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ABSTRACT

Despite significant improvements made in the past few decades, the public health challenges are not only so huge but are also growing and shifting at an unprecedented rate in India. The Government of India launched the National Rural Health Mission (NRHM) in 2005, under which many innovations have been introduced in the states to deliver healthcare services in an effective manner. One of the core strategies proposed in this mission was to create a village level social activist, designated as ASHA for every village. To a large extent, the actualisation of the goal of NRHM depends on the functional efficacy of the ASHA as the grassroots health activist. Therefore the present study has been planned for ascertaining how efficient the ASHAs are to play their defined roles effectively, what are the problems they are facing and to further suggest measure for optimization of their working. A cross-sectional, descriptive study was undertaken in Bageshwar and Nainital districts of Uttarakhand between March 2012 to May 2012. In-depth interviews were conducted with the accredited social health activists (ASHAs), the members of the Panchayati Raj institutions (PRIs), the auxiliary nurse midwife (ANMs), anganwadi workers (AWWs), and the members of the community. It was found that at many of the places the ASHAs had to cater a population more than the norm of 1000, compensation for ASHAs should be suitably increased. The irregularity in the area of supply of medicine kits should be investigated. Also capacity building training should be imparted to the ASHAs as they are unable to conduct meeting in the community.
1. INTRODUCTION
The past few decades have witnessed increasing concerns among developing countries including India on poor state of health and development of children. To underscore the need to position child survival at the heart of international agenda, reducing child mortality has been focused as one of the eight Millennium Development Goals (MDGs.) India as a signatory to the Millennium Summit Declaration (2000) aims at achieving the Millennium Development Goals (MDGs) by the year 2015. Reducing child mortality is one of the 8 MDGs. Although overall gains in child survival in India have been impressive, infant and child mortality levels are still high. National level figures has it’s own limitation in policy formulation and programme implementation. The scale and diversity of India present a huge challenge in addressing development goals including child survival.

2. THE STATE OF PUBLIC HEALTH IN INDIA: PROBLEM ANALYSIS
In spite of the progress made, a high proportion of the population, especially in rural areas, continues to suffer and die from preventable diseases, pregnancy and child birth related complications as well as malnutrition. In addition to old unresolved problems, the health system in the country is facing emerging threats and challenges. The rural public health care system in many States and regions is in an unsatisfactory state leading to pauperization of poor households due to expensive private sector health care. Figure 1 details the various causes of the poor public health in the rural areas of India.

Root causes

• Inadequate access to health facilities
• Lack of infrastructure
• Shortage of Doctors
• Absenteeism
• The doctors are low on competence
• Public Doctors are
  – having lucrative alternative work in the private sector
  – paid by salary
  – not monitored by supervisors
  – cannot be fired or have pay reduced under virtually any circumstances
**Inadequate access to health facilities**

The problem is, first and foremost, one of access. India has a rudimentary network of public hospitals and clinics in any case—the government estimated there was a shortage of 4,803 primary health centres and 2,653 community health centres in 2006—but the issue is particularly acute in rural areas. Public hospitals are rare outside of large cities—a significant problem in a country where some two-thirds of the population still live in the countryside. According to a study conducted by the Confederation of Indian Industry, the formal healthcare system reaches only about 50% of the total population.

Concentrations of public and private health care facilities in the urban areas and missing facilities in remote rural areas have thus become a common feature of the Indian health system. Furthermore, the burden of disease is disproportionately placed on the poor. Mortality rates, fertility rates and undernourishment are double as high in the poorest quintile of the population (Misra et al. 2003: 1)

**Lack of infrastructure**

Moreover, the delivery of healthcare services in rural areas is hampered by a dire lack of infrastructure. To take one basic example: around 20% of the 600,000 inhabited villages in India still have no electricity at all. And this official estimate understates the extent of the problem, as it defines an electrified village—very generously—as one in which at least 10% of households have electricity.

**Shortage of Doctors**

India is also desperately short of doctors, with only 645,825, or 0.6 per 1,000 people, in 2004, according to the World Health Organisation (WHO). Many locally trained physicians are tempted abroad by better pay and prospects; moreover, healthcare workers who do remain in India prefer the cities where job prospects and wages are better, resources are greater and the quality of life is far higher.

**Absenteeism:** Public Doctors in India are among the most absent in the world

**The doctors are low on competence**

**They don’t work to the level of their knowledge:** When public doctors do show up for work, the exert very little effort
3. SOLUTION ANALYSIS

To deal with the present state of public health especially in rural areas a combination of efforts is needed. Some of the ways in this direction can be:

- **Public health management approach** 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.

