A STUDY OF INTERFACE OF ASHA WITH THE COMMUNITY AND THE SERVICE PROVIDERS IN EASTERN UTTAR PRADESH

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Department of Community Medicine (SPM)

BRD MEDICAL COLLEGE, GORAKHPUR

UTTAR PRADESH

A Study of Interface of ASHA with the Community and the Service Providers in Eastern Uttar Pradesh

Chief Investigator

Prof. Deoki Nandan

Director

National Institute of Health and Family Welfare

Study Team

BRD Medical College, Gorakhpur

Prof. D.K. Srivastava

Dr. Shiv Prakash

National Institute of Health and Family Welfare

Dr.Vivek Adhish
Dr. K.S. Nair
Dr. Sanjay Gupta

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PREFACE

The National Rural Health Mission (NRHM) was launched by the Government of India on 12th April 2005 to carry out necessary architectural correction in the basic health care delivery system, with a plan of action that includes a commitment to increase public expenditure on health. The Mission envisages an additionality of 30% over existing annual budgetary outlays every year to fulfil the mandate to raise the outlays for public health from 0.9% of GDP to 2-3% of GDP. Under the Mission, multifarious activities have been initiated to strengthen the rural health care delivery system for the improvement of health of the rural population.

NRHM implementation framework does not envisage significant engagement of medical colleges in delivery of Mission interventions. The role of the medical colleges in RCH-II is largely limited to conduction of clinical skill based trainings. In the absence of any systematic engagement of medical colleges, faculty members of departments are clueless about the evidence-based technical strategies being pursued in the implementation of various National Health Programmes. There is a huge potential available in medical colleges of the country for undertaking innovations, facilitating programme interventions and conducting health systems research, which largely remains untapped.

The Rapid Assessment of Health Interventions (RAHI), a collaborative activity 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 (NIHFW) for developing partnerships with different organisations working in the field of health and family welfare. The objective of the project is to accelerate NRHM delivery in identified states by organising timely, quality and appropriate inputs through rapid assessments/reviews to address priority implementation problems. During the first phase of the RAHI project, the UNFPA supported 12 health systems research projects in five low-performing states viz. Madhya Pradesh, Jharkhand, Chhattisgarh, Uttar Pradesh, and Orissa. During the second phase, another 12 health systems research projects from 6 low performing states viz. Uttar Pradesh, Uttarakhand, Madhya Pradesh, Jharkhand, Bihar and Rajasthan were taken up.

The rationale for supporting such rapid assessments stems from the discussions during the periodic Joint Review Missions and Common Review Missions. An impressive number of innovations have been supported by the states to improve access and enhance service quality. Many innovations are currently underway in the states and districts to deliver health care services in an effective manner. The state and district programme managers wish to know how well these innovations are performing so that in case of gaps corrective measures can be taken to achieve the stated objectives. There has been an increasing recognition for incremental improvements in the programme delivery by undertaking quick and rapid health systems research and engineering the feedback into the processes. As an institutional response to such demand an attempt

has been made to develop a network of institutions and strengthen their capacities on rapid appraisal methodologies for generating programme -relevant information at local and regional levels.

The rapid appraisal of some of the interventions taken up in the second phase of RAHI project covered the issues of contribution of indigenous system s of medicine in operationalisation of 24x7 services, interface of ASHAs with the co mmunity and service providers, logistics and supply management system of drugs at different levels, functioning of mobile medical units, birth preparedness and complication readiness as a tools to reduce MMR, quality assessment of institutional deliveries , performance-based incentives to ASHA Sahyogini, referral transport systems, functioning of programme management units, functioning of RKS, utilisation of untied funds at various levels and utilisation and client satisfaction of RCH service. A present report entitled "A Study of Interface of ASHA with the Community and the Service Providers in Eastern Uttar Pradesh" by the BRD Medical College, Gorakhpur, was finalized by NIHFW in consultation with the UNFPA.

Findings and recommendations of these studies will trigger of a series of follow-up measures by programme managers in the state. We strongly feel availability of such a resource to the programme managers will provide necessary evidence-based inputs enabling them to make any mid-Course corrections and also scaling up. An added benefit will be incorporation of information about newer programmatic interventions in the medical curriculum.

Dr. Dinesh Agarwal
National Programme Officer, UNFPA

Prof. Deoki Nandan
Director, NIHFW

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Limitations of words are felt most when we wish to acknowledge our gratitude. But even then words appear the best alternative.

This study would not have been possible without the blessings and dynamic leadership of Dr. Deoki Nandan, Director, National Institute of Health and Family Welfare, New Delhi and his team. I was, I am and I will always remain indebted to him for his continuous encouragement, constructive critical comments and continuous, careful monitoring and supervision. He is a real GURU and a continuous source of inspiration.

I am highly grateful to Dr. Rakesh Saxena, Principal and Dean, BRD Medical College, Gorakhpur, for his whole hearted support in all the activities related to health and welfare of the society. He was always with me, as a strong support during this study. I express my sincere gratitude Dr. V.K. Tiwari, Project Co-ordinator for his concern and continuous co-operation in solving the all types of problems encountered during this study.

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I am grateful to all the mothers along with other community members, ASHAs, AWWs, ANMs, MOICs and PRI members for their co-operation and support in this study. I am highly indebted to Dr. L. P. Rawat, Additional Director, Health and Family Welfare, Gorakhpur Division along with Dr. R.N. Mishra, CMO Gorakhpur and Dr. Ajay Kumar for their constant support and guidance during this study. I am very much thankful to Dr O.N. Pandey, Statistician-cum-Associate Prof. Department of Social and Preventive Medicine, B.R.D. Medical College, Gorakhpur for his suggestions and kind help in statistical analysis of data. I am highly thankful to Mr. Ramesh Sharma and Mr Dharmendra Puri, DEO for his day and night assistance in all types of work, particularly related to computer work.

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Last but not the least; I extend my deep sense of gratitude and devotion to almighty GOD along with my parents for helping me at each and every step of my life.

Dr. D.K. Srivastava
Principal Investigator

ABBREVIATIONS

ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwife
APL	Above Poverty Line
ASHA	Accredited Social Health Activist
AWC	Anganwadi Center
AWW	Anganwadi Worker
BEE	Block Extension Educator
BPL	Below Poverty Line
CHC	Community Health Center
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 Suraksha 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 Center
PNC	Post Natal Care
PRI	Panchayati Raj Institutions
RAHI	Rapid Assessment of Health Intervention
RNTCP	Revised National Tuberculosis Control Programme
RTI	Reproductive Track Infection
SC	Scheduled Caste
SHG	Self Help Group
SIHFW	State Institute of Health and Family Welfare
SNP	Supplementary Nutrition Programme
STI	Sexually Transmitted Infection
ST	Scheduled tribe
UGPHC	Upgraded Primary Health Center
VHAI	Voluntary Health Association of India
VHSC	Village Health and Sanitation Committee

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Executive Summary

Introduction

Most of the health indicators of Uttar Pradesh is too poor in comparison to other states. It is more so in rural areas and that's also specially in case of mother and child health. Due to this fact Government of India selected the state of Uttar Pradesh as one of the 18 states, where National Rural Health Mission (NRHM) has been launched in the first stage.

The Government of India has launched the National Rural Health Mission (2005 -2012) on 12 April 2005, throughout the country, to provide comprehensive integrated health care to the rural people, especially the vulnerable sections of the society, women and children. The Mission will provide special focus on 18 states, including the states of Uttar Pradesh, Madhya Pradesh, Bihar, Rajasthan, Orissa, Jharkhand, Uttaranchal, Chhattisgarh, Assam, Arunachal Pradesh, Manipur, Nagaland, Meghalaya, Mizoram, Sikkim, Tripura, Jammu and Kashmir and Himachal Pradesh where demographic indicators/ health infrastructure are weak.

The mission promises additional outlays for health, empowerment at state and district level, technical competencies and increased convergence of health with hygiene and sanitation. With the decentralization of the programmes and funneling of funds, it sets the stage for District Management of Health, akin to the Sarva Shiksha Abhiyan.

For the underserved poor in the village level, the Mission spells hope in the form of a voluntary trained community health activist (ASHA) equipped with a drug kit; improved hospital facility at CHC level measurable as per the Indian Public Health Standards (IPHS); availability of drugs for generic common ailments at health centres; access to universal immunization; referral and escort services for institutional delivery; nutrition and medical care at Anganwadi level on a monthly basis on the health day, and through mobile medical unit at district level and availability of household toilets. The final vision is provision of comprehensive community health insurance to cover financial risks related to medical costs.

