

## Is educational level of ASHA matters for their effective functioning? A cross-sectional study in eastern Uttar Pradesh

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### Abstract

**Background:** The actualisation of the goal of NRHM depends on the functional efficacy of the ASHA as the grassroot health activist.

**Methods:** This is cross sectional study, based on a sample of 135 ASHA working in different areas of Chirigaon Block of Varanasi in eastern Uttar Pradesh (UP). ASHA were interviewed to ascertain the role of educational level on their effective functioning.

**Results:** In the present study about one third of ASHA had schooling up to class eight, 36.6% High School and 22.2% intermediate, and 10.4 % were graduates. Statistically significant association was observed between educational level & practices undertaken by ASHA in the community. At the same time the findings also indicate that ASHA educated up to class eight faces difficulty in filling Village Health Index Register provided to them.

**Conclusions:** The study recommends that if it is difficult to upgrade the minimum educational level for the appointment of ASHA, there is a strong need of regular training & monitoring of ASHA from other functionaries. Village Health Index Register should be simplified so that they can maintain the record properly. Otherwise, if women with good education have joined come forth to work as ASHA, this would certainly improve the service delivery.

**Key Words:** ASHA, Role of education, Village Health Index Register

### Introduction

One of the important goals of the National Rural Health Mission is to provide access to improved health care at the household level through female Accredited Social Health Activist (ASHA). The ASHA acts as a bridge between the ANM and the village, and she is accountable to the panchayat. ASHA has to create awareness about services in the community. She helps to promote referrals for universal immunisation, escort clients for RCH services, construction of house hold toilets and other health care delivery programs<sup>1</sup>. Each ASHA has been provided a 'village health index register' to maintain records.

To a large extent, the actualisation of the goals of NRHM depends on the functional efficacy of the ASHA as a grass root health activist. The efficacy depends on several factors—her own cognitive competency (including capacity building), aptitude and attitude, effective relationship with other key health functionaries like Anganwadi workers, Auxiliary nurse midwives, PHC staffs etc. Education is one of the important criteria for assessing performance. Studies have shown that the level of education is an important criterion for better performance although, the minimum educational level for selection criteria of ASHA is 8<sup>th</sup> Class and at some places it has been reduced to 5<sup>th</sup> class.

Although, earlier it has been observed that in community health volunteer program i.e., Mitadin (that was originally launched in Chhattisgarh in 2002), the formal education was

not considered as a selection criterion for Mitadins. But it was supposed to be the very successful model and later therefore upscaled in the form of ASHA all over the country. Hence the present study was undertaken to know about the role of education on the effective functioning of ASHA.

### Methods

This is cross sectional study based on a sample of 135 ASHA working in different areas of Chirigaon Block of Varanasi in eastern Uttar Pradesh (UP) under a sample survey entitled "Assessment of Work Performance of ASHA in selected Rural Block of Varanasi". Applying a multistage random sampling technique, the survey was conducted from October 2008 to October 2009. The selection of Block, Nyaya-panchayat and finally ASHA working in Nyaya-panchayats formed different stages of the sampling technique.

The data have been taken from the ASHA, stakeholders of ASHA i.e., ANM, AWW, Medical Officer, Gram Pradhan and also from the beneficiaries.

The basic instrument of data collection was a personal interview method. Detailed information regarding ASHA has been taken on socio-economic characteristics, knowledge, practices along with their assessment of work performance in the community. Also the data has been collected about the level of co-ordination of ASHA with ANM and AWW, views of ANM, Medical officer and Gram Pradhan about

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the performance on different responsibilities of ASHA. In this paper, the knowledge and practices about different responsibilities undertaken by ASHA in the community was assessed by their educational qualification. Chi-square test was used to find out the association between the variables using SPSS statistical software.

## Results & Discussion

The study of the profile of the ASHA in terms of age, education, marital status, caste and economic status is important as it might have a bearing on their functional efficacy.

**Table 1:** Socio-demographic characteristics of ASHA in Study Area

Characteristics	Number (n=135)	Percentage
<b>Age (in yrs)</b>		
≤35	114	84.4
>35	21	15.6
Mean age = 30.14 years		
<b>Caste</b>		
General	50	37.0
OBC	59	43.7
SC	26	19.3
<b>Educational Status</b>		
Eighth standard	42	31.1
High school	49	36.3
Intermediate	30	22.2
Graduation and above	14	10.4
<b>Marital Status</b>		
Married	135	100
Unmarried/widowed	-	-
<b>Status of training</b>		
Induction	135	100
IMNCI	135	100
Periodic	-	-

Table 1 shows that the majority of the ASHA (84%) were equal to or less than 35 years of age with most being in the age group of 25-30 years. The mean age was found to be 30.14 years. None of them was found to be below or above the prescribed preferable age group of 25-45 years. This finding holds unanimity with the study conducted by Srivastava DK et al<sup>2</sup>, in which more than half of the ASHAs were below 30 years of age. Almost, similar observation has been made by Neeraj Jain et al<sup>3</sup>, in which the majority of ASHA were below 40 years of age.

