"Competency Assessment of ASHAs in the four tribal blocks of Vadodara district, Gujarat"

A dissertation submitted in partial fulfillment of the requirements
For the award of

Post-Graduate Diploma in Health and Hospital Management

by

Gursimran Alagh

International Institute of Health Management Research

New Delhi-110075

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Under the guidance of

Ms. Archana Joshi,
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Deepak Foundation

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Certificate of Approval

The following dissertation titled **"Competency Assessment of ASHAs in the four tribal blocks of Vadodara district, Gujarat"** is hereby approved as certified study in management carried out and presented in a manner satisfactory to warrant its acceptance as a prerequisite for the award of **Post Graduate Diploma in Health and Hospital Management** for which it has been submitted. It is understood that by this approval the under signed do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

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Certificate from Dissertation Advisory Committee

This is to certify that **Ms. Gursimran Alagh,** a participant of **Post Graduate Diploma in Health and Hospital Management,** worked under our guidance and supervision. She is submitting this dissertation titled **"Competency Assessment of ASHAs in the four tribal blocks of Vadodara district, Gujarat"** in partial fulfillment of the requirements for the award of the **Post Graduate Diploma in Health and Hospital Management.**

This dissertation has the requisite standard and to best of our knowledge and no part of it has been reproduced from any other dissertation, monograph, report or book.

Ms. Anupama Sharma,
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Abstract

"Competency Assessment of ASHAs in the four tribal blocks of Vadodara district, Gujarat"

By

Gursimran Alagh

This study was basically done with the aim of assessing the competencies and the performance of the ASHAs trained by Deepak Foundation.To a large extent, the actualization of the goal of NRHM depends on the functional efficacy of the ASHA as the grassroots health activist. Her efficacy depends on several factors like her own cognitive competency (including capacity building), aptitude, and attitude, effective relationship with other key health functionaries like AWWs, ANMs, PHC staff etc., the dynamics between the ASHAs and PRIs including selection, interface, coordination, and supervision, and acceptance of the ASHAs by the community. Therefore the present study has been planned for ascertaining how efficient and competent the ASHAs are to play their defined roles effectively with the following objectives and to subsequently design a refresher training modules for them.

The present study reveals the impact of the trainings given to the on their work performance and knowledge of ASHAs regarding various health related activities, which have been initiated by Deepak Foundation in the four tribal blocks, Kawant, Naswadi, Pavi Jetpur and Chhota Udepur. The aim of this study was to assess the competencies of the ASHAs and to understand the post-training work performance of the ASHAs and the realities and challenges encountered by them in successful implementation of the various health related activities. The impact has been mainly measured through self administered questionnaires for ASHAs on knowledge, awareness, and practice. However, to assess effective activity and coordination with the government officials raking of the ASHAs was done by the ANMs/FHWs and MOs and in-depth interviews of the ANMs/FHWs, through FGDs.

Based on the findings and observations as stated above, the work performance of ASHAs appears clearly. It can be seen that the ASHAs almost have a good knowledge base regarding their awareness pertaining to their expected job related roles and responsibilities. According t to the rankings given by the ANMs/FHWs and the MOs most of the ASHAs fall in the average and good category. The focus group discussion with the VHSC members revealed that they are satisfied with the working of the ASHAs and say that they fulfil their roles and responsibilities effectively. The beneficiaries also said that they are happy with the ASHAs working in their village.

In totality in can be said that the ASHAs do have good competency in activities in which they are involved in a day to day basis and are linked to the incentives. Their need for trainings has been highlighted in areas like risk identification of the pregnant women, post partum women and newborns, in case of knowledge about other diseases and their role in VHSC.

ACKNOWLEDGEMENT

It is a proud moment, which gives me a great feeling to thank all those who helped and supported me in their own special way during my dissertation. It gives me esteem pleasure to present this study, and I whole heartedly thank each and everyone who helped me in completion of this task.

I wish to express my deep sense of gratitude to **Ms.Archana Joshi** (Director Deepak Foundation) and **Mrs.Nandini Srivastava** (Deputy Director Deepak Foundation) for giving me their valuable guidance, encouragement and motivation in carrying out my dissertation. I am truly thankful for whatever I have learnt from them.

I would also like to thank my mentor **Ms. Anupama Sharma**, **Dr. Sangram Kishore Patel** and **Dr. Sandeep Bhalla** who believed in me and have been my guiding force and pillar of strength throughout this study.

I would like to thank all the ASHAs, ANMs, MOs, VHSC members and Beneficiaries who agreed to be part of this study and helped to make this study a success.

I would also like to thank all the ORWs, Lab technicians and Field staffs who helped me through the project especially during field visits and in making it a memorable and an enriching experience.

I am grateful to IIHMR for providing me the opportunity to work at Deepak Foundation.

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ABBREVIATIONS

ANC	Antenatal care
ANM	Auxiliary nurse midwife
APL	Above poverty line
ASHA	Accredited social health activist
AWC	Anganwadi centre
AWW	Anganwadi worker
BPL	Below poverty line
CBO	Community-based organisation
CDMO	Chief District Medical Officer
CDPO	Child Development Project Officer
CHC	Community health centre
DOTS	Directly observed treatment short course
FGD	Focus group discussion
ICDS	Integrated Child Development Scheme
IFA	Iron and folic acid tablet
JSY	Janani Surakhya Yojana
MO	Medical Officer
MOHFW	Ministry of Health and Family Welfare
NRHM	National Rural Health Mission
PHC	Primary health centre
PNC	Postnatal care
PRI	Panchayati Raj Institutions
RTI	Reproductive track infection

SC	Schedule Caste
SHG	Self-help group
STI	Sexually transmitted infection
ST	Schedule Tribe
VHSC	Village Health and Sanitation Committee

PART 1

INTERNSHIP REPORT

INTERNSHIP REPORT

About DEEPAK FOUNDATION

Deepak Foundation, a corporate social responsibility of Deepak Group of Companies, was set up in 1982 with a dream of providing medical and healthcare facilities to the workers and local community near the industrial area of Nandesari. The focus was to reach out to the most vulnerable population groups i.e. women and children belonging to poor families. The Foundation has since evolved into a leading non-profit voluntary organization providing maternal and childcare services to over 2 million people across 1548 villages in all twelve blocks of Vadodara district, Gujarat.

The core intervention sectors of the Foundation are:-

• Promoting practices for safe motherhood and child survival.
• Making available health and pre-school education services.
• Ensuring sustainable livelihood for under-privileged and marginalized communities.
• Providing disaster relief and rehabilitation services.

Apart from maternal and childcare services, the Foundation has diversified into allied activities such as livelihood through natural resource management, empowering women through dairy cooperatives, savings groups and preservation of pithora art, promoting preschool education, HIV/AIDS prevention and disaster relief and rehabilitation. The Foundation implements its activities through sustainable Public Private Partnerships (PPP); by ensuring community participation through Community Based Organisations (CBOs); by working in close collaborations with national and international NGOs; and through the network of Civil Society Organisations. The strength of the Foundation lies in its cross-functional specialist workforce, with nearly 400 full time professional staff deployed across 22 different locations throughout Vadodara. Additionally, there are around 2091 village level women volunteers responsible for programme implementation activities at the village level. The entire team works under the overall supervision of the executive head, the Director.

Safe Motherhood and Child Survival Project

For the first time in Gujarat State

Achievements in 5 years of operation (2005-10)

• Inked the Memorandum of Understanding at District level in 2005 to implement the public health project - Safe Motherhood and Child Survival Project - to reduce maternal and infant mortality in all 1548 villages of Vadodara district.

• Registered and tracked 215,775 beneficiaries (pregnant and nursing women) during the project period (2005-2010).

• Built capacities of 4034 frontline women health workers for tracking the beneficiaries to conduct Behavior Change Communication and referral to tertiary care.

• Referred 18,613 emergency cases through 8 vehicles under emergency transport network in four remote tribal blocks since August, 2005 covering 700,000 population and scaled up the facility in rural blocks subsequently.

• Catered to 4391 deliveries and 991 gynecological surgeries free of cost through the only functional Comprehensive Emergency Obstetric and Newborn Care Unit in tribal blocks since February, 2006.

• Screened 84,628 beneficiaries for anemia through a Comprehensive Anaemia Control Project since August, 2007. Found 92% beneficiaries anaemic. Among 5442 severely anaemic cases 3324 (61%) of them were referred for treatment at tertiary care hospitals.

• Reached out to 61,511 out patients through two mobile health units in remote areas of tribal blocks since November, 2007 which was the highest performing units among the 88 mobile health units in the State.

• Catered to 4762 emergency cases referred for tertiary care through Help-Desk set-up at the government District hospital since October, 2006 to ensure prompt treatment and addressing all the requirements of the patients.

• Built capacities of 1494 out of 1548 Village Health and Sanitation Committees for developing a decentralized model for formulating the District Health Action Plan.

• Recorded an increase in institutional deliveries from 14% (2005) to 72% (2010) in tribal blocks.

• Recorded 41% decline in maternal mortality from 430 (2005) to 252 (2010) per 100,000 live births in tribal blocks.

• Recorded 7% decline in infant mortality from 57 (2005) to 53 (2010) per 1000 live births in tribal blocks.

My role in the organization

I am currently working at Deepak Foundation as a 'Public Health Specialist'. In these three months I have been involved in a number of activities. Some of these have been mentioned below;

- Proof reading of the manuscripts for the newsletter 'Deep Jyoti' printed by the organization.
- Translation of the video clips from Hindi to English.
- Making presentation for the conference on 'Role of women in science and technology' at 'Maharaja Sayaji Rao University' in Vadodara.
- Writing research proporsals.
- Writing a paper on 'Corporate Social Responsibility' for a conference at 'Maharaja Sayaji Rao University' in Vadodara.
- Preparing a brief report and article on 'Jan Samvad' (public dialogue) and 'Farmers Representative Committee' under the 'Kawant Livelihood Project' respectively.
- Competency Assessment of the ASHAs in the four tribal blocks of Vadodara district, Gujarat

PART 2

DISSERTATION REPORT

CHAPTER 1

INTRODUCTION

1.1 BACKGROUND

The Government of India launched the National Rural Health Mission (NRHM) in 2005. The aim was to provide accessible, accountable, affordable, effective and reliable primary health care, especially to the poor and vulnerable sections of the population. The Mission envisages equitable, and quality health care services to rural women and children in the country with greater emphasis on 18 highly focused states. It adopts a synergistic approach by encompassing non-health determinants that have a bearing on health such as nutrition, sanitation, and safe drinking water. The mission aims to achieve greater convergence amongst related social development sectors.

One of the core strategies proposed, to accomplish the goals, was to have a female Accredited Social Health Activist (ASHA) for every village with a 1,000 population. The Sub-centre is the most peripheral level of contact with the community under the public health infrastructure. This caters to a population norm of 5000, but is effectively serving much larger population at the Sub-centre level, especially in EAG States. With only about 50% MPW (M) being available in these States, the ANM is heavily overworked, which impacts outreach services in rural areas. Currently Anganwadi Workers (AWWs) under the Integrated Child Development Scheme (ICDS) are engaged in organizing supplementary nutrition programmes and other supportive activities. The very nature of her job responsibilities (with emphasis on supplementary feeding and pre school education) does not allow her to take up the responsibility of a change agent on health in a village. Thus a new band of community based functionaries, named as **Accredited Social Health Activist (ASHA)** is proposed to fill this void.

The ASHA programme is a critical component of the NRHM. She is a woman selected by the community, resident in the community, who is trained and supported to function in her own village to improve the health status of the community through securing peoples access to health care services, through improved health care practices and behaviours and through health care provision as is essential and feasible at the community level. She acts as an interface between the community and the public health system. As an honorary volunteer, ASHA receives performance-based compensation for promoting variety of primary health care services in general and reproductive and child health services in particular such as universal immunization, referral and escort services for institutional deliveries, construction of household toilets, and other healthcare interventions.

In order to enable the states for proper implementation, ASHA guidelines were formulated by the Ministry of Health and Family Welfare (MOHFW), Government of India (GOI) wherein institutional arrangements, roles and responsibilities, integration with ANM and Anganwadi, working arrangements, training, compensation, fund-flow etc were discussed. The training modules and facilitators guide were prepared and shared with the states for rolling out the trainings. The guidelines accorded flexibility to the states in designing the operationalization of the intervention. Many states modified the guidelines depending on the local context to suit their

requirements, in the true spirit of the NRHM guidelines of decentralized programme management.

1.2 RATIONALE FOR THE STUDY

Deepak Foundation set up in 1982 is the corporate social responsibility of Deepak Group of Companies (Deepak Fertilizers and Petrochemicals Corporation Limited and Deepak Nitrite Limited). The Foundation was set up in 1982 with the objective of providing maternal and child care services to the rural community residing in the petrochemical belt in Vadodara District of Gujarat.

In 2005, the Foundation started an intervention project "Safe motherhood and Child Survival (SMCS) as a partner of Department of Health and Family Welfare (MoHFW), Government of Gujarat, aiming to reduce the infant and maternal mortality in the District through the existing government health delivery systems in line with goals of National Rural Health Mission (NRHM) and State Population Policy. At the initial stage the programme started in the four tribal blocks (Kawant, Naswadi, Chota Udepur and Pavi Jetpur) of Vadodara district in 2005.

As part of this initiative, Deepak Foundation trained more than 700 Village Level Health Workers (VLHWs) during the period of 2005 -2007. After introduction of NRHM these VLHW's were absorbed as Accredited Social Health Activists (ASHAs) under the mission's programme in the year 2007 in four tribal blocks

The District Health Society recognized Deepak Foundation as the Training Resource Agency for ASHA training programs in Vadodara district. Thereafter, Deepak Foundation started ASHA trainings for the district since January 2008. The Foundation has imparted training to 852 ASHAs based on NRHM guidelines and among them 577 ASHAs have completed all five phases of their training. Deepak Foundation has a well established training Unit with qualified & experienced staff. The Foundation has developed systematic agenda for trainings of ASHAs incorporating NRHM guidelines. Various methods like class room sessions, video show, role plays, participatory exercises, guest lectures, exposure visits & group discussion are used to make the training interesting. Equipping ASHAs with clinical skills has also been a part of the training provided by the foundation.

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

1.3 REVIEW OF LITERATURE

India has made substantial progress in health determinants over the past decades. The critical indicators of health, including Infant Mortality Rate, Maternal Mortality ratio, Disease prevalence, morbidity as well as mortality rates have shown consistent decline over the years. These achievements are the cumulative result of several interconnected changes. The improved coverage and efficiency of public Health delivery system as well as expanding private health sector have contributed equal measures to ameliorating the suffering associated with adverse health events. The overall economic upturn as well as improvement in collateral determinants of health has assisted the country achieve critical milestones

The National Rural Health Mission was launched on April 12, 2005, to provide accessible, affordable and accountable quality health services to the poorest households in the remotest rural regions. The thrust of the Mission was on establishing a fully functional, community owned, decentralized health delivery system with intersectoral convergence at all levels, to ensure simultaneous action on a wide range of determinants of health like water, sanitation, education, nutrition, social and gender equality. NRHM has successfully provided a platform for community health action at all levels. In all the States, specific health needs of people have been articulated for local action. (FICCI,

Generating community participation is one of the core strategies under the NRHM. Among the various ways to achieve this is the increased involvement of the Panchayati Raj Institutions, establishment of village health and sanitation committees (VHSCs), involvement of key community members as representatives on hospital and district health committees like the Rogi Kalyan Samiti (RKS), but the most important by far, is the creation of a cadre of female link workers in the rural areas to interface between the community and the public health system. This new cadre, termed the Accredited Social Health Activist –"ASHA" – is a woman volunteer selected from and accountable to the community (village).