Each stakeholder is an important link in the chain of delivery and has to be suitably equipped and motivated to capitalize on the opportunity provided by the Mission. One of the key strategies under the NRHM is having a community health worker that is **ASHA** *(Accredited Social Health Activist)* for every village with a population of 1000. The focal point in this mission is creation of a new band of village level social health activist designated as ASHA. These ASHAs has to be selected from the females of local community and by the local community as per prescribed guidelines. She should be preferably 25-35 years of age group and at least with a qualification of 8th class. They will work voluntarily, but they will be paid some incentives for different types of activities.

General Objective

Rapid appraisal of the functioning of ASHA in the community and her interface with community and service providers.

Specific Objectives

1. *To study the actual selection procedure of ASHA and her training.*
2. *To assess the knowledge and communication skills of the ASHA.*

3. *To study the acceptability of ASHA by the community and the service providers.*
4. *To study the functioning of ASHA and her co-ordination with different stack holders.*

Methodology

Data collection from ASHAs and mothers were done on pre-designed and pre-tested structured schedules whereas in case of others IDIs were conducted through pre-designed and pre-tested interview schedule with different stakeholders. FGDs were conducted at village/community level for the study. The scheme of data collection is presented below:

Sl. No.	Levels of data collection	Respondents	Methods of data collection	Instrument used
1	District	CMO	In-depth interview	Semi-structure interview Schedule
2	Block	MO	-do-	-do-
3	Sub-center	ANM	-do-	-do-
4	Village	AWW	-do-	-do-
5	Village	ASHA	Interview	Structured schedule
6	Village	Community (Mothers who have delivered in last six months)	Interview	-do-
7	Village	Community (SHG members, PRI members, beneficiaries, community leaders)	FGD	Guidelines

SALIENT FINDINGS

Almost all the ASHAs are resident of local community and so a very effective link person in the delivery of health services and good health massage. In general selection of ASHAs appeared to be fair. However FGD and IDI with some of the stakeholders indicated that involvement of community in selection process was not to the desired level and in some cases selection of ASHAs was just on the liking of Gram Pradhan.

All the ASHAs have been given seven days induction training. This training could not be followed by four, four days periodic induction training for about a year. So a twelve days training at one stretch has been given to the majority of the ASHAs. In general ASHAs are satisfied and happy with the training. But their perception about their job responsibilities appeared to be incomplete and improper. Majority of them were not aware about their role in changing the behaviour about infant feeding, family planning, child marriage, girl education, hand washing and sanitation. They were also not very much aware about their role in birth and death registration.

Most important motivational factor for the ASHAs were the financial gain and hope of being absorbed in government job. Monetary gain in majority of cases was very little and to receive even this money sometime needed extra effort. There was a general demand from all stakeholders for a regular monthly payment of Rs. one thousand to each ASHAs besides the job related incentives.

In general monitoring and supervision of ASHAs by MO through ANM and AWW was satisfactory. However in many areas ASHAs were not functioning properly and even their relation with ANM and AWW were not satisfactory. Village health and sanitation committee has not been established in many villages and even where it has been established regular meetings are not being held.

All the ASHAs have been accepted very well in the community and are acting as a link between community and health providers. The faith and confidence of community on ASHAs are reflected by the demand of additional jobs like help in getting widow pension and ration card etc.

Most of the ASHAs preferred helping in delivery and immunization. These activities are also associated with financial incentives. But many other jobs like promotion of awareness on hygiene and sanitation, counseling on family planning etc. were drawing lesser attention probably due to lack of incentives.

Non-availability of proper transport facility mainly for pregnant mothers along with irregular supply and replenishment of medicinal kits were major problems faced by ASHAs.

KEY RECOMMENDATIONS

The process of selection of ASHAs has been completed, but in few places they are non-functional. In such situations after proper scrutiny selection of new ASHAs as per guidelines and with active involvement of community should be done.

Training of ASHAs are neither as per norms nor regular. Training is the backbone of capacity building and functioning of ASHAs. So it must be done timely, properly and effectively. It has to be ensured during training that ASHAs are well aware about there job responsibilities and are capable to fulfil their job responsibilities.

A provision of a minimum of Rs. one thousand per month as stipend has been recommended by most of the stakeholders during their FGD or IDI, as a strong motivating factor.

ASHAs being a new incumbent in health system needs a lot of cooperation, coordination and supportive supervision from other stakeholders like MO, ANM, AWW and community. It is being done but it must be strengthened with regular meeting of ASHAs, ANMs and AWWs under the chairmanship of block medical officers. All the doubts and confusions may also be clarified in this meeting. Village health and sanitation committee must be established in every village and its regular meeting should be ensured. Community members must be involved in this committee, to seek their participation and cooperation in various activities related to making a healthy village.

Inspite of the crucial importance of education and counseling for hygiene and sanitation, exclusive breast-feeding, complimentary feeding, family planning, ORS use, preventing early marriage and gender discrimination etc. is not being found in the agenda of ASHAs. So its importance must be emphasized during training and other meetings.

The availability of medicinal kit with each ASHAs along with regular replenishment of items inside it must be ensured.

A provision of proper, well equipped one or two ambulance on call to transport the pregnant mothers and other serious patients must be made for each block. It can be done on private public partnership basis.

Limitations of Study

A larger sample area with periodic follow-up study will be more fruitful.

Future Areas of Research

Major health problems of different area may differ and so training need assessment should be made region-wise. A periodic evaluation of functioning of ASHAs should be done at least ones every year for timely rectifications.

CHAPTER 1

INTRODUCTION

1.1 Genesis of Study

In spite of good progress in various fields, the country could not make desired dent on the health status and development of common man, more so in rural areas. Due to this fact a lot of innovative efforts and interventions are being introduced in the field of health in the country.

So the programme manager at various levels, i.e., district, state and national level are very keen to know its real evidence-based impact on common man, which will help in timely modifications of such intervention measures.

With this background in mind, NIHFW apex institute on health of the country under the Government of India, with a support of UNFPA organized a five day workshop on capacity building for rapid appraisal of health interventions from 21st July to 25th July 2008.

I along with Dr. Shiv Prakash, Asst. Professor in my department, participated in this workshop to strengthen the capacity of our institution for rapid appraisal of health intervention.

1.2 Rationale of Selection of Topic

Most of the health indicators of the Uttar Pradesh is too poor in comparison to other states specially in Eastern Uttar Pradesh. It is more so in rural areas and that's also specially in case of mother and child health. Due to this fact Government of India selected the Uttar Pradesh as one of the 18 states, where National Rural Health Mission (NRHM) has been launched in the first stage.

The Government of India has launched the National Rural Health Mission (2005-2012) on 12 April 2005, throughout the country, to provide comprehensive integrated health care to the rural people, especially the vulnerable sections of the society, women and children. The Mission will provide special focus on 18 states, including the states of Uttar Pradesh, Madhya Pradesh, Bihar, Rajasthan, Orissa, Jharkhand, Uttaranchal, Chhattisgarh, Assam, Arunachal Pradesh, Manipur, Nagaland, Meghalaya, Mizoram, Sikkim, Tripura, Jammu and Kashmir and Himachal Pradesh where demographic indicators/ health infrastructures are weak.

The Mission promises additional outlays for health, empowerment at State and district level, technical competencies and increased convergence of health with hygiene and sanitation. With the decentralization of the programmes and funneling of funds, it sets the stage for district management of health, akin to the Sarva Shiksha Abhiyan.

For the underserved poor at the village level, the Mission spells hope in the form of a voluntary trained community health activist (ASHA) equipped with a drug kit; improved hospital facility at CHC level measurable as per the Indian Public Health Standards (IPHS); availability of drugs for generic common ailments at health centres; access to universal immunization; referral and escort services for institutional delivery; nutrition and medical care at Anganwadi level on a monthly basis on the health day, and through mobile medical unit at district level and availability of household toilets. The final vision is provision of comprehensive community health insurance to cover financial risks related to medical costs.

Each stakeholder is an important link in the chain of delivery and has to be suitably equipped and motivated to capitalize on the opportunity provided by the Mission. One of the key strategies under the NRHM is having a community health worker that is **ASHA** (Accredited Social Health Activist) for every village with a population of 1000. The focal point in this mission is creation of a new band of village level social health activist designated as ASHA. These ASHAs has to be selected from the females of local community and by the local community as per prescribed guidelines. She should be preferably 25-35 years of age group and at least with a qualification of 8 th class. They will work voluntarily, but they will be paid some incentives for different types of activities.

