asphyxia, infections (37%) and injuries (3%). Poor or delayed "health care seeking" contributes to 70% of child deaths. Most deaths among under five are still attributable to just a handful of conditions and are avoidable through existing interventions.[5]

ASHAs play an important role in identifying child morbidity at the earliest and help in improving their health status. While working in the community ASHAs face certain challenges and need specific training to work effectively and efficiently.[6]

Present study was conducted to study the training need, challenges and opportunities faced by ASHAs while working in community.

Objectives:

a. To study the socio-demographic profile of ASHAs working in Murshidabad district of West Bengal.

b. To study the training status of ASHAs working in Murshidabad district of West Bengal.

c. To study the opportunities and challenges faced by ASHAs while providing maternal and child health care services.

Material and methods

Study area

Murshidabad had a total population of 7,102,430 as per 2011 census. Twenty percent of the population in the district were females of child bearing age (15-45 years) and 21% population were children of 0-6 years.

Study population: ASHAs who had worked in the district for at least one year were included in the study population.

Study design: A cross sectional study was conducted among ASHAs in Murshidabad district of West Bengal.

Sampling and Sample size: There were total 4270 ASHAs working in Murshidabad district. Calculated sample size was 237. The sample size was calculated within 95% confidence interval, absolute precision of 5%, non response rate of 10% and post natal visit by ASHAs up to 82% as reported by National Health Systems Resource Centre (NHSRC) study.[7]

A line list of all ASHAs working in Murshidabad district of West Bengal was created. From the line list of 4270 ASHAs, a sample of 237 ASHAs was selected by using systematic random sampling.

Data collection

Data collection was done by interviewing the ASHAs. Interview was conducted by using a pre-tested questionnaire developed by the National Health Systems Resource Centre, New Delhi.[17] The data collection instrument was translated in local Bengali language. Data was collected on socio-demographic characteristics, training, knowledge and practices about the ten functions in relation to mother and child health services performed by them in the last six months. Data collection was done by trained field workers and supervisors. Study was conducted from January to March 2012.

Data Analysis

Data analysis was done by using Epi-Info (3.5.1 version, CDC Atlanta, USA). Data was summarised by using Mean, Median and Proportions as statistical tool.

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. 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, Majority (n=208, 88%) received the recommended 23 or more days of training while the rest of them received less than 23 days of training. More than half (53%) of the ASHAs reported that their last training was held more than one year before. Most of the ASHAs (n= 219, 92%) reported that their training was residential. A total of 76% ASHAs mentioned that they had received training in first five modules. Out of 237 only 19 ASHAs received training in module 6 (maternal and child health care at advanced level) and only 5 ASHAs received training in module 7 (home based neonatal care) respectively. All except 3 ASHAs reported that they received money for attending the training. About 13% (n= 31) did not get any training material after completion of training (Table 2).

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

Particulars	Characteristics	Number	Percentage
Age	<35 years	90	37.97
	≥35 years	147	62.03
Marital Status	Married	228	96.2
	Widow, Divorced and Separated	9	3.8
Educational Level	Up to Secondary Pass	150	63.3
	Higher Secondary and 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)		

Table 2 Training status of ASHAs in Murshidabad district of West Bengal (n=237)

Particular	Characteristic	Number	Percentage
Duration of Training Days	23 Days and More	208	87.7
	Less than 23 days	29	12.3
When Last Training Held	Less than 6 Months back	80	33.7
	More than 6 Months	157	66.3
Whether Training was Residential	Yes	219	92.4
	No	18	7.6

Citation: Kunal KD, Amitabha D, Roy B, et al. Training, opportunities and challenges of accredited social health activists for providing maternal and child health care in murshidabad district of west bengal. *Obstet Gynecol Int J.* 2017;7(1):182–185. DOI: 10.15406/ogij.2017.07.00231

Table Continued...

Particular	Characteristic	Number	Percentage
Received Money for Attending Training	Yes	234	98.7
	No	03	1.3
Modules Taught	Modules 1 - 4	32	13.5
	Modules 5 - 7	205	86.5
Received Reading Material	Yes	206	86.9
	No	31	13.1

Non availability of transport for referring pregnant women for delivery (39%, n=93), and absence of services (n=83, 35%) or staff (n=36, 15%) at health facility were the main challenges faced by ASHAs while performing their work. ASHAs also felt that that lack of/loss of or damaged BPL cards (n=118, 50%), late registration of pregnancy (n=60, 25%) and lack of funds at the health facilities (n=49, 21%) as important barriers for getting the getting the JSY benefits for the mothers and themselves in the district. More than 71% (n= 169) of the ASHAs did not get incentives in time. Nearly one third (32.9%, n=78) of ASHAs faced any sort of difficulty like fever of children, lack of family support in the houses of the children, in delivering immunization services to children under 1 year of age. More than one third of the ASHAs (34.2%, n=81) faced difficulty in house to house visit (Table 3).

