ASSESSMENT OF THE FUNCTIONING OF ASHAS UNDER NRHM IN UTTAR PRADESH

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PREFACE

Despite significant improvements made in the past few decades, the public healt h 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 heal th 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 Departm ent 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 ca pacity 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 Con sortium (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 "**Assessment of Functioning of ASHAs Under NRHM in Uttar Pradesh**" by the State Institute of Health & Family Welfare, Indira Nagar, Lucknow, Uttar Pradesh, 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.

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We are thankful to Executive Director, CHART, Principal Secretary of the State, Director General, Family Welfare, Uttar Pradesh, all the CMOs and Block Medical Officers of the selected districts for providing support in completion of the study. We express our gratitude to all respondents in this research, without whose cooperation, this study would not have been impossible.

The completion of the present project would no t have been possible without the dedicated efforts of the research team in which every team member played a significant role.

Dr. Neera Jain
Member Secretary, CHART

ABBREVIATIONS

ANM	Auxiliary nurse midwife
ASHA	Accredited social health activist
AWW	Anganwadi worker
BCG	Bacillus Calmette Guerin
BNO	Block Nodal Officer
CHART	Centre for Health Action Research and Training
CSSM	Child survival and safe motherhood
CHC	Community health centre
DNO	District Nodal Officer
EAG	Empowered action group
FGD	Focus group discussion
FRU	First referral unit
FP	Family planning
GDP	Gross domestic product
GoI	Government of India
IDI	In-depth interview
IMR	Infant mortality rate
IEC	Information education & communication
JSY	Janani Suraksha Yojana
LB	Live-births
LHV	Lady health visitor
NFHS	National Family Health Survey
NRHM	National Rural Health Mission
NIHFW	National Institute of Health and Family Welfare
NGO	Non-government organisations
PHC	Primary health centre
PNC	Postnatal care
PRI	Panchayati Raj Institution
RAHI	Rapid Appraisal of Health Intervention
RCH	Reproductive child health
UNFPA	United Nations Fund for Population Action
UPA	United Progressive Alliance

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EXECUTIVE SUMMARY

INTRODUCTION

The National Institute of Health and Family Welfare, in collaboration with the UNFPA, undertook rapid appraisal of various health interventions with the concurrence of Government of India under the "Rapid Appraisal of Health Interventions" (RAHI) project. These studies were conducted in five low performing states, namely Madhya Pradesh, Uttar Pradesh, Orissa, Jharkhand, and Chhattisgarh, to understand the process of implementation of various programmes, schemes, and innovations under the NRHM. This report is based on rapid appraisal of the ASHA Scheme under the NRHM in Uttar Pradesh, where a total 129,312 ASHAs were selected against a target of 134,643 and 116,470 were trained till the start of study.

General Objective

To assess the recruitment and training process of the ASHAs, acceptability of the ASHAs in the community, status of payment of compensation, and eventually to furnish a set of suggestions to programme managers for making the project more effective.

Methodology

The appraisal was done in four districts of Uttar Pradesh namely, Varanasi, Moradabad, Lakhimpur-Kheri, and Jalaun (Orai), by using a cross sectional research design. Different stakeholders, comprising of four district nodal officers, 12 block nodal officers, 20 facilitators, 43 ANMs, 60 ASHAs, 43 AWWs, and 360 beneficiaries (using random technique), were included in the study. A few FGDs were conducted in eight blocks with the PRI members.

Salient Findings

- All the stakeholders, i.e. DNOs, BNOs, and facilitators, were aware of the steps for recruiting the ASHAs. However, one fourth of the facilitators did not carry out the FGDs/GDs activity in the villages;

- All the DNO, BNOs and the ASHAs found the training useful, but 37 per cent of ANMs did not express any opinion;
- The need for training to the ASHAs was expressed by almost all the DNOs, the BNOs including the ASHAs. About 16 per cent of the ANMs did not support recurrent trainings to ASHAs because it affected their routine works and it was not necessary. The involvement of the community, PRIs, NGOs, and AWW etc was limited and poor;
- The ASHAs' support in ANC services and immunization was significantly high in comparison to other services;
- The role of the ASHAs in institutional deliveries was appreciable. More than three-fourth of the beneficiaries were found satisfied with the ASHAs. The PRI members too were appreciative of ASHAs' presence in the village indicating acceptance of the ASHAs in the community;
- Non-availability of funds at district-level was not found to be a problem. Funds were being transferred to sub-district levels through e-banking;
- Almost all the BNOs had complete knowledge of the provisions of compensation money for the ASHAs;
- The majority of ASHAs and ANMs had incomplete knowledge about the compensation provisions made available under the scheme; and
- There were some constraints in making timely payments, i.e. non-submission of adjustment vouchers and utilization certificate followed by non/late availability of relevant guidelines /norms.

Key Recommendations

- A strategy should be in place to recruit the remaining ASHAs as early as possible to make the programme effective and efficient.
- Communication strategy needs to be designed to create awareness on the ASHA scheme for PRI members and at community level for better acceptance of ASHAs.
- To avoid the delays in compensation money, the mechanism developed by the State must be strictly followed.
- Self-explanatory and specific financial guidelines should be made available within time to the programme managers.

- Under the cascade model of training to the ASHAs, trainings should impart complete knowledge and skills to the trainees in a stipulated time.
- Quality of training should be enhanced and refresher training should be planned regularly.
- In specific to improving programme, a medicine kit to ASHA must be provided at the earliest to help the community serve better and readily.
- A process of community level monitoring, regular problem solving, and skill up-gradation should be developed as early as possible.

CHAPTER I

INTRODUCTION

A review of Indian healthcare programmes shows that different models of healthcare delivery were adopted in post Independent India which relied heavily on expansion of healthcare infrastructure in terms of primary health cent res, community health centres and sub-centres. Consistent additions to the peripheral facilities were planned to extend the outreach of maternal and child healthcare in rural areas. These centres remained poorly supervised and were inadequately supported by curative and referral care units. Therefore, they could address the preventive and promotive healthcare needs of the population only to a limited extent.