1.3 Services Expected from ASHAs

1. Primary medical care with her kit.
2. Control of diseases by information, education, sanitation and surveillance.
3. Service to women – ANC, INC, PNC.
4. Counseling on FP, safe abortion etc.
5. Child Immunization and Vitamin A supplementations.
6. Change in behaviour in BF, CF, birth spacing, sex discrimination, child marriage, girls education, care of the child especially newborn.
7. Household survey.
8. Collaborating with health functionaries.
9. Working with community for disease control.

Table 1.1 : Service Related Incentives of ASHA

<table>
<tr><td>1</td><td colspan="2">JSY</td><td>Rs 600/- (for ASHA-200, for transport 250, Food 150/-)</td></tr>
<tr><td>2</td><td colspan="2">Sterilization</td><td>Rs 250 (for ASHA as motivator and case follow-up)</td></tr>
<tr><td>3</td><td colspan="2">RI social mobilization</td><td>Rs. 150/- day</td></tr>
<tr><td>4</td><td colspan="2">PPI</td><td>Rs 50/- day</td></tr>
<tr><td>5</td><td colspan="2">Immediate PP care and BF</td><td>Rs 50/- case</td></tr>
<tr><td>6</td><td colspan="2">Complete RI + vit A</td><td>100/- child</td></tr>
<tr><td>7</td><td colspan="2">Registration of births and Deaths</td><td>Rs 5/-</td></tr>
<tr><td>8</td><td colspan="2">Complete DOTS treatment</td><td>250/-</td></tr>
<tr><td rowspan="2">9</td><td rowspan="2">Complete leprosy Treatment</td><td>Pauci</td><td>300/-</td></tr>
<tr><td>Multi</td><td>500/-</td></tr>
<tr><td>10</td><td colspan="2">Refraction and class to child</td><td>25/-</td></tr>
<tr><td>11</td><td colspan="2">Cataract operation and follow-up</td><td>50/-</td></tr>
<tr><td>12</td><td colspan="2">Two monthly meeting</td><td>Rs.100/- per meeting</td></tr>
</table>

Need of a village level local health worker was realized since very long. However Srivastava Committee on Medical Education and manpower constituted in 1975, and on the basis of its report, reorientation of medical education was launched along with rural health scheme. In this scheme village level health worker known as community health guide and trained birth attendant were trained. In 1975, Ministry of Social and Women Welfare started integrated child development service scheme, in which also a village level female worker known as Aanganwadi worker were selected for 1000 population. China, Thailand, Indonesia and Peru have had such programmes successfully.

Now under the NRHM the new cadre of ASHAs are under the selection and training process. About One million ASHAs are expected all over the country by the end of Mission period 2005-2012.

In UP, NRHM was launched on 7th September 2005. UP with a population of 1 82 million, only 5 countries in the world are having more population than UP and therefore it needs more resources and special efforts to make required dent. More than 1.25 lacs of ASHA have been selected in UP. NRHM has a commitment to make each village h ealthy and happy by providing the benefit of all the National Health Program mes by the health providers to the rural areas with the help of ASHA.

To perform their duties properly, ASHAs will need some specific knowledge and skills. It will be provided to them through induction training of 7 days and periodic trainings of 4 -4 days in 4 phases at the interval of 2 months. ASHA start their work just after induction training of 7 days and contact with village Panchayat.

So it is very well clear that success of this programme is to a large extent primarily dependent on the functional efficacy of ASHA as the grassroot social and health activist. Her efficacy will depend on many factors like her own educational and social background, attitude, aptitude, relationship with other health functionaries like AWW, ANM, other PHC staff, relationship with PRI members and acceptance of ASHA by the community.

But proper and effective training can improve all these factors.

Therefore this study was planned during the wo rkshop with following objective :

1.4 General Objective

Rapid appraisal of the functioning of ASHA in the community and her interface with community and service providers.

1.5 Specific Objectives

1. To study the actual selection procedure of ASHA and her training.
2. To assess the knowledge and communication skills of the ASHA.
3. To study the acceptability of ASHA by the community and the service providers.
4. To study the functioning of ASHA and her co-ordination with different stake-holders.

CHAPTER 2

METHODOLOGY

Type of Study : Descriptive (observational)
Study Design : Cross-sectional
Study Area : Gorakhpur and Maharajganj district of Eastern UP
Study Period : November 2008
Study Subjects
- ASHAs
- AWWs
- ANMs
- Medical Officers in-charge (MOs-I/c)
- Chief Medical Officers (CMOs)
- PRI members
- Members of the community (Beneficiary)
- SHG members

2.1 Sampling Design

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

2.2 Scheme of Sample Selection

Table 2.1 : Scheme of Sample Selection

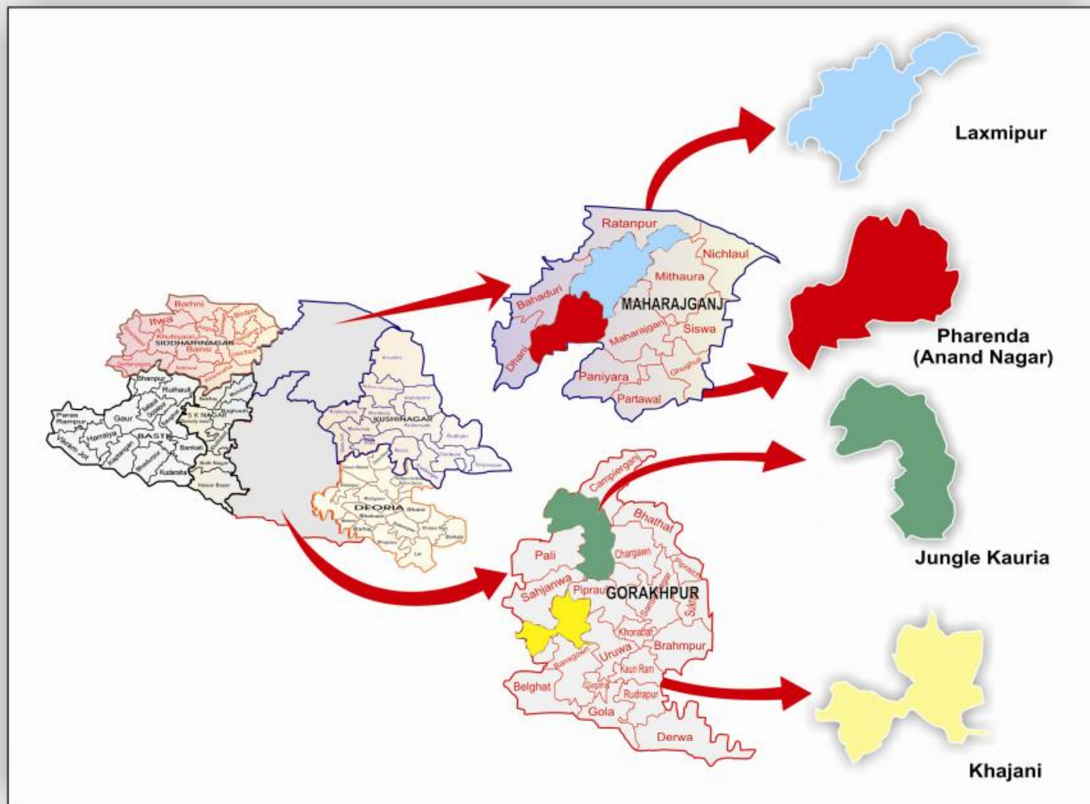
Sl. No.	Stage of selection	Method of selection	No. of units	Remark
1	District	Purposive	2	1 old district and other newer district
2	Block	Purposive	4	2 from each district. 1 nearer and other far from the district headquarters
3	CMO	Purposive	2	CMOs of the respective sample districts
4	MO	Purposive	4	MOs of respective block PHCs and CHCs
5	ANM	Random	20	5 from each PHC/CHC area
6	ASHA	Random	60	3 from each sub-centre
7	AWWs	Random	20	From selected sub-centre
8	Mothers	Random	120	From selected ASHA villages
9	FGD	Random	20	From selected sub-centre