Rationale for the formation of the ASHAs

The sub-centre which is the peripheral level of contact with the community under the public health infrastructure caters to a large population of 5000. The ANM is overworked, which impacts upon outreach services in rural areas. To complement the work of ANM, ASHA (the Accredited Social Health Activist) is selected through a selection process to fill the gaps in the health care delivery system. She is a volunteer who acts as a bridge between the community and the available health care system. The ASHA strengthens the link between health sector and community. She is working towards catylyzing behavioural change in rural and tribal areas of the state. ASHA is contributing towards enhancing quality of life with focus on health nutrition, sanitation, drinking water etc.

Objectives and strategy

She is expected to be the first port of call for any health related needs, especially of the deprived and vulnerable sections, including women and children. She is an honorary volunteer who is to receive performance based incentives for various activities and not any fixed remuneration or salary. According to the norms of implementation, one ASHA is to be selected for every 1000 rural population. This suggests that her workload (in terms of households and area) is much less than that of the female health workers (FHW/ANM) who are expected to serve about 3000-5000 population. It is therefore easier for the ASHA to adequately cover households in her work area and ensure better reach of services in collaboration with the FHW/ANM. Furthermore, as she is from the same community, she is likely to understand its health requirements better and would also be more acceptable to the people, making it easier for her to function effectively. The norms further state that the ASHA should be a woman who is a resident of the village; she may be married, divorced or widowed and preferably in the age group of 25- 45 years. She should also be literate, having studied at least up to the eighth standard. Her selection is to be done through a rigorous process involving various community groups, self help groups, Village Health Committee, Gram sabha etc. As part of her capacity building, she is expected to undergo a series of trainings to enable her to perform her tasks, which include creating awareness on health and its social determinants, promote "good" health practices and provide a minimum package of curative care and make timely referrals. She is also expected to mobilize the community and facilitate the members to access all types of health services, including those for maternal and child health. She is also expected to act as depot holder for essential provisions like ORS packets, iron folic acid tablets, chloroquine tablets, oral pills condoms etc. provided under the national programme. Thus, as her acronym ASHA (which means hope in several Indian languages) suggests she is truly a beacon of hope for the health needs of the rural population.

Roles and Responsibilities of ASHA

ASHA will be a health activist in the community who will create awareness on health and its social determinants and mobilize the community towards local health planning and increased utilization and accountability of the existing health services. She would be a promoter of good health practices. She will also provide a minimum package of curative care as appropriate and feasible for that level and make timely referrals. Her roles and responsibilities would be as follows:-

- ASHA will take steps to **create awareness** and provide information to the community on determinants of health such as nutrition, basic sanitation & hygienic practices, healthy living and working conditions, information on existing health services and the need for timely utilization of health & family welfare services.

- She will **counsel** women on birth preparedness, importance of safe delivery, breastfeeding and complementary feeding, immunization, contraception and prevention of common infections including Reproductive Tract Infection/Sexually Transmitted Infection (RTIs/STIs) and care of the young child.

- ASHA will **mobilize the community and facilitate them in accessing** health and health related services available at the village/sub-center/primary health centers, such as Immunization, Ante Natal Check-up (ANC), Post Natal Check-up (PNC), ICDS, sanitation and other services being provided by the government.

- She will **work with the Village Health & Sanitation Committee 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 i.e. Primary Health Centre/ Community Health Centre/ First Referral Unit (PHC/CHC /FRU).

- ASHA will **provide primary medical care** for minor ailments such as diarrhoea, fevers, and first aid for minor injuries. She will be a provider of Directly Observed Treatment Short-course (DOTS) under Revised National Tuberculosis Control Programme.

- She will also act as a depot holder for essential provisions being made available to every habitation like Oral Rehydration Therapy (ORS), Iron Folic Acid Tablet (IFA), chloroquine, Disposable Delivery Kits (DDK), Oral Pills & Condoms, etc. A Drug Kit will be provided to each ASHA. Contents of the kit will be based on the recommendations of the expert/technical advisory group set up by the Government of India.

- Her role as a provider can be enhanced subsequently. States can explore the possibility of graded training to her for providing newborn care and management of a range of common ailments particularly childhood illnesses.

- She will **inform** about the births and deaths in her village and any unusual health problems/disease outbreaks in the community to the Sub-Centres/Primary Health Centre.

- She will promote construction of household toilets under Total Sanitation Campaign.

- Fulfillment of all these roles by ASHA is envisaged through continuous training and upgradation of her skills, spread over two years or more.

Selection of ASHAs

- The general norm will be **'One ASHA per 1000 population'.** In tribal, hilly, desert areas the norm could be relaxed to one ASHA per habitation, dependant on workload etc.

- The States will also need to work out the district and block-wise coverage/phasing for selection of ASHAs.

- It is envisaged that the selection and training process of ASHA will be given due attention by the concerned State to ensure that at least 40 percent of the envisaged ASHAs in the State are selected and given induction training in the first year as per the

norms given in the guidelines. Rest of the ASHAs can subsequently be selected and trained during second and third year.

Criteria for Selection

- ASHA must be **primarily a woman resident of the village** - '**Married/Widow/Divorced'** and preferably in the age group of 25 to 45 yrs.

- ASHA 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.

Institutional Arrangements

The success of ASHA scheme will depend on how well the scheme is implemented and monitored. It will also depend crucially on the motivational level of various functionaries and the quality of all the processes involved in implementing the scheme. It is therefore necessary that well defined and yet flexible and participatory institutional structures are put into place at all levels from state level to village level. ASHA will be a central component of the NRHM and its institutional structure would reflect this.

(a) The District Health Society under the chairmanship of the District Magistrate/President Zila Parishad will oversee the selection process. Society will have representation from all related departments and civil society and the Panchayti Raj Institutions (PRIs). The Society will designate a District Nodal Officer and a Block Nodal Officer preferably a senior health person. The job of the Nodal Officers at the District and Block will be to facilitate the selection process by involving the Gram Sabha and Gram Panchayat, holding of training for ASHA and for trainers as per the guidelines of the scheme.

(b) At the village level it is recognized that ASHA cannot function without adequate institutional support. The women's committees (like self help groups or women's health committees), Village Health & Sanitation Committee of the Gram Panchayat, peripheral health workers especially ANMs and Anganwadi workers, and the trainers of ASHA and in-service periodic training would be major source of support to ASHA.

(c) At the block level, ASHA scheme will have a Block Co-ordination Committee with the Block Nodal Officer /Block Panchayat President as Chairperson. This committee will ensure **involvement** of PRIs and civil society and **support** of all related departments at the block level. Actual arrangements would vary depending on availability of a suitable NGO and of relative strengths and merits of different participants. If a suitable NGO is available at block level, the NGO would also be a member of the coordination committee.

(d) The Gram Panchayat would lead the ASHA initiative in three ways:-

(i) The Gram Sabha undertakes (through the process outlined earlier) the selection of ASHA.

(ii) It is involved in supporting the ASHAs in their work and itself undertaking many health related tasks through its statutory health committee. All ASHAs will be involved in this Village Heath & Sanitation Committee of the Panchayat either as members or as special invitees (depending on the state laws).

(iii) It develops the village health plan in coordination with ASHA. A part of the compensation incentive would be provided by/routed through Panchayats.

(e) In such situations where an NGO with good track record is available in the block level or a good NGO is willing to take up the responsibility, the entire selection and facilitation and training process can be given to the NGO. This will, however, not reduce the role of the Block Co-ordination Committee in overseeing the processes.

(f) The state level NRHM committee would have to monitor and support the District Health Society and District Nodal Officer through a network of coordinators/support NGOs.

(g) The ASHA strategy would be reflected in the State Action Plan, for which funds shall be released under the overall allocations under NRHM /RCH-II.

Role and Integration with Anganwadi

Anganwadi Worker (AWW) will Guide ASHA in performing following activities:-
·Organizing Health Day once/twice a month. On health day, the women, adolescent girls and children from the village will be mobilized for orientation on health related issues such as importance of nutritious food, personal hygiene, care during pregnancy, importance of antenatal check up and institutional delivery, home remedies for minor ailment and importance of immunization etc. AWWs will inform ANM to participate & guide organizing the Health Days at Anganwadi Centre (AWC).

- AWWs and ANMs will act as a resource persons for the training of ASHA.
- IEC activity through display of posters, folk dances etc. on these days can be undertaken to sensitize the beneficiaries on health related issues.
- AWW will be depot holder for drug kits and will be issuing it to ASHA. The replacement of the consumed drugs can also be done through AWW.
- AWW will update the list of eligible couples and also the children less than one year of age in the village with the help of ASHA.

- ASHA will support the AWW in mobilizing 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 immunization, health checkups / health days etc. to Anganwadi Centres.

Role and Integration with the ANM

- Auxiliary Nurse Midwife (ANM) will guide ASHAs in performing following activities:-

- She will hold weekly / fortnightly meeting with ASHA and discuss the activities undertaken during the week / fortnight. She will guide her in case ASHA had encountered any problem during the performance of her activity.

- AWWs and ANMs will act as a resource person for the training of ASHA.

- ANMs will inform ASHA regarding date and time of the outreach session and will also guide her for bringing the beneficiary to the outreach session.

- ANM will participate & guide in organizing the Health Days at AWC.

- She will take help of ASHA in updating eligible couple register of the village concerned.

- She will utilize ASHA in motivating the pregnant women for coming to sub centre for initial checkups. She will also help ANMs in bringing married couples to sub centres for adopting family planning.

- ANMs will guide ASHA in motivating pregnant women for taking full course of IFA Tablets and TT Injections etc.

- ANMs will orient ASHA on the dose schedule and side affects of oral pills.

- ANMs will educate ASHA on danger signs of pregnancy and labour so that she can timely identify and help beneficiary in getting further treatment.

- ANMs will inform ASHA on date, time and place for initial and periodic training schedule. She will also ensure that during the training ASHA gets the compensation for performance and also TA/DA for attending the training.

Working Arrangements

ASHA will have her work organized in following manner. She will have a flexible work schedule and her work load would be limited to putting in only about two-three hours per day, on about four days per week, except during some mobilization events and training programmes.

A. At AWC: She will be attending the AWC on the day when Immunization/ANC sessions are being organized. At least once or twice a week, she would organize health days for

health IEC, rudimentary health checkup and advice including medicine and contraceptive dispensation.

B. **At home:** She will be available at her home so as to work as depot holder for distribution of supplies to needy people or for any assistance required in terms of accompanying a woman to delivery care centre/FRU or RCH camp.

C. **In the Community:** she will organize/attend meetings of village women/health committees and other group meetings and attend Panchayat health committees. She will counsel and provide services to the families as per her defined role and responsibility.

Training

Capacity building of ASHA is critical in enhancing her effectiveness. It has been envisaged that training will help to equip her with necessary knowledge and skills resulting in achievement of scheme's objectives. Capacity building of ASHA has been seen as a continuous process.

Training Strategy

- **Induction Training:** After selection, ASHA will have to undergo series of training episodes to acquire the necessary knowledge, skills and confidence for performing her spelled out roles. Considering range of functions and tasks to be performed, induction training may be completed in 23 days spread over a period of 12 months. The first round may be of seven days , to be followed by another four rounds of training, each lasting for four days to complete induction training.

- **Training materials**: would be prepared according to the roles and responsibilities that the ASHA would need to perform. Her envisaged functions and tasks will be expanded into a listing of competencies and the training material would be prepared accordingly. The training materials produced at the national level would be in the form of a general prototype which states may modify and adapt as per local needs. The training material will include facilitator's guide, training aids and resource material for ASHAs.

- **Periodic Trainings:** After the induction training, periodic re-training will be held for about two days, once in every alternate month at appropriate level for all ASHAs. During this training, interactive sessions will be 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 opportunity will also be used for replenishments of supplies and payment of performance linked incentives. ASHAs will be compensated for attending these meetings.

- **On-the-job Training**: ASHAs needs to have on the job support after training both during the initial training phase and during the later periodic training phase it is needed to provide on the job training to ASHAs in the field, so that they can get individual attention and support that is essential to begin and continue her work. ANMs while conducting outreach sessions in the villages will contact ASHA of the village and use the opportunity for continuing education. NGOs can also be invited to take up the selection; training and

post training follow up. Similarly block facilitators identified earlier for selection of ASHAs can also be engaged for regular field support.

- **Training of trainers**: A cascade model of training is proposed. At most peripheral level, Block trainers (who are the members of identified block training teams) would have to spend at least the same number of days in acquiring the knowledge and skills as ASHAs. These ToTs will also have to be similarly phased. These trainers should be largely women and chosen by block nodal officer. The block teams would be trained by a district trainer's team. (Or Master trainers) who are in turn trained by the state training team. The duration of ToTs for District Training Teams (DTT) and State Training Teams (STT) will be finalized by the states depending on the profile of the members to be selected as DTT and STT.

- **Constitution of Training teams:** It follows that each state, district and block would have a training team compromising of three-four members. Existing NGOs especially those working on community health issues at the district / block level may also be entrusted with the responsibility for identifying trainers and conducting of TOTs The trainers would be paid compensation for the days they spend on acquiring or imparting training – both camp based training and on the job training. The similar guideline applies to the district level also where trainers would be drawn in from Programme Managers and NGOs. The State Institutes of Health and Family Welfare along with reputed and experienced NGOs would form training teams at the state level. State level training structures to be used for trainings under various National Health and Family Welfare Programmes Trainings may be adhered wherever feasible.

- **Continuing Education and skill upgradation**: A resource agency in the district of state (preferably an NGO) will be identified by the State. The resource agency in collaboration with open schools and other appropriate community health distance education schemes will develop relevant illustrated material to be mailed to ASHAs periodically for those who would opt for an
  eventual certification.

- **Venue of training**: The principle of choice of venue shall be that the venue should be close to their habitation that the training group should not be more than 25 to 30. In most situations this could be the PHC or alternatively Panchayat Bhavan or other facilities that are available.

- **National Level**: At the national level the NIHFW would in coordination with the National Rural Health Mission & its technical support teams and the Training Division of the Ministry will coordinate and organize periodic evaluation of the training programmes. The findings of these concurrent evaluations should be shared with State Governments.

- v **State level**: At the State level, the State Institute of Health and Family Welfare (SIHFW) in

- coordination with the State Training Cell of Directorate of Family Welfare will oversee the process of training, monitor and organize concurrent evaluation of training programme.

Compensation of ASHAs

- ASHA would be an **honorary volunteer** and would not receive any salary or honorarium. Her work would be so tailored that it does not interfere with her normal livelihood.