Infant and child mortality rates did show declining trends during the decade of 1980 and early 1990s, but maternal mortality ratio continues to remain high. The pace of decline of IMR, especially neo-natal mortality rate, has slowed down during the period of 1995-2005. Introduction of the CSSM in 1992 and the RCH in 1997 by the Government of India m arked as a paradigm shift in the provision of maternal and child care. But these attempts could produce limited results in the absence of sustained commitments, clear implementation strategies, and supportive supervision especially during the first phase o f the RCH.

The objective of the NRHM is to strengthen healthcare delivery system with a focus on the needs of the poor and vulnerable sections among the rural population. The NRHM has prioritized on low performing States to reduce regional imbalances in the health outcomes. The NRHM is also attending to the determinants of good health, like, sanitation, nutrition, and safe drinking water. Its architectural corrections include integration of different organizational structures, optimization of health manpower, decentralization and community participation, and extension of effective referral hospital care at community levels as per the Indian Public Health Standard in each block of the country. One of the main tenets of the programme is to identify one ASHA (Accredited Social Health

Activist) per 1000 population in the rural areas with the purpose of supporting community to access the public health services.

Framework of the NRHM underlines ASHA as a health activist in the community. She is expected to create awareness on health and its determinants, mobilize the community towards local health planning, and increase the utilization of the existing health services. The GoI issued certain guidelines to all the States to ensure that women with required capa city may only take the assignment as ASHA. The 23-day training in four phases was proposed to enhance the knowledge and skills of ladies identified as ASHAs. To make her functional in an appropriate manner, she is trained for seven day in the first instan ce on a set curriculum developed by the GoI. Also significantly, since ASHA receives a fixed honorarium as compensation money in lieu of each activity performed, the timely flow of this money is of paramount importance for her commitment and motivation

Operationalization of ASHA in the State

The ASHA scheme under the NRHM was launched in the year of 2005 in the State of Uttar Pradesh. Detailed guidelines for selection and training of ASHAs, their role, compensation for the training, and performance -based incentives were issued by the State Government. Up to December 2007, a total of 129,312 ASHAs were selected and 116,470 of them could be trained in the first phase of coaching. Although cascade of the training envisaged completion within a year' time, th e load of training in a large State like Uttar Pradesh proved the infeasibility of the proposal. Consequentially, a strategic change to merge the succeeding trainings in a single phase by completing the curriculum in 10 days at a go was made. Delay in payments to the ASHAs is still a barrier in the effective functioning of the scheme. To avoid the delays and making the payment to the ASHAs timely, the feedback from lowest levels is taken and corrective actions in the form of revised financial guidelines were made, apart from making sure that shortfalls of funds did not arise. This is proving successful in making the fund flow uninterrupted. Inadequate awareness on the part of service providers and the community is acting as an obstacle in proper implementat ion of the scheme.

Rationale

The role and responsibilities of ASHA indicate that she has a significant role in the achievement of the objective set for the mission. Looking at this massive plan of selection, training, and provision of payments to the ASH As on the one hand and their success in mobilizing the community to access the quality healthcare on the other, it was thought to undertake a rapid appraisal of the ASHAs at the very outset. Since no specific effort has been made to know the actual status of the selection and training of ASHAs, their acceptance by the community, and the system of compensation payments, this programme was implemented in U.P. The present study was planned to understand and analyze all these issues with the objectives given below.

General Objective

To undertake rapid appraisal of the functioning of ASHA scheme and evolve suggestions for its improvement.

Specific Objectives

To assess the implementation of the guidelines on recruiting and training of ASHAs;

- To ascertain the acceptability of the ASHAs by the community;
- To study the appropriateness and timeliness of payment of compensation money during training and performance -based incentives to be paid subsequently; and
- To suggest on how the ASHA schem e can be made more effective.

CHAPTER II

METHODOLOGY

Study Area

Varanasi, Moradabad, Lakhimpur-Kheri and Jalaun (Orai) Districts.

Study Design

Cross-sectional evaluation study, blending both quantitative and qualitative data.

Study Subjects

- DNOs,
- BNOs,
- Training Facilitators,
- ANM, AWW,
- PRI representatives, and
- Beneficiaries like pregnant and lactating mothers, beside the ASHAs.

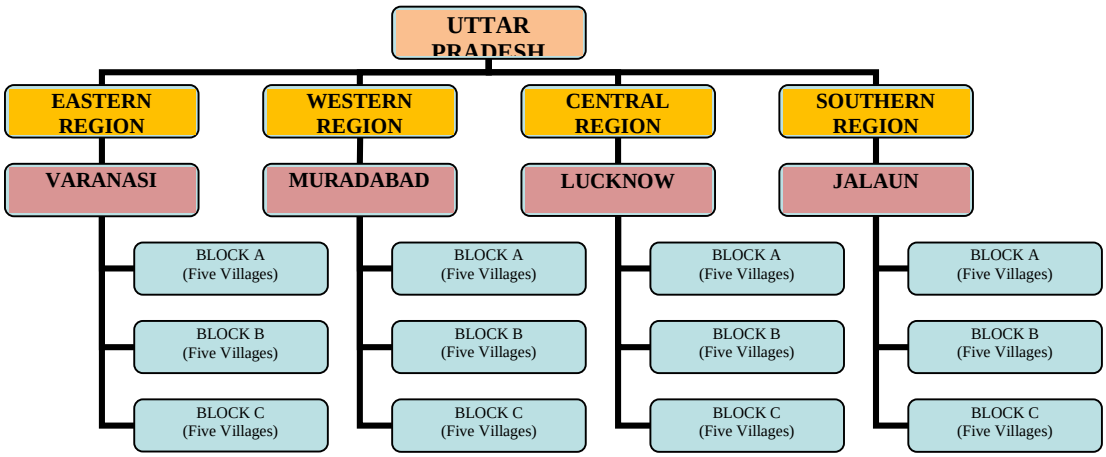
Sample Size

The study was conducted in four districts. Multi-stage random sampling design was used in the study. From each district, three blocks and from each block five villages were selected randomly.