- **Innovative uses of technology** One possible solution to improving rural healthcare in India might come through innovative uses of technology. Like using microchips to create portable ultrasound scanners. These could be delivered to villages, and the scan administered even by someone with no medical training—the actual reading could be done by trained medical staff in a hospital/clinic in a bigger city with the image transmitted electronically. There remain immense technological and logistical challenges to the implementation of even innovative strategies like this.

- **Community participation** is not only an influential concept for health care reforms but also the byword of today in development cooperation. Contrary to former development
policies implementing programmes in a “top-down” manner, community participation puts emphasis on “bottom-up” planning.

- **Increasing availability of health professionals in rural areas** A shortage of all categories of health personnel in the public health system has been well recognized in the country and this needs to be tackled on priority basis. In order to ensure the availability of health professionals in rural areas on a regular basis, the country still has to train a large number of health professionals to meet the health care needs of the growing population and increasing disease burden.

- **Adequate incentives to doctors** Posting of doctors with adequate incentives, both monetary as well as non-monetary benefits, such as improved infrastructure facilities of health care institutions, suitable accommodation, preferential school admissions for their children, increase in the age of retirement from 60 to 65 years, permission for private practice/pay clinics/evening clinics, posting spouses at same place etc. are certain important issues to be considered.

- Besides, decentralisation of recruitment to the district level, contractual appointments/engaging honorary consultants, posting of junior/senior residents at PHCs/CHCs may complement the HRH. Public-private partnership could go a long way strategically to bridge this gap. The public health challenges for communicable diseases, emerging infectious diseases and the growing burden of chronic diseases need a strong national policies to support public health. Capacity development for health research, policy development and analysis, programme development and evaluation, health care financing, etc. are equally important.

3.1 National Rural Health Mission (NRHM): A solution for improving the public health
The Government of India launched the National Rural Health Mission (NRHM) in 2005, under which many innovations have been introduced in the states to deliver healthcare services in an effective manner to provide accessible, accountable, affordable, effective and reliable primary health care, especially to the poor and vulnerable sections of the population. The Mission is to be implemented over a period of seven years (2005-2012). It envisages equitable and quality health care services to rural women and children in the country with greater emphasis on 18
highly focused states (including Uttarakhand). It adopts synergistic approach by encompassing non-health determinants that have a bearing on health such as nutrition, sanitation, and safe drinking water. The mission also aims to achieve greater convergence amongst related social development sectors. Figure 2 details the main approaches of NRHM scheme.

3.2 The Special Focus States
While the Mission covers the entire country, it has identified 18 States for special attention. These states are the ones with weak public health indicators and/or weak health infrastructure. These are Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu & Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttarankhand and Uttar Pradesh. While all the Mission activities are the same for all the States/UTs in the country, the high focus States would be supported for having an Accredited Social Health Worker (ASHA) in all villages with a population of 1000 and also in having Project Management Support at the State and District level. It also
articulated a need for including the health needs of the urban poor while planning for health through District Health Plans. The NRHM District Health Plans will cover District and Sub Divisional/Taluk Hospitals as well as they cater to rural households as well.

3.3 ASHA

One of the core strategies proposed in this mission was to create a village level social activist, designated as ASHA for every village with a 1,000 population. This was aimed to provide primary medical care, advice the villagers on sanitation, hygiene, antenatal and postnatal care, escorting expectant mothers to hospital for safe delivery etc. To perform her activity in a proper manner, the NRHM has envisaged capacity -building of the ASHA through training and motivating them through a performance -based compensation. It was suggested that ASHA would be chosen by and accountable to the Panchayat. She would act as an interface between the community and the public health system. As an honorary volunteer ASHA would receive performance-based compensation for promoting variety of primary health care services in general and reproductive and child health services in particular such as universal immunization, referral and escort services for institutional deliveries, construction of household toilets, and other healthcare interventions.

In order to enable the states for proper implementation, ASHA guidelines were formulated by the Ministry of Health and Family Welfare (MOHFW), Government of India (GoI) wherein institutional arrangements, roles and responsibilities, integration with ANMs and Anganwadi workers (AWW), working arrangements, training, compensation, fund-flow etc have been discussed. Many states depending on the local context modified the guidelines to suit their requirements, in the true spirit of the NRHM guidelines of decentralized programme management.

