Journal of Family Medicine and Preventive Medicine

SCIENTIFIC Research and Community

Research Article

Open Access

Women's Perspectives on the Role of Community Health Workers in Planning Family-Community Based Study in a Rural, Remote Region

Chhabra S[1]* and Sao PK[2]

[1]Senior Consultant, Obstetrics Gynecology, Tapan Bhai Mukesh Bhai Memorial Hospital, Research Centre and Proposed Medical College. Kharde, Shirpur, Dhule, Maharashtra, India

[2]Assistant Professor, Obstetrics Gynecology, Mahatma Gandhi Institute of Medical Sciences, Sewagram, Wardha, Maharashtra, India

ABSTRACT

Background: Community health workers (CHWs) are believed to play pivotal role in enhancing rural health, including guidance, assistance to couples in planning family. In India, Accredited Social Health Activists (ASHAs), special cadre of CHWs, program was introduced to bolster maternal child health, though their roles got extended to broader health initiatives. However, ASHAs' contribution to planning family does not seem to be to their full potential. Need to harness this special cadre of CHWs to promote planned families in rural communities is evident.

Methodology: Community based study was conducted over two years in a remote hilly region, in 140 villages with health care facility, (Study Center) in one of them.
Study sample comprised of 4500 women aged 20 to 49 Yrs. from diverse educational backgrounds, professions, economic status, and parity. Data was collected through interviews using predesigned structured questionnaire.

Results: Study revealed varied perceptions of CHWs roles in planning family among rural tribal women. Most respondents said that CWHs need to motivate health facility births and bring children to immunization clinics, 56%. However, their role in encouraging planning family was less acknowledged 12to 33%. Sterilization was most widely recognized method of planned family, where CWHs were expected to be facilitators, upto 75% Age, education. economic status, jobs, number of child births affected their perceptions and expectations. However most Women did expect CHWs to arrange family planning programs.

Conclusion: Present study underscores need for more robust awareness amongst communities about role of CHWs in promoting planned families in rural tribal communities. Strengthening ASHAs involvement in comprehensive family planning awareness, bridging gap between healthcare systems and communities, in planning families especially in remote regions is imperative.

***Corresponding author**
Chhabra S, Senior Consultant, Obstetrics Gynecology, Tapan Bhai Mukesh Bhai Memorial Hospital, Research Centre and Proposed Medical College. Kharde, Shirpur, Dhule, Maharashtra, India.

Received: December 10, 2024; **Accepted:** December 16, 2024; **Published:** December 23, 2024

Keywords: Community Health Workers, Planning Family, Rural Health Services, Accredited Social Health Activists, Family Planning Services

Background

Community health workers (CHWs) are pivotal in bridging the gap between health services and communities, especially in marginalized populations in rural, remote areas. India, with its diverse healthcare challenges, introduced the National Rural Health Mission (NRHM) in 2005, a pioneering initiative aimed at enhancing healthcare access for rural communities [1]. A key component of the NRHM was the introduction of Accredited Social Health Activists (ASHAs), special cadre of CHWs, envisioned as the cornerstone for rural health. The primary role of ASHAs was to improve maternal and child health, addressing critical issues such as, antenatal care, institutional deliveries, and immunization coverage [2]. ASHAs selected from the communities were envisioned to provide awareness and also guide and facilitate healthcare [3]. Each ASHA was assigned a village with a population of 1,000, and additional ASHAs were designated based on the size of the village [1]. Over the years these CHWs [ASHAs] have played an important role in promoting maternal and child health services, being instrumental in increasing institutional deliveries, and ensuring that children receive complete vaccination [4]. But the broader potential of ASHAs in planning families (PF) remains underutilized. Their program guidelines included tasks related to PF, such as counselling couples on contraceptive options, promotion of use of contraceptives, access to contraceptive services. CHWs were expected to create awareness of importance of small family, provide information on available methods of family planning (FP). Despite these expectations, their role in PF has faced several challenges.