Selection of Blocks and Districts

Keeping in view the different geographical regions of the State, namely, eastern, central, and western and Bundelkhand, one district from each region was selected. Thus Varanasi from eastern, Moradabad from western, Jalaun from Bundelkhand and Lakhimpur-Kheri from central region were selected. Three blocks from each district -- two close to the district headquarter and one remotely located from the district headquarter - were selected for the study. Thus 12 blocks from four districts were chosen for the study. From each block, five villages were selected

randomly .The list of selected districts, blocks and villages under stud y are shown in table-1.



Districts, Blocks and Villages under Study

District	Block and villages		
	Proximal-1	**Proximal-2**	**Remote***
Varanasi	**Chiraigaon**	**Pindra**	**Cholapur**
	• Rasoolpur • Salarpur • Seo • Umraha • Barai	• Phoolpur • Udhavpur • Ramaipatti • Chiurapur • Babatpur	• Barthali • Jadishpur • Sahadi • Tilmapur • Bhawanipur
Moradabad	**Kundarki**	**Mundapandey**	**Bellary**
	• Chakfazalpur • Kulwada • Pandia • Hariyana • Kazipura	• Niyamatpur • Madasana • Ganeshghat • Shivpuri • Dulari	• Mundiaraza • Fatehpurnatha • Sherpurmafi • Harara • Bichaula
Lakhimpur-Kheri	**Behzam**	**Bijua**	**Pallia Kalan**

	• Neemgaon • Paila • Dhakiabujurg • Lakhar • Khodrahia	• Bhanpur • Rajpur • Bheera • Bijuapurab • Bijuapachim	• Ittaia • Milinia • Trilokpur • Chandan Chowki • Dhuskia
Jalaun(Orai)	**Dakaur**	**Pindari**	**Kauthond**
	• Mohana • Makrecha • Khehta • Kusmilia • Mohamabad	• Jukhauli • Somai • Girthan • Keythri • Baragaon	• Nizampurnaka • Kauthond • Alampur • Madaripur • Hadrukh

* Remote Block implies a block at least 25 kms away from district headquarters.

The Programme Implementers enquired in the sampled District and Block included four District Nodal Officers (Dy.CMO), 12 Block Nodal Officers (12) , 60 ASHAs from each village , 43 ANMs, 43 AWWs, PRI members, and 310 beneficiaries

Tools and Technique

Both qualitative and quantitative data collection techniques were used. Data collection tools were developed, pre-tested, and administered to the subjects. Qualitative methods included checklists and in-depth interviews, comprising variables like process of selection, training and compensation payments to the ASHA, PRI's opinion on the programme, and providers' view about actual status of implementation of scheme. Focused Group Discussions (FGD) were also held.

Data Collection

The village was divided in three segments. Two eligible house-holds were selected following the right hand rule from each segment. Apart from this, eight FGD (two FGDs in each district) with PRI members were conducted. In-depth interviews with four DNOs and twelve BNOs were also conducted.

Two teams, each comprising of two supervisors and four investigators, collected the data in two selected districts concurrently. Principal Investigator/ Co-investigator/Supervisors conducted the FGDs and in-depth interviews. Data collection work was completed in December 2007.

Quality Assurance

The entire project was monitored and supervised by the Principal Investigator (PI). The co-investigator monitored the quality of data collection in the field by personally supervising 10% of the interviews at the block levels. All FGDs were conducted either by the Principal Investigator or the Co-investigator. Central monitoring team from the NIHFW closely monitored the training, field activities, data analysis, and report writing.

Data Analysis

The data collected in the form of recorded interviews was coded and each interview was transcribed with the help of field notes, and further translated by the hired field investigators on the same day of the field study.

Quantification was done for qualitative data by coding the responses of different stakeholders and merging into different headings by using adjectives as per guidelines for qualitative data entry interpretation and report writing format provided by the NIHFW.

CHAPTER III

FINDINGS AND DISCUSSION

Part -1 Results based on Quantitative Data

Recruitment/Selection Process

The success of innovation depends largely on the quality of inputs. It is assumed that the versatility of ASHA scheme - the pivotal human resource inputs under the NRHM - will determine the success of the NRHM Mission. Therefore, at the very outset, setting up standards for the selection of the ASHAs was considered very important. The rapid appraisal was carried out to find out how far the standards for the selection and training of the ASHAs are being used in the state of UP. Government of U.P. issued the directives in this context, which were to be adhered to during the selection procedure.

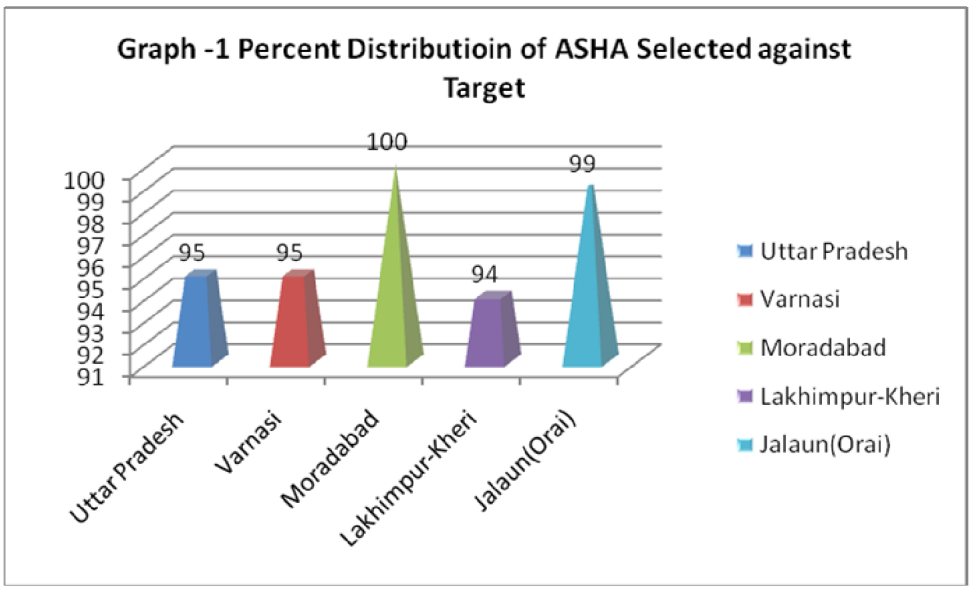
It was lucidly directed that a woman between 25 and 40 years of age, having at least the formal education up to 8th class, married (preferably daughter-in-law of the village) /widow with excellent communication skills and leadership quality was to be selected from the same village @ one per 1000 population.

