

Research Article

A Study to Assess the Knowledge, Attitude and Practice of Ashas towards the Community Based Assessment Checklist (CBAC) Form in the Rural Field Practice Area, RHTC Banda, District Sagar (Madhya Pradesh)

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ABSTRACT

Background: Non-communicable diseases (NCDs) account for nearly 63% of deaths in India, and one in four Indians faces a risk of premature death between 30 and 70 years of age due to NCDs. The Community Based Assessment Checklist (CBAC) is a universal screening tool used by Accredited Social Health Activists (ASHAs) to screen for common NCDs diabetes, hypertension, and oral, breast and cervical cancers among adults aged over 30 years, as part of Population-Based Screening under Comprehensive Primary Health Care (CPHC), initiated in 2016.

Objectives: To assess the knowledge, attitude, and practice of ASHAs regarding the purpose, components, and use of the CBAC form in early screening of NCDs in the rural field practice area of RHTC Banda, District Sagar, Madhya Pradesh.

Methods: A cross-sectional study was conducted among 180 ASHAs with at least six months of field experience, working under RHTC Banda, District Sagar (MP), over a three-month period. After obtaining informed consent, data were collected using a structured, pre-validated questionnaire covering demographic details and knowledge, attitude, and practice domains related to the CBAC form. Knowledge and practice were scored one point for each correct response and zero for an incorrect response; attitude was assessed on a five-point Likert scale (1 = strongly disagree to 5 = strongly agree). Mean scores were used to categorise participants as having adequate/inadequate knowledge and good/poor practice. Statistical analysis, including descriptive measures and appropriate tests of association, was performed using MS Excel 2023 and IBM SPSS software.

Results: Most participating ASHAs were aged 30-49 years with more than nine years of field experience. The mean knowledge score was 21.13 out of 24, with 88% of respondents demonstrating adequate knowledge and 12% inadequate knowledge. The mean practice score was 5.32 out of 6, with 89% showing good practice and 11% poor practice in screening and follow-up. The mean attitude score was 4.18 out of 5, reflecting a predominantly positive and favourable outlook, with most ASHAs perceiving the CBAC form as a useful screening tool.

Conclusion: ASHAs in the study area demonstrated satisfactory knowledge, practice, and attitude toward the CBAC form, indicating a good level of readiness for effective community-based NCD screening. These findings underscore the value of ongoing training and field-level support under CPHC and highlight the need for periodic refresher training to address residual gaps.

Keywords: CBAC Form, ASHA, Non-Communicable Diseases, Knowledge, Attitude and Practice, Comprehensive Primary Health Care, Community-Based Screening.

INTRODUCTION

Non-communicable diseases (NCDs) constitute a major and growing public health burden in India, accounting for approximately 63% of all deaths in the country. One in four Indians is

estimated to be at risk of premature death between the ages of 30 and 70 years due to NCDs such as diabetes, hypertension, and cancers.¹

In response to this burden, the Government of India initiated Population-Based Screening (PBS) for common NCDs as a component of Comprehensive Primary Health Care (CPHC) in 2016. Central to this initiative is the Community Based Assessment Checklist (CBAC), a universal screening instrument administered by Accredited Social Health Activists (ASHAs) at the community level.² The CBAC form is used to screen adults above 30 years of age for common NCDs, including diabetes, hypertension, and oral, breast, and cervical cancers.^{2,3-7} It captures lifestyle habits and risk factors associated with NCDs and generates a risk score for each individual, enabling early identification and referral of high-risk individuals.⁴

Since ASHAs are the frontline functionaries responsible for administering the CBAC form in the community, their knowledge, attitude, and practice (KAP) directly influence the effectiveness, accuracy, and reach of NCD screening efforts.^{4,5} Gaps in any of these domains can compromise the quality of screening and delay early detection and referral.⁶⁻¹⁷ Assessing the KAP of ASHAs toward the CBAC form is therefore essential to identify training needs and strengthen the screening programme at the grassroots level.⁷

Aim and Objectives

The present study was undertaken with the following objectives:

To assess the knowledge of ASHAs regarding the purpose and components of the CBAC form in the early screening of NCDs.

To assess the attitude of ASHAs toward the regular and effective use of the CBAC form in community-based health screening.

To assess the practices of ASHAs in utilising the CBAC form during routine screening activities.

MATERIALS AND METHODS

Study Design and Setting: A cross-sectional study was conducted in the rural field practice area of the Rural Health Training Centre (RHTC), Banda, District Sagar, Madhya Pradesh, under the Department of Community Medicine, Bundelkhand Medical College, Sagar. **Study population and duration:** The study included 180 ASHAs with at least six months of field experience, working under RHTC Banda. Data collection was carried out over a period of three months.

Data Collection Tool: After obtaining informed consent from each participant, data were collected using a structured questionnaire

covering demographic characteristics and items assessing knowledge, attitude, and practice regarding the CBAC form.

Scoring: Responses to knowledge and practice items were scored one point for a correct response and zero points for an incorrect response. The mean score for each domain was used to classify participants as having adequate or inadequate knowledge and good or poor practice. Attitude was assessed using a five-point Likert scale, with responses ranging from "strongly disagree" (score 1) to "strongly agree" (score 5).

Statistical Analysis: Data were analysed using descriptive statistics and appropriate tests of association. Analyses were performed using MS Excel 2023 and IBM SPSS software.

RESULTS

A total of 180 ASHAs working under the field practice area of RHTC Banda, District Sagar, completed the structured questionnaire, giving a 100% response rate.

