Original Study

Effectiveness of Mental Health Training Program on Knowledge, Attitude and Practices of ASHA workers of selected rural areas of Jabalpur: A Pilot Study

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Abstract

Introduction and background: One of the major challenges of successful integration of mental health into Primary health care is the lack of adequate knowledge, positive attitude, and skills for mental health service of community health professionals like ASHA participating in the care and treatment of people at primary health care levels. Accredited Social Health Activist (ASHA) may play a significant role in the early identification of mental health issues and in enhancing community health status.

Objective- The objective of the study was to assess effectiveness of mental health training program on knowledge, attitude and practices of ASHA workers of selected rural areas of Jabalpur.

Methodology- A quasi experimental pre-test post-test control group design was used to collect data from 22 ASHA workers who were selected using non probability purposive sampling technique. The Mental health training program was administered to experimental group for two days. Pre and Post Test knowledge, attitude and Practice was assessed using a structured knowledge questionnaire, attitude assessment scale and self-reported practice assessment scale respectively. The gathered pilot study data was analysed using descriptive and inferential statistics.

Results: There was a statistically significant improvement in knowledge, attitude and Practice of ASHA workers after intervention.

Conclusion: The findings of the pilot study revealed no ambiguity and the tools were feasible to conduct the main study.

Key words: Mental Health training Program, ASHA worker, Effectiveness, Knowledge, Attitude, Practice

Introduction

The maxim, "there is no health without mental health" underlines the fact that mental health is a quintessential and vital element of health. however, attaining this state of mental health is an enduring challenge, with over one billion people worldwide living with a mental or addictive disorder. Mental disorders are both leading causes of disability and significant risk factors for premature mortality. At all levels of sociodemographic development, this burden of morbidity and mortality is rising.[1,2] In India, approximately 6% of the population have a mental

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disorder such as schizophrenia. Suicide is a major public health problem, with over 100,000 suicides annually. Mental disorders in India are not necessarily experienced and understood in the same way as in Western countries and the vast majority of care is provided by the family. Many remain untreated, and those families who do seek treatment will often turn to non-allopathic providers including practitioners of Indian traditional medicine, religious healers, faith healers and astrologers. The scarcity of mental health professionals, particularly in rural areas, places specialist psychiatric care out of the reach of most people.[3]The World Health Organization (WHO) believes that the best approach to reducing the global burden of disease is to include mental health within PHC. The National Mental Health Program in India also supports the integration of mental health into primary healthcare, however only 24 of 600 districts are currently covered by this programme, indicating that there has been relatively limited success in putting this concept into reality.[4]

On 12 April 2005, the Government of India took a major welfare initiative by launching National Rural Health Mission (NRHM) in 18 states with weak public health indicators and infrastructure and extended it across the entire country. One of the key components of the National Rural Health Mission is to provide every village in the country with a trained female community health activist ASHA (Accredited Social Health Activist). Selected from the village itself and accountable to it, the ASHA will be trained to work as an interface between the community and the public health system. Q. N. Shah et al**.,** (2019) study shows how CHWs in India may benefit from formal mental health training and programming. In this cross-sectional study, self-administered questionnaires were used on CHWs in Vadodara, Gujarat, India. Two-tailed t-tests were run in Excel 2011. Anxiety (61%) and brain disease (61%), followed by stress (45%) and alcoholism (38%). CHWs doubt faith healers' capacity to treat mental illness (72.9%), but advocate psychiatric care for the mentally sick (84.4%). Over 50% of participants said mentally sick had a lower IQ and are unpredictable, but 80% said they can live in the community and recover with treatment and assistance (91%). The study suggests training CHWs to reduce stigmatizing ideas and increase mental disease awareness to scale up mental health treatment in low-resource regions[5].

The impact of a mental health education program on ASHAs' knowledge, attitudes, and practices (KAP) was assessed in a study by **Misra et al.** in 2021. In a district in western India, intervention research was carried out in 2016 and 2017 to enable ASHAs to offer mental health treatments. Before and after the intervention, a semi-structured questionnaire was given to intervention and control groups to gauge KAP's mental health. In two batches, an instructional program was delivered. For delivering instruction and training, hybrid techniques were used. In the intervention group, the "paired t test" was used to compare pre and post results, while the "unpaired t test" was used to compare baseline data. Results: After intervention, KAP of ASHAs showed a statistically significant improvement. The majority of ASHAs referred patients with mental health issues to public tertiary care facilities. According to the study, providing ASHAs with a brief training on mental health can help them become more successful in terms of knowledge, attitudes, and practices.[6] It is an evident from the studies cited above that the Short-term mental health training, may considerably enhance ASHA workers areas of knowledge, attitude, and practices. As a result, the investigator realized the need to carry out the particular study to assess the effectiveness of mental health training program on Knowledge, attitude and practices of ASHA workers.

