Evaluation of Functioning of Accredited Social Health Activists (ASHAs) in ICDS Related Activities

National Institute of Public Cooperation and Child Development
New Delhi

Evaluation of Functioning of Accredited Social Health Activists (ASHAs) in ICDS Related Activities

A Report

National Institute of Public Cooperation and Child Development

FOREWORD

One of the key components of NRHM was to create a band of female health volunteers, appropriately named "Accredited Social Health Activist" (ASHA) in each village within the identified states, to act as a bridge between the rural people and health services outlets. The task expected of ASHA requires that she works in close coordination with ANM and AWW for effective delivery of services. The present study conducted by NIPCCD has been an attempt to understand the contribution of ASHAs in ICDS related activities, in order to synergise service delivery under the ICDS and health systems to maximise its impact, as also, study the perception of ASHA of their role with respect to ICDS related activities, for bringing about corrective actions.

The study has helped gain insight on the knowledge and skills of ASHA on issues relating to maternal and child health and nutrition. The report throws light on valuable information about the existing interface between the ANM, AWW and ASHA, as also, the problems experienced in effective service delivery by ASHA. I am confident that this report would provide valuable inputs to planners, administrators, research scholars and other stakeholders working in the area of maternal and child health and nutrition, in bringing down the infant and maternal mortality in the country and achieving the Millennium Development Goals.

We appreciate the inputs provided by the Institutional Review Board in finalising the research design of the study. I acknowledge the painstaking efforts of Smt. Shanta Gopalakrishnan, Assistant Director and In charge of the Project in successfully completing the project in the stipulated time period with the able assistance of Ms. Priyanka Singh and Ms. Neha Sahai, Project Assistants. I extend my deep gratitude to Shri A.J. Kaul for the layout and design of the report.

(Dinesh Paul)
Director

Study Team

Overall Guidance and Support

Dr. Dinesh Paul
Director

Shri S.K. Srivastava
Additional Director

Dr. Neelam Bhatia
Joint Director

Project In Charge

Smt. Shanta Gopalakrishnan
Assistant Director

Project Assistants

Ms. Priyanka Singh
Ms. Neha Sahai

Layout and Design

Shri. A J. Kaul

CONTENTS

LIST OF TABLES

LIST OF FIGURES

1

INTRODUCTION

INTRODUCTION

The National Rural Health Mission (NRHM) (2005-12), is a government flagship programme, launched on the 12th April, 2005 in 18 states across the country, including eight Empowered Action Group (EAG) states, the North-Eastern states, Jammu & Kashmir and Himachal Pradesh, that seeks to provide effective health care to the rural population, especially the disadvantaged groups, by improving access, enabling community ownership and demand for services and strengthening public health systems for efficient service delivery. One of the key components of NRHM was to create a band of female health volunteers, appropriately named "Accredited Social Health Activist" (ASHA) in each village within the identified States to act as an interface between the community and the public health system. ASHAs are seen as be health activists in the community who will create awareness on health and its social determinants, counsel mothers on key health behaviours and mobilise the community towards local health planning and increased utilisation and accountability of the existing health services.

1.1 Criteria for Selection of ASHAs

The criteria for selection of ASHA as specified in the ASHA guidelines are as follows:

- ASHA must be primarily a woman resident of the village - 'Married/Widow/Divorced' and preferably in the age group of 25 to 45 yrs.
- She should have effective communication skills, leadership qualities and be able to reach out to the community. She should be a literate woman with formal education up to Eighth Class. This may be relaxed only if no suitable person with this qualification is available.
- Adequate representation from disadvantaged population groups should be ensured to serve such groups better.

1.2 Selection Process of ASHA

As per the Guidelines on ASHA, the District Health Society envisaged under NRHM is expected to oversee the process. The Society would designate a District Nodal Officer, preferably a senior health person, who is able to ensure that the Health Department is fully involved. S/he would also act as a link with the NGOs and with other departments. The

Society would designate Block Nodal Officers, preferably Block Medical Officers, to facilitate the selection process, organising training for trainers and ASHA as per the guidelines of the scheme (NRHM, 2005)[10].

1.3 Roles and Responsibilities of ASHA

The roles and responsibilities of ASHA are as follows:

- ASHA will take steps to create awareness and provide information to the community on determinants of health.
- ASHA will mobilise the community and facilitate them in accessing health and health related services available at the village/sub-center/primary health centers.
- She will work with the Village Health, Sanitation and Nutrition Committee of the *Gram Panchayat* to develop a comprehensive village health plan.
- ASHA will provide primary medical care for minor ailments such as diarrhoea, fevers, and first aid for minor injuries.
- She will promote construction of household toilets under Total Sanitation Campaign.

1.4 Training of ASHAs

Capacity building of ASHA is critical in enhancing her effectiveness. After the induction training of 23 days, periodic re-training is to be held for about two days, once in every alternate month at appropriate level for all ASHAs. During this training, interactive sessions are held to help refresh and upgrade their knowledge and skills, trouble shoot problems they are facing, monitor their work and also for keeping up motivation and interest. The list of competencies to be developed in ASHA after the 24 days training is at **Annexure-I.**

1.5 Performance Based Incentives to ASHAs

ASHA has been instituted as an honorary volunteer and do not receive any salary or honorarium. Her work is so tailored that it does not interfere with her normal livelihood. However, ASHAs are compensated - for the duration of her training both in terms of TA and DA; for participating in the monthly/bi- monthly training, as the case may be; under different national programmes for undertaking specific health or other social sector programmes with measurable outputs; and for key health related activities, for example, all eligible children

immunised, all newborns weighed, all pregnant women attended an antenatal clinic, etc). The Untied Fund of Rs.10,000/- at the Sub-centre level is used as monetary compensation to ASHA for achieving these key processes. The exact package of processes that form the package would be determined at the state level depending on the supply-side constraints and what is feasible to achieve within the specified time period (MOHFW, 2005)[9]. The basic compensation package provided for ASHA is placed at **Annexure-II**.

1.6 Convergence of ICDS with NRHM

The ICDS envisages convergence of nutrition and health programmes viz., supplementary nutrition, immunisation, health check-up of children, pregnant and lactating mothers. The concept of package of nutrition and health related services under the ICDS is based primarily on the consideration that the overall impact will be much more if the different services are delivered in an the integrated manner. Inter-sectoral convergences of ICDS and health programmes is also visualised with programmes for providing safe drinking water, sanitation, hygiene and nutrition under NRHM.

At the operational level, informal collaboration does exist between the Auxiliary Nurse Midwife (ANMs) and the Anganwadi Workers (AWWs) at the village level, between ICDS Supervisor and Lady Health Visitor (LHV) at sectoral level and Child Development Project Officer (CDPO) and Medical Officer (MO), PHC at block level. However, many of these efforts are disjointed and often operate under informal mechanisms. The MWCD and MOHFW have overlapping goals and therefore, convergence of programmes is essential for the success of ICDS and NRHM.

The key convergence areas and operational strategies for joint planning and implementation of the two programmes, namely- the ICDS and NRHM are as can be seen in the following Table:

S.No.	ANM	AWW	ASHA
1.	To be invited to the meeting of the Village Health and Sanitation Committee	To be invited to the meeting of the Village Health and Sanitation Committee	To be invited to the meeting of the Village Health and Sanitation Committee
2.	To assist in preparation of Village Health Plan	To assist in preparation of Village Health Plan	To assist in preparation of Village Health Plan

3.	Organise Village Health Day at AWC (Immunisation, ANC, PNC, Health Check- ups etc.)	Assist in organising Village Health Day. Register Children and Women for Immunisation, ANC, PNC, Health Check- ups etc.	Assist in organising Village Health Day. Help AWW in registering Children and Women for Immunisation, ANC, PNC, Health Check-ups etc.
4.		Mobilise beneficiaries (with the AWH/ASHA) for the Village Health Day through SHGs, Mothers Committee, beneficiaries of the ICDS Scheme	Mobilise beneficiaries for the Village Health Day under the guidance of AWW
5.	Attend to such referred cases on priority	Refer sick children, pregnant/lactating mothers to sub/centre, PHC/CHCs	Refer cases to sub/centre, PHC/CHC
6.	Impart health& hygiene education to the beneficiaries of Kishori Shakti Yojana (KSY)	Assist CDPO/ICDS Supervisor in the implementation of Kishori Shakti Yojana (KSY)	Assist AWW in her activities pertaining to KSY
7.		Depot Holder of Medicine Kit/Contraceptives under ICDS	Receive ASHA Kits/ Contraceptives from AWW
8.	Administer such drugs as specified by the MOHFW	Administer OTC drugs Distribution of ORS/IFA Tablets, DDK, & Condoms	Administer OTC drugs Distribution of ORS/IFA Tablets, DDK, & Condoms
9.	Implement IMNCI Home visits once in two months during pregnancy. (Once in the first week of delivery)	Home Visits – Once a month during pregnancy, Once in the first week of delivery. Second visits in second or third week as per the need	Implement IMNCI. Home visits at least once in a month during pregnancy. (Once in the first week of delivery)
10.	Maintain and update Eligible Couple Register		Help ANM to maintain and update Eligible Couple Register
11.		Counsel women on birth preparedness	Counsel women on birth preparedness
12.	Guide/Counsel women on safe/institutional delivery	Guide/Counsel women on safe/institutional delivery	Assist ANM/AWW in this work
13.			Assist/escort Women for institutional delivery
14.	Guide TBA (Trained Birth Attendant)		Guide TBA (Trained Birth Attendant)
15.			Facilitate referral of difficult cases
16.	Nutrition & Health Education	Nutrition & Health Education	Nutrition & Health Education
17.	Promote breastfeeding of Infant and Young Child Feeding Practices	Promote breastfeeding of Infant and Young Child Feeding Practices	Promote breastfeeding of Infant and Young Child Feeding Practices
18.	Share available information with the Village Registrar of Births and Deaths	Share available information with the Village Registrar of Births and Deaths	Ensure registration of all births and deaths of mothers with the Village Registrar of Births and Deaths

Joint meetings at the State, District and Block level of the functionaries for monitoring mechanism to ensure convergence of the schemes, joint evaluation and field inspection by the two Departments is already in place (MOHFW, 2007)[8].

1.7 Mother and Child Protection Card

One major initiative for accelerating reduction in maternal, neonatal and infant mortality and child undernutrition has been the adoption of WHO Child Growth Standards, with effect effect from 15 August 2008 in both ICDS and NRHM, through a joint circular dated 6 August 2008, issued by both the Secretaries of Women and Child Development and Health and Family Welfare, Government of India. This initiative has been enriched and complemented by another decision of both the ministries by introducing a common Mother and Child Protection Card for both ICDS and NRHM, to strengthen the continuum of care for pregnant mothers and children under-three years of age, incorporating the new WHO Child Growth Standards (www.wcd.nic.in)[30].

The MCPC is a maternal and child care entitlement card, a counselling and family empowerment tool which would ensure tracking of mother child cohort for health purposes. It is meant to promote key family care behaviours, highlights danger signs and links families to the referral system. The MCPC would enable gender disaggregated tracking, to ensure optimal care of the girl child.

1.8 Village Health, Sanitation and Nutrition Committee (VHSNC)

The Village Health, Sanitation and Nutrition Committee (VHSNC) /Village Water and Sanitation Committee (VWSC) formed at the village level has the responsibility to address issues of personal, domestic and environmental sanitation as key to preventive health. VHSC will motivate communities to adopt sanitary latrines at the household level. Wherever separate committees exist, Village Health and Sanitation Committees will collaborate with the Village Water and Sanitation Committees formed at the Gram Panchayat level under the Total Sanitation Campaign. Efforts would be made to merge the Village Health Committees

with the Village Water and Sanitation Committees to form a Village Water, Health, Sanitation and Nutrition Committee. Anganwadi Workers being a member of Village Health and Sanitation Committee are an important role player in health and sanitation awareness generation and are seen in the village as a role model (MOHFW, nd)[7].

1.9 Village Health and Nutrition Days (VHND)

An important activity of NRHM, Village Health and Nutrition Day (VHND) is to promote regular community-oriented health and nutrition activities. In order to share a common understanding about the activities to be undertaken and how these are to be operationalised while organising the VHND, a manual giving information about organising the VHND has been prepared giving clear cut guidelines for AWWs/ASHAs/ANMs/PRIs. The VHND is to be organised once every month (preferably on Wednesdays and for those villages that have been left out, on any other day of the same month) at the AWC in the village. This will ensure uniformity in organising the VHND. The AWC is identified as the hub for service provision in the RCH-II, NRHM, and also as a platform for inter-sectoral convergence. VHND is also to be seen as a platform for interfacing between the community and the health system.

1.10 Janani Suraksha Yojana

Janani Suraksha Yojana (JSY) is a safe motherhood intervention under the National Rural Health Mission (NRHM) being implemented with the objective of reducing maternal and neo-natal mortality by promoting institutional delivery among the poor pregnant women. The Yojana, launched on 12th April 2005 is being implemented in all states and UTs. JSY is a 100 per cent centrally sponsored scheme. JSY has identified ASHA, the Accredited Social Health Activist as an effective link between the Government and the poor pregnant women in 10 low performing states, namely the 8 (EAG) - Empowered Action Group (EAG) states and Assam and Jammu & Kashmir and the remaining North Eastern States. Her main role is to facilitate pregnant women to avail services of maternal care and arrange for referral transport (MOHFW, 2005)[11].

Current status of implementation reveals that there is rapid increase in the institutional deliveries, coupled with improvement in infrastructure, manpower and training resulting in improvement in the figures of Institutional deliveries in all major states except Jharkhand in the DLHS III data as compared with DLHS II. The growth in the institutional delivery figures is substantial in the five major states of Uttar Pradesh, Rajasthan, Madhya Pradesh, Odisha and Bihar.

On the other hand, the scheme is also facing operational problems in the payment of incentives to the beneficiaries, as well as, to ASHAs. The payments are delayed by three to four months (at times even a year in some states) and are often made only after repeated visits by the claimants. There are complaints of unauthorised deduction by the disbursing functionaries. While cheque payments reduce leakages, they delay the process further. Due to lack of identity cards or proof of address, many women are unable to open bank accounts and therefore cannot avail of the benefits. Recognising these shortcomings, most states have initiated steps to undertake systemic corrections and streamline the processes (Planning Commission, 2011)[12].

1.11 Drug Kits and its Regular Replenishment

As envisaged in the scheme of ASHA, a drug Kit is provided to ASHA to provide primary health care to the community like minor elements like fever, pain, first aid, etc. A similar medicine kit with easy to use and dispensable medicines to remedy common ailments, is already available with the AWW, for reaching out to the community. The medicines provided in both the kits are different, except for Paracetamol and Povidine/Favidone ointment.

The replenishment of medicines of the drug Kit provided to ASHA is made from PHC/Sub-Center stocks. However, a demand responsive logistic system reaching out to sector PHCs and to sub-centers is essential for maintaining the drug supply needed. The composition of drugs and supplies in the kit should reflect the understanding of community level care provision that saves lives of children.

1.12 Rationale of the Study

Sub-centre the most peripheral level of contact with the community under the public health infrastructure ideally caters to a population norm of 5000, but has been effectively

serving much larger population, especially in EAG States. With only about 50 per cent of Male Multi-purpose Health Workers (MPW-M) being available in these States, the ANM has been heavily overworked, which has adversely impacted outreach services in rural areas. Also under the Integrated Child Development Scheme (ICDS) the Anganwadi Workers (AWWs) engaged primarily in organising supplementary nutrition programmes, preschool education and other supportive activities was left with little or no time to take up the responsibility of a health behaviour change agent in a village.

Thus in order to address the health needs of rural population, especially the vulnerable sections of society, the Government of India launched a National Rural Health Mission (NRHM) in 2005. Accordingly a new band of community based functionaries, named as Accredited Social Health Activist (ASHA) has been created under the NRHM to act as a bridge between the rural people and health services outlets. ASHA as a health activist in the community creates awareness on health and its social determinants and mobilises the community towards local health planning and increased utilisation and accountability of the existing health services. She is a promoter of good health practices and also provides a minimum package of curative care as appropriate and feasible for that level and makes timely referrals.

The task expected of ASHA requires that she works in close coordination with ANM and AWW for effective delivery of services. The preliminary finding of the National ASHA Mentoring Group (NAMG) has revealed that there has been confusion in many States among the ASHAs on their own role and also among the AWWs and ANMs on the role of ASHA. In order to synergize service delivery under the ICDS and health systems and maximise impact, there is a need to assess the knowledge and skills of Accredited Social Health Activists (ASHA) on issues relating to maternal and child health and nutrition, as also perception of their role with respect to ICDS related activities, for bringing about corrective actions.

Objectives

The objectives of the study were to:

i. Assess the knowledge and skills of ASHA on issues relating to maternal and child health and nutrition and related ICDS services;
ii. Study the contribution of ASHAs in ICDS related activities;

iii. Study the perception of ICDS (CDPOs, Supervisors and AWW) and Health functionaries (MO, LHV and ANM) on the role of ASHA in ICDS related activities;

iv. Study the perception of the community (pregnant women, mothers with children upto six months and mothers with children between six months and two years); Village Health, Sanitation and Nutrition Committee Members, PRI member, teacher, etc. on the functioning of ASHA;

v. Learn about the various performance based incentives disbursed to ASHAs;

vi. Analyse the training needs of ASHA with respect to ICDS related services;

vii. Examine the existing interface between the ANM, AWW and ASHA; and

viii. Identify the problems and bottlenecks in effective service delivery by ASHA.

2

REVIEW OF LITERATURE

REVIEW OF LITERATURE

The MWCD and MOHFW have overlapping goals and therefore, convergence of programmes is essential for the success of ICDS and NRHM. At the operational level, informal collaboration does exist between the ANM and the AWW at village level, between ICDS Supervisor and Lady Health Visitor (LHV) at sectoral level and Child Development Project Officer (CDPO) and Medical Officer (MO), PHC at the block level. However, many of these efforts are disjointed and often operate under informal mechanisms.

The ASHAs, the new entrant into the health system, represent the cornerstone of NRHM's strategy to address the Millennium Development Goals (MDGs) on health related indicators. In order to maximise India's potential to achieve these goals through the NRHM, it is essential to improve ASHA's performance, specifically through the processes of recruitment, training, supervision, provision of incentives, coordination and cooperation with ANMs and AWWs. The key convergence areas and operational strategies for joint planning and implementation of the two programmes are already in place, however there is a need to review the operationalisation of convergence at the grassroots level.

An attempt has been made to review studies which have focused on knowledge of ASHAs related to maternal and child health issues, role perception and job performance of ASHAs related to maternal and child health, home visits, JSY, VHND, VHSNC, etc., as also, the existing interface of ASHA with the health and ICDS functionaries, PRI members and community members and the same has been presented in the following paragraphs.

2.1 Profile of ASHAs

The criteria for selection of ASHA are clearly specified in the ASHA guidelines. A review of the selection criteria followed, as has been elicited from the various studies is as follows:

National Health Systems Resource Centre (NHSRC, 2011)[18] conducted an evaluation of ASHA programme in eight states, namely, Andhra Pradesh, Assam, Bihar, Jharkhand, Kerala, Odisha, Rajasthan and West Bengal on 100 ASHAs, 600 beneficiaries, 100 AWWs, 100 PRI members and 25 ANMs and found that in all the states, all ASHAs were women and most were married. About two-thirds of ASHAs were in the 24 to 35 year age group, except in Kerala where only one-third belonged to this age group. In Rajasthan and Jharkhand the remaining were mainly in the 20 to 24 age group, whereas in Kerala, Assam, Odisha, Bihar and West Bengal the majority of the remaining were above 36 years of age (NHSRC, 2011) [18]. A study conducted by BRDMC, (2009)[3] found that more than half of ASHAs were in the age group 20-29 years.

Most ASHAs were from poor households, and the proportion of ASHAs who are scheduled caste or scheduled tribe is equal to or more than the proportion of the scheduled caste/ scheduled tribe population in most states. Tribal districts have usually preferred ASHAs from scheduled tribe background. Minorities are however under-represented (NHSRC, 2011) [18].

Most villages have selected ASHAs who are literate, because of insistence from state authorities. Only Odisha, Jharkhand and Andhra Pradesh have relaxed the literacy qualification. In these three states, 37 per cent in Odisha, 27 per cent in Jharkhand and 28 per cent in Andhra Pradesh the ASHA reported an educational qualification lower than Class VIII. The inability to relax the educational level where needed and raising the educational level even higher, as in West Bengal to class X has resulted in failure to find ASHAs in some of the needy areas (NHSRC, 2011) [18]. Other studies have revealed that majority of the ASHAs (90%) were having a qualification between 8th to class 12th class {BRDMC, (2009); Srivastava, D. K. et al. (2009); Mahyavanshi, K.D., et.al., (2011); and RNTMC (2009)}[3,26,16,23].

The density of ASHA deployment varies across and within states, with most states having over 50 per cent of ASHA catering to a population of less than 1000. In tribal areas of Jharkhand, Khammam and Banswara, ASHA density is less than one per 500, in about 25 per cent, 36 per cent and 19 per cent, respectively, indicating that states have interpreted the norms to suit their contexts to some extent. Bhatnagar, et al., (2009)[2], in a study conducted in

Udaipur district of Rajasthan on 180 ASHAs found that almost 50 per cent ASHAs were covering population ranging from 1000-1500.

2.2 Training Status of ASHAs

Bajpai, N. and Dholakia, H.R., (2011)[1] all of the ASHAs in the surveyed states had received less than the prescribed 23 days of training. All ASHAs had undergone induction training of 7 days {BRDMC, (2009); and Srivastava, D. K. et al. (2009)}[3,26]. Majority (86.66%) of the ASHA had received the second training {BRDMC, (2009)}[3].

2.3 Knowledge and Awareness of ASHA on Maternal and Child Health Issues

2.3.1 Antenatal Care (ANC)

A study conducted by MKCGMC, (2008)[17] on a rapid appraisal on functioning of Janani Suraksha Yojana in South Odisha in Ganjam, Gajapati and the Kandhamal districts of Odisha found that when the actual usage levels of JSY are analysed, it is found that the first contact was made by ASHAs with 70 per cent of the respondents for ANC during 12-24 weeks of pregnancy.

State Institute of Health & Family Welfare, (2008)[27] on assessment of functioning of ASHAs under NRHM in four districts of Uttar Pradesh revealed that as much as 14 per cent of the pregnant mothers had one or the other form of complications during pregnancy, out of which 35 per cent were facilitated by the ASHAs in getting the treatment. In a study conducted by Singh et al., (2008)[24] on factors influencing utilisation of ASHA services under NRHM in relation to maternal health in rural Lucknow on 350 recently delivered women (RDW) of the PHC Sarojininagar, being served by ASHA found that, early registration (within 16 weeks) was reported by roughly 70 per cent of recently delivered women. Adequate ANC comprising more than three antenatal visits, two doses of T.T injections and 100 iron and folic acid tablets was received by only 10 per cent of RDW. Haider, et al., (2008)[6], conducted a rapid appraisal of ASHA/ Sahiya (ASHA) to review the implementation status of ASHA/ Sahiya (ASHA) programmes in 10 blocks of Jharkhand found that only half of pregnant women reported that ASHA/ Sahiya visited them during pregnancy; and only one-fourth reported being facilitated by ASHA/ Sahiya in getting medicines and immunisations. The percentage of institutional delivery was higher among the women who

were in contact with ASHA/ Sahiya, as compared to the women who were not in contact with ASHA (16.8%). Similarly, the percentage of women who received postnatal care was higher among the women who were in contact with ASHA, as compared to the women who were not in contact with ASHA.

2.3.2 Natal Care

One of the tasks, where there is complete consensus that ASHA has a role, is the promotion of institutional delivery. Over 90 per cent of ASHAs are functional on this task. One reason for this good performance on this task is incentivisation as this is the most consistently incentivised activity. It is also one of the most supervised elements of the programme. A third contributory factor is that this activity requires relatively little knowledge or skills, on the job supervision or any other form of support. However even in the promotion of institutional delivery both coverage and effectiveness varies. In the best performing of districts over 20 per cent of pregnant women are not even met by the ASHA and that in poor performing districts where the ASHA is needed most, as much as half the pregnant women are left out, is a matter of deep concern. Increasing coverage requires that the ASHA reaches out to all- even those who clearly will not opt for institutional delivery- so that she can change behaviours, instead of prioritising her time, only for those most likely to yield her an incentive payment.

In some states like in Kerala and Andhra Pradesh, the level of institutional deliveries are already high and only about 50 per cent of those who opted for institutional delivery stated ASHA support's as contributing to their choice, and only about 30 to 35 per cent had JSY as a reason for the choice. In contrast, in Odisha, about 60 per cent of deliveries still take place at home according to DLHS 3 (IIPS,2010)[13]. Therefore when we find that 85 per cent of families are met by ASHA and of them nearly 94 per cent report institutional deliveries, this increase clearly reflects ASHA's effectiveness. This is further validated when 94 per cent of women who sought institutional delivery said they had been referred by the ASHA (NHSRC, 2011)[18].

Public Health Resource Society, (2009)[22] in a rapid assessment to assess that status of the community processes in the district initiative under National Rural Health Mission (NRHM) in the states of Bihar, Jharkhand and Odisha found that ASHAs felt that advising

pregnant women for institutional delivery was one of their prime agenda and they have not failed in that aspect.

2.3.3 Janani Suraksha Yojana (JSY)

MKCGMC, (2008)[17] found that only two–thirds of the ASHAs were aware of the functional aspects of the JSY scheme. This was a major gap as ASHAs are the principal front line functionaries who are expected to provide complete and accurate information to prospective users. The implementation of the Janani Suraksha Yojana found that for majority of users, the place of delivery was government health institutions and very few deliveries happened at home. Among non-users, a little over half of deliveries happened at home, while a few went to private clinics and charitable hospitals. A significant finding was that one-fifth of the non -users delivered in government hospitals but did not receive JSY compensation. This was primarily because of the non-availability of JSY card with these mothers. Roughly in half of the cases, the JSY card was made in 3-6 months of pregnancy, providing sufficient time for the mothers to obtain information about the JSY scheme from the ASHAs and also undergo ANC. However, in half of the users, registration was delayed beyond six months, thereby reducing the time available to ASHAs to interact with the potential beneficiary and initiate ANC check-ups.

The study found that roughly 40 per cent of the users got payments within one week, and another 40 per cent of users got it between a week and a month, and for the remaining 20 per cent, it took over a month to avail of the cash benefit. This delay results in lack of money at operational levels which in turn affects the release to money to ASHAs and eventually to the beneficiaries. Majority of the mothers are of the opinion that lack of 24 -hour services, absence of staff at hospitals, dirty conditions, poor supplies of medicines and rough attitude of the clinical staff, referrals to higher centres, and tests from outside are major deterrants in accessing JSY services (MKCGMC, 2008)[17].

ASHA accompanied one-fifth of the women to the health institution for delivery, while another 30 per cent women were accompanied by Anganwadi Worker, Dai, and ANM. Most (96%) of the beneficiaries reported that the presence of ASHAs facilitated in obtaining services at the place of delivery. ASHAs approached the medical personnel and helped in

expediting registration and other administrative activities in getting JSY cash incentive {MKCGMC, (2008); CORT, (2007); and SIHFW, (2008)}[17,4,27].

2.3.4 Postnatal Care (PNCs)

MKCGMC, (2008)[17] found that postnatal care was quite low (28.3%). The ASHAs facilitated three PNCs in less than one-fifth of the user-women and private practitioners conducted PNCs in 37.5 per cent non-users. Since PNC is an important component of the service continuum, a special thrust is required to enhance its uptake.

2.3.5 Newborn Care

Mahyavanshi, K.D., et.al., (2011)[16], found that majority (86.2%) of ASHAs had improper knowledge regarding newborn care and were unaware as to what advice to give to a mother for prevention of hypothermia and how to give kangaroo mother care. Although newborn visits have not yet been introduced, about 27 per cent of the ASHA in Dibrugarh, and 55 per cent in Karimganj were making home visits for the newborn.

When newborn care was incentivised, ASHAs in Angul, received a more reliable, higher and more accountable payment and are the best paid ASHAs in Odisha (NHSRC, 2011)[18].

2.3.6 Knowledge on Breastfeeding and Complementary Feeding

Knowledge on exclusive breastfeeding is over 80 per cent in all states except in Odisha where only 70 per cent of ASHA knew that the baby should be exclusively breastfed for six months. On the issue of adding fats and oils for complementary feeding, the knowledge levels were much lower, ranging from 1 per cent in Odisha to 44 per cent in Rajasthan. The higher knowledge and functionality on nutrition in Rajasthan is accounted for by the fact that the ASHA were part of the ICDS system, and probably had been trained with more rigour in nutrition topics (NHSRC, 2011)[18].

Effectiveness on nutrition was assessed on two parameters reported by mothers of children between six months to two years of age. On the proportion of children who were regularly using services of the Anganwadi the figures ranged from 84 per cent in Andhra

Pradesh, 75 per cent in Odisha, 69 per cent in Kerala, 68 per cent in West Bengal 62 per cent in Jharkhand, 50 per cent in Rajasthan, 41 per cent in Bihar, and 23 per cent in Assam. Regarding the proportion of children who were given complementary feeds at six months of age, the figures are low in most states, except for Kerala and Andhra Pradesh with about 72 per cent (NHSRC, 2011). Mahyavanshi, K.D., et.al., (2011)[16], found that almost all ASHAs had good knowledge, regarding prelacteal feed and knew the importance of early initiation of breast feeding i.e. within an hour of normal delivery. But over 70 per cent had poor knowledge regarding how many times the child should be breastfed during the daytime and night; problems in breast feeding (86%) and complementary feeding (71%).

The Population Council (2010)[21] conducted a study in Uttar Pradesh to determine the status of early and exclusive breastfeeding, to understand the facilitating factors and barriers in adopting the desired breast feeding practices and identify programmatic and behavior change communication (BCC) initiative that could accelerate the adoption of early and exclusive breastfeeding practices. The study found that many frontline health workers supported the practice of exclusive breastfeeding. However, as they were not aware of the composition of the breast milk and that breast milk contains 80 percent water, which is adequate for a child aged less than 6 months, they advised the women to feed the child water.

2.3.7 Immunisation

A second task for which the ASHA is incentivised is childhood immunisation. In Assam, over 96 per cent per cent of ASHAs are mobilising for immunisation sessions, and 94 per cent knew the correct timing of measles vaccine. Despite this, only 71 per cent of children in Dibrugarh and 55 per cent of Karimganj had actually received measles vaccine. Variation is also due to the response of ASHAs and local support systems to felt needs in the community, and by the ASHA exercising her own agency in decision making. This has implications both for programme design and for viewing immunisation rates as a consequence of supply side issues rather than demand side. In Andhra Pradesh alone, the study shows far lower coverage than the DLHS III and this needs further exploration (NHSRC, 2011) [18]. Out of 83 per cent newborns that were administered BCG vaccination, 59 per cent were facilitated by the ASHAs in getting the immunisation (SIHFW, 2007-08)[27]. Mahyavanshi, K.D., et.al., (2011)[16], found that though considerable proportion of ASHAs (63%) knew which are the vaccine preventable diseases. Majority (70%) of ASHAs had

poor knowledge regarding schedule of immunisation as they had little knowledge as to when to take child for vaccination and for which vaccine.

2.3.8 Childhood Illnesses

The Lancet Child Survival Series estimates that actions taken at the household and family level alone can prevent over 30 per cent of child deaths and a similar proportion (up to 37 per cent) of neonatal deaths. Aware and vigilant families are also more likely to ensure that their children get prompt and appropriate facility – based clinical care, further contributing to declines in mortality (Paul, V. K., et al., 2011)[20]. Mahyavanshi, K.D., et.al., (2011)[16], found that as compared to other diseases, ASHA's knowledge and practices were found to be better for diarrhoea, as majority (75%) knew when to give ORS and advice for immediate referral. Majority (85%) had adequate knowledge about malaria as they knew the causes and symptoms of malaria, as also when and how to make blood smear, but they lacked knowledge regarding measles (68%) and pneumonia (92%). In care during illness of the sick child, irrespective of programme theories and support, atleast 70 per cent of ASHAs were being consulted.

2.3.9 Family Planning Methods

The ASHA's knowledge regarding contraceptives is uniformly high in all states, ranging from 82 per cent to 98 per cent. Counselling for family planning is low in all high focus states except for Odisha (NHSRC, 2011) [18]. Out of the 40 per cent of mothers counselled for accepting any method of family planning, ASHAs were able to motivate 37 per cent to accept tubectomy (6%), condom (26%), IUD insertion (2%) and oral contraceptive pills (3%) (SIHFW, 2007-08)[27].

2.3.10 HIV/ AIDS

Most of the ASHA were aware about the HIV/AIDS and how it is transmitted but none of the ASHA knew about the Integrated Counseling & Testing Centre (ICTC) (Gosavi, et.al, 2009)[5].

2.4 Home Visits by ASHAs

Home visits are an opportunity to provide preventive, promotive and curative care. Bajpai, N. and Dholakia, H.R., (2011)[1], found that ASHAs visited on an average 3 to 4 households per day in a village.

2.5 Availability, Knowledge and Use of Medicine Kit

A drug kit is provided to the ASHA. The GOI issued model guidelines to streamline refilling of the ASHA drug kit. The contents of the kit were a part of the guidelines, but states have adapted the list in many cases. The kits are expected to be filled monthly. Except in Bihar the drug kit has been provided to all ASHA. Even when the kit has not been provided, ASHA are given some drugs to be dispensed. NHSRC, (2011) [18] demonstrate that where the ASHAs are supplied with drug kits and regular replenishment is being done, both ASHAs and beneficiaries report the use of ORS for management of diarrhoea and appropriate referral- demonstrating the high potential to provide prompt and appropriate management of childhood illnesses at the community level. Paracetomol and dicyclomine provide symptomatic relief, and IFA and albendazole are used in anemia and de-worming- all simple, safe and very effective.

CORT, (2007)[4] found that the Madhya Pradesh had not provided the kit, but few drugs were provided on an adhoc basis. However, most of the ASHA/ Sahiyas got the medicine kit consisting of chloroquine for fever, paracetamol for fever & pain, iron tablets for pregnant women, ORS for baby suffering from diarrhoea, Mala N & condoms and thermometer for measuring fever (but no one knew how to measure fever) and cotton & bandage but there was no clarity on medicine for diarrhoea and a medicine named 'Mandoor' (Public Health Resource Society, 2009)[22].

2.6 Knowledge and Awareness about Village Health & Nutrition Days (VHNDs)

The Village Health and Nutrition Days (VHND) were observed every month. ASHAs participated in collaboration with the ANMs and AWWs in almost all the villages. It was also found that ASHA also got information of pregnant and lactating mothers, Grade-III and Grade-IV children from the ANM and AWW to have effective coordination. Generally, weight measurement of pregnant woman and children in the age group of 0 to 3 years, BP

and abdominal check up of pregnant women, referral check up of sick children and medicine distribution was done in the VHNDs (Public Health Resource Society, 2009)[22].

2.7 Knowledge and Awareness about Village Health Sanitation Nutrition Committee (VHSNC)

A study conducted by KCDS, (2008)[14] on rapid appraisal of functioning of Village Health and Sanitation Committee (VHSCs) in Odisha found that the awareness about the objectives of the VHSCs was highest among the ASHAs, the ANMs, SHG members and the least among the PRI members. VHSC have been formed in Rajasthan, Jharkhand, Assam, Andhra Pradesh and Odisha (referred to as Gaon Kalyan Samiti).

KCDS, (2008)[14], observed that the range of membership among the committees varied from 10 to 31. Almost 60 per cent of the VHSCs did not have conveners, in the remaining 40 per cent of the VHSCs either AWWs (25%) or ASHAs (15%) were designated as the convener of the committee. Majority VHSCs do not have a chairperson, usually ward member/Sarpanch is designated as the chairperson.

The study found that majority of CDMOs/MOs, ANMs and ASHAs knew about the formation process, while only one out of the few PRI members knew about the process of formation of VHSC and none of the panchayat officials had any knowledge about its formation. With respect to involvement in VHSC formation, it was highest among the ASHAs, the ANMs and SHG members followed by CDMOs and PRI members. Except in Kerala, Assam and Odisha, and to a limited extent in West Bengal there is little systematic training of the VHSC members. The issues relating to cleanliness and sanitation (50%), awareness about health programmes (30%), village survey (25%), immunisation (10%), change of convener from ASHA to AWW (10%), use of sub-centre untied fund (5%) and undertaking IEC activities/wall painting (5%) were discussed during the meetings.

About half of CDMOs/MOs and ANMs knew that there is a provision of funds for VHSCs. All ASHA, ANM and CDMO/MOs reported that no funds were received for VHSC activity by them. The study also found that almost all CDMOs/MOs were aware about the Village Health Plan. Only some ASHA (18%) and ANM (18%) were of the opinion Village Health Plan was formulated in their locality. However, almost all stakeholders and over 80

per cent of ASHAs and ANMs informed that no work related to the village health plan has been made in their area (KCDS, 2008)[14].

2.8 Awareness, Satisfaction and Problems Related to Performance Based Incentives of ASHA

National guidelines for ASHA define her as a "honorary volunteer" to be compensated for her time in specific situations such as training attendance, monthly reviews, and other meetings. NIHFW, (2011)[18] found that in general all states incentivise the ASHA for JSY and immunisation and participation in review meetings and most incentives received are for these three activities.

Public Health Resource Society, (2009)[22] revealed that ASHA received the financial incentive according to the norms fixed by NRHM. However, UNFPA (2009)[28] found that a high proportion of ASHA (79%) did not get their payment regularly in Bihar, followed by nearly 50 per cent in Madhya Pradesh and Uttar Pradesh. Nearly one quarter in Odisha and one-fifth of the ASHA in Rajasthan reported not receiving their payment regularly. Gosavi, et.al, (2009)[5] revealed that almost all the ASHAs were aware that they would be getting performance based incentive but none of them were aware about how much incentives they will exactly get while doing that particular work.

2.9 Perception about Support and Supervision Provided to ASHA

People enumerated as supervisors by ASHAs are mainly ANM (75%), Medical Officers (30%) and AWW (16.66%). Most of the ASHAs (86.66%) got the support from these supervisors in solving their problem and majority of them (95%) were satisfied with their supervisors {BRDMC, (2009)[3]}. Public Health Resource Society, (2009) shows that most of the ASHA/ Sahiyas felt that support from AWW & ANM is not adequate and they also felt that ANMs should teach them new things like checking anaemia in women and about antenatal check-ups.

2.10 Role Perception, Job Performance and Contribution of ASHA in Care and Support of Women during Pregnancy and Delivery and Mothers with Children Under- Two

Kanth, Cherian and George (2010)[15], found that majority (78%) of ASHA had little or no knowledge about their role as specified under the guidelines on ASHA under NRHM. Only one-fifth (22%) of them had some understanding of their roles. Majority of them did not perceive care of the newborn or promotion of family planning services to be part of their role.

2.10.1 Perception of Health and ICDS Functionaries about Role of ASHA

Kanth, Cherian and George (2010) [15], found that ANMs and AWWs, village leaders and other community stakeholders had a limited understanding regarding the roles of the ASHA. Most of them perceived them as additional line workers under the Reproductive and Child Health Programme and that their roles were mainly to register pregnant women, mobilise the community to utilise the immunisation services and to provide support to mothers during the time of delivery. Most of them did not feel that they were a community health educator, or that their work involved addressing other social determinants of health like food security water and sanitation. The role of the ASHA as a social health activist was not understood by any of AWWs, ANM, and PRI members.

2.10.2 Job Performance and Contribution of ASHA

Bajpai, N. and Dholakia, H.R., (2011)[1] found that following up with mothers for ANC visits and accompanying them for deliveries were the two primary activities of ASHAs. Substantial proportion of ASHAs in Bihar (84%), Chhattisgarh (94%), Rajasthan (98%) and Uttar Pradesh (98%) conducted group discussions on health, nutrition, sanitation and family planning. Substantial proportion of ASHAs in Bihar (95%), Chhattisgarh (94%), Rajasthan (100%) and Uttar Pradesh (98%) registered pregnant women for ANC were visited only once for ANC.

SMSMC, (2008)[25] undertook a study to assess the quality of institutional deliveries in Jaipur District, Rajasthan. The study found that ASHAs create awareness on the need for skilled attendance at birth, on danger signs during pregnancy, counsel pregnant mothers for

birth preparedness, motivate them for antenatal check –ups and accompany them to health institutions at the time of institutional delivery, in addition to other roles and responsibilities

2.10.3 Perception of Beneficiaries

Public Health Resource Society, (2009)[22] found that there has been an overwhelming response of the community in stating that the ASHA was playing a critical role in facilitating the process of registration, administration of TT, consumption of IFA, colostrum feeding, exclusive breastfeeding, immunisation, etc. besides giving routine counseling and the intervention of ASHA resulted in dispelling various misconceptions and they were able to avail proper medical counseling and services on time regarding care during pregnancy and newborn care.

Public Health Resource Society, (2009) [22] studied that ASHAs not only accompanied pregnant women for delivery but also stayed through the delivery and till the mother reached home. Most of the ASHA/ Sahiyas mobilise children under-5 for routine immunisation. They also mobilise men and women for vasectomy/tubectomy and for other activities like distribution of bleaching powder, repair water hand pumps, sprinkling of kerosene oil in sewage ducts, etc.