Socio-Demographic Profile: Most ASHA workers in the study belonged to the 30–49 years age group. The majority had more than nine years of field experience, reflecting a relatively senior and experienced cadre of frontline workers in the study area. This level of experience is relevant to interpreting the knowledge and practice findings described below.

Knowledge: The mean knowledge score was 21.13 out of 24 (equivalent to 88.0% of the maximum attainable score). Based on the mean-score cut-off, approximately 88% of participants demonstrated adequate knowledge of the purpose and components of the CBAC form, while the remaining 12% showed inadequate knowledge.

Practice: The mean practice score was 5.32 out of 6 (88.7% of the maximum attainable score). Nearly 89% of ASHAs demonstrated good practice in the use of the CBAC form during screening and follow-up activities, while 11% showed poor practice.

Attitude: The mean attitude score, assessed on the five-point Likert scale, was 4.18 out of 5 (83.6% of the maximum attainable score). This reflected a predominantly positive and favourable outlook among most ASHAs, who perceived the CBAC form as a useful and relevant tool for community-based NCD screening.

Taken together, the three domains showed a consistent pattern of high performance, with practice scoring marginally higher than

knowledge, and attitude scoring somewhat lower than both although still well within the

favourable range. Table 1 and Figure 1 summarise these findings.

Table 1: Summary of Knowledge, Attitude and Practice Scores among ASHAs

Domain	Mean Score	Percentage Distribution	Interpretation
Knowledge	21.13 / 24	88% Adequate, 12% Inadequate	Adequate knowledge
Practice	5.32 / 6	89% Good, 11% Poor	Good practice in screening & follow-up
Attitude	4.18 / 5	Majority showed favourable attitude	Positive & favourable attitude

Figure 1: Knowledge, Attitude and Practice Scores of ASHAs towards the CBAC Form (N = 180)

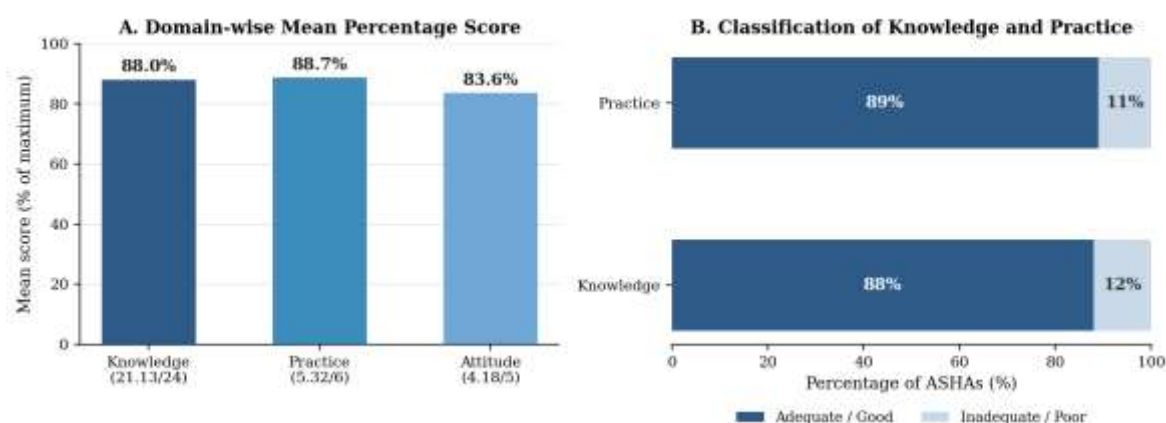


Figure 1: Knowledge, Attitude and Practice scores of ASHAs towards the CBAC form (N = 180) (A) domain-wise mean percentage score; (B) classification of knowledge and practice as adequate/good versus inadequate/poor.

DISCUSSION

Screening for NCDs at the community level is central to achieving the goal of comprehensive primary health care for all. In this study, ASHAs demonstrated high levels of knowledge, positive attitudes, and good screening practices, indicating strong familiarity with the CBAC form and its role in NCD screening.

The favourable performance observed may be attributable to the considerable field experience of the participants, the majority of whom had more than nine years of service, along with ongoing field-level orientation and supervision under the CPHC programme. Experience is likely to enhance both procedural competence and confidence in administering the CBAC form.⁸

Nonetheless, a small proportion of ASHAs displayed inadequate knowledge and poor practice, underscoring the continued need for periodic refresher training to consolidate skills and address knowledge gaps, particularly among newer or less experienced workers.⁹

These findings are consistent with those reported by Juneja et al., who similarly observed that the majority of ASHAs

demonstrated good knowledge of the CBAC form in their assessment under Ayushman Bharat CPHC.³ In contrast, some other Indian studies have reported considerably lower levels of preparedness among ASHAs for CBAC-based and broader NCD screening roles, with gaps in knowledge, training, supervision, and logistics such as an uninterrupted supply of forms.^{6,7,10-13} This variation across settings suggests that local factors including training intensity, supervisory support, and years of field experience meaningfully influence how well the CBAC tool is understood and used, and it reinforces the case for periodic reorientation rather than a one-time training input.^{9,12}

CONCLUSION

ASHAs in the rural field practice area of RHTC Banda, District Sagar, demonstrated satisfactory knowledge, practice, and attitude toward the CBAC form, indicating a good level of readiness for effective community-based NCD screening. These findings highlight the value of sustained training and field support provided under the CPHC framework in building frontline capacity for NCD screening.

Recommendations

Regular refresher training sessions should be provided to strengthen ASHAs' knowledge and screening accuracy, particularly for the subset demonstrating gaps.

Adequate and uninterrupted supply of CBAC forms and screening tools should be ensured at the field level.

Community awareness activities should be promoted to increase population participation in NCD screening initiatives.

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