

Full Length Research Paper

Intraorganizational human resource auditing of Ashas in Harahua block of Varanasi

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Intra-organizational auditing of human resource (AHR) evaluates personnel skill inventory in the organization towards identifying workers' potential and capabilities for desired output. Thus, it is mandatory that such evaluation of Accredited Social Health Activists (ASHAs) by respective Auxiliary Nurse Midwives (ANMs) could explore output components. The objectives of this study were to (1) obtain quantitative assessment of ASHAs by respective ANMs for pre-identified job competencies, namely, work aptitude, work culture and community involvement; (2) study the relationship between various attributes and socio-demographic factors with the overall job competency of the ASHAs. Twelve attributes for ASHAs' AHR on a 3-point Likert scale, designed by 4 experts, were selected through factor analysis after pretesting and clubbed into three job-competency groups, namely, five attributes for 'work aptitude' evaluation, four for 'work culture' and three for 'community involvement'. The 42 ANMs of Harahua block, Varanasi were trained by the researcher using a Fish Bowl Technique for homogeneous decision making while recording response to the attributes. The intra-organizational AHR was conducted by them on 209 ASHAs. In order to study the correlations, information from 97 ASHAs was collected. Less than 50% score was obtained by 28.2% of the ASHAs. 'Self-initiative' was observed to be significantly poor (<0.01). 'Situation adaptability' and 'programme compliance' differed significantly from 'attendance' and 'punctuality'. 'Leadership' and 'community relationship' scores had significant difference ($p=0.002$).

Key words: Intra-organizational human resource audit, skill inventory of ASHA.

INTRODUCTION

Auditing of human resource (AHR) is aimed at evaluating the skill inventory of personnel in any organization to identify their potential and capabilities (DeCenzo and Robbins, 2002). The skill inventory includes data about each employee's working style, knowledge, productivity, involvement, etc. Supervision and individual performance evaluation have been identified as important components for supporting community health worker programmes (Crigler et al., 2011). An understanding of these aspects of AHR might give an insight into issues like job

adherence and attrition, and explore the scope for training improvement (Delta Publishing, 2006). In the context of contemporary global urge to stir high impact health interventions through lower cadres of skilled and partially skilled community based workers (World Health Organization, 2008), India is not left behind. This is quite evident for the grass-root level workers, namely, the Accredited Social Health Activist (ASHA), Auxiliary Nurse Midwife (ANM), Anganwadi Worker (AWW) trio, where conceptual clarity is usually unasked for and more value

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is given to job dexterity (Mohapatra and Sood, 2003).

Various national health programmes, in order to make on-the-job assistance possible, have trained workers and managers from all tiers of the hierarchy. While this 'excessive layering' risks creation of near-equal workers and managers leading to friction, insubordination, unaccountability and blame shifting within the organization (Jaques, 1990), it seems to have turned out positively. Despite the fact that mutual non-linkage and insecurity has been cited (Haider et al., 2008), the trio usually maintain a healthy interaction (NHSRC, 2011). Unfortunately, even if majority of on-the-job training of ASHA is conducted by her ANM (a critical working relationship), the latter was neither officially recognized as a supervisor nor trainer of the ASHAs; thus, compromising the scope to improve the ASHA's performance (Bajpai and Dholakia, 2011). As the importance for supportive supervision is being vividly realized, it is logical to believe that intraorganizational continuous evaluation of ASHAs by respective ANMs should be a synonymous approach to generate improvement possibilities (Khatidja et al., 1993).

Thus, the present study was undertaken with the following objectives:

- (1) To obtain quantitative assessment of ASHAs by respective ANMs for pre-identified job competencies, namely, work aptitude, work culture and community involvement;
- (2) To study the relationship between various attributes and socio-demographic factors with the overall job competency of the ASHAs.

MATERIALS AND METHODS

This study was conducted in Harahua Community Development Block of Varanasi district, Uttar Pradesh from January to June, 2011. The 209 ASHAs of the block were identified and mapped along with their 42 ANMs. A set of job-performance attributes of ASHA was derived by a panel consisting of the senior-most professor of Community Medicine in Banaras Hindu University (BHU), an associate professor from the Faculty of Management Studies, BHU (both co-authors), Additional Chief Medical Officer In-charge (Health Programmes), Varanasi and the Medical Officer In-charge, Primary Health Centre, Harahua. Each attribute was scaled on a three-point Likert Scale, namely, poor, average and good and scored with positive semantic differentials (Osgood, 1957). A proforma was, thus, designed to be self-administered by the ANM. The attributes were pretested on 10 ANMs of adjacent Chiraigaon Community Development Block and 12 attributes were selected through factor analysis and were clubbed into 3 job-competency groups based upon experiential reasoning by the authors: five attributes for work aptitude evaluation, four for work culture evaluation and three for evaluating community involvement of the ASHA. The 42 ANMs were trained in three workshops to make them understand the meaning of each attribute followed by a fish-bowl technique exercise for appropriate scoring.