2.11 Perception About the existing Interface Between ASHA and ANM, AWW and PRI Members/ VHSNC Member

NHSRC, (2011)[18] found that there is no evidence of any major conflict between ANMs, AWWs and ASHAs, though this is one of the most commonly heard problems as perceived by the programme managers. Haider, et al., (2008)[6], found that almost all the ANMs agreed that they got help from ASHA/ Sahiya in immunisation. Some also took help in identifying pregnant women and give ANC. Similarly, almost all the ASHA/ Sahiya reported that the ANMs helped them in replenishing the drugs, as also, in getting the immunisations done for their beneficiaries. It was found that in some areas, ANMs took assistance of ASHA/ Sahiya in home visits, health education and health programmes like malaria, pulse polio etc.

Haider, et al., (2008) [6], revealed that linkage between AWW and ASHA/ Sahiya was low. More than half of AWWs reported that they did not receive any help from ASHA/ Sahiya. Some ASHA/ Sahiyas reported that AWWs do not ask them for help. However, in some places, they reported to have helped AWWs in collecting children for immunisation.

NHSRC, (2011)[18] found that even the assistance that ASHA received from the ANMs or the AWWs was limited. Less than half of ASHAs reported that they received assistance from ANMs and AWWs. The main support from the ANM was in immunisation of children and pregnant mothers and from the AWWs, it was mainly in identifying pregnant women. NHSRC, (2011) also found that ASHAs, however, did not share a good rapport with the PRI members. This was corroborated by Kanth, Cherian and George (2010)[15], that the ASHAs were hardly supported by the panchayat. The Mukhiya was only involved with their recruitment.

2.12 Problems Faced by ASHA and Suggestions to Improve Service Delivery

Public Health Resource Society, (2009)[22], however, revealed that ASHAs were facing problems in their day-today work like non availability of drugs for the drug kits on time; due to lack of communication facilities mobility within the health centers; lack of proper coordination with beneficiaries and other service providers due to non-availability of mobile phones; gradual loss of skills as no refresher training was given; problem in residing in hospital when ASHA accompanied the pregnant women to the hospital as there was no special room for use; no sufficient uniforms given to them for daily use; and frequent moving to the respective PHCs/CHCs for collecting the incentives. The demand for more monetary support, timely replenishment of drug, more support and cooperation from ANM and MOs to conduct the activities were suggested by most of the ASHAs to improve their functioning (NHSRC, 2011)[18].

3

METHODOLOGY

METHODOLOGY

3.1 Institutional Review Board

The Institutional Review Board offered its suggestions on the design and methodology of the study and the development of tools for data collection.

3.2 Methodology

The study was conducted in two of the EAG states (Odisha and Uttar Pradesh), two non-EAG states (Maharashtra and Karnataka) and one North-Eastern State (Assam). The data for the study has been collected through multi-stage stratified random sampling method. Perception of different stakeholders- ASHA, ICDS and health functionaries, beneficiaries (pregnant women, mothers with children upto six months and mothers with children between six months and two years; and community leaders (Sarpanch/ PRI members/Village Health, Sanitation and Nutrition Committee Members/ teacher), were ascertained through in depth interviews. In all, the sample comprised 100 ASHAs; 50 health functionaries; 130 ICDS functionaries; 300 beneficiaries; and 100 community leaders.

3.2.1 Sample Selection

The sample sizes for the study were as given below:

States (N=5)	**Assam**	**Karnataka**	**Maharashtra**	**Odisha**	**Uttar Pradesh**
Districts (N=5)	Nalbari	Udupi	Yavatmal	Keonjhar	Muzaffarnagar
Blocks (N=10)	Kamarkuchi	Udupi	Pusad	Harichandanpur	Khatauli
	Chamata	Karkala	Kalamb	Ghatagaon	Jansath
Villages (N=100)	**Block-** Kamarkuchi	**Block-** Udupi	**Block-Pusad**	**Block-Harichandanpur**	**Block-Khatauli**
	Bangalmor	Uliyargoli	Gahuli	Baizapada	Mansoorpur
	Dingaingi	Padu	Brahmangaon	Salabeda	Nawala
	Banekuchi	Yengudde	Shyampur	Dandasenapasi	Ghasipura
	Barsarkuchi	Kote	Nandora	Junga	Bopada
	Kathalbari	Mattu	Dhanora	Kaberiposi	Moghpur
	Khatkatara	Udayavara	Manjarjawala	Manoharpur	Tingahi
	Kodoitola	Kuthpadi	Hiwalni	Kalimati	Nonha
	Nijbataghiri	Kadekar	Jamnaik	Akhupal	Islamabad Johra

	Boragra	Alevoor-Kora	Kondhai	Jaunlipokhar	Bhainsi
		Manipura	Lobhirant Nagar	Raghunathpur	Beghrajpur
					Galibpur
	Block-Chamata	**Block-** Karkala	**Block-Kalamb**	**Block-Ghatagaon**	**Block-Jansath**
	Belsor	Miyar	Gangadevi	Pipilia	Ramraj
	Bangaon	Bajagoli	Aloda	Dhobapitana	Sambhaleda
	Nalisha	Kukkundoor	Sawalpur	Dandiposi	Gujjarhedi
	Uttar Amani	Durganagar	Nimbhora	Asanabani	Salarpur
	Tengabari	Ayappanagar	Dhanordi	Mundatangara	Rattod
	Thutikala	Hirgana	Umargaon	Ramachandrapur	Talda
	Nadla	Tellar	Rasa	Dhenkikot	Bhaleda
	Bhadra	Durga	Pophalni	Baghaghara	Chitoda
	Duokuchi	Jarkala	Mohodari	Murdabeda	Ghari
	Phulguri		Zadkinhi	Khantaghara	Khalwada
					Kawal
RESPONDENTS					
Health Functionaries					
ASHA (N=100)	20	20	20	20	20
ANM (N=20)	4	4	4	4	4
LHV (N=20)	4	4	4	4	4
Medical Officer (N=10)	2	2	2	2	2
ICDS Functionaries					
AWW (N=100)	20	20	20	20	20
Supervisor (N=20)	4	4	4	4	4
CDPO (N=10)	2	2	2	2	2
ICDS Beneficiaries					
Pregnant Women (N=100)	20	20	20	20	20
Mothers With Children upto 6 Months (N=100)	20	20	20	20	20

Mothers With Children between Six Months and Two Years (N=100)	20	20	20	20	20
Community Leaders (N=100) (VHSNC Members/ PRI Member/ Teacher)	20	20	20	20	20

3.2.2 Tools for the Study

The following research tools were used for the study.

Sch. No.	**Category**	**Method of data collection**	**Instrument used/Tools**
1	**ASHA**	In-depth Interview Schedule	Interview Schedule
2-4	**Health Functionaries** (MO, LHV, and ANM)	In-depth Interview Schedule	Interview Schedule
5-7	**ICDS Functionaries** (CDPO, Supervisor, AWW)	In-depth Interview Schedule	Interview Schedule
8-10	**ICDS Beneficiaries (from selected ASHA Villages)** *****Pregnant Women *Mothers with children upto 6 months *Mothers with children between six months and two years	In-depth Interview Schedule	Interview Schedule
11	**Community Leaders (Village Health, Sanitation and Nutrition Committee Members/ ASHA Facilitator/ PRI Member/Teacher)**	Interview Schedule	Interview Schedule

3.3 Field Testing

The tools proposed to be used in the study were field tested before the study was undertaken. The data was collected after a brief training of the investigators which aimed at making them understand: situation of maternal and child – India/ State with special reference to Sample States; ICDS and NRHM and its components; roles and responsibilities of ICDS

and Health functionaries; ASHA, their recruitment, training, roles and responsibilities; interface proposed between the health and ICDS functionaries with ASHA, orientation to tools/ guidelines for collection; etc. Consent was obtained from all sample beneficiaries before seeking any personal information.

3.4 Execution of the Study

Five research teams were deployed for data collection in the five sample States. The data for the study was collected with the help of identified experts, as Consultants in four sample States {2 EAG (Assam and Uttar Pradesh) and 2 Non-EAG (Maharashtra and Karnataka)} States; and through a NGO in Odisha, for the study. The Consultants are heading the Preventive Medicine/ Community Medicine in Medical colleges/ NGO Head in the States and some have also been identified for monitoring the ICDS Projects in their States or running a NGO of repute in the sample State. The Consultants / NGO Head coordinated the data collection through their research team and sent it to the institute. The data was collected after a brief training of the investigators. The List of Project Coordinators identified for data collection at the various sample states is placed at **Annexure-III**. The Consultants / NGO Head collected the data in the sample States with the help of local investigators hired for the purpose and sent it to the institute. For this, detailed Guidelines for Project Coordinators were evolved by the Institute **(Annexure-IV).**

4

RESULTS AND DISCUSSION

RESULTS AND DISCUSSION

The major findings and conclusions of the study are presented in the following paragraphs.

4.1 Profile of the Respondents

4.1.1 State-Wise Distribution of Respondents

The State-wise distribution of respondents is presented in **Table 1.**

Table 1: State-Wise Distribution of Respondents

Category of Respondents	EAG State		Non-EAG State		N E State	Total
	Uttar Pradesh n=20	Odisha n=20	Maharashtra n=20	Karnataka n=20	Assam n=20	n=100
	No.	No.	No.	No.	No.	No.
Health Functionaries						
ASHAs	20	20	20	20	20	100
Medical Officers	2	2	2	2	2	10
LHVs	4	4	4	4	4	20
ANMs	4	4	4	4	4	20
ICDS Functionaries						
CDPOs	2	2	2	2	2	10
Supervisors	4	4	4	4	4	20
AWWs	20	20	20	20	20	100
ICDS & Health Beneficiaries						
Pregnant Women	20	20	20	20	20	100
Mothers with Children less than 6 Months	20	20	20	20	20	100
Mothers with Children between 6 Months and 2 Years	20	20	20	20	20	100
Community Leaders						
PRI Members	2	9	20	19	11	61
VHSNC Members	0	11	0	1	2	14
School Teachers	18	0	0	0	5	23
ASHA Facilitator	0	0	0	0	2	2
	20	20	20	20	20	100

4.1.2 Age-Wise Distribution of ASHAs

The criteria for selection of ASHA are clearly specified in the ASHA guidelines. The age-wise distribution of ASHAs as ascertained from the present study is depicted in **Table 2.**

Most of the ASHAs were in the age group 35 to 39 years age- group (31%), followed by 30 to 34 years age group (23%).

Table 2: Age-Wise Distribution of ASHAs

	EAG State				Non-EAG State				N E State		Total	
	Uttar Pradesh n=20		Odisha n=20		Maharashtra n=20		Karnataka n=20		Assam n=20		n=100	
Age-group	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
20 to 24 years	1	5.0	0	0.0	4	20.0	0	0.0	0	0.0	4	4.0
25 to 29 years	5	25.0	8	40.0	4	20.0	0	0.0	2	10.0	11	11.0
30 to 34 years	8	40.0	2	10.0	6	30.0	7	35.0	2	10.0	23	23.0
35 to 39 years	3	15.0	7	35.0	3	15.0	7	35.0	11	55.0	31	31.0
40 to 45 years	3	15.0	2	10.0	3	15.0	6	30.0	4	20.0	18	18.0
45 years and above	0	0.0	1	5.0	0	0.0	0	0.0	1	5.0	2	2.0

4.1.3 Distribution of ASHAs by Educational Status

Table 3 gives the distribution of ASHAs by educational status. As per the selection criteria the minimum qualification of ASHA should be middle school passed, however, it was heartening to note that majority were either middle or high school passed, keeping in line with the selection criteria of ASHAs. The distribution of ASHAs who had passed primary school, middle school, high school, intermediate and graduation, was 3 per cent, 28 per cent, 46 per cent, 20 per cent and 3 per cent, respectively.

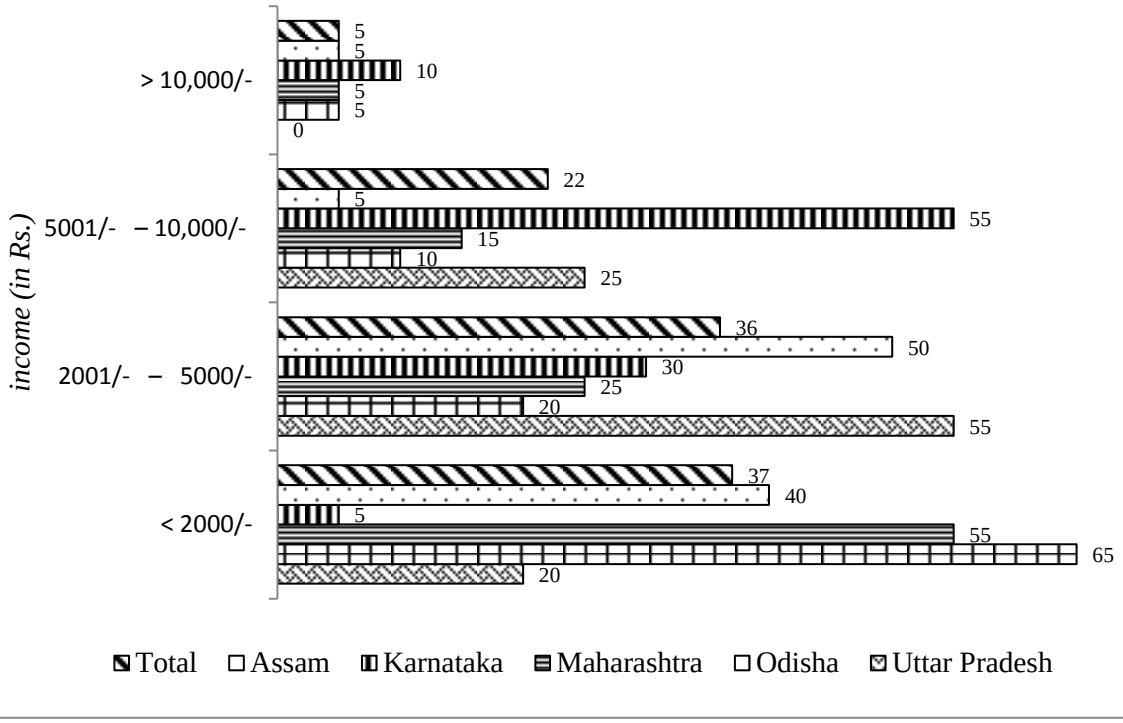
Table 3: Distribution of ASHAs by Educational Status

	EAG State				Non-EAG State				N E State		Total	
	Uttar Pradesh n=20		Odisha n=20		Maharashtra n=20		Karnataka n=20		Assam n=20		n=100	
Educational Status	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Illiterate	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
Primary School	0	0.0	1	5.0	1	5.0	0	0.0	1	5.0	3	3.0
Middle School	6	30.0	6	30.0	3	15.0	9	45.0	4	20.0	28	28.0
High School	7	35.0	9	45.0	9	45.0	9	45.0	12	60.0	46	46.0
Intermediate	5	25.0	3	15.0	7	35.0	2	10.0	3	15.0	20	20.0
Graduate	2	10.0	1	5.0	0	0.0	0	0.0	0	0.0	3	3.0

4.1.4 Family Income of ASHAs

Fig. 1 presents the distribution of ASHAs by monthly family income. About 37 per cent of ASHAs reported a monthly income less than Rs. 2000/-; 36 per cent of ASHAs reported drawing a monthly income between Rs. 2001/- to 5000/-, followed by 22 per cent drawing monthly income of Rs-5001/- to 10,000/-. Only ASHAs of Karnataka reported to be drawing a monthly income of Rs-5001 to 10,000/-.

Fig. 1 Family Income of ASHAs



4.1.5 Training Status of ASHAs

As per the norms, the induction training of ASHA should be completed in 23 days spread over a period of 12 months. The first round of seven days has to be followed by another four rounds of training, each lasting for four days to complete induction training. As shown in **Table 4,** the present study also revealed that all the ASHAs were trained, however, the duration of training ranged from 7 days to 23 days or more. The study further revealed that only 66 per cent of ASHAs had undergone the requisite training of 23 days or more. About one-fourth (24%) of them had undergone more than six rounds of training and another one-fourth had 5 to 6 rounds.

Table 4: Training Status of ASHAs

Training Status and Perception on Training	EAG State				Non-EAG State				N E State		Total	
	Uttar Pradesh n=20		Odisha n=20		Maharashtra n=20		Karnataka n=20		Assam n=20		n=100	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
More than 23 days	13	65.0	16	80.0	9	45.0	17	85.0	11	55.0	66	66.0
23 days	4	20.0	3	15.0	0	0.0	3	15.0	4	20.0	14	14.0
19 days	1	5.0	0	0.0	3	15.0	0	0.0	1	5.0	5	5.0
15 days	1	5.0	1	5.0	3	15.0	0	0.0	0	0.0	5	5.0
11 days	1	5.0	0	0.0	0	0.0	0	0.0	1	5.0	2	2.0
7 days	0	0.0	0	0.0	2	10.0	0	0.0	2	10.0	4	4.0
Any other (specify)	0	0.0	0	0.0	3	15.0	0	0.0	1	5.0	4	4.0
Number of rounds/exposure of training												
One	0	0.0	1	5.0	3	15.0	15	75.0	0	0.0	19	19.0
Two	3	15.0	0	0.0	3	15.0	2	10.0	0	0.0	8	8.0
Three	2	10.0	0	0.0	4	20.0	1	5.0	1	5.0	8	8.0
Four	9	45.0	1	5.0	5	25.0	1	5.0	0	0.0	16	16.0
Five	4	20.0	6	30.0	3	15.0	0	0.0	7	35.0	20	20.0
Six	1	5.0	0	0.0	1	5.0	0	0.0	3	15.0	5	5.0
Above six	1	5.0	12	60.0	1	5.0	1	5.0	9	45.0	24	24.0

4.1.6 Residential Status and Population Covered by ASHA

Fig. 2 and 3 gives the residential status and population covered by ASHAs. As per norms, an ASHA is supposed to cater to a population of 500-1000. The present study revealed that about half (48%) of ASHAs were catering to a population of over 1000 indicating a burden on them. Bhatnagar, et al., (2009), also found that almost 50 per cent ASHAs were covering population ranging from 1000-1500. This is a strong pointer for the health department to take immediate steps to appoint more ASHAs in such villages. It was, however, heartening to note that majority (99%) of ASHAs were resident of the village they were serving.

Fig. 2 Residential Status of ASHAs

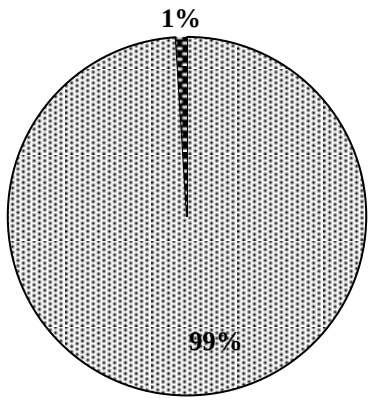
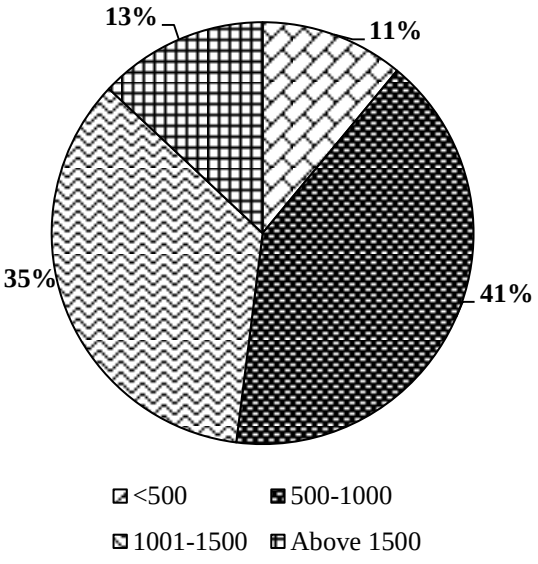


Fig. 3 Population Covered by ASHA



4.2 Awareness about the Selection Process and Role in the Selection of ASHAs

4.2.1 Perception of Health and ICDS Functionaries

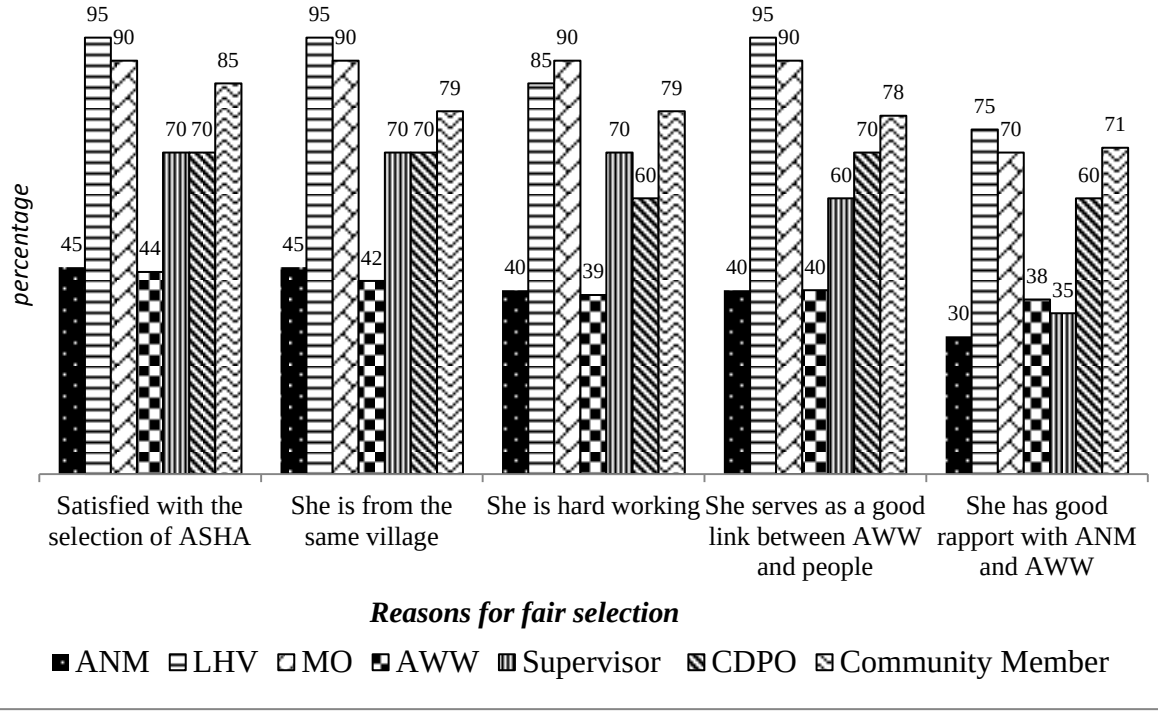
Table 5 presents the awareness of health and ICDS functionaries about the functioning and their role in the process of selection of ASHAs. Almost all the health functionaries {ANMs (100%), LHV (100%) and MOs (100%) and ICDS functionaries {AWWs (100%)} were aware of the ASHAs working in their respective areas. But only 55 per cent of ANMs; 40 per cent of LHVs; 60 per cent of MOs; and 51 per cent of AWWs were involved in the selection of ASHAs in their areas. The awareness of health and ICDS functionaries about the people involved in the selection of ASHAs, as well as, the selection procedure *'per se'* lacked clarity in general, which need to be created for improving their involvement with ASHAs in their respective areas.

The perception of the health and ICDS functionaries satisfied with the selection of ASHAs in their areas and the reasons, as reported for the same is presented in **Fig. 4**. The responses of ANMs and AWWs, who work closely with ASHAs, shows that majority of them were not satisfied with the ASHAs selected.

Table 5: Awareness among Functionaries about the Selection Process of ASHAs

Awareness about Role in the Process of Selection of ASHA	Health Functionaries						ICDS Functionaries	
	ANM n=20		LHV n=20		MO n=10		AWW n=100	
	No.	%	No.	%	No.	%	No.	%
Aware of ASHAs in their area	20	100.0	20	100.0	10	100.0	97	97.0
Involved in the selection of ASHAs	11	55.0	8	40.0	6	60.0	51	51.0
Awareness about the people involved in the selection process of ASHA								
PRI Member/Sarpanch	20	100.0	14	70.0	9	90.0	15	15.0
Medical Officer	7	35.0	16	80.0	7	70.0	8	8.0
LHV/ BEE	8	40.0	7	35.0	5	50.0	3	3.0
ANM	6	30.0	11	55.0	9	90.0	16	16.0
CDPO	1	5.0	1	5.0	0	0.0	2	2.0
Supervisor	3	15.0	6	30.0	3	30.0	4	4.0
AWW	4	20.0	10	50.0	3	30.0	2	2.0
NGO member	1	5.0	5	25.0	3	30.0	1	1.0
School Teacher	2	10.0	3	15.0	2	20.0	4	4.0
SHG member	4	20.0	5	25.0	3	30.0	0	0.0

Fig. 4 Perception of Functionaries about the Fair Selection of ASHA



4.3 Knowledge and Awareness about Maternal and Child Health Issues

4.3.1 Care during Pregnancy

Knowledge and Awareness of ASHA

ASHA's envisaged functions and tasks have been expanded into a listing of competencies to be developed in ASHA after 23 days training has been prepared. The present study made an attempt study the knowledge and awareness of ASHAs regarding care during pregnancy. The study revealed that in all, 65 per cent of ASHAs could mention about the timing of pregnancy test and 82 per cent could tell the correct procedure of conducting Nishchay Home Pregnancy Test **(Table 6)**.

Table 6: Knowledge and Awareness of ASHAs about Care during Pregnancy

Care during Pregnancy	EAG State				Non-EAG State				N E State		Total	
	Uttar Pradesh n=20		Odisha n=20		Maharashtra n=20		Karnataka n=20		Assam n=20		n=100	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Awareness about the timing of pregnancy test												
As early as possible, within a month	20	100.0	18	90.0	9	45.0	1	5.0	17	85.0	65	65.0
30-90 days	0	0.0	2	10.0	11	55.0	19	95.0	3	15.0	35	35.0
Nischay Home Pregnancy Test												
Knows the steps of the test	19	95.0	18	90.0	16	80.0	13	65.0	16	80.0	82	82.0
Calculation of Expected Date of Delivery (EDD)												
Could calculate EDD	12	60.0	8	40.0	8	40.0	19	95.0	12	60.0	59	59.0
Number of check-ups of pregnant women												
One	0	0.0	0	0.0	0	0.0	0	0.0	1	5.0	1	1.0
Two	3	15.0	0	0.0	2	10.0	0	0.0	0	0.0	5	5.0
Three	16	80.0	18	90.0	8	40.0	6	30.0	4	20.0	52	52.0
Four	0	0.0	1	5.0	7	35.0	3	15.0	13	65.0	24	24.0
Four and above	1	5.0	1	5.0	3	15.0	11	55.0	2	10.0	17	17.0
Investigations done during pregnancy												
Blood pressure	4	20.0	20	100.0	16	80.0	19	95.0	19	95.0	78	78.0
Checking weight	0	0.0	19	95.0	16	80.0	20	100.0	20	100.0	75	75.0
Abdominal examinations	19	95.0	15	75.0	12	60.0	20	100.0	20	100.0	86	86.0
Urine test	19	95.0	12	60.0	18	90.0	20	100.0	20	100.0	89	89.0
Blood test	19	95.0	15	75.0	18	90.0	20	100.0	19	95.0	91	91.0
Number of doses of tetanus toxoid during pregnancy												
One	0	0.0	3	15.0	0	0.0	0	0.0	5	25.0	8	8.0
Two	20	100.0	17	85.0	20	100.0	20	100.0	15	75.0	92	92.0

Calculating the expected date of delivery (EDD) was known to only 59 per cent of ASHAs. Considering that ASHA's role mainly revolves around detection of pregnancy and facilitating in the early registration of pregnancy, ASHA's skill in this area need to be upgraded for effective service delivery. As regards the minimum number of antenatal check-ups a women should have during pregnancy, 52 per cent of ASHAs responded as three check-ups and 24 per cent, as four check-ups. The investigation to be done during pregnancy as reported by the ASHAs included checking blood pressure (78%); checking weight (75%); abdominal examinations (86%); testing urine (84%); and blood (91%). Majority of ASHAs (92%) were aware of the need for taking two doses of tetanus toxoid injections. On the whole the knowledge of ASHAs about care during pregnancy, in EAG states and N E state was better than the non EAG states.

4.3.2 Anaemia during Pregnancy and its Prevention

Knowledge and Awareness of ASHA

The knowledge and awareness of ASHAs about prevention of anaemia during pregnancy is depicted in **Fig. 5.** The responses included consuming - dark green leafy vegetables (93%); jaggery (63%); animal food (56%); whole grain (53%); and iron and folic acid tablet (92%). The knowledge of ASHAs across all sample states was uniform.

ASHA is conceptualised as a health activist in the community who will create awareness on health and its social determinants. The current study revealed that there is a mismatch between the awareness level of beneficiaries and that of ASHAs about prevention of anaemia during pregnancy, which can be attributed to non-transference of knowledge of ASHAs to the beneficiaries, pointing towards the need for training ASHAs as health educator **(Fig. 6).**

Fig. 5 Knowledge and Awareness of ASHA about Prevention of Anaemia

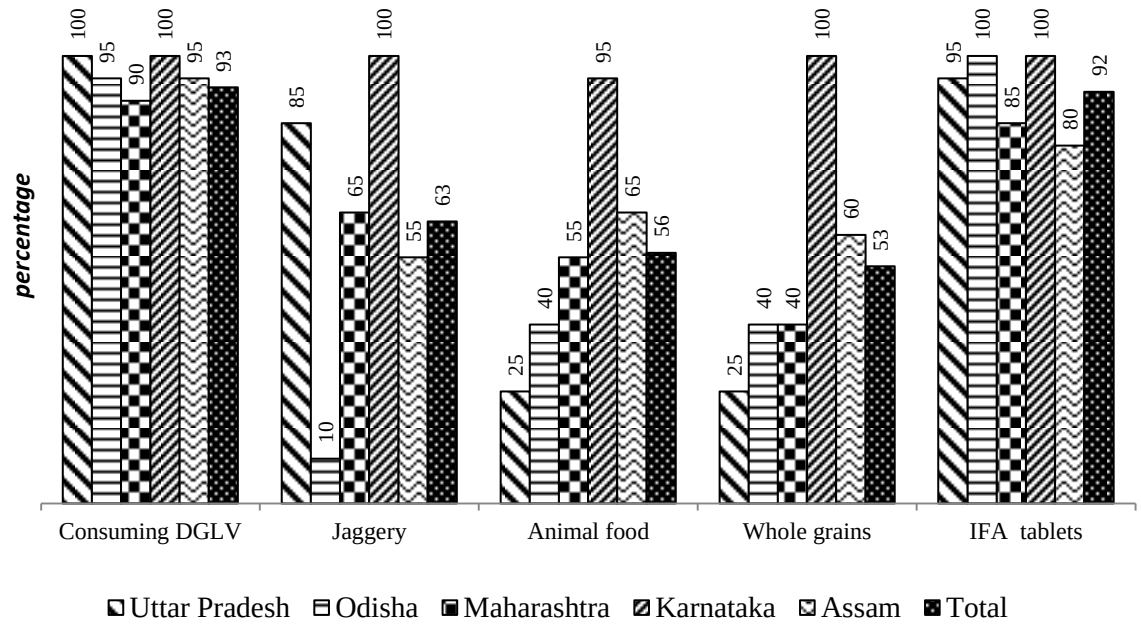
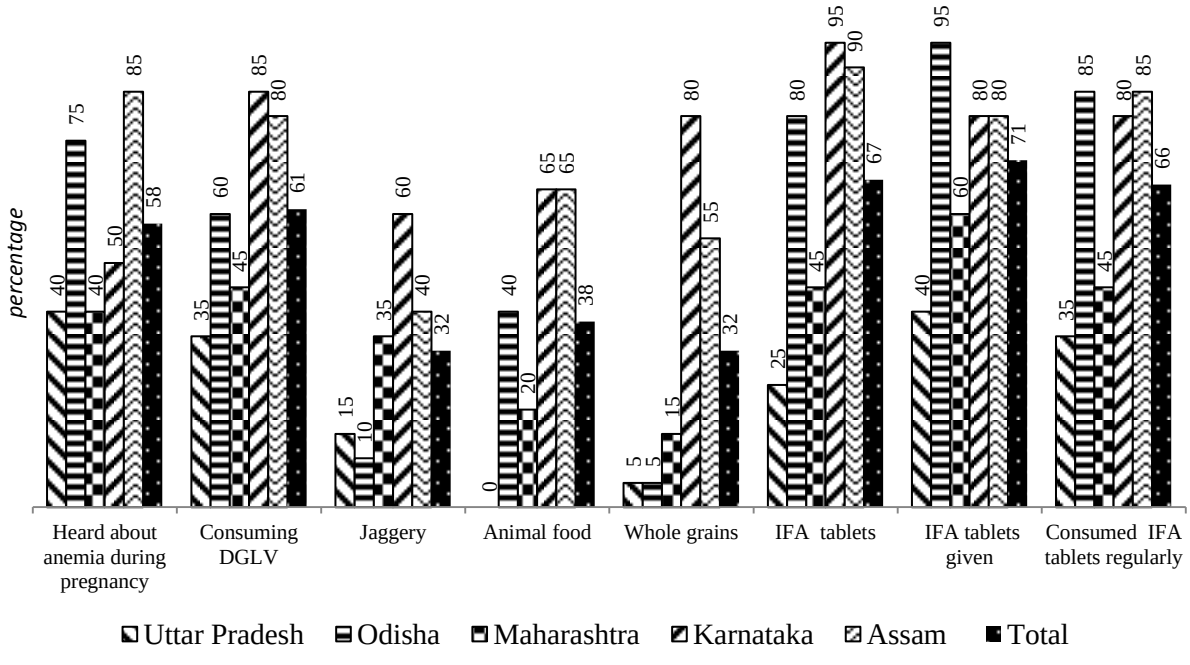


Fig. 6 Awareness among Beneficiaries about Prevention of Anaemia



4.3.3 Danger Signs during Pregnancy and Childbirth needing Referral

Knowledge and Awareness of ASHAs

The danger signs during pregnancy and childbirth needing referral as reported by ASHAs were bleeding during pregnancy or delivery (81%); severe anaemia (78%); swelling of feet (67%); convulsion or fit (62%); bursting of water bag (54%); cessation of foetal

movements (54%); labour pain for more than 12 hours (49%) ; severe headache (43%); and failure of expulsion of placenta within 30 minute after delivery (41%) were . The knowledge of ASHAs of Karnataka was far better than rest of the sample state; as majority of ASHAs had complete knowledge of danger signs during pregnancy and childbirth needing referral **(Table 7).**

Table 7: Knowledge and Awareness of ASHAs about Danger Signs during Pregnancy and Childbirth needing Referral

Danger Signs during Pregnancy and Childbirth needing Referral	EAG States				Non-EAG States				N E State		Total	
	Uttar Pradesh n=20		Odisha n=20		Maharashtra n=20		Karnataka n=20		Assam n=20		n=100	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Bleeding during pregnancy or delivery	11	55.0	18	90.0	14	70.0	20	100.0	18	90.0	81	81.0
Severe anaemia	14	70.0	18	90.0	13	65.0	20	100.0	13	65.0	78	78.0
High fever	2	10.0	9	45.0	6	30.0	20	100.0	9	45.0	46	46.0
Convulsions or fits	3	15.0	16	80.0	9	45.0	20	100.0	14	70.0	62	62.0
Blurring of vision	12	60.0	5	25.0	3	15.0	20	100.0	11	55.0	51	51.0
Severe headache	2	10.0	2	10.0	5	25.0	19	95.0	15	75.0	43	43.0
Swelling of feet	12	60.0	7	35.0	11	55.0	20	100.0	17	85.0	67	67.0
Labor pain for more than 12 hours	7	35.0	9	45.0	8	40.0	20	100.0	5	25.0	49	49.0
Bursting of water bag without labor pain	10	50.0	13	65.0	3	15.0	19	95.0	9	45.0	54	54.0
Failure of expulsion of placenta within 30 minutes after delivery	0	0.0	9	45.0	8	40.0	20	100.0	4	20.0	41	41.0
Cessation of foetal movements	3	15.0	6	30.0	9	45.0	20	100.0	16	80.0	54	54.0

4.3.4 Knowledge and Awareness about Janani SurakshaYojana (JSY)

Knowledge and Awareness of ASHAs

One of the tasks, where there is complete consensus that ASHA has a role, is the promotion of institutional delivery. Over 90 per cent of ASHAs are *functional* on this task. One reason for this good performance on this task is incentivisation as this is the most consistently incentivised activity (NHSRC, 2011). The study revealed that the knowledge of ASHAs about the eligibility criteria for getting assistance under the Janani Suraksha Yojana was grossly inadequate (**Fig. 7).**

Fig. 7 Knowledge and Awareness of ASHA about the Eligibility Criteria under Janani Suraksha Yojana (JSY)

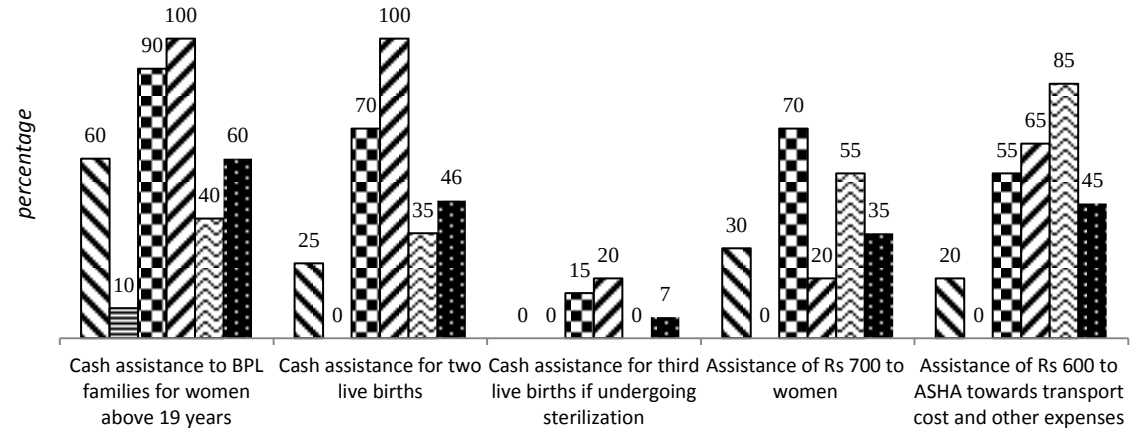
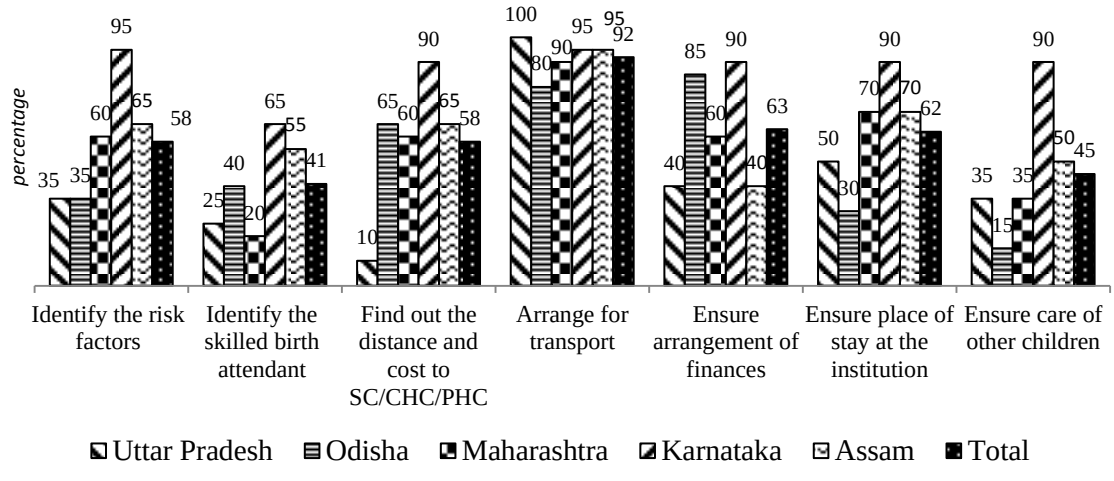


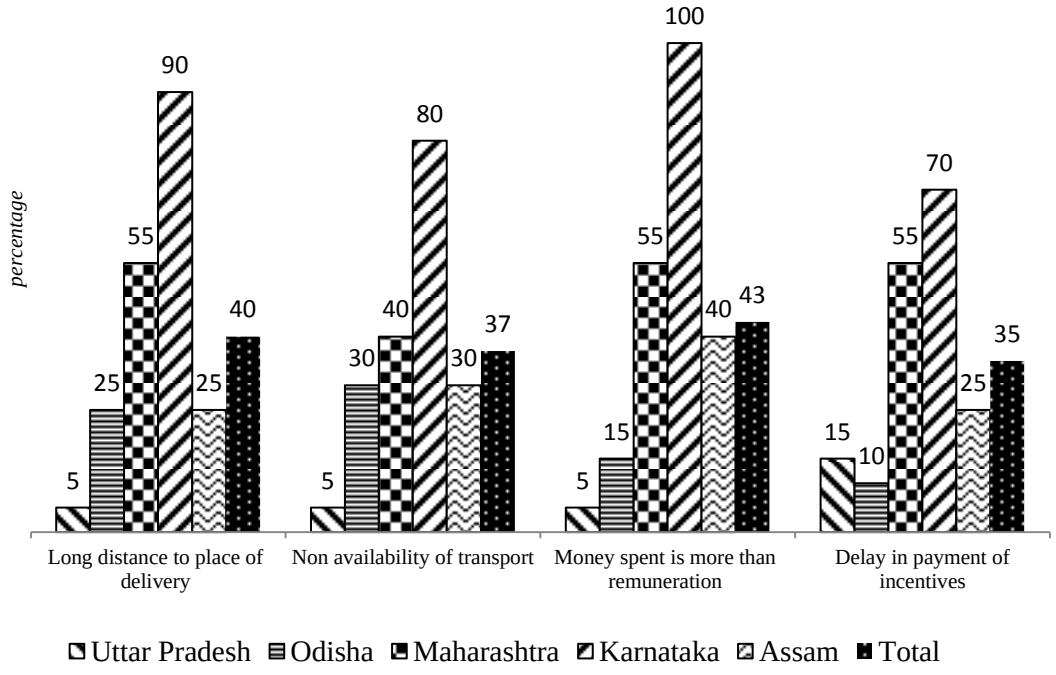
Fig. 8 depicts the major considerations for preparing the individual birth plan, which is one of the main expectations from the ASHAs for increasing the institutional deliveries in the country. The major considerations for drawing up an individual birth plan reported included identifying the risk factors (58%); identifying the skilled birth attendant (41%); find out the distance and cost to SC/CHC/PHC (58%); arrange for transport (92%); ensure arrangement of finances (63%); ensure place of stay at the institution (62%); and ensure care of other children (45%).

