A RAPID APPRAISAL OF FUNCTIONING OF ASHA UNDER NRHM IN CUTTACK, ORRISA

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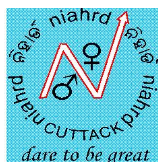

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PREFACE

Despite significant improvements made in the past few decades, the public health challenges are not only so huge but are also growing and shifting at an unprecedented rate in our country. The concerns shown by the organisations at the global level indicate that in view of the resurgence of various epidemics, both infectious and non -infectious, the situation can be handled only through a public health management approach. This urgency was realised and expressed in the Public Health Conference as the "Calcutta Declaration", which called for creating appropriate structure for public health professionals and promoting reforms in public health education and training.

The National Institute of Health & Family Welfare initiated a Public Health Education and Research Consortium (PHERC) with the objective of networking and engaging in partnerships with public health institutions in the country to enhance their research capacity. As the nodal agency for imparting in -service training to health personnel and conducting research under the NRHM, the Institute is an ideal partner to bring the Department of Community Medicine in medical colleges, nursing colleges and other public health education and training institutions in the healthcare delivery system into the mainstream healthcare system, and also to provide a platform for building networks for capacity building in these institutions.

Currently, under the National Rural Health Mission many innovations have been introduced in the states to deliver healthcare services in an effective manner. State programme managers would wish to know how well these innovations are performing so that in case of gaps they could take corrective measures to achieve the stated objectives. There has been an increasing recognition for incremental improvements in the programme delivery system by undertaking quick and rapid health systems research and engineering the feedback into the processes. An impending need was discerned to develop a cluster of institutions and strengthen their capacities on rapid appraisal methodologies for generating programme relevant information at local and regional levels.

The Rapid Assessment of Health Interventions (RAHI), a collaborative effort with the United Nations Population Fund (UNFPA), is a unique initiative taken under the wider umbrella of the 'Public Health Education and Research Consortium (PHERC)' of the National Institute of Health and Family Welfare to develop partnerships with different organisations working in the field of health and family welfare. The project objective is to accelerate programme implementation in the identified states by providing them with timely and appropriate research inputs for addressing priority implementation problems. The specific objectives of this initiative are to develop a network of state/regional

institutions for conducting health systems research and to provide technical support for steering locally relevant research based on the specific issues identified by the state/district programme managers.

During the first phase of the RAHI Project, the UNFPA India Office supported 12 health system research projects. In this phase, five low-performing states, viz. Madhya Pradesh, Jharkhand, Chhattisgarh, Uttar Pradesh and Orissa, were included. Initially, proposals were invited from medical colleges, NGOs and other health institutions. After rigorous screening of the proposals by the Technical Advisory Committee (TAG) consisting of eminent public health experts, 12 projects were finalised in a national workshop conducted at the NIHFW. The faculty of the NIHFW provided technical support for the finalisation of tools, training to investigators, planning and monitoring of data collection. A quality assurance mechanism was developed in consultation with the members of TAG and experts from the UNFPA. The progress of the projects was reviewed by the TAG from time to time. A draft report entitled "**A Rapid Appraisal of Functioning of ASHA Under NRHM in Cuttack, Orissa"** by the National Institute of Applied Human Research and Development, Kalyani Nagar, Cuttack, Orissa, was finalised by the institute in consultation with the UNFPA.

It is envisaged that the findings and recommendations of this study would trigger a series of follow-up measures by the programme managers concerned in the state. We also feel strongly about continued need for optimum engagement of available human resources in community medicine, paediatrics, obstetrics, and gynaecology departments of the medical colleges in such assessments. Such initiatives by the programme managers will end the current isolation of medical colleges and will be conducive for incorporating such public health interventions during undergraduate and post graduate training.

Dr. Dinesh Agarwal	Prof. Deoki Nandan
National Programme Officer, UNFPA	Director, NIHFW

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We are also grateful to the CDMOs of the districts of Jagatsinghpur and Mayurbhanj along with their team members for extending their support in every possible way during our field work. We are deeply obliged to the PRIs, the community members and other organisations of the districts for sparing their valuable time in responding to our queries. The ASHAs, the ANMs, and the AWWs deserve our special thanks since this study would not have been possible without their valuable contribution.

We also thank all the individual organisations whose contribution was extremely useful.

We express our thanks to the survey team for completing their assignment in a timely manner.

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ABBREVIATIONS

ADMO	Additional District Medical Officer
ANC	Antenatal care
ANM	Auxiliary nurse midwife
APL	Above poverty line
ASHA	Accredited social health activist
AWC	Anganwadi centre
AWW	Anganwadi worker
BEE	Block Extension Educator
BPL	Below poverty line
CBO	Community-based organisation
CDMO	Chief District Medical Officer
CDPO	Child Development Project Officer
CHC	Community health centre
DDK	Disposable delivery kits
DNO	District Nodal Officer
DOTS	Directly observed treatment short course
EAG	Empowered action group
FGD	Focus group discussion
FRU	First referral unit
ICDS	Integrated Child Development Scheme
IFA	Iron and folic acid tablet
JSY	Janani Surakhya Yojana
MO	Medical Officer
MOHFW	Ministry of Health and Family Welfare
NIAHRD	National Institute of Applied Human Research and Development
NIHFW	National Institute of Health and Family Welfare
NRHM	National Rural Health Mission
OBC	Other Backward Caste
ORS	Oral rehydration therapy
PHC	Primary health centre
PNC	Postnatal care
PRI	Panchayati Raj Institutions
RAHI	Rapid Assessment of Health Intervention
RNTCP	Revised National Tuberculosis Control Programme
RTI	Reproductive track infection
SC	Schedule Caste
SHG	Self-help group
SIHFW	State Institute of Health and Family Welfare
SNP	Supplementary Nutrition Programme
STI	Sexually transmitted infection
ST	Schedule Tribe
UGPHC	Upgraded primary health centre
VHAI	Voluntary Health Association of India
VHSC	Village Health and Sanitation Committee

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EXECUTIVE SUMMARY

Introduction

The National Rural Health Mission was launched in April 2005 with a commitment to provide effective healthcare to the rural population throughout the country in general and with special focus on the 18 low-performing states, including Orissa. The goal of this mission is to create a village level social activist, designated as ASHA, to provide primary medical care, advice the villagers on sanitation, hygiene, antenatal and postnatal care, escorting expectant mothers to hospital for safe delivery etc. To perform her activity in a proper manner, the NRHM has envisaged capacity-building of the ASHA through training and motivating them through a performance-based compensation.

General Objective

This study was undertaken to understand the functioning of the ASHAs in the community and then suggest strategies for improvement.

Specific Objectives

- To understand the selection procedure of ASHAs and their sustenance and motivational issues
- To study the training process and its output
- To explore the different aspects of functioning of ASHAs, and
- To offer recommendations for improved functional efficacy of the ASHAs.

Methodology

This was a cross-sectional, descriptive study with a blend of qualitative and quantitative techniques which was undertaken in Jagatsinghpur and Mayurbhanj districts of Orissa between September and December 2007. In-depth interviews were conducted with the members of the Panchayati Raj institutions (PRIs) and self-help groups (SHGs), the members of the Village Health and Sanitation Committees (VHSCs), the accredited social health activists (ASHAs), the auxiliary nurse midwife (ANMs), anganwadi workers (AWWs), Child Development Project Officer (CDPOs), Additional District Medical Officers (ADMOs), Medical Officers (MOs) and the members of the community. The selection of the subject for the study was through a multistage sampling.

The analysis and interpretations of data from different stakeholders have been summarized into many areas of strength and weakness, which are extremely useful to bring about improvement in the functioning of the ASHAs.

Salient Findings

- All the ASHAs are the resident of the village and have been selected by the community. This gives them the strength to perform better. Due to the involvement of women SHGs in the selection process, the selection process has been more transparent and the selected ASHAs are more acceptable to the community.
- The acceptance of the ASHAs in the community is better and the community perceive them as potential link between the community and healthcare sector. The community expects more work from them in the health and non-health sector activities like helping in getting old age pension, BPL Cards, etc which indicate the confidence they have on the ASHAs.
- There is good supportive monitoring system to supervise and facilitate the work of the ASHAs.
- According to the norm, there should be one ASHA per 1,000 population. But the majority of the ASHAs are catering to a population of more than 1,000 in Orissa. Due to hilly geographical terrain, the ASHAs even fail to visit certain hamlets, leaving certain sections of the population un-served and un-reached.
- The distribution of medicine is a key factor for addressing the common ailments at the community level and also a catalyst for community acceptance and participation. But about a quarter of the ASHAs interviewed have not even received medicine kits, and those who have received the kits are incomplete too.
- Most of the ASHAs indicate that the non-availability of transport facilities to visit the pregnant mothers is a major problem.
- Lack of communication or unwillingness on the part of the beneficiaries to inform the ASHAs lead to loosing her incentive. Besides, she also loses the incentive if the client opts for the delivery in a private hospital or nursing home.
- Majority of the ASHAs are not getting incentives on time. Even nearly a quarter of the ASHAs have not received incentives for more than six months.

Key Recommendations

- The compensation to the ASHAs should be suitably increased and the payment should be done at worksite without any delays
- Transportation facility for the pregnant mother to the health institution should be streamlined by making available Janani Suraksya Van in the PHC/CHC area round the clock on call from the ASHAs. Possibility of providing mobile phones to ASHAs

could be considered so that they can have connectivity with the community and health facility, and transport vehicles without any hassles .

- The VHSCs should be made functional in every village and should be motivated through incentive to prepare a comprehensive health plan. PRIs should be involved in every stage of planning, implementation and monitoring of VHSCs.
- A TOT for the ASHAs should be conducted. Refresher training at regular intervals should be imparted at the PHC, block and district levels on specific topics. It is suggested to publish a "news letter" in the local language on half-yearly or yearly basis for updating knowledge and skill for grassroots level functionaries, especially for the ASHAs.
- There is a need to strengthen the sub-centres by equipping them with infrastructure, logistics and instruments so that non-complicated normal deliveries can be conducted by the trained staff at the sub-centres in inaccessible areas.
- Irregularity i.e. in the area of supply of medicine kits, should be investigated and appropriate action should be taken.
- Activities like formulation of village health plan through VHSC, awareness and motivation for construction of household latrines, motivation for family planning and adolescent education by the ASHAs should be monitored by the health authorities.
- The PRI members and community leaders should be adequately oriented and sensitised so that community monitoring and social audit becomes effective. They should also be sensitised to make use of the Right to Information Act which is extremely important to understand the situation and take appropriate corrective measures.