In order to study the correlations, a sampling frame of all ASHAs was prepared in alphabetic order. Each alternate ASHA was selected for the purpose of analysis. Information for 97 ASHAs was validated by the software and hence included in the study. Data obtained was analyzed with MS Excel 2007 and Statistical Package for Social Sciences (SPSS)v16.0 using apposite statistical tests.

RESULTS

Table 1 shows the scores obtained by the ASHAs for different attributes with comparison across job-competency groups. The ASHAs had obtained significantly lower scores for 'self-initiative' as compared to other attributes that had been clubbed into the 'work aptitude' group. Even as the ANMs considered at least half of the ASHAs as fairly 'dependable' (50.2%) and appreciated their 'work style' (53.6%), almost every fourth ASHA was ranked as "poor" when it came to 'knowledge'. Around 55% ASHAs were found to have either average or even inferior scores for their 'productivity'. The variance in the scores given by the ANMs was least for 'self-initiative' and 'productivity' indicating consistent alignment of their opinion for these attributes. In the 'work culture' group, ASHAs were more frequently adjudged as "poor" for their 'situation adaptability' and functional compliance to the training given to them under different health programmes (19.6%) each. 'Punctuality' and regular 'attendance' at work had fetched the ASHAs significantly higher scores than the other two afore-mentioned attributes ($p=0.006$ at least and $p<0.001$ in most combinations). In the 'community involvement' competency, ASHAs fared exceptionally when it came to 'community relationship' (2.47 ± 0.721 ; over 60% ASHAs ranked "good"). The variance was also acceptably minimal (0.519) highlighting the similar views from most of their on-field intraorganizational auditors, that is, the ANMs. A significant difference was noted between the mean scores obtained for ASHAs' 'leadership' capability when compared with her 'relationship with the community' ($p=0.002$). 'Communication' skills formed a bridge between the two attributes with a mean score of 2.31 ± 0.762 .

The overall mean scores obtained in the different job competency groups were compared (Figure 1). It was found that there existed a significant difference across the groups ($p<0.001$). ASHAs had obtained low scores for 'work aptitude' as compared to 'work culture' (mean difference in scores with post-hoc Bonferroni= 0.179 ; $p<0.001$) and 'community involvement' (mean difference in scores with post-hoc Bonferroni= 0.161 ; $p<0.001$).

As shown in Table 2, a significant positive correlation was found between the size of service population and the ASHA's total AHR score ($p<0.001$). Increasing age seemed to have a significant inverse linear relationship with the total score ($r=3.0$, $p=0.003$), but this could explain only up to 9% of the variability (Figure 2). Distance from the mother Primary Health Centre (PHC) as well as years of experience as ASHA had no significant effect on the total score ($p=0.121$ and 0.806 , respectively).

Two indicators were considered in this study as proxies for estimating the economic standing of the ASHA: colour of ration card (red, yellow or white) and type of residence (kutcha, semi-pucca or pucca). However, ASHAs performance

Table 1. Mean scores of ASHAs for different attributes with intra-group comparison (n=209).