- However ASHA could be compensated for her time in the following situations:-

a) For the duration of her training both in terms of TA and DA. (so that her loss of livelihood for those days is partly compensated)
b) For participating in the monthly/bi- monthly training, as the case may be.
(For situations (a) and (b), payment will be made at the venue of the training when ASHAs come for regular training sessions and meetings).
c) Wherever compensation has been provided for under different national programmes for undertaking specific health or other social sector programmes with measurable outputs, such tasks should be assigned to ASHAs on priority (i.e. before it is offered to other village volunteers) wherever they are in position.
(For situation (c) disbursement of compensation to ASHAs will be made as per the specific payment mechanism built into individual programmes).
d) Other than the above specific programmes, a number of key health related activities and service outcomes are aimed within a village (For example all eligible children immunized, all newborns weighed, all pregnant women attended an antenatal clinic etc). The Untied Fund of Rs.10,000/- at the Sub-centre level (to be jointly operated by the ANM and the Sarpanch) could be 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.
(For situation (d) the payment to ASHAs will be made at Panchayats).

- Group recognition/ awards may also be considered.

- Non-monetary incentive e.g. exposure visits, annual conventions etc can be considered.

- A drug kit containing basic drugs should be given.

1.4 OPERATIONALIZATION IN GUJARAT

The Accredited Social Health Activist (ASHA) has been envisaged as a village level platform for expanding the reach of the health care system in the remotest of places and to provide equal access to all.

(i) STATUS: At present, a total of 29,695 ASHAs has been selected in the state. The selection and training of ASHA is ongoing place and the required no. of ASHAs will be in place shortly. The selection of ASHA has been decentralised down to the district level in order to expedite the selection process.

(ii) TRAINING: The training of ASHA is an ongoing process, Government of Gujarat aims to provide all five module training to every ASHA. Till now 98.56 % of ASHA have been trained in 1st module, similarly 96 % and 90 % of ASHA have been given training of 2nd and 3rd module respectively. 82.90 % ASHA received training in 4th module. Around 46.49 % of ASHA completed training of all 5 modules. Many of the ASHA could not complete all the modular training as they left the work in between. Apart from these modular trainings, ASHAs have been given training on Pregnancy Testing Kits, Salt Testing Kits and water testing in collaboration with Water & Sanitation Departments, malaria testing, epidemic control etc.

(iii) SUPERVISION: Providing regular supervision and handholding support to the ASHAs has been one of the key features in ensuring its success. Monthly review meetings are conducted at PHCs by the concerned Medical Officers with the ASHAs and service providers. This provides a sound ground for the ASHAS to interact with the service providers as well as ensures a two way feedback process. The replenishment of medicines and payment of incentives are ensured during these meetings. The State Headquarter also makes it a point to be in regular contact with the ASHAs using SATCOM. This system has ensured that the ASHAs are regularly updated in various health related topics and also keep them active in health, water and sanitation campaigns.

(iv) ASHA SAMELLANS: For training the ASHA on aspects of health "ASHA samellans" are held at the district level where all ASHA were given ID card to develop a sense of ownership among them which also serve the purpose of their identification in the community. Also IEC stalls were kept in samellans for orienting the ASHA on the concepts of health, her roles and responsibilities, The ASHA were told about their incentive entitlement. An ASHA diary has been given to ASHAs for planning of work and report keeping in the Samellan. In the new PIP, CUG mobile phone facility is also given to all the ASHAs for better program monitoring.

(v) PROVISION OF DRUG ITS: The drug kit with basic and supplies is provided to all ASHA. In year 2010-11 all the ASHA have been provide ASHA kit. ASHA kit comprises ASHA bag, weighing scale, Thermometer and necessary drugs. Regular stocks of ASHA kit will be provided to ASHA so that she can provide primary health care for minor ailments, fever, pain, first aid etc. to the community.

(vi) SUPPORTIVE STRUCTURE FOR ASHA

- **ASHA Resource Centre (New initiative for tribal districts of state)**
  The ASHA resource centre has been conceptualized to improve the quality of the programme specifically for ASHA strategy. Department of Health & Family welfare, Government of Gujarat has resolved the Guidelines and Framework for formation of ASHA resource centre. The centre will established at state level and will work under the supervision of the Mission Director (NRHM). However, there would be a Governing body to look into policy level issues and deal with inter sectoral coordination. For the supervision of the ARC activities and review of day to day functioning there will be an ARC executive committee. The same structure of Governing body and executive committee will be placed at district level. Since the Resource centre is the new initiative, it is decided to first implement it in 12 tribal districts of the state.

- **Proposed Functions of the ASHA Resource Centre:**

a) **Developing of IEC material:** ARC will be responsible for developing or collecting the IEC material from different agencies for dissemination during the training. The facilitation kit including flip books, chart, posters etc on different related issues will be developed and disseminated. Need based IEC material will be developed from time to time.
b) **Planning of Monthly Meetings:** It is planned to conduct monthly meeting of ASHAs at block level to resolve day -to -day functional problems faced by ASHA and to ensure the progress of the activities conducted by ASHA. It is very important to revise the concepts and contents to improve the learning process .The topics covered during the training will be revised in the monthly meeting. ARC will develop tentative monthly agenda for the monthly meetings; provide required resource material and IEC material. It will develop the monitoring mechanism for the meetings.
c) **Delopment of Reporting formats and registers:** ASHA is envisaged as a voluntary worker and to facilitate her work some very easy and basic reporting formats and registers will be developed. The registers and the formats will be used by ASHA only to streamline her priorities. ARC will develop the formats and will orient ASHA for its utility and use.
d) **Processing of Statistical Data and records:** On the basis of reports and registers of ASHA and other sources of data, ARC will compile the statistical data, analyze the data and provide the feedback of the programme to the Mission.
e) **Intersectoral Coordination pertaining to ASHA**: ASHA is conceptualized as a volunteer responsible for the Health needs of the particular village. The credibility of ASHA in the community could be used by other Development Departments to promote their objectives. ARC will coordinate with different departments and facilitate empanelment of ASHAs in various other programmes like SARVA Shish Abhiyan, Total Sanitation Programme etc.
f) **Capacity building of ASHA for her role in Village Health Plan:** NRHM is promoting the down - up approach for implementation of different health programmes. It is proposed to form Village Health & Sanitation Committee and Village Health Teams

(VHT) to address the health needs of the Village. ASHA will be one of the important members of VH & SC and VHT. ARC will be responsible for capacity building of ASHA so that she could help in planning and implementation of Health Programmes in the Village.

g) **Organize Quarterly meeting of Mentoring Group:** A Mentoring Group is constituted to provide overall guidance to the programme and act as a think - tank for the programme. The mentoring group will provide technical inputs and support mechanism. ASHA Resource Center will conduct the quarterly meetings of the mentoring group and incorporate the valuable inputs provided by the group in the programme.

h) **Provision of services of Helpline:** ASHA in near future will work in entire state. There will be more than 32,000 ASHA in the State. Time to time trainings or monthly meetings may not suffice the need of the ASHA. So the ARC will form the helpline for the ASHA and associated functionaries. ARC will respond to the queries or clarifications needed in the field. ARC will ensure that the prompt help is provided to ASHA.

i) **Organizing ASHA Sammelan, Exposure visits:** There will be Sammelans at State level, Zonal level and District level to share the experiences of ASHA and for cross learning's. ARC will organize such events with the help of State Health Society and District Health Society. ARC will also organize the exposure visits with in the state and outside the state

j) **Other issues related to the functioning of ASHA:** Some of the functions of ARC is mentioned above. The role of ARC is multifaceted and visualized in broader sense. The functions of ARC could be revised as per the need and requirement of the programme. Some new roles could also be incorporated

k) **Linkages of ASHA Resource Center:** ASHA Resource Center are a Hub for ASHA Component under NRHM, which will work in close association with Mission Director. The Mission Director will be involved in major decisions like recruitment of professionals. ARC will provide support to the districts through NRHM and all the administrative guidelines will be issued through NRHM. The process of manpower recruitment has started by the state.

1.5 OBJCETIVES OF THE STUDY

1.5.1 General Objective

The broad objective of the study is mentioned below:

- To evaluate the Competency and Performance of the ASHAs in the four tribal blocks of the Vadodara district at different levels

1.5.2 Specific Objectives

However, specifically the study aims at the following:

- To assess the impact of the trainings imparted to the ASHAs under standard NRHM module on their knowledge, awareness and practices
- To assess the perception of the different stakeholders and beneficiaries on the effectivity and efficiency of the working of the ASHAs
- To evaluate the ability of the ASHAs to track and maintain database of all pregnant and nursing mothers in their operational areas
- To identify the gaps in the capacity building of the ASHAs
- To assess the need for ASHAs refresher training module on the basis of the perceptions at different levels.

CHAPTER 2

DATA AND METHODS

Type of Study: Descriptive (observational)

Study Design: Cross-sectional

Study Area: Out of the 12 blocks in Vadodara district four tribal blocks were selected namely Kawant, Chhota Udepur, Naswadi and Pavi Jetpur.

Profile of the study area

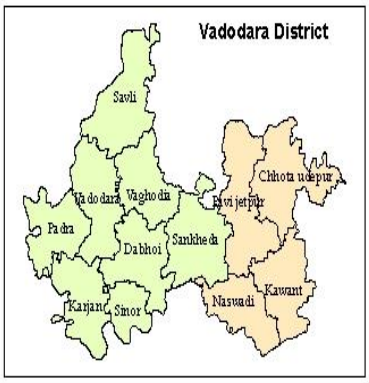
Vadodara is one of the economically, socially and culturally progressive districts in the state of Gujarat. As per the 2001 Census, Vadodara district with the population of 36.39 lakhs is the third most populated district in the state. 43 percent of its population is tribal, which makes it a tribal district. The district has many large industries and reputed higher educational institutions. The district's overall literacy rate is higher (70.8%) than that for the state (69.1%) but it is lower in rural Vadodara (57.6%) and still lower among rural women (44.1%). The study was conducted in the four tribal talukas of Vadodara districts. The population of these four talukas together is 19.8 percent of the district's population (***Table1.1***). In these talukas, percentage of population below 6 years age is 17, which is significantly higher than that in the district (13%), indicating higher fertility in these talukas. Sex ratios in these talukas are higher, ranging from 945 to 983, compared to 919 of the district indicating no serious sex bias against female babies. However, literacy, particularly female literacy in these talukas is low, almost half that of the district.

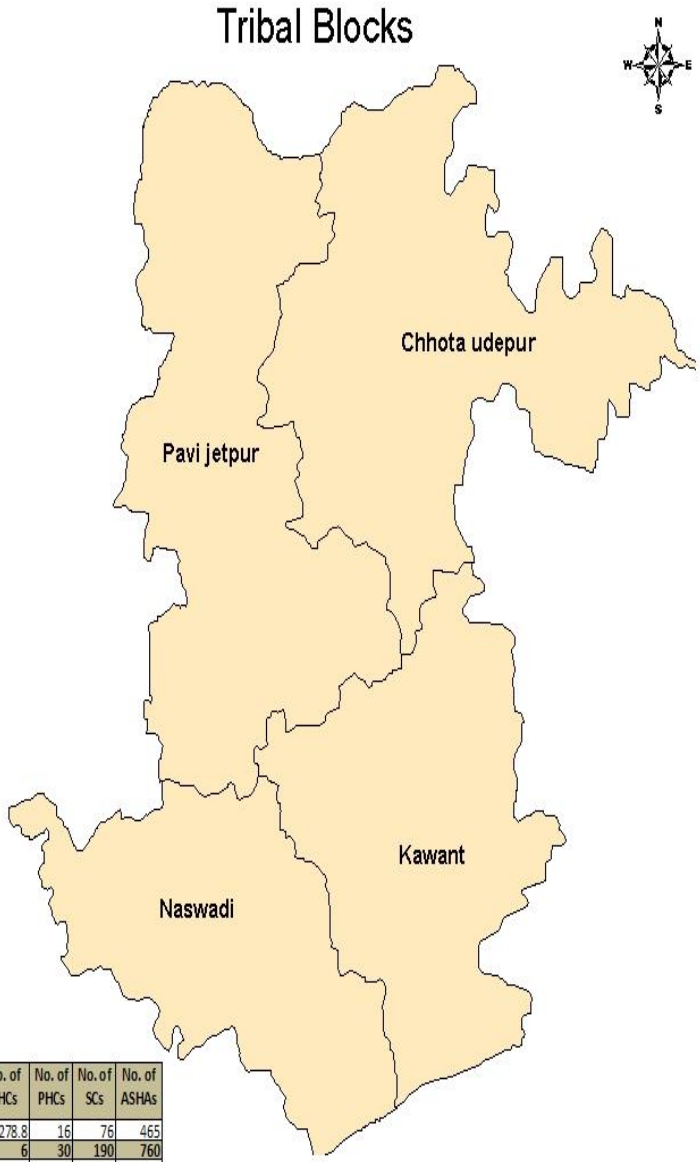
Table 1.1: Demographic indicators of the project area (Census 2001)
Indicators of districts in Vadodara, Chhota Udepur, Kawant, Naswadi and Pavi Jetpur

Sno.	Details	Unit	Kawant	Chhota Udepur	Naswadi	Pavi Jetpur
1	Geographical area	sq. km	619	748	535	805
2	Total Villages	no.	133	144	219	212
3	Total Population	no.	170524	202697	124828	225894
4	Total ST Population	no.	157738	175480	107547	1775183
5	Total SC population	no.	4195	6389	1672	5463
6	Total Literate Population	no.	47224	51344	50502	95058
7	Demographical Indicators					
A	Density(population per sq km)	Person	276	271	233	280
B	Sex Ratio(no. of females per 1000 males)		974	982	957	945
C	Growth Rate 1991-2000		22.73	22.59	16.2	13.15
D	Birth Rate		24.78	19.83	12	18.4
E	Death Rate		9.2	10.15	21.5	9.6
F	IMR		46.36	49.84	41.2	42
G	MMR		2.23	1.62	2.45	2.6
H	CPR		60.22	50	63.8	58.4
8	Total BPL Families	no.	20643	21972	12988	22280
9	Health					
A	No. of SC's	no.	48	18	44	
B	No. of PHC's	no.	6	7	5	10
C	No of CHC'S	no.	1	2	1	2
D	No. of Ayurvedic/Homeopathic doctors	no.	3	2	1	6
E	No. of beds available	no.	48	126	1	136

The study area has been highlighted in Map 1

Map 1:





Sno.	Blocks	No. of villages	No. of villages	Population	No. of households	Household size	Avg. popn. per village	% STs	No. of CHCs	No. of PHCs	No. of SCs	No. of ASHAs
DISTRICT		1,553	1,548	1,995,580	388,524	5.1	1289	45	7,278.8	16	76	465
TRIBAL – SUB		709	706	7,00,732	1,23,327	5.7	993	87	6	30	190	760
1	Pavi Jetpur	213	212	2,25,894	41,621	5.4	1066	78	2	10	52	269
2	Chhota Udepur	144	144	1,79,486	28,390	6.3	1246	95	2	7	45	175
3	Kawant	133	133	1,70,524	29,691	5.7	1282	93	1	8	52	168
4	Naswadi	219	217	1,24,828	23,625	5.3	575	86	1	5	45	148

Study Period: 3 months (March to May, 2011)

Study Unit:

- Accredited Social Health Activist (ASHAs)
- Auxiliary Nurse Midwife (ANMs)
- Medical Officers (MOs)
- Village Health and Sanitation Committee (VHSC) members
- Beneficiaries

2.1 SAMPLING

A purposive sampling method was followed in case of ASHAs, ANMs and MOs, wherein all the mentioned stakeholders were covered. For Beneficiaries and VHSC members random sampling was used. The sample area selection comprised of selection of Blocks, PHC's, SC's and villages with the above mentioned study subjects.