CHAPTER I

INTRODUCTION

Background

There is a recognised need for further research, capacity development of the existing regional health institutions in carrying out rapid appraisals of the ongoing interventions. Therefore the present project has been designed with the primary objective of building capacities of regional medical colleges and other collaborating institutions in the low -performing states in rapid appraisal methodologies, to conduct health interventions in their area of operations as well as to concurrently conduct appraisals of major health interventions which have the potential of getting nationally scaled up. It has been envisaged that on one side this activity will bring significant improvement in partner institutions' capacities to support local governments in conducting relevant health systems research and on the other this would generate evidence-based recommendations to effect mid-term modifications for improvement in service delivery mechanisms.

Operationlisation in Orissa

In the above backdrop, the Orissa state level National Rural Health Mission (NRHM) was launched on June 17, 2005 and till October 8, 2007, as many as 34,178 ASHAs have been selected and positioned in the state, with 20,740 of them receiving induction training to develop their skill-sets and knowledge for performing their role efficiently. The training has been conducted through a cascade model by the block teams. Apart from induction training advanced training have been given to 10,864 ASHAs.

Rationale

To a large extent, the actualisation of the goal of NRHM depends on the functional efficacy of the ASHA as the grassroots health activist. Her efficacy depends on several factors--her own cognitive competency (including capacity building), aptitude, and attitude, effective relationship with other key health functionaries like Anganwadi workers, auxiliary nurse midwives PHC staff etc., the dynamics between the ASHAs and PRIs including selection, interface, coordination, and supervision, and acceptance of the ASHAs by the community. Therefore the present study has been planned for ascertaining how efficient the ASHAs are to play their defined roles effectively with the following objectives.

Key Objective

To undertake a rapid appraisal of the functioning of ASHA in the community so as to suggest strategies for improvement.

Specific Objectives

- To study the selection procedure of the ASHAs, their sustenance and motivational issues
- To study the training in terms of input, process and output
- To explore the functioning of ASHA, and
- To offer recommendations towards enhancement of functional efficacy of the ASHAs.

CHAPTER II

METHODOLOGY

Study Areas

Jagatsinghpur and Mayurbhanj districts of Orissa.

Study Design

Type of Study

Cross-sectional Descriptive Study.

Study Subjects

- PRI Members
- Self-Help Group Members
- Members of the Village Health and Sanitation Committees
- ASHAs/AWWs
- Chief District Medical Officers
- Additional District Medical Officers
- Medical Officers in-charge
- ANMs
- Child Development Programme Officers
- Members of the Local Community.

Sampling Design

A multi-stage sampling design in which a mix of purposive and random approaches has been used. The sample selection comprises selection of districts, blocks and villages with the above mentioned study subjects.

Table 1: Scheme of Sample Selection

Sl. No.	Stage of selection	Method of Selection	No of Units	Remark
1	District	Purposive	2	1 tribal district with tribal population more than 50% and another non-tribal rural district.
2	Block	Purposive	4	@ 2 from each district. 1 nearer and other far from the district headquarters
3	CDMO	Purposive	2	CDMOs of the respective sample districts
4	ADMO	Purposive	2	ADMOs of sample districts
5	MO	Purposive	4	MOs of respective block PHCs and CHCs
6	CDPO	Purposive	4	CDPOs of the respective sample blocks
7	ANM	Random	8	@ 2 from each PHC/CHC area
8	PRI/CBO	Random	8	@ 2 from each block
9	ASHA	Random	80	@ 20 from each sample block. A list of ASHAs having more than 1 year experience was collected and from among them 20 were selected randomly.
10	Village for FGD	Random	8	@ 2 from each sample block. 2 villages were selected in each block from among the 20 villages from where ASHAs were selected.
11.	FGDs with AWWs		4	10 AWWs were selected on the basis of availability in each block from among 20 villages where ASHAs were selected for the study.
12	FGD with community		8	Village leaders, School teachers, Leaders of SHGs, Elderly women, Lactating mothers and JSY beneficiaries were included for FGD.

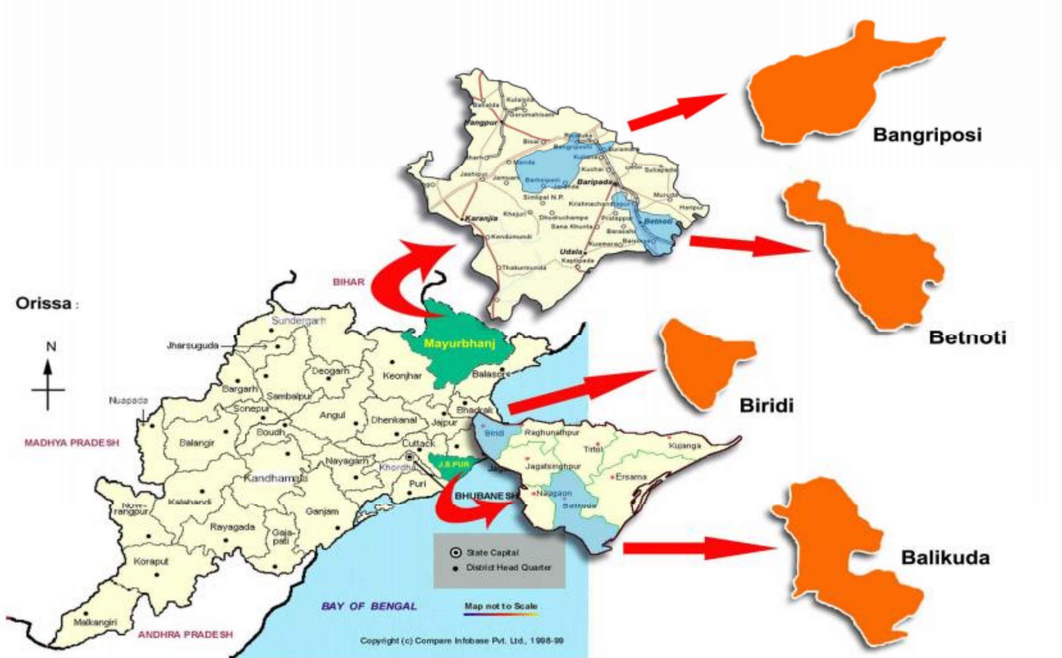
Data Collection

Table 2 List of Selected Study Areas

Sl No	Name of the District	Name of the Block	Name of the Sub-centre
1	Jagatsinghpur	Biridi	Balia Basundhara
		Balikuda	Balikuda Ichhapur
2	Mayurbhanj	Betnoti	Kuntapur Sathilo
		Bangiriposi	Bangiriposi Banakati

The study area has been highlighted in *Map 1*

Map 1: Study Site



Data Collection Tools

Data collection has been done through pre-designed and pre-tested interview schedules with different stakeholders by conducting in-depth interviews. FGDs have been conducted at village/community levels for the study. The selection of data collection is presented in Table 2.3.

Table 3 Scheme of Data Collection

Sl. No.	Levels of Data Collection	Respondents	Methods of Data collection	Instrument Used
1	District	CDMO, ADMO	In-depth interview	Semi structure interview Schedule
2	Block	MO, CDPO	-do-	-do-
3	Sub-centre	ANM	-do-	-do-
4	Village	PRI/CBO	-do-	-do-
5	Village	ASHA	-do-	-do-
6	Village	Community (SHG members, PRI members, beneficiaries, community leaders)	FGD	Guidelines
7	Village	AWW	FGD	- do -

Field Work

A team consisting of one supervisor and two investigators have been recruited for each block. Thus 12 staff have been selected for the four blocks and they have been provided with intense training for three days at the National Institute of Applied Human Research and Development (NIAHRD). They have then been deployed to the field sites with requisite logistic support.

Data Analysis and Interpretation

The information obtained from CDMOs, ADMOs, MOs, PRI members, CDPOs and ANMs have all been tabulated. Data collected from IDIs of ASHAs have been entered into the SPSS software as the numbers of samples are comparatively large and responses are mostly in structured format. The responses have been recorded into different categories as per the requirement and the frequency tables have been generated for interpretation. Wherever required, graphs have been prepared for better interpretation. The responses have been categorised according to the structure of the report into different sections and subsections. For qualitative data, a semi-quantification has been done by coding the responses for different stakeholders and merging them into different headings, using adjectives as the guidelines provided by NIHFW with slight modifications.

Adjectives Used

Proportion of Respondent	Adjectives Used
<10 %	Very few
10 -19 %	Some
20 – 29 %	Nearly a quarter
30-39 %	Nearly one third
40 – 59 %	Nearly half
60-79%	Majority over half
>80 %	Most

Ethical Clearance: The project structure has been examined and cleared by the Review Board of the Ethical Committee of NIHFW for ethical considerations.

CHAPTER III

FINDINGS AND DISCUSSION

The data collected through various instruments at district, bl ock and village levels from functionaries like the CDMOs, the ADMOs, the MOs, the CDPOs, the ANMs, PRI members, the ASHAs, the AWWs and the local community have been analysed, triangulated and discussed in this chapter.

Profile of ASHAs

Study of the profile of the ASHAs in terms of age, education, marital status, caste, poverty status and income level is important as it might have a bearing on their functional efficacy. The analysis of the profile has been presented in Table-3.1.