Fig. 8 Major Considerations for Preparing the Individual Birth Plan



The various problems encountered in the implementation of the JSY scheme as reported by ASHAs include non-availability of transport (37%); long distance to place of delivery (40.0%); money spent is more than the remuneration received (43.0%); and delay in payment of incentives (35.0%) **(Fig. 9).**

Fig. 9 Problems in the Implementation of Janani Suraksha Yojana



4.3.5 Knowledge and Awareness about Newborn Care

Newborn care is very important in preventing neonatal deaths, particularly essential care of the normal newborn to prevent illness, extra care of low birth weight babies, and access to quality emergency care for the sick newborn.

Table 8: Knowledge and Awareness of ASHAs about Newborn Care

Knowledge and Awareness of ASHA about Newborn Care	EAG State				Non-EAG State				N E State		Total	
	Uttar Pradesh n=20		Odisha n=20		Maharashtra n=20		Karnataka n=20		Assam n=20		n=100	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Awareness about General Newborn Care												
Keeping the child warm	10	50.0	19	95.0	16	80.0	20	100.0	19	95.0	84	84.0
Not bathing baby until the 2nd day in case of normal weight	1	5.0	6	30.0	8	40.0	11	55.0	9	45.0	35	35.0
Not bathing until the 7th day in case of low birth weight baby	13	65.0	12	60.0	3	15.0	17	85.0	12	60.0	57	57.0
Initiating breastfeeding immediately after birth	20	100.0	16	80.0	15	75.0	20	100.0	19	95.0	90	90.0
Keeping the child away from people who are sick	2	10.0	9	45.0	8	40.0	20	100.0	10	50.0	49	49.0
Weighing the child at birth	1	5.0	13	65.0	6	30.0	20	100.0	11	55.0	51	51.0
Give special care if weight is below 2.5 kg.	3	15.0	3	15.0	7	35.0	20	100.0	9	45.0	42	42.0
Keeping the cord dry	0	0.0	9	45.0	5	25.0	20	100.0	9	45.0	43	43.0
Care of Low Birth Weight Babies												
Providing extra warmth	12	60.0	19	95.0	13	65.0	20	100.0	18	90.0	82	82.0
Wrapping the baby in sheets and blankets	6	30.0	14	70.0	12	60.0	20	100.0	17	85.0	69	69.0
Covering the head to prevent heat loss	9	45.0	12	60.0	10	50.0	20	100.0	11	55.0	62	62.0
Placing the baby mother's abdomen	6	30.0	12	60.0	10	50.0	20	100.0	11	55.0	59	59.0
Keeping hot water bottles on the sides of the baby	1	5.0	2	10.0	3	15.0	17	85.0	4	20.0	27	27.0
Encouraging to feed the baby frequently	20	100.0	19	95.0	14	70.0	20	100.0	17	85.0	90	90.0

Table 8 present the knowledge and awareness of ASHAs about care of newborn. The newborn care, as reported by ASHAs included keeping the child warm (84%); not bathing the child until the 2nd day in case of normal weight (35%); not bathing the child until the 7th day in case of low birth weight (57%); initiating breastfeeding immediately after birth (90%); weighting the child at birth (51%); keeping the child away from people who are sick (49%); keeping to cord dry (43%); and giving special care a child with birth weight below 2.5 kg.

(42.0%). Regarding care of low birth weight babies, the responses included providing extra warmth (82%); covering the head to prevent heat loss (62%); placing the baby on mother's abdomen (59%); keeping hot water bottle on the side of baby (27%); and encouraging to feed the baby frequently (90%). The knowledge level of ASHAs of Karnataka was the best, followed by Assam, Odisha, Maharashtra and Uttar Pradesh.

Fig. 10 presents the knowledge of ASHAs about the causes of neonatal mortality. Low birth weight babies (94%); prematurity (82%); and pneumonia (67%) have been reported as the major causes of neonatal mortality by the ASHAs. There is a considerable gap in knowledge among the ASHAs across all the sample states.

Fig. 11 depicts the knowledge of ASHAs about the danger signs in newborn. Baby unable to cry (87%); weak suck or refusal to breastfeed (86%); fever/cold to touch (67%); yellow palms and soles (66%); and lethargic/unconscious (63%) has been reported by ASHAs as the major danger signs in newborn. The knowledge level of ASHAs of Karnataka was the best followed by Assam, Maharashtra, Odisha and Uttar Pradesh.

Fig. 10 Knowledge of ASHAs about Neonatal Mortality

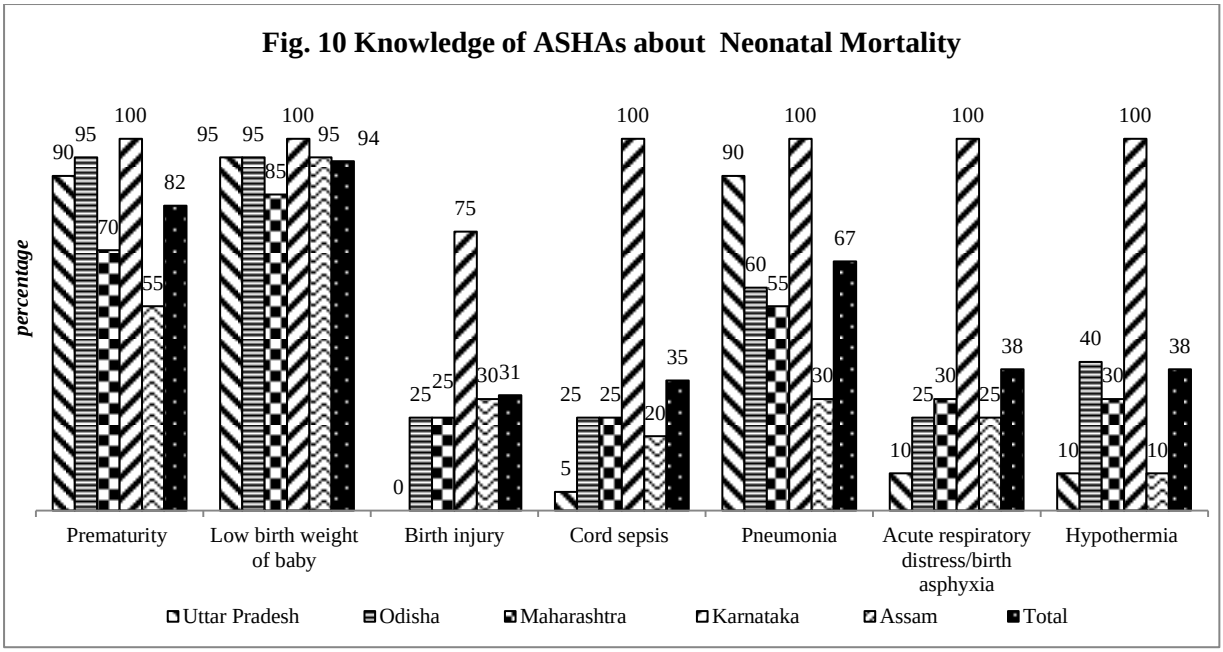
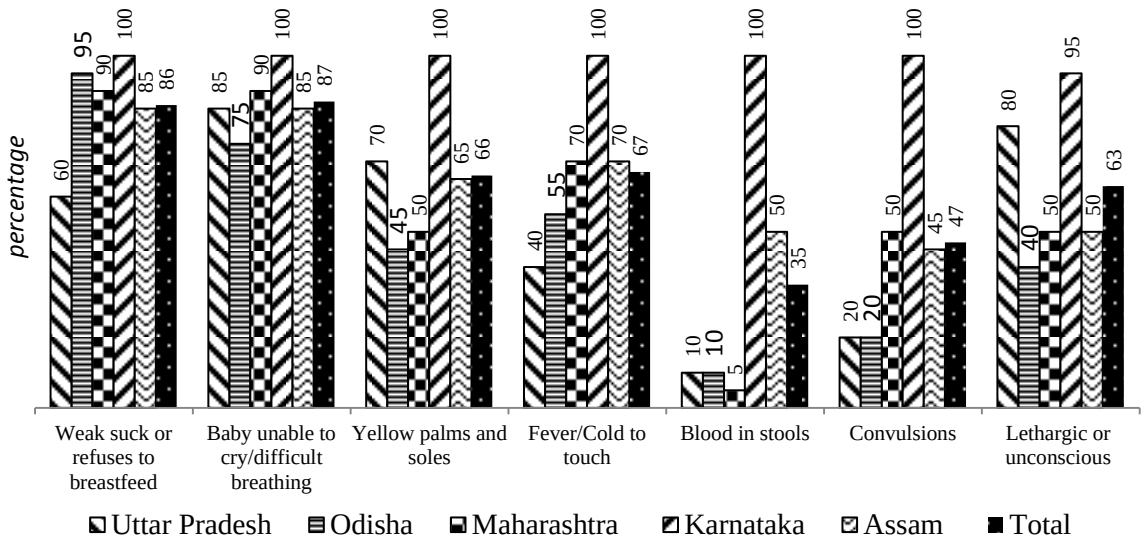


Fig. 11 Knowledge of ASHAs about Danger Signs in Newborn

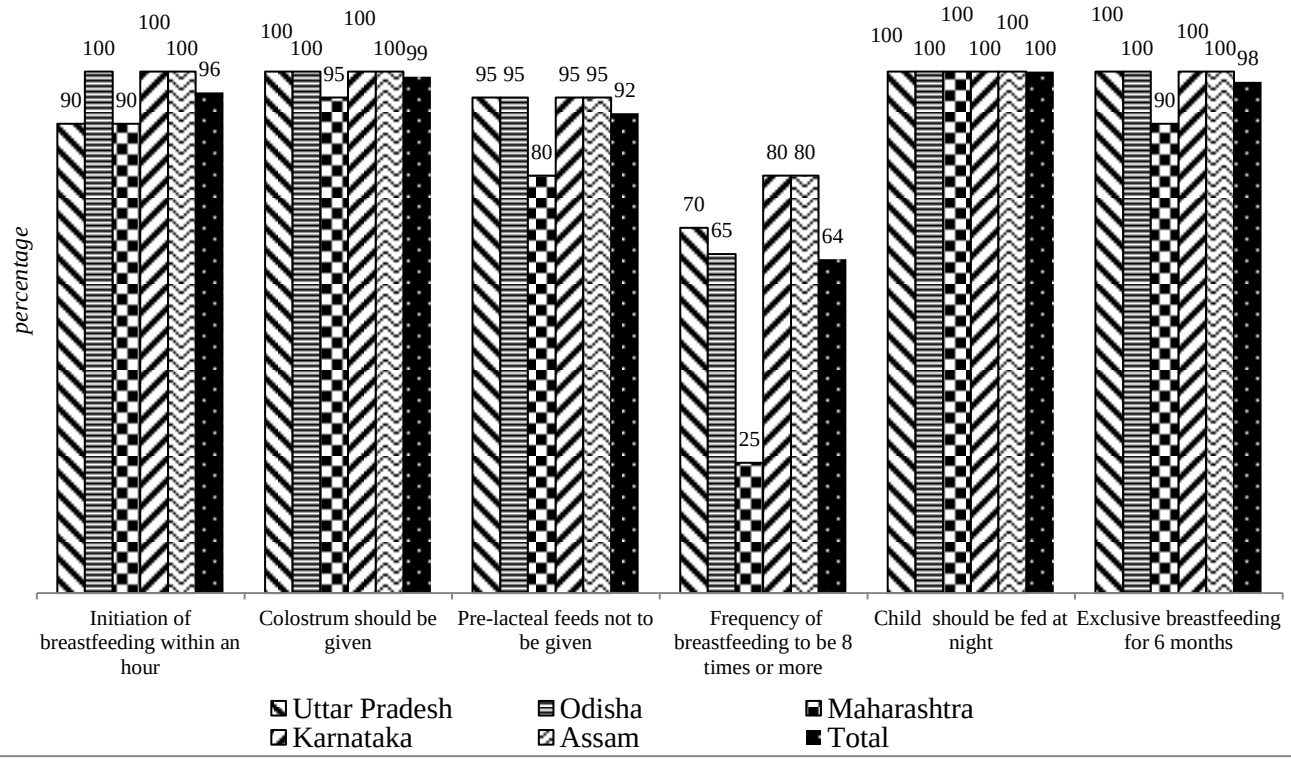


4.3.6 Knowledge and Awareness of ASHAs about Breastfeeding

Knowledge and Awareness of ASHAs

Fig. 12 presents the knowledge of ASHAs, the health activists, about breastfeeding. The knowledge of ASHAs about initiation of breastfeeding within an hour; feeding colostrum; avoiding pre-lacteal feeds; breastfeeding 8 times or more in a day; feeding child at night; and exclusive breastfeeding for six months was reported by 96 per cent, 99 per cent, 92 per cent, 64 per cent, 100 per cent and 98 per cent of ASHAs. The knowledge level of ASHAs across the entire sample was uniform. The aspect of initiation, frequency of breastfeeding and exclusive breastfeeding would need to be reiterated to strengthen the knowledge of ASHAs on breastfeeding.

Fig. 12 Knowledge and Awareness of ASHAs about Breastfeeding

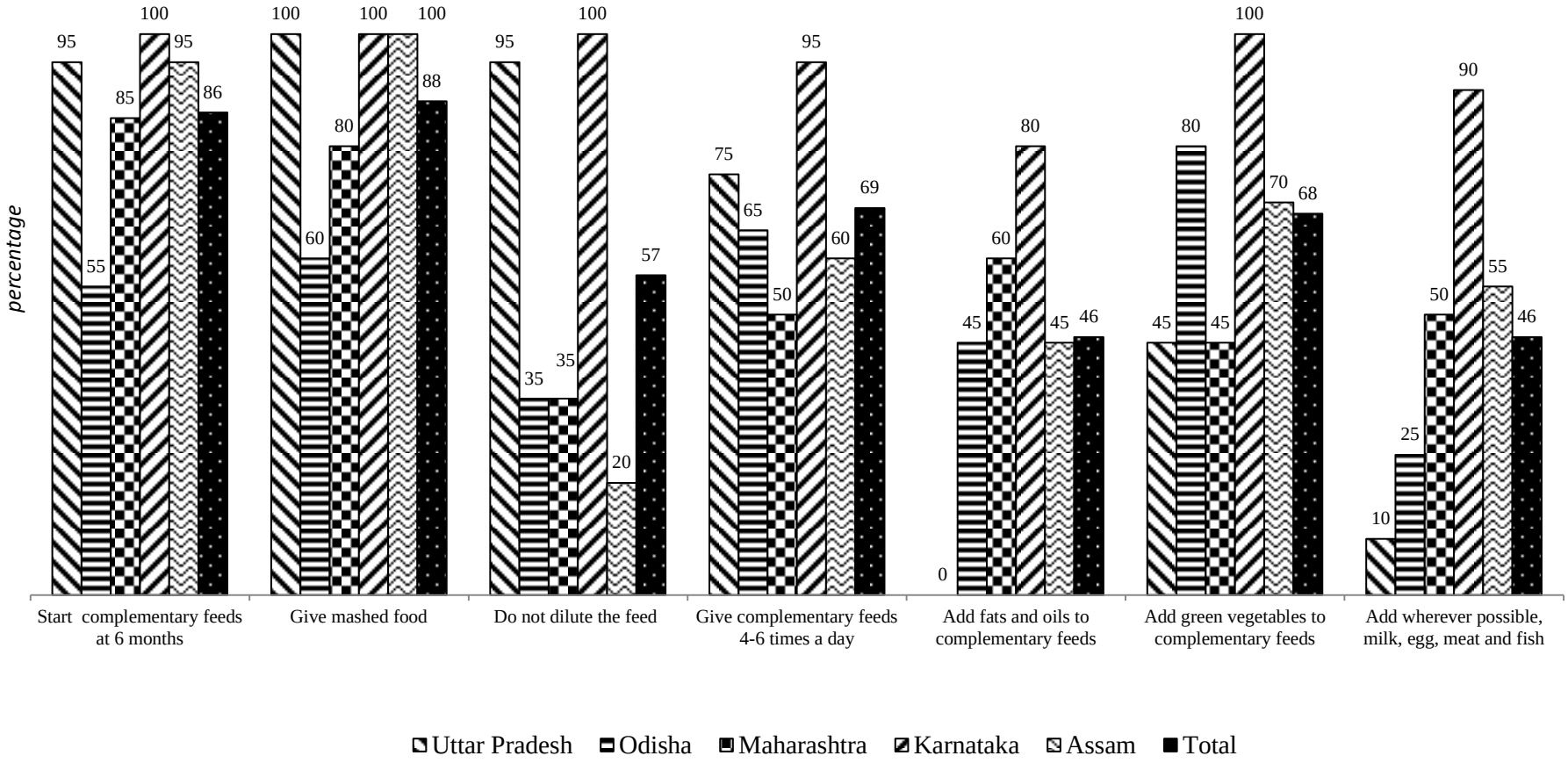


4.3.7 Knowledge and Awareness of ASHAs about Complementary Feeding

Knowledge and Awareness of ASHAs

The transition from exclusive breastfeeding to family foods, referred to as complementary feeding, typically covers the period from 6 to 18-24 months of age, and is a very vulnerable period. It is the time when malnutrition starts in many infants, contributing significantly to the high prevalence of malnutrition in children under five years of age world-wide. Research has shown that caregivers require skilled support to adequately feed their infants. **Fig. 13** present the advice about complementary feeding ASHA gives to mothers. There is a considerable gap in the knowledge as regards 'not diluting the food' (57%); 'frequency of complementary food' (49%); 'making the food energy dense by adding fats and oil (46%); etc. across all the sample states, except Karnataka.

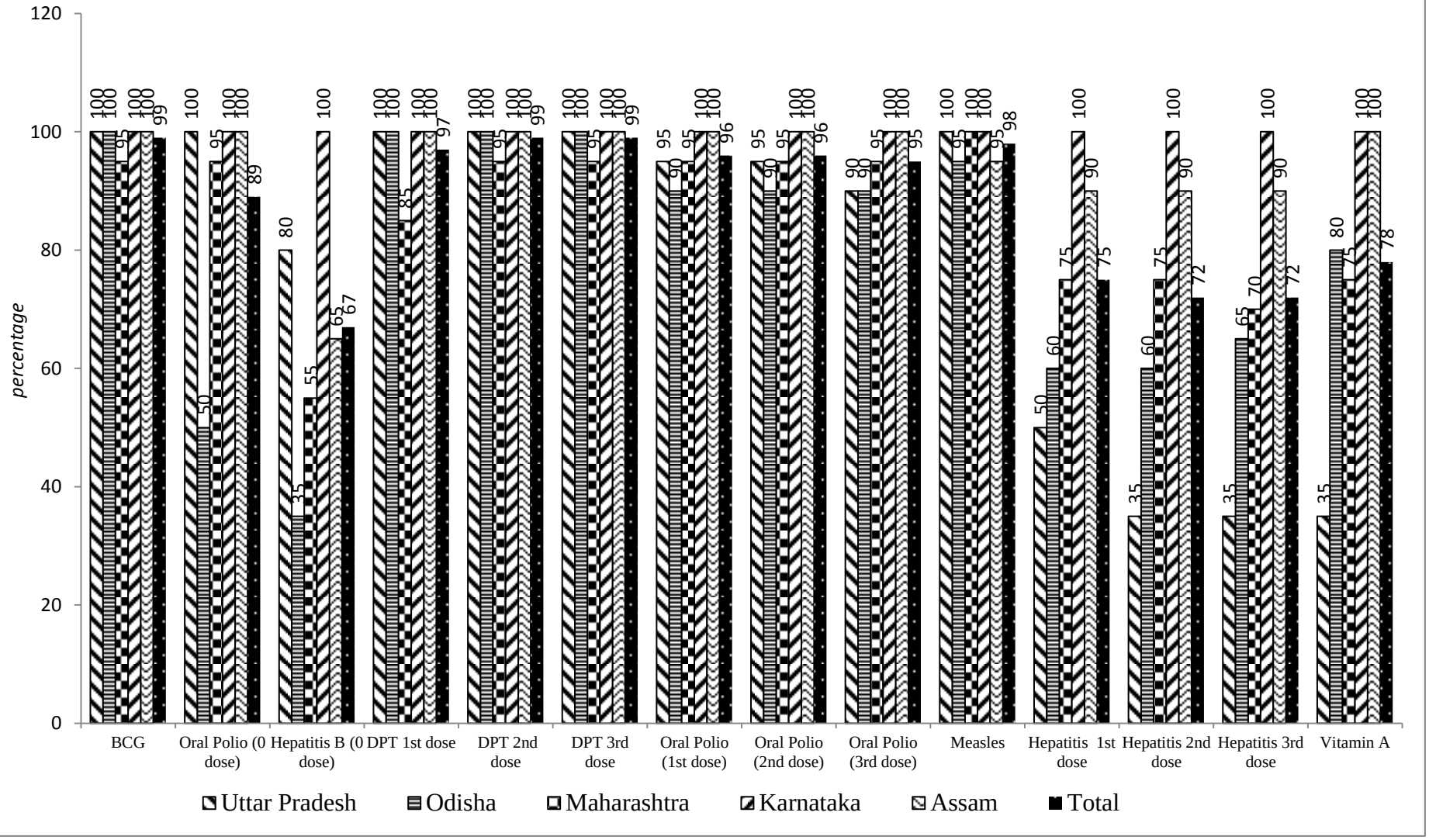
Fig. 13 Knowledge and Awareness of ASHAs about Complementary Feeding



4.3.8 Knowledge and Awareness of ASHAs about Immunisation Schedule

A second task for which the ASHA is incentivised is childhood immunisation. Mahyavanshi, K.D., et.al., (2011), found that though considerable proportion of ASHAs (63%) knew which are the vaccine preventable diseases. Majority (70%) of ASHAs had poor knowledge regarding schedule of immunisation as they had little knowledge as to when to take child for vaccination and for which vaccine. As can be seen in **Fig. 14** the level of knowledge of ASHAs across all the sample states of the present study is considerably good, with the exception for doses of Hepatitis B and vitamin A supplementation.

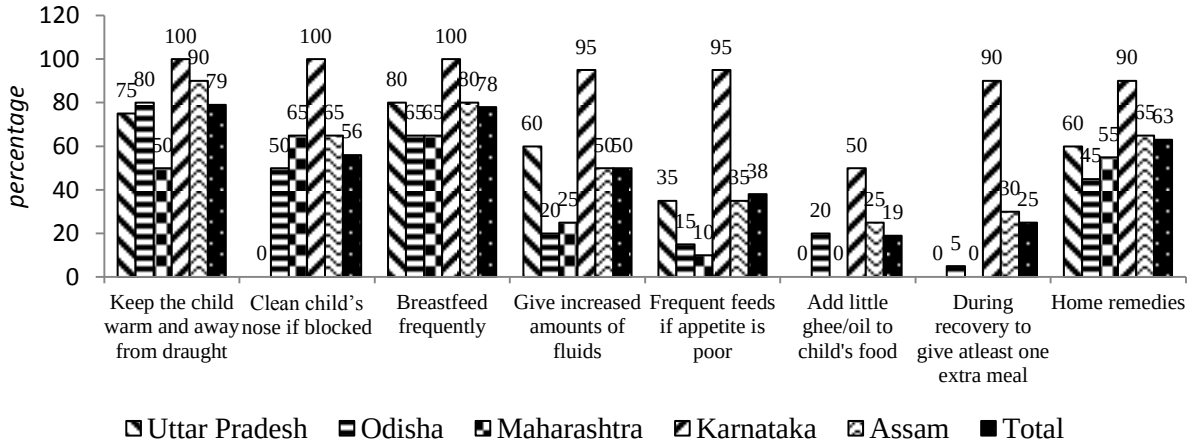
Fig. 14 Knowledge and Awareness of ASHAs about Immunisation Schedule



4.3.9 Knowledge and Awareness of ASHAs about Care at Home during Cough and Cold

Fig. 15 present knowledge and awareness of ASHAs regarding care of children at home with cough and cold. The knowledge level of ASHAs across all the states, except Karnataka, needs upgradation on aspects, such as, 'clean child's nose if blocked'; 'giving increased amount of fluid'; 'increasing frequency of feeds'; 'making food energy dense by adding oil/ghee'; and 'to give an extra meal during the recovery phase'.

Fig. 15 Knowledge and Awareness of ASHAs about Care at Home during Cough and Cold



4.3.10 Knowledge and Awareness of ASHAs about Care during Diarrhoea

Table 9 gives the knowledge of ASHAs about care during diarrhoea. The steps of preparing oral rehydration solution (ORS) was known to only 52 per cent of ASHAs, though almost all ASHAs (98%) were advising mother to give ORS during diarrhoea. The potential for saving lives through ORS, has been one of the main reason for introducing the ASHAs under NRHM. There is therefore a dire need to upgrade the knowledge of ASHAs relating to danger signs in diarrhoea, method of preparation of ORS and frequency and quantity of ORS to be given to a child, and feeding after the diarrhea, during convalescence.

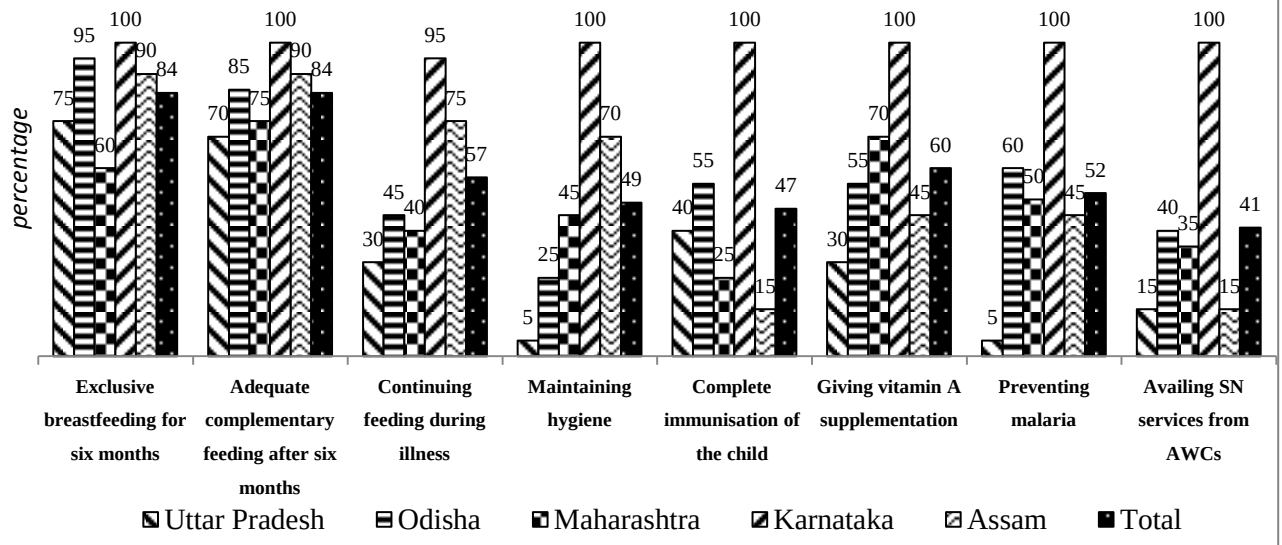
Table 9: Knowledge and Awareness of ASHAs about Care during Diarrhoea

Knowledge and Awareness	EAG State				Non-EAG State				N E State		Total	
	Uttar Pradesh n=20		Odisha n=20		Maharashtra n=20		Karnataka n=20		Assam n=20		n=100	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Steps in preparing ORS Q42												
Correct	2	10.0	10	50.0	9	45.0	19	95.0	12	60.0	52	52.0
Advice Given to a Mother with a Child Having Diarrhoea But no Dehydration												
Continue breastfeeding if still on breastfeeds	13	65.0	18	90.0	16	80.0	20	100.0	20	100.0	87	87.0
Give ORS	20	100.0	19	95.0	19	95.0	20	100.0	20	100.0	98	98.0
Give home available fluids	18	90.0	10	50.0	8	40.0	19	95.0	17	85.0	72	72.0
Give frequent small sips	2	10.0	0	0.0	9	45.0	19	95.0	11	55.0	41	41.0
If the child vomits; wait for 10 minutes and continue feeding	1	5.0	3	15.0	6	30.0	20	100.0	2	10.0	32	32.0
Continue giving extra fluids until diarrhoea stops	9	45.0	9	45.0	6	30.0	20	100.0	13	65.0	57	57.0
To contact AWW/ ANM immediately if												
Child becomes sicker	16	80.0	12	60.0	15	75.0	20	100.0	16	80.0	79	79.0
Not able to drink or breastfeed	12	60.0	10	50.0	13	65.0	20	100.0	14	70.0	69	69.0
Drinks poorly	5	25.0	7	35.0	12	60.0	20	100.0	11	55.0	55	55.0
Develops a fever	2	10.0	5	25.0	8	40.0	20	100.0	12	60.0	47	47.0
Has blood in the stool	1	5.0	3	15.0	4	20.0	19	95.0	12	60.0	39	39.0

4.3.11 Knowledge and Awareness of ASHAs about Prevention of Malnutrition

When asked about the various measures for prevention of malnutrition, the various measures reported by ASHAs include exclusive breastfeeding for six month (84%); continuing feeding during illness (57%); complete immunisation (47%); vitamin A supplementation (60%); preventing malaria (52%); and availing supplementary nutrition services from AWCs (41%) **(Fig. 16).** The knowledge levels of ASHAs, across all sample states, need improvement.

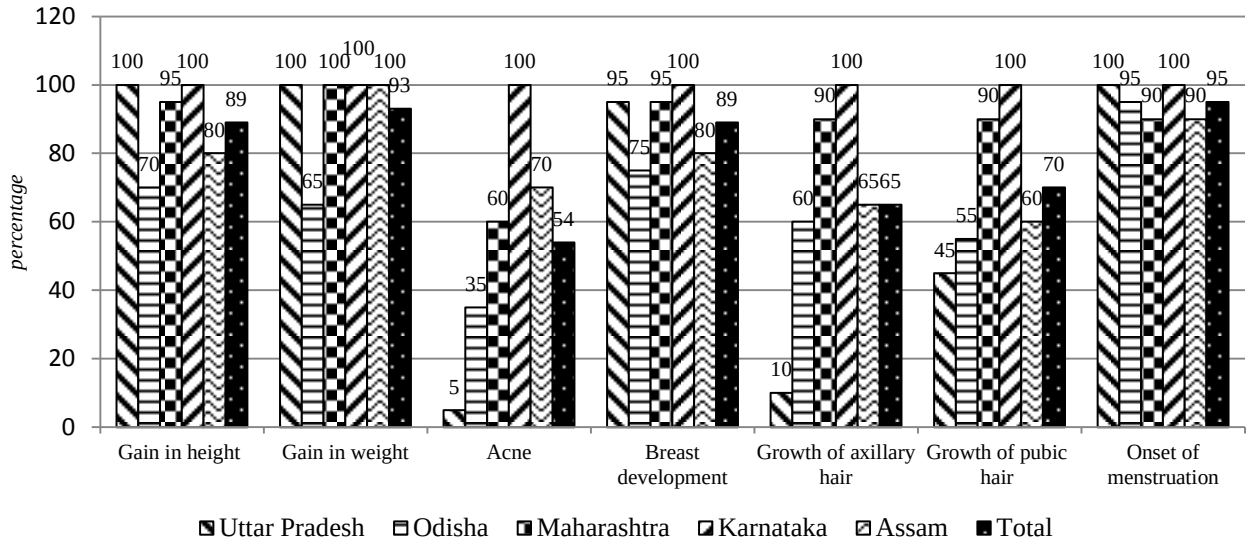
Fig. 16 Knowledge and Awareness of ASHAs about Prevention of Malnutrition



4.3.12 Awareness of ASHAs about Physical Changes during Adolescence

The awareness of ASHAs regarding changes during adolescence was limited in all sample states **(Fig. 17)**. The bodily changes those ASHAs related with adolescence were- onset of menstruation (95%); gain in weight (93%); gain in height and breast development (89%); growth of pubic hair (70%); and growth of axillary hair (65%).

Fig. 17 Awareness of ASHAs about Physical Changes during Adolescence



4.3.13 Knowledge and Awareness of ASHAs about Family Planning Methods

The awareness of ASHAs as regards the methods of family planning, as also, about the conditions under which abortion is permitted was elicited **(Fig. 18 and Fig. 19)**. Awareness of ASHAs about vasectomy was low, reflecting the 'gender milieu' of the states. Awareness about the condition under which abortion is permitted revealed a serious knowledge gap, across all the sample states. The conditions under which abortion is permitted included- 'risk to the life of a pregnant woman' (63%); 'failure of the family planning method' (59%); 'risk of child having physical or mental abnormalities' (58%); and 'pregnancy as a result of rape' (37%).

Fig. 18 Knowledge and Awareness of ASHAs about Family Planning Methods

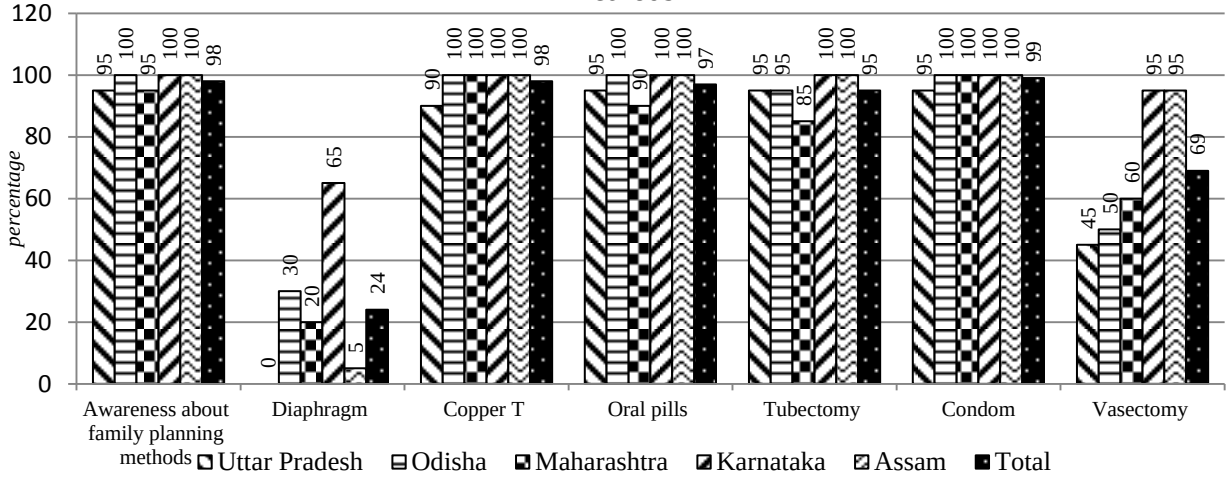
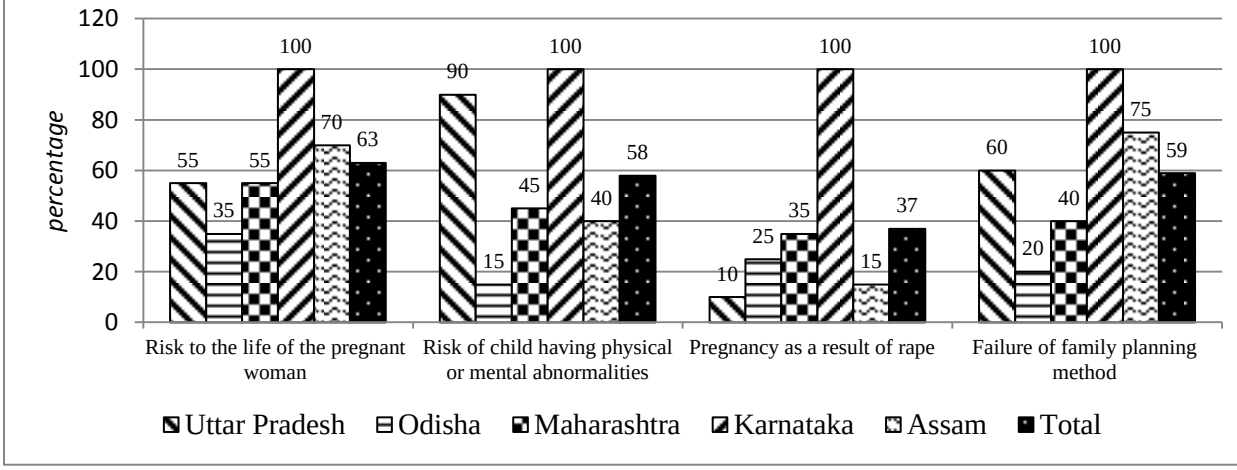


Fig. 19 Knowledge and Awareness of ASHAs about Conditions under which Abortion is Permitted



4.3.14 Knowledge and Awareness of ASHAs about Reproductive Tract Infections (RTIs)/ Sexually Transmitted Infections (STIs)

The common sign and symptoms that ASHAs could relate to RTIs/STIs include foul smelling vaginal discharge (61%); burning during urination (76%); itching in vulva (78%); ulcer in pubic region (35%); pain in lower back (54%); pain or bleeding during intercourse (42 %); and changes in menstrual bleeding (35%). The major lacunae in the knowledge relating to prevention of RTIs/STIs which need to be substantiated, includes the need for partner treatment in STIs; having single mutually faithful sexual partner; correct condom usage; maintaining menstrual hygiene; and observing aseptic techniques during delivery/abortion **(Fig. 20 and 21).**

Fig. 20 Knowledge and Awareness of ASHAs about Common Symptoms of RTIs/STIs in Women

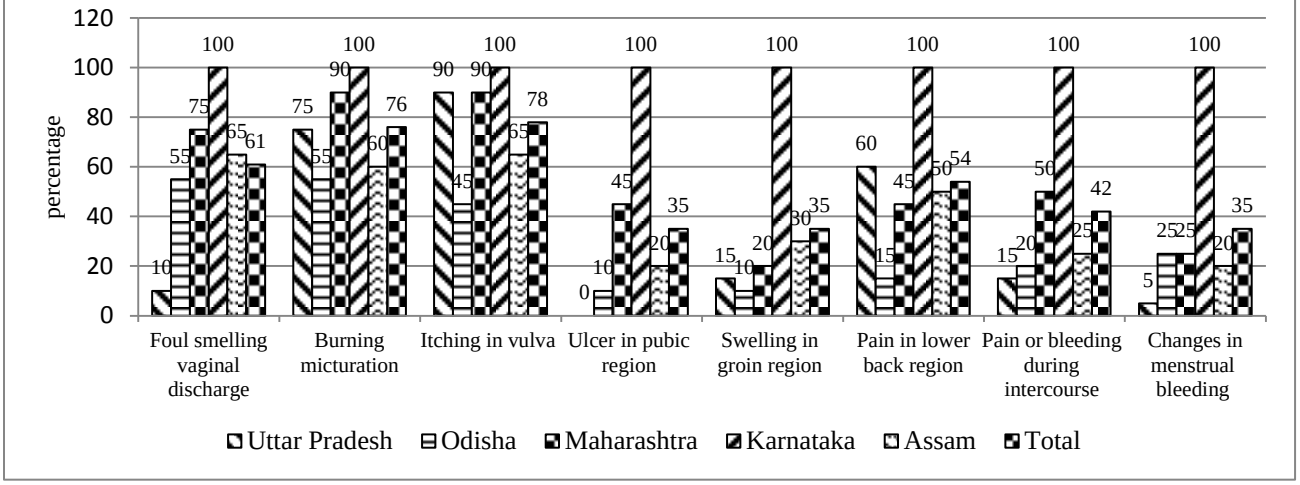
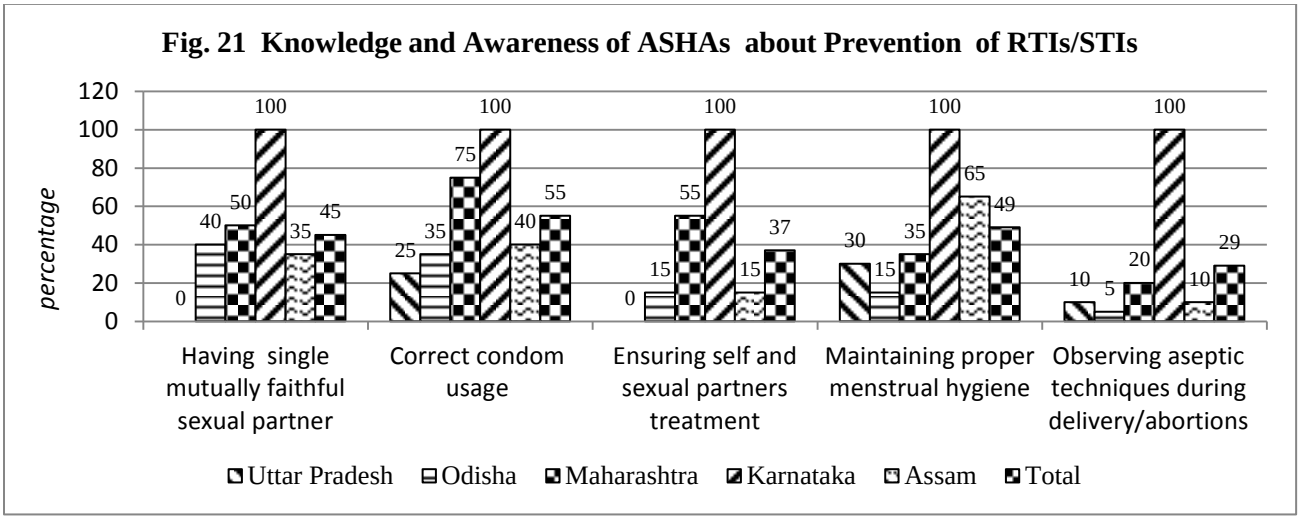


Fig. 21 Knowledge and Awareness of ASHAs about Prevention of RTIs/STIs



4.3.15 Knowledge and Awareness of ASHAs about HIV/AIDS

Fig. 22 presents the knowledge and awareness of ASHAs about HIV/AIDS. Causative agent of AIDS was not known to majority of ASHAs. Awareness about mother-to-child transmission of HIV during pregnancy, childbirth and breastfeeding was also dismal. There is need for concept clarification as regard 'how HIV does not spread' (**Fig. 23).** As regard prevention of HIV, the use of safe blood/blood product for transfusion to prevent HIV was known to only few ASHAs across the sample states **(Fig. 24).** Theme-based seminars/workshops for ASHAs should be organised at the block level for concept clarification on the subject.