S/N	Attribute	AHR ranking by ANM			Mean±SD	Variance	Within group	
		Poor	Average	Good			ANOVA	Sig. with Bonferroni
Job competency group: Work aptitude								
1	Work Style	48 (23.0)	49 (23.4)	112 (53.6)	2.31±0.822	0.675	F=13.754 P<0.001	MD ₁₋₂ =1.000; MD ₁₋₃ =0.111; MD ₁₋₄ =1.000; MD ₁₋₅ <0.001; MD ₂₋₃ =0.188; MD ₂₋₄ =1.000; MD ₂₋₅ <0.001; MD ₃₋₄ =0.188; MD ₃₋₅ =0.004 MD ₄₋₅ <0.001
2	Productivity	33 (15.8)	82 (39.2)	94 (45.0)	2.29±0.725	0.525		
3	Knowledge	52 (24.9)	81 (38.8)	76 (36.4)	2.11±0.776	0.602		
4	Dependability	44 (21.1)	60 (28.7)	105 (50.2)	2.29±0.794	0.631		
5	Self-initiative	73 (34.9)	95 (45.5)	41 (19.6)	1.85±0.724	0.525		
Job competency group: Work culture								
1	Situation adaptability	41 (19.6)	90 (43.1)	78 (37.3)	2.18±0.735	0.541	F=11.288 P<0.001	MD ₁₋₂ =1.000; MD ₁₋₃ <0.001; MD ₁₋₄ <0.001; MD ₂₋₃ =0.006; MD ₂₋₄ <0.001; MD ₃₋₄ =1.000
2	Programme compliance	41 (19.6)	79 (37.8)	89 (42.6)	2.23±0.756	0.572		
3	Attendance	30 (14.4)	51 (24.4)	128 (61.2)	2.47±0.734	0.539		
4	Punctuality	28 (13.4)	44 (21.1)	137 (65.6)	2.52±0.721	0.520		
Job competency group: Community involvement								
1	Communication	38 (18.2)	68 (32.5)	103 (49.3)	2.31±0.762	0.581	F=6.039 P=0.003	MD ₁₋₂ =0.584 MD ₁₋₃ =0.098 MD ₂₋₃ =0.002
2	Leadership	45 (21.5)	74 (35.4)	90 (43.1)	2.22±0.776	0.602		
3	Community relationship	28 (13.4)	55 (26.3)	126 (60.3)	2.47±0.721	0.519		

Values in parentheses indicate percentage share within the attribute.

Table 2. Correlations with total AHR score (n=97).

Statistic	Service population	Distance from the mother PHC (km)	Years of experience	Age (years)
Mean±SD	1233.51±612.413	11.92±6.226	3.92±0.672	33.87±5.245
Correlation	r _s =0.454	r=-0.131	r=-0.025	r=-0.300 (r ² explains only 9% variability)
P value	<0.001	0.201	0.806	0.003

as estimated by the total AHR score did not change significantly across the subgroups of these indicators (p=0.025 and 0.886, respectively). The number of children the ASHA had, also, did not affect her performance much (p=0.123). Notably, ASHAs hailing from joint families had a higher score of 28.91±6.295 which was significantly

different (p=0.002) from that of ASHAs having a nuclear family. Education had a certain impact in facilitating better performance as mean scores obtained kept increasing with education while variance kept decreasing. Scores of ASHAs not educated beyond middle school differed significantly from that of ASHAs with education up to

education up to intermediate (p=0.030), and graduate and above (p<0.001). A significant difference existed between the means of the total scores obtained by ASHAs from scheduled castes/scheduled tribes and other backward classes (p=0.031). Details have been enumerated in Table 3.

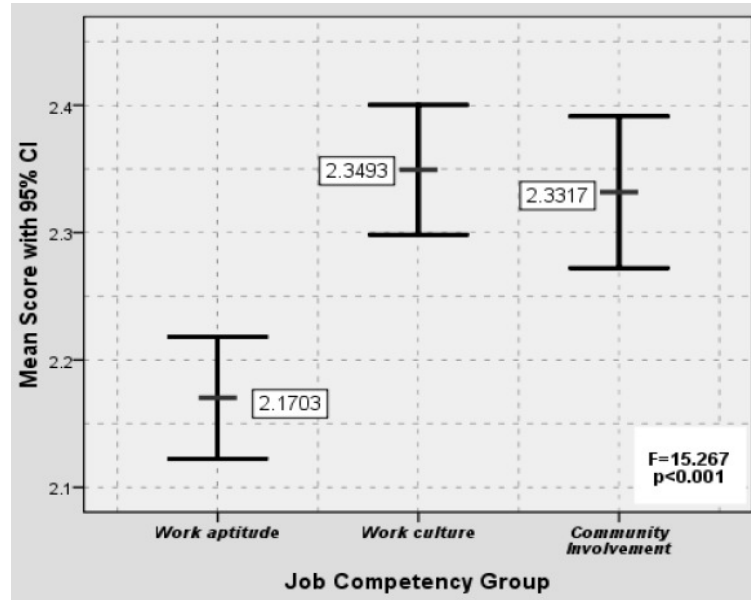


Figure 1. Mean scores of job competency groups with confidence intervals.

Table 3. Comparison of socio-demographic factors of ASHAs with their total AHR score.