Table 4: Profile of ASHAs in the Sample District

Profile	Districts				Total	
	Jagatsingpur		Mayurbhanj			
Age group in yrs.	**No.**	**%**	**No.**	**%**	**No.**	**%**
25 – 29	10	25.0	24	60.0	34	42.5
30 – 34	13	32.5	7	17.5	20	25.0
35 – 39	9	22.5	5	12.5	14	17.5
40 – 44	8	20.0	4	10.0	12	15.0
Total	40	100.0	40	100.0	80	100.0
Education						
5th – 7th class	14	35.0	6	15.0	20	25.0
8th – 9th class	11	27.5	15	37.5	26	32.5
10th and above	15	37.5	19	47.5	34	42.5
Total	40	100.0	40	100.0	80	100.0
Marital status						
Married	22	55.0	36	90.0	58	72.5
Separate	5	12.5	2	5.0	7	8.8
Widow	13	32.5	2	5.0	15	18.8
Total	40	100.0	40	100.0	80	100.0
Caste						
SC	14	35.0	4	10.0	18	22.5
ST	1	2.5	23	57.5	24	30.0
OBC	11	27.5	6	15.0	17	21.3
General	14	35.0	7	17.5	21	26.3
Total	40	100.0	40	100.0	80	100.0
Economic Status						
BPL	22	55.0	37	92.5	59	73.8
Non-BPL	18	45.0	3	7.5	21	26.3
Total	40	100.0	40	100.0	80	100.0

Age distribution indicates that nearly half of the ASHAs are in the age group 25 -29, a quarter in the age group 30-35, some in 35-39 and some in the 40-44 age bracket. Thus

the age structure of the ASHAs can be considered to be young as nearly 70% are below 35 years and none is above 45 years. This is a major strength of the programme. The young can be made to deliver service with motivation and capacity building support. However, the age composition in rural Jagatsinghpur is bit older than the tribal Mayurbhanj district. Nonetheless in rural Jagatsinghpur, the age composition of the ASHAs is also young with 57.5% below 35 and none above 44 years.

Level of education is an important criterion of performance. Even though the selection criteria are 8th Class and at some places it has been reduced to 5 th Class. Approximately half of the ASHAs have high school level education or more (42.5%). Surprisingly, in the tribal Mayurbhanj district, the level of education is much better than the rural Jagatsinghpur district.

The marital status reveals that majority (72.5%) are married, very few are separated and some are widows.

The caste composition reveals that the SCs (22.5%) and STs (30%) together constitute more than half of the total sample, while OBC and General Castes are 21.3% and 26.3% respectively. In the tribal district, the SCs (10%) and STs (57.5%) together constitute about 70%, while the OBCs and General Castes are 15% and 17.5% respectively. In the rural district, SCs and STs together constitute 37.5% and OBCs and General Castes together make up of 62.5%. The caste compositions of the ASHAs very well represents the social mosaics of the two districts. Around three -fourths of the ASHAs belong to below poverty line and nearly a quarter belong to the above poverty line (APL) category.

The profile of the ASHA is of young age, better education level, representative of the caste composition and drawn from BPL status.

Population Coverage

The classification of sample villages according to the population size is presented in Table-3.2.

Table 5: Population Covered by ASHAs

Population	Name of the Districts				Total	
	Jagatsingpur		Mayurbhanj			
	No	%	No	%	No	%
< 1000	21	52.5	16	40.0	37	46.3
1001 to 1500	17	42.5	22	55.0	39	48.8
Above 1500	2	5.0	2	5.0	4	5.0
Total	40	100.0	40	100.0	80	100.0

The size of the population to be served is important from the service delivery point of view. Nearly half of the villages have population within 500-1,000, nearly half within 1,000-1,500 and very few have over 1,500. Interestingly, in the tribal Mayurbhanj district, which is very sparsely populated, has nearly half of the villages with a population above 1,000. The tribal villages sit in the hamlets, spread over large distances and cut by hillocks, rivers and canals. In Jagatsinghpur district, nearly half of the villages are with population over 1,000. However, the villages in rural Jagatsinghpur are densely populated and relatively compact.

Selection Procedure of ASHAs

The guideline for the selection criteria of the ASHAs envisage that they should be married/widowed/divorced and resident of that village having an age limit of 25 -45 years and must be an 8th standard pass. In case the education criteria can't be meet, it can be reduced to 5th standard. The selection process envisages that the CDMO is the District Nodal Officer (DNO) and MOsI/C of PHCs/CHCs is the Block Nodal Officer for the selection of the ASHAs. The MO and CDPO will appoint block level facilitator. The AWWs, the ANMs and the block facilitator will be trained in the selection process and they will conduct minimum of three FGDs and inform the community about the selection criteria, process and roles and responsibilities of the ASHAs. The ANMs at the community level will conduct a meeting where AWWs, presidents/secretaries of the SHGs will participate. Each SHG will propose a name for the ASHA. All the names will be discussed and the most suitable candidate will be selected through consensus. In case the consensus is not achieved, the selection will be done by lottery. The selected name will be furnished to the Block Nodal Officer along with the proceeding of meeting.

The views of the CDMOs, the ADMOs, the MOs corroborate that the selection criteria and selection process as per the guideline have been adopted. The ANMs' role is crucial in the selection process. All the eight ANMs are aware of the selection procedure, have received guidelines and are able to detail out the selection procedure. Seven out of eight ANMs are present during selection process.

The PRI members have been probed regarding the selection procedure of the ASHAs. All of them unanimously state that they are aware of and have been involved in the selection process. They also confirm that selection has been done in the village meeting with adequate participation of SHGs, AWWs, ANMs and other elderly persons of the village.

To triangulate the selection procedure, it's pertinent to look at the education, qualification and marital status of the ASHAs. The education and qualification revealed

that most of them are of 8th or more class passed and very few (about 5%) are up to 5th class because of non-availability of suitable candidates. The residential status and marital status reveal clear adherence to the guideline.

Further, when ASHAs have been asked about their process of selection, the responses pointed towards the adherence of guideline *(Table-3.3)*.

Table 6: Selection procedures followed: Views of ASHAs

How the ASHAs was selected	Name of the district				Total	
	Jagatsingpur		Mayurbhanj			
	No	%	No	%	No	%
Voting among SHGs	4	10.0	2	5.0	6	7.5
Lottery	7	17.5	4	10.0	11	13.8
Recommendation SHG/ANM/AWW/teachers	4	10.0	4	10.0	8	10.0
Qualification and experience	7	17.5	11	27.5	18	22.5
Voting by village committee	1	2.5	1	2.5	2	2.5
Unanimously selected	10	25.0	7	17.5	17	21.3
No other candidate	7	17.5	11	27.5	18	22.5
Total	**40**	**100.0**	**40**	**100.0**	**80**	**100.0**

The perception of AWWs regarding the selection criteria and selection process has been captured through four GDs held in two districts where 33 AWWS participated. The synthesis of their views indicates that they are by and large aware of the selection criteria and were also involved in the selection process. The narration of the events at certain places indicates smooth selection at some places and conflict at some others.

Case – 1

Village: - Patalipura, Block, Betanoti, District Mayurbhanj
According to the SHG secretary, "ANM didi informed Sarapanch, ward member, SHGs and village leaders regarding selection of one woman as the ASHA and briefed them on the selection criteria and roles and responsibilities. A day for meeting was selected. In the selection meeting all members were present and selected the only available women as the ASHA because there were no other candidates. All the members supported her because she is very active and energetic".

Case – 2

Village: - Uttarasasan, Block: Biridi, District Jagatsinghpur

A schoolteacher present in the FGD informed that in the selection meeting the health supervisor came. The ANMs, AWWs, Sarapanch and some eminent persons of the village were also present. There, all the candidates were considered on merit and finally a lottery was drawn among the best qualified and one woman was selected as the ASHA; and all the members present in the meeting endorsed her selection.

The above case studies clearly indicate that the selection processes of ASHAs in the villages are by and large fair and rational and community pe ople are also involved.

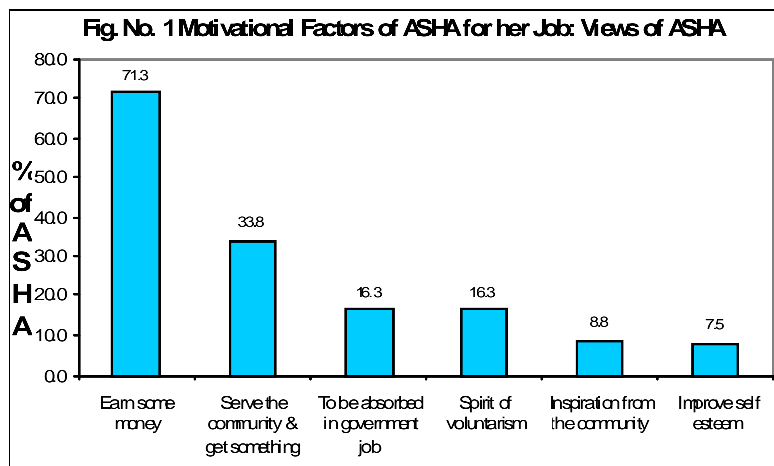
Sustenance and Motivational Factors

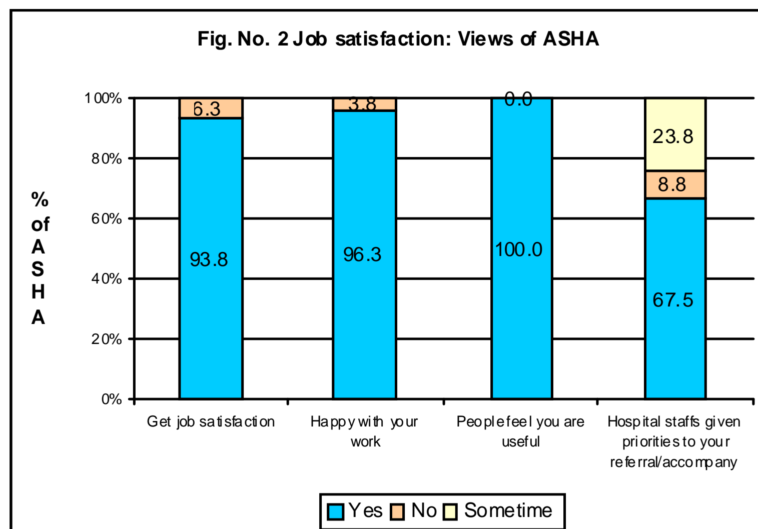
The sustenance of the programme depends on the long -term motivational factors for the ASHAs to keep her going with spirit and enthusiasm. To analyse this aspect, factors such as job satisfaction, compensation, recognition and utility of her job are considered. Besides two other important factors for her sustenance like training and capacity building, monitoring and supervision have also been analysed and discussed in the next section. Factors related to job satisfaction and recognition are the following:

Table 7: Views of ASHAs regarding motivational factors related to job satisfaction and recognition