PF is essential for public health too, encompassing a range of services, interventions aimed at enabling individuals and couples to achieve the desired family size and spacing between

pregnancies. Reducing fertility rates has been a priority to address the country's burgeoning population too. However PF is not just about population control, it is also about empowering couples to making informed choices for planning family. CHWs intimate knowledge of local customs, cultures, and languages make them invaluable in disseminating information and mobilize communities for having planned families. They serve as a crucial link between rural communities and programs. The success of family planning programs (FPP) requires awareness and enabling environment where individuals can access and use contraceptives effectively. CHWs often encounter resistance and cultural barriers in promoting FP, which necessitate not only knowledge, but also strong communication and advocacy skills.

Objectives

To know the perceptions of women from rural remote communities, about the role of ASHAs, special cadre of CHWs in having planned families accessing services and use of FP modalities.

Material and Methods

Study Design: Cross-sectional study

Study Setting: The study was conducted in rural tribal communities located in a remote forestry hilly region.

Inclusion Criteria: Women aged between 20 to 49 years, willing to participate in the study.

Sample Size: A minimum of 20 women from each village were included. The total sample size for the study was 4,500 women rounding the figure after sample size calculation [5].

Data Collection: A predesigned tool with yes or no answers and short answers, was used for conducting interviews of the study participants in villages at mutually convenient places. Information was recorded on a hard tool during the interviews. Participants were not given tool to fill.

Results

Overall only 20 to 33% women ranging with different variables perceived that CWHs had any role in planned families. In women with some education, numbers were higher 33.3 % (P value 0.001). (Table 1) However their main perceptions were that CHWs roles were to ensure facility births and bring children for immunization. Statistically significant difference was seen among women of 30 to 39 years about role of CHWs for health facility births, 54.6 % (859) (P value of 0.001). Significant difference was found among women of 20 to 29 years old, 53.7 % (1197) who talked of CHWs role in bringing children to immunization clinics. A statistically significant difference was found among women of 40 to 49 years about CHWs role in PF. Statistically significant difference was seen among women who were illiterate or with primary education (32.3% - 311 & 31% - 416) compared to women with secondary or higher education (41% - 862 & 41.9% - 39) in perception of CHWs role in facilitating birth at a health facility (p-value of 0.001.). A statistically significant difference was seen among women with no formal education (33.1% - 319) and women with primary or secondary education (48%-643 & 39.8%- 836) in their perception of CHWs role in bringing children to immunization clinics (p-value of 0.001), 33.3%-319compared to women with primary education (17.2% - 230) for planning family (p-value 0.00 I).A statistically significant difference was seen among women from the middle-upper class (49.2% - 251) and the upper class. Statistically significant difference was seen among women from middle class (56.1% - 595) about ASHAs role in bringing children to immunization clinics compared to illiterate or less educated (p-value of 0.001). A statistically significant difference was seen among women with higher births, being more aware of role of CHWs in health facility birth (40.7% - 543) and bringing children to immunization clinics (43.8% - 585) compared to women with lower parity (P value of 0.001). (Table 1) A significant difference was observed among women aged 30 to 39 years expecting the most from CHWs (76.9%- 1210) regarding their choice of method of family planning, sterilization (50.8% - 799) being the most commonly chosen mode for which ASHAs could help. A significant difference was found among women with secondary education sterilization (42.7%- 898) as the mode for planning a family with help of CHWs. However more illiterate and women with primary education expected ASHAs to arrange for programs 27.8% (268).and 31% (415) respectively for the choice of mode of help compared to others. A difference was seen among women with lower economic status having the most expectations from Asha's (83.3 % 1174) for choice of method of PF, sterilization (45.7% 645) contraceptive mode (32.4% - 457) to make the method available (15% - 211) and arrange programs (68.3% -963). A significant proportion of women with one and two children said that CHWs could help in the contraceptive method (34.7% - 531) for PF, and ASHAs and arrange programs (33.5%- 512) for helping them (Table 2).