For two fifth of the ASHAs (40.5%, n=96) there were different prevailing social issues hindering their services in the community. Among them more than one third (36.5%, n=35) reported that the served population belonging to minority community was a major issue of social hindrance. Other issues were lower and higher caste of served population and themselves belonging to minority community respectively. Most of the ASHAs received good support from ANM (85%, n=202) followed by ASHA facilitators (6%, n=14). More than half (60.3%, n=141) of them told that it was the ability help others which they liked most in performing their job. This was followed by financial contribution to family for 43.9% (n=104) of the ASHAs. More than three fourth (75.9%, n=180) of the ASHAs mentioned that more trainings needed was the support they require for their work (Table 4).

Table 3 Challenges faced by ASHAs in Murshidabad district of West Bengal (n=237)

Particulars	Characteristics	Number	Percentage
Challenges in referring Pregnant Women	No Transport Available	93	39.2
	No Services at Health Facility	83	35.0
	Resistance of the Families	52	21.9
	No Roads	40	16.9
	No staff at Health Facility	36	15.2
	No Support in Families	33	13.9
	Resistance from Local Dai	16	6.8
	High Expenses	16	6.7
	BPL card issues	118	49.8
Challenges of ASHA for getting JSY benefits	Late Registration of Pregnancy	60	25.3
	No fund at Health Facility	49	20.7
	No Previous Registration	46	19.4
	Incomplete forms/ID	42	17.7
	Non Availability of Transport	22	9.3
	High Expenses for 2nd trip	11	4.6
	No Staffs at Health Facility	9	3.8
Challenges for Providing Immunisation Services	Yes	78	32.9
Challenges for Home Visits	Yes	81	34.2
Not getting Incentive in time	Yes	169	71.3
Social Issues Hindering ASHAs	Yes	96	40.5
Social Issues Faced by ASHAs (n=96)	Low caste of Population	21	21.9
	High caste of Population	20	20.8
	Minority Community	35	36.5
	Minority Community of ASHA herself	20	20.8

Table 4 Opportunities available to ASHAs in Murshidabad district of West Bengal (n=237)

Particulars	Characteristics	Number	Percentage
What did ASHA like in her job	Able to help others	143	60.3
	Financial Contribution	104	43.9
	Better care of Children	85	35.9
	Scope for Independence	73	30.8
	Enhancement of Skills	72	30.4
	Respect in the Family	39	16.5
	Higher status in Community	37	15.6
Support ASHAs need	More Training Sessions	180	75.9
	More Monetary Support	138	58.2
	Timely filling of drug kit	137	57.8
	More Supportive Supervision	116	48.9
	Better response to Referral	96	40.5

Discussion

In Murshidabad, most of the ASHAs conformed to the standard selection criteria in terms of age, marital status and education.[7,8] However, about one third of them were not residents of areas they served. Most of them served more than 1000 population. Their knowledge about the new born and child health care was inadequate. House to house visits for post partum check up and promotion of immunization were the most common functions conducted by the ASHAs.

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. On an average one ASHA had served about 1500 population which might have caused overburdening 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.[7] 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.

Though about 88% of the ASHAs in the district were trained for ≥23 days, only 10% of them were trained in module 6 and 7. These two modules cover advanced mother and child health issues including home based new-born care. 18 Lack of training in these modules was reflected in the knowledge levels about some essential issues in maternal and child health care. For example, less than half of them did not know that foul smelling discharge is an important sign to look for after delivery. Their knowledge on counselling to mothers about early breast feeding and exclusive breast feeding as well as new born care was also inadequate. More than half of the ASHAs did not know the correct method of preparation of ORS. About of third of them did not know about chest wall in drawing as a sign of severe pneumonia. These observations point towards the fact that there was deficiency in ASHAs` knowledge on breast feeding practices, low birth weight of new born babies, correct ORS preparation, danger signs and management of common childhood illnesses. For that more continued training in home based neonatal and childhood care is necessary which are contained in ASHA training modules number six and seven.[9]

Our study identified certain challenges faced by ASHAs while performing their job as well as barriers for getting JSY benefits. This included not getting the financial incentives in time, non-availability of transport for referring pregnant women for delivery and absence of services or staff at the health facility. Lack of BPL card of the mothers was the main barrier in getting JSY benefits both for ASHA herself and the mother. Majority of the ASHAs also reported that they needed more training sessions as support to their job. About one third of the ASHAs were Muslims in the district where two third of the populations were Muslims.

One third of them thus faced difficulty in house to house visits. This problem was aggravated by the fact that one ASHA there had to serve considerably more people than the national norm. Programme managers need to address these challenges in order to improve the functioning of the ASHAs in the district.

Recommendations

a. ASHAs should be trained on soft skills and human skills to deal with social challenges.

b. Training of ASHAs should be completed in all modules during specified period of time.

c. More and more opportunities should be made available to enhance the motivation of ASHAs.

Acknowledgments

None.

Conflicts of interest

None.

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