One may presume that the work performance of the ASHA could be affected by her marital status, at least to some extent. However, no question could rise on this issue because all the ASHA in present study were found married. The other studies above mentioned i.e., Srivastava et. al<sup>2</sup>, and Neeraj Jain et. al<sup>3</sup>, have also showed that more than 90% of the ASHAs were married. All the ASHA found in the study area were Hindu by religion. A caste-wise review of the selected ASHA indicated that the majority belonged to the OBC category (43.75) while 37% were from the General category followed by 19.3% belonged to SC category.

The guidelines put emphasis on minimum education up to class eight for the appointment of ASHA. In the present study, the percentage of the ASHA with education up to class eighth was 31.3%, high school 36.6%, intermediate 22.2%, and graduation and above 10.4%. In other way, about two-third of total respondents were having education up to high school. These observations were better than the findings reported in a previous study<sup>3</sup> where majority (53.3%) of the ASHA were educated upto the middle-school.

**Table 2:** ASHA's Knowledge according to their Educational Status (n=135)

Awareness about ASHA's job responsibilities	Educational Status				Group differences
	Eighth Standard (n=42)	High School (n=49)	Inter-Mediate (n=30)	Graduate (n=14)	
<b>Create community awareness on determinants of health</b>					
Yes	8(19.0)	12(24.5)	17(56.7)	10(71.4)	$\chi^2 = 21.4^{***}$ df=2
No	34(81.0)	37(75.5)	13(43.3)	4(28.6)	
<b>Counsel pregnant lady on safe delivery, ANC, breastfeeding, contraception etc</b>					
Yes	16(38.1)	46(93.9)	28(93.3)	12(85.7)	$\chi^2 = 46.73^{***}$ df=2
No	26(61.9)	3(6.1)	2(6.7)	2(14.3)	
<b>Work with VHSC to develop a Village Health Plan</b>					
Yes	8(19.0)	11(22.4)	20(66.7)	12(85.7)	$\chi^2 = 35.50^{**}$ df=3
No	34(81.0)	38(77.6)	10(33.3)	2(14.3)	
<b>Mobilize community to access health services at different facilities</b>					
Yes	17(40.5)	35(71.4)	24(80.0)	14(100)	$\chi^2 = 21.14^{***}$ df=2
No	25(59.6)	14(28.6)	6(20.0)	-	
<b>Medical care for minor ailments</b>					
Yes	6(14.3)	9(18.4)	9(30.0)	7(50.0)	$\chi^2 = 69^*$ df=2
No	36(85.7)	40(81.6)	21(70.0)	7(50.0)	
<b>Inform AWW/ANM about birth and death</b>					
Yes	9(21.4)	32(65.3)	26(86.7)	13(92.9)	$\chi^2 = 41.5^{***}$ df=3
No	33(78.6)	17(34.7)	4(13.3)	1(7.1)	
<b>Visiting new born</b>					
Yes	26(61.9)	24(51.0)	22(73.3)	12(85.7)	$\chi^2 = 7.5$ df=3
No	16(38.1)	25(49.0)	8(26.7)	2(14.3)	

Figures in the parentheses represent the percentage

\* $p < 0.05$ ; \*\* $p < 0.01$ ; \*\*\* $p < 0.001$

$\chi^2$  values is calculated after merging the columns graduate and intermediate educational level

The above table depicts that the knowledge about their job responsibilities was higher among ASHA, who were educated up to intermediate followed by Graduate and above. Effect of education of ASHA on their knowledge of job responsibilities was found to be statistically significant (respective p-values are given in table). Though studies on correlation of education of ASHA with their knowledge were not conducted previously, yet Saraswati Swain et al<sup>4</sup> & Bella Patel Utteker et al<sup>5</sup> have explored ASHA familiarity with their tasks. Majority of the ASHA had reasonably good knowledge of antenatal and child care services which is coherent with the present findings.

**Table -3** shows the effect of educational level on activities done by ASHA in the community. ASHA educated up to intermediate & above were performing more activities assigned to them than ASHA educated upto high school & eight standard. Similarly practices were also not correlated with the education of ASHA in previous studies. Several studies i. e S.Haider et al<sup>6</sup> & Shobha Malini et al<sup>7</sup> showed that most preferred activities were Antenatal care & promotion of institutional deliveries as compared to other activities.