Table 1: Perceptions of Rural Tribal Women Regarding the Role of CWHs in Context of Planning Family

Variables	Perceptions about CHWs work										
	Total	Motivating health facility birth	%	Bringing children to Immunization clinics	%	Encouraging family planning	%	Others	%	Don't know	%
AGE											
20 to 29	2230	526	23.6	1197	53.7	459	20.6	16	0.7	32	1.4
30 to 39	1574	859	54.6	384	24.4	289	18.4	14	0.9	28	1.8
40 to 49	696	243	34.9	240	34.5	198	28.4	5	0.7	10	1.4
TOTAL	4500	1628	36.2	1821	40.5	946	21	35	0.8	70	1.6
EDUCATION											
ILLITERATE	964	311	32.3	319	33.1	315	32.7	76	7.9	13	1.3
PRIMARY	1340	416	31	643	48	230	17.2	17	1.3	34	2.5
SECONDARY	2103	862	41	836	39.8	370	17.6	12	0.6	23	1.1

HIGHER SECONDARY	93	39	41.9	0	0	31	33.3	0	0	0	0
TOTAL	4500	1628	36.2	1821	40.5	946	21	35	0.8	70	1.6
PROFESSION											
HOUSEWIFE	502	185	36.9	161	32.1	134	26.7	7	1.4	15	3
LABOURER	1443	489	33.9	532	36.9	392	27.2	10	0.7	20	1.4
OWNFARM LABOUR	2498	939	37.6	1101	44.1	405	16.2	18	0.7	35	1.4
OTHERWORK	8	0	0	8	100	0	0	0	0	0	0
LOCAL/ OTHER PLACE	49	15	30.6	19	38.8	15	30.6	0	0	0	0
TOTAL	4500	1628	36.2	1821	40.5	946	21	35	0.8	70	1.6
ECONOMIC STATUS											
UPPER CLASS	165	32	19.4	61	37	35	21.2	14	8.5	23	13.9
MIDDLE UPPERCLASS	510	251	49.2	120	23.5	101	19.8	15	2.9	23	4.5
MIDDLE CLASS	1060	215	20.3	595	56.1	235	22.2	3	0.3	12	1.1
MIDDLELOWER CLASS	1355	593	43.8	481	35.5	281	20.7	0	0	0	0
LOWER CLASS	1410	537	38.1	564	40	294	20.9	3	0.2	12	0.9
TOTAL	4500	1628	36.2	1821	40.5	946	21	35	0.8	70	1.6
PARITY											
P.0	1635	543	33.2	590	36.1	474	29	9	0.6	19	1.2
P.1-P.2	1530	542	35.4	646	42.2	309	20.2	12	0.8	21	1.4
P.3-P.5 Above	1335	543	40.7	585	43.8	163	12.2	14	1	30	2.2
TOTAL	4500	1628	36.2	1821	40.5	946	21	35	0.8	70	1.6

Table 2: Expectations of Rural Tribal Women from CWHs in Context of Planning Family