4. GOALS AND OBJECTIVE OF STUDY

4.1 Anticipated outcome of the study

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

4.2 Specific Objective of the Study

a) To study the working of the ASHA and investigate the problems experienced by them at workplace.

b) To assess the satisfaction level of working of ASHA as experienced by the community.

c) To offer recommendations for improved functional efficacy of the ASHAs.

5. METHODOLOGY

A systematic procedure will be adopted for the study. A cross-sectional, descriptive study with a blend of qualitative and quantitative techniques undertaken in Bageshwar and Nainital districts of Uttarakhand between March 2012 to May 2012. The study included the four villages from Kapkot block in Bageshwar district and 4 villages from Haldwani block in Nainital district. In-depth interviews were conducted with the members of the Panchayati Raj institutions (PRIs), the accredited social health activists (ASHAs), the auxiliary nurse midwife (ANMs), anganwadi workers (AWWs), and the members of the community.

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Levels of Data Collection</th>
<th>Respondents</th>
<th>Number of respondents</th>
<th>Methods of Data collection</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Subcentre</td>
<td>ANM</td>
<td>6</td>
<td>In –depth interviews</td>
</tr>
<tr>
<td>2</td>
<td>Village</td>
<td>PRI members</td>
<td>6</td>
<td>In –depth interviews</td>
</tr>
<tr>
<td>3</td>
<td>Village</td>
<td>ASHA</td>
<td>20</td>
<td>In –depth interviews</td>
</tr>
<tr>
<td>4</td>
<td>Village</td>
<td>AWW</td>
<td>6</td>
<td>In –depth interviews</td>
</tr>
<tr>
<td>5</td>
<td>Community</td>
<td>Community members (teachers, elderly women, lactating women)</td>
<td>-</td>
<td>In –depth interviews and FGDs</td>
</tr>
</tbody>
</table>

**Table 1: Scheme of Data Collection**

Different tools will be used as instrument for collecting data for research work. In order to understand the issues better, data collection focused on two sources of information. Primary data, from semi-structured interviews (Annex) with selected stakeholders namely ASHA,
ANM, AWW, PRI members and Community members. Secondary source of information was literature review (see references). Focus group discussion with Community members was also used to know their views.

The information obtained from ASHAs, ANMs, AWW, PRI and community members have all been assessed. The responses have been recorded into different categories as per the requirement and were interpreted. In the report the responses have been categorised according to the structure of the report into different sections and subsections.