It was also directed that a senior officer of Health Department at district level would ensure the inter-departmental co-ordination. He would also elicit desired support from concerned NGOs in the area. The District Health Mission had to nominate the in-charge of the CHC/PHC, as the BNO had to ensure that selection of ASHAs is according to the State's directives.

The BNO had to identify 10 or more facilitators in each block. Every facilitator had to cover approximately 10 villages. The females from local NGOs, *Mahila Mandal, Aganwadis,* female health workers or other members of society were to be taken on priority as facilitators.

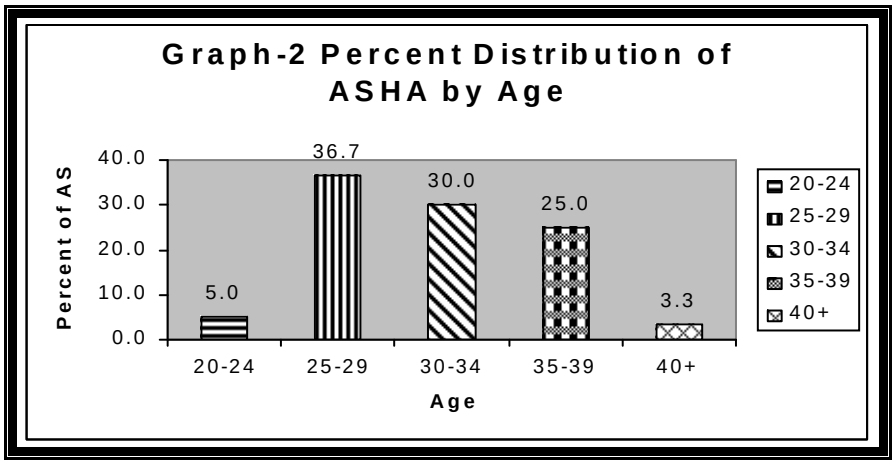
All the identified facilitators of the district had to be imparted two -day training in a workshop regarding the programme and the selection procedure. These facilitators had to decide at least three most approp riate names from each village by conducting a FGD. The list of so decided names had to be submitted to the concerned *gram sabha* which in turn had to approve one name from the list on the basis of the appropriateness. Further the village health society h ad to sign the agreement with the selected ASHA.

Selection of ASHA



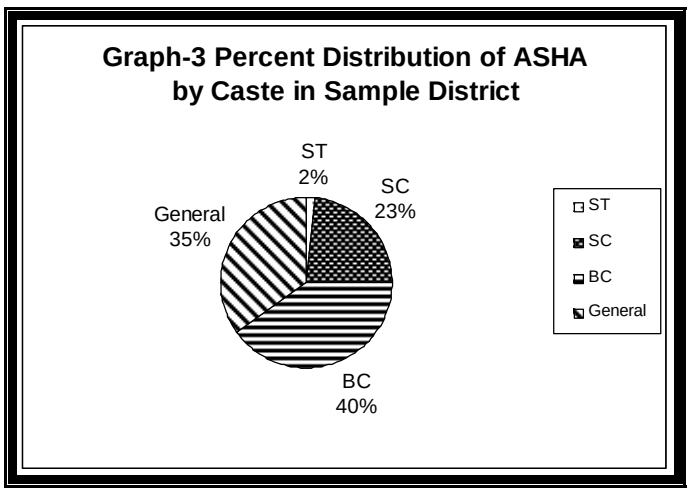
As evident, five per cent of the ASHAs were yet to be selected. The backlog is relatively more in Varanasi (5%) Lakhimpur (6%), and just 1% less in Jalaua, while Moradabad completed selection of ASHAs.

Age Distribution of ASHA



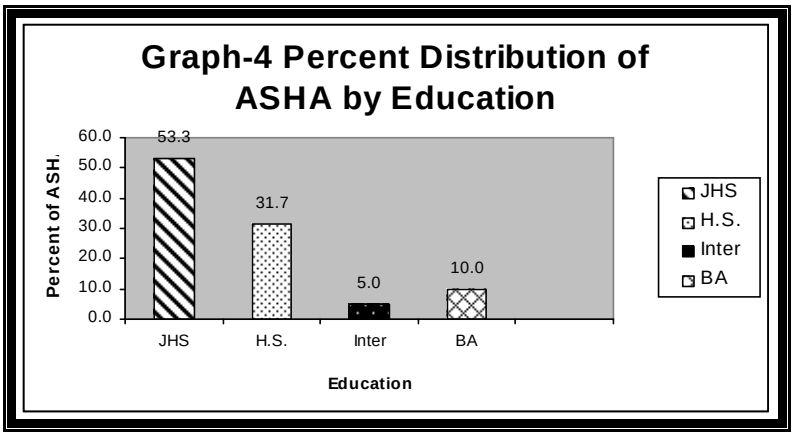
Only 3.3% ASHAs were more than prescribed the age of 40 years in the guideline of selection of ASHA.

Composition of Caste



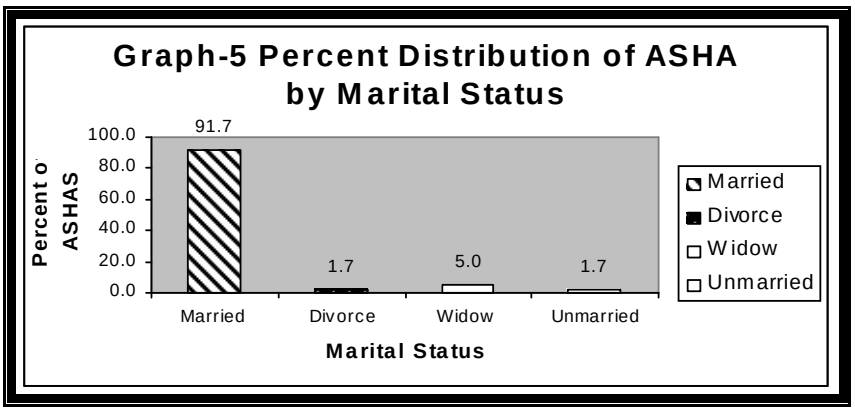
As much as 35% ASHAs came from general category (which contains possibil ity of higher caste more than any) while 40% of them were BC, 25% from SC (23%), and ST (2%). This classifications needs to be addressed in terms of caste composition in each district.