2.2 SCHEME OF SAMPLE SELECTION

The scheme of sample collection followed during **the** study is given below:-

Table 2: Scheme of sample collection

Sno.	Stage of selection	Method of selection	No. of units	Remarks
1	Block	Purposive	4	Out of the 12 blocks in Vadodara district, four tribal blocks were chosen for the study
2	MO's	Purposive	26	All the MO's (PHC's) in the 4 blocks
3	ANM's	Purposive	190	All the ANM's (SC's) in the 4 blocks
4	ASHA's	Purposive	780	All the trained ASHA's in the 4 blocks
5	VHSC's	Random	72	
6	Beneficiaries	Random	12	2 in each block (1 pregnant and 1 lactating mothers)

2.3 DATA COLLECTION

The competency assessment of ASHAs adopted a blended methodology and included application of both quantitative and qualitative techniques.

Table 3: Scheme and tools used for data collection

Sno.	Level of data collection	Respondents	Method of data selection	Instrument used	Method of data collection
1	PHC	MO	Purposive	In-depth interview	Semi-structured interview schedule
2	Sub-centre	ANM	Purposive Random	Questionnaire In-depth interviews	Semi-structured Semi-structured interview schedule
3	Village	1. VHSC 2. ASHA	Random A) Purposive B) Random	FGD A) Questionnaire B) In-depth interviews	Guidelines A) Semi-structured B) Semi-structured interview schedule

2.5 DATA COLLEECTION TOOLS

Data collection of this primary study has been done through pre-designed and pre-tested semi-structured self administered questionnaires of ASHAs, ranking list with MOs and ANMs and indepth interviews with all the stakeholders. FGDs have been conducted at the village level of the VHSC member for the study.

Tools for Primary Data Collection

2.5.1 Quantitative Instrument:

a) For ASHAs

A semi-structured self-administered schedule **(Enclosed in Annexure1)** was prepared for ASHAs to assess their knowledge, awareness and practices. It comprised of thirteen sections which have been described below;

- ***Background characteristics*** which includes information about their demoghraphic and socio-economic characteristics, the number of villages and households they provide their services to and the trainings received so far.

- ***Roles and responsibilities*** included information pertaining to their knowledge of their job related roles and responsibilities performed in their day to day work environment and at the different healthcare facilities, activities undertaken for the identification of the.

- ***Birth and death registration*** comprised of information with relation to the numbers f cases and numbers registered in the last 3 months of births, infant and maternal deaths in the last 3 months and 1 year respectively, the activities undertaken for the registration of the birth and death cases.

- ***Health facilities*** included information with relation to the knowledge of the ASHAs about their nearby health facility and the kind of health services available there.

- ***ANC care*** contained the information in relation to the ANC visits, activities undertaken to ensure proper ANC care.

- ***Delivery*** section aimed to gather information pertaining to the steps undertaken by the ASHA when she comes to know that a woman is in labour, to assess the component wherein the ASHA is supposed to accompany and escort the beneficiary to the nearby health facility for delivery.

- ***PNC care*** captured the information related to the PNC visits, messages given at the time of PNC visit and newborn care.

- ***Risk identification*** section focused on the knowledge and the ability of the ASHAs to identify the danger signs at the time of pregnancy, during delivery, post partum woman and newborn.

- ***Birth spacing*** section focused on the advantages of birth spacing and messages given for counseling the eligible couples about the different family planning methods.

- ***Immunization and Mamta Divas*** included information about the different activities about undertaken on the Mamta Divas / Immunization day at the SC / AWC.

- ***Other diseases*** section caprtured the information of the ASHAs about the different diseases like anaemia, TB, Malaria and Leprosy.

- ***Records and registers*** section focused on the different records and registers maintained by the ASHA with special focus on the MIS register developed by Deepak Foundation.

- ***Communication and counseling*** section basically focused on the different meetings attended by the ASHAs in a month and the issues discussed in these meetings.

- ***Village Health and Sanitation Committee*** section focused on the knowledge of the ASHA about the role of VHSC, VHSC fund utilization and the contribution of ASHA in these meetings.

- ***National programmes*** contained information about the different programmes run by the government at the National level.

- ***Transport facility*** basically focused on the types of facilities available and made use of in case referring and accompanying the patient to the health facility.

Once the tool was developed it was translated into Gujarati. It was then pre-tested in the village named Baheli (not a part of the study). The changes that came across were accordingly incorporated and the modified questionnaire was thus formed.

b) For ANMs and MOs

During the process of data collection all the interviewed ANM/FHWs were asked to rank ASHAs under them on the basis of their behaviour, knowledge, awareness, practice, efficiency in service delivery to the beneficiaries, maintaining records and registers, coordination with the ANM/MO and training of ASHAs etc. A ranking list was developed for the ANMs and MOs **(Enclosed in Annexure 1)** based on the nominal scale (*). The type of scale followed was a standard 'Likert scale' (**).They had been asked to rank the ASHAs working in coordination with them on a scale of 1 to 5; wherein 1 means bad, 2 means fair, 3 means average, 4 means good and 5 means very good. Then all the scores were added and a composite variable rank had been prepared.

The ranking was done in the following manner:-

Fig 2: Ranking list

Rank	Description of the attribute
Rank 1	Bad
Rank 2	Fair
Rank 3	Average
Rank 4	Good
Rank 5	Very good

(*) A measurement scale in which numbers are assigned to attributes of objects or classes of objects solely for the purpose of identifying the objects.

(**) The Likert Scale is an ordered, one-dimensional scale from which respondents choose one option that best aligns with their view. There are typically between four and seven options. Five is very common.All options usually have labels, although sometimes only a few are offered and the others are implied.A common form is an assertion, with which the person may agree or disagree to varying degrees.In scoring, numbers are usually assigned to each option (such as 1 to 5).

2.5.2. Qualitative instrument - Qualitative data was collected through indepth interviews of all the ANMs, MOs and Beneficiaries. FGDs were conducted with the VHSC members. Guidelines for the In-depth interviews and FGDs were prepared.

a.) Indepth interview of the ANMs/FHWs and MOs

Indepth interview guidelines where prepared for the indepth interviews with the ANMs and MOs **(Enclosed in Annexure 1).** The major areas of focus in these guidelines are given below:-

- **Background information** of the respondent containing information about the age, educational qualification, caste, marital status and socio-economic status.
- The section on **Coordination meetings** focused on the number of ASHAs working in coordination with the ANMs/FHWs and the MOs, the number of times they meet the ASHAs working in coordination with them and the benefits they feel are of working in coordination with the ASHAs responsible at their SC/PHC respectively.
- The section on **Institutional deliveries, ANC, PNC and Newborn care** focused on the contribution of the ASHAs towards improved institutional care and betterment in the ANC, PNC and Newborn care.
- The next section of **Family Planning** focused on the role of the ASHA in effectively communicating and counseling the eligible couples to adopt the most suitable method of family planning.
- The section of **Immunization** laid stress on the role and impact of the ASHAs in convincing the mothers to get their child to the PHC/SC for complete vaccination coverage.
- The ANMs/FHWs/MOs were then asked about **any problems they faced** till date while working in coordination with the ASHAs and the areas of training where the ASHAs lack knowledge and need training.

b.) In-depth Interview with the beneficiaries

The areas of focus in the indepth interviews of the beneficiaries **(Enclosed Annexure 1)** were:-

- **Background information** of the respondent pertaining to the age, educational qualification, caste, socio-economic status, occupation and years since marriage of the woman and the age, educational qualification and occupation of the husband.
- **Roles and responsibilities** section focused on the number and time of visits made by the ASHAs to the beneficiaries house and the messages imparted at the time of these visits.
- **Birth registration section focused** on the birth certificate of the newborn and the role of ASHA in helping the beneficiary to get one.
- **Health facilities** was a section wherein the beneficiaries were asked about the different health facilities and the type of services available in her vicinity that the ASHA informed her about.
- **Antenatal care** section had questions related to the fact that how did the ASHA come to know about a pregnant woman in her area, activities undertaken by her once she comes to know about it and what messages she imparts to the beneficiary.
- **Postnatal care and newborn care** section laid stress on the number of PNC and Newborn visits the ASHA made and the counseling sessions that are suppose to be followed henceforth.
- **Risk identification** section focused on the messages given to the beneficiary by the ASHAs at the time of counseling sessions or home visit about the various danger signs and complications during pregnancy, at the time of delivery, during PNC period and in case of newborns.
- **Birth spacing** section focused on the counseling given by the ASHA about the different types of family planning methods available.
- **Immunization and Mamta Divas** section had questions related to the activities undertaken during this time and the role of ASHA.
- **Other diseases** section tried to capture the knowledge of the beneficiary about different diseases like malaria, TB, leprosy etc.
- **National programmes** was a section with reference to the knowledge of the beneficiary about Janani Suraksha Yojana and Chiranjivi Yojana.

- **Transport facility** was a section which focused on the type of transport facility the beneficiary made use of in case of emergency.

d.) FGD guidelines with the VHSC members

As a part of the study focus group discussions were conducted with the members of Village Health and Sanitation Committees[1] (VHSCs). The VHSCs consist of 11-13 members inclusive of:-

- Gram Panchayat members from the village
- Frontline health functionaries such as ASHA, AWW, ANM
- Leader of Self Help Group (SHG) and , Community gate keepers

Primarily the FGDs were conducted to solicit the perception of VHSC members regarding the role of ASHAs in:-

- The social mobilization and voicing the health concerns of the community
- Availing and accessing the public health services
- Coordination with various government stakeholders to address the health concerns

Schedule of Focus Group Discussions:

Eight focus groups were conducted in four tribal blocks of Vadodara district as outlined below.

Fig 3: Schedule for Focus Group Discussion

Block	Date	Village
Pavi Jetpur	19/01/2011	Khandiya Amadara
	20/01/2011	Gadh
Chhota Udepur	27/01/2011	Dumali
	23/03/2011	Mandalwa
Kanwat	25/03/2011	Dhaanpur
	25/03/2011	Khaadnibara
Naswadi	22/12/2010	Vashvaani
	22/12/2010	Khambhayata

(*) As decentralizations and community participation have been considered key strategies for making health services effective, the NRHM launched the concept of formation of Village Heath and Sanitation Committees (VHSCs) in all villages.

2.6 Data Processing and Data analysis

2.6.1. Quantitative Instrument:

All the quantitative data related to the ASHAs, ANMs, and MOs was entered into Cs-pro 4.0 version and subsequently converted into the Statistical Package for Social Sciences (SPSS) version 17.0. The analysis and the tabulation plan was done by computing descriptive statistics and compare means according to the type of the variable. The mean (± standard deviation) was computed for continuous variables while categorical variables were assessed by computing frequencies (percent).

2.6.2. Qualitative instrument:

All the qualitative data collected from the different stake holders (ANMs/FHWs, MOs, VHSC members and Beneficiaries) was entered and analyzed through Microsoft office 2007. The frequency tables have been generated and for interpretation. Wherever required graphs have been prepared for better interpretation. The responses have been categories according to the structure of the report into different sections and subsections.

2.7 Quality assurance

Quality assurance was ensured at the time of data entry and analysis by randomly checking the questionnaires being coded and entered into the SPSS software to ensure proper authenticity of the data.

2.8 Ethical clearance

The project structure, framework and the tools used have been closely examined and approved by the CDHO and DPC of the Vadodara district.

Chapter 3

RESULTS AND FINDINGS

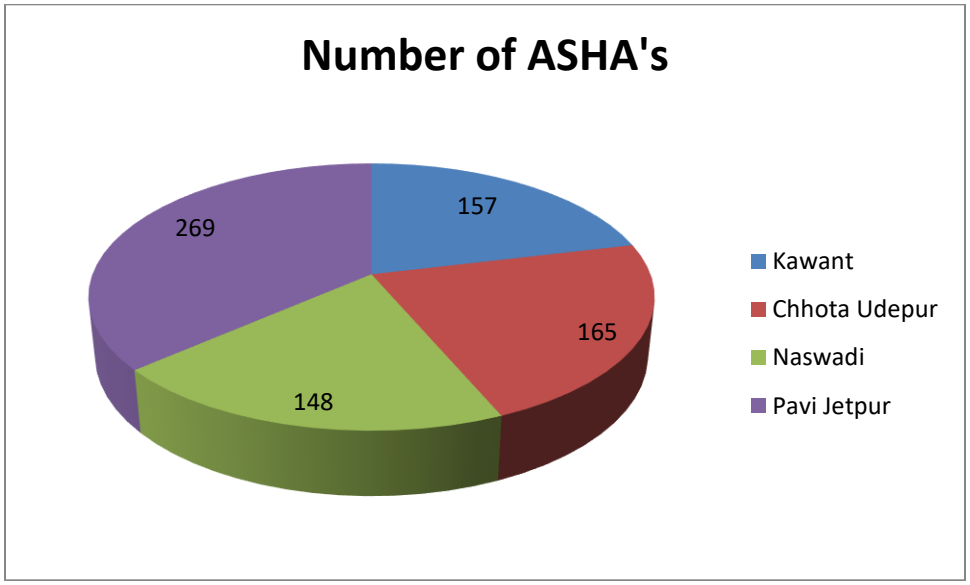
Quantitative data

The data collected through various instruments at block. SC, PHC and village level from the different functionaries like the BHOs, MOs, ANMs, ASHAs, VHSC members and beneficiaries have been analyzed, triangulated and discussed in this chapter. **(Enclosed in Annexure 2)**

1.) ASHA

Background characteristics

Fig 4:



The total sample of the ASHAs in the four blocks comprised of 760. Out of which 157 were in the Kawant block, 165 in Chhota Udepur block, 148 in Naswadi block and 269 in Pavi Jetpur block.

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

In terms of the demographic characteristics firstly the mean age of the ASHAs in the four blocks comes to around 30 years with a range of minimum of 25 years to a maximum of 35 years. It was seen that in case of the marital status around 16 percent of the ASHAs were unmarried, 78

percent of them were currently married and 6 percent of them fell in the others category. This others category in relation to the marital status includes those who are separated, divorcee and widow. The highest percentage of unmarried ASHAs was found to be 27 percent in Naswadi and the highest percentage of ASHAs who were married were in Pavi Jetpur at 82 perecent.

The study of the socio-economic characteristics showed that more than 90 percent of the ASHAs were either SC or ST. Only about nine percent of the ASHAs belonged to the others category with reference to their caste. More than 50 percent of the ASHAs belonged to the APL category, around 40 percent of the ASHAs were in the BPL category and only about 4 percent of them did not have a card.

The average mean of the number of villages under an ASHA showed that it came to around 1.2 with a range of minimum of 1 to a maximum of 2 villages under one ASHA. The mean of the population size covered by the ASHA was around 1549. This varied from block to block. As in case of Kawant the mean of the population covered by the ASHA came to about 1468, in Chhota Udepur it was around 1608, in Naswadi it was around 944 and in Pavi Jetpur it came to about 1639. This shows that the maximum population coverage was in Pavi Jetpur and minimum in Naswadi.

