

## Research Article

# Problems faced by ASHA workers for malarial services under NVBDCP: a cross sectional study

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### ABSTRACT

**Background:** About 95% of the country's population resides in malaria endemic areas. The NVBDCP is multi-faceted public health programme in the country. The NVBDCP became an integral part of the NRHM launched in 2005. In NRHM, ASHA worker should be placed at grass root level. So role of ASHA is critical at grass root level. Problems faced by ASHA, it will affect the performance. So, ASHA workers positioned at village, Population catered by them, education, work experience, problems related to incentive and any other problems should be considered. The primary objective was to know the problems faced by ASHA workers for malarial services under NVBDCP in Jamnagar district.

**Methods:** A cross-sectional study was conducted in rural areas of the district by using multistage sampling.

**Results:** There was vacant post of ASHA in one village of low performing sub-centre. ASHA having work experience of less than one year was concentrated in poor performing sub-centre villages. More than one third ASHA served > 2000 population and more than half of them belonged to low performing sub centres. Around one sixth ASHA workers had difficulty in getting incentive or any problems. Majority of them belonged to low performing sub centres-villages.

**Conclusions:** Main identified problems were some areas were far to reach by them, getting incentive for work and populations catered by them were too high. Most of them belonged to low performing sub centre-villages. All of above findings had affected the performance of ASHA workers.

**Keywords:** ASHA, NVBDCP

### INTRODUCTION

About 95% of the country's population resides in malaria endemic areas, and 80% of malaria reported in the country is confined to regions that have more than 20% of their population residing in tribal, hilly, difficult and inaccessible areas. The most affected states are: Andhra Pradesh, Chhattisgarh, Gujarat, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Odisha, Rajasthan and West Bengal.<sup>1</sup>

The NVBDCP is presently one of the most comprehensive and multi-faceted public health

programmes in the country. The NVBDCP became an integral part of the NRHM launched in 2005.<sup>2</sup> NVBDCP is following a goal of Millennium Development Goal no. 6, i.e. to combat malaria. Its objectives are Reduce malaria morbidity and mortality by 50% by 2012 (Base line year is taken 2006). Targets fixed were Annual blood examination rate over 10 percent, Annual parasite incidence 1.2 or less and 25% reduction in morbidity and mortality due to malaria by 2010 and 50% by 2012.<sup>3</sup>

In NRHM, ASHA worker is positioned at grass root level. Early diagnosis and prompt treatment is a cornerstone of malaria control. In India, artemisinin

combination therapy (ACT) became the first-line treatment for falciparum malaria and rapid diagnostic test (RDTs) kits were recommended for use at the grass-root level in the malaria treatment policy (2010).<sup>4</sup> The ASHA will be involved in diagnosis and treatment of malaria cases on a day to day basis. She will screen fever cases suspected to be suffering from malaria, using RDTs and blood slides and administer anti-malarial treatment of positive cases. So, role of ASHA worker is critical at grass root level.

Problems faced by ASHA, it affect the performance of ASHA workers. And ultimately it would affect NVBDCP. So, there is a need to identify those problems faced by ASHA workers related to malarial activities under NVBDCP. So, ASHA workers positioned at village, Population catered by ASHA workers, education, work experience, problems related to incentive and any other problems faced by them should be considered.

**METHODS**

The present study was conducted in rural areas of the study (Jamnagar) district. A cross-sectional study was conducted for a period was one year, i.e. From July 2013 to June 2014. Out of the total talukas, one PHC was selected from each taluka by simple random sampling technique. After selecting the PHCs, visits have been made to the PHCs. From each PHC, three sub-centres were selected on the basis of performance of last year’s ABER and API and were classified as High performing

sub centre, Average performing sub centre and Low performing sub centre. From each sub centre, one village was selected randomly. From each village, one ASHA worker was interviewed. So, in total 30 ASHA workers were included in the present study.

The data entry was done using Microsoft Office Excel 2007 and data analysis was done using EPI INFO and in Microsoft Office Excel 2007. Appropriate statistical tests were applied

The study protocol was reviewed and approved by the institutional ethical committee of the institution. Prior consent was taken after fully explaining the purpose of the study.

One ASHA worker per 1000 population.<sup>5</sup>

**RESULTS**

In Present study table 1 shows that, ASHA workers were in position in almost all villages. One village of low performing sub-centre had vacant post of ASHA worker.

Table 2 shows interesting findings of the is that ASHA having work experience of less than one year was concentrated in poor performing sub-centre villages, whereas of those with work experience of more than one year, majority were in high performing sub centre-villages. Though, it was not statistically significant.

**Table 1: Distribution of sub centre-villages as per availability of ASHA workers.**

Sub centers	Total sub centre-villages (N=30)	High performing sub centers-villages (N=10)	Average performing sub centers-villages (N=10)	Low performing sub centers-villages (N=10)
ASHAs				
In position	29(96.67%)	10(100%)	10(100%)	9(90%)
Vacant posts	1(3.33%)	0(0%)	0(0%)	1(10%)

**Table 2: Distribution of sub centre-villages as per availability of ASHA workers.**

ASHAs		Total sub centre-villages (N=29)	High performing sub centre-villages (N=10)	Average performing sub centre-villages (N=10)	Low performing Subcentre-villages (N=9)
Education*	Primary	18(62.07%)	6(60%)	6(60%)	6(66.67%)
	Secondary	11(37.93%)	4(40%)	4(40%)	3(33.33%)
Since when working**	≤1 year	11(37.93%)	2(20%)	3(30%)	6(66.67%)
	>1 year	18(62.07%)	8(80%)	7(70%)	3(33.33%)

\*Kruskal Wallis test value 0.0001 at df: 2, p value: 1; \*\*Kruskal Wallis test value 3.6 at df: 2, p value: 0.1

About table 3, as per norms there is one ASHA worker per 1000 population. The size of the population to be

served is an important aspect from the service delivery point of view.