Variable	Total	Yes	%	Methods of family Planning Where Expectations for Assistance						Mode of Assistance			
AGE				Sterilization	%	Contraceptive modes	%	Others	%	Arrange programs	%	Make method available	%
20 to 29	2230	1452	65.1	745	33.4	574	25.7	133	6	478	21.4	974	43.7
30 to 39	1574	1210	76.9	799	50.8	352	22.4	59	3.7	359	22.8	851	54.1
40 to 49	696	385	55.3	99	14.2	275	39.5	11	1.6	152	21.8	233	33.5
TOTAL	4500	3047	67.7	1643	36.5	1201	26.7	203	4.5	989	22	2058	45.7
EDUCATION													
ILLITERATE	964	612	63.5	328	34	259	26.9	25	2.6	268	27.8	344	35.7
PRIMARY	1340	847	63.2	405	30.2	406	30.3	36	2.7	415	31	432	32.2
SECONDARY	2103	1537	73.1	898	42.7	521	24.8	118	5.6	285	13.6	1252	59.5
HIGHER SECONDARY	93	51	54.8	12	12.9	15	16.1	24	26	21	22.6	30	32.3
TOTAL	4500	3047	67.7	1643	36.5	1201	26.7	203	4.5	989	22	2058	45.7
PROFESSION													
HOME MAKER	502	281	56	123	24.5	121	24.1	37	7.4	156	31.1	125	24.9
AGRICULTURE LABOURER	1443	895	62	364	25.2	479	33.2	52	3.6	349	24.2	546	37.8
CASUAL LABOURER*	2498	1814	72.6	1113	44.6	601	24.1	100	4	459	18.4	1355	54.2
SHOP KEEPER	57	57	100	43	75.4	0	0	14	25	25	43.9	32	56.1
TOTAL	4500	3047	67.7	1643	36.5	1201	26.7	203	4.5	989	22	2058	45.7
ECONOMIC STATUS													
UPPER CLASS	165	142	86.1	58	35.2	32	19.4	52	32	68	41.2	74	44.8

MIDDLEUPPER CLASS	510	245	48	145	28.4	78	15.3	22	4.3	121	23.7	124	24.3
MIDDLE CLASS	1060	673	63.5	354	33.4	298	28.1	21	2	370	34.9	303	28.6
MIDDLELOWER CLASS	1355	813	60	441	32.5	336	24.8	36	2.7	219	16.2	594	43.8
LOWER CLASS	1410	1174	83.3	645	45.7	457	32.4	72	5.1	211	15	963	68.3
TOTAL	4500	3047	67.7	1643	36.5	1201	26.7	203	4.5	989	22	2058	45.7
PARITY													
P.0	1635	1178	72	758	46.4	325	19.9	95	5.8	325	19.9	853	52.2
P.1 - P.2	1530	1162	75.9	598	39.1	531	34.7	33	2.2	512	33.5	650	42.5
P.3 – P. P.5 Above	1335	707	53	287	21.5	345	25.8	75	5.6	152	11.4	555	41.6
TOTAL	4500	3047	67.7	1643	36.5	1201	26.7	203	4.5	989	22	2058	45.7

Discussion

The findings of the present cross-sectional study provided valuable insights into the perceptions and expectations of rural tribal women regarding the role of CHWs in planning families in remote region. The implications of these findings and their relevance in the context of rural healthcare and FPP are evident. The study also revealed that perceptions of women about this special cadre of CWHs' role in PF was much less 12 to 30% compared to their role for health facility births and bringing children for immunization 20 to 55% and it varied significantly among different demographic groups. Age, education, profession, economic status, and parity all influenced the numbers of tribal rural women with positive perceptions. Overall numbers of younger respondents, those with higher education and those engaged in non-agricultural jobs were more for PF. This variation underscores the importance of having system for targeted awareness and information awareness tailored to specific demographic groups to enhance knowledge about CHWs roles in supporting and helping them in planning families, with desired numbers too.

These findings align with existing research on the challenges faced by community health workers like ASHAs in rural areas. Lack of awareness about their roles can impede their effectiveness in promoting FP. Addressing this knowledge gap through community-based initiatives and strengthening the pre and in-service training of CHWs in family planning counselling, promoting, supporting and helping can be instrumental in improving FPP too [6].

The study also highlighted the expectations that rural tribal women have from CHWs in the context of FPP. However the majority of study subjects expected ASHAs to help with Sterilization 55 to 85%, a well-known and widely practiced method of limiting family size. Findings suggested that CHWs can play a crucial role in facilitating access to sterilization. Around 20 to 40% respondents expected assistance with contraceptive modes choice, indicating a need to increase potential, guide about various contraceptive methods and their easy availability. This aligns with the broader goal of FPP to offer a range of, contraceptive options to meet individual preferences and needs. The study also highlights the importance of ASHAs in making FP methods available and organizing programs, around 25 to 70%, demonstrating the potential of CHWs to act as facilitators in promoting FP services in remote areas. The findings of this study underscore the need for targeted interventions to enhance ASHAs' effectiveness in promoting FP within rural tribal communities. Strengthening ASHAs' training and support systems is imperative to ensure they have the knowledge and communication skills required to address the specific needs of diverse demographic groups. Awareness of the communities needs to be there and the CHWs should receive comprehensive preservice training in counselling for planned family, first child, interval between two and number of children too. It should also include information about various contraceptive methods, their benefits, and potential side effects. Training should also focus on improving communication and advocacy skills to address cultural barriers and misconceptions related to planning family and contraceptives for spacing and permanent and create a system so that rural communities know the potential of CHWs [7].