Roles and responsibilities

- When the ASHAs were asked to list down their roles and responsibilities it was found that though most of them were well aware of their roles and responsibilities but there were certain roles and responsibilities which became more prominent as compared to the others.
    1) Around 35 percent of the ASHAs mentioned about the role of knowing about the village people. The main activities undertaken in this are identification of the village people, identification of the pregnant women and also to make regular home visits in the village.

    2) About 20 percent of them have mentioned about their role to help and make the village health action plan wherein their main responsibility is to arrange faliya meeting and to help in arranging VHSC meetings in the village.

    3) About 25 percent of them feel that conducting BCC activities in the village are their major job related role. The main aim of these BCC activities is to bring about effective communication for health behavior change.

    4) Around 15 percent of them mentioned about the linkages the ASHAs have to make with the government officials like the AWW, ANM, TBA and MPHW.

    5) About 40 percent of them feel that counseling is a major component of their work. The ASHAs are supposed to counsel and motivate the beneficiaries on various issues like:-

- ✓ Adolescent health related (to give iron pills to the adolescent girls and to educate them on the importance of having proper balanced nutritious food).
- ✓ Pregnancy and childbirth (to ensure that the pregnant woman has atleast three ANC checkups, 100 IFA tablets, 2 TT injections, deworming tablets, ASHA estimates the date of delivery of the woman and counsels her about the importance of institutional delivery, she also counsels them on the topic of delivery preparedness like to save money, to keep a delivery kit ready etc,).
- ✓ Giving PNC care (she makes PNC visits to the home of the post partum women and counsels her about the importance of PNC checkup and nutrition related issues).
- ✓ Risk identification (she is responsible for the identification of the danger signs during ANC, delivery, PNC and in case of newborns).
- ✓ Child health and nutrition (she makes newborn visits, counsels the mother regarding the importance of colostrums feeding, exclusive breastfeeding for the first six months, cord care, KMC, she advises to keep the baby warm and dry and not to bathe him / her immediately after delivery atleast for a few days and about the importance of vaccionation).
- ✓ Unmet needs of contraception (she counsels them about the importance of family planning, she gives information about the different permanent and temporary methods available).
- ✓ She counsels about the intimate problems (like STIs / AIDs)
- ✓ Counselling about the chronic ailments (like cancer, TB, leprosy)
- ✓ Choosing simple healthcare options (to inform the village people about the health services available, first-aid and about certain basic medicines).
- ✓ To organize health and nutrition day (at this time the ASHA provides snacks to the beneficiaries under the ICDS scheme, she helps the ANM at the SC in taking height and weight of the beneficiaries and she monitors the activities of ICDS in the village).

6) Around 45 percent of the ASHAs have responded that escorting patients to the hospital as their main job role and responsibilities. She accompanies the pregnant woman for ANC checkup, arranges transport facility for them and escorts the patients with any health related issue or in case of delivery to the nearby health facility.

7) Only about one tenth of them have mentioned that they act as primary medical care and depot holders. The ASHA refers the cases of delivery, fever, diarrhea, accident or any other emergency to the nearby health facility as soon as she gets to know about these new cases in her village. ASHAs are not able to act as depot holders because they do not have the medicines kit having a stock of medicines for emergency and primary care.

8) Less than 30 percent of them have mentioned about the maintenance of records and registers. The ASHAs are supposed to register pregnancy, birth, death, adolescent girls, post partum women etc.

- The ASHAs were asked about the activities they undertake for the identification of the pregnant woman in around 40 percent of the responses it was seen that the woman had herslf informed the ASHA about her pregnancy and that she had been missing periods for the past few months. In this case the ASHA used to confirm the pregnancy status of the woman through the Urine Pregnancy Strip and in case the pregnancy is confirmed she also registered the pregnant woman. In about less than 30 percent of the cases the ASHA identified the pregnant woman at the time of her home visit. In about 10 percent of the cases it was seen that the ASHA came to know from other women in the village, in around seven percent of the cases the ANM informed the ASHA about a new pregnant woman in her village and in only about five percent of the cases she came to know about it from the AWW. In less than one percent of the cases the ASHA came to know form the local dai.

Some of the other responses that had come for the activities undertaken for the identification of a pregnant women in the village of the ASHA was when the women has vomiting, feeling of laziness, dizziness, nausea, if she passes urine frequently and when she does not feel like eating food. These responses were received in about 15 percent of the cases.

- In terms of the activities undertaken for ANC care it was seen that around 25 percent of the ASHAs made sure that the registered the pregnant woman within 12-16 weeks of pregnancy. Around 40 percent of them pre informed the beneficiaries about the date, time and place of availability of the ANM either at the SC /AWC. Then then ensured that all these women received all the three ANC checkups comprising of 100 IFA tablets, two TT injections, deworming tablets etc. Also around 25 percent of them ensured that the woman gets all the prerequisite body examinations and investigations done like weight, height, abdominal examination, BP measurement, Hb testing etc.) About 30 percent of them informed the beneficiaries about the importance of proper nutrition, she counseled them to have a proper balanced diet comprising of green leafy vegetables, pulses, milk, iodized salt etc. In almost about half of the responses it was seen that the ASHAs had counseled the woman about the activities to be undertaken for the preparation of the delivery like saving money, keeping the delivery kit ready. In around 20 percent of the cases it was seen that the ASHAs do inform the pregnant women about the nearby health facilities and herself calls 108 as and when needed.

Some of the other responses that had come across are the counseling of the mothers about colostrum feeding, exclusive breastfeeding the newborn and complimentary feeding. There were also responses referring to the efforts made by the ASHAs to track and motivate the dropout cases of ANC, she helps the woman in the JSY registration and to get the JSY incentive. She also asks the woman about her last menstrual period and then accordingly advices the woman about

her expected date of delivery. She also advices the women about the importance of taking rest for atleast one to two hours in the afternoon and to reduce their travelling time.

- With reference to the activities undertaken at the time of delivery it has been found that around 40 percent of the ASHAs said that they inform the pregnant woman and their families about the nearest health facility and advises them to contact to call 108 in case of any emergency. More or less about half of the respondents say that they escort the pregnant woman to the health facility for delivery and also in case of any complication or emergency. About 20 percent of them said that they counseled the women that in case because of any undue circumstances they have to have home delivery then it should only be through a skilled birth attendant and not through the local dai / bhuva. Around 10 percent of them say that they inform the pregnant woman about the five cleans that must be practiced at the time of delivery like clean hands, clean surface, clean new blade, clean cord tie and cord stump. About 20 percent of them have said that they refer the pregnant woman to the nearby health facility in case of any danger sign observed and counsel only for delivery at the PHC / any other private hospital. Around 40 percent of them counseled the beneficiaries about delivery preparedness activities that can be undertaken like preparation of clothes, money etc.

Some of the other responses where that in case of home delivery they advise about the importance and need to keep the place of delivery warm and dry and also that a SBA / ANM / ASHA should be present at the time of delivery so that in case of any complication signs can be managed. In only some of the instances did the ASHA refer to the danger signs at the time of delivery.

- In terms of the activities undertaken for PNC care it was found that around 25 percent of them said that they make visits to the post partum woman within 24 hours, on the third day, seventh day and 28th day. They advised the women to go in for atleast one checkup within two weeks of delivery and subsequently regular PNC checkups by the doctor in the PHC. They also helped the women in registration in the hospital. In about 25 percent of the cases she counseled about the importance of exclusive breastfeeding and the various techniques of breastfeeding the newborn. In less than 25 percent of the cases she counseled the women about the importance of adopting family planning and the various contraceptives that she can make use of during this period. In about 35 percent of the cases she counseled the women about the importance of proper nutrition both for the mother and the newborn. She adviced her about having green leafy vegetables, pulses, non vegetarian foods, frits, iodized salt etc. In about 10 percent of the cases the ASHAs said that they advised the women to visit the ANM in case they observe or have any minor complaints like sore breasts, cracked nipples, foul smelling discharge, excessive pain in legs etc.

Some of the other responses were where the ASHA counseled the women about taking proper rest, importance of maintaining proper hygiene and sanitation, she helped them to obtain the

ICDS snacks from the AWC. She assisted the ANMs at the SC to conduct post natal clinic for the identification of the danger signs of these post partum women.

- In terms of the activities undertaken for newborn care about 15 percent of them said that they make visits to the newborn. About 20 percent of them said that they weigh the child within 24 hours, on the third day and on the seventh day. In less than 20 percent of the cases she counseled the mothers about the importance of KMC, to keep the baby warm and dry, cord care and not to bathe him / her for the first seven days. She also advised the women to wrap their baby in a clean and dry cloth. In about 10 percent of the cases if the ASHA found at the time of recording weight of the child that the baby has low birth weight then in those cases she refers the newborn to the PHC for immediate care and treatment. In 25 percent of the cases she informed the mothers about the importance of immunization. She explained them regarding the importance of having vaccination and also informed them about the various diseases against which the vaccine protects the child. In about 40 percent of the responses the ASHA informed the mothers about the importance of breastfeeding the child as it has a benefit both for the newborn and the mother, she advised them to feed colostrum to the newborn, about exclusive breastfeeding the newborn for the first six months and about the various techniques of breastfeeding. In 25 percent of the cases she explained them about the importance of giving proper complimentary foods to their child and that these should be initiated only after the first 6 months, till then no external food should be given to the child.

Some of the other activities undertaken for newborn care by the ASHA are the registration of the newborns. She also assists and helps the ANMs to carry out the screening of the newborns at risk or with certain visible danger signs at the SC.

- **Important messages that the ASHA provides to the women and others in the family as an educator and counsellor**

About 50 percent of the ASHAs said that they counsel the women about the importance of having institutional deliveries over home deliveries. In about 15 percent of the cases they say that they advise them to have their deliveries through a skilled birth attendant in case of urgency to have home delivery. In about 40 percent of the cases the ASHA motivated the women to go in for regular ANC checkups wherein they can have 100 IFA tablets, two TT injections, deworming tablets, abdominal checkup , BP measurement, recording weight and Hb test. In about 35 percent of the cases she advised them about regular PNC checkup for the maintenance of proper health of the mother and the child. In 15 percent of the cases she advised the mothers about the importance of KMC, cord care, immunization, delaying bath of the newborn for the first seven days and the importance of wrapping the newborn in a clean and dry cloth after birth. In 20 percent of the cases she advised the beneficiaries about the importance of adopting family planning methods. She counseled them about permanent and temporary methods of family

planning. In about 35 percent of the cases she informed them about the importance of having proper nutritious food containing green leafy vegetables, pulses, milk, non-vegetarian food etc.

Some of the other responses that have emerged are informing them about the various ICDS activities, Mamta Divas,the importance of taking proper rest and not to lift heavy objects during pregnancy. She also counseled them about 108 service and that they should immediately contact 108 in case of any emergency.

- **Role played at the PHC / SC**

About 20 percent of the ASHAs say that they help the ANM / FHW / MO to call the beneficaireis to the centre. As soon as they come to know about the new cases of delivery, fever, diarrhea or in case of any other emergency and accident they refer the patients to the PHC / SC for proper line of treatment. ASHA helps the ANM in registration of the beneficiaries. She plays a supporting role with the ANM, said by about 25 percent of the ASHAs. She said that in 40 percent of the cases she helps the ANM / FHW during the Mamta Divas activities. She helps the ANM / FHW in filling the Mamta card. She weighs the beneficiaries and records their height. In 15 percent of the cases she contributes in the disbursement of the JSY money. In 25 percent of the responses it was seen that the ASHA helps the beneficiaries to get medicines and other supplies form the PHC / SC.

*Some of the other responses that have emerged are that they help in filling the MIS register **(by Deepak Foundation)**, assist in case of any help required at the time of delivery and also help for the malaria check-up by testing blood and preparation of slides. These slides are the given to the PHC. They also test water for its portability **(initiative taken by Deepak Foundation)**.*

- **Activities undertaken when the ASHA comes to know about a pregnant woman in the village**

As soon as the ASHA comes to know that there is a pregnant woman in their village in 80 percent of the responses it was found that in order to confirm the pregnancy of the woman she asked the woman about her last menstrual period from which she calculated the expected date of delivery in case the urine pregnancy strip shows the pregnancy test to be positive. In 70 percent of the cases she refers the pregnant woman to the PHC for her checkup by the MO to confirm her pregnancy status.

- **Activities undertaken when the ASHA comes to know about a birth in the village**

When the ASHA comes to know about the birth of the newborn in her village almost half of them at first make a visit to the newborn's house. In around 40 percent of the cases she checks the newborn and in 60 percent of the cases she weighs the newborn. In 20 percent of the cases in

case she finds that the newborn has low birth weight she refers him / her to the nearby health facility. In about 20 percent of the cases she registers the newborn. Around 30 percent of the ASHAs help the mothers to get a birth certificate for their child.

Some of the other activities which were highlighted were distribution of 'Janmakshar' ***(initiative taken by Deepak Foundation')*** *in almost half of the reponses.*

- **Activities undertaken when the ASHA comes to know about maternal death in the village**

As soon as the ASHA comes to know about a maternal death in her village then in 35 percent of the cases she first makes a visit to that woman's home. In 20 percent of the cases she gathers information related to the cause of death of the woman. In 60 percent of the cases she gets the death registered with the ANM / Gram panchayat. In 25 percent of the cases she helps the family to get the death certificate.

Some of the other activities which ca,e into notice were the registration of the maternal death in the MIS register ***(initiative taken by 'Deepak Foundation')*** *in most of the reponses.*

- **Activities undertaken when the ASHA comes to know about infant death in the village**

When the ASHA comes to know about an infant death in 20 percent of the cases she first makes a visit to the newborns home. Then in 15 percent of the responses it was observed she gathered information about the cause of death. In about more than half of the cases she registers the death with the ANM and the Gram panchayat. In about 30 percent of the times she helaps them to get the death cetificate.

In some of the other responses it was seen that the ASHA registers the death in the MIS register ***(initiative taken by 'Deepak Foundation')*** *and she informed about the death at the AWC and gtes it registered there.*

- **Health facilities available at the PHC**

It was seen that when the ASHAs were asked about the helath facilities available in their near vicinity almost all of them could name the SC and PHC in their village. Quite a good number also mentioned about the CHC, CEmONC and the other private health facilities in their area. About 40 percent of them mentioned about the availability of physical infrastructure like proper designated government building available, furniture, bed etc. Only around 8 percent of them mentioned about the support services like regular water supply, regular electricity supply, telephone line in working condition, laboratory, transport facility etc. In about 60 percent of the cases they mentioned about the manpower available like the MO's and ANM's. In around less than 20 percent of the cases the response referred to the availability of the drugs like drugs for

TB (20%), drugs for malaria (18%), anti rabies vaccine (12%) and anti snake venom medicine (8%). In about 50 percent of the cases the respondents said that there was a facility of maternal and child health at the PHC wherein there was a facility of ANC clinic, 24 hours delivery and newborn care. About 35 percent of them said that at the PHC there was a facility of family planning and contraception which included the availability of contraceptives, oral pills and condoms and the option of safe MTP and abortion facility. About 25 percent of them said that there was a facility of vaccination at the PHC. 40 percent of them said that sputum examination for tuberculosis was done. Around 15 percent of them said that at the PHC Hb and urine examination was done. In 5 percent of the cases the PHC was locked.