6. DESCRIPTION OF STAKEHOLDERS INVOLVED: STAKEHOLDERS ANALYSIS

The main stakeholders involved in the programme are PRI Members, ASHAs, AWWs, ANMs, Community members, District level officials, State level officials, officials at national level. Figure 3 shows the various stakeholders as per their level of involvement in the programme. The first level stakeholders who are the main stakeholders include are ASHAs, PRI Members, AWWs, ANMs and local Community members. These stakeholders are at the grass root level and are the visible faces of the scheme in the community. The second level stakeholders who are not directly related to the programme include CDMO, ADNO, NGOs working in public health, and the government’s Ministry of Health and Family Welfare at state level. These stakeholders though not coming in direct contact with the public but are responsible for the implementation of the scheme in many ways. Stakeholders involved at the third level are the Ministry of Health and Family Welfare at National level, also the global community. Stakeholder power analysis is depicted in figure 4 showing the stakeholders main features like their key interest in the programme, their impact etc.
Figure 3: Levels of stakeholders involved with NRHM
<table>
<thead>
<tr>
<th>Stakeholders</th>
<th>Key Interest</th>
<th>Important to Project</th>
<th>Influence to project</th>
<th>Participation</th>
</tr>
</thead>
</table>
| ASHA                             | • Achievement of goals assignned to them.  
  • To work as an interface between the community and the public health system  
  • Attending more patients to get more incentives | High. As project success depends on their performance. | High  
  • They will mobilise the community and facilitate them in accessing health and health related services | • Main grass root workers connecting and motivating the people towards the healthcare system  
  • Promoter of good health practices  
  • Create awareness on health and its social determinants  
  • Mobilise the community and facilitate them in accessing health and health related services |
| ANM                              | • Guide ASHA in bringing the beneficiary  
  • guide ASHA as resource persons for the initial and periodic training to the | High Roles of Auxiliary Nurse Midwife (ANM) and ASHA have been integrated in various ways | High  
  • Will assist in smooth functioning of ASHA and | • Hold weekly/fortnightly meeting with ASHA, and provide on-job raining |
| AWW                              | • Guide ASHA in performing on health related activities  
  • Guide and help ASHA in performing on health related activities | Medium  
  • AWW will guide ASHA in performing activities such as organising Health Day | Medium |
| PRI Members                      | • Making available health related database to all stakeholders, including Panchayats at all levels | Medium  
  • Involve in selection of ASHA  
  • ASHAs would be selected by and be accountable to the Village Panchayat, The Village Health Plan, and promote inter-sectoral integration | Medium |
| Members of the Local Community (teachers, elderly women, lactating women) | • Access to good health facilities | Medium  
  • Are involved as the of the target group | Medium  
  • As they should be accepting the services being brought up | • As the beneficiary of the programmes |
<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>District Administration</strong></td>
<td>• Preparation of integrated District Action Plan as per the NRHM mandate Constitution of District Health Mission led by Zilla Parishad to lead the activities under NRHM</td>
</tr>
<tr>
<td><strong>Medium</strong></td>
<td>Involved in activities like Constitution of District Health Mission led by Zilla Parishad to lead the activities under NRHM, Total Sanitation Campaign (TSC) in the district.</td>
</tr>
<tr>
<td><strong>Medium</strong></td>
<td>Will form bodies at district level to monitor the various development</td>
</tr>
<tr>
<td><strong>Low</strong></td>
<td>Exploring models of Public-Private Partnership to supplement with services in the district, like contractual engagement of district paramedics, hiring services of district specialists on payment of remuneration</td>
</tr>
<tr>
<td><strong>State Officials</strong></td>
<td>Organizing State and Divisional/District level stakeholder workshops involving Department of Health, Family Welfare, AYUSH, Women and Child Development, Panchayati Raj</td>
</tr>
<tr>
<td><strong>Low</strong></td>
<td>Preparation of integrated State Action Plan</td>
</tr>
<tr>
<td><strong>Low</strong></td>
<td>Forming the state level bodies</td>
</tr>
<tr>
<td><strong>State Officials</strong></td>
<td>Each State shall develop its own strategy for National Rural Health Mission (NRHM) under the overarching guidelines of the Government of India</td>
</tr>
</tbody>
</table>

**Figure 4: Stakeholder analysis**
7. WORKING AND VIEWS OF STAKEHOLDERS REGARDING DIFFERENT ASPECTS OF THE ASHA

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

7.1 Profile of ASHAs

Study of the profile of the ASHAs in terms of age, education, marital status, caste and income level is important as it might have a bearing on their functional efficacy. All the ASHAs interviewed had the profile of young age and better education level. The education and qualification revealed that most of them are of 8th or more class passed. The residential status and marital status reveal clear adherence to the guideline.

7.2 Selection Procedure of ASHAs

The perception of ASHA, AWW, ANM and PRIs regarding the selection criteria and selection process has been captured through informal interview.

The guideline for the selection criteria of the ASHAs envisage that they should be married/widowed/divorced and resident of that village having an age limit of 25 -45 years and must be an 8th standard pass. In case the education criteria can’t be met, it can be reduced to 5th standard. The selection process envisages that the CDMO is the District Nodal Officer (DNO) and MOsI/C of PHCs/CHCs is the Block Nodal Officer for the selection of the ASHAs. The MO and CDPO will appoint block level facilitator. The AWWs, the ANMs and the block facilitator will be trained in the selection process and they will conduct minimum of three FGDs and inform the community about the selection criteria, process and roles and responsibilities of the ASHAs. The ANMs at the community level will conduct a meeting where AWWs, presidents/secretaries of the SHGs will participate. Each SHG will propose a name for the ASHA. All the names will be discussed and the most suitable candidate will be selected through consensus. In case the consensus is not achieved, the selection will be done by lottery. The selected name will be furnished to the Block Nodal Officer along with the proceeding of meeting.
The views of ASHA, AWW, ANM and PRI members corroborate that the selection criteria and selection process as per the guideline have been adopted. The ANMs’ role is crucial in the selection process. The PRI members have been probed regarding the selection procedure of the ASHAs. All of them unanimously state that they are aware of and have been involved in the selection process. They also confirm that selection has been done in the village meeting with adequate participation of SHGs, AWWs, ANMs and other elderly persons of the village.

The narration of the events at certain places indicates smooth selection at some places and conflict at some others.