2.3 List of Selected Study Area

Table 2.2: List of Selected Study Area

Sl. No.	District	Block	Sub-centre
1	Gorakhpur	Khajni	Uswa, Shahidabad, Chatai, Katghar, Aauji
		Jungle Kaudia	Jungle Kaudia, Kewar loa, Ahirauli, Kolhua, Naya Gaon
2	Maharajganj	Laxmipur	Mudli, Puranderpur, Singhpur Dharauli, Laxmipur, Jungle Gulharia
		Pharenda	Lejar Mahadewa, Pharenda Bujurg, Manikaura, Semra Maharaj, Jhamat

2.4 The Study Area has been Highlighted in Map



2.5 Data Collection Tools

Data collection from ASHAs and mothers were done on pre-designed and pre-tested structured schedules whereas in case of others IDIs were conducted through pre -designed and pre-tested interview schedule with different stakeholders. FGDs were conducted at village/community level for the study. The scheme of data collection is presented below:

2.6 Scheme of Data Collection

Table 2.3: Scheme of Data Collection

Sl. No.	Levels of data collection	Respondents	Methods of data collection	Instrument used
1	District	CMO	In-depth interview	Semi-structure interview Schedule
2	Block	MO	-do-	-do-
3	Sub-centre	ANM	-do-	-do-
4	Village	AWW	-do-	-do-
5	Village	ASHA	Interview	Structured Schedule
6	Village	Community (Mothers who have delivered in last six months)	Interview	-do-
7	Village	Community (SHG members, PRI members, beneficiaries, community leaders)	FGD	Guidelines

2.7 Organization of Fieldwork

A team consisting of supervisors, field investigators and data entry operators were selected after proper scrutiny and interview. A total of four supervisors, eight field investigators and two data entry operators were selected for data collection and compilation on purely temporary contractual basis. All of them were properly and intensively trained for three days that is on eleventh, twelfth and 31st October 2008. This training was both classroom as well as field level. Supervisors also helped in development and pre-testing of study tools. They also helped in route mapping of selected sites, to avoid the inconvenience in searching the sites at the time of data colle ction.

Principal investigator and co-principal investigator also visited the study area well before data collection procedure in the field to seek cooperation of concerned authorities and respondents.

Two teams, each consisting of two supervisors and four investigators were constituted for field work. One helper along with driver and vehicle was attached with each team. Both the teams visited the different study sites and collected the data from study subjects on pre - formed and pre-tested data collection tools.

2.8 Ethical Clearance

The project structure was examined and cleared by ethical committee of the Institution Review Board at NIHFW for ethical considerations.

2.9 Quality Assurance

In order to ensure the quality of the data the Principal Inve stigator (P.I)/Co P.I scrutinized that information collected through interviews. They conducted the FGDs at the village level and in-depth interview of senior officials.

CHAPTER 3

FINDINGS AND DISCUSSIONS

The data collected through various instruments at district, block and village level from functionaries like CMOs, Medical Officers, ANMs, ASHAs, AWWs and community has been analyzed, triangulated and discussed in this chapter.

3.1 Profile of ASHA

i. Age: Age distribution showed that more than half (53.33%) of ASHAs were in the age group 20-29 years, very few (6.67%) were above 40 years and none below 20 years. This trend was more marked in district Maharajganj than Gorakhpur. Thus we can say that majority of the ASHAs may be considered young and it was more marked in district Maharajganj with 59.38% in 20-29 years age group. This may be a strength for programme as they are energetic and enthusiastic and may deliver better service with proper motivation and capacity building.

Table 3.1.1 : Age Distribution of ASHA

District	Gorakhpur				Maharajganj				Grand total	%
Blocks	**Khajni**	**Jungle Kauria**			**Laxmi-pur**	**Phare- nda**				
Age	**No.**	**No.**	**Sub Total**	**%**	**No.**	**No.**	**Sub Total**	**%**		
<20	0	0	0	0	0	0	0	0	0	0
20-29	6	7	13	46.43	9	10	19	59.38	32	53.33
30-39	6	7	13	46.43	5	6	11	34.38	24	40
>= 40	1	1	2	7.14	2	0	2	6.25	4	6.66
Total	**13**	**15**	**28**	**100**	**16**	**16**	**32**	**100**	**60**	**100**

ii. Educational Background: It is an important criterion of the capability of an individual for capacity building and performance. Most of the ASHAs (>90%) were having a qualification between 8th to 12th class; which is sufficient for their proper learning and performance as ASHA.

Table 3.1.2 : Educational Status Distribution of ASHA

District	Gorakhpur				Maharajganj				Grand total	%
Blocks	**Khajni**	**Jungle Kauria**			**Laxmi-pur**	**Phare-nda**				
Educational Status	**No.**	**No.**	**Sub Total**	**%**	**No.**	**No.**	**Sub Total**	**%**		
< 5th	3	1	4	14.29	0	0	0	0	4	6.66
5-7th	0	0	0	0	0	0	0	0	0	0
8-10th	6	11	17	60.71	13	11	24	75	41	68.33
Inter	4	3	7	25	3	4	7	21.88	14	23.33

Graduate	0	0	0	0	0	1	1	3.125	1	1.66
PG	0	0	0	0	0		0	0	0	0
Total	**13**	**15**	**28**	**100**	**16**	**16**	**32**	**100**	**60**	**100**

iii. Caste: The caste composition of ASHA showed roughly equal distribution between SC (38.33%), OBC (35%) and General (26.67%), very well representing the s ocial structure of representative area. It appears to serve the society in a better way.

Table 3.1.3 Caste Distribution of ASHA

District	**Gorakhpur**				**Maharajganj**				**Grand total**	**%**
Blocks	**Khajni**	**Jungle Kauria**			**Laxmi-pur**	**Phare-nda**				
Caste ↓	**No.**	**No.**	**Sub Total**	**%**	**No.**	**No.**	**Sub Total**	**%**		
SC	6	4	10	35.71	4	9	13	40.63	23	38.33
OBC	2	7	9	32.14	7	5	12	37.5	21	35
General	5	4	9	32.14	5	2	7	21.88	16	26.66
Total	**13**	**15**	**28**	**100**	**16**	**16**	**32**	**100**	**60**	**100**

iv. Marital Status: Almost all the ASHAs were married except two, out of whom one was widow and other one separated.

Table 3.1.4 Marital Status Distribution of ASHA

District	**Gorakhpur**				**Maharajganj**				**Grand total**	**%**
Blocks	**Khajni**	**Jungle Kauria**			**Laxmi-pur**	**Phare-nda**				
Marital Status	**No.**	**No.**	**Sub Total**	**%**	**No.**	**No.**	**Sub Total**	**%**		
Married	13	14	27	96.43	15	16	31	96.88	58	96.66
Widow	0	1	1	3.571	0	0	0	0	1	1.66
Separated	0	0	0	0	1	0	1	3.125	1	1.66
Total	**13**	**15**	**28**	**100**	**16**	**16**	**32**	**100**	**60**	**100**

More than half (61.67%) of ASHAs belonged to below poverty line. It is also an indicator of poverty status of rural areas of this region and the selection of ASHA from the poorer segment of the society.

TABLE3.1.5 : Economic Status Distribution of ASHA

District	Gorakhpur				Maharajganj				Grand total	%
Blocks	Khajni	Jungle Kauria			Laxmi-pur	Phare-nda				
Economic Status	No.	No.	Sub Total	%	No.	No.	Sub Total	%		
BPL	8	10	18	64.29	8	11	19	59.38	37	61.66
APL	5	5	10	35.71	8	5	13	40.63	23	38.33
Total	**13**	**15**	**28**	**100**	**16**	**16**	**32**	**100**	**60**	**100**

3.2 Selection Procedure of ASHAs

The guideline for selection criteria of ASHA envisages that she should be married/widow/ divorced and resident of that village having an age limit of 25-45 years and educational qualification of 8th standard pass. In case the education criteria can't meet, the same can be reduced up to 5th standard. The selection process envisages that CMO is the District Nodal Officer (DNO) and MO I/C of PHC/CHC is the Block Nodal Officer for the selection of ASHA. The MO and CDPO will appoint block level facilitator. The AWW, ANM 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 ASHA. ANM at the community level will conduct a meeting where AWW, presidents/secretaries of all the SHGs will participate. Each SHG will propos e a name for ASHA. All the names will be discussed and the most suitable candidate will be selected as ASHA 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 no dal officer along with the proceeding of meeting.