Materials and Method

The research design adopted for the study was quasi- experimental pre-test post-test control group design in which two groups (control group and experimental group) were selected experimental group was given intervention and no intervention was given to control group. The pilot study was conducted at Seth Govind Das Victoria Hospital, Jabalpur from 1st July to 31st July 2022, among 22 ASHA workers of Jabalpur block who met the predetermined criteria. The prior written permission was obtained to conduct the study from the Chief Medical Officer, Jabalpur. An informed consent was obtained from respondents prior to the study, the purpose of the study was explained to the subjects and confidentiality was assured to all the subjects. Pre Test was administered to assess knowledge, attitude and practice of ASHAs regarding mental health in both the groups at the baseline by using structured

knowledge questionnaire, attitude assessment scale and self-reported practice scale respectively. After the administration of questionnaire, all participants of the intervention group underwent a well-designed mental health training program. Training was imparted for 2 days; divided into four sessions of 45 mins each. Post intervention data were collected after one months from both the groups. Analysis of data was done using descriptive and inferential statistics.

Reliability of the Tools

The tools' reliability was measured on 22 ASHA workers. The test-retest method was used to determine the reliability, which was computed using Karl Pearson's correlation coefficient, which was r = 0.76 for the structured knowledge questionnaire, r = 0.96 for the attitude assessment scale, and r = 0.93 for the self-reported practice assessment scale. As a result, all the tools were found to be reliable for measuring ASHA workers' knowledge, attitude, and practice.

Results

A total of 22 ASHA worker 11 in experimental and 11 in control participated in the study. According to the Table 1 majority of ASHA workers4 (36.36%) in control group were from the age group 20-30 years, 3 (27.27%) were from the age group 31-35 years. In education majority 6 (54.55%) of ASHA workers were having education up to matriculation. All 11 (100%) were married, family income per month of ASHA workers were 9 (81.82%) below Rs. 5000, most of them 5 (45.45%) were living in joint family. Most 10 (90.91%) of them had working experience of more than 5 years and 6 (54.55%) serve population size of more than 1500 and 6 (54.55%) visits home 2-4 days per week and all 11(100%) had no previous experience/ training related to mental health. In experimental group Majority 7 (63.64%) of ASHA workers were in the age group of 31-35 years, 7 (63.64%) were having formal education upto 8th class, all were 11 (100%) married and having family income below Rs 5000, most of them 6 (54.55%) were living in joint family, 9 (81.82%) were having experience of more than 5 years, 6 (54.55%) were serving a population size of 1000 to 1500, 9 (81.82%) were carrying out home visits 2-4 days per week and all were 11 (100%) having no previous experience/ training.

Table 1: Frequency and percentage distribution of ASHA workers based on their socio-demographic variables in control group and experimental group.

Demographic Variables	Control Group		Experimental Group	
	f	P (%)	f	P (%)
1. Age (in years)				
a) 25-30	4	36.36	2	18.18
b) 31-35	3	27.27	7	63.64
c) 36-40	2	18.18	1	9.09
d) Above 40	2	18.18	1	9.09
2. Education				
a) Formal education up to 8th class	4	36.36	1	9.09
b) Up to matriculation	6	54.55	2	18.18
c) Senior secondary	1	9.09	1	9.09
d) Higher secondary	0	0.00	7	63.64
3. Marital Status				
a) Single	0	0.00	0	0.00
b) Married	11	100.0	11	100.0
c) Divorced	0	0.00	0	0.00

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4. Family Income per month				
a) Below 5000/-	9	81.82	11	100.0
b) Rs. 5001/- to 10,000/-	2	18.18	0	0.00
c) Above Rs 10000/-	0	0.00	0	0.00
5. Type of family				
a) Nuclear	4	36.36	3	27.27
b) Joint	5	45.45	6	54.55
c) Extended	2	18.18	2	18.18
6. How long have you been working as ASHA?				
a) Less than one year	0	0.00		0.00
b) One year to 5 years	1	9.09	2	18.18
c) More than 5 years	10	90.91	0	0.00
7. What population size do you serve?				
a) Less than 1000	5	45.45	3	27.27
b) 1000 to 1500	0	0.00	6	54.55
c) More than 1500	6	54.55	2	18.18
8. How many days do you go for home visit per week?				
a) <2 days	5	45.45	2	18.18
b) 2-4 days	6	54.55	9	81.82
c) >4 days	0	0.00	0	0.00
9. Any experience/training related to mental health				
a) Previous experience of working with mentally ill individual/ /rehabilitation centre	0	0.00	0	0.00
b) Short term training course	0	0.00	0	0.00
c) No previous experience/ training	11	100.0	11	100.0

The table no 2 depicts the frequency, percentage, mean and standard deviation of pretest and post test scores of knowledge, attitude and practice of ASHA workers in control and experimental group. In comparison of overall pre-test and post-test mean knowledge scores within experimental and control group; it was seen that; experimental group mean 16.63 was higher than control group 9.81. In comparison of overall pre-test and post-test mean attitude scores within experimental and control group it was seen that; experimental group mean 95.27 was higher than control group 58.36. In Comparison of overall pre-test and post-test mean practice scores within experimental and control group; experimental group mean 37.27 was higher than control group 23.27.