Factors and views of ASHA	**Name of the district**				**Total**	
	Jagatsingpur		**Mayurbhanj**			
	No	**%**	**No**	**%**	**No**	**%**
Motivating Factors						
To be absorbed in government job	5	12.5	8	20.0	13	16.3
Earn some money	29	72.5	28	70.0	57	71.3
Improve self esteem	2	5.0	4	10.0	6	7.5
Serve the community and get something	17	42.5	10	25.0	27	33.8
Inspiration from the community	2	5.0	5	12.5	7	8.8
Spirit of voluntarism	8	20.0	5	12.5	13	16.3
Get job satisfaction						
Yes	36	90.0	39	97.5	75	93.8
No	4	10.0	1	2.5	5	6.3
Total	40	100.0	40	100.0	80	100.0
Happy with your work						
Yes	37	92.5	40	100.0	77	96.3
No	3	7.5			3	3.8
Total	40	100.0	40	100.0	80	100.0
Prestige gone up in village						
Yes	38	95.0	31	77.5	69	86.3
No	1	2.5	4	10.0	5	6.3
Not sure	1	2.5	5	12.5	6	7.5
Total	40	100.0	40	100.0	80	100.0
People feel you are useful						
Yes	40	100.0	40	100.0	80	100.0
Hospital staffs gives priority to your referrals/when you accompany						
Yes	26	65.0	28	70.0	54	67.5
No	5	12.5	2	5.0	7	8.8
Sometime	9	22.5	10	25.0	19	23.8
Total	40	100.0	40	100.0	80	100.0

The most important factor motivating them for this job is to earn some money as indicated by the majority (71.3%) of the ASHAs. The second most important factor is that this job gives them opportunity to serve the community as well (33.8%). The ASHA is a volunteer, this philosophy is subscribed by some of them, and still some others also aspire for a government job in this process *(Fig. 3.1)*. The most important finding is that most of them are satisfied with their job and also happy with the nature of work. *(Fig. 3.2)*. Most (86.3%) of them feel that their prestige has gone up in the village due to their engagement as the ASHA *(Fig. 3.3)*. Majority of them also feel that hospital staff give priorities to the cases of ASHAs when they either refer or accompany them. All the ASHAs opine that the community considers their job useful.





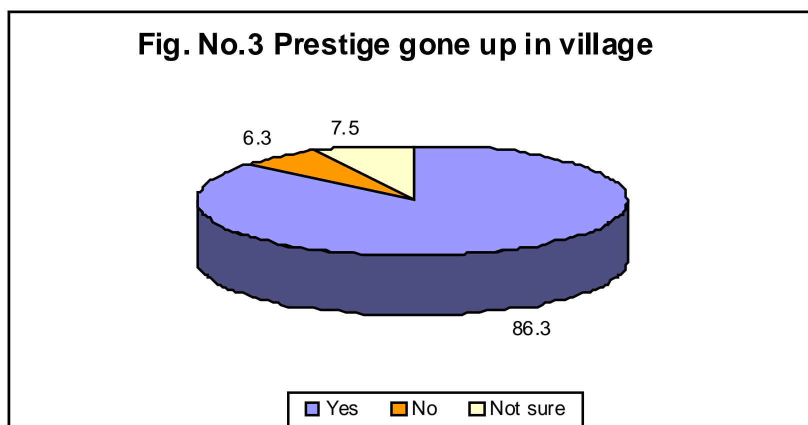


Fig. No.3 Prestige gone up in village

Monetary compensation is an important motivational factor for the ASHAs. The findings are presented in Table 3.5.

Table 8: Views of ASHA regarding Motivation factors related to monetary compensation

Factors and views of ASHA	**Name of the district**				**Total**	
	Jagatsingpur		**Mayurbhanj**			
	No	**%**	**No**	**%**	**No**	**%**
Average monthly honorarium from different sources*						
< 200	3	7.5	10	25.0	13	16.3
200-400	28	70.0	26	65.0	54	67.5
401-600	7	17.5	2	5.0	9	11.3
600-900	2	5.0	2	5.0	4	5.0
Total	40	100.0	40	100.0	80	100.0
Are you satisfied with the honorarium you get every month						
Yes	2	5.0	3	7.5	5	6.3
No	38	95.0	37	92.5	75	93.8
Total	40	100.0	40	100.0	80	100.0
If no why (Multiple answers accepted)						
Incentives not regular	18	47.4	32	80.0	50	62.5
Amount less as compared in workload	29	76.3	21	56.8	50	66.7
Sufficiency of amount						
Yes	1	2.5	3	7.5	4	5.0
No	39	97.5	37	92.5	76	95.0
Total	40	100.0	40	100.0	80	100.0
Monthly minimum expectation						
500-1000	10	25.6	12	32.4	22	28.9
1001-2000	20	51.3	24	64.9	44	57.9
2001-3000	8	20.5			8	10.5
3001-4000	1	2.6	1	2.6	1	2.5
Total	39	100.0	37	100.0	76	100.0

Factors and views of	Name of the district				Total	
Expectation of gratifications by authority at the time of paying compensation						
Yes	1	2.5	10	25.0	11	13.8
No	39	97.5	28	70.0	67	83.8
Sometimes			2	5.0	2	2.5
Total	40	100.0	40	100.0	80	100.0

* *This is arrived at on the basis of the actual amount received by them so far and dividing the same by the number of months they have worked.*

It is seen that the monthly compensation received by ASHAs from different sources are in the range of Rs. 200 to 400; only a few (5%) receive compensation within a range of Rs. 600 to 900. Most (93.8%) of the ASHAs are not satisfied with the amount of compensation they receive (95.0%). More than half (57.9%) of them expect a monthly minimum honorarium in the range of Rs. 1,000-2,000. One important finding is that the ANMs expect financial gratification at the time of disbursing the compensation as pointed out by some of the ASHAs (16.3%).

Support is another important factor for sustenance. The community members unanimously find the role of the ASHA very useful for them. All the motivational factors including adequate compensation, skill and capability building are conducive factors for the sustenance of the programme in the long-run. The ASHA is playing an important role and has the possibility to improve the health of mother and children in future. Hence there should be a well-thought out plan to involve her more in the system with suitable capacity-building support and a structure for better compensation.

The views that emerge from most of the FGDs are that "the compensation of the ASHAs in comparisons to her contribution is quite meagre. Further, capacity building and more compensation would encourage her to do the job with enthusiasm and spirit.

Training of ASHAs

Given the educational background, the socio-economic situation and the nature of ASHAs' responsibility, her capacity building through training are the most important factors to achieve the objective of the scheme. The scheme envisages a three-pronged strategy---induction training followed by a periodic training, and on the job training. The induction training is for 23 days over a year. The first round may be of seven days, to be followed by another four rounds of training, each lasting for four days. Though the training material is produced at the national level, states have the freedom to modify the contents as per local needs. The training materials will include facilitators guide, training aids and resource materials of the ASHAs.

The induction training will be followed by periodic training for about two days, once in every alternative month for all ASHAs. This training will be of interactive sessions to help refresh and upgrade their knowledge and skills and solve the problems they are facing, monitor their work and keep up their motivation and interest. The ASHAs need on the job support in the field, both during the initial training phase and later also. This will provide individual attention and support that is essential to carry out her work in the early stages of her career. This can be done through the ANMs, NGOs and block facilitators.

The process of training of the ASHAs has been evaluated by interviewing them, besides the CDMOs, the ADMOs, the MOs and the ANMs. All the ASHAs have been imparted induction training for a week at places like UGPHC, PHC and CHC. In Jagatsinghpur district, the second phase of the induction training has been completed for 16 days at a stretch after an interval of nine months of the first phase induction training. This have deviated the philosophy of the second phase of induction training, to be conducted at four instances of four days each. This must have hindered the optimal output from the training. In Mayurbhanj district, the frost phase of induction training is for duration a week, and in the 2nd phase, further induction training has been organised after an interval of 7-9 months for duration of four days.

Surprisingly the ASHAs point out that they have received all the four training modules and their induction training has been completed. This is also corroborated by the fact that no further induction training has been done even though a periods of 17 months have lapsed. This implies that the district authorities have violated the philosophy and the purpose of the training by squeezing the 16 days training module to just about 4 days.

While most of the ASHAs admit that the training is beneficial (97.5%), nearly half of them (41.3%) don' consider the training to be adequate. Majority of the ASHAs (87.5%) are satisfied with the training, while 12.5% are not. There is no periodic training as pointed out by the ASHAs. Majority of the ASHAs (78.8%) says all the trainers were able to explain their topic properly while about a quarter of them inform that some trainers have been not able to explain the topic properly. All the trainees have been given the training modules and they have gone through them.

Table 9: Views of ASHAs about Training Received

Training	Districts				Total	
	Jagatsingpur		Mayurbhanj			
	No	%	No	%	No	%
Imparted with induction training						
Yes	40	100.0	40	100.0	80	100.0
Total	40	100.0	40	100.0	80	100.0
Duration of 1st training						

7 days	40	100.0	40	100.0	80	100.0
Place of training						
UGPHC	20	50.0	0	0	20	25.0
PHC/CHC	20	50.0	40	100.0	60	75.0
Total	40	100.0	40	100.0	80	100.0
After 1st training were you given other training						
Yes	40	100.0	40	100.0	80	100.0
For how many days						
16 days	40	100.0			40	50.0
4 days			40	100.0	40	50.0
At what interval						
Within one year	40	100.0	40	100.0	80	100.0
After one year	-	-	-	-	-	-
Total	40	100.0	40	100.0	80	100.0
Was training adequate						
Yes	37	92.5	10	25.0	47	58.8
No	3	7.5	30	75.0	33	41.3
Total	40	100.0	40	100.0	80	100.0
Was training beneficial to you						
Yes	40	100.0	38	95.0	78	97.5
No			2	5.0	2	2.5
Total	40	100.0	40	100.0	80	100.0
Are you satisfied with the training programme						
Yes	40	100.0	30	75.0	70	87.5
No			10	25.0	10	12.5
Total	40	100.0	40	100.0	80	100.0
Periodical training done later						
Total	40	100.0	40	100.0	80	100.0
How many trainers were able to explain the topics properly						
All	31	77.5	32	80.0	63	78.8
Some	9	22.5	8	20.0	17	21.3
Total	40	100.0	40	100.0	80	100.0
Were you given modules						
Yes	40	100.0	40	100.0	80	100.0
Gone through modules						
Yes	40	100.0	40	100.0	80	100.0
Receive any stipend during training period						
Yes	40	100.0	40	100.0	80	100.0

The synthesis of the views of the health functionaries like the CDMOs, the ADMOs, the MOs and the ANMs unanimously agree that the ASHAs need further training. The CDPOs also agree to the above and emphasise upon time-to-time refresher training in the areas like mother and child health, anaemia, malaria, leprosy and TB. The CDPOs indicate more training on ANC/PNC, immunization, feeding practices of children are required to enhance the capability of the ASHAs for better and efficient delivery of services.