Education of the ASHAs



The guidelines put emphasis on education up to junior high school level. Only 53.3% of the ASHAs had schooling up to JHS, 31.7% HS and 5% intermediate, and 10% were graduates. This again needs to be examined in the context of educational level of the ASHAs from each category of caste.

Marital Status of ASHA



It is good that 91.7% ASHA were married. The share of unmarried was just 1.7 per cent.

Analysis of the information reveals that 74 per cent of the stakeholders knew and followed the steps proposed for recruitment. However, 26 percent of f acilitators

did not conduct FGDs for short-listing the names of ASHAs. This was strengthened from 88.3% of ASHAs who were also unaware about the FGDs happening in their villages. The facilitators responsible to short-list ASHAs had not carried out full procedure in the selection. Majority of facilitator stated that there was heavy pressure from gram sabha for a particular candidate. All the nominated facilitators belonged to Health Department while it was directed that facilitators must come from across the departments and also from NGOs. However, the representation of other departments was missing in reality during the selection process.

Table-1: Steps taken during Recruitment

Recruitment steps	**Facilitator**	**DNO**	**BNO**	**ASHA**
	N=23	**N=4**	**N=12**	**N=60**
Whether facilitator was in the village for short-listing	23 (100.0)	4 (100.0)	12 (100.0)	13 (21.7)
Whether FGDs were conducted for short-listing	17 (74.0)	4 (100.0)	12 (100.0)	7 (11.7)
Filling of FGD forms and their submission to BMOs	No	No	No	No

B. Training:

Training of Trainers (TOT) was organized for imparting training to the ASHAs. Through in-depth interviews with the DNO and the BNO, it was tried to ascertain whether the guidelines issued by the government were followed. Findings reveal that the district and block training teams were formed and their training was conducted as per the State government guidelines. Facilitator guide for trainers, teaching aids and reading materials for the ASHAs were also provided to them. In Uttar Pradesh, till now, only first phase of the ASHA training could have been

completed, and 116,470 out of the total 129,312 ASHAs have been trained for seven days.

Status of Training of the ASHAs by District and Block

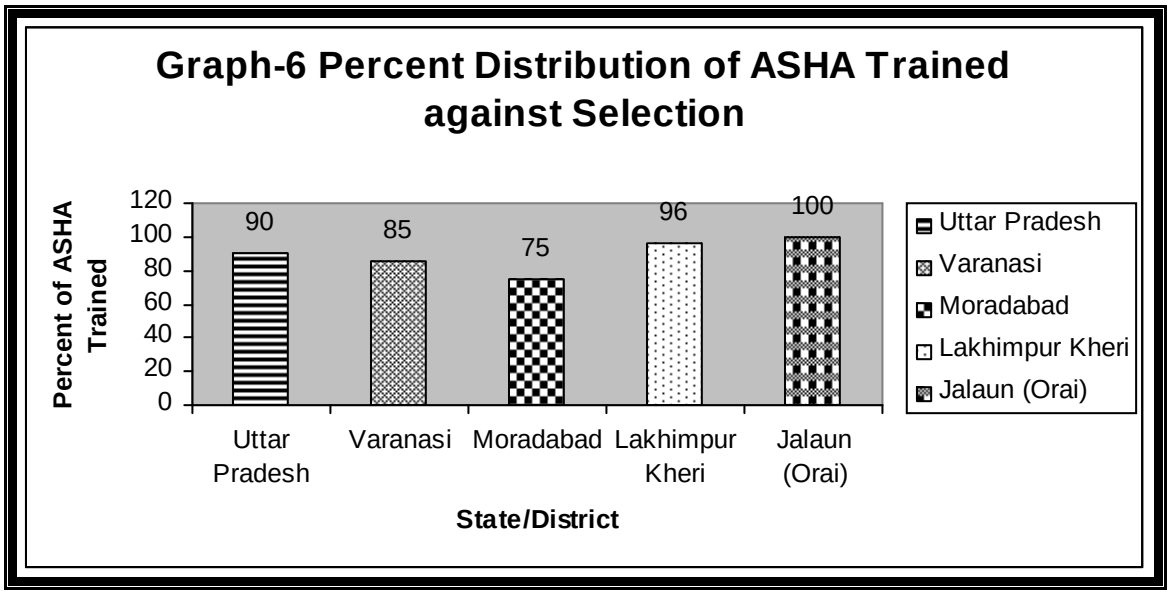
Table-5 shows that in Uttar Pradesh about 10 p er cent of selected ASHAs are still to be trained. All the CMOs / DNOs of districts where the training could not be completed cited shortage of training budget as the reason behind this backlog.
Several components of training were asked to ascertain to wha t extent these ASHAs had retained the knowledge about different contents taught to them. Extent of retentions of the subject matter were taken confirmed "without probe" and recall laps in the form of "with probe". The topic wise analysis of the responses showed that knowledge of the ASHAs about the eleven listed contents "without probe" ranged from 10 per cent to 85 per cent, while in case of "with probe" it ranged from 45 to 100 per cent as shown in Table 6. Another interesting trend observed is that a number of ASHAs recalling the topics covered under training after giving them the list of contents. It shows that after sometime, the ASHAs have been unable to retain all the functions and responsibilities to be undertaken by them. They were found to be m ore aware of the subjects related to delivery where recall-lapse was found minimum ranging from 13 per cent in case of ANC and natal services, and 23 per cent in immunization services as against 55 per cent of the ASHAs, who could not recall whether someth ing about the NRHM was taught to them or not?.