The views of CMOs, MOs corroborated that the selection criteria and selection process as per guideline have been adopted. The ANM's role is crucial in the selection process. All were aware of the selection procedure, had received guidelines and were able to detail out the selection procedure. However MO and CMO in their interview accepted about some push, pull and pressure during selection process but all these were managed effectively, showing that all the power of selection rest with village panchayat.

On probing the various members of selection process, it was revealed that each ANM acted as facilitator for 10-12 villages and she gave the name of three candidates from each village with the help from various community members, as per guidelines given to her. Out of these candidates, Gram Pradhan, after consultation with others, recommended just one name per village to MO/C for final selection and training.

Majority of the AWW were aware about the selection process of ASHA, except four AWW who were not aware about selection process.

In order to triangulate the selection procedure, it is pertinent to look at the education, qualification and marital status of ASHAs. The education and qualification reveale d that most of them were of 8th or more class passed and very few (about 5%) were up to 5th class because of non-availability of suitable candidates. The residential status and marital status revealed clear adherence to the guideline.

All these facts clearly indicated that the selection process of ASHA in the villages wer e by and large fair and rational along with involvement of community. However in some cases it was only the liking of Pradhan as narrated by some members in FGD.

Further, when ASHAs were asked about their process of selection, the responses pointed towards the adherence of guideline.

In about half of the villages (43.33%) there was no other proper candidate s for selection. In most of the villages (61.67%) there was not a single self -help group and only 20% selected ASHA were members of self-help group. We can say that it is a reflection of poor social awareness and activities in the rural areas of eastern U.P.

Majority of the AWW (93.33%) were aware about the selection process of ASHA, except four (6.66%) AWW who were not aware about selection process. They think that in about half the villages (43.33%) there were no other proper candidates for selection. Only 48.33% were of the view that there was proper candidate for selection for the post of ASHA.

Self Help Group in the Village

In most of the villages (61.67%) there was not a single self help group . However in 16.66% of villages there was one self-help group.

Table 3.2.3 : No. of Self Help Group in the Village

District	Gorakhpur				Maharajganj				Grand total	%
Blocks	Khajni	Jungle Kauria			Laxmi-pur	Phare-nda				
No. of SHG	No.	No.	Sub Total	%	No.	No.	Sub Total	%		
0	7	8	15	53.57	8	14	22	68.75	37	61.66
1	3	3	6	21.43	3	1	4	12.5	10	16.66
2	2	2	4	14.29	3	1	4	12.5	8	13.33
3	0	1	1	3.57	2	0	2	6.25	3	5
4	0	1	1	3.57	0	0	0	0	1	1.66
> 4	1	0	1	3.57	0	0	0	0	1	1.66
Total	**13**	**15**	**28**	**100**	**16**	**16**	**32**	**100**	**60**	**100**

And only 20% selected ASHA were members of self help group. We can say that it is a reflection of poor social awareness and activities in the rural areas of eastern U.P.

Table 3.2.4: ASHA as Member of SHG

District	Gorakhpur				Maharajganj				Grand total	%
Blocks	Khajni	Jungle Kauria			Laxmi-pur	Phare-nda				
ASHA as member of SHG	No.	No.	Sub Total	%	No.	No.	Sub Total	%		
Yes	2	6	8	28.57	2	2	4	12.5	12	20
No	11	9	20	71.43	14	14	28	87.5	48	80
Total	**13**	**15**	**28**	**100**	**16**	**16**	**32**	**100**	**60**	**100**

3.3 Training of ASHA

Given the educational background, the socio-economic situation and the nature of ASHA job responsibility, her capacity building through training is most important and crucial to achieve the objective of the scheme. The scheme envisages three pronged strategy i.e. induction training followed by a periodic training, and on the job training. The induction training proposed under the scheme is for 23 day over a period of twelve month. The first round may be of 7 days is to be followed by another 4 rounds of training, each lasting for 4 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 ASHAs.

The induction training will be followed by periodic training for about two days, once in every alternative month for all the 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 career. This can be done through the ANM s, NGOs and block facilitators.

The process of training of ASHAs was evaluated by interviewing the ASHAs, CMOs, MOs and ANMs. All the ASHAs were imparted induction training for a period of 7 days at places like block and district. The 2nd phase of induction training could not be attended by about 13% of the ASHAs.

The 2nd phase of induction training was completed for duration of 12 days at a stretch after an interval of about one year after first phase induction training. This have deviated the philosophy of 2nd phase of induction training, which was supposed to be conducted at 4 instances of 4 days duration each. This must have hindered the optimal output from the training.

Almost all the ASHAs admitted that the training was sufficient, satisfactory and beneficial. All the trainees were given the training modules and they had gone through them. Majority (96.67%) were paid stipend for the training, but two did not receive the stipend due to some reason.

3.4 Views of ASHAs about Training Received

All ASHAs in both the districts said that they have undergone induction training of 7 days. They were of the view that the induction training was sufficient. They gained adequate knowledge in the training. All of them were satisfied with the training. Albout 86.66% of the ASHA received the second training and only 13.33% of the ASHA were not able to receive the second training. Training modules have been given to all. All of them read the training module. About 96.66% of the ASHA received the money during the training. Only two of them (3.33%) did not received any money during the training.

The synthesis of the views of the health functionaries like CMOs, MOs and ANMs unanimously reflect further need of training of the ASHAs. They emphasized upon time -to-time refresher training in the areas like mother and child health, anemia, malaria, leprosy and TB.

3.5 Sustenance and Motivational Factors

The sustenance of the programme depends upon the long-term motivational factors for the ASHAs to keep her going with spirit and enthusiasm. In order to analyze this aspect, factors such as job satisfaction, compensation, recognition and utility of her job were considered. Besides two other important factors for her sustenance like training and capacity building; monitoring and supervision have also been analyzed and discussed in the next section. Factors related to job satisfaction and recognition has also been studied.

Major motivating factor for ASHAs were either money (81.66%) or absorption in government job (66.66%). However some were also interested in charity (43.33%) and improvement in self-esteem (36.66%).

Table 3.6.1: Motivating Factors for ASHA

District	**Gorakhpur**				**Maharajganj**					
Blocks	**Khajni**	**Jungle Kauria**			**Laxmi-pur**	**Phare-nda**			**Grand total**	**%**
Motivating factors	**No.**	**No.**	**Sub Total**	**%**	**No.**	**No.**	**Sub Total**	**%**		
Absorption in government job	8	10	18	64.28	10	12	22	68.75	40	66.66
Earning money	11	12	23	82.14	13	13	26	81.25	49	81.66
Serving society	7	8	15	53.57	5	6	11	34.37	26	43.33
Self-esteem improvement	5	5	10	35.71	7	5	12	37.50	22	36.66

About one-third of ASHAs were earning more than Rs.800 per month whereas one-third were earning less than Rs. 400 per month, showing the varying capability of ASHAs .

Table 3.6.2: Amount of Monthly Stipend Received

District	Gorakhpur				Maharajganj					
Blocks	**Khajni**	**Jungle Kauria**			**Laxmi-pur**	**Phare-nda**			**Grand total**	**%**
Monthly Stipend	**No.**	**No.**	**Sub Total**	**%**	**No.**	**No.**	**Sub Total**	**%**		
<200	5	3	8	28.57	2	3	5	15.63	13	21.66
200-400	2	0	2	7.143	2	3	5	15.63	7	11.66
400-600	2	4	6	21.43	4	3	7	21.88	13	21.66
600-800	2	3	5	17.86	1	1	2	6.25	7	11.66
>800	2	5	7	25	7	6	13	40.63	20	33.33
Total	**13**	**15**	**28**	**100**	**16**	**16**	**32**	**100**	**60**	**100**

A good number of ASHAs (25%) conveyed about the extra efforts (monitory gratification etc.) to get their incentives.