Knowledge of ASHAs

The knowledge of ASHAs on the nature of the activities and job responsibility is the pre - requisite for effective service delivery. The ASHAs have been interviewed to assess their knowledge about their job responsibilities. The data are presented in *Table– 3.7*.

Table 10: ASHAs' Knowledge about their Job Responsibility

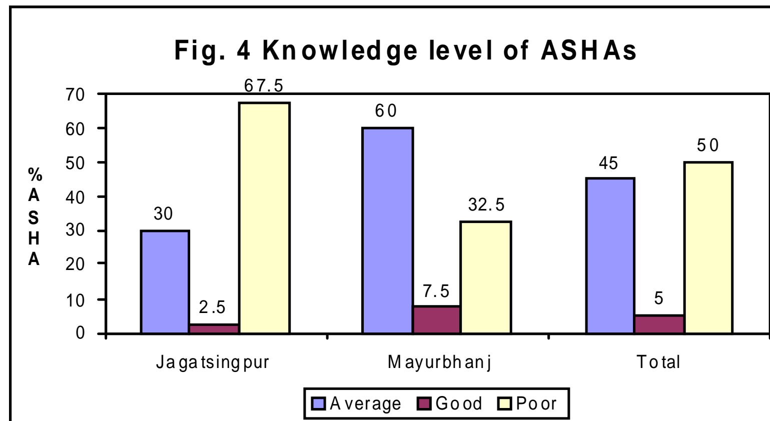
Jobs supposed to be done by the ASHA	Name of the district				Total	
	Jagatsingpur		Mayurbhanj			
	No	%	No	%	No	%
Create community awareness on determinants of health	15	37.5	24	60.0	39	48.8
Counsel community on safe delivery, ANC/PNC, breastfeeding, immunization, contraception and prevention of RTI and STI	32	80.0	33	82.5	65	81.3
Mobilize community to access health services at different facilities	8	20.0	26	65.0	34	42.5
Work with VHSC to develop a village health plan	3	7.5	7	17.5	10	12.5
Accompany pregnant mothers to hospitals	34	85.0	33	82.5	67	83.8
Depot holder of medicine and also Providing DOTs.	10	25.0	26	65.0	36	45.0
Motivate the community for construction of household toilet	15	37.5	24	60.0	39	48.8
Inform AWW/ANM about birth and deaths	3	7.5	6	15.0	9	11.3
Sample size	40		40		80	

It reveals that most of the ASHAs have comprehended accompanying pregnant mother to hospital and counselling community on safe delivery, ANC/PNC, breastfeeding, immunization, contraception and prevention of RTIs/STIs as their role and responsibility. As regards their job responsibilities like creating community awareness on determinants of health, mobilising the community to access healthcare services at different facilities, depot holder of medicine and DOTS provider and motivating the community for construction of household toilets, nearly half couldn't specify. Most of the ASHAs also fail to specify the two other job responsibilities namely assisting VHSCs to develop village health plan and informing AWWs/ANMs about birth and deaths.

This finding is significant in the light of the fact that one of the key motivational factors which drive ASHAs are financial gains and since delivery and site -related events are financially rewarding, they are becoming the areas of primary interest to the ASHAs. A strategy should be devised wherein the ASHAs develop expertise in other significant

areas of her activity spectrum such as helping develop village health plans and facilitating registration of vital events with the ANMs/AWWs

The level of knowledge of ASHAs on their job responsibilities is classified into three groups--poor, who could specify <3 responsibilities, average 4-6 and good >6 responsibilities. The results are presented in *Fig. 3.4*.



Half of the ASHAs have poor knowledge about their job responsibilities and 45% have average knowledge and 5% good knowledge. Interestingly, the scenario in the tribal Mayurbhanj district is better than the rural non-tribal Jagatsinghpur district. In Mayurbhanj district nearly two-thirds have average (60%) to good (7.5%) level of knowledge while it is only one-third in Jagatsinghpur district.

Functioning of ASHAs

The entire sample ASHAs have more than one year of work experience. Therefore, it is valid to evaluate their activities in promoting the objectives of the NRHM.

Regarding the efficacy of functioning of ASHAs, views of health authorities like the CDMOs, the ADMOs, the MOs, the ANMs, the CDPOs, the PRI members like Sarapanch, the Panchayat Samiti members, the ward member and the CBOs have been obtained and analysed. All the two CDMOs, the ADMOs, three out of four MOs, three out of four CDPOs, seven out of eight ANMs, all PRI members, and the CBOs have expressed their satisfaction on the functioning of the ASHAs. Only the MO of Bangiriposi PHC, the CDPO of Betanati and the ANM of Balikuda have expressed contrary views. The views of PRI members on the functions of ASHA are encouraging.

"It is because of the ASHA, the health service is available to the poor and at their door steps. Pregnant mothers get better delivery facility at hospitals. People can get a few medicines for common diseases at their door steps. People also get all

type of information regarding the JSY, immunization, and TB etc from the ASHA. They are functioning well in our area. She is really like a ray of hope " says the Sarapanch of Bagalpur G.P, Jagatsinghpur district.

Activities Undertaken by the ASHAs

They have been asked about the activities they are undertaking in the field and the result is tabulated in *Table-3.8*.

Table 11: Activities undertaken by ASHAs

Activities under taken by ASHAs	Districts				Total	
	Jagatsingpur		Mayurbhanj			
	No	%	No	%	No	%
Registration of pregnant mother	21	52.5	34	85.0	55	68.8
Counselling on ANC, PNC, safe delivery	31	77.5	36	90.0	67	83.8
Accompany pregnant mother to hospital	37	92.5	37	92.5	74	92.5
Distribution of IFA, Oral pills, ORS	35	87.5	35	87.5	70	87.5
Distribution of DOTS	5	12.5	26	65.0	31	38.8
Inform AWW/ANM on birth and death	3	7.5	4	10.0	7	8.8
Help AWW in supplementary nutrition feeding	11	27.5	18	45.0	29	36.3
Motivate for construction of latrines	17	42.5	17	42.5	34	42.5
Help ANM for immunization	33	82.5	31	77.5	64	80.0
Education to adolescent	1	2.5	6	15.0	7	8.8
Motivate the couple for family planning			6	15.0	6	7.5
Sample size	40		40		80	

The most important activities enumerated by the ASHAs are accompanying the pregnant women to the hospital (92.5%) counselling them on AWC, PNC and safe delivery (84%), distribution of IFA and oral pills (87.5%), registration of pregnant mother (68.8%), mobilising the mothers for their children's immunization, and helping the ANMs on the immunization day (80%). The activities like informing AWWs/ANMs on birth and death motivating community to construct household toilets, motivating the couple for family planning have assumed least priority among the ASHAs. Besides, ASHAs have indicated their involvement in certain activities like helping AWWs in preparation of food, distribution of ration and weighing the babies at the AWCs. During our interaction with different ASHAs it has been revealed that the AWWs are trying to take undue advantage from the ASHAs in taking their assistance.

The activities which ASHA are unable to perform

The ASHAs have been asked open-ended questions to enumerate the jobs that they are not able to undertake for various reasons. *(Table – 3.9).*

Table 12: ASHAs not able to do Certain Activities

Activities ASHA were not able to do	Districts				Total	
	Jagatsingpur		Mayurbhanj			
	No	%	No	%	No	%
Organising meeting and creating awareness	9	22.5	14	35.0	23	28.8
Taking serious patients to higher facilities	2	5.0	8	20.0	10	12.5
Motivating community for construction of toilets	11	27.5	13	32.5	24	30.0
Stay with the patient in hospital	5	12.5	1	2.5	6	7.5
Paper work of JSY/other register card	1	2.5	2	5.0	3	3.8
Distribution of condom and Mala-D			2	5.0	2	2.5

Nearly 30% of the ASHAs have indicated that they are unable to motivate the community for construction of toilets and not able to organise meeting. Besides, a few of them have also pointed out that they are not able to take serious patients to higher facilities, stay with the patients in the hospital, do paper work of the JSY and other register/records and distribution of condoms and oral pills.

Except for the activities like taking patients to higher centres and staying with them in the hospital, this observation is indicative of the lack of capacity and skills of the ASHAs. This can be overcome by paying special attention on these specific issues during capacity building exercises and timely guidance by supervisors for executing these important tasks including referrals.

Medicines Distribution by ASHAs

One of the important responsibilities of the ASHAs is to act as a depot holder of medicines to be made available to every habitation. These include items like ORS, IFA, DDK, Chloroquine, oral pills, condoms etc. Drug kits are to be supposed to be provided to each ASHA. The *Table 3.10* furnishes information on receipt of medicine kit by the ASHAs.