Table-2: Contents of ASHA Training (N=60)

Contents	Without Probe	With Probe	Increment	Don't remember
Orientation Aspects				
• About NRHM	9(15%)	27(45%)	30%	33(55%)
• Role & responsibility of ASHA	41(68%)	56(93%)	25%	4(7%)
Clinical Aspects				
• About ANC & Natal	51(85%)	59(98%)	13%	1(2%)
• About PNC	12(20%)	51(85%)	65%	9(15%)
• Breast feeding	46(77%)	60(100%)	23%	0
• Supplementary food	14(23%)	42(70%)	47%	18(30%)
• Child & Mother Immunization	46(77%)	60(100%)	23%	0
Management Aspect				
• Co-operation &co-ordination with block &village level members	33(55%)	51(85%)	30%	9(15%)
• Counselling &community participation	6(10%)	34(57%)	47%	26(43%)
• Team work &meeting	13(22%)	36(60%)	38%	24(40%)
• Co-operation &co-ordination with ANM &Other sectors	27(45%)	58(97%)	52%	2(3%)

Training related issues like contents, place, and duration of training, its usefulness, need for further training, and the honorarium received by the ASHAs during the course of training, were also assessed across PRIs, the BNO, and the ANMs. All the DNOs and BNOs found the training as useful while 37 per cent of ANMs did not express any opinion on this issue. As much as 16 per cent of the ANMs said that recurrent trainings to ASHAs affect their routine work. Further need of training to the ASHAs was considered necessary by all the DNOs, BNOs and the ASHAs. About 12 per cent of ASHAs also informed that the duration of training was less than seven days.

Training Status of the ASHAs



Knowledge on Compensation Amount

Awareness of the BNOs, the ASHAs and the ANMs about the different amounts of compensation to be paid to the ASHAs for carrying out different activities was ascertained. It was observed that while the BNOs had more or l ess complete knowledge of the provisions, only 57 per cent of the ASHAs and 70 per cent of the ANMs had the knowledge of the various compensatory provisions under the scheme.

Table-3 : Knowledge about the Compensation

Compensation money	**BNO N=12**	**ASHA N=60**	**ANM N=43**
Knowledge on compensation money for different activities for ASHA	12 (100%)	34 (57%)	30 (70%)

Availability of Budget

Frequent shortfalls in budgets were also observed in the study district s, against the requirement in different programme heads creating pending liabilities and resulting in delayed payments to the ASHAs. It was also observed that whenever budget is allocated to the district, the effort is to immediately transfer it to the sub-district level through e-banking. This system was introduced in the State in March 2007. Funds were not utilized within the stipulated time due to non-orientation of the staff on e-banking transactions and transfer of money from the districts without any accompanying directives.

Difficulties in Fund Flow

There were several hindering factors which delayed the disbursement of claims by the ASHAs. Most of the DNOs and the BNOs admitted that unavailability of funds at operational level was due to non-submission of adjustment vouchers and utilization certificates. Unavailability of relevant guidelines also contributed to this lethargy. It was also observed that non-operation of imprest money account and requirement exceeding the available funds were al so responsible for the delay in fund releases. Most of the officials said that late transfer of money under the head 'additionalties under NRHM' account, a main source of payments to the ASHAs, has been the foremost obstacle in timely payments. This pro blem is compounded by apathetic attitude of the staff at district and sub-district hospitals. One of the CMOs was pointing out the problem of non-submission of required financial formalities in the district from the PHC.

Acceptability of ASHA- A Client Perspective

Acceptability of the ASHAs to the community including the type of activities performed by her was assessed by administering a questionnaire to the lactating mothers. The analysis revealed that out of 360 lactating mothers, 90 per cent were registered for ANC services and about 63 per cent got their registration through the ASHAs. Of the total number of ANC registrations, a little more than two-third

(67 per cent) of the expectant mothers got their check-ups during pregnancy through the ASHAs which shows a high degree of involvement of the ASHAs in this area. About 65 per cent of the ANC cases received T.T. doses through the ASHAs. About 41 per cent and 12 per cent mothers received IFA tablets and supplementary food respectively through the AS HAs. As much as 14 per cent of the pregnant mothers had one or the other form of complication during pregnancy, out of which 35 per cent were facilitated by the ASHAs in getting the treatment which is again an indication of helping the beneficiaries to acc ess the health delivery services.

Promotion of Institutional Delivery

The analysis of the quantum of work being done by the ASHA under the JSY scheme showed that half of the total deliveries took place at homes, while 42% at public health service units, and the rest at private nursing homes. Out of total institutional deliveries, around three fourth (70%) were motivated and facilitated by the ASHAs. Arrangement of and payment for transport were made by the ASHAs for 22% of the deliveries conducted at public institutions. It was also observed that in 6% of the home-deliveries, the ASHAs arranged trained dai/ANM at homes.

Out of 83 % newborns that were administered BCG vaccination, 59 % were facilitated by the ASHAs in getting the immunization. About 40 per cent were counselled for acceptance of any method of family planning by the ASHAs, out of whom six percent turned up as acceptor of tubectomy, 26 per cent as condom users while less than two percent got IUD inserted, and three per cent started the use of either oral pills or some other traditional methods. It looks encouraging that within a very short period of time, the ASHAs were able to motivate 37% to accept one or other method of family planning.

The acceptability of the ASHAs by community can be gauged through their level of effective involvement in various activities for facilitating the community to access public health delivery services. As the ASHAs are providing the services voluntarily to the community and are not paid workers, their inv olvement in facilitating

community in the access of health delivery services to such a high extent implies that they are well accepted by the community. However more than three -fourths of the beneficiaries were found satisfied with the ASHAs' activities.

Table-4: Status of Selection of ASHA in U.P . and Selected Districts and Blocks

State/Districts	Target	Selected	Short fall	Short fall in (%)
Uttar Pradesh	134,643	129,312	5,331	3.96
VARANASI	1,900	1,811	89	4.68
• Pindra	245	242	3	1.22
• Cholapur	249	224	25	10.04
• Chiragaon	194	192	2	1.03
MORADABAD	2,631	2,631	0	0.00
• Kundarki	230	230	0	0.00
• Munda pandey	179	179	0	0.00
• Bellary	195	184	11	5.64
LAKHIMPUR KHERI	2,891	2,720	171	5.91
• Behzam	166	166	0	0.00
• Bijua	210	182	28	13.33
• Pallia	185	145	40	21.62
JALAUN(ORAI)	966	961	5	0.52
• Kuthond	109	107	2	1.83
• Dakaur	119	119	0	0.00
• Pindari	129	129	0	0.00

The selection of the ASHAs fell short by just 3.96% in Uttar Pradesh. Among the study districts, the higher shortfall was in Lakhimpur -Kheri followed by Varanasi(4.68%), Jalaun -Orai(0.52%) and Moradabad (0%). The village -wise variation is evident from the table, highest in Pallia(21.62%) Village followed by Bijua (13.33%) and Cholapur(10.04%)

Broad steps involved in selecting the ASHAs were: i) appointment of facilitator to short-list ASHAs, ii) their orientation on the process of recruitment, iii) conduction of FGDs for short -listing, iv) consultation with approval by PRI

representatives, and v) agreement between *Pradhan* and the ASHA. The first three steps relate to identification process of the ASHAs and the rest to their approval.