Table 2: Frequency, percentage, mean and standard deviation of pretest and post test scores of knowledge, attitude and practice in control and experimental group.

Variable	**Control Group**								**Experimental Group**							
	Pre-Test				**Post Test**				**Pre-Test**				**Post Test**			
Level of knowledge	**f**	**P(%)**	**Mean**	**SD**	**f**	**P(%)**	**Mean**	**SD**	**f**	**P(%)**	**Mean**	**SD**	**f**	**P(%)**	**Mean**	**SD**
Poor	8	72.73			7	63.63			9	81.82			3	27.27		
Average	3	27.27	8.81	2.04	4	36.36	9.81	2.08	2	18.18	8.54	1.8	4	36.36	16.63	5.4
Good	0	0.00			0	0			0	0			4	36.36		
Level of attitude	**f**	**P**	**Mean**	**SD**	**f**	**P**	**Mean**	**SD**	**f**	**P**	**Mean**	**SD**	**f**	**P**	**Mean**	**SD**

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Unfavourable attitude	8	72.73	57.36	3.89	6	54.54	58.3	4.96	9	81.8	56.9	3.17	0	0	95.27	3.13
Moderately favourable	3	27.27			5	45.45			2	18.1			0	0		
Favourable attitude	0	0			0	0			0	0			11	100		
Level of practice	**f**	**P**	**Mean**	**SD**	**f**	**P**	**Mean**	**SD**	**f**	**P**	**Mean**	**SD**	**f**	**P**	**Mean**	**SD**
Poor	8	72.73	22.81	3.09	7	63.64	23.27	3.49	7	63.63	23.45	3.64	0	0	37.27	1.55
Average	3	27.27			4	36.36			4	36.36			3	27.27		
Good	0	0			0	0			0	0			8	72.72		

The effectiveness of mental health training program was assessed by comparing post test score of knowledge, attitude and practice in control and experimental groups. As depicted in table no 3 in the post test comparison of knowledge score the t test value was 4.45 which was higher than P value 0.00123, in the post test comparison of attitude score the t test value was 19.44 which was higher than P value 0.00001, similarly in the post test comparison of practice score t test value was 13.63 which was higher than P value 0.00001. All the comparisons show a statically significant difference which suggests that mental health training program was effective in improving the knowledge, attitude and practice of ASHA workers.

Table 3: Comparison of Post test score of knowledge, attitude and practice in control and experimental group

Knowledge	**Mean**	**SD**	**t test**	**P value**	**Result**
Post-test control	9.81	2.08	4.45	0.00123	Significant
post-test experiment	16.63	5.4			
Attitude	**Mean**	**SD**	**t test**	**P value**	**Result**
Post-test control	57.27	5.79	19.44	<.00001	Significant
Post-test experimental	95.27	3.13			
Practice	**Mean**	**SD**	**t test**	**P value**	**Result**
Post-test control	23.27	3.49	13.63	<0.00001	Significant
post-test experimental	37.27	1.55			

Discussion

The findings of the study have proved that there was a significant improvement in the Knowledge, Attitude, Practice among ASHA workers in the experimental group after the administration of Mental health Training Program. The effectiveness of the training program among ASHAs in the current study support the study findings carried out by Patel & Misra, (2022) which evaluated the effectiveness of a mental health education program on knowledge, attitude, and practices (KAP) of ASHAs. A total of 112 ASHAs, 55 in the intervention group and 57 in the control group, participated in the study. After intervention, mean score of KAP was 69.67 and 50.36 in intervention and control group, respectively, which was statistically significant; $P < 0.0001$. Mean of correct responses to knowledge items is seen to be increased in all components of knowledge after intervention in intervention group, whereas this is almost similar in the control group. The increase is statistically significant; $P < 0.0001$. A statistically significant improvement, $P < 0.0001$, was seen after intervention in the intervention group in almost all components of attitude and practice explored.

A statistically significant mean score of correct responses to knowledge items, attitude, and practice after intervention seen in the current study is in line with other intervention studies that reported positive change in KAP of the participants.[7,8,9]

Conclusion

The findings of pilot study revealed that, it was feasible to conduct the main study in selected settings. There was no ambiguity in the tool and the tool was found feasible and practicable to proceed with main study. The pilot study also demonstrates that ASHAs may be effectively trained in mental health through a brief training program and can improve their knowledge, attitude and practice in relation to mental health. This is crucial for underdeveloped nations where mental health professionals are in short supply. Similar study on broader scale could be taken up in scaling up the mental health services in rural communities.

Confict of Interest - Nil

Source of Funding – Self

Ethical Clearance - Ethical permission was obtained from the institutional ethical committee for conducting this research and informed consent was taken from the participant before initiation of the data collection.

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