Table 13: Receipt of Medicines kits by ASHA

View of ASHAs	Districts					Total	
		Jagatsingpur		Mayurbhanj			
		No	%	No	%	No	%
ASHAs receive medicine kit	Yes	20	50.0	40	100.0	60	75.0
	No	20	50.0			20	25.0
	Total	40	100.0	40	100.0	80	100.0
Medicines							
ORS	Yes	20	100.0	36	90.0	56	93.3

View of ASHAs	Districts					Total	
	No	0		4	10.0	4	6.7
Paracetamol	Yes	18	90.0	27	67.5	45	75.0
	No	2	10.0	13	32.5	15	25.0
IFA	Yes	20	100.0	40	100.0	60	100.0
Beta dine ointment	Yes	19	95.0	5	12.5	24	40.0
	No	1	5.0	35	87.5	36	60.0
Chloroquine	Yes	7	35.0	4	10.0	11	18.3
	No	13	65.0	36	90.0	49	81.7
Cotton gauge	Yes	19	95.0	40	100.0	59	98.3
	No	1	5.0			1	1.7
Ayurvedic medicines	Yes	17	85.0	37	92.5	54	90.0
	No	3	15.0	3	7.5	6	10.0
Thermometer	Yes	19	95.0	18	45.0	37	61.7
	No	1	5.0	22	55.0	23	38.3
Soap	Yes	1	5.0	23	57.5	24	40.0
	No	19	95.0	17	42.5	36	60.0
Oral pills and condom	Yes	2	10.0	2	5.0	4	6.7
	No	18	90.0	38	95.0	56	93.3
Metronidazole	Yes			12	30.0	12	20.0
	No	20	100.0	28	70.0	48	80.0
Medicines regularly replenished	Yes	1	5.0	10	25.0	11	18.3
	No	19	95.0	30	75.0	49	81.7
Sample size		20	100.0	40	100.0	60	100.0

As much as 60 out of the 80 ASHAs (75%) have received the kit with medicine and six have received the empty kits. Thus a quarter have not been provided with medicine in kits and all of them belong to Jagatsinghpur district. Surprisingly, medicine kits received by the ASHAs do not have the complete set of medicines. Common medicines and instruments like Chloroquine (81.7%), Metronidazole (80%), Betadine ointment (60%), oral pills and condoms (93.3%) are not available with them in most of cases. Thermometer is also not available in nearly one-third of the kits. Surprisingly, the common Paracetamol tablet is also not available in a quarter of the kits.

The ASHAs have been asked about whether the supply of medicine is in time and whether they are regularly replenished. Most (81.7%) of the ASHAs have stated that the medicine kits are not replenished regularly. Since minor symptoms like fever and diarrhoea are commonly occurring events in every village setting and ready availability of drugs with the ASHA will not only enhance her reputation amongst the community but also make her more acceptable to them, it is pertinent that essential medicines are supplied in full to them on regular basis.

The majority of the ASHAs have pointed out their lack of knowledge on proper dose schedule of AYUSH medicines that are in the kit because of lack of their knowledge about the utility of those medicines.

Most Preferred Activities

The majority (73.8%) of the ASHAs have pointed out that accompanying the pregnant mother to hospital is their most preferred activity. The second most preferred activity for them is taking children to ANMs for immunizatio n. (23.8%) *Table 3.11*.

Table 14: Most preferred activities according to ASHAs

Most preferred activities	Districts				Total		
	Jagatsingpur		Mayurbhanj				
	No	%	No	%	No	%	Qualifier
Accompany pregnant mother to hospitals	28	70.0	31	77.5	59	73.8	Majority
Children for immunization	10	25.0	9	22.5	19	23.8	Nearly a quarter
Care of mother and child	2	5.0			2	2.5	Very few
Total	40	100.0	40	100.0	80	100.0	

Coincidently, these are the two activities, which are linked to financial incentives. Hence it may be that the activities linked to financial incentives are getting priority and other activities are being ignored.

Persons Referred and Accompanied

During the last three months, the number of pregnant women referred/accompanied by the ASHAs is tabulated in *Table 3.13*. It has been revealed that a about one -tenth of them have not referred or accompanied any case, 42.5% of them have referred or accompanied only one to three cases, and nearly one -third of the ASHAs have referred or accompanied around six cases and some (16.3%) have even referred/accompanied more than seven cases. Average number of persons referred/accompanied during the past three months is four per ASHA. This is more in Mayurbhanj district than the Jagatsinghpur district *(Table-3.13)*. Most of them have stated (84.9%) that the patients referred/accompanied by them did not face any difficulty while some of them (15.1%) have stated that the patients faced certain difficulties (*Table 3.13*).

On further probing, it has been made clear the perception rega rding the treatment meted out to the referred patients to the PHCs/CHCs. Nearly half of them have stated that the patients get priority when they accompany them. Nearly a quarter have stated that the referred patients get some priority. But some of them (1 7%) have stated that even the hospital staffs demand money from the referred patients. If their financial demand is not met, they show lack of cooperation. *(Table 3.13).*

According to one ASHA from Jagatsinghpur district,

Doctor demands Rs. 200 for each delivery case that I accompany. If I deny paying he refuses to put his signature in JSY Card.

Another ASHA of Mayurbhanj district said,

Dai demands Rs. 50, ANM Rs. 100 and even the doctor demand money at the time of delivery and if it is a male child beneficiary is forced to fulfil their demand.

Table 15: Attitude towards ASHAs referrals: Views of ASHAs

Person referred by ASHAs	**Districts**				**Total**	
	Jagatsingpur		**Mayurbhanj**			
	No	**%**	**No**	**%**	**No**	**%**
None	3	7.5	4	10.0	7	8.8
1-3	24	60.0	10	25.0	34	42.5
4-6	10	25.0	16	40.0	26	32.5
>=7	3	7.5	10	25.0	13	16.3
Total	40	100.0	40	100.0	80	100.0
Average	3		5		4	
Referral cases facing difficulty						
No	34	91.9	28	77.8	62	84.9
Yes	3	8.1	8	22.2	11	15.1
Total	37	100.0	36	100.0	73	100.0
Acceptance of referral at institutional						
Priority was given if ASHA accompanied	20	54.1	21	58.3	41	56.2
Got some priority	5	13.5	12	33.3	17	23.3
No priority was given	1	2.7	0	-	1	1.4
Demanded money in Govt. hospital	11	29.7	3	8.3	14	19.2
Total	37	100.0	36	100.0	73	100.0
Type of cases accompanied to hospital						
Pregnant women to hospital for institutional delivery.	22	55.0	13	32.5	35	43.8
Malaria and high fever patients	3	7.5			3	3.8
TB patients for treatment	2	5.0			2	2.5

Approximately half (43.8%) of the ASHAs have had the opportunity to accompany pregnant women to hospital for delivery. Only 3.8% have accompanied malaria and high fever cases, and 2.5% TB patients for treatment. *(Table 3.12).*

ASHAs' association with Village Health Sanitation Committees

Association of the ASHA with VHSC is one of her assigned responsibilities. But ironically, most of the ASHAs (82.5%) have indicated that the villages do not have a VHSC. Only some (14 out of 80) of the ASHAs have indicated about the existence of

VHSC. Out of them 11 have attended the meeting during the last one month to one week. In the meeting topics like care of pregnant mother, care of children, education of adolescent kids, timely immunization, construction of toilets, awareness on cl ean and safe drinking water, importance of breastfeeding, difficulties of ASHA are discussed. Even in 11 out the 14 cases where VHSC existed, they have not prepared any plan for the development of the health programme. As an ironic example, in one of the v illages of Mayurbhanj district, the ASHA herself collects her drinking water from a source which is highly polluted and unhygienic (as shown in the photograph). This is a serious concern that most of the villages do not have VHSC. The poor scenario of VHS C has also been reflected in the FGDs among the community members *(Table 3.13)*.

Table 16: ASHAs' Association with Village Health and Sanitation Committees: Views of ASHAs

ASHA's view on association with VHSC	Districts				Total	
	Jagatsingpur		Mayurbhanj			
	No	%	No	%	No	%
Existence of VHSC in your village						
Yes	12	30.0	2	5.0	14	17.5
No	28	70.0	38	95.0	66	82.5
Total	40	100.0	40	100.0	80	100.0
Attend any VHSC of your village						
Yes	12	30.0	2	5.0	14	17.5
Last meeting attended						
Before a month	6	50.0	2	100.0	8	57.1
Before a fortnight	4	33.3			4	28.6
Last week	2	16.7			2	14.3
Point of discussion						
Care of pregnant mother	2	22.2	1	3.8	3	8.6
Care of children	2	7.7	0	-	2	3.1
Education to adolescent	1	4.0	0	-	1	1.6
Timely immunization services	2	7.7	0	-	2	3.1
Motivation for construction of toilets	5	17.2	0	-	5	7.5
Awareness on clean drinking water, sanitation, hygiene	4	14.3	0	-	4	6.1
Difficulties of ASHA	3	11.1	1	2.6	4	6.1
Any health plan prepared by VHSC						
Yes	3	7.5	0	-	3	3.8
No	9	22.5	2	5.0	11	13.8
VHSC does not exist	28	70.0	38	95.0	66	82.5
Total	40	100.0	40	100.0	80	100.0

ASHAs' Association with AWCs/SCs/PHCs/CHCs

Almost all the ASHAs (79 out of 80) are visiting the AWCs while one is not. This single case is due to personal rivalry. Mostly the ASHAs are required to go to the AWC very

frequently either once/twice a week or once a fortnight. On the work they do at the AWC, it has been reported that their major work is to mobilise pregnant women and children for immunization, take mothers for ANC/PNC, as sists the AWWs in weighing the babies, and distribution of supplementary food among others.
Activities undertaken by the ASHA at AWC are more prominent in tribal Mayurbhanj district than rural Jagatsinghpur district *Table 3.14*.

According to 37.5% of ASHAs, they visit the sub-centres for immunization and ANC/PNCs. ASHAs also visit the sub-centres for other purposes like for collecting JSY Cards and medicines. Majority of ASHAs (91.3%) help the ANMs in updating register for eligible couples.

A large majority (71.3%) of the ASHAs visit the PHCs/CHCs for common ailments of children, pregnant women for check-up, malaria or high fever cases for treatment.