Fig. 22 Knowledge and Awareness of ASHAs about Modes of Transmission of HIV

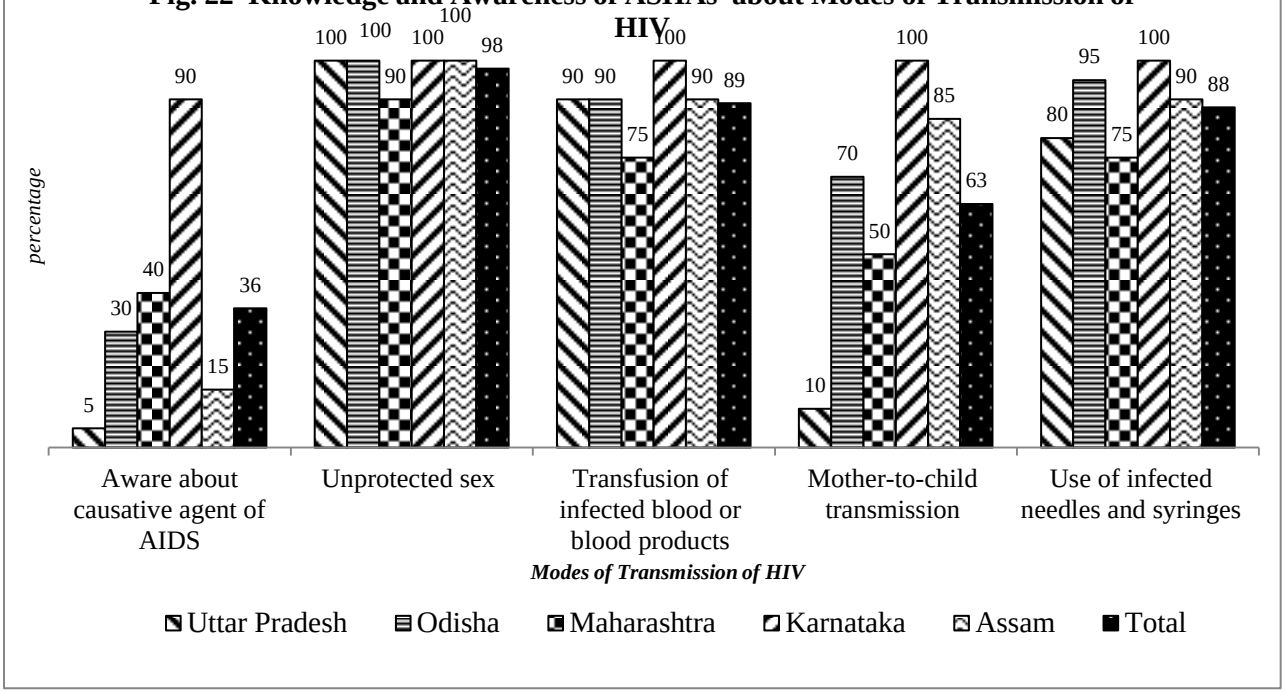
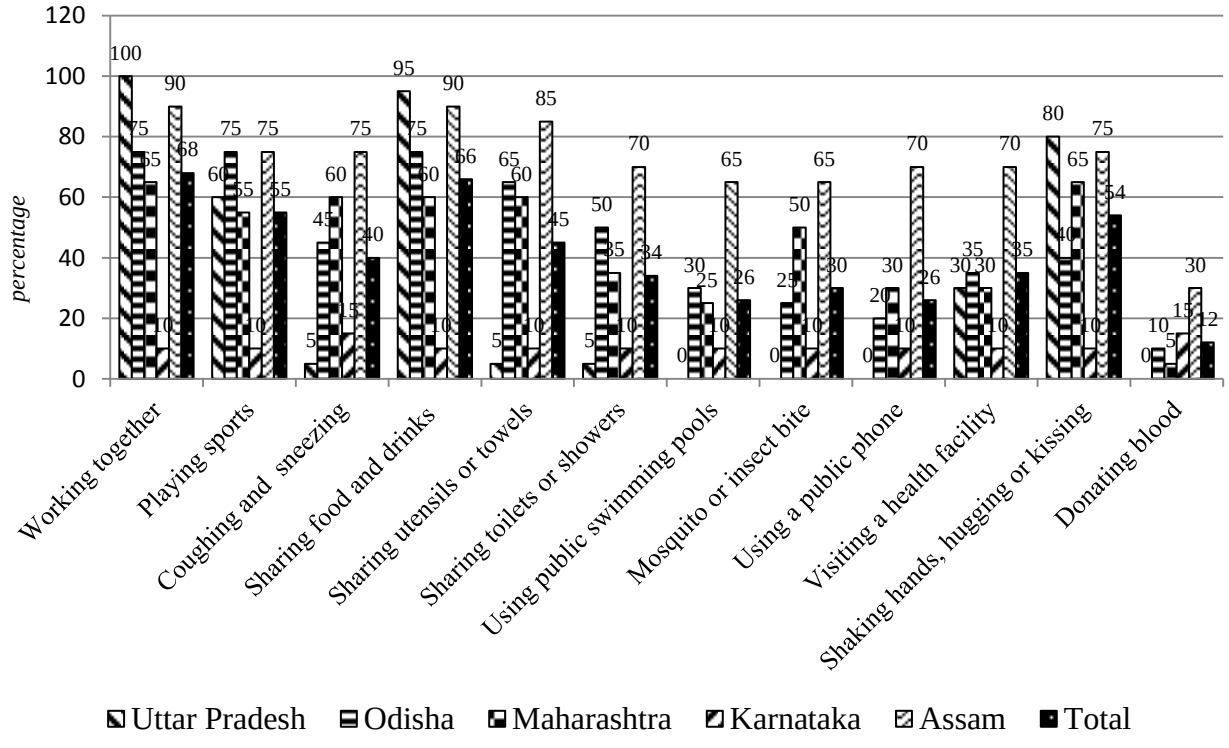
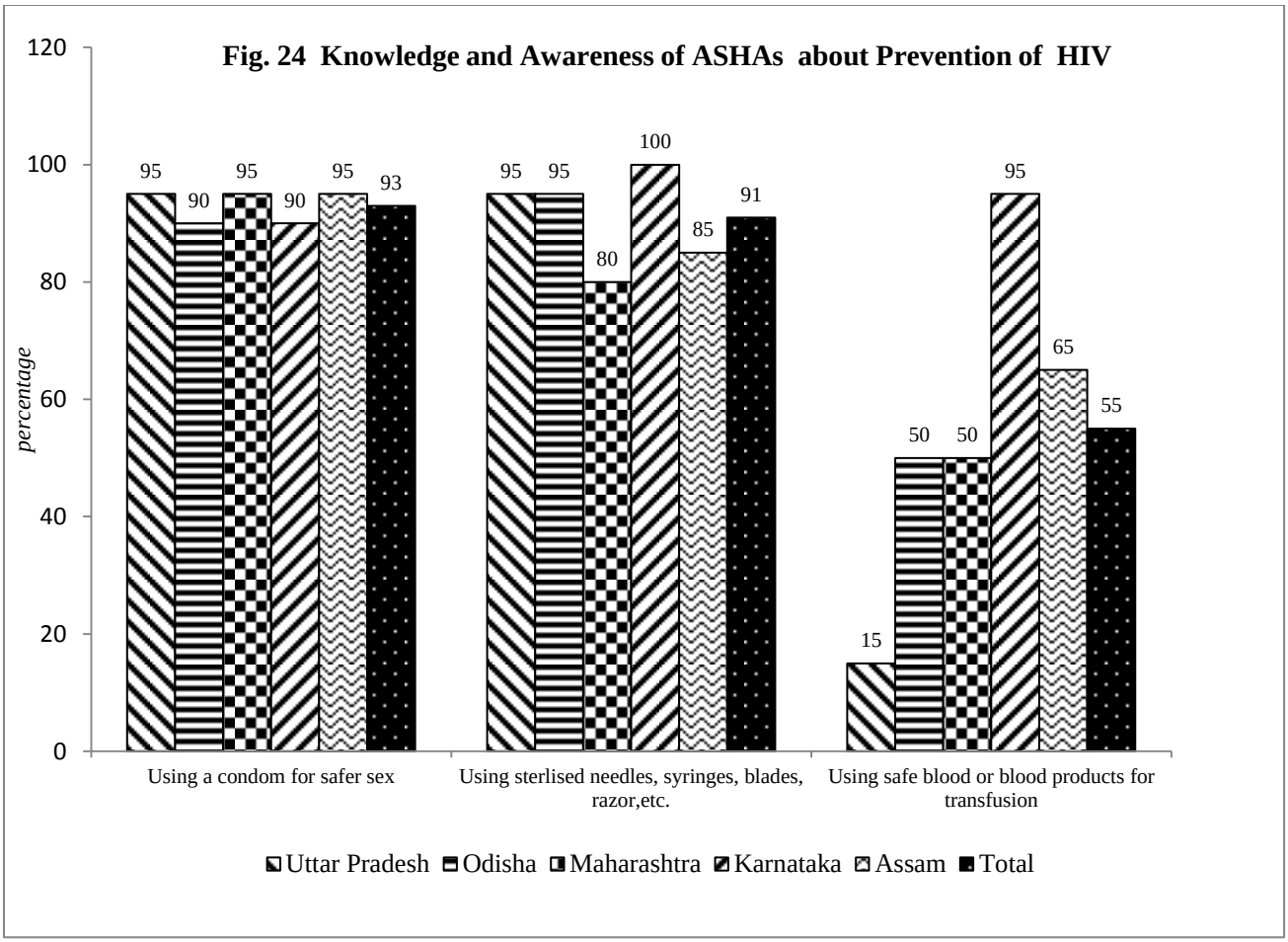


Fig. 23 Knowledge and Awareness of ASHAs about How HIV does not Spread





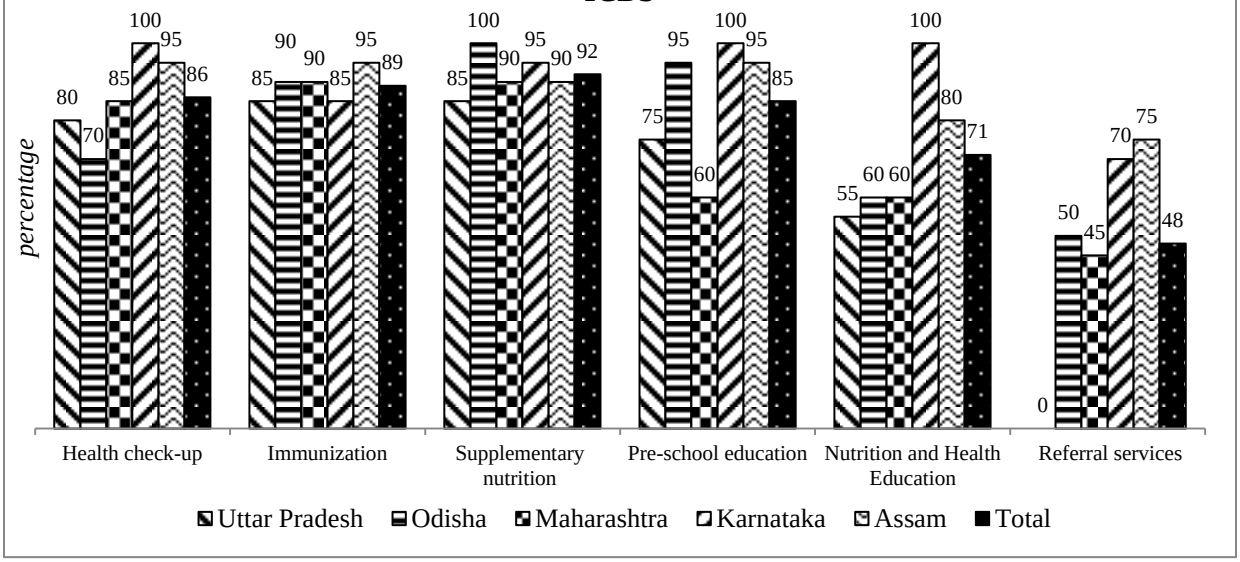
4.4 Awareness and Contribution of ASHAs in ICDS Related Activities

4.4.1 Knowledge and Awareness of ASHAs about Services provided under ICDS

As per the Guidelines on ASHA, the AWW will guide ASHA in performing many activities**.** ASHA will provide support to the AWW in mobilising pregnant and lactating women and infants for nutrition supplement. She would also take initiative for bringing the beneficiaries from the village on specific days of immunisation, health checkups / health days etc. to the AWCs. **Fig. 25** presents the knowledge and awareness of ASHA about services provided under ICDS. The study revealed that the knowledge of ASHAs about the health check-up; immunisation, supplementary nutrition and pre-school education was 86 per cent, 89 per cent, 92 per cent and 85 per cent respectively. However, the knowledge level was low for nutrition and health education (71%) and referral

services (41%) which needs to be improved urgently, if ASHAs have to serve as an effective link between AWW and the community.

Fig. 25 Knowledge and Awareness of ASHAs about Services Provided under ICDS



4.4.2 Awareness and Use of Mother and Child Protection Card by ASHA, ANM and AWW

The Mother and Child Protection (MCP) Card is a maternal and child care entitlement card, a counselling and family empowerment tool which would ensure tracking of mother child cohort for health purposes. It links critical contact points for strengthening the continuum of care and improving utilisation of key ICDS, NRHM services, including immunisation and Janani Suraksha Yojna. Besides, it is meant to promote key family care behaviours, highlights danger signs and links families to the referral system.

Fig. 26 presents the awareness and use of MCP Card by ASHA, ANM and AWW. Almost all the ASHAs, ANMs and AWWs were aware about the MCP Card and had helped the mothers in procuring them. Mothers were the holders of the MCP Card in majority of the cases. The MCP Card has been mainly used by ASHAs and ANMs for explaining about ANC services and explaining about preparation for delivery; and AWWs for explaining about childhood illnesses; and advising about nutrition, immunisation, etc.

Awareness among Beneficiaries

Fig. 27 presents the awareness among beneficiaries about the Mother and Child Protection Card (MCP Card). The MCP Card has been used most, in Assam followed Karnataka, Odisha,

Maharashtra and Uttar Pradesh, among the sample states. On corroboration of responses of beneficiaries on usage of MCP Card by ASHAs, the study revealed that there is over reporting by ASHAs on usage of MCP Card. There is a gross disparity between the MCP Card usage for various issues as reported by ASHAs and beneficiaries. MCP card usage as reported by ASHA and beneficiaries include explaining about ANC services (82% and 46%); explaining danger signs during pregnancy (50% and 35%); explaining about preparation for delivery (52% and 37%); explaining about danger signs in newborn (42% and 28%); counselling after weighing (55% and 30%); explaining about childhood illness and its prevention (41% and 24%) respectively.

Fig. 26 Awareness and Use of Mother and Child Protection Card by ASHA, ANM and AWW

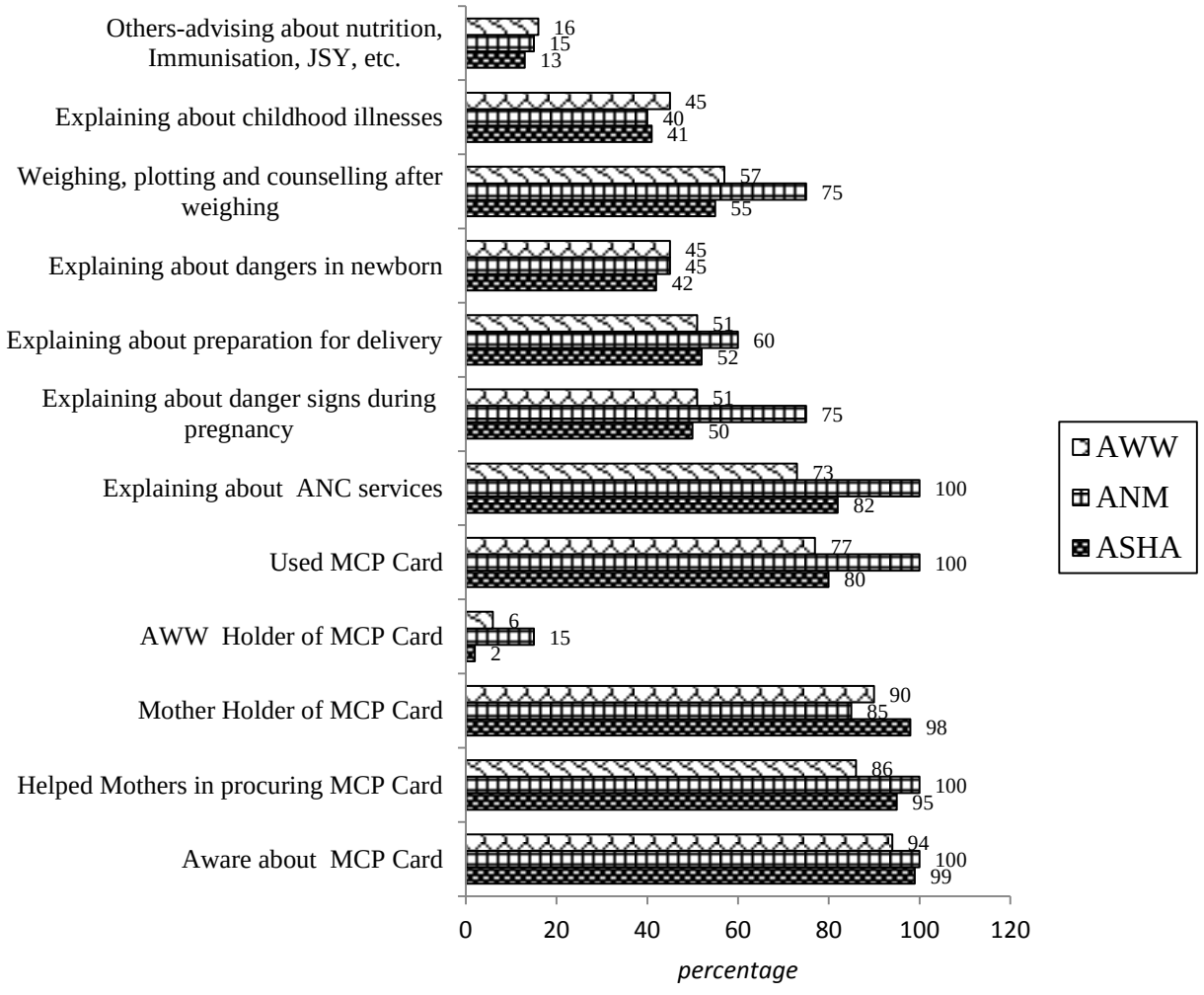
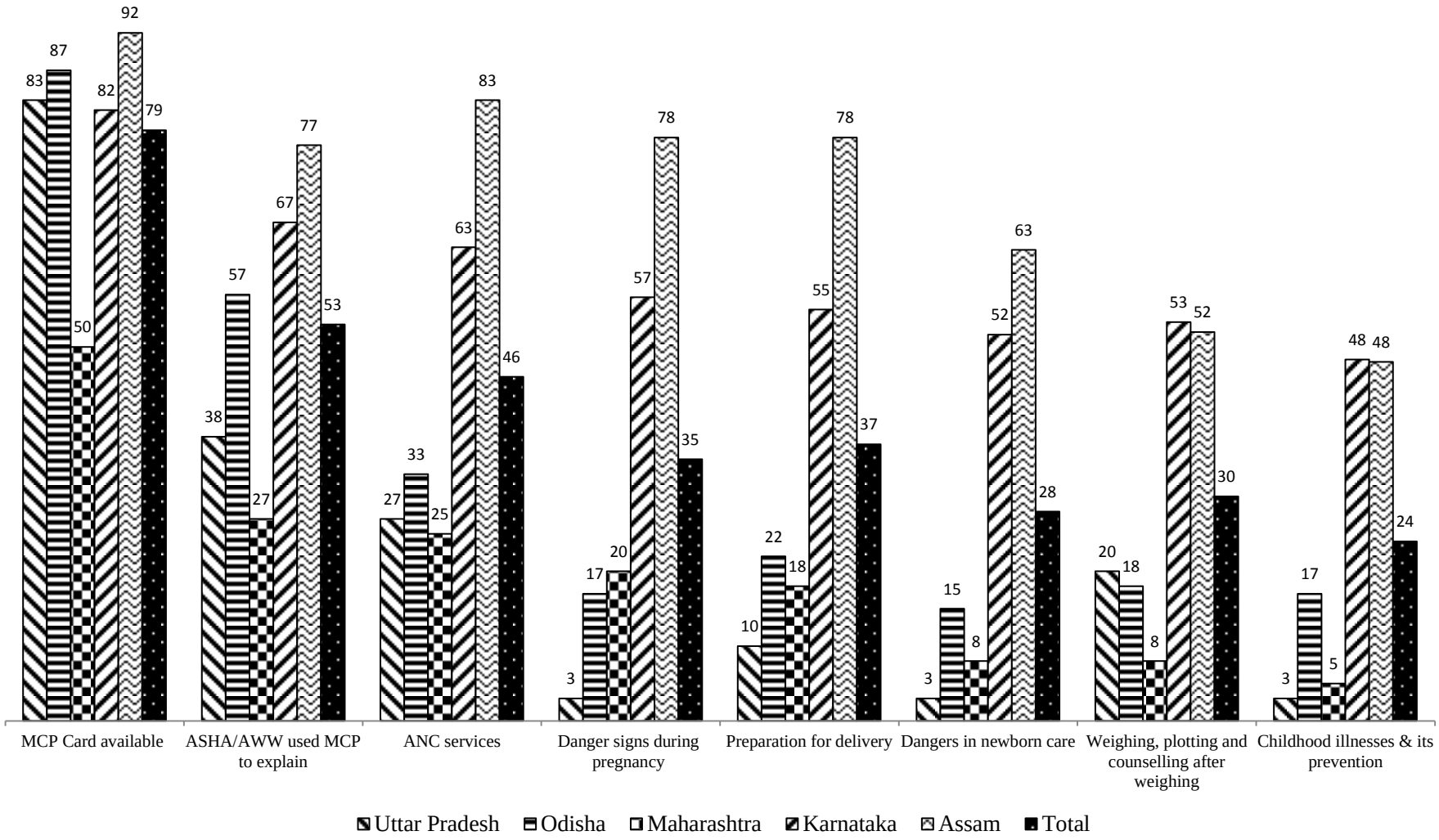


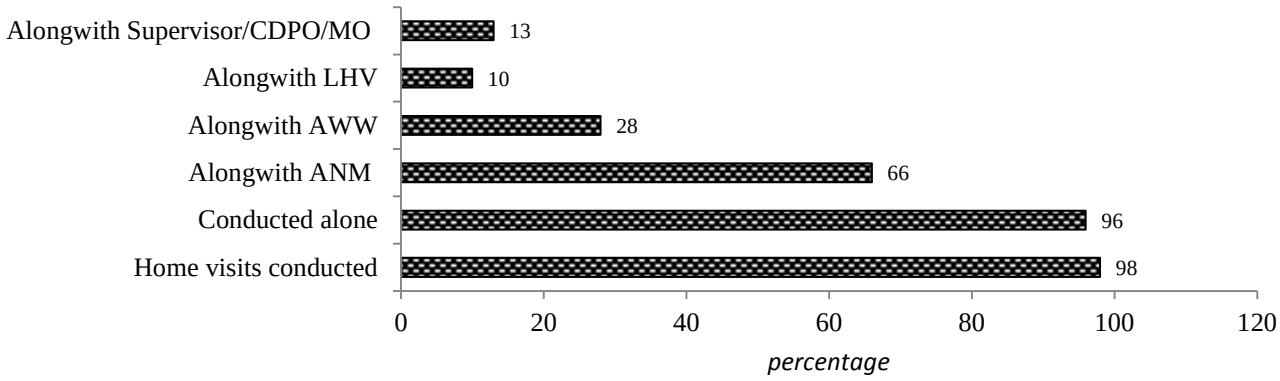
Fig. 27Awareness among Beneficiaries about the Mother and Child Protection Card



4.4.3 Conducting Home Visits

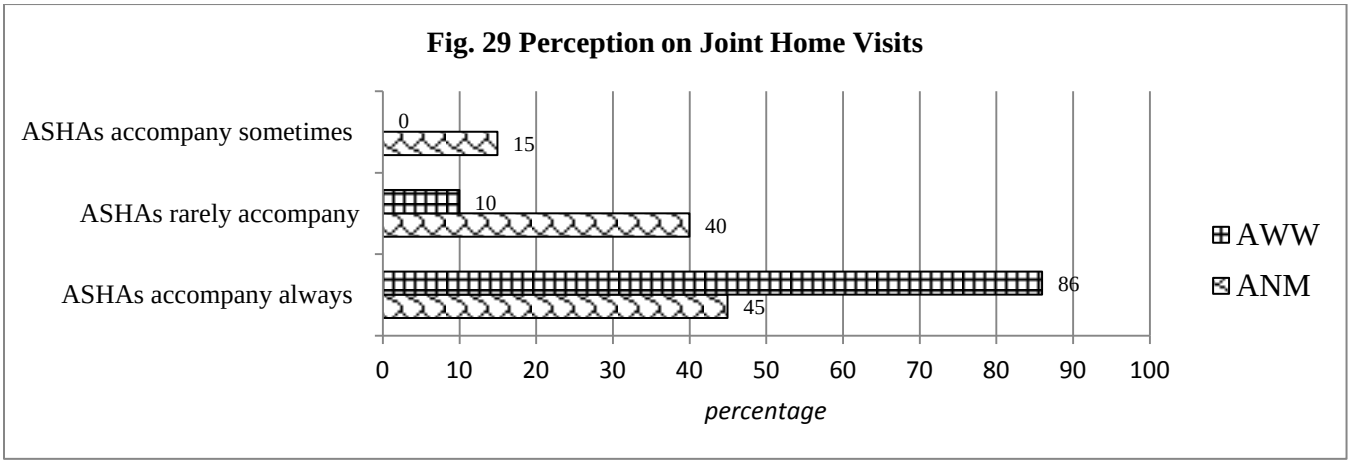
Home visits are an opportunity to provide preventive, promotive and curative care. **Fig. 28** presents the modalities of home visits by ASHAs. Majority (98%) of ASHAs reported conducting home visits. Around 96 per cent of admitted conducting home visits alone. Home visits were also conducted along with ANM; AWW; LHV; and Supervisor/CDPO/MO by 66 per cent; 28 per cent; 10 per cent and 13 per cent respectively.

Fig. 28 Modalities of Home Visits of ASHAs



There were some discrepancies in responses of ASHAs and AWWs on joint home visits. **Fig. 29** presents the responses of AWWs and ANMs on joint home visits. On the one hand, 86 per cent of AWWs reported that ASHAs always accompany them during the home visits and on the other hand, only 28 per cent of ASHAs reported about conducting joint home visits with AWWs. Forty five per cent of ANMs reported that ASHAs rarely accompany them during home visits. This finding calls for a need for clear-cut guidelines on home visits by the health and ICDS functionaries, as also role clarification on the same.

Fig. 29 Perception on Joint Home Visits



Responses of ASHAs, ANMs and AWWs on Postnatal Visits at Home

PNC is an important component of the service continuum, a special thrust is required to enhance its uptake. However MKCGMC, (2008) found that postnatal care was quite low. The ASHAs facilitated three PNCs in less than one-fifth of the user-women and private practitioners conducted PNCs in 37.5 per cent non-users. **Fig. 30** presents the postnatal visits at home by ASHAs, ANMs and AWWs as seen in the present study. Most of ASHAs reported carrying out postnatal home visits, followed by ANMs, and AWWs. The visits to a postnatal mother on the 1st day, 3rd day, 7th day, 21st day and 42nd day was 81 per cent, 84 per cent, 83 per cent, 48 per cent and 30 per cent by ASHAs, it was 40 per cent, 45 per cent, 30 per cent, 15 per cent and 20 per cent by ANMs; and 36 per cent, 36 per cent, 33 per cent, 11 per cent and 10 per cent by AWWs respectively. Keeping in view the Millennium Development Goals, there is an urgent need to streamline postnatal home visits among the grassroots level workers for reduction in IMR and MMR

Fig. 30 Perception about Postnatal Visits at Home

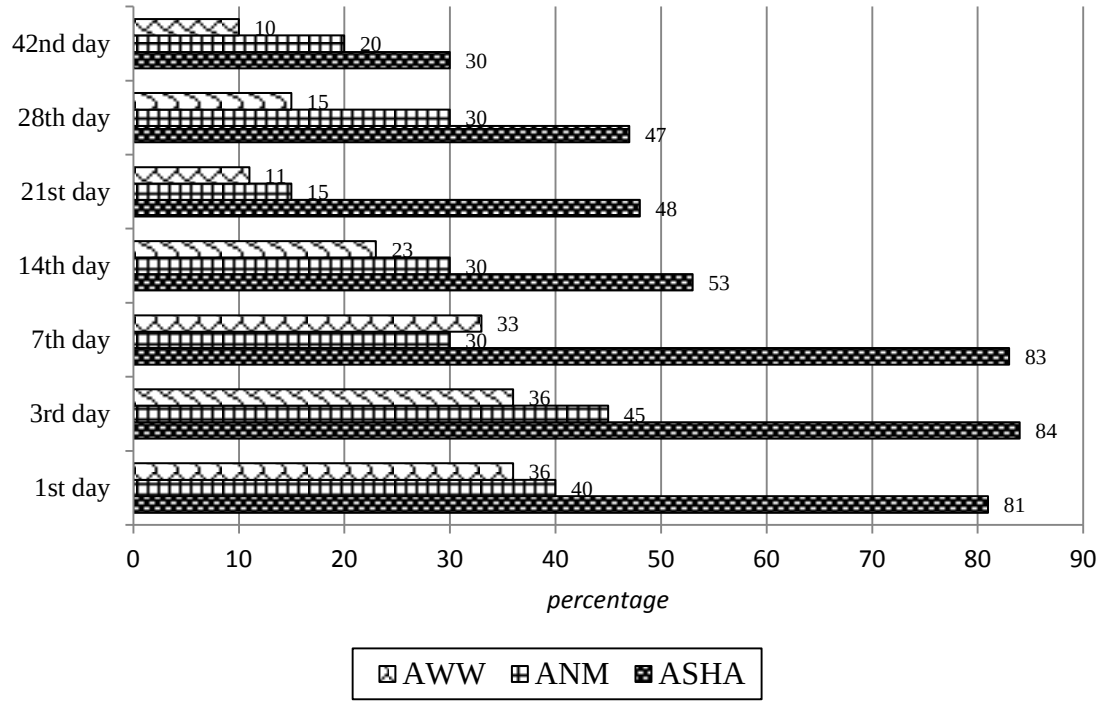
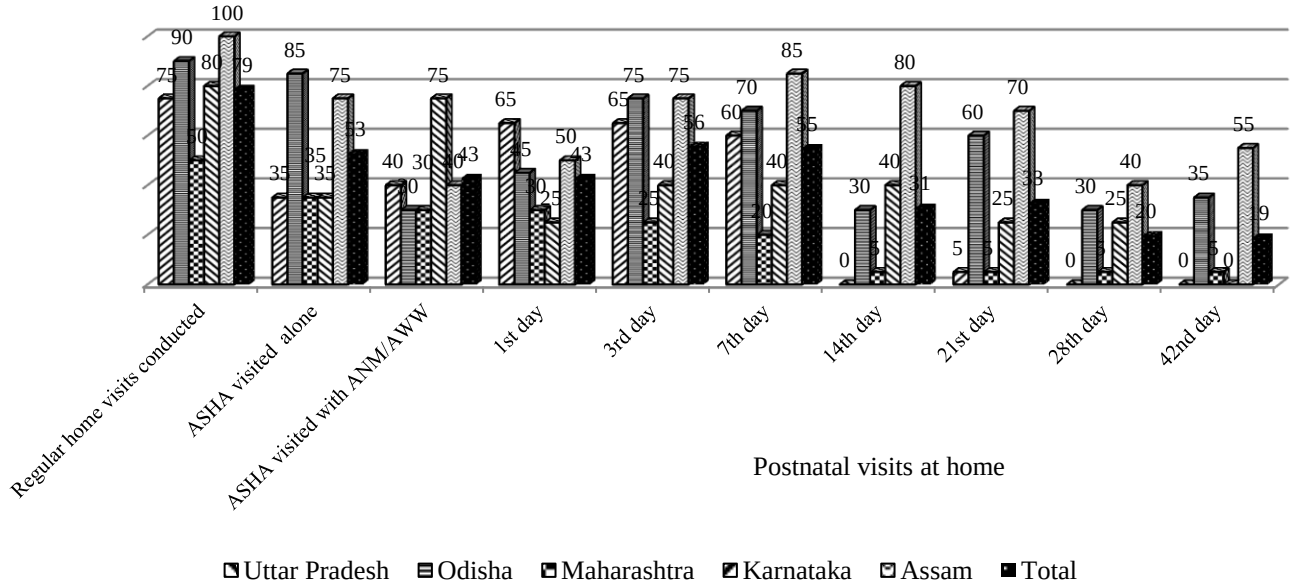


Fig. 31 presents the feedback of beneficiaries on the home visits by ASHAs, ANMs and AWWs. Home visits are being carried out regularly in Assam, followed by Odisha, Karnataka, Uttar Pradesh and

Maharashtra. About 85 per cent of beneficiaries of Odisha; and 75 per cent of beneficiaries of Assam were visited by ASHAs, alone. About 75 per cent of beneficiaries of Karnataka reported that ASHA visited them along with ANMs or AWWs. The percentage of beneficiaries who were visited at home, soon after delivery, during the postnatal period, for all sample states, were 1st day (43%); 3rdday (56%); 7thday (55%); 14th day (31%); 21st day (33%); 28thday (20%); and 42nd day (19%). On comparing the responses of beneficiaries on the postnatal visits at home, the study suggests gross over reporting by ASHAs. There is a need for developing clear and concise graded supportive supervision for monitoring home visits by the grassroots level workers.

Fig.31 Feedback of Beneficiaries on Home Visits by ASHAs, ANMs and AWWs



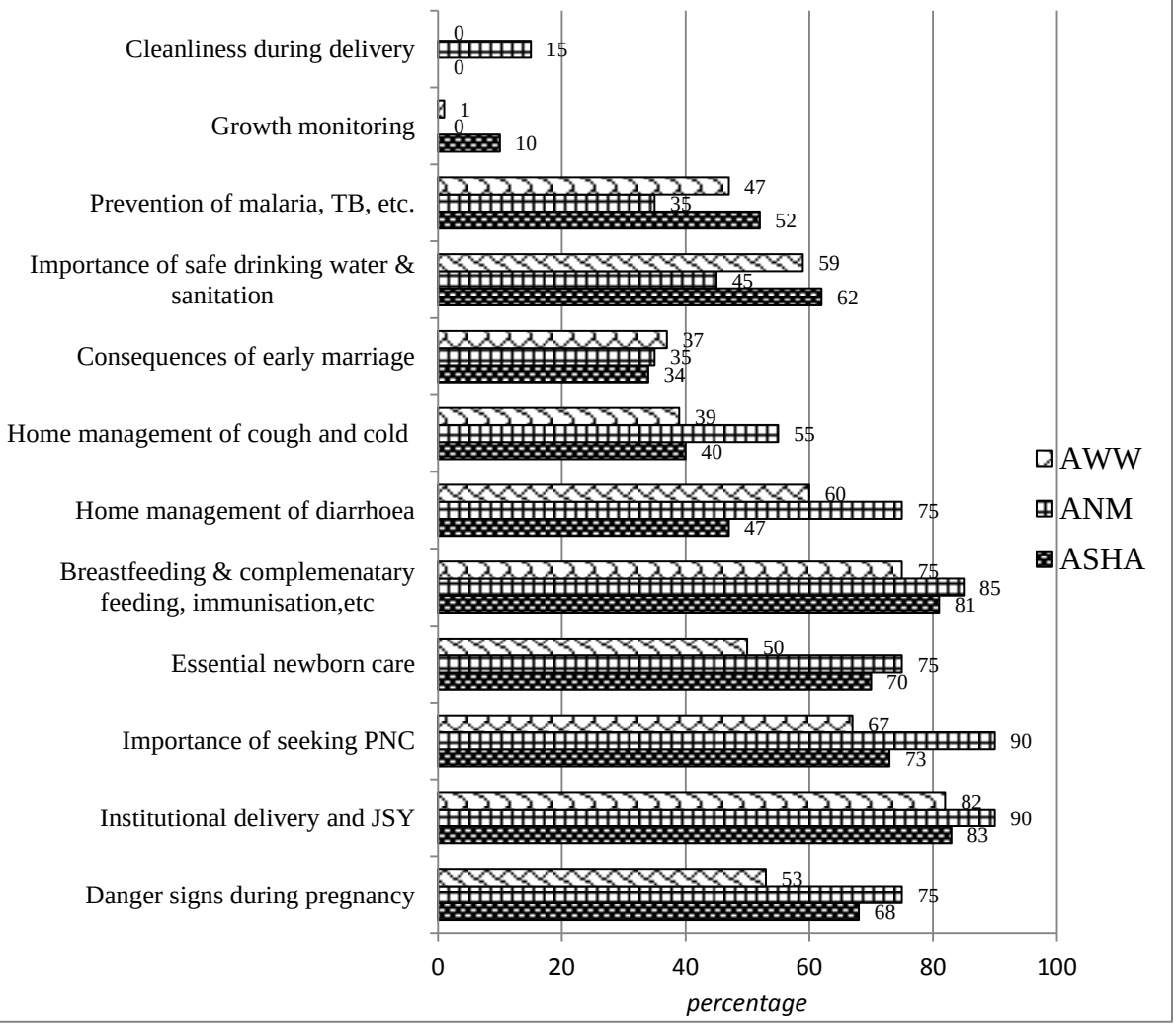
Issues Discussed during Home Visits

Reported by ASHAs, ANMs and AWWs

As can be seen in **Fig. 32**, institutional delivery and JSY; breastfeeding, complementary feeding and immunisation; importance of seeking PNC; essential new born care; and danger signs during pregnancy were reported to be taken up for discussions during the home visits, more often, by all the ASHAs, ANMs and AWWs. The other topics such as home care during illness like diarrhoea and cold & cough;

consequences of early marriage; importance of safe drinking water and sanitation; cleanliness during delivery; growth monitoring; prevention of malaria, tuberculosis, etc. were not discussed much during the home visits.