Table 3.6.4: Extra Effort to Get the Stipend

District	Gorakhpur				Maharajganj					
Blocks	**Khajni**	**Jungle Kauria**			**Laxmi-pur**	**Phare-nda**			**Grand total**	**%**
Extra effort to get the stipend	**No.**	**No.**	**Sub Total**	**%**	**No.**	**No.**	**Sub Total**	**%**		
Yes	1	6	7	25	6	2	8	25	15	25
No	12	9	21	75	10	14	24	75	45	75
Total	**13**	**15**	**28**	**100**	**16**	**16**	**32**	**100**	**60**	**100**

Table 3.6.5: Details of Extra Effort to Get the Stipend

District	Gorakhpur				Maharajganj					
Blocks	**Khajni**	**Jungle Kauria**			**Laxmi-pur**	**Phare-nda**			**Grand total**	**%**
What Extra effort	**No.**	**No.**	**Sub Total**	**%**	**No.**	**No.**	**Sub Total**	**%**		
N A/Do not Know	10	9	19	67.86	13	15	28	87.5	47	78.33
Do not received	1	2	3	10.71	2	1	3	9.375	6	10
Bribe	2	4	6	21.43	1	0	1	3.125	7	11.66
Total	**13**	**15**	**28**	**100**	**16**	**16**	**32**	**100**	**60**	**100**

Majority of the ASHAs (71.66%) were satisfied with their incentives. However a good proportion (43.33%) were ready to serve even without incentives.

Table 3.6.6: Satisfaction with the Stipend

District	Gorakhpur				Maharajganj					
Blocks	**Khajni**	**Jungle Kauria**			**Laxmi-pur**	**Phare-nda**			**Grand total**	**%**
Satifaction with the stipend	**No.**	**No.**	**Sub Total**	**%**	**No.**	**No.**	**Sub Total**	**%**		
Yes	4	5	9	32.14	4	4	8	25	17	28.33
No	9	10	19	67.86	12	12	24	75	43	71.66
Total	**13**	**15**	**28**	**100**	**16**	**16**	**32**	**100**	**60**	**100**

Table 3.6.7: Willingness to Work Without Stipend

District	Gorakhpur				Maharajganj					
Blocks	**Khajni**	**Jungle Kauria**			**Laxmi-pur**	**Phare- nda**			**Grand total**	**%**
Willingness to work without Stipend	**No.**	**No.**	**Sub Total**	**%**	**No.**	**No.**	**Sub Total**	**%**		
Yes	2	7	9	32.14	11	6	17	53.13	26	43.33
No	6	5	11	39.29	4	7	11	34.38	22	36.66
Payment on time	5	3	8	28.57	1	3	4	12.5	12	20
Total	**13**	**15**	**28**	**100**	**16**	**16**	**32**	**100**	**60**	**100**

The people primarily inspiring them to work as ASHA were Gram Pradhan (53.33%), family members (33.33%) and ANMs (23.33%). All the ASHAs accepted that their reputation has gone up in their village. Almost all (95%) agreed that patients referred by them got priority in health centres and hospitals. Majority (83.33%) of the ASHAs realized their job responsibility as very important. People enumerated to be of major help in their job were mainly ANM/AWW (63.33%) and medical officers/hospital staff (28.33%).

Table 3.6.8: Inspirational Force Behind ASHA

District	Gorakhpur				Maharajganj					
Blocks	**Khajni**	**Jungle Kauria**			**Laxmi-pur**	**Phare-nda**			**Grand total**	**%**
Who inspired you	**No.**	**No.**	**Sub Total**	**%**	**No.**	**No.**	**Sub Total**	**%**		
Pradhan	2	15	17		5	10	15		32	53.33
Husband/ Family members	4	5	9		6	5	11		20	33.33
ANM	6	2	8		4	2	6		14	23.33
Self	1	1	2		2	7	9		11	18.33

Villagers	1	0	1		1		1		2	3.33
Others	0	2	2		1	2	3		5	8.333

All the ASHAs were of the view that their reputation in the village has been increased after getting this job. All were agreed that the patients get priorities when referred by them to PHCs. All the ASHAs were also of the view that villagers appreciate you as an assistant. And they (83.33%) think that their responsibility is very important. Only 16.66% of the ASHAs were of the view that their responsibility is average.

Table 3.6.9 : Person Responsible for Betterment of ASHA's Work

District	**Gorakhpur**				**Maharajganj**					
Blocks	**Khajni**	**Jungle Kauria**			**Laxmi-pur**	**Phare-nda**			**Grand total**	**%**
	No.	**No.**	**Sub Total**	**%**	**No.**	**No.**	**Sub Total**	**%**		
ANM/AWW	10	8	18		10	10	20		38	63.33
MO/Hospital staff	4	7	11		4	2	6		17	28.33
Villagers	1	4	5		0	0	0		5	8.333
Pradhan	2	3	5		1	1	2		7	11.66
NGO	2	0	2		5	3	8		10	16.66
Family members/ others	2	3	5		0	2	2		7	11.66

Regular replacement of essential supply was found with 65% ASHAs .

Table 3.6.10 : Getting Essential Supply of ASHA's Need

District	**Gorakhpur**				**Maharajganj**					
Blocks	**Khajni**	**Jungle Kauria**			**Laxmi-pur**	**Phare-nda**			**Grand total**	**%**
Getting essential supply	**No.**	**No.**	**Sub Total**	**%**	**No.**	**No.**	**Sub Total**	**%**		
Yes	9	8	17	60.71	9	13	22	68.75	39	65
No	4	5	9	32.14	7	3	10	31.25	19	31.66
Sometimes	0	2	2	7.14	0	0	0	0	2	3.33
Total	**13**	**15**	**28**	**100**	**16**	**16**	**32**	**100**	**60**	**100**

Support is another important factor for sustenance. The community members unanimously found the role of ASHA very useful for them. All the motivational factors including adequate compensation, skill upgradation and capability are conducive for the sustenance of the programme in the long run. The ASHA is playing an important and crucial role and

has a potential 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 emerged from most of the FGDs were that the compensation of ASHA, in comparisons to her contribution is quite meager. Further capacity building and more compensation would encourage her to do the job with enthusiasm and spirit.

3.6 Views of ASHAs Regarding Motivational Factors Related to Job Satisfaction and Recognition

Table 3.6.11: Monthly Stipend Received From

District	**Gorakhpur**				**Maharajganj**					
Blocks	**Khajni**	**Jungle Kauria**			**Laxmi-pur**	**Phare-nda**			**Grand total**	**%**
Monthly Stipend received from	**No.**	**No.**	**Sub Total**	**%**	**No.**	**No.**	**Sub Total**	**%**		
None	1	0	1		0	0	0		1	1.66
Don't know	1	0	1		0	0	0		1	1.66
MO/IC	5	2	7		5	2	7		14	23.33
Clerk	4	8	12		3	1	4		16	26.66
ANM/AWW	1	0	1		2	4	6		7	11.66
Supervisor	1	5	6		4	6	10		16	26.66
Others	0	0	0		2	0	2		2	3.33

Interface with the Community

3.7 Social Acceptance and Community Support

The ASHA has to work in the community for the rural poor. She has to motivate every household and generate awareness in the community for ANC, PNC, safe delivery practices, immunization, importance of breast-feeding, family planning and sanitation etc. Her work will be accomplished if she is well accepted and supported by the community. Twenty FGDs that were conducted, indicated that ASHAs were well accepted in the community and considered as a friend to the household especially for the pregnant and lactating mothers and children.

The interview with ASHA also captured certain points to probe into the acceptability of ASHA in the community.

3.8 Community Acceptance

All the ASHAs were of the view that people of all castes and religion call her for services. 95% of the ASHA were of the view that all the households call her for services. Only 5% of the ASHAs were of the view not all that all the households call her for services. The reason for this was not given by her. This shows that all the ASHAs were acceptable to all castes and religion and most (95%) of them were being called by all types of households.

Table 3.8.1: Meeting in the Village

District	Gorakhpur				Maharajganj				Grand total	%
Blocks	Khajni	Jungle Kauria	Grand total	%	Laxmi-pur	Phare-nda				
Meeting conduction	No.	No.	Sub Total	%	No.	No.	Sub Total	%		
Yes	13	15	28	100	16	16	32	**100**	60	100
No	0	0	0	0	0	0	0	0	0	0
Total	**13**	**15**	**28**	**100**	**16**	**16**	**32**	**100**	**60**	**100**

Table 3.8.2: People Attended the Meeting

District	Gorakhpur				Maharajganj				Grand total	%
Blocks	Khajni	Jungle Kauria	Grand total	%	Laxmi-pur	Phare-nda				
People attended the meeting	No.	No.	Sub Total	%	No.	No.	Sub Total	%		
All	5	3	8	28.57	10	7	17	53.13	25	41.66
Some people	8	8	16	57.14	6	9	15	46.88	31	51.66
Very few	0	4	4	14.29	0	0	0	0	4	6.66
Total	**13**	**15**	**28**	**100**	**16**	**16**	**32**	**100**	**60**	**100**

All the ASHAs were conducting the meeting and in about 41.66% of the meetings it was well attended.