Table 17: ASHAs Association with AWC/SC/PHC/CHC: Views of ASHAs

ASHAs association with AWCs/SCs/PHCs/CHCs	**Districts**				**Total**	
	Jagatsingpur		**Mayurbhanj**			
	No	**%**	**No**	**%**	**No**	**%**
ASHA visits AWC						
Yes	39	97.5	40	100.0	79	98.8
No	1	2.5			1	1.3
Total	40	100.0	40	100.0	80	100.0
How frequently ASHA visits						
Once in a week	15	38.5	19	47.5	34	43.0
Twice in a week	15	38.5	9	22.5	24	30.4
Once in a fortnight	8	20.5	10	25.0	18	22.8
Once in a month	1	2.6	2	5.0	3	3.8
Total	39	100.0	40	100.0	79	100.0
What Work ASHAs do at AWCs						
For immunization of mother and children	23	57.5	38	95.0	61	76.3
Visit Antenatal mothers and take them to AWC for check-up	18	45.0	36	90.0	54	67.5
Assist the AWW in distribution of supplementary food	30	75.0	34	85.0	64	80.0
Assisting in weighing babies	20	50.0	14	35.0	34	42.5
Assisting in record keeping antenatal, post natal and eligible couple register	3	7.5	5	12.5	8	10.0
Assisting in village survey	1	2.5	1	2.5	2	2.5
Inform AWW about new eligible couples and birth and death	4	10.0	1	2.5	5	6.3
Sub-centre for immunization and ANC/PNC						
Yes	23	57.5	7	17.5	30	37.5
No	17	42.5	33	82.5	50	62.5

Total	40	100.0	40	100.0	80	100.0
Sub-centre for other purpose than immunization and check -up						
For collecting JSY card	8	20.0	2	5.1	10	12.5
Collecting medicines	1	2.6	1	2.5	2	2.5
Others	2	5.0			2	2.5
Help ANM in updating eligible couple register						
Yes	39	97.5	34	85.0	73	91.3
No	1	2.5	6	15.0	7	8.8
Total	40	100.0	40	100.0	80	100.0
Are you visiting to PHC/CHC						
Yes	29	72.5	28	70.0	57	71.3
No	11	27.5	12	30.0	23	28.8
Total	40	100.0	40	100.0	80	100.0
If to PHC yes Specify purpose						
Take infant in case of common ailments	15	51.7	17	60.8	32	56.1
Pregnant women for check-up	8	27.6	10	35.8	28	49.1
High fever/malaria cases for treatment	4	13.8	3	10.7	7	12.3
Other severe or complicated diseases	4	13.8	5	17.9	9	15.8
Attend monthly BPHC meeting						
Yes	27	67.5	22	55.0	49	61.3
No	13	32.5	18	45.0	31	38.8
Total	40	100.0	40	100.0	80	100.0

ASHAs are required to attend monthly meeting of block PHCs for review of the programme. But about half are not doing so due to distance, inability to meet the travel cost from own pocket. This fact should be looked into because if ASHAs don't attend BPHC meetings and share their experiences with the supervisors, it will not only result into lack of communication between these two, but also lead to lack of support which is expected in form of guidance and logistics and also deprive the block and district level planners of essential field information to prioritise their activities on a logical and evidence-based construct.

Social Acceptance and Community Support

The ASHAs have to work in the community for the rural poor. They have to motivate every household and generate awareness in the community for ANC, PNC, safe delivery practices, immunization, importance of breastfeeding, family planning and sanitation etc. Their work will be accomplished if they are well-accepted and supported by the community. Eight FGDs that were conducted indicate that ASHAs are well -accepted in the community and considered as a friend to the household especially for the pregnant and lactating mothers and children. The PRI members, SHG members, community leaders, and mothers who participated in the FGDs, are very out spoken in their praise for the ASHA. Some of their views are worth quoting.

"At the time of her need, we help ASHA from the SHG fund and co -operate her to accompany the patient to health facility".

The interview with ASHAs also captured certain points to probe into the acceptability of the ASHAs in the community (Table 3.15).

Table 18: Community Acceptance: Views of ASHAs

Aspects of community acceptance	**District**				**Total**	
	Jagatsingpur		**Mayurbhanj**			
	No	**%**	**No**	**%**	**No**	**%**
Visit to households						
Yes	40	100.0	39	97.5	79	98.8
No	0	0	1	2.5	1	1.3
Total	40	100.0	40	100.0	80	100.0
Reasons for no visit						
Rich family don't accept services			1	2.5	1	1.3
Are you called by families						
Yes	34	85.0	36	90.0	70	87.5
No	5	12.5	2	5.0	7	8.8
Sometime	1	2.5	2	5.0	3	3.8
Total	40	100.0	40	100.0	80	100.0
Reason for not being called by all families (7)						
Rich family do not call	3	60.0	0	0	3	42.9
Upper caste people do not call	2	40.0	1	50.0	3	42.9
Not good terms with me	0	0	1	50.0	1	14.3
Total	5	100	2	100	7	100
Invitees to attend meetings convened by you						
Pregnant women	27	93.1	16	72.7	43	84.3
Lactating mother	14	48.3	6	27.3	20	39.2
Mother of children (0-6 yrs)	1	3.4	3	13.6	4	7.8
All mothers	9	31.0	4	18.2	13	25.5
Adolescent girls	3	10.3	1	4.5	4	7.8
PRI/MSS members	8	27.6	9	40.9	17	33.3
SHG members	19	65.5	10	45.5	29	56.9
ANM	14	48.3	18	81.8	32	62.7
AWW	20	69.0	15	68.2	35	68.6
School teachers	1	3.4			1	2.0

It has been revealed that all most all ASHAs (98.8%) paid visit to all household in the village, barring one exception who states that "she did not feel the necessity to visit rich household". It has also been revealed that most ASHAs (87.5%) indicate that they are called in by all the families. However, a few have indicated that rich families as well as upper caste families do not call them for services. It does not matter if rich families are not calling them but it matters when the needy families of the upper caste do not seek

their help at the time of need on the pretext of caste. It is fortunate to find that majority, over half of ASHAs, conduct meeting where they invite the pregnant and lactating mothers, adolescent girls, PRI members, SHG members to genera te awareness in the community. The analysis of the views that has emerged in the FGDs and the data from interview with ASHAs point out that ASHAs have got better acceptance in the community and they are also making effort to reach out to the community.

It is worth mentioning the views of villagers who said that "we understand very well that to get the maximum benefit out of the programme. There should be a two -way support mechanism between the community and ASHA."

Community Satisfaction and Expectations

The level of community satisfaction is judged by IDIs with the PRI members, representative of the CBOs, and FGD with AWWs and community.
Four out of five PRI and two out of three CBOs are happy with the functions of the ASHAs as the community is satisfi ed with the work, while the third CBO feels that is it only somewhat satisfactory.

*"***They are the potential link between the community and health sector. Presently, their function is developing," remarks the CBO of the Ballikuda block in Jagatsinghpur di strict.**

According to the remaining one PRI member, the community is divided over her function as some are satisfied with her work while others are not. All the five PRI members and three CBOs have asserted that the community is benefited by the ASHA in some way or other. All of them have emphasised on the role of the ASHA as a facilitator for institutional delivery, immunization of mothers and children and distribution of some medicines. Like the PRI members and CBOs, the AWWs have also expressed positive views on the activities of the ASHA in the community. The FGDs among community members reveal that the community members are by and large satisfied with the work of the ASHA.

She is mainly involved on the promotion of institutional delivery and immunizati on. One universal demand that emerges from the community is that the ASHA should have sufficient stock of the medicines for the common ailments like fever, diarrhoea, cold, cough and minor injuries. One important view that has come up during one FGD in Mayurbhanj is worth quoting.

"Earlier in the absence of the ASHA, the common illiterate rural pregnant women were being harassed, neglected and finally exploited by the health functionaries. Now the ASHA is acting like a watchdog and common pregnant women are being given the due importance in the hospitals."

All the ASHAs have indicated that community members are happy with their work and they also do give credit for it. However majority are of the opinion that the community expects more work from them. When asked to elaborate what type of work the community expects, they have pointed out that (i) supply of medicines for common illness ((ii) assistance for getting old age pension and (iii) helping them get the BPL Card s are the commonest of all.

According to most of them, accompanying the pregnant women and helping them in getting JSY benefit, immunization of mother and children are the work, which gets her maximum credit in the community. However a few have also said that supply of common medicine also gets credit in the community.

Monitoring, Supervision and Co-ordination

The mechanism of monitoring and supervision of the work of ASHA has been assessed through the IDIs with the CDMOs, the ADMOs, he CDPOs and the ANMs. Besides, ASHAs have also been interviewed about the monitoring process.

The CDMOs and the ADMOs monitor the work of the ASHAs through the health functionaries in the hierarchy. According to them, ASHAs and ANMs have good co-ordination. The ASHA is acting as a supporting hand to the ANM and the AWW and they in turn act as a guide to the ASHA. That is strengthening the delivery of services.

Out of the four MOs of CHCs, three are of the view that they have control over the ASHAs and they monitor their work. All of them feel that the ASHAs and the ANMs, the ASHAs and the AWWs work in coordination with each other mostly in the registration of pregnant women, ANC/PNC, immunization and safe delivery etc. The AWWs, the ASHAs and the ANMs are working together in different national health programme. All the four CDPOs have affirmed that the ASHAs and the AWWs are working hand–in–hand in activities like health check-up camps, immunization, home visits, organising fixed health days and recording of birth and death. Their views regarding co-ordination of the ASHAs and the AWW are also very positive. Seven out of the eight ANMs reported that they monitor and supervise the work of ASHAs two to four times a month in occasions like health day, immunization day, etc.

Most of the ASHAs point out that, they are supervised by th e ANMs (98.8%) and the AWWs (99.0%) and some of the ASHAs say that they are supervised by the MOs (10.0%). They also say that the supervising authorities clarify their doubts (96.3%) and help to improve their efficacy (93.8%) *(Table - 3.16)*

Table 19 : Views of ASHA regarding Monitoring, Supervision and Coordination

Parameter of monitoring and supervision	**Districts**				**Total**	
	Jagatsingpur		**Mayurbhanj**			
	No	**%**	**No**	**%**	**No**	**%**
Person supervises ASHA						
AWW	34	85.0	38	95	72	90.0
ANM	39	97.5	40	100	79	98.8
PRI	11	27.5	5	12.5	16	20.0
Medical officer	0	-	8	20	8	10.0
Health Worker (Male)	0	-	2	5	2	2.5
BEE	3	7.5	7	17.5	10	12.5
Supervisors clarify doubts						
Yes	39	97.5	38	95	77	96.3
Sometimes	1	2.5	2	5	3	3.8
Total	40	100	40	100	80	100
Are they helpful						
Yes	39	97.5	36	90	75	93.8
Sometimes	1	2.5	4	10	5	6.2
Total	40	100	40	100	80	100
Get support from PRI, SHG, AWW, ANM and other SHGs at the time of need						
Yes	40	100.0	40	100.0	80	100.0
Who help you most						
ANM	26	65.0	29	72.5	55	68.8
AWW	12	30.0	8	20.0	20	25.0
SHG	2	5.0	2	5.0	4	5.0
PRI	0	-	1	2.5	1	1.3
Total	40	100.0	40	100.0	80	100.0

The different areas where the ASHAs receive support from different personnel have been furnished at *Table 3.17*.