Fig. 32 Issues discussed during Home Visits



4.4.4 Availability, Knowledge and Use of Medicine Kit

Responses of ASHAs

The availability of medicine kits, knowledge of ASHAs about the contents of medicine kit and medicines/contents found available in the medicine kit, on physical verification is presented in **Table 10** Medicine kit was available with 100 per cent of ASHAs of Odisha; 95 per cent of ASHAs of Karnataka; 80 per cent of ASHAs of Maharashtra; 75 per cent of ASHAs of Assam and only 5 per cent ASHAs of

Uttar Pradesh. The awareness about the contents of medicine kit was fair among the ASHAs of all sample states. The availability of medicine in the kit was poor or lacking in Maharashtra (25%); Karnataka (25%); and Assam (30%). On physical verification, the medicine found available in the kit included mainly paracetamol (36%); albendazole tablets (37%); IFA tablets (49%); ORS (54%); condom and oral contraceptive pills (38%); pregnancy testing kit (35%); etc. The status of replenishment of the medicine was also very poor in all the sample states, except Odisha, which requires immediate attention and suitable instructions in this regard may be issued by State Governments on replenishment of medicines.

Table 10: Awareness of ASHAs about Availability and Contents of Medicine Kit

Availability and Contents of Medicine Kit	EAG State				Non-EAG State				N E State		Total	
	Uttar Pradesh n=20		Odisha n=20		Maharashtra n=20		Karnataka n=20		Assam n=20		n=100	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Availability of Medicine Kit with ASHAs												
Medicine Kit available	1	5.0	20	100.0	16	80.0	19	95.0	15	75.0	71	71.0
Awareness about contents of Medicine Kit												
Paracetomol tablets	18	90.0	19	95.0	17	85.0	19	95.0	15	75.0	88	88.0
Albendazole tablets	1	5.0	15	75.0	11	55.0	11	55.0	13	65.0	51	51.0
Iron Folic Acid (IFA) tablets	18	90.0	20	100.0	15	75.0	13	65.0	15	75.0	81	81.0
Chloroquine tablets	7	35.0	14	70.0	10	50.0	8	40.0	14	70.0	53	53.0
Oral Rehydration Salts (ORS)	18	90.0	20	100.0	17	85.0	18	90.0	12	60.0	85	85.0
Eye ointment	0	0.0	5	25.0	3	15.0	4	20.0	4	20.0	16	16.0
Condoms and oral contraceptive pills	16	80.0	20	100.0	2	10.0	10	50.0	15	75.0	63	63.0
Pregnancy testing kits	16	80.0	19	95.0	3	15.0	16	80.0	8	40.0	62	62.0
Malaria testing kits	3	15.0	20	100.0	5	25.0	12	60.0	7	35.0	47	47.0
Disposable Delivery Kit	1	5.0	18	90.0	3	15.0	2	10.0	13	65.0	37	37.0
Others (iodine, cotton, DOT medicine, anti-malaria medicines, etc.)	0	0.0	4	20.0	0	0.0	0	0.0	2	10.0	6	6.0
Availability of all medicines in the Kit												
Availablity of all medicines in the Kit	0	0.0	16	80.0	5	25.0	5	25.0	6	30.0	32	32.0
Physical verification of medicines/contents												
Paracetomol tablets	1	5.0	14	70.0	14	70.0	18	90.0	9	45.0	56	56.0

Albendazole tablets	0	0.0	10	50.0	10	50.0	8	40.0	9	45.0	37	37.0
Iron Folic Acid (IFA) tablets	1	5.0	19	95.0	11	55.0	8	40.0	10	50.0	49	49.0
Chloroquine tablets	0	0.0	11	55.0	6	30.0	4	20.0	9	45.0	30	30.0
Oral Rehydration Salts (ORS)	1	5.0	18	90.0	12	60.0	13	65.0	10	50.0	54	54.0
Eye ointment	0	0.0	5	25.0	1	5.0	2	10.0	0	0.0	8	8.0
Condoms and oral contraceptive pills	1	5.0	18	90.0	1	5.0	6	30.0	12	60.0	38	38.0
Pregnancy testing kits	1	5.0	19	95.0	0	0.0	12	60.0	3	15.0	35	35.0
Malaria testing kits	0	0.0	18	90.0	1	5.0	9	45.0	4	20.0	32	32.0
Disposable Delivery Kit	0	0.0	20	100.0	0	0.0	1	5.0	8	40.0	29	29.0
Others (iodine, iron syrup, DOTS medicine, nischay home pregnancy card, etc.)	0	0.0	3	15.0	0	0.0	1	5.0	0	0.0	4	4.0
Status of replenishment of medicines												
Three months ago	1	5.0	20	100.0	5	25.0	10	50.0	4	20.0	40	40.0
Six months ago	3	15.0	0	0.0	6	30.0	2	10.0	8	40.0	19	19.0
More than one year ago	16	80.0	0	0.0	6	30.0	8	40.0	7	35.0	37	37.0

Responses of ASHAs, Health and ICDS Functionaries

Table 11 presents the status of availability of medicine kit and its replenishment, as perceived by ASHAs, Health and ICDS functionaries. The awareness level of health functionaries on the replenishment status of medicines in the kit was better than that of ICDS functionaries, namely, the AWWs, Supervisors and CDPOs.

Table 11 : Responses of Functionaries on Availability of Medicine Kit with ASHA and its Replenishment

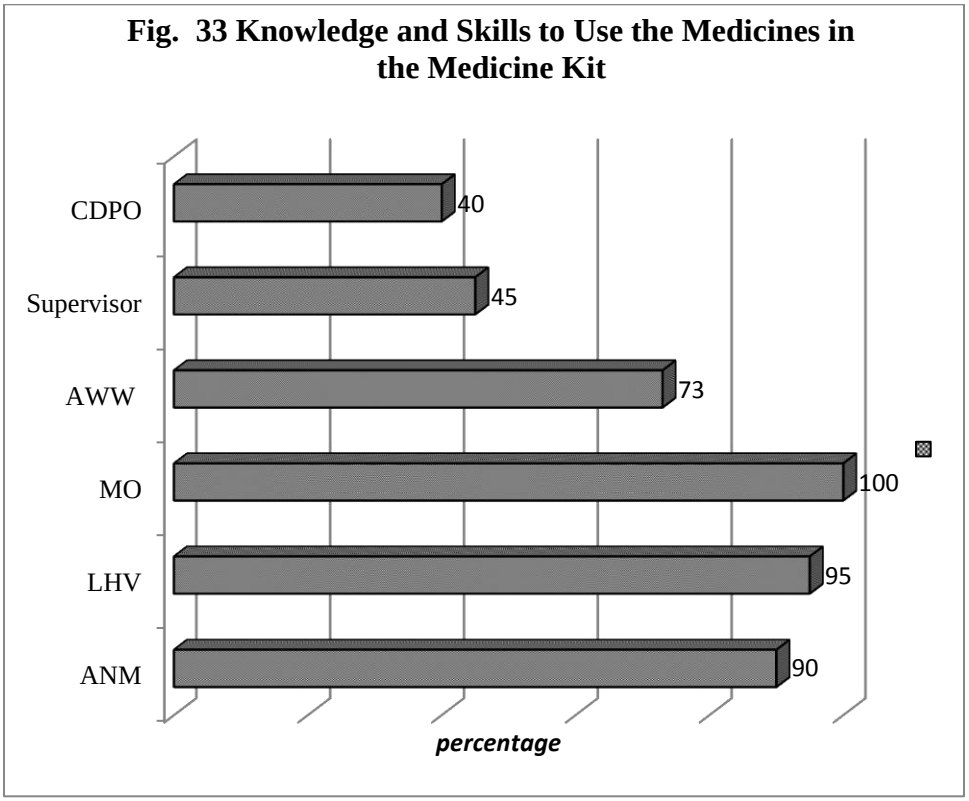
Responses on Medicine Kit		ASHA n=100		Health Functionaries						ICDS Functionaries					
				ANM n=20		LHV n=20		MO n=10		AWW n=100		Supervisor n=20		CDPO n=10	
		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Availability of Medicine Kit	Available	71	71.0	18	90.0	17	85.0	10	100.0	76	76.0	12	60.0	5	50.0
Availability of all Medicines in the Medicine Kit	Available	32	32.0	3	15.0	8	40.0	4	40.0	27	27.0	7	35.0	3	30.0

Periodicity of Replenishment of Medicines in the Kit	Three months ago	40	40.0	3	15.0	7	35.0	4	40.0	15	15.0	1	5.0	0	0.0
	Six months ago	19	19.0	3	15.0	5	25.0	1	10.0	11	11.0	4	20.0	0	0.0
	More than one year ago	37	37.0	8	40.0	6	30.0	3	30.0	18	18.0	3	15.0	2	20.0

Perception of Health and ICDS Functionaries about the Knowledge and Skills of ASHAs to Use the Medicines in the Medicine Kit

Almost all MOs (100%), LHVs (95%) and ANMs (90%) and AWW (73%) were of the view that the ASHAs possessed adequate knowledge and skills to use the medicines provided in the medicine kit **(Fig. 33).** About 73 per cent of AWWs, 45 per cent of Supervisors and 40 per cent of CDPOs shared the opinion that ASHAs possessed adequate knowledge and skills to use the medicines provided in the medicine kit.

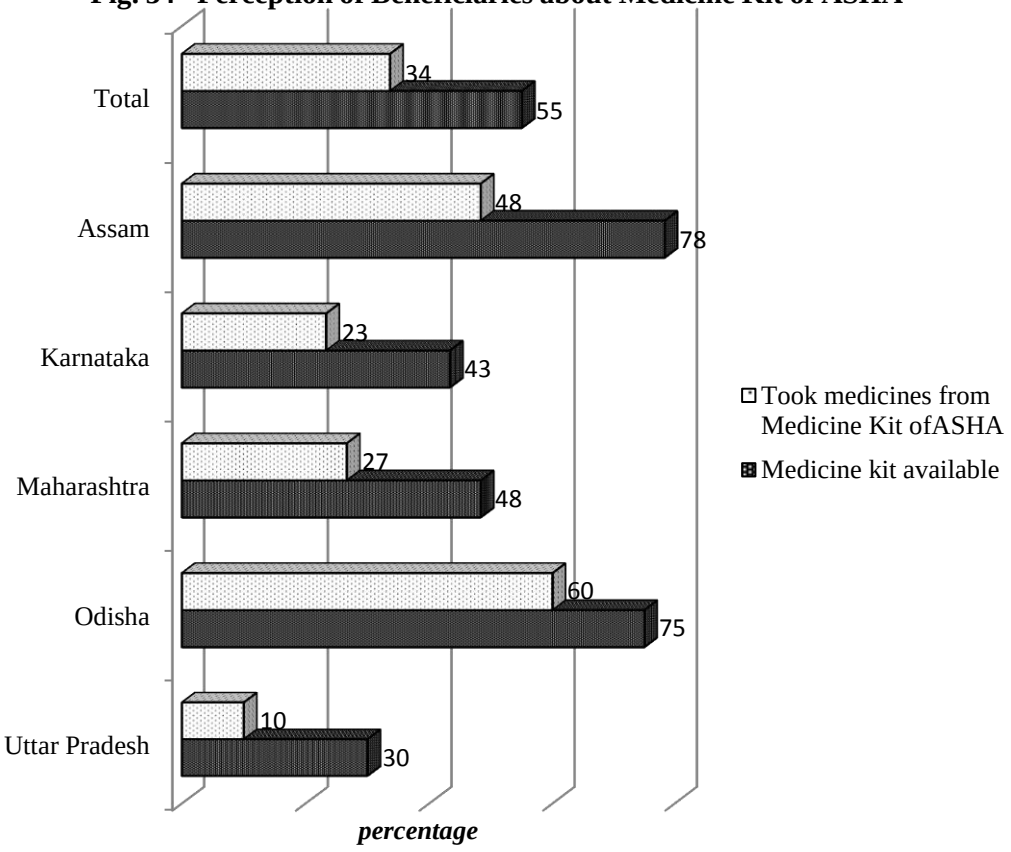
Fig. 33 Knowledge and Skills to Use the Medicines in the Medicine Kit



Perception of Beneficiaries

It is disheartening to note that only 55 per cent of beneficiaries reported availability of medicine kit with the ASHAs. Only 34 per cent of beneficiaries had taken medicines from ASHA. The usage reported was the maximum for Odisha (60%), followed by Assam (48%), Maharashtra (27%), Karnataka (23%) and Uttar Pradesh (10%) **(Fig. 34).** There is a dire need to look into this aspect of availability of medicine kit and availability of the medicines in the kit, if we want ASHAs to be accepted by the community.

Fig. 34 Perception of Beneficiaries about Medicine Kit of ASHA



4.4.5 Knowledge and Awareness about Village Health and Nutrition Days (VHNDs)

Awareness of ASHAs, ANMs, and AWWs

VHND is one of the very critical event to help increase the coverage of services related to maternal and newborn care and child health. **Table 12** presents the responses of ASHAs, ANMs and AWWs on the role

played by ASHAs in the organisation of Village Health and Nutrition Days (VHNDs). The role perceived by ASHAs was lucid, as compared to ANMs and AWWs. The percentage of ASHAs, ANMs and AWWs who had contributed in identifying and motivating women for ANC was 90 per cent, 50 per cent and 30 per cent; in identifying infants who needed immunisation was 80 per cent, 40 per cent and 32per cent; in ensuring that malnourished children consulted ANM was 66 per cent, 40 per cent and 21 per cent; and in coordinating with AWWs and ANMs in organising the VHNDs was 66 per cent, 35 per cent and 23 per cent, respectively. The perception of their role with respect to identifying and motivating children with special needs; preparing the list of TB patients for dispensing anti-TB drugs; etc was rather low for all the ASHAs, ANMs and AWWs in the sample.

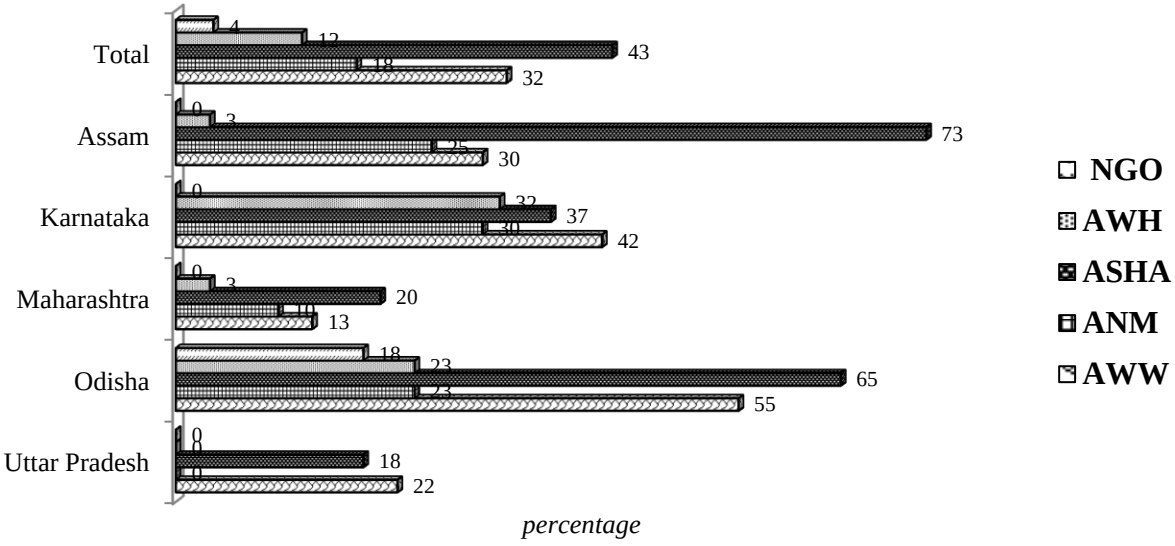
Table 12: Awareness about the Role of ASHA in the Organisation of Village Health and Nutrition Days (VHNDs)

Awareness about the Role in Village Health and Nutrition Days (VHND)	ASHA n=100		Health Functionaries ANM n=20		ICDS Functionaries AWW n=100	
	No.	%	No.	%	No.	%
Identified and motivated women for ANC for first time or for repeat visits	90	90.0	10	50.0	30	30.0
Identified infants who need immunisation, where left out or dropped-out	80	80.0	8	40.0	32	32.0
Ensured that malnourished children come for consultation with the ANM	66	66.0	8	40.0	21	21.0
Identified and motivated children with special needs, particularly girl children	51	51.0	5	25.0	19	19.0
Prepared list of TB patients who need anti-TB drugs and ensure their presence	30	30.0	1	5.0	12	12.0
Coordinated with the AWW and the ANM	66	66.0	7	35.0	23	23.0
Ensured that all listed women and children come for services	68	68.0	8	40.0	23	23.0

Source of Information about VHND as Reported by Beneficiaries

The beneficiaries' source of information about the VHNDs in all the sample states was mainly ASHA, as conceived in the programme, followed by AWWs, ANMs and AWHs **(Fig. 35).**

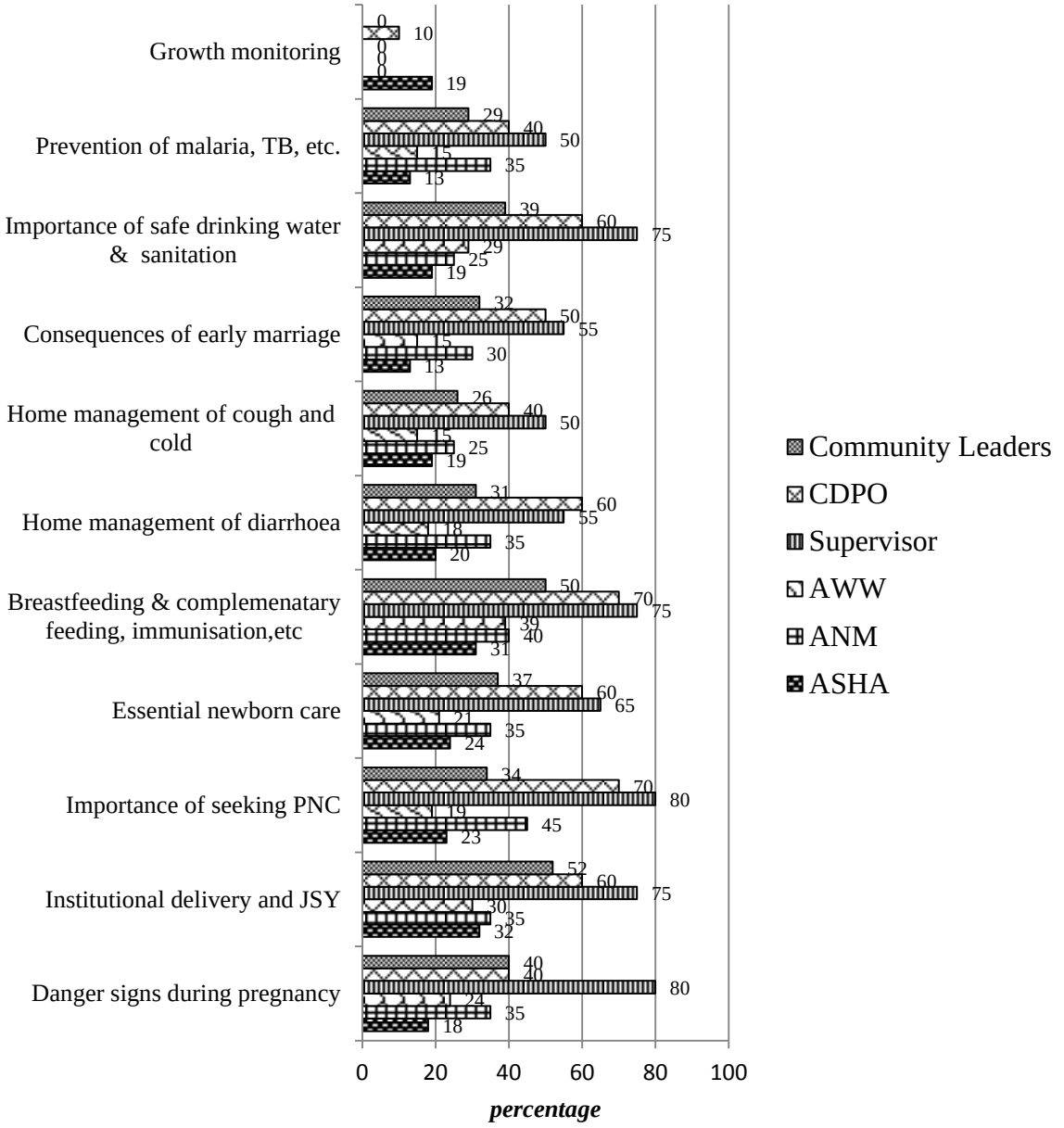
Fig. 35 Source of Information about Village Health and Nutrition Days (VHNDs) as Reported by Beneficiaries



Issues discussed in the VHNDs as Reported by ASHAs, Health Functionaries, ICDS Functionaries, Community Leaders and Beneficiaries

The present study revealed that breastfeeding, complementary feeding and immunisation; institutional delivery and JSY; and danger signs during pregnancy have been the major issues discussed during the VHNDs. The other issues that were discussed included importance of PNC; essential newborn care; home management of cold and cough and diarrhoea; consequences of early marriage; importance of safe drinking water; etc. The response of Supervisors was most lucid and clear followed by that of CDPOs and community leaders. This finding, however, needs to be taken with caution, as the responses of ASHAs, ANMs, AWWs, and more importantly, beneficiaries are not as apparent as it should have been **(Fig. 36).**

Fig. 36 Issues dicussed during the Village Health and Nutrition Days



4.4.6 Awareness about Village Health, Sanitation and Nutrition Committee (VHSNC)

Awareness of ASHAs

As per the guidelines, an ASHA has been created to work with the Village Health, Sanitation and Nutrition Committee (VHSNC) of the *gram panchayat* to develop a comprehensive village health plan. She will arrange escort/accompany pregnant women & children requiring treatment/ admission to the nearest pre- identified health facility. An attempt was made in the present study to elicit

awareness of ASHAs about VHSNCs. All the ASHAs of Odisha; Karnataka; Assam and majority of ASHAs in Maharashtra (70%) were aware of the formation of VHSNC in their respective areas. ASHAs themselves, ANMs and AWWs were listed by majority of ASHAs, as members of VHSNC. The awareness about the identified convenor and chairperson of VHSNC was better among ASHAs of Odisha, followed by Karnataka and Assam. In Uttar Pradesh, only 20 per cent of ASHAs reported the existence of VHSNC in their village, and only 5 per cent ASHA was aware of the designated convenor and chairperson of the VHSNC. This warrants attention of programme managers for issuing relevant instructions regarding formation and functioning of VHSNC. Less than half of ASHAs (47%) had undergone an orientation training on VHSNC *per se* **(Table 13)**.

Table 13: Awareness of ASHAs about the Formation of Village Health, Sanitation and Nutrition Committee (VHSNC)

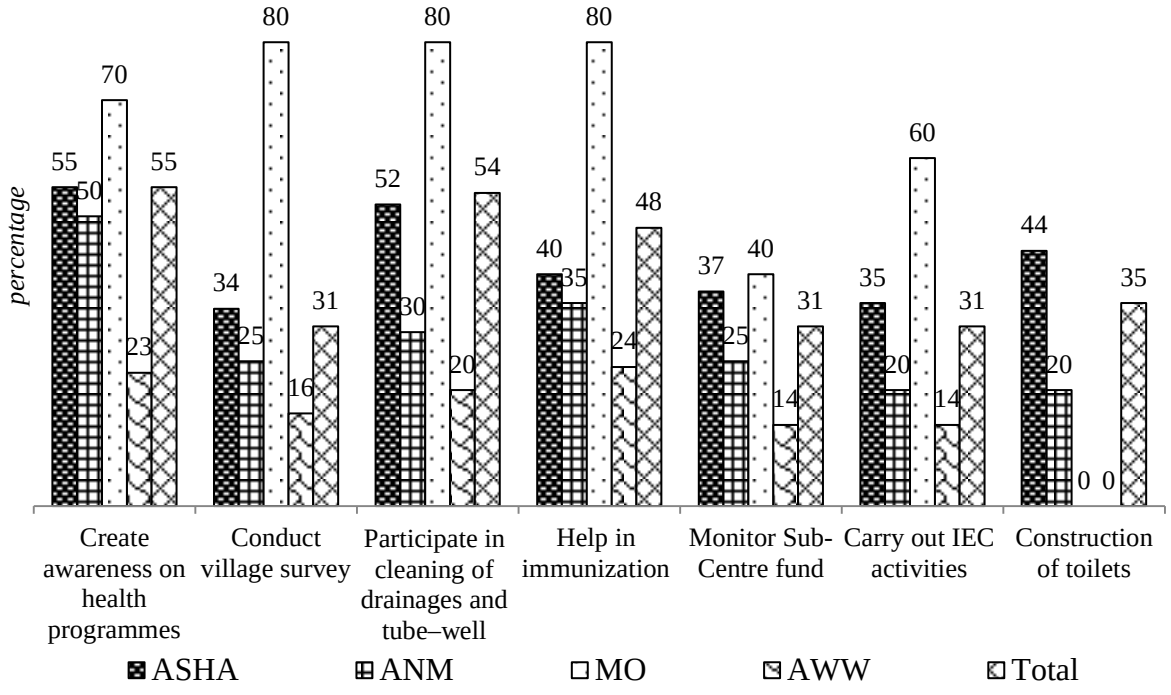
Awareness about VHSNC	EAG State				Non-EAG State				N E State		Total	
	Uttar Pradesh n=20		Odisha n=20		Maharashtra n=20		Karnataka n=20		Assam n=20		n=100	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Formation of VHSNC												
VHSNC Formed	4	20.0	20	100.0	14	70.0	20	100.0	20	100.0	78	78.0
Members of VHSNC												
ASHA	3	15.0	20	100.0	3	15.0	19	95.0	20	100.0	65	65.0
AWW	2	10.0	20	100.0	9	45.0	19	95.0	19	95.0	69	69.0
ANMs	3	15.0	4	20.0	8	40.0	19	95.0	19	95.0	53	53.0
SHG Member	0	0.0	18	90.0	5	25.0	13	65.0	10	50.0	46	46.0
Ward Member	1	5.0	18	90.0	7	35.0	18	90.0	15	75.0	59	59.0
Adolescent Girls	0	0.0	2	10.0	3	15.0	7	35.0	7	35.0	19	19.0
School Teachers	1	5.0	5	25.0	3	15.0	13	65.0	17	85.0	39	39.0
Village Youth Clubs	0	0.0	10	50.0	3	15.0	11	55.0	13	65.0	37	37.0
Sarpanch	1	5.0	1	5.0	8	40.0	12	60.0	14	70.0	36	36.0
PTA	0	0.0	4	20.0	0	0.0	4	20.0	8	40.0	16	16.0
Local NGOs	0	0.0		0.0	0	0.0	4	20.0	4	20.0	8	8.0
Designated Convenor of VHSNC												
ASHA	1	5.0	2	10.0	0	0.0	15	75.0	14	70.0	32	32.0
AWW	0	0.0	18	90.0	7	35.0	2	10.0	4	20.0	31	31.0
Designated Chairperson of VHSNC												
Ward/Sarpanch	1	5.0	19	95.0	6	30.0	13	65.0	13	65.0	52	52.0
CDMOs/MOs	0	0.0	0	0.0	1	5.0	1	5.0	2	10.0	4	4.0
H.M of school	0	0.0		0.0	0	0.0	1	5.0	0	0.0	1	1.0
Attended Orientation Training												
Attended the orientation training	1	5.0	18	90.0	1	5.0	17	85.0	10	50.0	47	47.0

Table 14: Awareness of ASHAs about the Activities of Village Health, Sanitation and Nutrition Committee (VHSNC)

Awareness about VHSNC	EAG State				Non-EAG State				N E State		Total	
	Uttar Pradesh n=20		Odisha n=20		Maharashtra n=20		Karnataka n=20		Assam n=20		n=100	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Number of meetings of VHSNC held in the last one year												
One	1	0.0	0	0.0	2	5.0	0	0.0	10	35.0	13	13.0
Two	2	10.0	0	0.0	2	10.0	1	5.0	1	5.0	6	6.0
Three or more	1	5.0	20	100.0	2	10.0	17	85.0	8	40.0	48	48.0
Attendance at the VHSNC meeting												
ASHA	3	15.0	20	100.0	3	15.0	18	90.0	19	95.0	63	63.0
AWW	2	10.0	20	100.0	4	20.0	17	85.0	19	95.0	62	62.0
ANMs	3	15.0	4	20.0	4	20.0	18	90.0	16	80.0	45	45.0
Adolescent Girls	0	0.0	1	5.0	0	0.0	8	40.0	12	60.0	21	21.0
School Teachers	2	10.0	5	25.0	1	5.0	15	75.0	17	85.0	40	40.0
Village Youth Clubs	0	0.0	8	40.0	1	5.0	12	60.0	12	60.0	33	33.0
Sarpanch/PRI Member	3	15.0	3	15.0	4	20.0	16	80.0	16	80.0	42	42.0
Local NGOs	0	0.0	2	10.0	0	0.0	5	25.0	5	25.0	12	12.0
Others-SHG Member, Ward Member, Community Members	0	0.0	17	85.0	0	0.0	0.0	0.0	0	0.0	17	17.0
Activities undertaken by VHSNCs												
Created awareness activity on health programmes	4	20.0	15	75.0	3	15.0	18	90.0	15	75.0	55	55.0
Conducted village survey	1	5.0	3	15.0	2	10.0	15	75.0	13	65.0	34	34.0
Participated in cleaning of drainages and tube–well	4	20.0	14	70.0	3	15.0	18	90.0	13	65.0	52	52.0
Helped in immunisation	1	5.0	7	35.0	5	25.0	16	80.0	11	55.0	40	40.0
Monitoring Sub -centre fund	0	0.0	5	25.0	1	5.0	15	75.0	16	80.0	37	37.0
Carried out IEC activities	0	0.0	2	10.0	2	10.0	14	70.0	17	85.0	35	35.0
Construction of toilets	0	0.0	14	70.0	1	5.0	13	65.0	16	80.0	44	44.0
Activities of VHSNC recorded in a register												
Recording of activities	1	5.0	19	95.0	6	30.0	17	85.0	16	80.0	59	59.0

Table 14 and Fig. 37 give the number of VHSNC meetings held in a year, attendance at VHSNCs and activities undertaken by VHSNCs. On the whole, almost 48 per cent of ASHAs reported holding of at least three or more meetings of VHSNCs in a year. The meeting was attended mainly by ASHAs (63%); AWW (62%); ANMs (45%); Sarpanch/PRI member (42%); school teacher (40%), etc. The major activities of VHSNCs was on creating awareness about health programmes (55%); cleaning of drainage and tube wells (52%); construction of toilets (44%); helping in immunisation (40%); carrying out IEC activities (35%); etc. About 60 per cent of ASHAs reported about recording of activities undertaken by VHSNC.

Fig. 37 Activities of Village Health, Sanitation and Nutrition Committee



Micro planning has been a major thrust under the NRHM for improving the health and nutritional status of women and children. Majority (80%) of ASHAs in Karnataka and Assam, followed by 65 per cent in Odisha and 15 per cent, each, in Uttar Pradesh and Maharashtra were aware about the development of Village Health Plan. The involvement of ASHAs in the development of Village Health Plan ranged from 10 per cent in Uttar Pradesh and Maharashtra to 75 per cent in Assam.

The status of the village Health Plan was known to 80 per cent of ASHAs of Assam; 70 per cent of ASHAs of Karnataka and 65 per cent ASHAs of Maharashtra **(Table 15)**.

Table 15: Awareness of ASHAs about Development of a Village Health Plan

Awareness, Involvement and Status	EAG State				Non-EAG State				N E State		Total	
	Uttar Pradesh n=20		Odisha n=20		Maharashtra n=20		Karnataka n=20		Assam n=20		n=100	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Awareness about the development of Village Health Plan (VHP)												
Aware	3	15.0	13	65.0	3	15.0	16	80.0	16	80.0	51	51.0
Involvment in the development of Village Health Plan (VHP)												
Involved	2	10.0	13	65.0	2	10.0	12	60.0	15	75.0	44	44.0
Status of Village Health Plan (VHP)												
VHP developed	3	15.0	13	65.0	3	15.0	14	70.0	16	80.0	49	49.0

4.5 Awareness, Satisfaction and Problems in Performance Based Incentives to ASHA

Responses of ASHAs

NIHFW, 2011 found that in general all states incentivise the ASHA for JSY and immunisation and participation in review meetings and most incentives received are for these three activities. The present study also found that one of the most popular performance based incentivised activities, among all the respondents is promoting institutional deliveries under the Janani Suraksha Yojana **(Table 16).**

Table 16: Awareness of ASHAs about Performance Based Incentives

Perception on Adequacy of Performance Based Incentives	EAG State				Non-EAG State				N E State		Total	
	Uttar Pradesh n=20		Odisha n=20		Maharashtra n=20		Karnataka n=20		Assam n=20		n=100	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
For attending non residential training	0	0.0	20	100.0	20	100.0	14	70.0	18	90.0	72	72.0
For attending meeting	14	70.0	20	100.0	20	100.0	0	0.0	10	50.0	64	64.0
JSY and Institutional Delivery	19	95.0	20	100.0	20	100.0	15	75.0	20	100.0	94	94.0
Motivation for female sterlisation	14	70.0	20	100.0	16	80.0	15	75.0	19	95.0	84	84.0
Motivation for male sterlisation	0	0.0	11	55.0	16	80.0	11	55.0	19	95.0	57	57.0
Immunisation session	18	90.0	20	100.0	13	65.0	20	100.0	18	90.0	89	89.0
Working for pulse polio immunisation	18	90.0	20	100.0	20	100.0	19	95.0	19	95.0	96	96.0
Organising village health and nutrition day	0	0.0	20	100.0	3	15.0	16	80.0	9	45.0	48	48.0
DOTS	2	10.0	16	80.0	15	75.0	13	65.0	17	85.0	63	63.0
Motivating for household toilet construction	0	0.0	20	100.0	14	70.0	6	30.0	10	50.0	50	50.0
Preparing malaria slide	0	0.0	18	90.0	17	85.0	18	90.0	19	95.0	72	72.0
Motivating for cataract surgery	1	5.0	15	75.0	17	85.0	4	20.0	2	10.0	39	39.0
Detection, referral, confirmation, and complete treatment of leprosy case	0	0.0	3	15.0	11	55.0	9	45.0	2	10.0	25	25.0
Others- transportation charges, VHSNC meeting	2	10.0	4	20.0	3	15.0	3	15.0	0	0.0	12	12.0

There is a need to orient ASHAs on the spectrum of activities for which incentives are provided and update ASHAs on their rights. As also, to go beyond the existing gender milieu, as reflected in more number of tubectomy cases than vasectomy in the communities.

Table 17 : Awareness of Health & ICDS Functionaries and Community Leaders about Performance Based Incentives

Performance Based Incentives	Health Functionaries				ICDS Functionaries						Community Leaders	
	ANM n=20		LHV n=20		AWW n=100		Supervisor n=20		CDPO n=10		n=100	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Services compensated with Performance Based Incentives												
For attending non residential training	9	45.0	15	75.0	21	21.0	10	50.0	5	50.0	29	29.0
For attending meeting	20	100.0	19	95.0	29	29.0	13	65.0	3	30.0	37	37.0
Jananai Suraksha Yojana- Institutional delivery	10	50.0	19	95.0	45	45.0	20	100.0	8	80.0	75	75.0
Motivation for female sterlisation	20	100.0	16	80.0	34	34.0	18	90.0	6	60.0	41	41.0
Motivation for male sterlisation	6	30.0	13	65.0	28	28.0	14	70.0	4	40.0	28	28.0
Immunisation session	20	100.0	19	95.0	45	45.0	18	90.0	7	70.0	40	40.0
Working for pulse polio immunisation	9	45.0	19	95.0	31	31.0	17	85.0	9	90.0	47	47.0
Organising village health and nutrition day	10	50.0	19	95.0	24	24.0	14	70.0	5	50.0	31	31.0
DOTS	6	30.0	12	60.0	19	19.0	9	45.0	5	50.0	19	19.0
Motivating for household toilet construction	6	30.0	8	40.0	16	16.0	8	40.0	2	20.0	10	10.0
Making malaria slide	5	25.0	14	70.0	15	15.0	6	30.0	3	30.0	18	18.0
Motivating for cataract surgery	6	30.0	12	60.0	12	12.0	8	40.0	3	30.0	8	8.0
Detection, referral, confirmation, registration and complete treatment of leprosy case	3	15.0	11	55.0	12	12.0	8	40.0	4	40.0	11	11.0

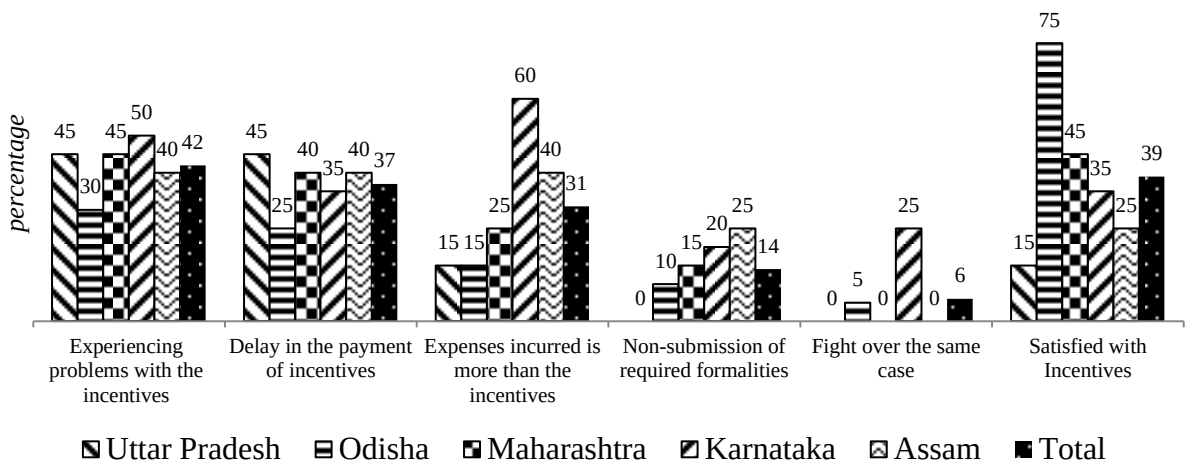
Table 17 presents the awareness of health & ICDS functionaries and community leaders about performance based incentives given to ASHAs. The awareness level of health functionaries was better than that of ICDS functionaries. One of the most popular performance based incentivised activities, among all the respondents is promoting institutional deliveries under the Janani Suraksha Yojana, more so because of the strong advocacy adopted for popularizing it in the country.

Problems in Performance Based Incentives

As Reported by ASHAs

Fig. 38 presents the satisfaction and problems faced by ASHAs in relation to the performance based incentives, as perceived by ASHAs themselves. Satisfaction in relation to performance based incentives was expressed by 75 per cent of ASHAs of Odisha. Majority of the ASHAs in other sample states {Uttar Pradesh (15%); Maharashtra (45%); Karnataka (35%); and Assam (25%)} were not satisfied with performance based incentives. The problems experienced as reported by ASHAs included, 'delay in the payment of incentives'; 'expenses incurred being more than the incentives provided'; 'non-submission of required formalities'; and 'fight over the same case'.

Fig. 38 Problems in Performance Based Incentives as Reported by ASHAs

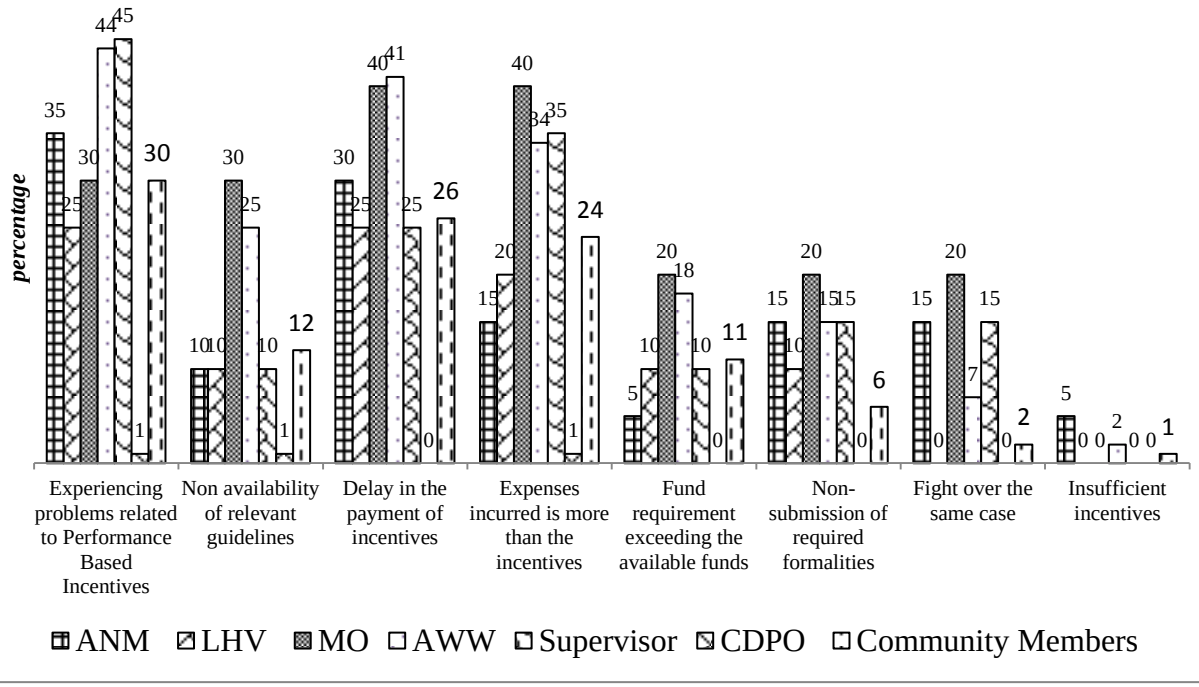


Perception of Health and ICDS Functionaries

Fig. 39 presents the problems faced by ASHAs in relation to the performance based incentives, as perceived by the health & ICDS functionaries and community leaders. Roughly one-third of all respondents expressed that the ASHAs are experiencing problems with the performance based incentives. Most of the problems expressed by ASHAs themselves were corroborated by the health & ICDS functionaries and community leaders. However, in addition, the health & ICDS

functionaries and community leaders articulated other problems such as, 'fund requirement exceeding the available funds'; and 'non-availability of relevant funds'.