3.9 Monitoring, Supervision and Co-ordination

The mechanism of monitoring and supervision of the work of ASHA was assessed through the in-depth interview of the CMOs, MOs and ANMs. Besides, ASHAs were also interviewed about the monitoring process.

CMOs and MOs monitor the work of ASHA through the health functionaries in the hierarchy. According to them ASHAs and ANMs have a good co-ordination. ASHA is

acting as a supporting hand to the ANM and AWW and they in turn act as a guide to the ASHA. That is strengthening the delivery of services.

All the 4 MOs stated that they have control over ASHA and they mon itor their work. All of them have felt that the ASHA and ANM, ASHA and AWW work in coordination with each other mostly in the registration of pregnant women, ANC/PNC, immunization and safe delivery. The AWW, ASHA and ANM were working together in different national health programmes.

In most of the ASHAs (93.33%) villages there were Aanganwadi centers and ASHAs were having a good relationship with Aanganwadi Worker and known to her very well. People enumerated as supervisors by ASHAs are mainly ANM (75%), medical officers (30%) and AWW (16.66%). Most of the ASHAs (86.66%) go t the support from these supervisors in solving their problem and majority of them (95%) were satisfied with there supervisors .

Table 3.9.1: Supervision of ASHA

District	Gorakhpur				Maharajganj				Grand total	%
Blocks	**Khajni**	**Jungle Kauria**	**Grand total**	**%**	**Laxmi-pur**	**Phare-nda**				
Supervision of ASHA	**No.**	**No.**	**Sub Total**	**%**	**No.**	**No.**	**Sub Total**	**%**		
AWW	3	0	3		6	1	7		10	16.66
ANM	11	11	22		12	11	23		45	75
MO	6	3	9		5	4	9		18	30
PRI	2	1	3		1	1	2		5	8.33
Supervisor	0	1	1		1	1	2		3	5
Others	2	1	3		2	1	3		6	10

86.66% of the ASHAs told that the supervisor solved their problems, 10% of the ASHAs were of the view that the supervisor don't solved their problems and only 3.33% of the ASHAs were of the view that the supervisor sometimes solved their problems. 20% of the ASHAs told they solved their problems personally, 73.33% of the ASHAs told they solved their problems officially, 3.33% of the ASHAs told they solved their problems personally as well as officially and 3.33% of the ASHAs had no response to this question. Most of the ASHAs were satisfied from this work only 3 of them (5%) were not satisfied from this work.

3.10 Activities Undertaken by ASHA

Most Preferred Activities

The majority (73.33%) of the ASHAs have pointed out that most preferred activities for them were taking children to ANM for immunization followed by helping in delivery (56.66%) and family planning (53.33%).

Table 3.10.1: Distribution of Work Expectation from ASHA

District	Gorakhpur				Maharajganj				Grand total	%
Blocks	Khajni	Jungle Kauria	Grand total	%	Laxmi-pur	Phare-nda				
	No.	No.	Sub Total	%	No.	No.	Sub Total	%		
Help in delivery	4	7	11		12	11	23		34	56.66
Family planning	6	7	13		10	9	19		32	53.33
Immunization	8	11	19		11	14	25		44	73.33
Taking patients to health centre	6	1	7		1	0	1		8	13.33
Birth and death registration	1	0	1		2	0	2		3	5
Educating people about nutrition	4	5	9		4	0	4		13	21.66
Sending to pre. mother to health centre under JSY	1	3	4		0	0	0		4	6.66
Distribution of medicines	4	3	7		2	6	8		15	25
Widow/ration card	1	1	2		1	0	1		3	5

In query to their job perception, majority of the ASHAs enumerated helping in delivery (56.60%), family planning (53.33%), immunization (73.33%), medicine distribution (25%) and nutritional education (21.66%).

Most important activities performed by the ASHAs were helping in immunization (83.33%), keeping record of pregnant women (43.33%), escor ting pregnant women for delivery (36.66%) and distributing the medicines (56.66%). However job preferred by them were immunization and family planning (63.33%) followed by helping in delivery (56.66%).

Most of the ASHAs (96.66%) felt that villagers were happy with them but most of them (71.66%) informed that villagers were expecting additional jobs like help in getting widow pension, ration card etc. There was more demand of medicines as enumerated by many ASHAs.

Most of the ASHAs expected more incentives, more means and better means of transportation for patients, for the improvement of their function.

Common problem faced by the ASHAs were problem in transportation, availability of vaccines, medicines and even the doctors along with lack of literacy in com munity.

Table 3.10.2: Distribution of Work Done b ASHA

District	Gorakhpur				Maharajganj				Grand total	%
Blocks	Khajni	Jungle Kauria	Grand total	%	Laxmi-pur	Phare-nda				
	No.	No.	Sub Total	%	No.	No.	Sub Total	%		
Distribution of medicines	5	11	16		6	12	18		34	56.66
Keeping record of pregnant women	5	4	9		12	5	17		26	43.33
Immunization/FP services/regist.	10	13	23		13	14	27		50	83.33
Taking preg. women to hospital for delivery	6	8	14		3	5	8		22	36.66
Health meeting in village	2	0	2		4	2	6		8	13.33
Sending parents to health centre	3	4	7		5	2	7		14	23.33
Educating people about nutrition	2	2	4		2	2	4		8	13.33

Table 3.10.3: Distribution of Work Liked Best by ASHA

District	Gorakhpur				Maharajganj				Grand total	%
Blocks	Khajni	Jungle Kauria	Grand total	%	Laxmi-pur	Phare-nda				
Work you like best	No.	No.	Sub Total	%	No.	No.	Sub Total	%		
Delivery	7	13	20		8	6	14		34	56.66
To participate in cleanliness of village	4	4	8		5	2	7		15	25
Immunization/ FP services/ registration	7	10	17		9	12	21		38	63.33
Survey	4	3	7		4	1	5		12	20
Delivery check-up	4	3	7		5	1	6		13	21.66
Distribution of medicines	0	1	1		4	1	5		6	10
Sending parents to health centre	3	3	6		4	1	5		11	18.33

Table 3.10.4: Reasons for not Being Able to Work Properly

District	Gorakhpur				Maharajganj				Grand total	%
Blocks	Khajni	Jungle Kauria	Grand total	%	Laxmi-pur	Phare-nda				
Work not able do properly	No.	No.	Sub Total	%	No.	No.	Sub Total	%		
Can do all work	8	10	18		5	4	9		27	45
Distribution of medicines/ immunization	2	3	5		5	6	11		16	26.66
Problem for transporting of parents due to non-availability of vehicle	1	0	1		5	3	8		9	15
In delivery	2	2	4		5	2	7		11	18.33

Table 3.10.5: Satisfaction of Villager with ASHA Services

District	Gorakhpur				Maharajganj				Grand total	%
Blocks	Khajni	Jungle Kauria	Grand total	%	Laxmi-pur	Phare-nda				
Satisfaction of Villager	No.	No.	Sub Total	%	No.	No.	Sub Total	%		
Yes	13	14	27		15	16	31		58	96.66
No	0	0	0		1	0	1		1	1.666
No response	0	1	1		0	0	0		1	1.66

Expectation by Villagers

About 71% of the ASHAs were of the view that more work is expected from them by the villagers. Out of which were widow pension, requirement of medicine for villagers, help in preparation of ration card and free services are few.

Table3.10.6: More Expectation of Work by Villager

District	Gorakhpur				Maharajganj				Grand total	%
Blocks	Khajni	Jungle Kauria	Grand total	%	Laxmi-pur	Phare-nda				
More expectation of work by villager	No.	No.	Sub Total	%	No.	No.	Sub Total	%		
Yes	11	13	24		4	15	19	59.38	43	71.66
No	2	2	4		12	1	13	40.63	17	28.33
Total	**13**	**15**	**28**		**16**	**16**	**32**	**100**	**60**	**100**

Table 3.10.7: Work Expectations from ASHA

District	Gorakhpur				Maharajganj				Grand total	%
Blocks	**Khajni**	**Jungle Kauria**	**Grand total**	**%**	**Laxmi-pur**	**Phare-nda**				
Work	**No.**	**No.**	**Sub Total**	**%**	**No.**	**No.**	**Sub Total**	**%**		
Widow pension	1	1	2		0	0	0		2	3.333
More medicines	3	2	5		5	2	7		12	20
Free services	0	1	1		0	2	2		3	5
Ration card	0	1	1		0	0	0		1	1.666
Others	3	1	4		2	0	2		6	10
No Response/Not Applicable	7	11	18		10	13	23		41	68.33

For betterment of work around 83.33% expect better pay, 43.33% feels mor e medicines should be given to them, 23.33% feels better means of transport facilities for the patients, 13.33% of the patients feels more training should be given to them whereas only 1.66% feels that Incentive should be given for more work.