**Table 3:** Practices undertaken by ASHA according to their Educational Status (n=135)

Practices of Job responsibilities	Educational Status				Group differences
	Eighth Standard (n=42)	High School (n=49)	Inter-Mediate (n=30)	Graduate (n=14)	
<b>Creating community awareness on determinants of health</b>					
Yes	6(14.3)	20(40.8)	21(70.0)	10(71.4)	$\chi^2 = 27.86^{***}$
No	36(85.7)	29(59.2)	9(30.0)	4(38.6)	
<b>Counselling pregnant lady on safe delivery, ANC, breastfeeding, contraception etc</b>					
Yes	21(50.0)	48(98.0)	30(100.0)	14(100.0)	+ $\chi^2 = 12.7^{***}$ df=1
No	21(50.0)	1(2.0)	-	-	
<b>Working with VHSC to develop a village health plan</b>					
Yes	14(33.3)	22(44.9)	19(63.3)	11(78.6)	$\chi^2 = 11.82^{**}$
No	28(66.7)	27(55.1)	11(36.7)	3(21.4)	
<b>Mobilizing community to access health services at different facilities</b>					
Yes	15(35.7)	39(79.6)	23(76.7)	14(100.0)	++ $\chi^2 = 28.2^{***}$ df=2
No	27(64.3)	10(20.4)	7(23.3)	-	
<b>Informing AWW/ANM about birth and death</b>					
Yes	17(40.5)	49(100.0)	30(100.0)	11(78.6)	+ $\chi^2 = 7.1^{**}$ df=1
No	25(59.5)	-	-	3(21.4)	
<b>Visiting new born</b>					
Yes	25(59.5)	45(91.8)	28(93.3)	14(100.0)	++ $\chi^2 = 23.9^{**}$ df=2
No	17(40.5)	4(8.2)	2(6.7)	-	
<b>Escorting/Accompanying pregnant mother to hospital</b>					
Yes	40(95.2)	49(100.0)	30(100.0)	14(100.0)	Fisher's exact test p=0.09
No	2(4.8)	-	-	-	
<b>Distributing DOTS</b>					
Yes	27(64.3)	41(83.7)	21(70.0)	11(78.6)	$\chi^2 = 4.85$ df=2
No	15(35.7)	8(16.3)	9(30.0)	3(21.4)	
<b>Pulse polio round</b>					
Yes	42(100.0)	47(95.9)	28(93.3)	13(92.9)	Fisher's exact test p=0.32
No	-	2(4.1)	2(6.7)	1(7.1)	
<b>Mobilizing cataract patient for operation and post operative care</b>					
Yes	15(35.7)	22(44.9)	11(36.7)	9(5.9)	$\chi^2 = 4.02$
No	27(64.3)	27(55.1)	19(63.3)	5(8.1)	

Figures in parentheses indicates the percentage

\*\*p< 0.01; \*\*\*p<0.001

+ $\chi^2$  test was applied after clubbing graduate, intermediate and High school for statistical analysis,

++ $\chi^2$  value was obtained after clubbing graduate and Intermediate, Fisher's exact test is applied between eighth standard and above

**Table 4:** Record and Educational Status of ASHA (n= 135)

Village Health Index Registers	Education status of ASHA				
	Up to eighth (n=42)	High School (n=49)	Intermediate (n=30)	Graduate (n= 14)	Total (n= 135)
Not filled	32 (76.2)	17 (34.7)	1 (3.3)	-	50 (37.0)
Partially filled	10 (23.8)	25 (51)	16 (53.3)	3 (21.4)	54 (40.0)
Completely filled	-	7 (14.3)	13 (43.3)	11 (78.6)	31 (23.0)
$\chi^2 = 33.8^{**}$ , df = 4					

Figures in parentheses indicates the percentage  
 \*\* p < 0.01;  $\chi^2$  value is calculated after merging the columns graduate with intermediate

The educational status of the ASHA can also affect her ability to fill up the Village Health Index Register (VHIR) as shown in table 4. When it was enquired from them about the maintenance of record, it was found that ASHA educated up to eighth class were not able to fill the prescribed register i.e. VHIR. While 78.6% of the ASHA with Education upto graduate or above were able to complete the registers, which indicates that the complexity of registers could be beyond the comprehension of the most of the ASHA educated up to eighth class. An overall analysis reveals that only 23% registers were complete, 40% were partially filled and 37% were found blank. No supporting reasonable references in this issue of study were available.

The analysis indicates that there is a role of educational status of ASHA for proper knowledge and practices of their community outreach work. In the present study statistically significant association was observed between educational level & practices undertaken by ASHA in the community. At the same time, the findings also indicates that the ASHAs educated up to 8<sup>th</sup> found difficulty in filling registers provided to them. Therefore, the study recommends that if it is difficult to upgrade the minimum educational level for the appointment of ASHA, then there is a strong need of regular training & monitoring of ASHAs from other functionaries. Village Health Index Register should be simplified so that they can maintain the record properly. Otherwise, if women with good education have joined come forth to work as ASHA, this would certainly improve the service delivery.

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