Case – 1

Village: - Padampur Daveliya, Block- Haldwani, District- Nainital, PHC- Motahaldhu

According to Kusum Joshi one of the ASHA, “I had given my name and details needed like certificates to one of the PRI member. They had their meeting for selection together with ANM and others. In the selection meeting all members were present and then selected the my name out of other few names and all the members present in the meeting endorsed her selection”.

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

7.3 Sustenance and Motivational Factors

The sustenance of the programme depends on the long -term motivational factors for the ASHAs to keep her going with spirit and enthusiasm. To analyze this aspect, factors such as job satisfaction, compensation, recognition, training, capacity building, monitoring, supervision and utility of her job were considered.

The most important factor motivating them for this job is to earn some money as indicated by the majority of the ASHAs. The second most important factor is that this job gives them opportunity to serve the community as well. The ASHA is a volunteer, this philosophy is subscribed by some of them, and still some others also aspire for a government job in this process. The most important finding is that most of them are satisfied with their job and also happy with the nature of work. Most of them feel that their prestige has gone up in the village due to their engagement as the ASHA. All the ASHAs opine that the community considers their job useful.
Monetary compensation is an important motivational factor for the ASHAs. It is seen that the monthly compensation received by ASHAs from different sources are in the range of Rs. 100 to 400 as sometime they do not have any patient in a month; only a few receive compensation within a range of Rs. 600 to 900. Most of the ASHAs are not satisfied with the amount of compensation they receive. More than half of them expect a monthly minimum honorarium in the range of Rs. 1,000 -2,000. Support is another important factor for sustenance. The community members unanimously find the role of the ASHA very useful for them.

7.4 Training of ASHAs

The scheme envisages a three -pronged strategy---induction training followed by a periodic training, and on the job training. The induction training is for 23 days over a year. The first round may be of seven days, to be followed by another four rounds of training, each lasting for four days. Though the training material is produced at the national level, states have the freedom to modify the contents as per local needs. The training materials will include facilitators guide, training aids and resource materials of the ASHAs. The induction training will be followed by periodic training for about two days, once in every alternative month for all ASHAs. This training will be of interactive sessions to help refresh and upgrade their knowledge and skills and solve the problems they are facing, monitor their work and keep up their motivation and interest. The ASHAs need on the job support in the field, both during the initial training phase and later also.

The process of training of the ASHAs has been evaluated by interviewing them and also the ANMs. All the ASHAs have been imparted induction training for a week at places like PHC and CHC. In Nainital district, the second phase of the induction training has been completed for 15 days at a stretch after an interval of eight months of the first phase induction training. This have deviated the philosophy of the second phase of induction training, to be conducted at four instances of four days each. This must have hindered the optimal output from the training.

The ASHAs point out that they have received all the four training modules and their induction training has been completed. While most of the ASHAs admit that the training is beneficial, nearly half of them don’t consider the training to be adequate. Majority of the ASHAs are satisfied with the training, while a few were not. The synthesis of the views of the health functionaries like the ANMs unanimously agree that the ASHAs need further training.
7.5 Knowledge of ASHAs

The knowledge of ASHAs on the nature of the activities and job responsibility is the prerequisite for effective service delivery. The ASHAs have been interviewed to assess their knowledge about their job responsibilities.

It reveals that most of the ASHAs have comprehended accompanying pregnant mother to hospital and counselling community on safe delivery, ANC/PNC, breastfeeding, immunization, contraception and prevention of RTIs/STIs as their role and responsibility. As regards their job responsibilities like creating community awareness on determinants of health, mobilising the community to access healthcare services at different facilities, depot holder of medicine and DOTS provider and motivating the community for construction of household toilets, nearly half couldn’t specify.

This finding is significant in the light of the fact that one of the key motivational factors which drive ASHAs are financial gains and since delivery and site-related events are financially rewarding, they are becoming the areas of primary interest to the ASHAs. A strategy should be devised wherein the ASHAs develop expertise in other significant areas of her activity spectrum such as helping develop village health plans and facilitating registration of vital events with the ANMs/AWWs.

7.6 Functioning of ASHA

The entire sample ASHAs have more than one year of work experience. Regarding the efficacy of functioning of ASHAs, views of authorities like the ANMs, the PRI members like Sarapanch, the Panchayat Samiti members, the ward member and the community members have been obtained and analysed. All of them have expressed their satisfaction on the functioning of the ASHAs. The views of PRI members on the functions of ASHA are encouraging.