Fig. 39 Perception of Health & ICDS Functionaries and Community Leaders about the Problems in Performance Based Incentives



4.6 Support and Supervision provided to ASHA

Responses of ASHAs

The success of the ASHA initiative largely depends on regular and reliable supervision**.** **Table 18** gives the responses of ASHAs on the support and supervision she receives from health and ICDS functionaries. The study revealed that ASHA has been receiving support and supervision from ANMs (91%); AWWs (82%); Supervisor (56%); Medical Officer (41%); LHV (39%); ASHA Facilitator (34%); PRI Members (31%); and NGOs (16%). The activities carried out during the mentoring visits include - helping ANM and AWW in updating health related information (75%); reviewing and verification of work (68%); providing support to manage health related problems encountered (58%); solving problems with regard to payments and address grievances (48%); providing training and refresh or update knowledge and skills (47%); provide refills to the medicine kit (45%); and developing work plan (42%).

Table 18: Responses of ASHAs on Support and Supervision by Health and ICDS Functionaries

Support and Supervision of ASHA	EAG State				Non-EAG State				N E State		Total	
	Uttar Pradesh n=20		Odisha n=20		Maharashtra n=20		Karnataka n=20		Assam n=20		n=100	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Provider of Support and Supervision												
LHV	4	20.0	9	45.0	3	15.0	13	65.0	10	50.0	39	39.0
ANM	16	80.0	19	95.0	17	85.0	20	100.0	19	95.0	91	91.0
AWW	9	45.0	19	95.0	15	75.0	20	100.0	19	95.0	82	82.0
Supervisor	14	70.0	6	30.0	6	30.0	19	95.0	11	55.0	56	56.0
Medical Officer	13	65.0	1	5.0	4	20.0	16	80.0	7	35.0	41	41.0
PRI/ PRI Member	1	5.0	2	10.0	1	5.0	16	80.0	11	55.0	31	31.0
ASHA Facilitator	0	0.0	2	10.0	2	10.0	16	80.0	14	70.0	34	34.0
Others- NGO staff, community leaders, etc.	0	0.0	12	60.0	0	0.0	4	20.0	0	0.0	16	16.0
Activities during Mentoring Visits												
Help AWW/ ANM in updating health related information	5	25.0	16	80.0	17	85.0	17	85.0	20	100.0	75	75.0
Reviewing and verification of work	19	95.0	15	75.0	8	40.0	16	80.0	10	50.0	68	68.0
Provide support to manage the health problems encountered	7	35.0	10	50.0	11	55.0	18	90.0	12	60.0	58	58.0
Provide training and refresh or update knowledge and skills	4	20.0	6	30.0	6	30.0	18	90.0	13	65.0	47	47.0
Developing work plan	2	10.0	4	20.0	4	20.0	19	95.0	13	65.0	42	42.0
Building rapport and motivation	1	5.0	6	30.0	6	30.0	19	95.0	15	75.0	47	47.0
Solve problems with regard to payments and address grievances	12	60.0	2	10.0	6	30.0	15	75.0	13	65.0	48	48.0
Provide refills to the medicine kit	2	10.0	17	85.0	6	30.0	15	75.0	5	25.0	45	45.0
Others-provide information about VHND, immunisation	0	0.0	4	20.0		0.0			0	0.0	4	4.0

Responses of Health and ICDS Functionaries

Table 19 gives the responses of health and ICDS functionaries on the support and supervision they provide to ASHAs. All MOs, 90 per cent LHVs and 50 per cent ANMs reported that they were providing support and supervision to ASHAs. ICDS functionaries {(Supervisors (60%); CDPOs (50%); and AWWs (40%)} also reported providing support and supervision to ASHAs. About 90 per cent of MOs, 60 per cent of LHVs and 35 per cent ANMs reported that they help ASHAs in 'building rapport and motivation' which was acknowledged by only 47 per cent of ASHAs.; 85 per cent of MOs, 60 per cent of LHVs and 35 per cent ANMs reported on 'reviewing and verification of work' which was accepted by 70 per cent of ASHAs; 80 per cent of MOs, 50 per cent of LHVs and 35 per cent ANMs reported, 'providing training and refresh or update knowledge and skills' this was corroborated by 47 per cent of ASHAs; and 80 per cent of MOs, 60 per cent of LHVs and 40 per cent ANMs reported, 'providing support to manage health related problems encountered', which was certified by only 58 per cent of ASHAs.

To sum up, there is over reporting by the health functionaries on the support they provide to ASHAs. As can be seen, 'mentoring', *per se* is limited during these visits, hence, clear strategies and procedure for supervision need to be defined along with a list of supervisory activities. The skills for supervision also need to be taught to all the personnel who will be conducting these activities.

Table 19: Responses of Health and ICDS Functionaries about Support and Supervision provided by them to ASHA

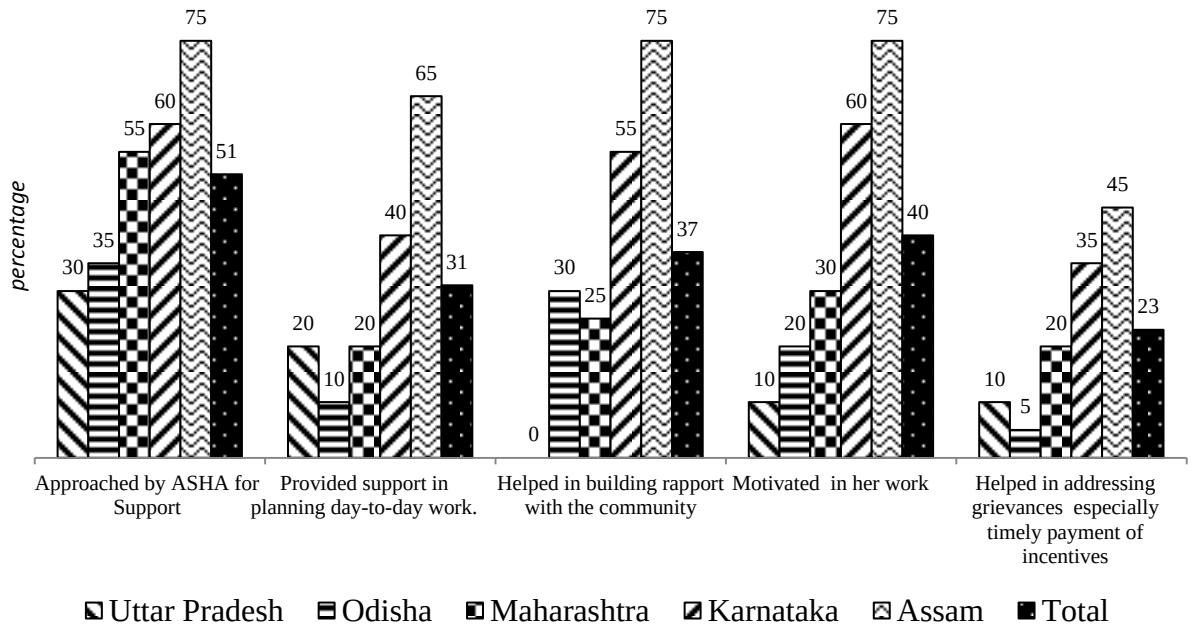
	Health Functionaries						**ICDS Functionaries**					
Support and Supervision to ASHA	**ANM n=20**		**LHV n=20**		**MO n=10**		**AWW n=100**		**Supervisor n=20**		**CDPO n=10**	
Providing support and supervision to ASHA	10	50.0	18	90.0	10	100.0	40	40.0	12	60.0	5	50.0
Activities performed during the Mentoring Visits												
Updating health related information	9	45.0	14	70.0	5	50.0	20	20.0	9	45.0	2	20.0
Reviewing and verification of work	10	50.0	17	85.0	8	80.0	17	17.0	7	35.0	4	40.0
Provide support to manage the health problems encountered	8	40.0	12	60.0	8	80.0	29	29.0	5	25.0	3	30.0

Provide training and refresh skills	7	35.0	10	50.0	8	80.0	8	8.0	4	20.0	2	20.0
Developing work plan	7	35.0	7	35.0	5	50.0	14	14.0	6	30.0	1	10.0
Building rapport and motivation	7	35.0	12	60.0	9	90.0	22	22.0	5	25.0	2	20.0
Disbursing the payments of performance based incentives	6	30.0	5	25.0	5	50.0	11	11.0	3	15.0	1	10.0
Refills the medicine kit	6	30.0	10	50.0	3	30.0	5	5.0	2	10.0	2	20.0
Others-Visit of PNC	1	5.0	2	10.0	1	10.0	0	0.0	0	0.0	1	10.0

Support and Supervision provided by Community Leaders

Fig. 40 presents the responses of community leaders on the support and supervision provided by them to ASHAs. As shown only 51 per cent of the community leader reported that they were approached by ASHA, for any kind of support. The nature of assistance provided by community leaders to ASHAs, included, helping ASHAs plan their daily work (31%), helping in building rapport with the community (37%), motivating her in her work (40%) and helping in addressing grievances, especially, timely payment of incentives (23%).

Fig. 40 Responses of Community Leaders on Support and Supervision of ASHA



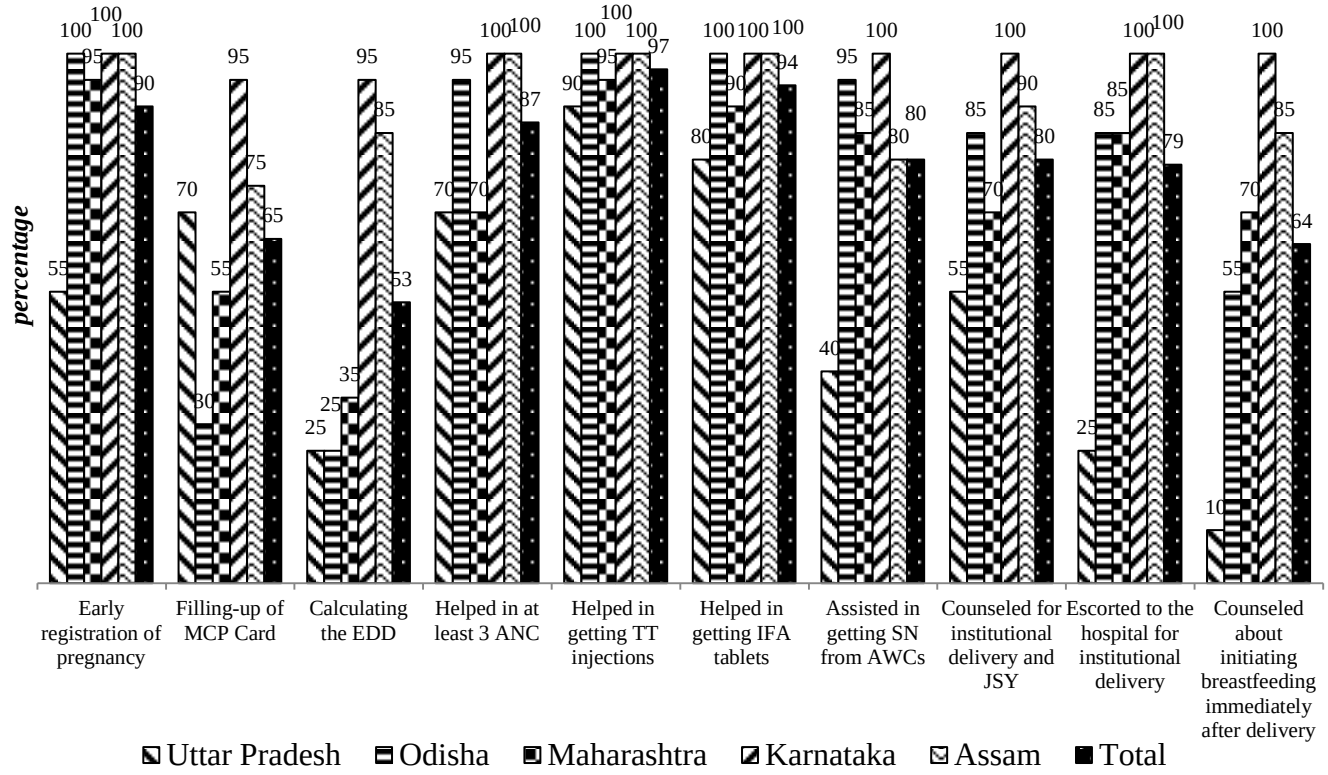
4.7 Role Perception, Job Performance and Contribution of ASHA in the Care and Support of Women during Pregnancy and Delivery and Mothers with Children below Two-Years

4.7.1 Role Perception and Job Performance of ASHA related to Care of Women during Pregnancy and Delivery

Perception of ASHA

The study revealed that ASHAs' perception of their role and the job performed with respect to care during pregnancy is fairly good, however, the knowledge and skills that need to be substantiated for ASHAs of all the sample states include 'calculating the expected date of delivery'; 'availing supplementary nutrition from AWCs'; and 'counselling for initiating breastfeeding immediately after birth'. The ASHAs of Uttar Pradesh have not perceived their roles with respect to 'helping women in early registration of pregnancy'. 'escorting the pregnant woman for delivery'; 'counselling for intuitional delivery' 'help in availing and supplementary nutrition form AWCs' and 'counselling for initiation breastfeeding immediate after delivery'. The major lacunae in the job perception of ASHAs of Odisha was in the areas with regard to 'filling-up of Mother and Child Protection Card'; and in Maharashtra the gap in knowledge and skill was in 'calculating the expected date of delivery' **(Fig. 41).**

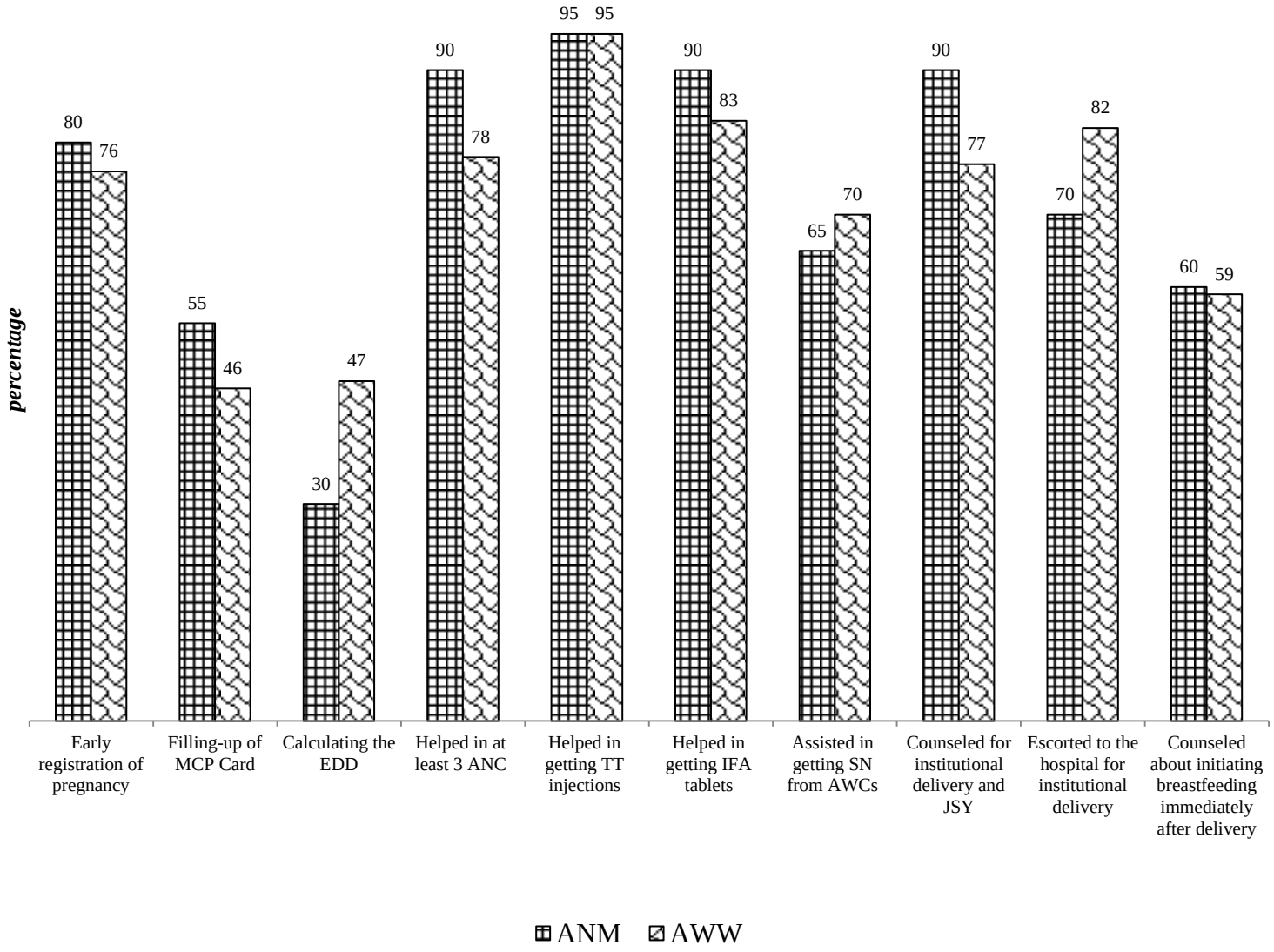
Fig. 41 Role Perception and Job Performance of ASHAs related to Care of Women during Pregnancy and Delivery



Responses of ANMs and AWWs

The responses of ASHAs were verified by ANMs and AWWs on the job performed by ASHAs related to care of pregnant women **(Fig. 42).** The job performed by ASHAs, as agreed upon by both ANMs and AWWs revolved around early registration (80% and 76%); helping pregnant women get TT injections (95% and 95%); help in getting IFA tablets (90% and 83%)) and three ANCs (90% and 78%)%); help in getting SN at AWCs (60% and 75%); counselling for institutional delivery and JSY (90% and 74%); escorting to hospital during delivery (70% and 82%). However, the job performed by ASHAs was low with respect to helping in filling-up of MCP card; calculating EDD; advising about initiating about breastfeeding; etc. The ANMs' feedback about ASHA was more apparent and lucid than the AWWs.

Fig. 42 Perception of ANMs and AWWs on the Role and Job Performed by ASHAs related to Care of Women during Pregnancy and Delivery



Feedback from Beneficiaries

Table 20 presents the feedback of beneficiaries on antenatal care provided by ASHA during pregnancy. The study revealed that around 80 per cent of beneficiaries were visited at home by ASHAs. Out of these, 51 per cent were first order and 36 per cent were second order pregnancy. Around 13 per cent were in the first trimester, 42 per cent in the second trimester and 45 per cent were in the third trimester of pregnancy. Unfortunately only about 70 per cent of pregnant women in their first trimester were registered at the AWCs, defeating the very purpose of appointing an ASHA in a village to improve early registration of pregnancy. The number of ANC check-ups, if assessed against a minimum of three check-ups as advocated under NRHM, the study revealed that ASHAs were playing significant role in timely check-up of pregnant women. It was inspiring to note that 80 per cent of the ANC were carried out in the government institutions, as recommended. The investigations done during pregnancy included checking blood pressure (80%); weight (83%); abdominal examinations (71%); and blood tests and urine test (63%). In Uttar Pradesh, a good proportion of beneficiaries (45%) were not visited by ASHAs at their home, which is a matter of concern. The status of investigations done during pregnancy was poor in both Uttar Pradesh and Maharashtra. Around 69 per cent women had received two doses of tetanus toxoid injections.

Fig. 43 illustrates the responses of beneficiaries on the nature of care and support received from ASHAs during pregnancy. Responses of beneficiaries included that ASHAs-helped in getting TT injections (65%); helped in getting IFA tablets (61%); counselled for institutional delivery and Janani Suraksha Yojna (52%); and helped in getting supplementary nutrition from AWCs (51%); and helped in receiving at least three ANC check-ups (50%). Helping in early registration of pregnancy; filling of Mother and Child Protection Card; informing about expected date of delivery; informing and motivating to attend Village Health and Nutrition Day; accompanying to the hospital for institutional delivery; counselling about initiating breastfeeding immediately after delivery; and counselling about birth spacing methods/sterilisation have not been carried out satisfactorily by ASHAs, as conceptualised in the scheme. Therefore, ASHAs have to be motivated, guided and effectively monitored by their supervisors.

Table 20 : Responses of Beneficiaries on Care and Support provided by ASHA during Pregnancy

States		No. of sample Beneficiary women	ASHAs visited home during pregnancy	Order of pregnancy					Stage of pregnancy (in trimesters)			Registration at the AWC			
				1st	2nd	3rd	4th	5th or more	1st	2nd	3rd	Registered	Timing of registration (in trimesters)		
													1st	2nd	3rd
Uttar Pradesh	No.	20	11	4	3	1	2	1	1	4	6	10	9	1	0
	%	100.0	55	36.4	27.3	9.1	18.2	9.1	9.1	36.4	54.5	90.9	81.8	9.1	0.0
Odisha	No.	20	19	9	10	0	0	0	0	9	10	19	15	4	0
	%	100.0	95	47.4	52.6	0.0	0.0	0.0	0.0	47.4	52.6	100.0	78.9	21.1	0.0
Maharashtra	No.	20	14	5	7	1	1	0	2	7	5	14	9	3	2
	%	100.0	70	35.7	50.0	7.1	7.1	0.0	14.3	50.0	35.7	100.0	64.3	21.4	14.3
Karnataka	No.	20	16	10	2	1	1	2	3	7	6	16	12	2	2
	%	100.0	80	62.5	12.5	6.3	6.3	12.5	18.8	43.8	37.5	100.0	75.0	12.5	12.5
Assam	No.	20	20	13	7	0	0	0	4	7	9	20	10	4	6
	%	100.0	100	65.0	35.0	0.0	0.0	0.0	20.0	35.0	45.0	100.0	50.0	20.0	30.0
Total	No.	100	80	41	29	3	4	3	10	34	36	79	55	14	10
	%	100.0	80	51.3	36.3	3.8	5.0	3.8	12.5	42.5	45.0	98.8	68.8	17.5	12.5

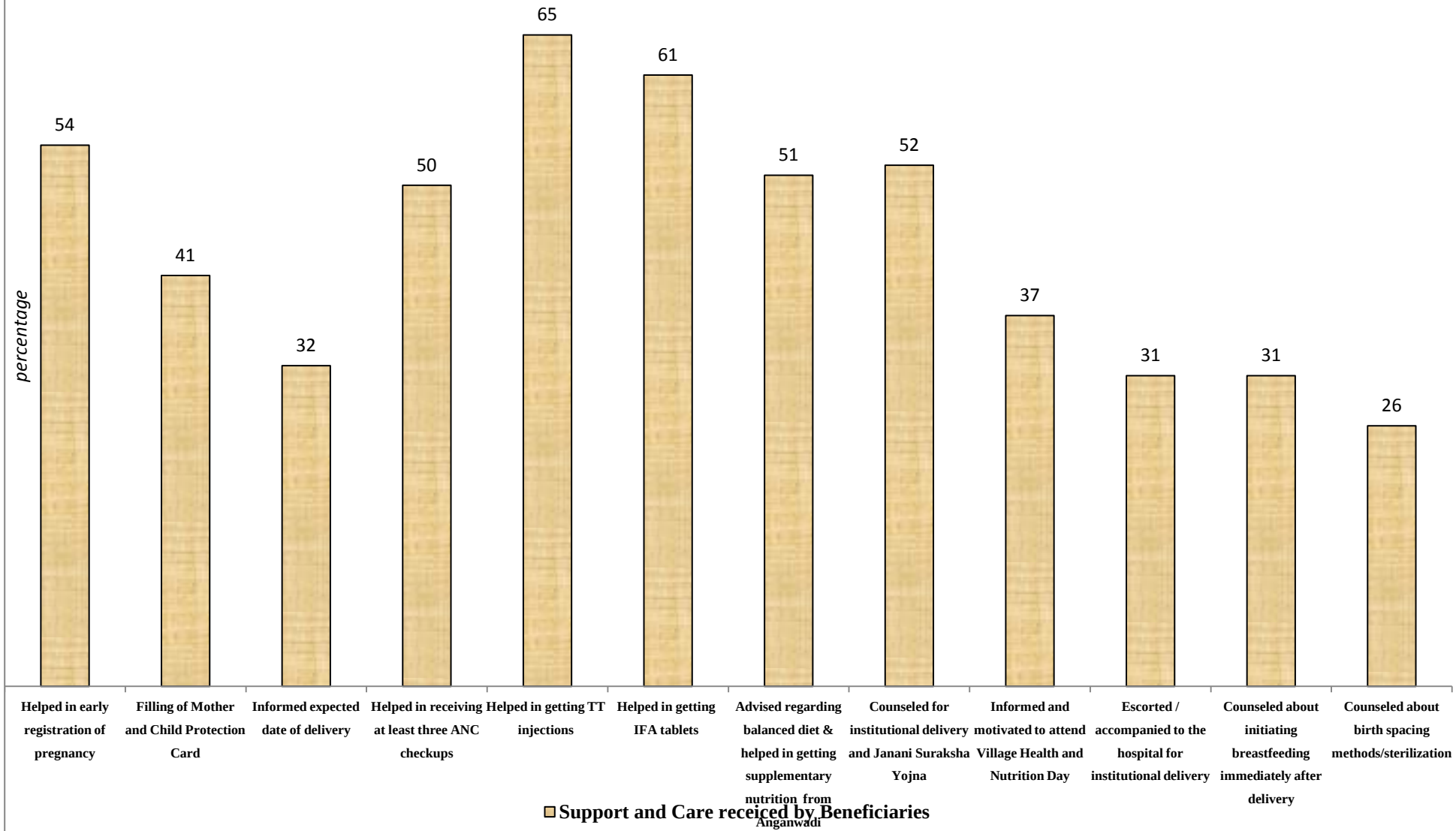
Contd……

Table 20 : Responses of Beneficiaries on Care and Support provided by ASHA during Pregnancy

Contd…

States		Number of check-ups				Place of check-ups					Investigations done during pregnancy				Number of doses of TT given	
		1	2	3	4 and more	AWC	Sub Centre	CHC/ PHC	Dist. Hosp.	Pvt. Hosp.	Blood pressure	Checking weight	Abd. exam.	Urine and blood test	One	Two
Uttar Pradesh	No.	2	8	1	0	7	0	0	0	4	1	1	5	6	4	7
	%	18.2	72.7	9.1	0.0	63.6	0.0	0.0	0.0	36.4	9.1	9.1	45.5	54.5	36.4	63.6
Odisha	No.	4	4	3	8	15	1	2	0	1	18	18	12	6	7	12
	%	21.1	21.1	15.8	42.1	78.9	5.3	10.5	0.0	5.3	94.7	94.7	63.2	31.6	36.8	63.2
Maharashtra	No.	7	3	2	2	4	1	5	2	2	11	13	8	6	7	7
	%	50.0	21.4	14.3	14.3	28.6	7.1	35.7	14.3	14.3	78.6	92.9	57.1	42.9	50.0	50.0
Karnataka	No.	0	1	0	15	0	3	2	2	9	16	16	15	16	3	13
	%	0.0	6.3	0.0	93.8	0.0	18.8	12.5	12.5	56.3	100.0	100.0	93.8	100.0	18.8	81.3
Assam	No.	3	5	6	6	8	7	4	1	0	18	18	17	16	4	16
	%	15.0	25.0	30.0	30.0	40.0	35.0	20.0	5.0	0.0	90.0	90.0	85.0	80.0	20.0	80.0
Total	No.	16	21	12	31	34	12	13	5	16	64	66	57	50	25	55
	%	20.0	26.3	15.0	38.8	42.5	15.0	16.3	6.3	20.0	80.0	82.5	71.3	62.5	31.3	68.8

Fig. 43 Support and Care received by Beneficiaries from ASHA during Pregnancy and Delivery



Feedback of Beneficiaries on the Natal and Postnatal Care

Table 21 presents the feedback of beneficiaries on the natal and postnatal care. Around 58 per cent of deliveries were conducted in CHC/PHC/Govt. hospital. It was heartening to note that deliveries conducted at home were only 7 per cent. Around 85.7 per cent of the home deliveries were conducted by dais and the remaining 14.3 per cent by ANMs/LHVs. The main reasons expressed by the mothers for home deliveries were- that the family was not ready for institutional delivery (71.4%) and perceived problems in getting payment under JSY (28.6%). Cash assistance was received by 63 per cent of beneficiaries. About 59 per cent mothers admitted that ASHAs stayed with them. The most encouraging finding has been that 91 per cent of beneficiaries were weighed at birth.

Table 21: Responses of Beneficiaries on Care and Support provided by ASHA during Delivery

Natal Care Practices	EAG State				Non-EAG State				N E State		Total	
	Uttar Pradesh n=20		Odisha n=20		Maharashtra n=20		Karnataka n=20		Assam n=20		n=100	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Place of delivery												
At home	4	20.0	0	0.0	3	15.0	0	0.0	0	0.0	7	7.0
Nursing home/ private hospital	10	50.0	2	10.0	11	55.0	12	60.0	0	0.0	35	35.0
CHC/PHC/Govt. hospital	6	30.0	18	90.0	6	30.0	8	40.0	20	100.0	58	58.0
Person who conducted the delivery at home												
Dai	3	75.0	0	0.0	3	100.0	0	0.0	0	0.0	6	85.7
ANM/LHV	1	25.0	0	0.0	0	0.0	0	0.0	0	0.0	1	14.3
Reasons for delivery at Home												
Family not ready for institutional delivery	3	75.0	0	0.0	2	66.6	0	0.0	0	0.0	5	71.4
Problems with getting payment under JSY	1	25.0	0	0.0	1	33.3	0	0.0	0	0.0	2	28.6
Cash assistance received under JSY	6	30.0	18	90.0	10	50.0	9	45.0	20	100.0	63	63.0
ASHA stayed in the hospital during delivery	7	35.0	18	90.0	4	20.0	10	50.0	20	100.0	59	59.0
Child weighed at birth	15	75.0	20	100.0	16	80.0	20	100.0	20	100.0	91	91.0

4.7.2 Role Perception and Job Performance of ASHA Related to Care of Children Under-Two

Perception of ASHA

One of the major responsibilities of ASHA is care of newborn care and management of childhood illnesses. **Fig. 44** presents the perception of ASHAs of their role related to care of children under-two. Role perception and job performance of ASHAs with respect to care of children under-two, across all the sample states was moderate. It was disappointing to note that most of ASHAs of Uttar Pradesh have not perceived their role with respect to care of young children. The areas that need upgradation of knowledge and skill was related to 'helping mothers in availing services, namely, supplementary nutrition, weighing of children, etc. at AWCs'; 'using the MCP card for educating the mother'; 'care during illness', 'dispensing medicine'; and 'where to go, in case of emergency in children'. Overall, the orientation of ASHAs in 'care of children under-two' needs substantial upgradation of knowledge and skills.

Responses of ANMs and AWWs

Fig. 45 presents the responses of ANMs and AWWs about the job performed by ASHAs related to care of children under-two. The job performed by ASHAs as agreed upon by both ANMs and AWWs focussed mainly around - advising on exclusive breastfeeding (75% and 63%)) and complementary feeding (75% and 70%)); assisting in getting immunisation including vitamin A (75% and 71%)) and advising mothers about keeping the baby warm (70% and 55%). The job performed was low for care related to-helping in getting the child weighed at the AWCs; weight plotting and counselling mothers on feeding, cord care, bathing, etc; assisting in getting IFA tablets; using the MCP Card for educating mothers; educating on care during illnesses and where to go in case of complications; dispensing medicines from the kit; mobilising community for VHND; etc. Here again, the ANMs' responses on the role of ASHA was more forthcoming than the AWWs.

Fig. 44 Perception of ASHAs about their Role and Job Performed related to Care of Children Under-Twos

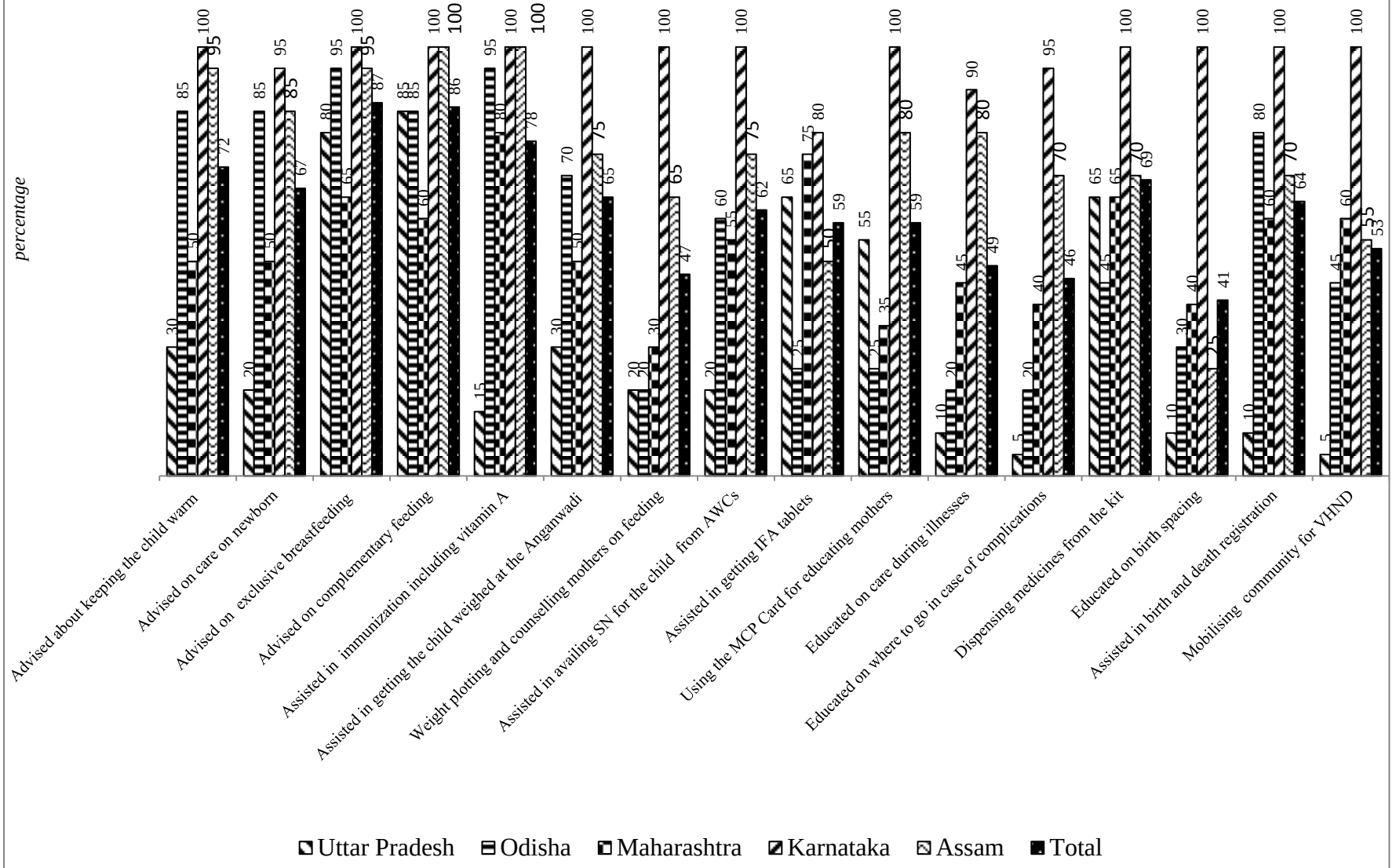


Fig. 45 Perception of ANMs and AWWs on the Job Performed by ASHA related to Care of Children Under-Twos

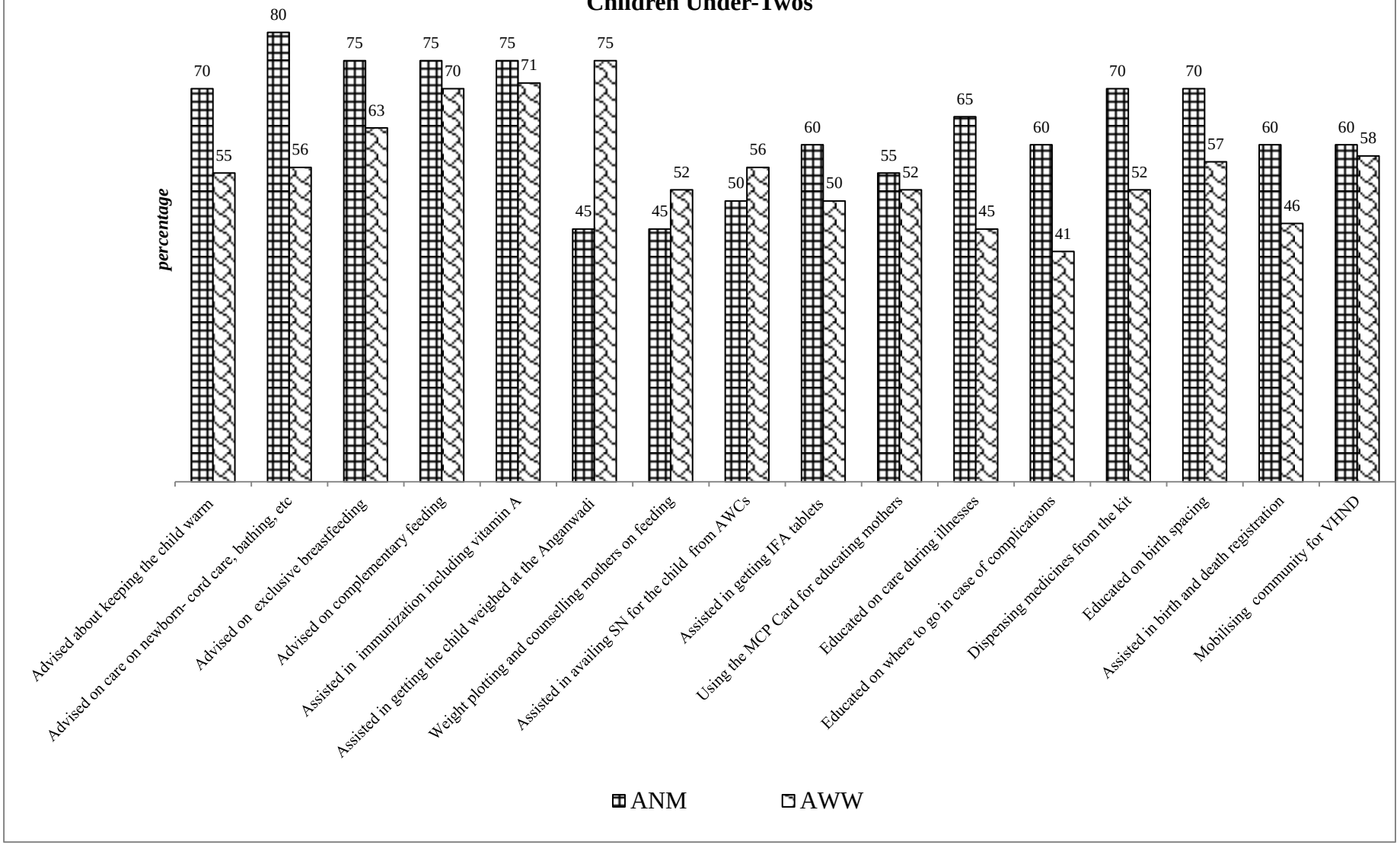
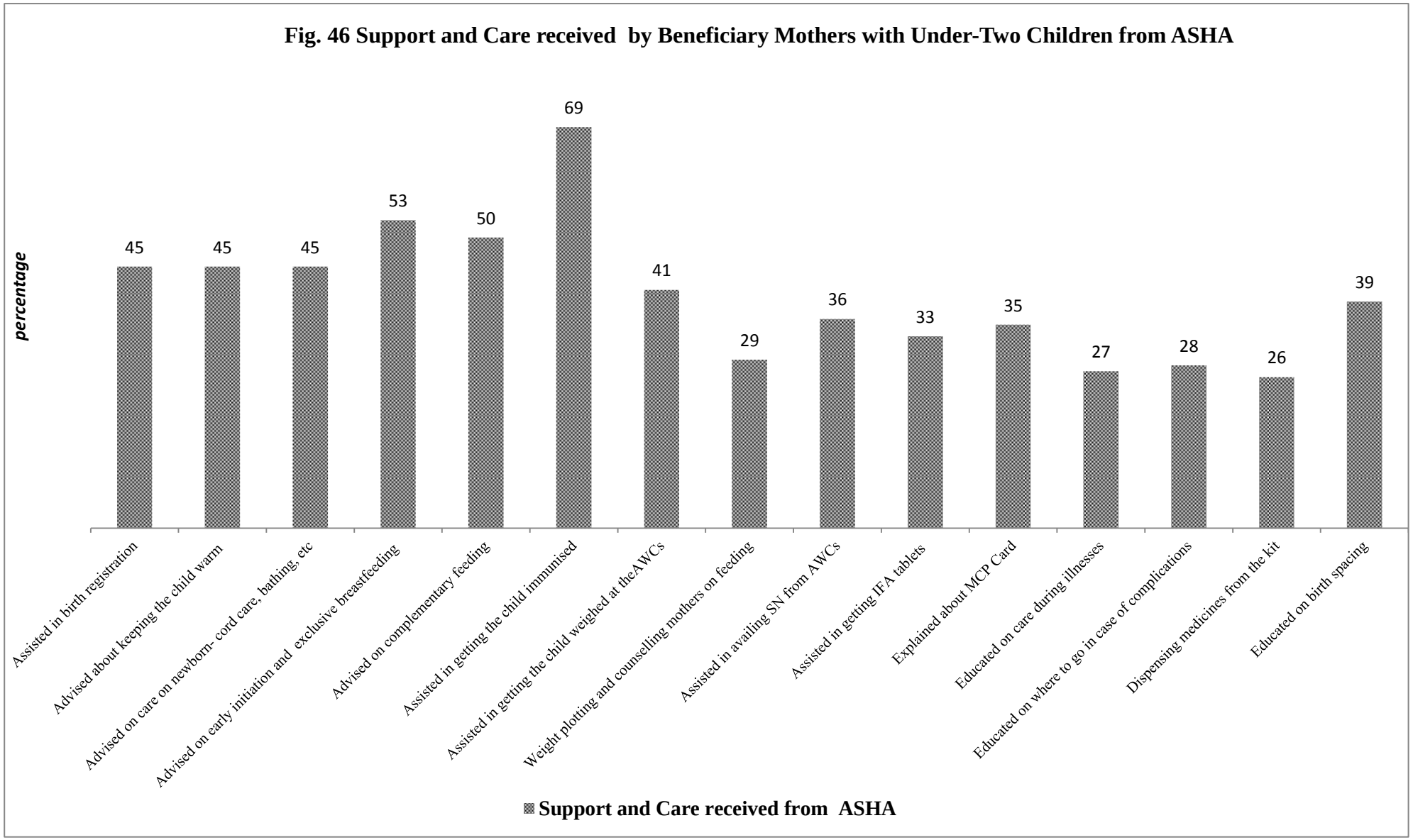