- **Health facilities available at the SC**

From the responses received it was seen that about 40 percent of them said that at the SC the facility available was physical infrastructure like proper designated government building, furniture, bed, examination table in working condition etc. About 5 percent of them mentioned about the support services available like regular water and electricity supply. About 50 percent of them mentioned about the manpower (ANM/FHW). In 60 percent of the cases they mentioned about the equipments available at the SC like blood pressure apparatus in proper, sterilizer instrument and weighing machine in proper working condition. 10 percent of them mentioned about the facility of delivery being available at the SC. About half of them said that at the SC blood testing was done for malaria. About 60 percent of them said that there was an availability of contraceptives, oral pills and condoms at the SC. About five percent of them said that either the SC facility was not available or the SC was locked.

Some of the other facilities available there are organization of the Anaemia control ***(initiative taken by Deepak Foundation')*** *Nutrition programme. Many of them also mentioned about the Mamta Divas celebrations being carried out at the SC.*

- **Health facilities available at the CHC**

From the response recieved about the health facilities available at the CHC it was seen that about 35 percent of them referred to the physical infrastructures available like the proper designated government buiding, furniture, bed etc. 10 percent of them referred to the support services available like the the regular water and electricity supply. 15 percent of them mentioned about the manpower with special focus on the ANM/ FHW/ MO. About 60 percent of them referred about the 24 hour delivery services available. Around 40 percent of them referred about the essential and emergency obstetric care services. More than half of them said that there were family planning services available at the CHC. Less than 30 percent of them mentioned about the safe abortion services available. About 50 percent of them mentioned about the newborn care services available at the CHC.

Some of the other responses that came to light were the availability of medicines, treatment of malaria, dengue cases and checkup of HIV / AIDS etc.

- **Health facilities available at the CEmONC**

To the facilities available at CEmONC the responses showed that most of them mentioned that delivery takes place at CEmONC. About 60 percent of them said that there was a facility of blood transfusion and blood was available here. Almost half of them responded that at CEmONC facility was available pertaining to the treatment and operation in case a woman is not able to conceive. About 40 percent of them also mentioned about the sonography facility available. About 30 percent of them also referred to the laboratory facility available at the centre.

A brief about CEoMNC

Deepak Medical Foundation started its health-related activities way back in 1981 in Nandesari village, 20 km away from Vadodara. Initially, the activities started in the form of general OPDs. At present, a 15-bedded multispeciality hospital is operational which caters to about 50,000 rural population of nearly 33 surrounding villages. The hospital provides preventive and curative medical services to the local community as well as to the industrial workers. Currently, the hospital is staffed with resident doctors and efficient nursing and paramedical staff. The hospital has a well equipped operational theater, ultrasound machine, labor room and an intensive care unit. Recently a new initiative of the hospital has been CEmONC unit which provides services related to the delivery, newborn care, surgical services and blood transfusion facility to the rural population.

- **Health facility at which the ASHA accompanies the beneficiaries**

It was found that about 60 percent of them accompanied the beneficiaries to the PHC. About half of them accompanied them to the SC. About one fifth of them went wit h the beneficiaries to the CEmONC centre. About 10 percent of them said that in case of any emergency or incase the beneficiary asks for any help the ASHA then accompanies them to the private hospital.

- **Identification of the pregnant women in their area**

When the ASHAs were asked as to how did they come to know whether a woman was pregnant in her area the maximum response was received in the context of the confirmation of the pregnancy through urine pregnancy strip. About 60 percent of them said that they identified whether a woman was pregnant or not by identifying her symptoms like vomiting, nausea, dizziness, if the woman does not feel like eating food etc. About 30 percent of them said that in

case a woman informs the ASHA that she has missed her periods for the past one or two months then the ASHA refers that woman to the PHC so that she can get her checkup done from the MO at the PHC to confirm her pregnancy status.

- **Important messages that ASHA gives to the pregnant woman at the time of visit**

It has been seen that at the time of visit to the pregnant woman 60 percent of the ASSHAs say that they inform the beneficiaries about regular ANC checkups which needs to be done atleast three times. They also counsel them about the importance of having 100 IFA tablets in about 60 percent of the cases. Half of them have said that they inform them about the importance of having institutional deliveries over home deliveries and vaccination. About 40 percent of them have said that they motivate the beneficiaries with regard to the PNC checkup, about the health facilities available in their nearby area and about delivery preparedness (to save money, pack their clothes and keep the delivery kit ready. About 10 to 15 percetn of them also inform the beneficiaries about the importance of having a proper balanced nutritious meal for the proper health status of the mother nad the child.

Some of them have said that they inform the beneficiaries about the incentives obtained under the JSY scheme, not to lifet heavy weights and to take prepoer rest.

- **Issues discussed with the beneficiaries at the time of ANC visit**

It was found that maximum responses were received in this area pertaining to the counseling of the beneficiaries about the importance of institutional delivery over home delivery and that in case she delivers in the hospital the ASHA herself will accompany her to the hospital for delivery. Majority of them also motivated the beneficiaries about the importance of proper nutrition both for the mother nad the newborn like colostrums feeding, exclusive breast feeding, complimentary feeding, proper balanced nutritious diet for the mother etc. about half of them also motivated the beneficiaries about the importance of having atleast three ANC checkups, 100 IFA tablets, delivery preparedness, importance of preparing a clean, dry and warm place for delivery in case of emergency when the mother needs to deliver at home.

Only few of them advised the mothers about the importance of newborn care wherein the baby should be put in close contact with the mothers chest so that the baby gets proper warmth and the body weight of the baby is maintained, in terms of cord care the importance of maintaining hygiene at the time of cord cutting and that nothing should be applied on the corn. Also the baby should not be bathed for the initial few days after birth.

- **Issues discussed with the beneficiaries at the time of Delivery**

About 80 percent of the ASHAs have said that they inform the woman about the importance of breastfeeding the child. They say that they inform the mother about feeding the newborn the first yellow milk – colostrum and she explains them about exclusively breastfeeding the newborn for th first six months. About 40 percent of them have said that they explain the mothers about the different techniques of breastfeeding especially to the first time mothers. About 25 percent of them inform the mothers about KMC, importance of cord care and that not to bathe the newborn initially for the first few days.some of them also inform them about the need of getting a birth certificate for the newborn and may assist them in getting one if they require any help regarding the same.

- **Issues discussed at the time of PNC visit**

Around half of the ASHAs have said that they inform the mothers about the advantage of breastfeeding, colostrum feeding and the various techniques of breastfeeding the newborn. About 20 percent of them advised the mothers about KMC, the need of cord care and not to bathe the newborns for the first seven days. Around 10 percent of them said that they advise the mothers to go I for regular checkups at the PHC/ SC by the MO/ANM. About 15 percent of them have said that they inform the mothers about the different family planning methods that can be used in order to ensure birth spacing. About 40 percent of them advised the mothers about the importance of having a proper balanced and nutritious diet.

Some of the other responses that came out were the advise given by the ASHAs about the need for proper rest and sleep during the day. Also they advised the mothers about the importance of maintaining proper hygiene so as to ensure that proper health of the mother as well as the newborn is maintained.

- **Escorting to the health facility**

Most of the ASHAs accompany the woman for delivery to the nearby health facility. It has been observed that around 80 percent of the ASHAs stay at the facility till the time the baby is delivered and about 70 percent of them leave when the woman is registered at the health facility and taken to the labour room. Around 30 percent of them remain there till the woman is discharged and about 20 percent of them said that they leave the health facility the moment they feel that there assistance may not be required.

The circumstances under which the ASHAs are unable to accompany the beneficiary to the health facility are if the beneficiary has gone out of station (80%), when she is not informed

(50%), if the call comes late at night (40%), family members do not feel the need to inform her (20%) and if she is buzy in some other health activities or meeting (10%) etc.

- **Risk identification**

When the ASHAs were asked to specify the signs they look for to identify a postpartum woman or a newborn at risk the responses received were visibly low aas compared to the other questions asked in the self administered questionnaire. From the responses gathered it was seen that in cas of post partum women the ASHAs referred to high fever (30%), vaginal bleeding (30%), foul smelling vaginal discharge (foul smelling/watery discharge/ leakage) (15%) and pain in the abdomen (25%).

In case of newborns the signs mentioned by the ASHAs were poor sucking or feedinh (40%), difficult/slow/fast breathing (45%), high fever (30%) and baby becomes cold and pale (40%).

- **Other diseases**

a) Anaemia

With reference to anemia when the ASHAs were asked about the symptoms of anaemia they referred to pale skin/fingertips/nails/tongue and breathlessness or fatigue in 50 percent of the responses and breathlessness (15%) and swelling of hands and feet (20%). For the prevention of anaemia the responses received were consumption of green leafy vegetables, milk and milk products and iron rich foods in 80% of the cases and only about 15% of them referred to the IFA tablets.

b) TB

Some of the major symptoms of TB that have come across from the ASHAs point of view are persistent cough lasting for 3 or more weeks especially with sputum (70%),weight loss and low grade fever during evening (60%) and about half of them mentioned about loss of appetite. For the prevention of TB around 45 percent of them referred about DOTS. About 30 percent of them said about blood test and only about 25 percent of them mentioned about sputum test.

c) Malaria

In case of the question pertaining to Malaria only some of the ASHAs had actually attempted this question. Among those who had attempted when asked about the symptoms of malaria they mentioned about the causes of malaria like through mosquito bites, uncovered hands and legs etc. Only 20 percent of them had mentioned about just one symptom and that too about high fever and chills.

d) Leprosy

Similarly, as observed for malaria the responses received were very few. The ASHAs were unable to recollect the symptoms of leprosy. Among the responses received only about 40 percent of them mentioned about the white patches on the skin and 20 percent of them referred to the numbness of the patches and the redness of these patches.

❖ **Village Health and Sanitation Committee**

Most of the ASHAs attended these meetings once a month (80%), about 10 percent of them attended twice a month and the rest attended the meetings according to their convenience and as and when they get time.

It was seen that most of the ASHs were members of the VHSCs. Majority of them were aware of the role of VHSC like to create awareness in the village about the available health services and their entitlements (60%), to develop a village health plan based on the assessment of the situation and the priorities of the community (75%), to analyze the key issues and problems pertaining to the village level health (80%) and to maintain village health register and health information board and calendar (10%).

The VHSC funds were utilized in various areas like health facility and equipments, hygiene and sanitation, emergency transportation and preparedness for any natural calamity and IEC material (board etc.).

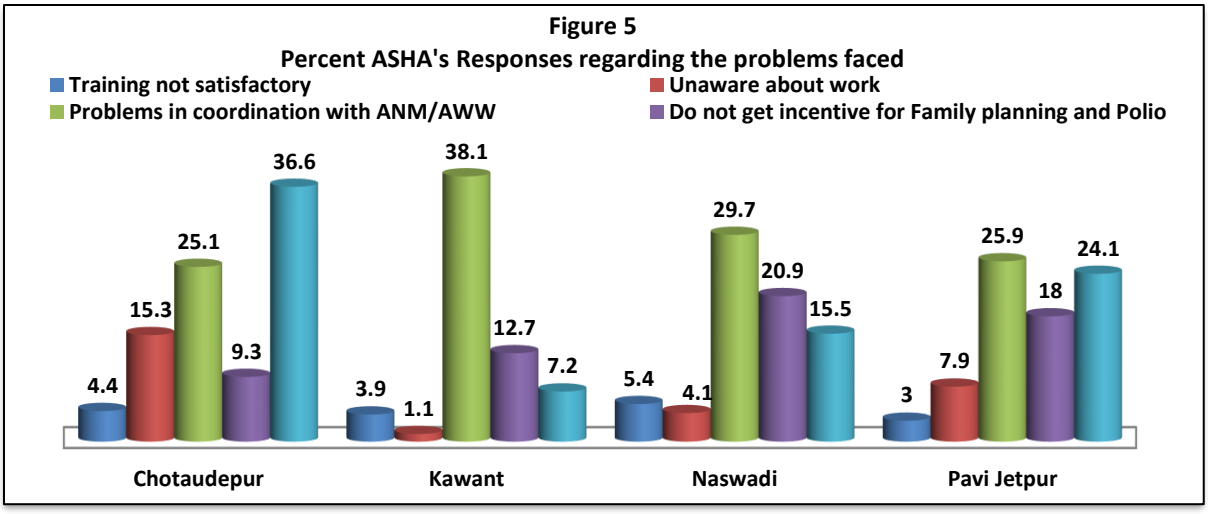
❖ **Role in JSY and Chiranjivi Yojana**

The basic role that the ASHA plays in JSY and Chiranjivi Yojana which has come into light is the identification of the beneficiary mostly after delivery and getting her registered under the JSY or Chiranjivi Yojana. She prepares her card and submits it to the ANM/FHW. The incentive is then received by the woman directly from the ANM/FHW or in certain cases the NA.FHW herself hands it over to the ASHA so that she can distribute it to the beneficiary at the time of her visit in the village.

❖ **Problems faced by ASHA**

The responses regarding various problems encountered by ASHAs were also captured. The major problem that they faced was that they were not getting their incentives either at right time or in right amount and coordination with ANM and AWW. In all the four blocks there is an observed lack of coordination with the ANM/AWW. In Chhota Udepur more than one-thirds (36.6%) of ASHAs felt that they did not get regular incentives followed by Pavi Jetpur (24.1%),

Naswadi (15.5%) and Kawant (7.2%). Though the intensity of the problem is low but 21 percent of the ASHA's in Naswadi complained they have not received incentives for Family planning and Polio followed by Pavi Jetpur (18%), Kawant (12.7%) and Chotaudepur (9.3%). It is also evident that about two in every 10 (15.3%) ASHA's are unaware about their work in Chota



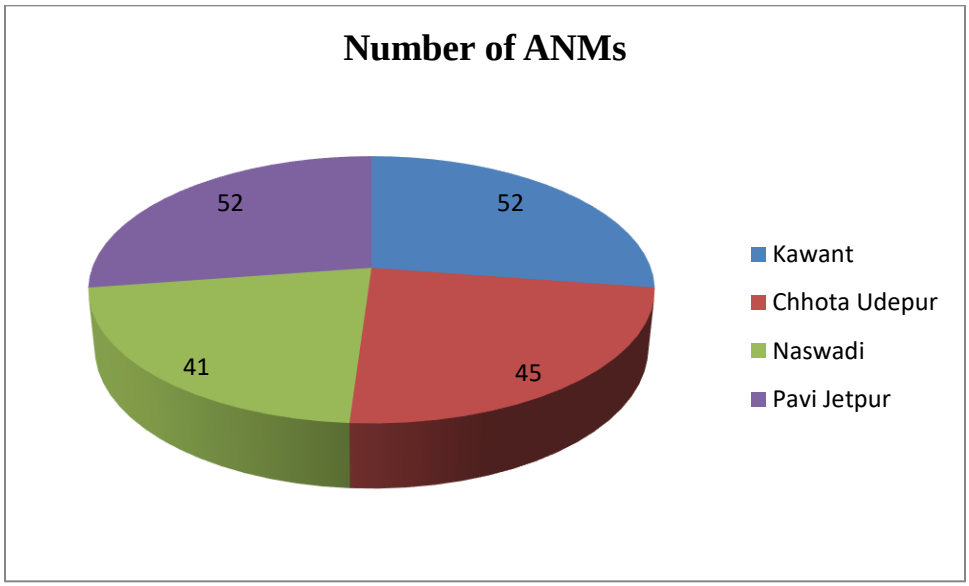
Udaipur followed by Pavi Jetpur (7.9%), Naswadi (4.1%) and Kawant (1.1%).