“ASHA is a new hope of many people who earlier were not able to get any health facilities. Pregnant mothers get better delivery facility at hospitals. People can get a few medicines for common diseases at their door steps. Also people now get many health related information at their door steps from the ASHA. They are functioning well in our area. She is really like a ray of hope” says one of the school teacher at Kapkot block in Bageshwar district.
7.7 The Activities which ASHA are Unable to Perform

Few of the ASHAs have indicated that they are unable to motivate the community for construction of toilets and not able to organize meeting. Besides, a few of them have also pointed out that they are not able to take serious patients to higher facilities, stay with the patients in the hospital, do paper work of the JSY and other register/records and distribution of condoms and oral pills. Except for the activities like taking patients to higher centres and staying with them in the hospital, this observation is indicative of the lack of capacity and skills of the ASHAs. This can be overcome by paying special attention on these specific issues during capacity building exercises and timely guidance by supervisors for executing these important tasks including referrals.

7.8 Social Acceptance and Community Support

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

7.9 Community Satisfaction and Expectations

The level of community satisfaction was judged during interviews with the PRI members, AWWs and community members. All of them have emphasised on the role of the ASHA as a facilitator for institutional delivery, immunization of mothers and children and distribution of some medicines. The AWWs have also expressed positive views on the activities of the ASHA in the community. The FGDs among community members reveal that the community members are by and large satisfied with the work of the ASHA. She is mainly involved on the promotion of institutional delivery and immunization. One universal demand that emerges from the community is that the ASHA should have sufficient stock of the medicines for the common ailments like fever, diarrhoea, cold, cough and minor injuries.
All the ASHAs have indicated that community members are happy with their work and they also do give credit for it. However majority are of the opinion that the community expects more work from them.

8. PROBLEMS: ANALYSIS OF THE FINDINGS

Many of the ASHAs are catering to a population of more than the stipulated norm of 1,000. Some population in some of the villages in the Bageshwar district is spread over large areas and intercepted by hills and rivers. Due to these natural barriers, the ASHAs even failed to visit certain areas and certain section of the population remained un-served and un-reached.

The ASHAs are very keen on some of their job responsibilities like registration of pregnant women, ANC/ PNC, immunization, but the neglect areas are motivating the people for construction of toilets, participation in VHSC and development of comprehensive village health plan, family planning, adolescent education etc. The activities linked to financial incentives are getting priority and other activities are given less importance by the ASHAs.

Transportation of expectant mothers is a major problem. In the villages, the transport services are not available specially at night time. Further the charges are much higher than the sanctioned amount for transportation. Since ASHA is the link between community and health service, any delay in transportation may lower her credibility in the community which may decrease her effectiveness.

The entire compensation received by ASHAs per month is very low which is quite inadequate for their sustenance. The members in the community, PRIs and ANMs have indicated the inadequacy of the compensation to the ASHAs. Further majority of the ASHAs are not getting incentives in time. This is a negative motivational factor which needs to be tackled.

Few of the ASHAs reported they received medicine kits which were incomplete in many respects. The majority of ASHAs lack knowledge on proper doses of drugs. They are not able to use AYUSH medicines that are in the kit because of lack of knowledge about the doses and utility of these drugs.

While accompanying the expectant mothers to the institutions and staying there the ASHA has to incur more expenditure on food, stay etc. than the sum provided to her under the scheme.
Another operational problem is when ASHA provide all the approved services of ANC and immunization but fail to get the incentive if she missed the opportunity to accompany the mother to the health facility due to some reasons. The most important reason for such incidence is lack of communication on that critical moment, or due to the unwillingness of the beneficiaries to inform her. Besides, she also loses the incentive if the client opted for the delivery in private hospital or nursing home.

More than a quarter of ASHAs are unable to conduct meeting in the community because they are unable to motivate the target group

9. RECOMMENDATIONS: A WAY FORWARD

An assessment of the population catered to by each ASHA should be made at the PHC and sub-centre level under the guidance of district NRHM office and redistribution of areas should be made among the ASHAs so as to keep the population norms limited to 1000 or less. In sparsely populated areas intercepted by hills and rivers, the norm should be relaxed.

The neglected areas in her functioning are to work with VHSC which are either non-existence or non-functional in most cases. The VHSC should be revamped or constituted and ASHAs should be motivated to prepare comprehensive health plan. Possibility of providing incentives for the purpose should be explored.

ASHAs should also be oriented to give importance to the job of motivating for the family planning measures and adolescent education.