Table 3.10.8: Expectations by ASHA for Better Work

District	Gorakhpur				Maharajganj				Grand total	%
Blocks	**Khajni**	**Jungle Kauria**	**Grand total**	**%**	**Laxmi-pur**	**Phare-nda**				
Expectations by ASHA for better work	**No.**	**No.**	**Sub Total**	**%**	**No.**	**No.**	**Sub Total**	**%**		
Better pay	12	11	23		14	13	27		50	83.33
More medicines	8	7	15		4	7	11		26	43.33
Better means of transportation of patients	3	5	8		3	3	6		14	23.33
More training	1	2	3		4	1	5		8	13.33
Incentive for more work	0	1	1		0	0	0		1	1.666
Total	**13**	**15**	**28**	**100**	**16**	**16**	**32**	**100**	**60**	**100**

Main problems faced by the ASHAs are transportation, timely availability of vaccine s, availability of doctor at PHC, lack of literacy in the community. 5% ASHA also feels that ANM and Panchayat are creating problems to them. About 43. 33% of the ASHA feels that they are having no problems.

Table 3.10.9: Problem Faced by ASHA

District	Gorakhpur				Maharajganj				Grand total	%
Blocks	Khajni	Jungle Kauria	Grand total	%	Laxmi-pur	Phare-nda				
	No.	No.	Sub Total	%	No.	No.	Sub Total	%		
Transportation	2	2	4		7	3	10		14	23.33
Timely availability of vaccine	2	2	4		1	2	3		7	11.66
Availability of doctor	1	2	3		1	1	2		5	8.33
Lack of literacy in the community	1	1	2		0	4	4		6	10
Panchyat/ANM		1	1		2	0	2		3	5
No problem	7	8	15		5	6	11		26	43.33

Discussion

Almost all the ASHAs are resident of local community and act as effective link person in the delivery of health services and providing health messages. In general, selection of ASHAs appeared to be fair, with th e exception in few villages, where selection of ASHAs was just on the liking of Gram Pradhan. As a majority of them are in the younger age group, and enthusiastic, they may deliver better service with proper motivation and capacity building. All the ASHAs have been given seven days induction training; this could not be followed by four, four days periodic induction training for about a year. So a twelve days training at one stretch was given to the majority of the ASHAs. In general ASHAs are satisfied and happy with the training. Their perception about their job responsibilities appeared to be incomplete and improper. Majority of them were not aware about their role in changing the behaviour about infant feeding family planning, child marriage, girl education, hand washing and sanitation. They were also not very much aware about their role in birth and death registration. In spite of the crucial importance of education and counseling for hygiene and sanitation, exclusive breast -feeding, complimentary feeding, family planning, ORS use, preventing early marriage and gender discrimination etc. is not being found in the agenda of ASHAs. So its importance must be emphasized during the training and other meetings. The synthesis of the views of the health functionaries like CMOs, MOs and ANMs unanimously reflect further need of training of the ASHAs. They emphasized upon time-to-time refresher training in the areas like mother and child health, an aemia and malaria.

Most important motivational factor for the ASHAs is the financial gain and hope of being absorbed in government job. Monetary gain in majority of cases is very little and to receive even this money sometime needed extra effort. There was a general demand from all stakeholders for a regular monthly payment o f Rs.1000/- to each ASHAs besides the job related incentives.

In general, monitoring and supervision of the ASHAs by MO through ANM and AWW was satisfactory. However in many areas ASHAs were not functioning

properly and even their relation with ANM and AW W were not satisfactory. Similar findings were also reported in earlier studies conducted in Orissa, Jharkhand and Uttar Pradesh. Village health and sanitation committee has not been established in many villages and even where it has been established regul ar meetings are not being held. All the ASHAs have been accepted very well in the community and are acting as a link between community and health providers. The faith and confidence of community on ASHAs are reflected by the demand of additional jobs like help in getting widow pension and ration card etc.

Most of the ASHAs preferred helping in delivery and immunization. These activities are also associated with financial incentives. But many other jobs like promotion of awareness on hygiene and sanitation, counseling on family planning etc. were drawing lesser attention probably due to lack of incentives. Non-availability of proper transport facility mainly for pregnant mothers along with irregular supply and replenishment of medicinal kits were major probl ems faced by the ASHAs.

CHAPTER 4

CONCLUSION AND RECOMMENDATIONS

Conclusion

Almost all the ASHAs are resident of local community and so a very effective link person in the delivery of health services and good health massages. In general selection of the ASHAs appeared to be fair. However FGD and IDI with some of the stakeholders indicated that involvement of community in selection process was not to the desired level and in some cases selection of ASHAs was just on the liking of Gram Pradhan .

All the ASHAs have been given seven days induction training. This training could not be followed by four, four days periodic induction training for about a year. So a twelve days training at one stretch has been given to the majority of the ASHAs. In general ASHAs are satisfied and happy with the training. But their perception about their job responsibilities appeared to be incomplete and improper. Majority of them were not aware about their role in changing the behaviour about infant feeding family planning, child marriage, girl education, hand washing and sanitation. They were also not very much aware about their role in birth and death registration.

Most important motivational factor for the ASHAs were the financial gain and hope of being absorbed in government job. Monetary gain in majority of the cases was very little and to receive even this money sometime needed extra effort. There was a general demand from all stakeholders for a regular monthly payment of Rs. one thousand to each ASHAs besides the job related incentives.

In general monitoring and supervision of the ASHAs by MO through ANM and AWW was satisfactory. However in many areas ASHAs were not functioning properly and even their relation with ANM and AWW were not satisfactory. Village health and sanitation committee has not been established in many villages and even where it has been established regular meetings are not being held.

All the ASHAs have been accepted very well in the community and are acting as a good link between community and health providers. The faith and confidence of community on the ASHAs are reflected by the demand of additional jobs like help in getting widow pension and ration card etc.

Most of the ASHAs preferred helping in delivery and immunization. These activities are also associated with financial incentives. But many other jobs like promotion of awareness on hygiene and sanitation, counseling on family planning etc. were drawing lesser attention probably due to lack of incentives.

Non-availability of proper transport facility mainly for pregnant mothers along with irregular supply and replenishment of medicinal kits were major problems faced by the ASHAs.

Recommendations

The process of selection of the ASHAs has been completed, but in few places they are non-functional. In such situations after proper scrutiny selection of new ASHAs as per guidelines and with active involvement of community should be done.

Training of ASHAs are neither as per norms nor regular. Training is the backbone of capacity building and functioning of the ASHAs. So it must be done timely, properly and effectively. It has to be ensured during training that the ASHAs are well aware and capable to fulfil their job responsibilities.

A provision of a minimum of Rs. one thousand per month as stipend has been recommended by most of the stakeholders during their FGD or IDI, as a strong motivating factor.

ASHAs being a new incumbent in health system needs a lot of cooperation, coordination and supportive supervision from other stakeholders like MO, ANM, AWW and community. It is being done but it must be strengthened with regular meeting of the ASHAs, ANMs and AWWs under the chairmanship of block medical officers. All the doubts and confusions may also be clarified in this meeting. Village health and sanitation committee must be established in every village and its regular meeting should be ensured. Community members must be involved in this committee, to seek their participation and cooperation in various activities related to making a healthy village.

Inspite of the crucial importance of education and counseling for hygiene and sanitation, exclusive breast-feeding, complimentary feeding, family planning, ORS use, preventing early marriage and gender discrimination etc. is not being found in the agenda of ASHAs. So its importance must be emphasized during training and other meetings.

The availability of medicinal kit with each ASHA along with regular replenishment of items inside it must be ensured.

A provision of proper, well equipped one or two ambulance on call to transport the pregnant mothers and other serious patients must be made for each block. It can be done on private public partnership basis.

Limitations of the Study

A larger sample area with periodic follow-up study will be more fruitful.

Future Areas of Research

Major health problems of different area may differ and so training need assessment should be made region-wise. A periodic evaluation of functioning of the ASHAs should be done at least ones every year for timely rectifications.

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