Fig. 46 Support and Care received by Beneficiary Mothers with Under-Two Children from ASHA



Feedback from Beneficiaries

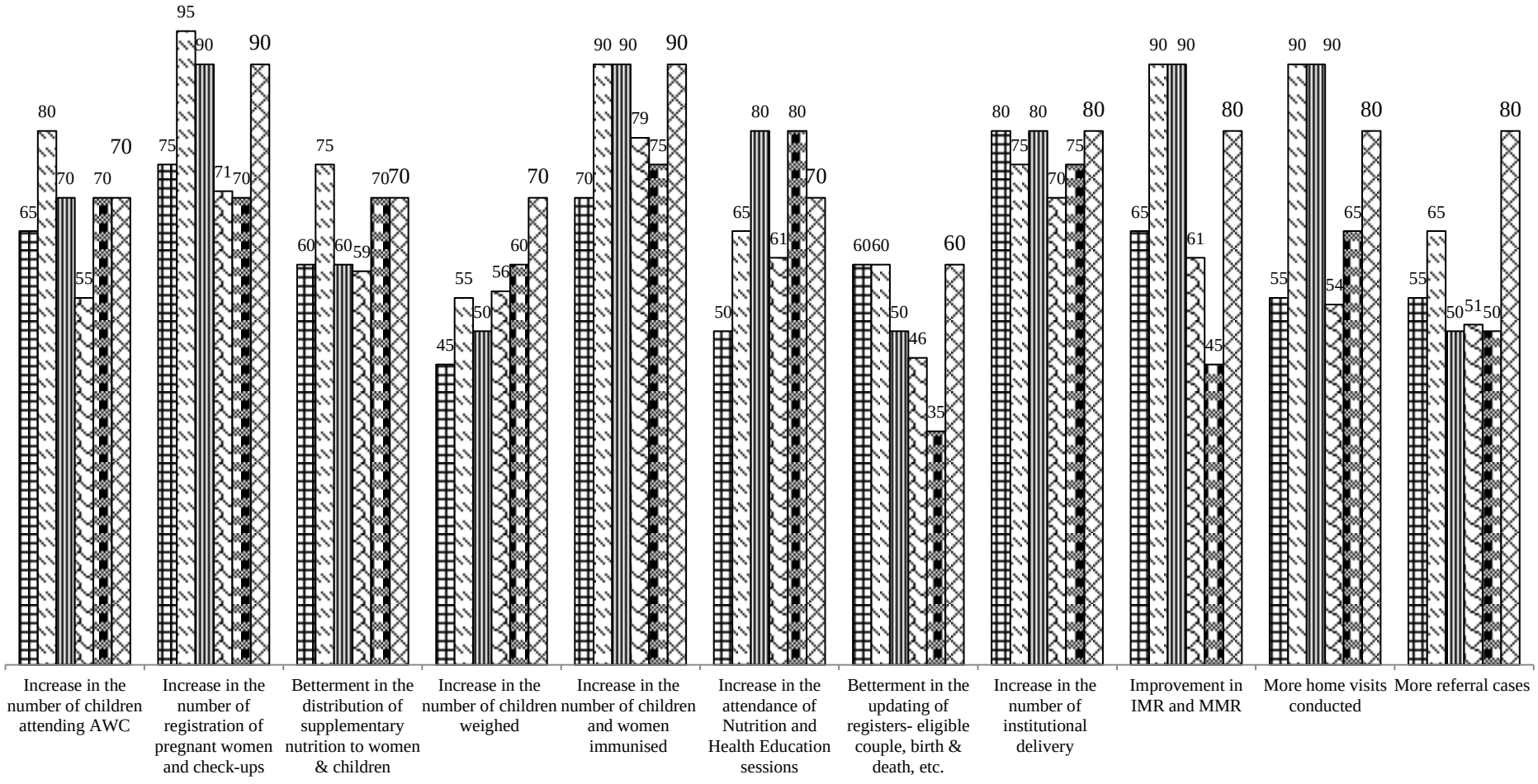
Fig. 46 illustrates the responses of beneficiaries on the nature of care and support provided by ASHAs to mothers with children under-two. The main form of support received by the beneficiaries from ASHAs included assistance in getting the child immunised (69%); advice on early initiation and exclusive breastfeeding (53%); advice on complementary feeding (50%); assistance in birth registration; advice on care of newborn- cord care, bathing, etc (45%); and assistance in getting the child weighed at the AWCs (42%). Helping in weight plotting and counselling mothers on feeding; assisting in availing SN from AWCs; explaining about MCP Card; educating on care during illnesses; educating on where to go in case of complications; dispensing medicines from the kit; educating on birth spacing; etc. has not been internalised satisfactorily by ASHAs.

4.7.3 Contribution of ASHAs in Outreach and Utilisation of ICDS Services

Perception of Health and ICDS Functionaries

Fig. 47 illustrates the perception of Health and ICDS functionaries on the contribution of ASHAs in outreach and utilisation of ICDS services. The contribution of ASHAs as has been perceived by health and ICDS functionaries include, increase in the number of children and women immunised; increase in the number of registration of pregnant women and check-ups; more home visits conducted; improvement in IMR and MMR; increase in the number of institutional delivery; increase in the attendance of Nutrition and Health Education sessions; increase in the number of children attending AWC; betterment in the distribution of supplementary nutrition to women & children; more referral cases; and increase in the number of children weighed

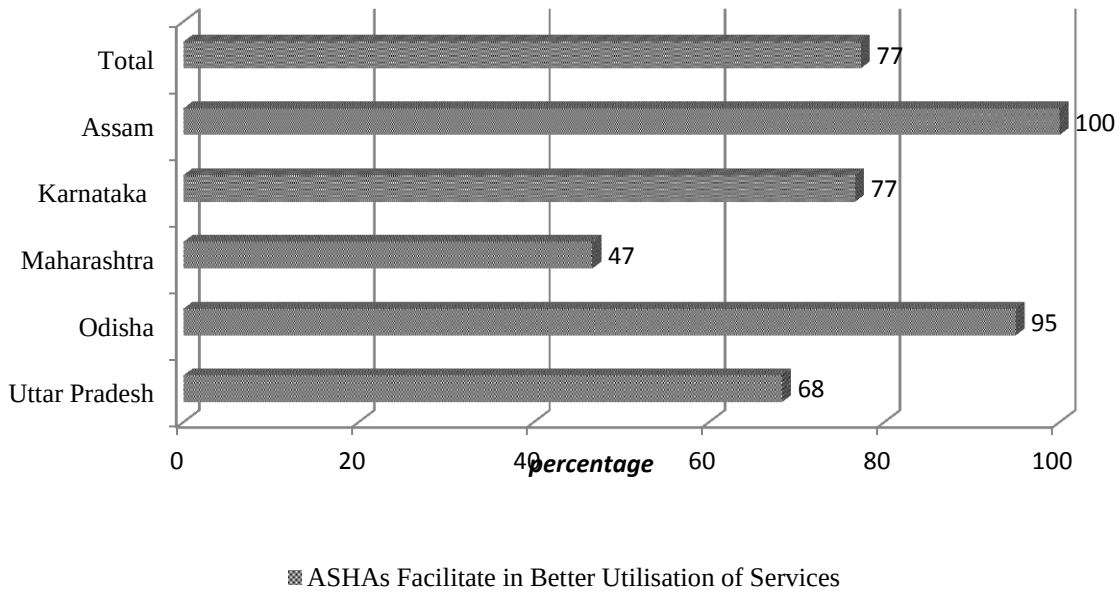
Fig. 47 Perception of Health and ICDS Functionaries on Contribution of ASHA in Outreach and Utilisation of ICDS Services



Perception of Beneficiaries

Fig. 48 illustrates the percentage of beneficiaries who have perceived ASHAs role as facilitator in better outreach and utilisation of ICDS services. In all, 100 per cent of beneficiaries of Assam; 95per cent of beneficiaries of Odisha; 77 per cent of beneficiaries of Karnataka; 68 per cent of beneficiaries of Uttar Pradesh; and 47 per cent of beneficiaries of Maharashtra reported ASHA has facilitated in better utilisation of services.

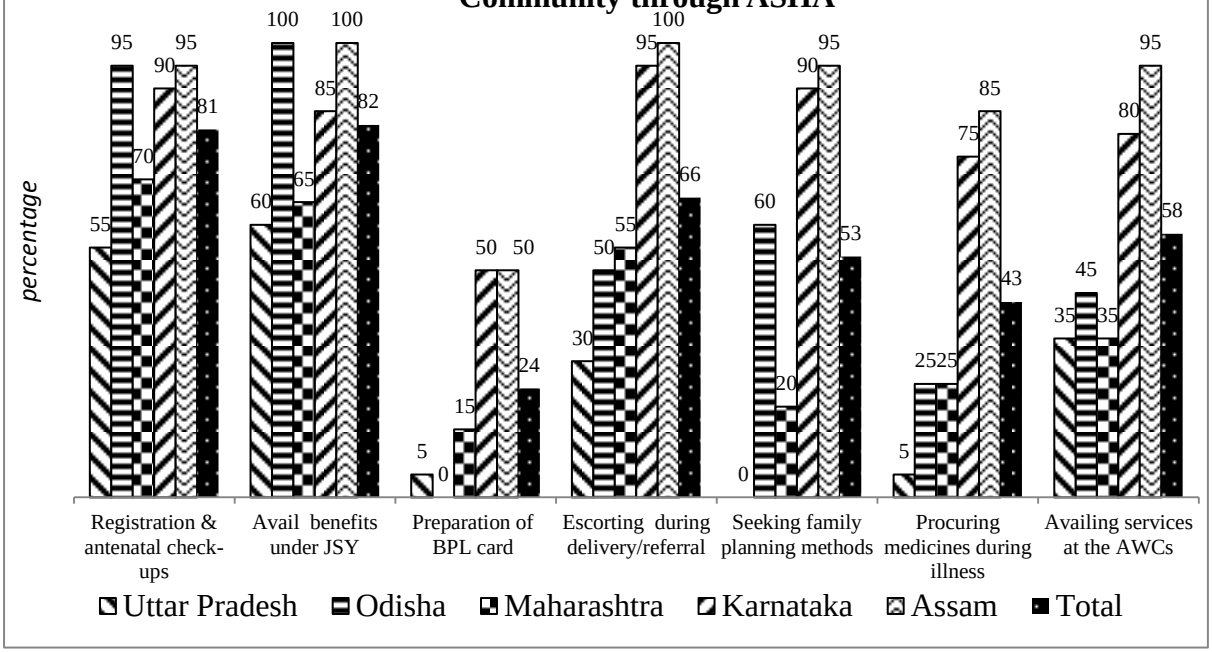
Fig. 48 Perception of Beneficiaries on ASHA's Role as Facilitator in Better Utilisation of Services



Perception of Community Leaders

Fig. 49 illustrates the perception of community leaders on services availed by the community through ASHAs. The services availed by the community, as perceived by the community leaders include, availing benefits under JSY (82%); registration and ANCs (81%); escorting during delivery (66%); availing services at the AWCs (58%); seeking family planning methods; etc.

Fig. 49 Perception of Community Leaders on Services availed by the Community through ASHA



To sum up, with the inception of ASHAs under the NRHM, there has been a definite increase in the number of children and women immunised; increase in the number of registration of pregnant women, AN check-ups; more home visits conducted; improvement in IMR and MMR status; and increase in the number of institutional delivery. However, contribution of ASHAs in ICDS related activities, such as, providing support in weighing, distribution of supplementary nutrition, NHED, referral of children, etc. is minimal.

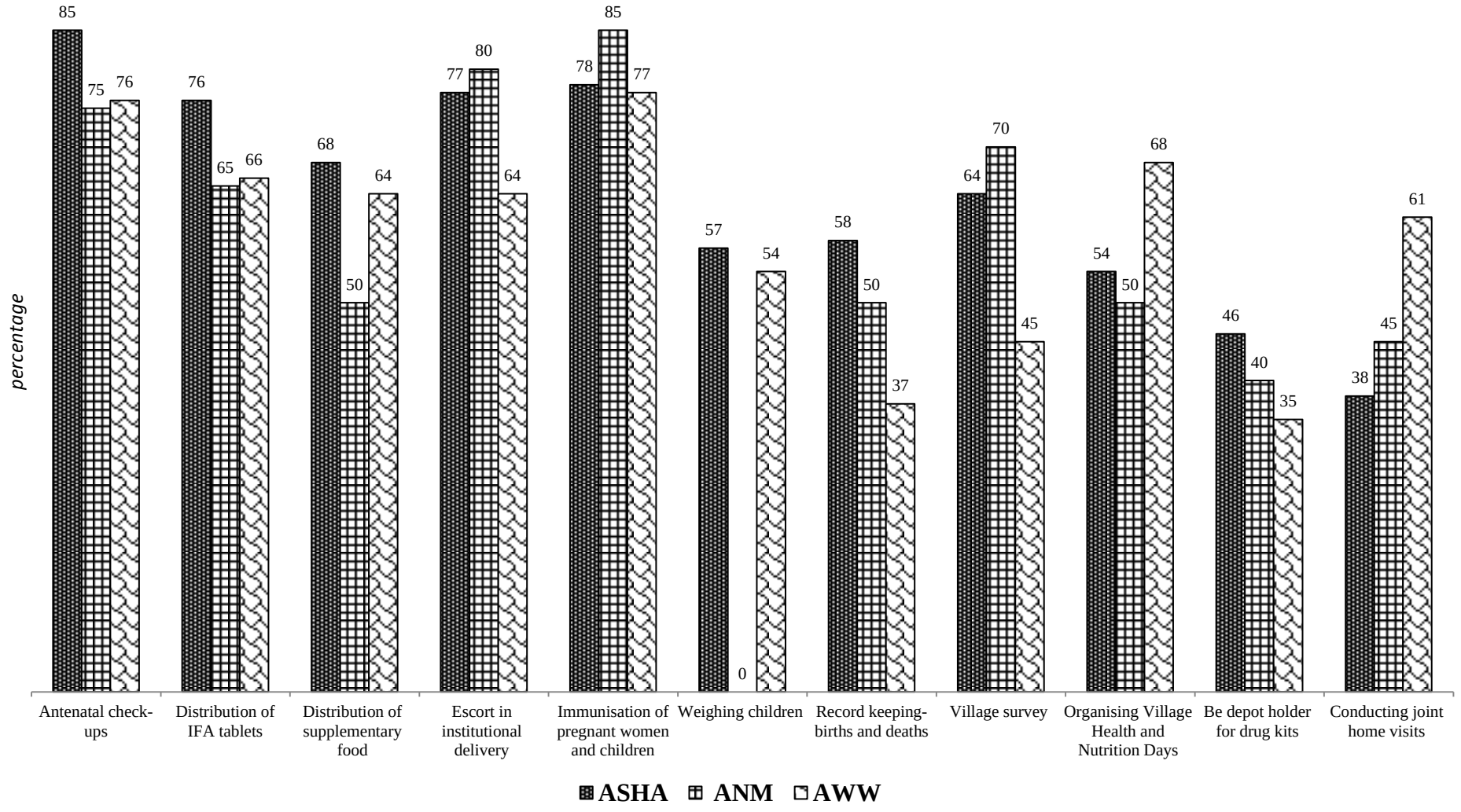
4.8 Perception about the Interface Existing between ASHA and ANM, AWW & Community Leaders

Nature of Support provided by ASHAs in AWC Activities as reported by ASHAs, ANMs and AWWs

Haider, et al., (2008), found that almost all the ANMs agreed that they got help from ASHA/ Sahiya in immunisation. Some also took help in identifying pregnant women and give ANC. Similarly, almost all the ASHA/ Sahiya reported that the ANMs helped them in replenishing the drugs, as also, in getting the immunisations done for their beneficiaries. It was found that in some areas, ANMs took assistance of ASHA/ Sahiya in home visits, health education and health programmes like malaria, pulse polio etc.

Fig. 50 depicts the replies of ASHAs in the present study, on the support she provides in AWCs activities, as also, the responses of ANMs and AWWs on the nature of support provided by ASHAs in AWCs activities. The activities of ASHAs agreed with by ANMs are 'escorting during institutional delivery'; 'assisting in immunisation of children and pregnant women', and 'assisting in village survey'. Similarly, the activities of ASHAs confirmed by AWWs include 'assisting in organising Village Health and Nutrition Days'; and 'conducting joint home visits'. 'Assisting AWWs in weighing of children' has been acknowledged by the AWWs, however, ANM has not corroborated the same, this may be because she is not directly carrying out the weighing activity herself and so may not be aware of it. The point worth noting is that the involvement of ASHAs in non-incentivised activities at AWCs is minimal or lacking which needs to be addressed squarely, if we want to strengthen the care of women and children at the grassroots level.

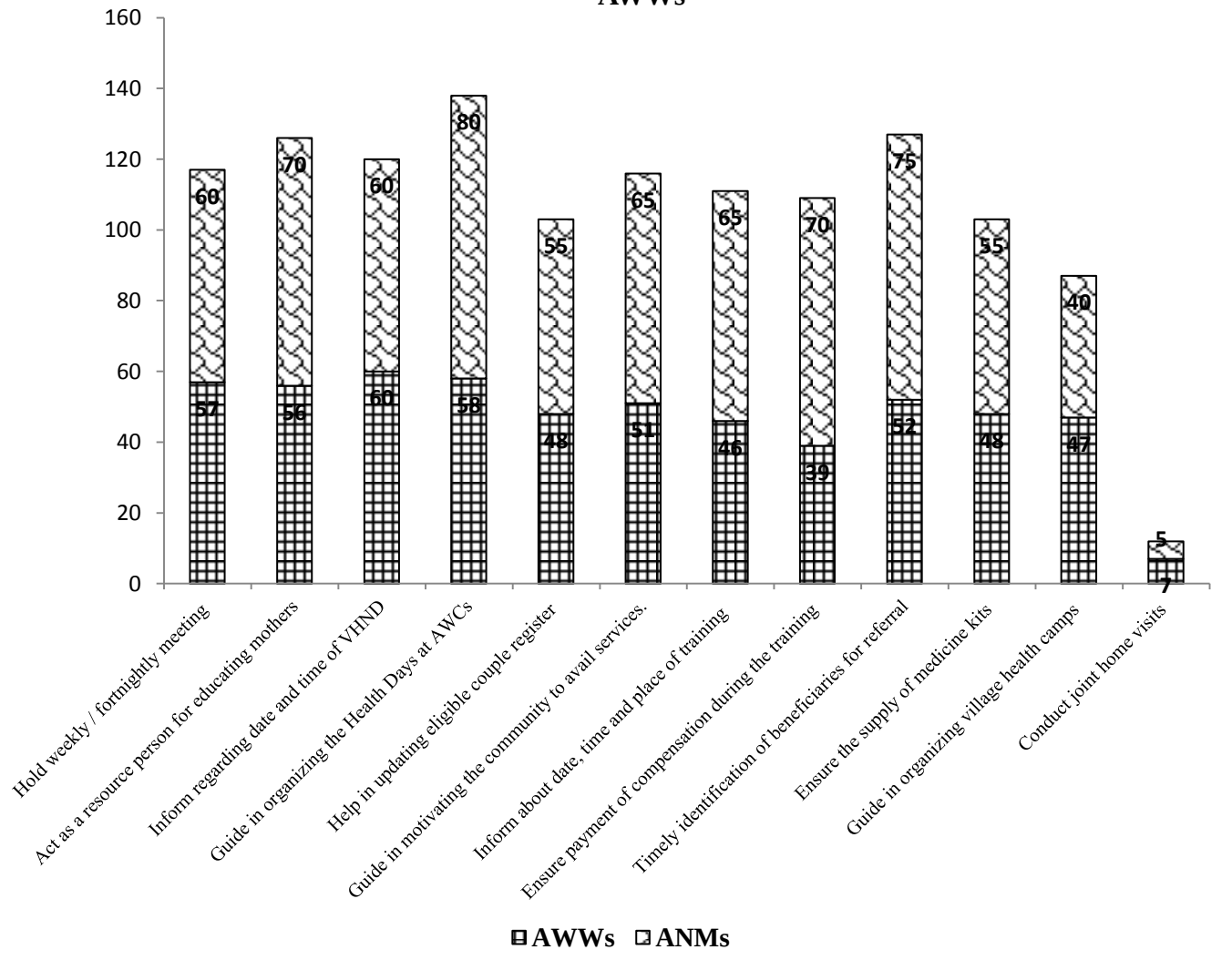
Fig. 50 Nature of Support provided by ASHAs in AWC Activities as Reported by ASHAs themselves, ANMs and AWWs



Nature of Support provided to ASHAs as reported by ANMs and AWWs

Fig. 51 presents the responses of ANMs and AWWs on the nature of support provided by them to ASHAs in performing her job responsibilities. As can be seen, the extent of support provided by ANMs in the work of ASHAs is greater than the support provided by AWWs to ASHAs. The areas where in the ANMs and AWWs are helping out ASHAs evenly, is mainly in the 'organisation of VHND'; 'holding of weekly meetings'; 'updating eligible couple register'; and 'in organizing health camps'. Furthering better interface between the three grassroots level workers would yield better utilisation of services by the community.

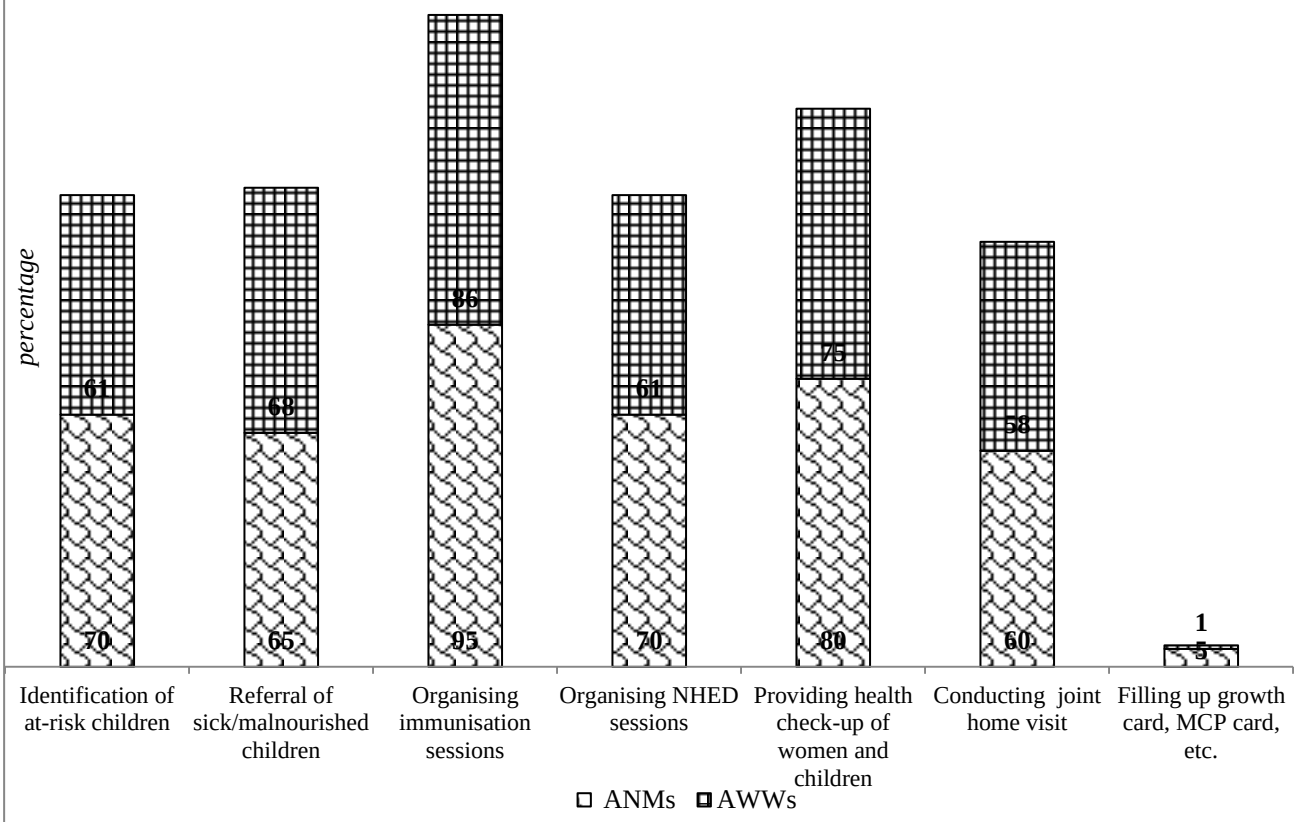
Fig. 51 Nature of Support provided to ASHAs as reported by ANMs and AWWs



Nature of Assistance provided by ANMs at AWCs

As regard the nature of assistance provided in the activities of AWCs, as reported by ANMs themselves, along with the feedback from AWWs on the same, the study revealed that it has been in the form of 'referral of malnourished/sick children'; 'conducting joint home visits'; 'providing health check-up of women and children'; and in 'organising immunisation sessions'. There is coordination existing between the two worker at the grassroots level, i.e. mainly in the health related activity but it is lacking in nutrition related services like supplementary nutrition, organising NHED sessions, growth monitoring, etc. **(Fig. 52).**

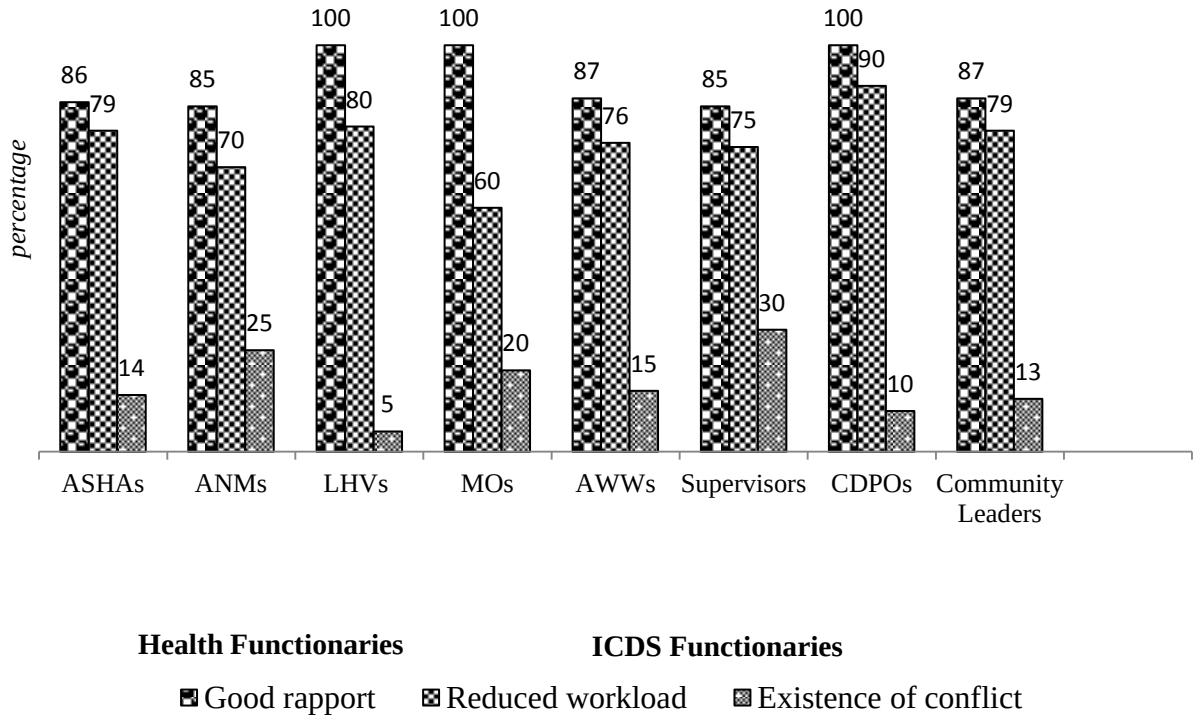
Fig. 52 Nature of Assistance provided at AWCs as reported by ANMs and AWWs



Perception of Health and ICDS Functionaries and Community Leaders on Existing Interface with ASHA

The present study attempted to explore the existing interface of ASHAs with the health and ICDS functionaries and community leaders. By and large the ASHAs seem to be sharing a good rapport with the health and ICDS functionaries and community leaders. The study revealed that there is minimal conflict existing at the grassroots levels. ASHAs have been successful in reducing the workload on ANMs and AWWs, to some extent. ASHAs if trained well and used optimally could result in better reach and utilisation of services, impacting women and children. **(Fig. 53)**

Fig. 53 Perception of Health and ICDS Functionaries and Community Leaders on Existing Interface with ASHA



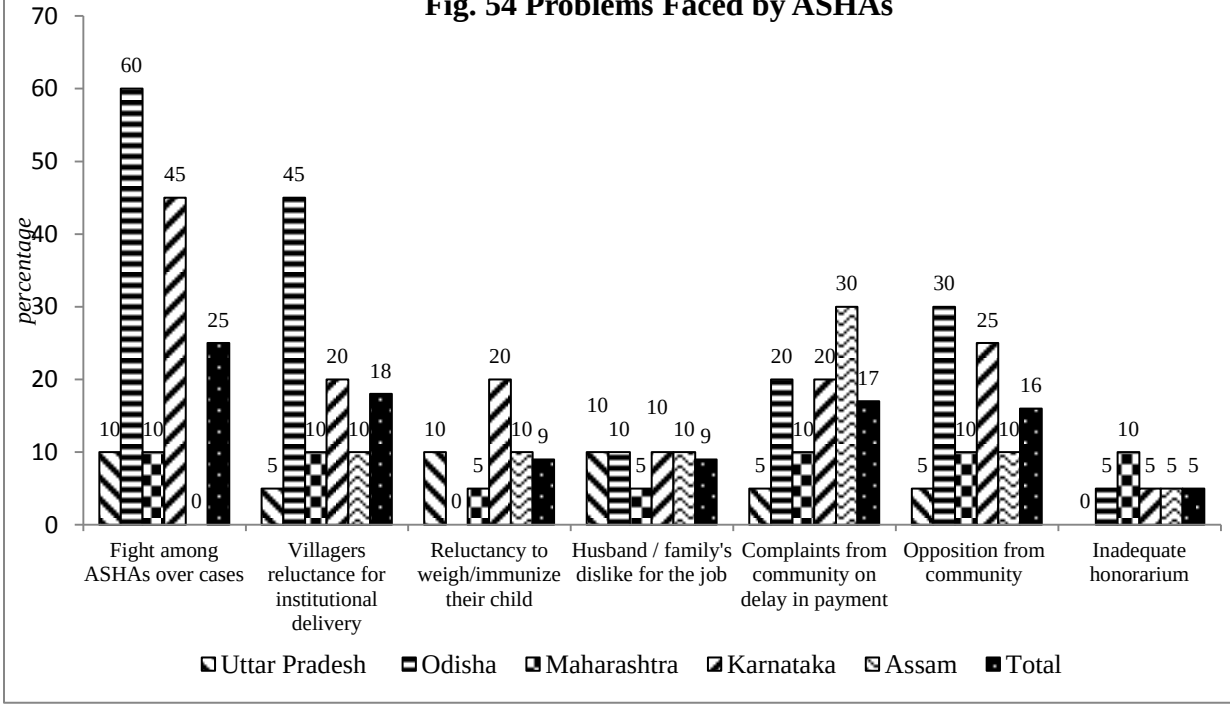
To sum up, we can say, that interface among the three grassroots workers, namely the ASHA, ANM and AWW, definitely exists, but it is mainly for furthering incentivised health activities. A greater interface may have to be built through joint training of workers, on the New WHO Child Growth charts; IMNCI, on the usage of MCP Card, JSY, IGMSY and Sabla scheme,

for better understanding of the schemes and programmes and harmony among the workers in service delivery.

4.9 Problem Faced by ASHAs

Fig. 54 presents the problem faced by ASHAs in the sample states. The main source of income of ASHAs is through the incentive they receive for the work they do and the problem ASHAs faced, as perceived by them, are also mainly 'fight among ASHAs over cases'. This has been expressed by 60 per cent of ASHAs of Odisha and 45 per cent of ASHAs of Karnataka. The problem has not been reported by any of the ASHAs of Assam and very few by ASHAs of Uttar Pradesh (10%) and Maharashtra (10%). There is still 'reluctance of villagers for institutional delivery'; 'reluctance to get their child weighed/immunised' and 'opposition from community experienced by ASHAs in their work' of Odisha and Karnataka. This is a pointer to the need for more advocacy in the state with respect to introducing ASHA as one of the health provider in the village, without which it would be difficult for the programme to yield the desired results.

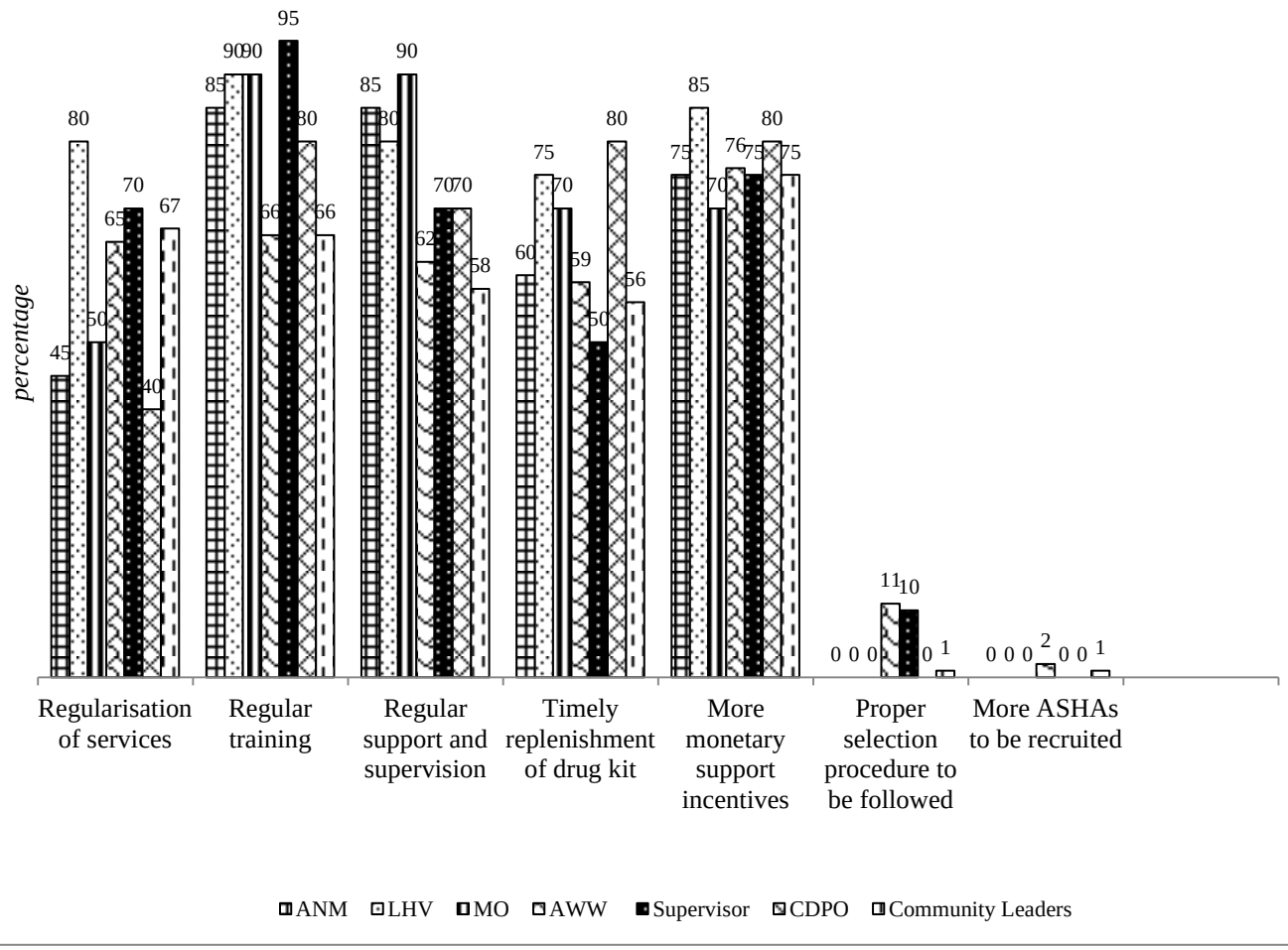
Fig. 54 Problems Faced by ASHAs



4.10 Suggestions for Improving Service Delivery by ASHAs

Fig. 55 depicts the various suggestions offered by health and ICDS functionaries and community leader for improving services delivery by ASHAs. The most lucid and clear suggestion has been on the need for 'regular training' and 'support & supervision' for effective services delivery by ASHAs. The next suggestion to follow was regarding job security, *per se*, in term of either 'regularisation of service; or 'more monetary support', for keeping the motivation alive to do work. 'Timely replenishment of medicine kit' provided to ASHAs is another major setback in the effective delivery of services, which needs to be addressed. Some 'not so loud' suggestions are the 'need for more ASHAs' and 'adhering to proper selection procedure in the recruitment of ASHAs'.

Fig. 55 Suggestions for Improving the Service Delivery by ASHA



5

CONCLUSIONS

CONCLUSIONS

The major findings and conclusions of the study are presented in the following paragraphs.

5.1 Profile of the Respondents

- In line with the criteria for selection of ASHAs, the study revealed that roughly half of the ASHAs were in the age group 30 to 39 year age- group (54%). It may be mentioned that 20 per cent of ASHAs in Maharashtra are in the age group of 20-24 years, much below the prefered age mentioned in the selection criteria.
- Majority of ASHAs (91%) were married, very few ASHAs among the respondent were unmarried (1%), divorced (4%), or widow (4%).
- Majority of ASHAs belonged to the backward classes (73%) {Scheduled Caste (18%), Scheduled Tribe (18%) and OBCs (37%)}. Furthermore, it is inspiring to note that a good majority (70%) of the beneficiaries, also belonged to Backward Classes, for social inclusion of such groups as envisaged in the scheme.
- Majority were either middle or high school passed, keeping in line, with the selection criteria of ASHAs.
- Almost all of ASHAs were resident of the village they were serving, as conceptualised in the scheme. But, roughly half (48%) of ASHAs were catering to a population of over 1000 indicating a burden on them, which needs to be rationalised.
- Roughly two-fifth of ASHAs reported drawing a monthly income less than Rs. 2000/-; which is too meager, and needs to be looked at again.
- The study revealed that only 66 per cent of ASHAs had undergone the requisite training of 23 days or more, which means about one-third of ASHAs lack basic training to carry out their job responsibilities. This is a serious finding and needs to be dealt with utmost urgency.

5.2 Awareness about the Selection Process of ASHA

- Almost all the health functionaries and ICDS functionaries were aware of the ASHAs working in their respective areas. The awareness of health and ICDS functionaries about the people involved in the selection of ASHAs, as well as, the selection procedure *'per*

se' lacked clarity in general, which need to be created for improving their involvement with ASHAs in their respective areas.

- The responses of ANMs and AWWs, who work closely with ASHAs, shows that they were not satisfied with the ASHAs selected.