Compensation for ASHAs should be suitably increased. Payment should be done at the work site without any delay through cheque. Possibility of making direct release of money up to PHC level should be explored by the NRHM. The compensation of the ASHAs in comparisons to her contribution is quite meagre. Further, capacity building and more compensation would encourage her to do the job with enthusiasm and spirit.

While monitoring the performance of the ASHA the Village Health Committee should ensure that the disbursement of compensation to the ASHA and beneficiary mothers is timely and proper. The activities like formulation of village health plan through VHSC, awareness and motivation for construction of household latrines, motivation for family planning and adolescent education by the ASHAs should be monitored by the health authorities.
Capacity building training should be imparted to the ASHAs by appropriate master trainers strictly following the training guidelines at PHC level preferably in residential mode.

Refresher training at regular interval should be imparted at PHC block and district level on specific topics.

The irregularity in the area of supply of medicine kits should be investigated and appropriate action should be taken. The ASHAs must get the medicine kits complete in all respects and replenished regularly.

The sub-centre should be equipped with infrastructure, logistics and instruments so that non-complicated normal delivery can be conducted by the trained staff at the sub-centre level in remote inaccessible areas.

Possibility of providing mobile phones to the ASHAs could be considered so that they can have connectivity with the community and health facility, transport vehicles, without any hassles.
ANNEXURE

1. INTERVIEW SCHEDULE FOR ASHA

   A. Personal and family profile of ASHA
      1) Name
      2) Age (Yrs)
      3) Educational Qualification (Highest education)
      4) Marital status
         a) Married
         b) Single
         c) Divorced
         d) Widow
      5) Economic status
         a. BPL
         b. Non-BPL
      6) Monthly income_______ (Rs/month)
      7) Type of Family
         a) Nuclear
         b) Joint
         c) Extended

   B. How do you got selected and from where you got the information of recruitment?

   C. Work profile of the ASHA
      1. Approximate time spent per day by ASHA_____________________
      2. Population Size covered by ASHA
         a. Less than 1000
         b. 1001 to 1500
         c. Above than 1500
      3. Sustenance and Motivational Factors related to work: Factors and views of ASHA

         Motivating Factors
         • To be absorbed in government job
         • Earn some money
         • Improve self esteem
         • Inspiration from the community
         • Spirit of voluntarism
         • Serve the community and get something

         Get job satisfaction
         • Yes
         • No
Happy with your work

- Yes
- No

Prestige gone up in village

- Yes
- No
- Not Sure

People feel you are useful

- Yes
- No

Hospital staffs gives priority to your referrals/when you accompany

- Yes
- No
- Sometimes

4. Views of ASHA regarding Motivation factors related to monetary compensation

   i. Average monthly honorarium from different sources
      - <200
      - 200-400
      - 400-600
      - 600-900

   ii. Are you satisfied with the honorarium you get every month
       - Yes
       - No

   iii. If no why (Multiple answers accepted)
        - Amount less as compared in workload
        - Incentives not regular
        - Other _______________________________________________________

   iv. Monthly minimum expectation(Rs/month)
       - 500-1000
       - 1001-2000
       - 2001-3000
       - 3001-4000

   v. Expectation of gratifications by authority at the time of paying compensation
       - Yes
       - No
       - Sometimes
5. Views of ASHAs about Training Received
   a. Imparted with induction training
      - Yes
      - No
   b. Duration of 1st training __________
   c. Place of training- UGPHC/PHC/CHC
   d. After 1st training were you given other training
      - Yes
      - No
   e. For how many days
      - 16 days
      - 7 days
      - 4 days
   f. At what interval
      - Within one year
      - After one year
   g. Was training adequate
      - Yes
      - No
   h. Was training beneficial to you
      - Yes
      - No

6. ASHAs’ Knowledge about their Job Responsibility

   I. To create community awareness on determinants of health- yes/ no
   II. To counsel community on safe delivery, NC/PNC, breastfeeding, immunization, contraception and prevention of RTI and STI- yes/ no
   III. To mobilize community to access health services at different facilities- yes/no
   IV. To work with VHSC to develop a village health plan- yes/no
   V. To accompany pregnant mothers to hospitals- yes/no
   VI. To motivate the community for construction of household toilet-yes/no
   Inform AWW/ANM about birth and deaths