Finding which of concern was that, more than one third (37.93%) ASHA served > 2000 population and more than half of them belonged to low performing sub centres.

Table 4 shows problems faced by ASHA i.e. difficulty in getting incentive and other problems. In Present study, total 4 (13.79%) ASHA workers had difficulty in getting

the incentive for her work, from which half belongs to low performing sub centres villages. Total 5 (17.24%) ASHAs had faced any problem during work, majority from low performing sub centres-villages. Main identified problems were some areas were far to reach by them and population catered by ASHA workers were too high (standard 1 ASHA/1000 population).

**Table 3: Population catered by ASHA workers.**

ASHAs Population	Total sub centre-villages (N=29)	High performing sub centre- villages (N=10)	Average performing sub centre-villages (N=10)	Low performing Sub centre-villages (N=9)
<500	0(0%)	0(0%)	0(0%)	0(0%)
501 - 1000	1(3.35%)	0(0%)	1(10%)	0(0%)
1001-1500	13(44.83%)	7(70%)	4(40%)	2(22.22%)
1501-2000	4(13.89%)	2(20%)	1(10%)	1(11.11%)
>2000	11(37.93)	1(10%)	4(40%)	6(66.67%)

**Table 4: Distribution of ASHA workers as per problems faced during work.**

ASHAs Problems	Total sub centres-villages (N=29)	High performing sub centres-villages (N=10)	Average performing sub centres-villages (N=10)	Low performing subcentres-villages (N=9)
ASHA having difficulty in getting the incentive for her work	4(13.79%)	1(10%)	1(10%)	2(22.22%)
Any problem faced in during work*	5(17.24%)	1(10%)	1(10%)	3(30%)

## DISCUSSION

Table 2 shows various components of ASHA workers i.e. education and work experience. In present study, eighteen (62.07%) ASHA workers were studied up to primary and eleven (37.93%) ASHA workers were studied up to secondary. Total eleven (37.93%) ASHA workers had experience ≤1 year and eighteen (62.07%) ASHA workers had experience >1 year.

In a study by Mahesh Choudhary, majority of ASHA workers were having primary (49.49%) and secondary (34.02%) level of education. Also some of them were educated up to higher secondary (11.34%) and graduate (5.15%) level.<sup>6</sup> Dr. Umrao Singh Rao also found in their study that majority (80%) of ASHAs were 8th class pass.<sup>7</sup>

In a study by Mahesh Choudhary, almost similar findings to present study were found that one third of ASHA workers (32.99%) working from 2-3 years and another one third (32.47%) were working from last 1 year only. Of the rests, one sixth (17.53%) were working since 1-2

years and another one third (32.47%) were working from last 1 year only. Of the rests, one sixth (17.53%) were working since 1-2 years and another one sixth (17.01%) were working since 3-4 years.<sup>6</sup>

Table 3 shows, majority (44.83%) of ASHA worker served 1001-1500 population. Only few ASHA (3.35%) served 501-1000 population. Around 4 (13.89%) ASHAs had 1501-2000 population.

In the study by Dr. B. Mohapatra, there is increased workload of ASHA (looking after a population of 2000 as per the norm of catering population of 1000) as a result poor performance indicated.<sup>8</sup>

## CONCLUSION

There was a vacant post of ASHA worker in one village of low performing sub-centre. ASHA having work experience of less than one year was concentrated in low performing sub-centre villages. Most of the ASHA workers served the population above the standard level and half of them belong to low performing sub centre-

villages. Main identified problems were some areas were far to reach by them, getting incentive for work and population catered by ASHA workers were too high (standard 1 ASHA /1000 population). Most of the ASHA workers faced any problems belongs to low performing sub centre-villages. All of above findings affected the performance of ASHA workers related to malarial services. This can affect the NVBDCP and its target ABER >10% and API <1.3.

ASHA is an important community member who assists in malaria control activities. She was very instrumental in implementing “Early Diagnosis and Complete Treatment (EDCT) strategy” of malaria control. Most important motivational factor for the ASHAs is the financial gain. An assessment of the population catered by each ASHA should be done at the PHC and sub-centre level under the guidance of district NRHM office. Also, if indicated, areas should be redistributed among the ASHAs so as to keep the population norms limited to 1000 or less to deliver the service effectively.

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## REFERENCES

1. National vector borne disease control programme, Ministry of Health and Family Welfare, GOI. <http://nvbdcp.gov.in/malaria3.html>.
2. Sunderlal. Textbook of community medicine, third edition.
3. Kishore J. National Health Programs of India tenth edition page no.328.
4. Malaria treatment policy. National Vector borne disease Control Programme, Ministry of Health and Family Welfare, GOI, 2010.
5. National Rural Health Mission MOHFW, GOI. <http://nrhm.gov.in/communitisation/asha/asha-support-mechanism/supporting-mechanism.html>.
6. Choudhary M. evaluation of functioning of asha workers under NRHM, A dissertation submitted to Saurashtra University, 2014.
7. Rao US. Role of ASHA in Promoting Safe Delivery in Rajasthan. Population Research Centre, Mohan Lal Sukhadia University, Udaipur, 2007-2008.
8. Mohapatra B. An Assessment to Understand the Functioning and Impact of JSY in Orissa. Cuttack Orissa: Department of Community Medicine, SCB Medial College, 2008.

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