Table 20: Support received by ASHA from different he alth authorities: Views of ASHAs*

Sl No	ANM	AWW	MO	PRI	HW (M)
1	(66%) Mothers counselling- regarding ANC/PNC, immunization, breast feeding and family planning	(53.7%) Counselling of mothers and children to come to AWC for immunization, ANC, PNC		(11.2%) Helps in arranging transport	
2	(35%) Give medicines and advices about proper doses	(21.2%) Helps in registering pregnant women at AWC		(5%) Helps in motivating the community to use household toilets	(5%) Gives various information regarding health programme like (DOT, polio, leprosy and advises to work properly
3	(21.2%) Helps in collecting information on birth and death	(27.5%) Helps in giving status of immunization, nutrition of mothers and children of the village	(11.2%) Supervises TB cases and helps in motivating left over immunization cases	(3.7%) Involve ASHA in meeting held in village and discussion regarding her activities	(6.2%) Helps in organizing pulse polio programme and advises to maintain sanitation status of village
4	(22.5%) Helps in filling up JSY card	(2.5%) Helps in organising meeting at AWC			
5	(18.7%) Helps in maintaining register	(15%) Helps in maintenance of records about birth and deaths			

** The figure in the parenthesis indicated proportion of opinion of ASHAs.*

Over half of the ASHAs say that the ANMs support them in counselling the mothers on ANC/PNC, immunization, exclusively breastfeeding and family planning (66%) and nearly one-third in the supply of medicines and their appropriate doses to be administered (35%). Some of the ASHAs (15 -20%) also opine that ANMs support them on collecting information on birth and death, maintenance of records and registers.

The major area of support provided by the AWWs is counselling the mothers and children for immunization (53.7%). Some of the ASHAs (15 -28%) also state that the AWWs help them in knowing the status of immunization and nutrition status of mother and children of the vill age, registration of pregnant women at AWCs and maintenance of

records of birth and death. Very few ASHAs (2.5%) say that the AWWs extend support them in organising meeting at AWCs.

Again very few ASHAs (3.11%) inform that PRI members support in arranging transportation of the mothers for institutional delivery, motivating the community to use household toilets and involve them in village meeting for discussion regarding their activities.

Some ASHAs (11.2%) point out that the MOs guide them in supervising TB cases and helping in motivating the left over immunization cases.

A few ASHAs inform that (6.2%) the male health supervisors help them in organising pulse-polio camps and maintenance of sanitation of villages. Similarly very few (5%) report that health workers provide them with information on health programmes like DOTs, Polio, etc.

The essence of the above discussion is that there is good monitoring and support system for ASHAs. But the support extended by the PRI members is minimal. Moreover th e support is limited to counselling of mothers, ANC, PNC and immunization. The other areas of ASHAs' functions should also be monitored and supported.

CHAPTER IV

RECOMMENDATIONS

Area of Concern	Actions Recommended
1. Policy & Planning	
1.1. Coverage of Area by the ASHAs	
Majority of the ASHAs are catering to a population of more than the stipulated norm of 1,000. The tribal Mayurbhanj district, which is very sparsely populated, has 60% of the villages with population above 1,000. The tribal villages sit in the hamlets spread over large areas and intercepted by hills and rivers. Due to these natural barriers, the ASHAs even failed to visit certain hamlets and certain section of the population remained un-served and un-reached.	An assessment of the population catered to by each ASHA should be made at the PHC and sub-centre level under the guidance of district NRHM office and redistribution of areas should be made among the ASHAs so as to keep the population norms limited to 1000 or less. In sparsely populated areas intercepted by hills and rivers, the norm should be relaxed
The ASHAs are very keen on some of their job responsibilities like registration of pregnant women, ANC/ PNC, immunization, but the neglect areas are motivating the people for construction of toilets, participation in VHSC and development of comprehensive village health plan, family planning, adolescent education etc. The activities linked to financial incentives are getting priority and other activities are given less importance by the ASHAs.	The neglected areas in her functioning are to work with VHSC which are either non-existence or non functional in most cases. The VHSC should be revamped or constituted and ASHAs should be motivated to prepare comprehensive health plan. Possibility of providing incentives for the purpose should be explored. PRIs need to be sensitised and involved in every stages of planning, implementation and monitoring of VHSC. ASHAs should also be oriented to give importance to the job of motivating for the family planning measures and adolescent education.
Transportation of expectant mothers is a major problem. In the villages, the transport services are not available specially at night time. Further the charges are much higher than the sanctioned amount for transportation. Since ASHA is the link between community and health service, any delay in transportation may lower her credibility in the community which may decrease her effectiveness.	Two/three Janani Surakshya vans should be available round the clock in PHC/CHC area in different strategic sub-centres to provide service on call. According to JSY guideline, the ANM should keep a contingency amount of at least Rs. 1,500 with the ASHA. This instruction should be strictly followed.

The entire compensation received by ASHAs per month is very low which is quite inadequate for their sustenance. The members in the community, PRIs, CBOs and ANMs have indicated the inadequacy of the compensation to the ASHAs. Further majority of the ASHAs are not getting incentives in time. Even though, small in number (16.3%), some ASHAs have indicated that health functionaries expected something from their already meagre amount of compensation at the time of disbursement. This is a negative motivational factor which needs to be tackled.	Compensation for ASHAs should be suitably increased. Payment should be done at the work site without any delay through cheque. Flow of fund under JSY should be regular and on time from the Mission Directorate right up to the PHCs/ANM sub-centres. Possibility of making direct release of money up to PHC level should be explored by the NRHM. While monitoring the performance of the ASHA the Village Health Committee should ensure that the disbursement of compensation to the ASHA and beneficiary mothers is timely and proper.
VHSC are not functional	The activities like formulation of village health plan through VHSC, awareness and motivation for construction of household latrines, motivation for family planning and adolescent education by the ASHAs should be monitored by the health authorities. The PRI members and community leaders should be adequately oriented and sensitised so that community monitoring and social audit becomes effective. They should be sensitised to make use of the Right to Information Act which is extremely important to understand the situation and take appropriate corrective measures.
1.2. Training	
Only a meagre 5% of the ASHAs have good knowledge about their roles and responsibilities and the remaining had either poor or average knowledge in approximately equal proportion. This is a gray area and major bottleneck for the success of the programme. Gross irregularities and violation of purpose and philosophy in conducting the training of the ASHAs are revealed from the study.	Capacity building training should be imparted to the ASHAs by appropriate master trainers strictly following the training guidelines at PHC level preferably in residential mode. For conducting the training of the ASHA, training of Trainers should be conducted and in each district there should be a group of trainers for the purpose. It is suggested to publish a "news letter" in local language for updating knowledge and skill for grass-root level functionaries and specially for the ASHAs. This news letter should be on half-yearly or annual basis. Refresher training at regular interval should be imparted at PHC block and district level on specific topics.
2. Logistics	
About a quarter of the ASHAs interviewed have not even received medicine kits. Some received empty kits. Those who received medicine kits are incomplete in many respects.	The irregularity in the area of supply of medicine kits should be investigated and appropriate action should be taken. The ASHAs must get the medicine kits complete in all respects and replenished regularly. District NRHM cell should have a system of vigilance for this.

The majority of ASHAs lack knowledge on proper doses of drugs. They are not able to use AYUSH medicines that are in the kit because of lack of knowledge about the doses and utility of these drugs.	Besides, giving the orientation on the topic, a "reference sheet in Oriya" should be prepared with appropriate doses, symptoms and procedure of administering the allopathic and AYUSH drugs in the medicine kits.
Nearly a quarter of the ASHA have stated that the health personnel demanded money from the patients referred to institutions by them. Display board under JSY is not found in any of the health institutes.	Demand of money from the clients and ASHAs by the staffs should be strictly forbidden and the guilty be dealt with properly. The PRIs, community members should be sensitised not to yield to such unethical practices by service providers. Display board must be ensured and appropriate action should be taken for non installation of the same.
While accompanying the expectant mothers to the institutions and staying there the ASHA has to incur more expenditure on food, stay etc. than the sum provided to her under the scheme.	The sub-centre should be equipped with infrastructure, logistics and instruments so that non-complicated normal delivery can be conducted by the trained staff at the sub-centre level in remote inaccessible areas. For this training of the existing HW (female) and traditional birth attendant should be considered on priority basis.
3. Communication & Co-ordination	
Another operational problem is when ASHA provide all the approved services of ANC and immunization but fail to get the incentive if she missed the opportunity to accompany the mother to the health facility due to some reasons. The most important reason for such incidence is lack of communication on that critical moment, or due to the unwillingness of the beneficiaries to inform her. Besides, she also loses the incentive if the client opted for the delivery in private hospital or nursing home.	Possibility of providing mobile phones to the ASHAs could be considered so that they can have connectivity with the community and health facility, transport vehicles, without any hassles. The ASHAs should be equipped with the communication skill so that she can convince the family members of expectant mothers the importance of ASHAs as an accompany because she is the best link between the pregnant mother and service providers regarding her history and condition. Local MNGOs, FNGOs, Youth Clubs & PRI members could be requested to come forward to extended help regarding transport and other services.
More than a quarter of ASHAs are unable to conduct meeting in the community because they are unable to motivate the target group	The technique for community mobilisation should be incorporated in their future training curriculum.
4. Initiative taken by Orissa in the selection process	The involvement of women SHG leaders in the selection process has been quite effective for community participation in the selection process and acceptance of the selected ASHA. This can also be a model for other parts of the country.

Finally social vision and strong political will is extremely important for t he success of any programme in the country.

Limitations of the Study

The sample area of study should have included districts from the most backward KBK and western region of the state to have proper representation.

Future Areas of Research

Training need assessment for the ASHAs is a major area of research for designing the capacity-building training for the ASHAs.

Assessment of functional efficacy of the ASHAs should also be made in other districts especially in KBK and western districts of Orissa.

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