7. Activities undertaken by ASHAs

   Yes   No
   a) Registration of pregnant mother
   b) Counselling on ANC, PNC, safe delivery
   c) Accompany pregnant mother to hospital
   d) Distribution of IFA, Oral pills, ORS
   e) Distribution of DOTS
   f) Inform AWW/ANM on birth and death
   g) Help AWW in supplementary nutrition feeding
   h) Motivate for construction of latrines
i) Help ANM for immunization  
 j) Education to adolescent  
 k) Motivate the couple for family planning  

8. Community Acceptance: Views of ASHAs
   a. Do you make visit to households.  
      - Yes  
      - No  
   b. If no, reasons for no visit _____________________________________________  
   c. Are you called by families/  
      - Yes  
      - No  
      - Sometimes  
   d. Reason for not being called by all families?  

   e. Who are the invitees to attend meetings convened by you - Pregnant women/  
      Lactating mother/ Mother of children (0-6 yrs) /All mothers/ Adolescent girls  
      /PRI/MSS members / SHG members / School Teachers/ other  

2. INTERVIEW QUESTIONS WITH THE ANM
   - Name and Educational qualification  
   - Number of ASHA under you in this subcenter?  
   - How much population each of the ASHA covers?  
   - What all are the jobs of ASHA?  
   - Do you feel that working of ASHA is benefitting the villagers in your area?  
   - How were the ASHA selected?  
   - Was the training imparted to them and do you feel the training is adequate?  
   - Do you feel the community is satisfied with the ASHA?  
   - What factors motivate the ASHA towards work?  
   - What do ASHAs report to you as the problems they face?  

3. INTERVIEW QUESTIONS WITH THE AWW
   - Name of the AWW  
   - Number of Aganwadi workers in this center?
- Names of the villages under this Aganwadi?
- Do you know about the ASHA under the NRHM?
- Do you work/meet together monthly or weekly?
- Do you know how are ASHAs selected in your area?
- Do you think that the health facilities has improved because of ASHA?
- Are you satisfied the way ASHA work?
- Do you think that people are satisfied with the working of ASHA?

4. INTERVIEW QUESTIONS WITH THE PRI MEMBERS

- How is PRI involved in the NRHM?
- How was the PRI involved in selection of ASHA?
- Do you feel that working of ASHA is benefitting the villagers in your area?
- Do you feel the community is satisfied with the ASHA.
- What factors motivate the ASHA towards work?
- What do ASHAs report to you as the problems they face?
# ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ADMO</td>
<td>Additional District Medical Officer</td>
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<tr>
<td>ANC</td>
<td>Antenatal care</td>
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<tr>
<td>ANM</td>
<td>Auxiliary nurse midwife</td>
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<tr>
<td>APL</td>
<td>Above poverty line</td>
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<tr>
<td>ASHA</td>
<td>Accredited social health activist</td>
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<tr>
<td>AWC</td>
<td>Anganwadi centre</td>
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<td>AWW</td>
<td>Anganwadi worker</td>
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<tr>
<td>BEE</td>
<td>Block Extension Educator</td>
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<tr>
<td>BPL</td>
<td>Below poverty line</td>
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<tr>
<td>CBO</td>
<td>Community-based organisation</td>
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<tr>
<td>CDMO</td>
<td>Chief District Medical Officer</td>
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<tr>
<td>CDPO</td>
<td>Child Development Project Officer</td>
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<td>CHC</td>
<td>Community health centre</td>
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<tr>
<td>DOTS</td>
<td>Directly observed treatment short course</td>
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<tr>
<td>FGD</td>
<td>Focus group discussion</td>
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<tr>
<td>ICDS</td>
<td>Integrated Child Development Scheme</td>
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<td>IFA</td>
<td>Iron and folic acid tablet</td>
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<tr>
<td>JSY</td>
<td>Janani Surakhya Yojana</td>
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<tr>
<td>MO</td>
<td>Medical Officer</td>
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<tr>
<td>NIHFW</td>
<td>National Institute of Health and Family Welfare</td>
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<td>NRHM</td>
<td>National Rural Health Mission</td>
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<tr>
<td>OBC</td>
<td>Other Backward Caste</td>
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<tr>
<td>ORS</td>
<td>Oral rehydration therapy</td>
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<tr>
<td>PHC</td>
<td>Primary health centre</td>
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<td>PNC</td>
<td>Postnatal care</td>
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<td>PRI</td>
<td>Panchayati Raj Institutions</td>
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<td>RTI</td>
<td>Reproductive track infection</td>
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<td>SNP</td>
<td>Supplementary Nutrition Programme</td>
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<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
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<tr>
<td>VHSC</td>
<td>Village Health and Sanitation Committee</td>
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