Demographic factor	AHR score (Mean±SD)	ANOVA/t-test	P value	Sig. with Bonferroni
Ration card				
1 Red	23.71±7.319	F=1.514	0.225	MD ₁₋₂ =0.821
2 White	26.90±7.636			MD ₁₋₃ =0.293
3 Yellow	28.09±6.199			MD ₂₋₃ =1.000
Type of house				
1 Kutcha	27.56±6.683	F=0.121	0.886	MD ₁₋₂ =1.000
2 Semi-pucca	26.92±7.370			MD ₁₋₃ =1.000
3 Pucca	27.70±6.359			MD ₂₋₃ =1.000
Type of family				
1 Nuclear	24.58±6.433	t=3.136	0.002	--
2 Joint	28.91±6.295			
Family size (number of children)				
1 ≤ 2	28.71±5.932	t=1.556	0.123	--
2 >2	26.62±7.025			
Education (includes current status)				
1 Primary/Middle school	24.04±7.486	F=6.587	<0.001	MD ₁₋₂ =1.000; MD ₁₋₃ =0.030; MD ₁₋₄ <0.001; MD ₂₋₃ =1.000; MD ₂₋₄ =0.059; MD ₃₋₄ =0.209
2 High school	26.23±7.002			
3 Intermediate	28.39±5.545			
4 Graduate/Above	32.25±3.642			
Caste				
1 SC/ST	25.88±6.731	3.127	0.048	#MD ₁₋₂ =0.031
2 OBC	29.44±5.797			#MD ₁₋₃ =0.810
3 Others	26.33±7.126			#MD ₂₋₃ =0.055

*Calculated for each pair using independent samples t-test as post-hoc Bonferroni was not useful.

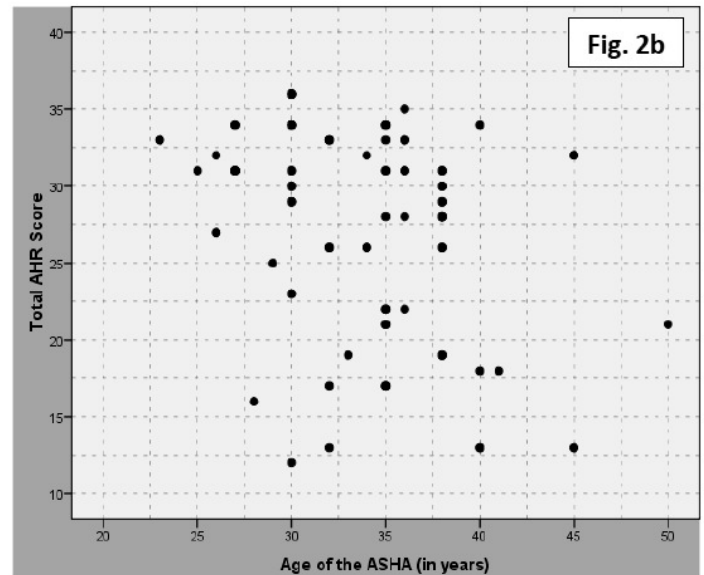
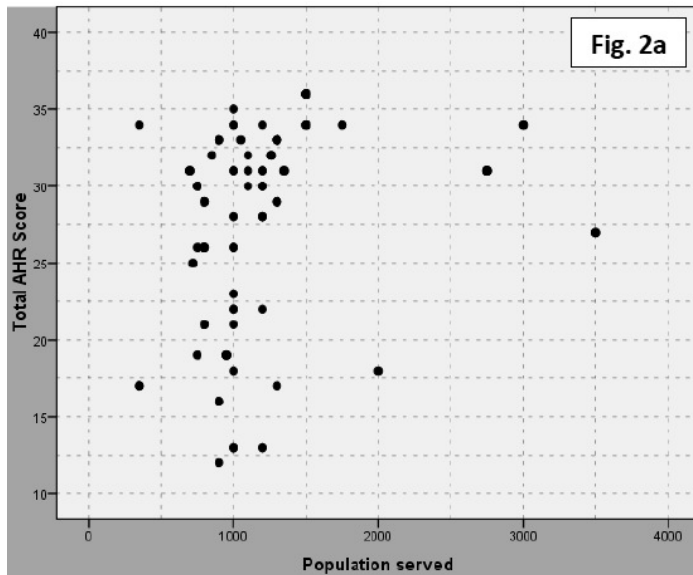


Figure 2. Correlation of (a) population served by ASHA and (b) Age of ASHA, with her total AHR score.