2.) ANM

- **Background information**

The sample size of the ANMs was 190. Out of which 52 were from Kawant, 45 were from Chhota Udepur, 41were from Naswadi and 52 were from Pavi Jetpur block, as represented in the figure given below.

Fig 6:



Study of the background characteristics of the ANMs has show that the mean age in completed years of the ANMs is 39 which ranges from a minimum of 19 and maximum of 56. It has been seen that around 50 percent of the ANMs were upto class 10^{th} pass, 34 percent of them were 12^{th} pass and only about 15 percent of them were graduates. Only about two percent of them were post-graduates and that too in Chhota Udepur and Pavi Jetpur block. Around 52 percent of the ANMs were STs, 22 percent of them were SCs and about 25 percent of them fall in the others category. Majority of the ANMs (80%) were married, 14 percent of them were unmarried and around six percent of them fall in the others category; which includes the ones that are separated, divorced or widow. More than 80 percent of them fall in the bracket of APL and only about nine percent of them belong to the household in the BPL category and 11 percent of them are the ones who do not have the card. The mean of the duration of the stay (in years) of the ANM at the SC comes to around nine years. In Kawant it is around nine years, in Chhota Udepur eight years,

Naswadi eight years and in Pavi Jetpur it is about 10 years. The mean of the population size covered by the ANMs comes to around 4042 with a range of minimum 1500 and maximum 7891. The minimun size of the population was covered at 1500 in Naswadi and maximum of 7891 in Chhota Udepur. The mean of the number of households covered by the ANMs is 562 with a range of minimum 225 and maximum of 1200. Comparing the four blocks the minimum number of households were covered in Kawant at 225 and maximum in Pavi Jetpur at 1200. The mean of the number of ASHAs working in coordination with the ANMs comes to around four with a range of three as minimum and seven as maximum.

- **Ranking of ASHAs as per ANMs**

The findings of these rankings showed that;

- In terms of the overall behaviour of the ASHAs it was found that around 44 percent of them were good, 25 percent of them were average, 22 percent of them were very good, seven percent of them were fair and only four percent of them found to be were bad. Blockwise it was seen that the highest bad ranking was 11 percent was for Naswadi and nill for Chhota Udepur. In terms of highest rank of very good it was found to be with Pavi jetpur at 29 percent and lowest at 17 percent with Chhota Udepur. With reference to the behaviour at the SC 40 percent of them were good, 31 percent of them were very good, 19 percent of them were average, seven percent of them were found to be fair and three percernt of them were bad. The highest rank for very good behaviour at the SC was in Pavi Jetpur at 40 percent and the highest rank in bad category was in Naswadi at 11 percent. With the view of the behaviour of the ASHA with the ANM it was seen that 39 percent of them were very good, 38 percent of them were good, 15 percent of them were average, four percent of them were fair and bad each. The highest rank order of very good category was in Pavi Jetpur at around 50 percent and the highest rank of bad category was in Naswadi at 10 percent. With reference to the category of behaviour of the ASHAs with the beneficiaries it was found that 40 percent of them were very good, 35 percent of them were good, 17 percent of them were of the average category, four percent of them were in the fair and bad category each. The highest rank of very good behaviour with the beneficiaries was in Pavi jetpur at 50 percent and highest for the bad category was in Naswadi at 9.6 percent.

- The next category being the knowledge it was seen that the ranking of the ASHA's overall knowledge showed that 40 percent of the ASHAs were good, 35 percent of them were average, 12 percent were very good, nine percent were fair and five percent of them fall in the category of bad. The highest rank for the very good category was in Pavi Jetpur at 15 percent and lowest in Naswadi at eight percent. The highest rank of the bad category was in Naswadi at 13 percent and nill in Chhota Udepur. With reference to the knowledge about the roles and responsibilities as an ASHA it was seen that 38 percent of them were good, 33 percent of them were very good, 20 percent of them were average, six percent were fair and three percent of them were of the bad category. The highest rank order of very good was in Pavi Jetpur at 37 percent and similarly highest rank order of the

bad category was in Naswadi at 10 percent. With the next category being the knowledge about the facilities at the SC it was found that 36 percent of the ASHAs fall in the good category, 31 percent of them were in the very good category, 22 percent of them were average, six percent of them were fair and five percent of them were bad. Blockwise it was seen that the highest rank of the very good category was in Pavi Jetpur and highest for the bad category was Naswadi at 12 percent. From the next category being knowledge about the ANC care it was found that 35 percent of the ASHAs were very good, 35 percent of them were good, 20 percent were average, seven percent were fair and three percent of them were bad. On the whole it was found that in comparison to the other blocks the highest rank order for the very good category was in Pavi Jetpur and for bad category it was in Naswadi at 11 percent. In terms of knowledge about the care at the time of delivery 33 percent of them were good, 32 percent of them were very good, 24 percent of them were average, seven percent of them were of the fair category and four percent of them were bad. The highest rank of very good was found in Pavi Jetpur at 40 percent and similarly 12 percent for Naswadi. With the knowledge about PNC care it was found that 35 percent of the ASHAs were good, 30 percent of them were very good, 23 percent were average, nine percent were fair and four percent were bad. Comparing it blockwise it was seen that the highest rank order for the very good category was in Pavi Jetpur at 37 percent and similarly for bad category it was highest in Naswadi. From the next category being knowledge about family planning it was seen that 32 percent of them were very good, 29 percent were good, 22 percent of them were average, 12 percent were of the fair category and five percent of them were bad. Moving on to the knowledge about immunization it was seen that 48 percent of them were very good, 29 percent were good, 14 percent were average, 5 percent were fair and 4 percent were bad. In comparison to all the four blocks it was seen that the highest rank for very good category was in Pavi Jetpur at 60 percent and similarly for the bad category it was 11percent.

- In terms of the category of awareness it was seen that in totality 35 percent of the ASHAs fall in the good category, 34 percent of them were average, 13 percent were very good, 12 percent of them were fair and six percent of them were bad. Comparing the four blocks it was found that the highest percentage of ASHAs in the very good category was 18 percent and lowest was 10 percent. The highest rank order of the bad category was in Naswadi at 16 percent and nill in Chhota Udepur. With reference to the specific category of the awareness of the ASHAs about the identification of the beneficiaries it was seen that 38 percent of them were very good, 34 percent of them were good, 18 percent of them were average, six percent were fair and four percent were bad. Comapring the four blocks it was found that the highest rank order for the very good category was in Pavi Jetpur at 50 percent and similarly for Naswadi at 11 percent. Moving on to the awareness about the risk identification of the pregnant women it was found that 38 percent of them were very good, 34 percent of them were good, 18 percent were average, six percent were fair and three percent were bad. Overall it was found that the highest percentage of the ASHAs in the very good category was in Kawant at 38 percent

and similarly 15 percent in Naswadi. In the next category of the awareness of the ASHAs about the risk identification of the post partum women it was seen that 36 percent of them were good, 30 percent were very good, 19 percent were average, 12 percent were fair and three percent were of the bad category. In terms of blockwise comparison the highest very good rank was seen in Kawant at 31 percent and highest in bad category was in Naswadi at 15 percent. With the next category of the awareness of the risk identification of the newborn it was seen that 32 percent of them were of the of the good category, 29 percent of them were average, 23 percent were very good, 10 percent were fair and 6 percent were bad. In terms of blockwise comparison highest percentage of the very good category was in Pavi Jetpur at 31 percent and highest for the bad category was in Naswadi at 15 percent.

- With the study of the next category of practice it was found that 37 percent of them were good, 36 percent were very good, 17 percent were average, 6 percent were fair and 4 percent were bad. Comparing it blockwise it was found that in the rank order of very good highest was 44 percent in Pavi Jetpur and lowest of 26 percent in Chhota Udepur. In terms of the rank of bad it was highest at 11 percent in Naswadi and nill in Chhota Udepur.

- Moving to the next category of efficiency in service delivery to the beneficiaries it was found that 36 percent of them were good, 31 percent of them were very good, 22 percent of them were average, seven percent of them were fair and four percent of them were bad. In terms of blockwise comparison the highest in the rank of very good was for Pavi Jetpur at 44 percent and lowest in Chhota Udepur at 26 percent. For the category of the rank order bad it was highest at 11 percent in Naswadi and nill in Chhota Udepur.

- In the category of maintaining records and registers 36 percent of them were good, 32 percent of them were very god, 19 percent were average, nine percent of them were fair and four percent of them were bad. The highest percentage of the ASHAs in the very good category was in Pavi Jetpur at 41 percent and lowest of 26 percent in Naswadi. Similary, for the bad category it was highest at 10 percent in Naswadi and lowest of 0.9 percent in Pavi Jetpur.

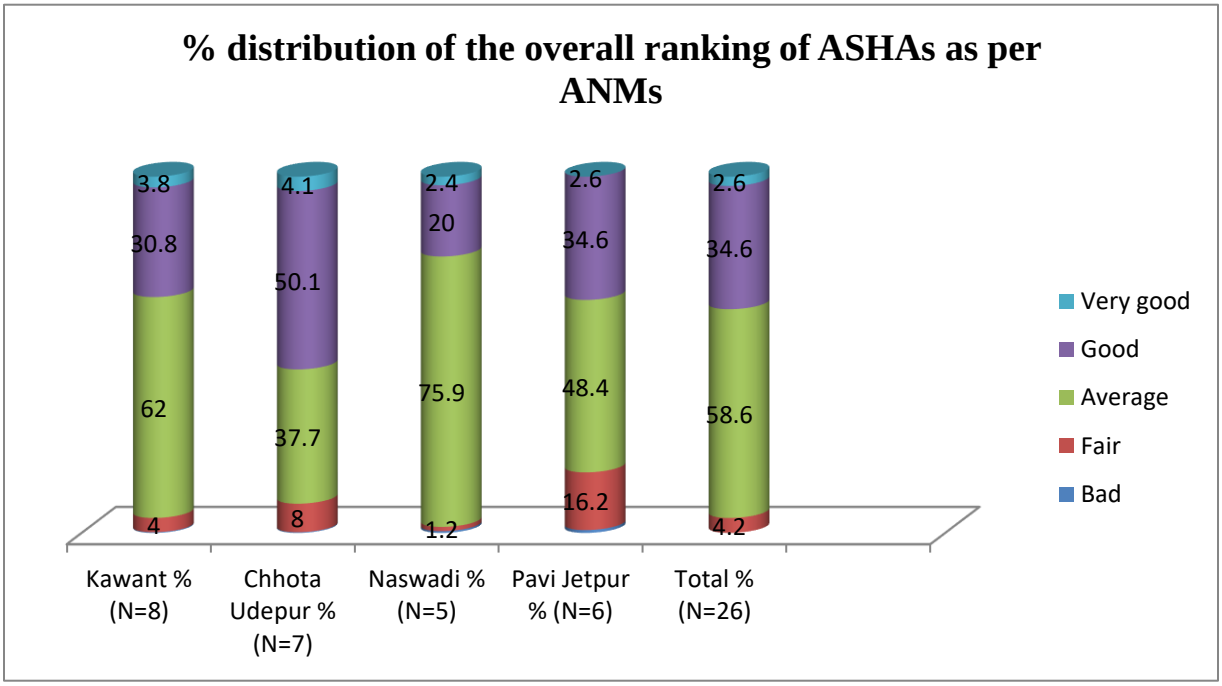
- From the category of the coordination with the ANM it was seen that 42 percent of them were very good, 33 percent of them were good, 19 percent of them were average, four percent of them were bad and three percent of them were fair. In terms of blockwise comparison the highest percentage of ASHAs in the very good rank were in Pavi Jetpur at 60 percent and lowest in Chhota Udepur at 28 percent. Similarly, in terms of the bad category it was found to be highest in Naswadi at 10 percent and nill in Chhota Udepur.

- Moving on to the category of the training of the ASHAs it was seen from the results that 37 percent of them were very good, 34 percent of them were good, 19 percent were average, five percent of them were in the fair and bad category each.

In terms of blockwise comparison highest percentage of ASHAs in the very good category were in Pavi Jetpur at 46 percent and lowest of 23 percent in Naswadi. In terms of the bad category it was seen that it was highest in Naswadi at 14 percent and lowest of 0.5 percent in Chhota Udepur.

From the figure 4 given below it can be seen that the overall ranking of the ASHAs as per the ANMs shows that maximum of the ASHAs (59%) are in the average category. About 35 percent of them are in the good category. About four percent of them are bad. Around three percent of them are very good. None of them fall in the bad category in the opinion of the ANMs.

Fig 7:

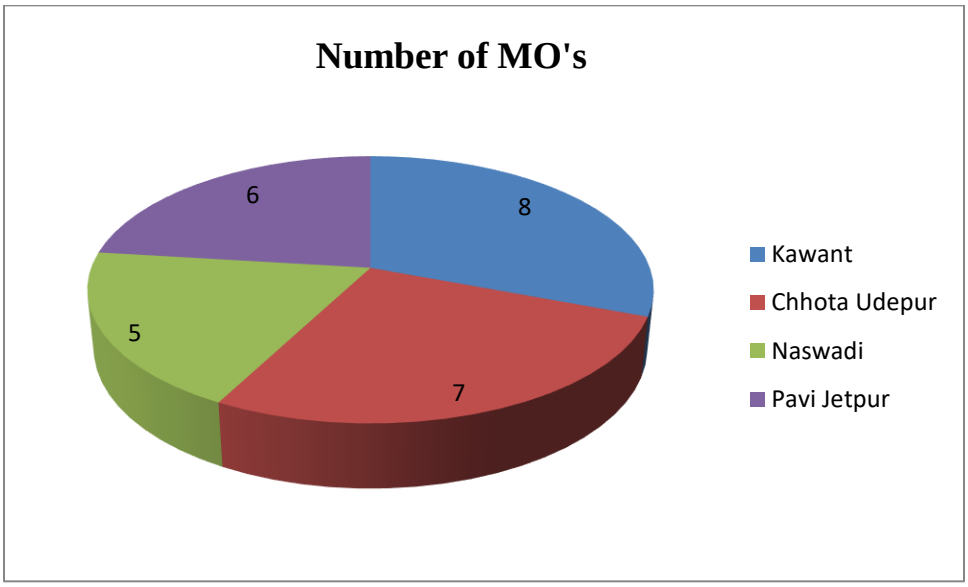


3.) MO's

- **Background information**

The sample size of the MOs was 26. Out of which 8 were from Kawant, 7 from Chhota Udepur, 5 were from Naswadi and 6 were from Pavi Jetpur block, as represented in the figure given below.