In the light of the proposed government procedure, it was tried to assess the status of ASHA selection in UP and in sample districts during the study. It is also to be ascertained that all the prescribed steps for selection were undertaken. Districts/block wise target of selection of the ASHAs and their actual position is shown in table-3

Analysis of the information gathered from the facilitators, the DNOs and the BNOs reveals that 74 per cent of the stakeholders knew and followed the steps proposed for recruitment. About 26 per cent of facilitators stated that they did not conduct FGDs for short-listing the names of ASHAs. This fact was further strengthened when it was observed that 88.3% of the ASHAs were also unaware about the FGDs happening in their villages. It seems that the facilitators responsible to short -list ASHAs had not done justice to their work. Majority of them stated that there was heavy pressure from gram sabha in favour of a particular candidate All the nominated facilitators belonged to the health department while it was directed that facilitators must come from across the departments and also from NGOs, which shows that representation of other depart ments was missing in the selection process.

Part -2 Result based on Qualitative Data

One of the block nodal officers said: "We had already received the guidelines from the district HQ. Accordingly facilitators were appointed, they identified t he appropriate women from amongst the various sects of inhabitation for selection and sent their names to Pradhan. Then the Gram Pradhan selected required number of the ASHAs from amongst them and sent it back to us at PHC."

- "**Humare pradhan ji ko PHC bula ya gaya tha. bataya gaya ki gram sabha mey jansankhya ke hisab se 1499 par ek ASHA ka chyan hona hai. pradhan ji ne hum logo ko bataya. phir baithak hui jismey ANM**

,didi,pradhan ji aur panchyat mitra thay, sab ko bataya gaya ki jo mahilayein echchhuke hain, padhi likhi hain, veh avedan patra bhar den. jo mahilayein echchhuke thi unhone avedan kiya phir gram sabha ki baithak mein hi anomodan kiya, anubandh bhi hua" *(Our Pradhan was called at PHC. He informed that on the basis of village population of 1499 , one ASHA has to be appointed. Pradhan told us, then with ANM Pradhan ji and panchyat mitre, a meeting was held. Everyone was told about that whosoever interested and educated can give application. Interested ladies gave applications, then at gram sabha meeting, the applications were approved. In that meeting, pradhan, PHCs personnel and ANM were present. Contract was also singed by the ASHAs)*

- PRI members were also not correctly aware about the steps of selection. One of the pradhans told " **bahin ji (ANM) ya daktar sahib se malum chala ke ASHA ko chunnne ke liye bahin ji ko panchyat mein naam dena hai"**

- Consent has to be submitted to the village body for the selection of ASHAs. Like-wise the views of most of the *Pradhans* regarding procedure adopted for selection runs like "***Mere pas do teen nam aye, jisko panchyat ki khuli baithak mey ek hazar ki jansankhya ke liye ek asha ka anumodan kar daktar sahib ke pas bhej diya"*** (I have received 2-3 names for selection of ASHAs which were presented in the open session of Panchayat. One qualified woman's name was approved and sent to Medical Officer in -charge of the concerned CHC/PHC.)

- One of the panchayat member said " ***pradhan ji dwara malum chala ki chayan kiya ja raha hai ,aise mahila ko chuney jo karmath h o, kam se kam, 8 pass tatha milansar ho, aisa nahi ki bulay to vah aye nahi,bina shiksha ke sab adhura hai"*** .(I knew from *Pradhan ji* that ASHAs are being selected. I suggested to him that "select such a women who is at least 8 th pass and of friendly nature, available in need. Without education every thing is incomplete.)

- The analysis regarding the procedure of recruitment of ASHAs indicates that only facilitators, the DNO and the BNO had the correct knowledge about the selection procedure. Knowledge and p articipation of community, PRIs, other sectors like NGOs need enhancement for advancement equate community ownership in further selecting and owning this important human asset under the NRHM.

- "***Hamari bharti ke bad prathmic swasthya kendra per sat din ki traning di gai thee jismey ASHA key aath kaam batai gai they, iss training ke pheley hum kucch naihee jantey they, jo training de gai thee whey kaphi pheydeymand thi"(*** After our appointment, seven days training was imparted to me at PHC in which ASHA's eigh t works were taught. Before this training, I did not know any thing. The training was very useful to me): ASHA

- "***hum ko her do-teen mahney bad training milnee chayyey Jis se hum aur acchaa kam kar saktey hey"***(We should be given training in every two or three months so that we can work better): ANM

- When the ASHA training was evaluated with PRI members, it was found that they knew a bit about the place, duration, and conduction of training, but the awareness about training content was almost nil.
- "***Hum to ye dekhte thy ki rojana, ek -aadh hufta tak training ke liye jati thi, prathmic swasthya kendra per training hoti thi".*** (I was seeing that she was going to PHC for a week or so for training): Pradhan.
- "***Mai puchhta rahta hu ki batao, kya training chal rahi hai? Do training shyad abhi hui haihai. block se pata kiya, to kaha abhi training chal rahi hai. abhi aur training baki hai .***" (I keep asking the ASHAs about their training. I have also enquired from the block about the training for the ASHAs. They told t hat the training is going on. Remaining training will be done in future): Pradhan.