ASHAs themselves can actively engage with local leaders, self-help groups, and women's committees to create a supportive environment for planned family system by being bridges between communities and CHWS. Building partnerships with community influencers can help overcome resistance and encourage open discussions about planned family concepts amongst women, CHWs [8]. Community leaders can bridge the gap between women and CHWs. Also regular supervision and support from healthcare supervisors are crucial to ensure that CHWs effectively implement FP activities and provide accurate information. Supervisors should provide guidance and monitor their progress in promoting planned families [9].

Targeted awareness campaigns should be conducted to improve knowledge of communities about CHWs' roles in FP among rural tribal women. These campaigns should be culturally sensitive and designed to reach different demographic groups effectively. Age, education, profession, economic status, parity all influenced their perceptions.

Regular supervision and support from healthcare supervisors are essential to ensure that these special CHWS effectively implement FP activities and provide accurate information to communities, who need to be aware of possible support.

Conclusion

Present study sheds some light on the awareness level and expectations of rural tribal women regarding in plan family in remote rural regions. Demographic factors such, as age, education, profession, economic status, and parity affected women's awareness. These insights underscore the importance of tailored interventions and targeted awareness campaigns to bridge the gap and enhance effectiveness in promoting. rural tribal women's expectations from CHWs to provide comprehensive information on contraceptive methods and facilitate access to FP services. The study highlighted the potential for CHWs to act as facilitators in making FP methods available and organizing programs, thus contributing significantly to improving FP services in remote areas.

Funding and Acknowledgement

There was no funding except for honorarium to the field assistant for field data, authors are grateful and thanks are also due to communities for all the cooperation and support.

Conflict of Interest: Nil

References

1. (2023) Ministry of Health and Family Welfare, Government of India. National Rural Health Mission https://nhm.gov.in/.
2. Scott K, Shanker S (2010) Tying their hands? Institutional obstacles to the success of the ASHA community health worker programme in rural north India. AIDS Care 22: 1602-1608.
3. (2023) National Health Systems Resource Centre. ASHA Training Modules https://nhsrcindia.org/sites/default/files/2021-02/Induction-Training-Module-for-ASHA-English_0.pdf.
4. (2023) Family Planning Contraception. World Health Organization https://www.who.int/teams/sexual-and-reproductive-health-and-research-(srh)/areas-of-work/family-planning-and-contraception.
5. calculator.net https://www.calculator.net/.
6. Singh A, Ogallah R, Ram F, Pallikadavath S (2012) Sterilization regret among married women in India: Implications for the Indian National Family Planning Program. Int Perspect Sex Reprod Health 38: 187-195.
7. Cleland J, Bernstein S, Ezeh A, Faundes A. Glasier A, et al. (2006) Family planning: the Unfinished agenda. Lancet 368: 1810-1827.
8. Singh A, Pallikadavath S, Ram F, Alagarajan M (2015) Do Health Management Information Systems (HMIS) Improve the Availability, Quality, and Use of Health Data in Low Income Countries? A Systematic Review. PLoS One 10: e0120201.
9. Santhya KG, Haberland N, Ram F, Sinha RK, Mohanty SK (2007) Consent and coercion: Examining unwanted sex among married young women in India. Int Fam Plan Perspect 33: 124-132.

Copyright: ©2024 Chhabra S. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.