5.3 Knowledge and Awareness about Maternal and Child Health Issues

- Majority of ASHAs (82%) could tell the correct procedure of conducting Nishchay Home Pregnancy Test. Calculating the expected date of delivery (EDD) was known to only 59 per cent of ASHAs. Considering that ASHA's role mainly revolves around detection of pregnancy and facilitating in the early registration of pregnancy, ASHAs skill in this area need to be upgraded for effective service delivery.
- On the whole the knowledge of ASHAs about care during pregnancy, in EAG states and N E state was better than the non EAG states, which may be attributed to the increased attention the EAG states have received under NRHM.
- It is worthwhile to note that there is a mismatch between the awareness level of beneficiaries and that of ASHAs, about prevention of anaemia during pregnancy, which can be attributed to non-transference of knowledge and awareness of ASHAs to the intended beneficiaries, pointing towards the need for revamping training and supportive supervision.
- The knowledge of ASHAs about the eligibility criteria for getting assistance under the Janani Suraksha Yojana was grossly inadequate, which needs to be substantiated.
- JSY scheme, in spite, of being in place for over five years, still roughly 40 per cent of ASHAs are experiencing problems related to JSY such as, non-availability of transport; long distance to travel to reach the place of delivery; insufficient remuneration against money spent; and delay in payment of incentives. There is a need to streamline modalities for transport and payment of cash incentives to ASHAs.
- The knowledge level of ASHAs regarding care of newborn is superficial. Knowledge about bathing a newborn, care of low birth weight babies, cord care, how to keep the warm baby, etc., essential for reducing the neonatal mortality is inadequate to yield desired results.

- The knowledge level of ASHAs on breastfeeding across the entire sample was incomplete. The aspect of initiation, frequency of breastfeeding and exclusive breastfeeding would need to be reiterated to strengthen the knowledge of ASHAs on breastfeeding. The knowledge level of beneficiaries with regard to frequency of breastfeeding and exclusive breastfeeding was also found to be inadequate.
- There is a considerable gap in the knowledge about complementary feeding advice ASHAs gives to mothers as regards 'not diluting the food'; 'frequency of complementary food'; 'making the food energy dense by adding fats and oil; etc. across all the sample states, except Karnataka, this finding, however, needs to be taken with caution..
- The level of knowledge of ASHAs about the immunisation schedule across all the sample states is considerably good, with the exception for doses of Hepatitis B and vitamin A supplementation, needing updating. But the knowledge of beneficiaries about the immunisation schedule was low, again pointing to the fact the knowledge of ASHA is not getting translated into changing behavior at the community level.
- Regarding care at home during cough and cold, the knowledge level of ASHAs across all the states, except Karnataka, needs upgradation on aspects, such as, 'cleaning child's nose if blocked'; 'giving increased amount of fluid'; 'increasing frequency of feeds'; 'making food energy dense by adding oil/ghee'; and 'to give an extra meal during the recovery phase'.
- There is a dire need to upgrade the knowledge of ASHAs relating to danger signs in diarrhoea, method of preparation of ORS and frequency and quantity of ORS to be given to a child, and feeding after the diarrhea, during convalescence.
- The knowledge level of ASHAs about prevention of malnutrition, across all sample states, need improvement, especially with regard to availing supplementary nutrition services from AWCs; continuing feeding during illness; complete immunisation; vitamin A supplementation; and preventing malaria.

5.4 Awareness and Contribution of ASHAs in ICDS Related Activities

- The percentage of ASHAs who could list the services provided under ICDS such as, the health check-up; immunisation, supplementary nutrition and pre-school education was 86 per cent, 89 per cent, 92 per cent and 85 per cent respectively. However, the awareness

level, was low for nutrition and health education (71%) and referral services (41%). ASHAs would have to be properly oriented to all the services being offered under the ICDS if she has to serve as an effective link between AWW and the community.

- The study revealed that almost all the ASHAs, ANMs and AWWs were aware about the MCP Card and also reported using it. The MCP Card has been mainly used by ASHAs and ANMs for explaining about ANC services and explaining about preparation for delivery; and by AWWs for explaining about childhood illnesses; and advising about nutrition, immunisation, etc. ASHAs require a clear and tangible aid to remember key information and clearly communicate the same during outreach work and MCP Card is one such aid, which should be used to exploited to the maximum.
- Majority (98%) of ASHAs reported conducting home visits. Around 96 per cent of them admitted conducting home visits alone. There were some discrepancies in responses of ASHAs and AWWs on joint home visits. Also the issues discussed during the home visits are customary and limited. This finding calls for a need for clear-cut guidelines on home visits by the health and ICDS functionaries, as also role clarification on the same.
- The percentage of beneficiaries who were visited at home, soon after delivery, during the postnatal period, for all sample states, were 1st day (43%); 3rdday (56%); 7thday (55%); 21st day (33%); and 42nd day (19%). On comparing the responses of beneficiaries with those reported by ASHAs on the postnatal visits at home, the study presents gross over reporting by ASHAs. There is a need for developing clear and concise graded supportive supervision for monitoring home visits by the grassroots level workers.
- Medicine kit was available with 100 per cent of ASHAs of the state of Odisha; 95 per cent of ASHAs of Karnataka; 80 per cent of ASHAs of Maharashtra; 75 per cent of ASHAs of Assam and only 5 per cent ASHAs of Uttar Pradesh. The awareness about the contents of medicine kit was fair among the ASHAs of all sample states. The availability of medicines in the kit was poor or lacking in Maharashtra (25%); Karnataka (25%); and Assam (30%). The status of replenishment of the medicine was also very poor in all the sample states, except Odisha, requiring immediate attention and warrants issuing of suitable instructions in this regard by State Governments on replenishment of medicines.

- Only 73 per cent of AWWs, 45 per cent of Supervisors and 40 per cent of CDPOs shared the opinion that ASHAs possessed adequate knowledge and skills to use the medicines provided in the medicine kit.
- It is disheartening to note that only 55 per cent of beneficiaries reported availability of medicine kit with the ASHAs. Only 34 per cent of beneficiaries had taken medicines from ASHA. There is a dire need to look into this aspect of availability of medicine kit and availability of the medicines in the kit, as also, adequate training of ASHAs on the use of medicines in the medicine kit, if we want ASHAs to be accepted by the community.
- As regards the awareness of role of ASHAs, ANMs and AWWs in the organisation of Village Health and Nutrition Days (VHNDs). The role perceived by ASHAs was lucid, as compared to ANMs and AWWs. However, VHND was restricted mainly to incentivised activities like, ANCs and immunisation activities with no nutrition education. There is a need to hold VHNDs regularly with full intended content and regularity.
- All the ASHAs of Odisha; Karnataka; Assam and majority of ASHAs in Maharashtra (70%) were aware of the formation of VHSNC in their respective areas. However, in Uttar Pradesh, only 20 per cent of ASHAs reported the existence of VHSNC in their village, and only 5 per cent of ASHAs were aware of the designated convenor and chairperson of the VHSNC. Also, less than half of all ASHAs (47%) only had undergone an orientation training on VHSNC *per se*. This warrants attention of programme managers for issuing relevant instructions.
- Micro planning has been a major thrust under the NRHM for improving the health and nutritional status of women and children. Majority (80%) of ASHAs in Karnataka and Assam, followed by 65 per cent in Odisha and 15 per cent, each, in Uttar Pradesh and Maharashtra were aware about the development of Village Health Plan. The involvement of ASHAs in the development of Village Health Plan ranged from 10 per cent in Uttar Pradesh and Maharashtra to 75 per cent in Assam.
- One of the most popular performance based incentivised activities, among all the respondents is promoting institutional deliveries under the Janani Suraksha Yojana. There is a need to orient ASHAs on the spectrum of activities for which incentives are provided and update ASHAs on their rights.

- The problems experienced in relation to performance based incentives as reported by ASHAs included, 'delay in the payment of incentives'; 'expenses incurred being more than the incentives provided'; 'non-submission of required formalities'; and 'fight over the same case'.

5.5 Support and Supervision provided to ASHA

- The success of the ASHA initiative largely depends on regular and reliable supervision**.** The study revealed that there is over reporting by the health functionaries on the support they provide to ASHAs. Mentoring, *per se* is limited in scope during these visits, hence, clear strategies and procedure for supervision need to be defined along with a list of supervisory activities. The skills for supervision also need to be taught to all the personnel who will be conducting these activities. There is a need to showcase/document successful models for combined supportive supervision of AWWs, ANMs and ASHAs as has been tried out in Valsad in Gujarat (UNICEF, 2011)[29].

5.6 Role Perception, Job Performance and Contribution of ASHA in Care and Support of Women during Pregnancy and Delivery and Mothers with Children below Two-Years

- Upon verification by beneficiaries, ANMs and AWWs of job performed by ASHAs, during pregnancy & delivery and in the care of mothers with children under-two, the study revealed that there was gross over reporting by ASHAs, as well as ANMs and AWWs, on the job performed by ASHAs during pregnancy & delivery and in the care of children under-two, as against the care and support received by beneficiaries, as reported by them.
- The activities over reported by ASHAs, ANMs and AWWs with respect to pregnancy and delivery include - early registration of pregnancy; helping mothers in- receiving at least three ANC checkups; getting TT injections; getting IFA tablets; counseling for institutional delivery and JSY; escorting to the hospital for institutional delivery; counseling about initiating breastfeeding immediately after delivery; and filling of Mother and Child Protection Card. It may be mentioned that most of the above activities are incentivised and

seemingly has been performed with greater enthusiasm compared to other tasks. The point to be noted is that, even for these activities there has been over reporting by ASHAs.

- Similarly, there has been over reporting by both ASHAs and ANMs with respect to activities related to care of mothers with children under-two. It may be mentioned that the responses of AWWs are slightly more in tune with those of the beneficiaries for care of mothers with children under-two. The activities over reported by both ASHAs and ANMs with respect to care of mothers with children under-twos include, advising about - keeping the child warm; care of newborn- cord care, bathing, etc; exclusive breastfeeding; complementary feeding; providing assistance in - getting the child weighed at the AWCs; getting IFA tablets; educated on care during illnesses; and assisting in birth registration. It is stated that the beneficiaries' reporting of the job performed by ASHAs related to care of mothers with children under-twos, was far less, than for activities with respect to pregnancy and delivery, most of which are incentivised.
- With the inception of ASHAs under the NRHM, there has been a definite increase in the number of children and women immunised; increase in the number of registration of pregnant women, AN check-ups; more home visits conducted; improvement in IMR and MMR status; and increase in the number of institutional delivery. However, contribution of ASHAs in ICDS related activities, such as, providing support in weighing, distribution of supplementary nutrition, NHED, referral of children, etc. is minimal.

5.7 Perception about the Interface Existing between ASHA and ANM, AWW and Community Leaders

- The responses of ANMs and AWWs on the nature of support provided by ASHAs in AWCs activities were elicited through the study. The activities of ASHAs agreed with by ANMs are 'escorting during institutional delivery'; 'assisting in immunisation of children and pregnant women', and 'assisting in village survey'. Similarly, the activities of ASHAs confirmed by AWWs include 'assisting in organising Village Health and Nutrition Days'; and 'conducting joint home visits'. 'Assisting AWWs in weighing of children' has been acknowledged by the AWWs, however, ANM has not corroborated the same, this may be because she is not directly carrying out the weighing activity herself and so may not be aware of it. The point worth noting is that the involvement of ASHAs in non-incentivised

activities at AWCs is minimal or lacking which needs to be addressed squarely, if we want to strengthen the care of women and children at the grassroots level.

- The responses of ANMs and AWWs on the nature of support provided by them to ASHAs in performing her job responsibilities revealed that the extent of support provided by ANMs in the work of ASHAs is greater than the support provided by AWWs to ASHAs. The areas where in the ANMs and AWWs are helping out ASHAs evenly, is mainly in the 'organisation of VHND'; 'holding of weekly meetings'; 'updating eligible couple register'; and 'in organising health camps'. Furthering better interface between the three grassroots level workers would yield better utilisation of services by the community.
- The nature of assistance provided in the activities of AWCs, as reported by ANMs themselves, along with the feedback from AWWs on the same, revealed that the assistance has been in the form of 'referral of malnourished/sick children'; 'conducting joint home visits'; 'providing health check-up of women and children'; and in 'organising immunisation sessions'. There is coordination existing between the two workers at the grassroots level, i.e. mainly in the health related activity but it is lacking in nutrition related services like supplementary nutrition, organising NHED sessions, growth monitoring, etc.
- The present study attempted to explore to existing interface of ASHAs with the health and ICDS functionaries and community leaders. By and large the ASHAs seem to be sharing a good rapport with the health and ICDS functionaries and community leaders. The study revealed that there is minimal conflict existing at the grassroots levels. ASHAs have been successful in reducing the workload on ANMs and AWWs, to some extent. ASHAs if trained well and used optimally could result in better reach and utilisation of services, impacting women and children.
- To sum up, we can say, that interface among the three grassroots workers, namely the ASHA, ANM and AWW, definitely exists, but is disjointed and often operate under informal mechanisms and is seen mainly for furthering incentivised health activities. A greater interface may have to be built through joint training of workers, on the New WHO Child Growth charts; IMNCI, on the usage of MCP Card, JSY, IGMSY and Sabla scheme, for better understanding of the schemes and programmes and harmony among the workers in service delivery.

5.8 Problem Faced by ASHAs

- The main source of income of ASHAs is through the incentive they receive for the work they do and the problem ASHAs faced, as perceived by them, are also mainly 'fight among ASHAs over cases'.
- The study points to the fact that there is still 'reluctance of villagers for institutional delivery'; 'reluctance to get their child weighed/immunised' and 'opposition from community experienced by ASHAs in their work' of Odisha and Karnataka. This is a pointer to the need for more advocacy in the state with respect to introducing ASHA as one of the health provider in the village, without which it would be difficult for the programme to yield the desired results.

5.9 Suggestions for Improving Service Delivery by ASHAs

- The most lucid and clear suggestion has been on the need for 'regular training' and 'support & supervision' for effective service delivery by ASHAs. The next suggestion to follow was regarding job security, *per se*, in term of either 'regularisation of service; or 'more monetary support', for the keeping the motivation alive to do work. Timely replenishment of medicine kit' provided to ASHAs is another major setback in the effective delivery of services, which needs to be addressed. Some 'not so loud' suggestions are the 'need for more ASHAs' and 'adhering to proper selection procedure in the recruitment of ASHAs'.

6

RECOMMENDATIONS

RECOMMENDATIONS

The major recommendations drawn, based on the findings of the present study are as follows:

- The study has revealed that roughly half of ASHAs were catering to a population of over 1000 indicating a burden on them, which needs to be rationalised. It is recommended that selection criteria formulated for selecting ASHAs, be adhered to strictly. There is a definite need for developing a mechanism for recruiting additional ASHAs if the norm set for population to be covered by an ASHA, exceeds 1000 population.
- Performance based incentives have certainly helped to improve the performance of the tasks to which it is linked. The study also reveals that incentivised activities under NRHM are being carried out with more zeal. In order that the prerequisites to save a mother and child are well executed, it is recommended that, they also may be incentivised. For eg. provide monetary incentives for registration of pregnant woman, for each antenatal care visit, and for institutional delivery, to ensure ASHA is compensated throughout the woman's pregnancy. There is a need to consider providing monetary incentive for home-based newborn follow-up, at Rs 200 per newborn visited , as tried out in Angul district of Odisha and for full immunisations beyond primary immunisations (e.g. for boosters, vitamin A supplementation, etc.). This would also ensure a better monthly income.
- The study revealed that only 66 per cent of ASHAs had undergone the requisite training of 23 days or more, which means that about one-third of ASHAs lack basic training to carry out their job responsibilities. This is a serious impediment to success and needs to be dealt with utmost urgency.
- The study also revealed that competencies required in maternal and child care, including the essential home based newborn care are inadequate and incomplete among the ASHAs. The knowledge of ASHA on various topics like ANC care, danger signs during pregnancy, complication during delivery, new born care, immunisation schedule, role and responsibilities of ASHA and linkage of ASHA with different stakeholders at the grass roots level needs to be reinforced through monthly meeting, subsequent rounds of trainings and reorientation training at CHC/PHC. Under the cascade model of training to the ASHA, trainings should provide complete knowledge and skills to the trainees within

the stipulated time. Also quality of training should be enhanced and refresher trainings should be planned regularly.

- The present study has revealed that the awareness of ASHAs regarding changes during adolescence; methods of family planning; prevention of RTIs/STIs; and awareness about HIV/AIDS was incomplete, but with proper orientation ASHAs can be utilised effectively for the betterment of the community. The Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (RGSEAG), also called Sabla, is currently being implemented in 200 districts of the country. With ASHA, as yet another grassroots level worker in the community, it is recommended that they be empowered to train the *Sakhis* and *Sahelis,* to reach out to the adolescents with quality services.
- The study revealed that knowledge level of ASHA about ICDS services was low and incomplete. The percentage of ASHAs who could list the services provided under ICDS such as, the health check-up; immunisation, supplementary nutrition and pre-school education was 86 per cent, 89 per cent, 92 per cent and 85 per cent respectively. However, the awareness level, was low for nutrition and health education (71%) and referral services (41%). Knowing about ICDS services to improve access to the same, weighing the child, analysing causes of malnutrition, and feeding counseling skills are prerequisites listed in the essential competencies to be developed in an ASHA. This necessitates that ASHAs are properly oriented to all the services being offered under the ICDS, if she has to serve as an effective link between AWW and the community.
- The study revealed that almost all the ASHAs, ANMs and AWWs were aware about the MCP Card and also reported using it. The MCP Card has been mainly used by ASHAs and ANMs for explaining about ANC services and explaining about preparation for delivery; and AWWs for explaining about childhood illnesses; and advising about nutrition, immunisation, etc. MCP card is a clear and tangible aid for communicating health, nutrition and development related messages for ASHA, which she can use during the outreach work, and hence, all ASHAs have to be trained in its usage, to exploit its benefit to the maximum. There is a need to consider joint training of ASHAs, ANMs and AWWs on ICDS and related activities.
- The introduction of a common Mother and Child Protection Card for both ICDS and NRHM, to strengthen the continuum of care for pregnant mothers and children under-

three years of age, incorporating the new WHO Child Growth Standards, warrants that a column be specified in the MCP Card for ASHAs, as well, to record the care given by them to women and children.

- Majority (98%) of ASHAs reported conducting home visits. Around 96 per cent of ASHAs admitted conducting home visits alone. There were some discrepancies in responses of ASHAs and AWWs on joint home visits. Also the issues discussed during the home visits are customary and limited. This finding calls for a need for clear-cut guidelines on home visits by the health and ICDS functionaries, as also role clarification on the same, to maximise health gain.
- Medicine kit was available with 100 per cent of ASHAs of Odisha; 95 per cent of ASHAs of Karnataka; 80 per cent of ASHAs of Maharashtra; 75 per cent of ASHAs of Assam and only 5 per cent ASHAs of Uttar Pradesh. The awareness about the contents of medicine kit was fair among the ASHAs of all sample states. The availability of medicine in the kit was poor or lacking in Maharashtra (25%); Karnataka (25%); and Assam (30%). The status of replenishment of the medicine was also very poor in all the sample states, except Odisha. Hence, there is a need for ensuring availability of medicine kit and medicines in the kit, as well as, enhanced skills of ASHA to use it, if we want ASHAs to be accepted by the community and be able to perform her duties as a depot holder of medicines, as envisaged in the scheme.
- The study found that VHND was popularly known as 'immunisation day' and restricted mainly to incentivised activities like, ANCs and immunisation activities with no nutrition education. There is a need to hold VHNDs regularly with full intended content and regularity.
- The study revealed overlapping of roles and responsibilities between the three grassroots level workers, namely ANM, AWW & ASHA and hence there is no clear cut accountability on them. There is therefore a need to develop a clear and defined, main responsibility/accountability of each in relation to the other for all major activities at the community level, so that she is fully aware of the roles and activities she must fulfill. There is also greater need to ensure that the distinct roles and responsibilities are clearly communicated between the ASHA, ANM, and AWW, to avoid overlap and increase efficiency.

REFERENCES

REFERENCES

1. Bajpai, N. and Dholakia, H.R., (2011). Improving the Performance of Accredited Social Health Activists in India. *Columbia Global Centres,Working Paper No 1, 2011, May*. New York, Columbia University.

2. Bhatnagar, R., *et al.*(2009). An Assessment of Performance Based Incentive System for ASHA Sahyogini in Udaipur, Rajasthan. *Indian Journal of Public Health, 53(3): pp 166-70.*

3. B.R.D. Medical College, Department of Community Medicine, Gorakhpur, Uttar Pradesh, (2009). A Study of Interface of ASHA with the Community and the Service Providers in Eastern Uttar Pradesh (sponsored by UNFPA and NIHFW). New Delhi, NIHFW.

4. Centre for Operations Research & Training (CORT), (2007). Assessment of ASHA and Janani Surakhsha Yojana in Madhya Pradesh (Sponsored by UNFPA). Vadodara, CORT.

5. Gosavi, SV, et al. (2009). ASHAs' Awareness and Perceptions about their Roles and Responsibilities: A Study from Rural Wardha. Wardha, Dr. SushilaNayar School of Public Health, Department of Community Medicine, MGIMS, Sevagram Dist. Wardha, Maharashtra.

6. Haider, S., et al., (2008). A Rapid Appraisal of Sahiya (ASHA) in Jharkhand. *Journal of Health and Population*, 2008, Vol. 31 (2), pp.80-84

7. India, Ministry of Health and Family Welfare, New Delhi. (nd) Guidelines for Village Health and Sanitation Committees, Sub Centres, PHCs and CHCs. New Delhi, 18 pgs

8. India, Ministry of Health and Family Welfare, New Delhi. (2007). Monthly Village Health Nutrition Day: Guidelines for AWWs/ASHAs/ANMs/PRIs.. New Delhi, 17 pgs

9. India, Ministry of Health and Family Welfare, National Rural Health Mission, New Delhi. (2005). Compensation Package for Accredited Social Health Activists (ASHA). New Delhi, 2 pgs

10. India, Ministry of Health and Family Welfare, National Rural Health Mission, New Delhi. (2005). Guidelines on Accredited Social Health Activists. New Delhi, 11 pgs

11. India, Ministry of Health and Family Welfare, National Rural Health Mission, New Delhi. (2005). Janani Suraksha Yojana: Guidelines for Implementation. New Delhi, 27 pgs. http://www.mohfw.nic.in/NRHM/RCH/guidelines/JSY_guidelines_09_06.pdf

12. India, Planning Commission, New Delhi. (2011). Mid Term Appraisal: Eleventh Five Year Plan 2007-2012. New Delhi, 17 pgs

13. International Institute of Population Sciences. Mumbai and Ministry of Health and Family Welfare, New Delhi. (2010). Key Indicators, District Level Household and Facility Survey-3, 2007-08. Mumbai. pp. 249-268

14. Kalinga Centre for Social Development (KCDS), (2008). Rapid Appraisal of Functioning of Village Health and Sanitation Committee (VHSCs) under NRHM in Orissa (Sponsored by NIHFW and UNFPA). Bhubaneswar, Orissa.

15. Kanth, Vandana, Cherian, Anil and George, Jameela (2010). The Contribution of Accredited Social Health Activist (ASHA) under Rural Health Mission (NRHM) in the Implementation of Comprehensive Primary National Health Care East Champaran District Bihar (State) India. New Delhi, Emmanuel Hospital Association.

16. Mahyavanshi, K. D., et al., (2011). A Cross Sectional Study of the Knowledge, Attitude and Practice of ASHA Workers regarding Child Health (under five years of age), in Surendranagar District. *Healthline, 2011,. 2 Jul.- Dec. (2).*

17. MKCG Medical College, Department of Community Medicine, Berhampur, Orissa, (2008). A Rapid Appraisal on Functioning of Janani Suraksha Yojana in South Orissa (Sponsored by NIHFW and UNFPA). Berhampur, Orissa.

18. National Health Systems Resource Centre (NHSRC) (2011). Evaluation of Accredited Social Health Activist (ASHA) Programme. New Delhi, National Rural Health Mission (NRHM).

19. National Institute of Health & Family Welfare (NIHFW), (2011). A Study to Assess some Operational Factors in Implementation of ASHA Scheme in Uttar Pradesh. New Delhi.

20. Paul, V. K., et al. (2011). India: Towards Universal Health Coverage 2. Reproductive Health, and Child Health and Nutrition in India: Meeting the Challenge. {www.thelancet.com) Published online January 12, 2011 DOI:10.1016/S0140-6736(10)61492-4}

21. Population Council (2010). Increasing Early and Exclusive Breastfeeding in Rural Uttar Pradesh: Implications for Behavior Change Communication. *Policy Brief No. 5.* New Delhi.

22. Public Health Resource Society, (2009). A Rapid Assessment of Communitization Processes of the National Rural Health Mission in Jharkhand, Orissa and Bihar. New Delhi.

23. R.N.T. Medical College, Udaipur (2009). Assessment of Performance Based Incentive System for ASHA Sahyogini in Udaipur District, Rajasthan (sponsored by NIHFW and UNFPA). New Delhi, NIHFW.

24. Singh K. Manish, et al., (2008). Factors Influencing Utilization of ASHA Services under NRHM in relation to Maternal Health in Rural Lucknow. *Journal of Community Medicine*, Vol. 35 (3), pp.414-419.

25. S.M.S.Medical College, Department of Community Medicine, Jaipur. (2008). A Quality Assessment of Institutional Deliveries in Jaipur, Rajasthan (sponsored by NIHFW and UNFPA). Jaipur, the author.

26. Srivastava, D. K. et al. (2009). A Study of Interface of ASHA with the Community and the Service Providers in Eastern Uttar Pradesh. *Indian Journal of Public Health, 53(3): pp 133-6*.

27. State Institute of Health & Family Welfare (SIHFW) (2008). Assessment of Functioning of ASHAs under NRHM in Uttar Pradesh (sponsored by NIHFW and UNFPA). Lucknow.

28. UNFPA, (2009). Concurrent Assessment of Janani Suraksha Yojana (JSY) in Selected States (Bihar, Madhya Pradesh, Orissa, Rajasthan, Uttar Pradesh). New Delhi.

29. UNICEF, 2011. Mamta Abhiyan: Delivering Convergent Services for Improved Maternal and Child Health. *Briefing Paper Series 7: Innovations, Lessons and Good Practices*, pp.1-20

30. www.wcd.nic.in. Mother and Child Protection Card under ICDS and MRHM. Secretary's Letter. 2010, March. 2 pgs

ANNEXURES

Annexure-I

Compensation Package for Accredited Social Health Activists (ASHAs)

SI. No.	Head of Compensation	Suggested Compensation (in Rs.)/per case	Estimated case/work load per ASHA per annum	Estimated Maximum out go for compensation per ASHA per annum
1	JSY-Institutional Delivery (rural) LPS	350 for ASHA & 250 for ref. transport	13	7800
	Urban	200	9	1800
2	Motivation for Tubectomy/Motivation for Vasectomy/NSV	150/200	8/4	1200/800
3	Immunization Session	150	12	1800
4	Pulse Polio Day-if it is full day work it should be Rs. 75/-	75	6	150
5	Organizing Village Health Nutrition Day	150	12	1800
6	DOTS	250	1	250
7	Household Toilet Promotion Fee	75	12	1200
8	Detection, referral, confirmation and registration of Leprosy case/after complete treatment for PB Leprosy cases/after complete treatment for MB Leprosy cases	100/200/400	1/1/1	100/300/500
	Total			**17,200**

Sample activities and performance based payments to ASHAs in some States

1. Madhya Pradesh

- Non-residential trainings @ Rs. 100/- per day
- Making Malaria slides @ Rs. 5/- per case subject to a maximum of Ra. 50/- p.m.

2. Rajasthan

- Social mobilization on VHND* @ Rs. 150/- per session
- Cataract surgery @ Rs. 175/- per case
- Non-residential trainings @ Rs. 100/- per day
- Attending monthly meeting @ Rs. 100/- per day
- Motivating families for sanitary toilets @ Rs. 30/- per toilet for APL and Rs.20/- for BPL families & Rs. 10/- for regular usage for six months only

3. Uttarakhand

- Social mobilization on VHND days @ Rs. 25/- per session
- Cataract surgery @ Rs. 175/- per case
- Non-residential trainings @ Rs. 100/- per day
- Attending monthly meeting @ Rs. 100/- per day
- Motivating families for sanitary toilets @ Rs. 50/- per family

4. Jharkhand

- Social mobilization on VHND @ Rs. 150/- per session
- Cataract surgery @ Rs. 175/- per case

5. Orissa

- Pulse Polio Day Rs. 25/- per day
- Non-residential trainings @ Rs. 100/- per day
- Motivating families for sanitary toilets @ Rs. 50/- per families
- Village Health & Nutrition Day

Annexure-II

Competencies to be Developed in ASHAs after 23 Days Training

General Skills

1. Awareness of qualities that need to be inculcated to successfully work as ASHA
2. Skills of conducting a village level meeting
3. How to talk with the women in the community – knowledge and skill
4. How to record her work- the ASHA diary; knowing what is expected of her.
5. How to maintain her register and the drug kit stocks .
6. Assist the VHSC and ANM in village health planning

Maternal Care

7. Knowledge of ANC; what are the components of a full and what are the complications in this period requiring referral.(especially to know about testing for anemia and its correction, and role of BP and weight measurements).
8. Knowledge of Safe delivery
9. Skill in micro-planning for safe birth – counselling on choice of which facility and provider to choose depending on provider availability and risks, arrangements for transport, arrangement for escort, arrangements for finance.
10. Determining Last Menstrual Period – knowledge and skill
11. Determining EDD based on LMP.
12. Recording pregnancy outcomes as abortion, live birth, still birth or newborn death
13. Recording pregnancy data after interviewing pregnant woman. Screening of pregnant woman for problems and danger signs and refer.
14. Imparting Health education to pregnant women and need based referral.
15. Understand the processes in labour (helps to understand and plan for safe delivery)
16. Attend and observe delivery and record various events
17. Recording the time of birth in Hrs, Min and seconds, using digital wrist watch
18. Understand obstetric emergencies and readiness for emergencies including referral

Essential Home Based Newborn Care

19. Knowledge of what HBNC means and her roles in it.
20. Observation of baby at 30 seconds and 5 minutes for movement of limbs, breathing and crying
21. Skill to provide normal care at birth. (dry the baby, wrap the baby, keep baby warm and initiate breastfeeding)
22. Skill to measure newborn temperature
23. Skill to weigh newborn and decide whether the baby is normal or low birth weight.
24. Determining whether the baby is term or preterm
25. Conduct examination of newborn and determine whether the baby has any abnormality (curved limbs, jaundice, bump on head, cleft lip), how the baby is suckling, whether baby has loose limbs and cry of baby. Provide care of eyes (treat pus purulent discharge from eyes with tetracycline, for normal eyes apply tetracycline ointment as prophylactic), umbilicus (keep cord dry and clean. If pus is observed apply G.V. paint) and skin care (for redness or cracking of skin apply G. V. paint or apply talcum powder to keep skin folds dry)
26. Understand importance of early and exclusive breastfeeding
27. Expressing milk and feeding babies who cannot suckle at birth
28. Manage breastfeeding problems (engorgement, cracked nipple, mother feels she does not have enough milk)

29. Provide breastfeeding support
30. Counsel for breastfeeding
31. Ability to identify hypothermia and hyperthermia in newborns
32. How to keep the newborns warm
33. How to re-warm cold babies
34. Control newborn temperature in hot weather

Child Care and the CHW Role

35. Planning the home visits- which child to visit and at what frequency.
36. Knowledge of the immunisation schedule
37. Child immunisation tracking skills to ensure that complete immunisation in the community.
38. Access to ICDS services- knowing the child's entitlements
39. Weighing the below 5 child- what grades of malnutrition mean?
40. Analysis of causes of malnutrition in a specific child- the role of feeding practices, role of illnesses, of familial and economic factors and of access to services.
41. Six essential feeding advices- breastfeeding, complementary feeding, fats and oils, frequency of feeding, greens and reds and feeding through an illness. How to adapt the message to each household.
42. Knowledge of causes of diarrhoea and prevention of diarrhoea
43. Diagnosis of dehydration and ability to ascertain if referral is required.
44. Skill in preparing and demonstrating ORS use to the mother/caregiver
45. Skill in counselling the mother for feeding during diarrhoeal episode
46. Knowledge of signs of Acute Respiratory Infections (ARI) – fever, chest indrawing, breath counting; and ability to manage mild vs moderate ARI with CTM, and refer the severe ones.
47. Testing for anemia and getting it treated.

The next set of four competencies are particularly applicable to high malaria areas, or where there is high prevalence of tuberculosis

48. Managing fever in the young child- when to suspect malaria, how and when to test, when to refer, when and what to treat.
49. Knowledge about malaria and its prevention.
50. Protecting pregnant women and the young child from malaria.
51. When to suspect tuberculosis, the prevention of tuberculosis.

Sick New Born Care

52. Identify low birth weight and preterm babies.
53. Knowledge of risks of preterm low birth weight.
54. How to care for LBW , preterm babies.
55. Explain care of LBW babies to mothers
56. Identify birth asphyxia and manage with mucus extractor
57. Observing for the signs of sepsis and their symptomatic management.
58. Diagnose newborn sepsis and manage it with cotrimoxazole.
59. Knowledge of referral of newborns – when, where, how.

Contraception and Family Planning

60. Understanding contraceptive needs. Helping poor families' access contraception.
61. Knowledge of availability of safe abortion services. Helping women in need of such services to access safe abortion services.
62. Counselling for delay in age of marriage, age of first child and in spacing the child.

Annexure-III

List of Project Coordinators at Various Sample States

S.No.	Sample State	District	Name, Designation and Address of the Project Coordinators
1	Assam	Nalbari	Dr. Achyut Kumar Baishya Professor & Head Deptt. of Community Medicine Guwahati Medical College Guwahati
2	Karnataka	Udupi	Dr. Pawan Kumar Prof. & Head Deptt. of Community Medicine Kasturba Medical College, Manipal University Manipal-576104, Karnataka
3	Maharashtra	Yavatmal	Dr. B. S. Garg Director, Professor & Head, DSNSPH Deptt. of Community Medicine Mahatma Gandhi Institute of Medical Sciences, Sewagram – 442102, Wardha, Maharashtra
4	Odisha	Keonjhar	Smt. Dharitri Rout Secretary Women's Organization for Socio-Cultural Awareness Baladeview Colony, Mining Road, Dist. Keonjhar-758001 Odisha
5	Uttar Pradesh	Muzaffarnagar	Dr. Jai Vir Singh Professor & Head Deptt. of Community Medicine Muzaffar Nagar Medical College, Muzaffar Nagar Uttar Pradesh

Annexure-IV

Evaluation of Functioning of Accredited Social Health Activists (ASHAs) in ICDS Related Activities

Guidelines for Project Coordinators

Data Collection

Five research teams will be deployed for data collection in the five identified sample States. The data for the study would be collected with the help of CMU Consultants / Resource Persons/ Experts in all the Sample States {2 EAG (Orissa and Uttar Pradesh) and 2 Non-EAG (Maharashtra and Karnataka)} States; and in the one North Eastern Sample State (Assam) for the study. The Consultants are heading either the Department of Social and Preventive Medicine/ Community Medicine in Medical colleges, Schools of Social Work or Home Science Colleges in the States and have been identified for monitoring the ICDS Projects in their States. The Consultants / Resource Persons/ Experts will coordinate data collection through their research team and send it to the institute. The data thus obtained will be analysed and a report would be prepared.

Specific Responsibilities of Coordinator (Consultants / Resource Persons/ Experts/ Faculty Member)

i) Selection of District
ii) Selection of Block
iii) Selection of Villages
iv) Orientation of the interviewers.
v) Liaisoning with the MO, LHV, ANM, CDPO, Supervisor, AWWs and Beneficiaries at the village level
vi) Organizing data collection so as to finish the required number of interviews in each village within the stipulated time
vii) Checking of filled in schedules.

Orientation of Interviewers/Investigators

The **Coordinator (Consultants / Resource Persons/ Experts/ Faculty Member**) would be responsible for planning and orientation of the interviewers as well as covering of the following contents:

a) Orientation of the interviewers on situation of maternal and child health – India/ State with special reference to Sample States; ICDS and NRHM and its components; roles and responsibilities of ICDS and Health functionaries; ASHA, their recruitment, training, roles and responsibilities; Guidelines on Village Health, sanitation and Nutrition Committee; Guidelines on Village Health and Nutrition Day; Interface proposed between the health and ICDS functionaries with ASHA, orientation to tools/ guidelines for collection; etc.

b) The investigators should be instructed to do physical verification of the medicine kit before noting the contents of the medicine kit.

c) The investigators should also be instructed to observe and make note of things/situations that may add value to the study;

d) Filling up of schedules

e) Techniques of interviewing and practical hands-on experience on filling-up of schedules.

Selection of Sample (ASHAs, Functionaries & Beneficiaries)

- Coordinator (Consultants / Resource Persons/ Experts /Faculty Member) should make it a point to select District where ICDS has been operational and ASHAs have been selected and appointed.
- From each District two Blocks should be selected randomly. From each District two Blocks should be selected randomly.
- From each Block, ten villages should be selected randomly.
- The Coordinator (Consultants / Resource Persons/ Experts /Faculty Member) should ensure that the MO, LHV and ANM selected are monitoring and supervising the ASHAs.
- The selection of AWW should be from selected ASHA villages; the Supervisor from the circles of selected ASHA villages.

- Coordinator (Consultants / Resource Persons/ Experts /Faculty Member) should ensure that the ICDS beneficiaries are from selected ASHA villages.
- Further, pregnant women, Mothers with children upto 6 months and Mothers with children between six months and two years should be selected from selected ASHA villages.
- The PRI Member/Village Health, Sanitation and Nutrition Committee Member/ASHA Facilitator/Teacher should also be selected from selected ASHA villages.
- The following respondents from different categories of sample groups/functionaries will be included in the study from each State:

S. No.	Category	Number per State	Sampling Method	Sample	Total No.
Health Functionaries					
1.	ASHA	1/Village	From selected villages	1x20	20
2.	ANM	2/Block	Monitoring ASHAs of selected villages	2x2	4
3.	LHV	2/Block		2x2	4
4.	Medical Officer	1/Block		1x2	2
ICDS Functionaries					
5.	AWW	1/Village	From selected villages	1x20	20
6.	Supervisor	2/Block	From the circles of selected ASHA villages	2x2	4
7.	CDPO	1/Block		1x2	2
ICDS Beneficiaries (from selected ASHA Villages)					
8.	Pregnant Women	1/ Village	random	1x20	20
9.	Mothers with children upto 6 months	1/Village	-do-	1x20	20
10	Mothers with children between six months and two years	1/ Village	-do-	1x20	20
Others (from selected ASHA Villages)					
11	PRI Member/Village Health, Sanitation and Nutrition Committee Member/ASHA Facilitator/Teacher	1/Village	random	1x20	20
			GRAND TOTAL		**136**

Logistics

- As far as possible, the members of the research team (interviewers) should travel together for data collection.
- Rapport and introduction of the team should be made with the functionaries of the Health/ ICDS project, ASHAs and beneficiaries before initiating data collection.

Filling-up of Schedules

i) Questions need to be asked in the same order as given in the schedule.

ii) The responses should be put neatly against the questions.

iii) In open-ended questions, the responses should be filled neatly and legibly.

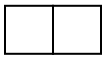
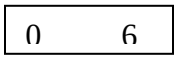
iv) All the questions should be asked and no question should be left unattended or incomplete. **Do not leave any box vacant/empty.** The **universal coding system** has to be followed which will run across all schedules as follows:

Code 0 – to be used for '**no response' (NR)**

Code 8 – To be used/filled for '**Do not know' (DK)**

Code 9 – To be used for '**Not applicable' (N.A)**

Wherever **actual no.** is to be filled, the boxes have to be filled in the following manner. For example, if the no. is 6

In case of two boxes  fill 

v) In **multiple choice questions** whatever response is given by the respondent should be considered as 1 (i.e., 'yes') and the other responses choices/blank boxes should be filled as 0 (i.e., 'no response'). Otherwise for each question/item, the code to be filled as specified against the question itself.

vi) **In multiple choice questions**, try to fit the responses in one of the answers given. In case one is not able to do so, write the remarks/answers received on the side. **Do not increase or make any box on your own.**

vii) While filling schedules, interviewers may be cautioned to assess if respondents are giving socially desirable answers. They may probe carefully to solicit the correct

information. This would require all interviewers to be alert and observant so as to record valid and realistic replies only.

viii) Biases and prejudices is in no way should creep in while administering the schedules.

ix) Interviewers should be able to ask questions in local dialect/language without distorting their meanings. These responses would be recorded as per the format given in schedule and in English language only.

x) In no way, the interviewer should disapprove the statements made by the respondents and as far as possible should also avoid evaluative gestures or comments

xi) The filled-in schedules should be duly checked by the Coordinator (Consultants / Resource Persons/ Experts /Faculty Member).

xii) The unfilled portion if any checked by the Coordinator should be filled-in the next day.

Stacking/Packing of Schedules

i) Arrange and bundle complete set of schedules for each State

ii) Each packet would have identification slip as follows:

1. Name of the State _____
2. Name of the District_____
3. Name of the Block_____
4. No. of Schedules in each category_____
5. Name & Signature of (Consultants / Resource Persons/ Experts /Faculty Member)_____

Time Schedule for Data Collection

Data collection work in ICDS project should be completed within 30 days with the help of interviewers who should be Post-graduate/PG students from respective College/University.