DISCUSSION

The novelty of the concept of ASHA has been seconded by strategic planning for selection, training, incentives and support mechanisms. ASHA is trained to form an interface between the public health care delivery system and the community from where she hails (National Rural Health Mission (NRHM), 2006) and has been the anvil of the NRHM at the village level for most health programmes. As NRHM entered its last year in 2012, the way the ASHA programme has shaped up has been reviewed quite positively by many (NHSRC, 2011; MOHFW, 2010). In these seven years of NRHM, ASHA has had more interaction with ANM than perhaps any other health functionary. An intraorganizational human resource auditing of ASHA by the ANM is promising with scopes to identify existent loopholes. The importance of high quality training, on-the-job support and regular supervision for ASHA has already been reported (NHSRC, 2011; Bajpai and Dholakia, 2011).

The present study reports lack of self-initiation and leadership virtues in ASHA. Given the background of ASHA, a woman from the rurals, it naturally demands enormous extroversion from her to step out of her home, and meet and face the world. This aptly explains why ASHA usually finds herself intimidated in situations that require her active intervention as a leader or decision maker. It is affirmative to find out that ASHA, lacking a self-initiative, plays a subordinate to ANM. This indicates that a hierarchy is maintained where the subordinate waits for the superior's directives instead of working on her own. However, leadership quality is one of the prerequisites for selection as ASHA (NRHM, 2005). The ASHA training modules of NRHM and Comprehensive Child Survival

Programme (CCSP) have taken note of this and hence have laid much stress on role-realization and self-identity of the woman who takes up the role.

On the other hand, programme non-compliance and poor knowledge could be reflective of incompetent and inadequate training; serious brain churning required on this aspect of ASHAs' training as mostly this task is delegated through public private partnership models, quality and uniformity-check of which is very difficult. Mid-term evaluation of NRHM by Earth Institute of Columbia University recommended that ASHAs required proper recruitment, comprehensive training (e.g., full induction on-the-job and regular refresher), effective oversight, and payments that are timely and adequate (Bajpai et al., 2009).

The incentivized jobs of ASHA have been taken up with exemplary interest by her. On the other hand, timely release of incentive has been considered as key link to ASHA's job satisfaction and performance (NHSRC, 2011; Bhatnagar et al., 2009). The inclination towards incentivized job makes ASHA unavailable in her village on many occasions. The need to rush to the PHC at Harahua to facilitate beneficiaries seriously compromises her scope to initiate any other duty on her own or adapt to situational requirements for jobs that do not fetch her incentive. It has been evident in the present study that ASHAs lack situational adaptability and self-initiative.

The welcome finding is ASHAs' attendance and punctuality at her workplace, which the ANMs appreciate the most during routine immunization sessions, mostly. That is also the occasion when the ANM witnesses the ASHA's communication and community relationship. In Harahua, it was found out from the ANM that ASHA was doing fairly well for both attributes. A study from Eastern

Uttar Pradesh showed that even though ASHA is well connected with the society, she needs regular support, training and cooperation from other functionaries (Bajpai and Dholakia, 2011; Srivastava et al., 2009).

The selection of ASHA from the village itself seems to have paid its dividends. The “work culture” and “community involvement” job competency group scored the highest AHR points followed by “work aptitude” in that order. “Work culture” has considered skills that are mostly behavioral and can be inculcated with discipline while “work aptitude” requires the potential for innovation and resilience, which are very difficult to achieve.

The better performance of ASHAs from joint families over those with nuclear family is something to be highlighted. Joint families are likely to give more support in domestic work and this could be allowing ASHA to dedicate more time and attention to her work. The social support system for such ladies should also be higher which reflects in their work.

The study also shows a significant difference between the performance of ASHAs with education less than the requisite minimum for selection (standard 8th) (NRHM, 2005) in comparison to those educated up to intermediate or above. However, this only reinforces the fact that “better the education, better the performance” while simultaneously providing support to the aptness of keeping standard 8th as the criterion minimum. Even if this study suggests no significant difference in the total AHR scores of the ASHAs educated up to middle school and those up to high school, we should be very careful while thinking of raising the selection cut-off lest we repeat what happened in West Bengal when Class X was the notified minimum—unavailability of eligible candidates and under-representation of weaker sections of the society (NHSRC, 2011).

Conclusion

Auditing of human resource is essential to understand the skill inventory. It is pertinent to mention here that ASHAs have been trained by different types of modules and groups. In spite of that, they still lack in knowledge culminating in programme non-compliance, poor self-initiative, situation non-adaptability and absent leadership virtues causing compromised community involvement. The different modules introduced to the ASHAs are mostly forced on them during training, a futile exercise, which is more semantic than strategic. It is recommended that categorical components should be chosen using appropriate adult learning techniques to improve the human resource we have in ASHA.

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