- The above reasons can be corroborated with the statement given by the community members as " ***Kuchh ASHA to kaam hi nahi kar rahi hain.***

humare gaoan ki ASHA to subke ghar ja ti bhi nahi, bade logo key ghar ki bahu hai kahan wo sub ke ghar ghumegi" (Some ASHAs are not working. In our village ASHA dose not visit every household as she is a daughter-in-law of upper caste).

- The importance of ASHA in the words of a PRI: ***"ASHA to humare liye aise hai jaisey sabji mey aalo, kahin bhi mila dijiye, sub jagah kam ata hai, dekhiyey (ASHA) merey gaon ki ladkiya hain, hili mili hain, parai nahi hain, such-dukh mey satth deti hain, jitna ho sakta hai, karti hain."***(ASHAs for health service are like potatoes in any vegetable. ASHAs hail from our own village, our own home. They help villagers as far as they can). Such views and feeling were found in all the community FGDs.

Result in Brief

The measure findings are: All the stakeholders i.e. the DNOs, the BNOs and facilitators were aware of steps of recruiting the ASHAs. However one fourth of the facilitators did not carry out the FGDs/GDs activity in the villages. All the DNOs, the BNOs and the ASHAs found the training useful. However, 37 per cent of ANMs did not express any opinion. About 16 per cent of the ANMs did not support recurrent trainings to the ASHAs because it affects their routine works and it is not necessary. The involvement of the community, PRIs, NGOs, and AWW etc. was limited and poor. The ASHAs' support in ANC services and immunization was significantly high in comparison to other services. The role of the ASHAs in institutional deliveries was appreciable. More than three-fourth of the beneficiaries were found satisfied with the ASHAs. PRI members too were appreciative of ASHA's presence in the village indicating acceptance of ASHAs in the community. Non-availability of funds at district was not found to be a problem. Funds were being transferred to sub-district level through e-banking. Almost all the BNOs had complete knowledge of the provisions of compensation money for the ASHAs. The majority of ASHAs and ANMs had incomplete knowledge about the compensation provisions made available under the scheme. There were some constraints in making timely payments i.e. non-submission of

adjustment vouchers and utilization certificate followed by non/late availability of relevant guidelines /norms.

Proposed cascade –model of training to the ASHAs was not paying dividends as the inter-phase duration of training is becoming too long, which is adversely affecting the knowledge and confidence of the ASHAs.

CHAPTER IV

RECOMMENDATIONS

The Key Recommendations :

- A strategy should be in place to recruit the remaining ASHAs as early as possible to make the programme more effective and efficient.
- Communication strategy needs to be designed to create awareness on the ASHA scheme for PRI members and at community levels for better acceptance of the ASHAs.
- To avoid the delays in compensation money, the mechanism developed by the State must be strictly followed.
- Self-explanatory, specific financial guidelines should be made available within time to the programme managers.
- Under the cascade model of training to the ASHA, trainings should provide complete knowledge and skills to the trainees within the stipulated time.
- Quality of training should be enhanced and refresher trainings should be planned regularly. In specific to improving programme, a medicine kit to ASHA must be provided at the earliest to help the community serve better and promptly.
- A process of community level monitoring, regular problem solving, and skill up-gradation should be developed as early as possible.

Policy issues

- Delay in selection: Backlog in the ASHAs is retarding the rapid scale-up of the programme.
- Low level of awareness about the components of the ASHA scheme amongst the PRI's members/community leaders.
- Sometime interrupted fund flow from top to bottom leads to low morale of functionaries and adversely affects the programme.

- The provision of distance-wise payments of transportation charges to the ASHA (in case she accompanies the beneficiaries of the JSY) functionaries and adversely affects the programme.
- The provision of distance-wise payments of transportation charges to the ASHA (in case she accompanies the beneficiaries of the JSY) without directive from the State are creating confusion.
- Although it has been two years since the start of the programme in the State, selection of the ASHAs is still not complete. This impacts the overall implementation of the programme. An attempt should be made to recruit the remaining ASHAs as early as possible.
- Awareness generation programme on the ASHA scheme for PRIs and community should be organized at regular intervals.
- The mechanism developed by the State for ensuring uninterrupted fund flow from State to operational level units must be strictly followed so that delays in the compensation payments may be avoided. Self-explanatory, specific and clear financial guidelines should also be made available in time to various programme managers.
- A distance-wise distribution of transportation amount be fixed and communicated to the district and sub-district level managers.
- The time period envisaged in cascade model of training to the ASHAs should be shortened to ensure regular upgradation of skills and knowledge

Limitations of the study

- Duration of the study was too short, therefore a large sample-size could not be attempted .
- Small sample size restricts the generalization of findings. So the findings emerged are indicative only and cannot be generalized.
- Study area could have been extended to a wider geographical area to have a representative population.

Future Directions of Research

- A micro level study on the payments of incentives to the ASHAs and other factors affecting their motivational levels with a view to suggest modification in the processes may be under taken in future.
- Periodic training needs assessments to input into curriculum modifications and it can be a regular research activity

REFERENCES

1. Special issue on National Rural Health Mission, Quarterly Journal of the Indian Public Health Association, Vol.xxxxix. No.3, July -Sept,2005
2. National Rural Health Mission, State Action Plan, Uttar Pradesh (2005-12), Department of Family Welfare, Uttar Pradesh.
3. National Family Health Survey (NFHS-3), Vol. I & II ,2005-06
4. National Rural Health Mission, Meeting People's Health needs in rural areas, Framework for Implementation, 2005-2012), Ministry of Health & family Welfare, GoI, New Delhi. .
5. ASHA, Facilitator's Guide Book No.1, Ministry of Health & family Welfare, GoI New Delhi
6. ASHA, Path Pradershika -1 SIHFW ,Lucknow, GoUP.
7. NRHM –the progress so far, www.mohfw.nic.in/NRHM
8. Draft Guidelines NRHM (2005-12) www.mohfw.nic.in
9. Kumar,Satish,"Challenges of Maternal Mortality Reduction and Opportunities under National Rural Health Mission - A critical Appraisal " Indian Journal of Public Health ,Vol,xxxxix No. -3 July-Sept 2005.
10. Nandan .D: "National Rural Health Mission –Rhetoric or Reality. Indian Journal of Public Health, Vol,xxxxix No. -3 July-Sept 2005.