Fig 8:



Study of the background characteristics of the MOs has show that the mean age in completed years of the MOs is 32 which ranges from a minimum of 24 and to a maximum of 58. In terms of educational qualification 58 percent of them were MBBS, 27 percent of them were BAMS and 15 percent BHMS. It was found that there was no BAMS doctor in Naswadi and in Pavi Jetpur there was no BHMS doctor. In terms of the caste around 58 percent of the MOs fall in the others category, 31 percent of them were found to be in the ST category and only 12 percent were in the SC category. Majority of the MOs (76.9%) were married and only 23 percent of them were unmarried. Around 96 percent of the MOs fall in the category of APL and only four percent in the category of BPL and that too in Chhota Udepur. The mean of the duration of stay in the PHC as an MO (in years) comes to around 23. In Kawant, Chhota Udepur and Naswadi it came to around two years and in Pavi Jetpur it is about three years. The mean of the number of ASHAs

working in coordination with the MOs comes to around 23 with a range of 10 as minimum and 29 as maximum.

- **Ranking list of the ASHAs as per the MO's**

Like the ANMs the MOs were also asked to rank the ASHA. The findings of these ranking scales shows the results that follow;

- In terms of the overall behaviour of the ASHAs it was found that around 39 percent of them were good, 31 percent of them were in the average and very good category and none of them were in the fair or bad category. Blockwise it was seen that the highest rank of very good it was in Pavi Jetpur at 67 percent and none of the ASHAs fell in the category of very good in Chhota Udepur. With reference to the behaviour at the PHC 39 percent of the ASHAs fell in both the good and very good category, 23 percent of them were found to be fair and none were in the category of fair and bad. The highest rank of very good behaviour at the PHC was in Pavi Jetpur at 67 percent. With the view of the behaviour of the ASHA with the MO it was seen that 46 percent of them were very good, 42 percent of them were good, 12 percent of them were average and nill in the category of fair and bad. The highest rank order of very good category was in Pavi Jetpur at around 67 percent. With reference to the category of behaviour of the ASHAs with the beneficiaries it was found that 42 percent of them were very good, 39 percent of them were good, 15 percent of them were of the average category, four percent of them were fair and none of them fell in the bad category. The highest rank of very good behaviour with the beneficiaries was in Pavi jetpur at 67 percent.

- The next category being the knowledge it was seen that the findings of the overall ranking of the ASHA's knowledge it showed that half of them were in the average category, 46 percent of them were good, four percent of them were very good. None of them were either fair or bad. The highest rank for the very good category was in Pavi Jetpur at 17 percent. With reference to the knowledge about the roles and responsibilities as an ASHA it was seen that 46 percent of them were good, 39 percent of them were average, 15 percent of them were very good and nill in the fair and bad category. The highest rank order of very good category was in Chhota Udepur at 29 percent. With the next category being the knowledge about the facilities available at the PHC it was found that 54 percent of the ASHAs fall in the good category, 23 percent of them fall in both the average and very good category, none of them fall in the fair or bad category. Blockwise it was seen that the highest rank of the very good category was in Naswadi at 60 percent. From the next category being knowledge about the ANC care it was found that 62 percent of the ASHAs were good, 19 percent of them were very good, 15 percent of them were average, four percent were fair and nill in the bad category. On the whole it was found that in comparison to the other blocks the highest rank order for the very good category was in Chhota Udepur at 43 percent. In terms of knowledge about the care at the time of delivery 39 percent of them were in the average category, 35 percent of them were good, 27 percent of them were very good and none of them

were in the fair and bad category. The highest rank of very good category was found in Kawant at 38 percent. In the knowledge about PNC care it was found that 39 percent of the ASHAs were in the average category, 35 percent were in the good category, 27 percent were very good and none of them fell in the fair or bad category. Comparing it blockwise it was seen that the highest rank order for the very good category was in Naswadi at 40 percent. From the next category on knowledge about family planning it was seen that 39 percent of them were very good, 31 percent were good, 23 percent of them were average, eight percent were of the fair category and none of them fell in the bad category. Moving on to the knowledge about immunization it was seen that half of them were good, 27 percent were very good, 23 percent were average and none of them were in the category of fair and bad. In comparison to all the four blocks it was seen that the highest rank for very good category was in Pavi Jetpur at 50 percent.

- In terms of the category of awareness it was seen that in totality 46 percent of the ASHAs fall in the good category, 39 percent of them were in the average category, 12 percent were very of the fair category, four percent were very good and none of them were in the bad category. Comparing the four blocks it was found that the highest percentage of ASHAs in the very good category was 17 percent in Pavi Jetpur. With reference to the specific category of the awareness of the ASHAs about the identification of the beneficiaries it was seen that 42 percent of them were good, 39 percent of them were very good, 19 percent of them were of the average category and none of them were in the fair or bad category. Comparing the four blocks it was found that the highest rank order for the very good category was in Pavi Jetpur at 50 percent. Moving on to the category on the awareness about the risk identification of the pregnant women it was found that 39 percent of them were good, 31percent of them were average, 23 percent were very good, eight percent of them were fair and none of them were in the bad category. Overall it was found that the highest percentage of the ASHAs in the very good category was in Chhota Udepur at 43 percent. In the next category of the awareness of the ASHAs about the risk identification of the post partum women it was seen that half of them were in the average category, 39 percent were good, eight percent were very good, four percent were in the fair category and none of them were bad. In terms of the blockwise comparison the highest very good rank was seen in Pavi Jetpur at around 17 percent. With the next category on the awareness of the risk identification of the newborn it was seen that 39 percent of them were of the good category, 35 percent of them were in the average category, 15 percent were in the fair category, eight percent were very good and four percent were bad. In terms of blockwise comparison highest percentage of the very good category was in Pavi Jetpur at 17 percent and highest for the bad category was in Naswadi at 20 percent.

- With the study of the next category of practice it was found that 58 percent of them were good, 19 percent of them were in the very good and average category each, four percent were bad and none of them fell in the fair category. Comparing it blockwise it was found that in the rank order of very good category was highest in

Pavi Jetpur at 33 percent and lowest at 13 percent in Kawant. In terms of the bad category it was highest at 20 percent in Naswadi.

- Moving to the next category of efficiency in service delivery to the beneficiaries it was found that 54 percent of them were good, 19 percent of them were in the very good and average category each, eight percent of them were in the fair category and none of them were in the bad category. In terms of blockwise comparison the highest in the rank of very good was for Pavi Jetpur at 33 percent and lowest in Kawant at 13 percent.

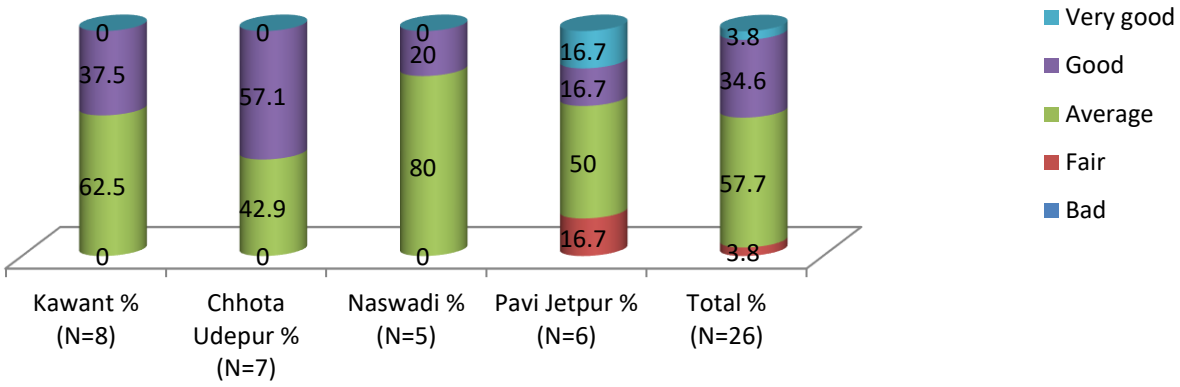
- In the category of maintaining records and registers 62 percent of them were good, 23 percent of them were in the average category, eight percent of them were of very good category and four percent of them were in the fair and bad category each. The highest percentage of the ASHAs in the very good as well as the bad category was in Pavi Jetpur and Naswadi block at 17 percent respectively.

- From the category of the coordination with the MO it was seen that 58 percent of them were in the good category, 31 percent of them were very good, eight percent of them were average, four percent of them were fair and none of them fell in the bad category. In terms of blockwise comparison the highest percentage of ASHAs in the very good rank were in Chhota Udepur at 43 percent and lowest in Kawant at 13percent.

- Moving on to the category of the training of the ASHAs it was seen from the results that half of them were in the good category, 27 percent of them were in the average category, 19 percent were very good, four percent were bad and none of them were in the fair category. In terms of blockwise comparison the highest percentage of ASHAs in the very good category was in Pavi Jetpur at 33 percent and nill in Naswadi. In terms of the bad category it was seen that it was highest in Pavi Jetpur at 17 percent.

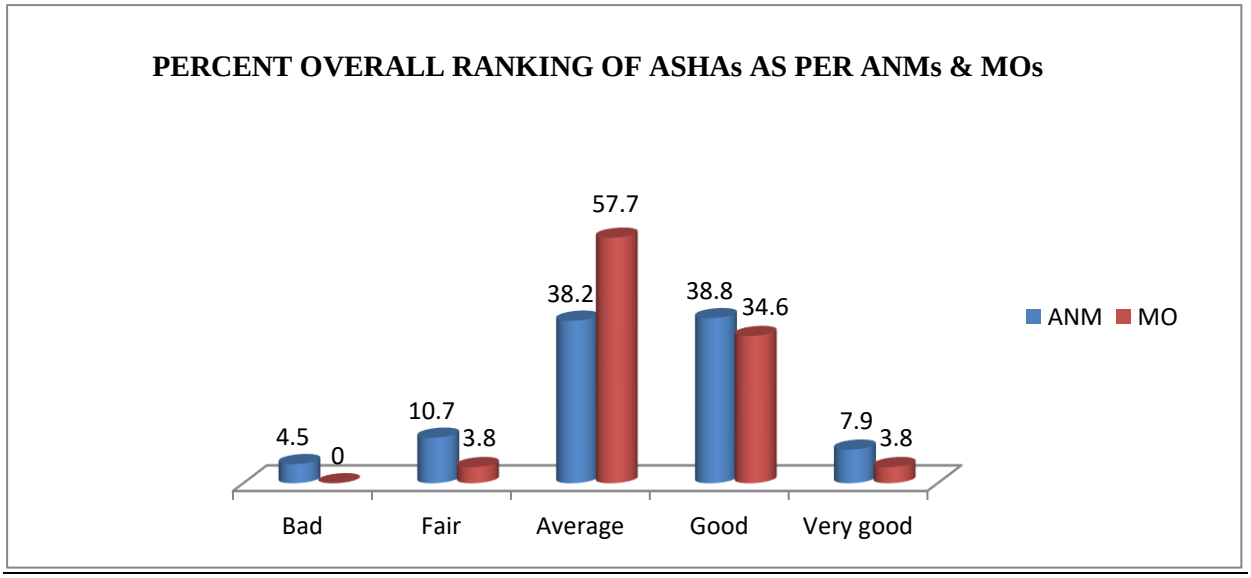
As seen from the figure given below the overall ranking by the MO's of the ASHAs shows that majority of the ASHAs fall in the average category with around 58 percent. Around 35 percent of the ASHAs are good. About four percent of the ASHAs fall in the fair and very good category. According to the MO's none of them fall in the bad category.

fig 9
Percent distribution of the overall ranking of ASHAs as per MOs



COMPARISON OF THE RANKING OF THE ASHAs AS PER ANMs & MOs

*As can be seen from the graph in **fig 10** given below showing the comparison of the ranking scales by the MO's and ANM's it can be said that according to the MO's maximum percentage of the ASHAs fall in the average category and according to the ANM's maximum are in the good category. According to the MO's none of the ASHAs fall in the bad category while around five percent of the ANM's do feel that the ASHAs fall in the bad category.*



Qualitative analysis

a.) ANMs / FHWs

- **Coordination meetings**

❖ During the indepth interviews with the ANMs / FHWs it was found that all most all of them (98.2%) meet the ASHAs for coordination meetings. It was seen that on an average each ANM / FHW meets the ASHAs working under them around four times a month. This varied from a minimum of one to a maximum of more than five times a month. While comparing the four blocks it was seen that the mean of the number of coordination meetings varied from three times in Kawant, two times in Chhota Udepur, three times in Naswadi and four times in Pavi Jetpur. On an average it was seen that the number of ASHAs working in coordination with the ANMs were around 7; with a minimum of 2 and a maximum of 7. In all the four blocks the average mean of the number of ASHAs under them ranged between 3 to 4.

❖ Almost all the ANMs / FHWs (96.8 %) are of the opinion that there are benefits of having coordination meetings with the ASHAs. Almost half of them feel that one of the biggest advantage of having these meetings is their easy access to the information given by the ASHA related to the new developments in the village. She informs them about the new cases of fever, diarrhea, delivery, ANC, family planning etc. Based on these information the ANM can register the problem, examine the patient and then subsequently can refer them to the PHC for a suitable and apt line of treatment. Around one fourth of them feel that these meetings are the most suitable time to assess the ASHAs monthly progress report and review her work in the past month. Subsequently during these meetings the ASHA informs the ANM / FHW about the different problems she has been facing on the field related to the work issues, problem in motivating and counseling the beneficiaries or even service delivery to the beneficiaries. Once these problems come out in the open efforts are taken by the ANM/FHW to address to these problems, assess the gaps or loopholes and provide a most suitable solution for the same. During these meetings around one sixth of them said that they give trainings to the ASHAs with the focus to strengthen their job related roles and responsibilities. Also almost one sixth of them feel that during these meetings they can pass on the information related to ANC and PNC care to the ASHAs. About one fifth of them say that during this time they train the ASHAs about the different aspects of family planning; with special focus on how to motivate and counsel the eligible couples to adopt the most suitable family planning methods. About one tenth of them are of the opinion that during these meetings they give the ASHAs information pertaining to TB and Leprosy. Also around one sixth of them have said that they take this time of the coordination meetings to inform the ASHAs about the new programmes and initiatives taken up by the government, the information of which the ANM / FHW receives during PHC / Block level meeting.

- **Institutional deliveries, ANC, PNC and Newborn care**

❖ All the ANMs / FHWs have said that ASHAs have a role to play in case of institutional deliveries, ANC & PNC care and newborn care. More than half of them have said that they refer the pregnant and post partum woman to the PHC and also accompanies the pregnant woman to the PHC for delivery. Almost half of them also said that the ASHA makes it a point to call 108 as soon as she comes to know that a woman is having labour pains and also in case of any other emergency, accident case etc. In the opinion of about half of the ANMs / FHWs the ASHA makes regular ANC and PNC visits to the woman's house. One fourth of them have agreed that during the time of home visits the ASHAs they discuss about ANC care components like IFA tablets, TT injections, medicines, importance of nutrition for the mother and newborn and the elements of newborn care like KMC, importance of cord care, immunization (different vaccines available), breastfeeding, colostrums feeding and complimentary feeding. One seventh of them say that the ASHAs have a role to play in the identification of the beneficiaries and motivates them for institutional deliveries. Some of the other benefits that have come across are that she identifies, counsels and refers the children in grade three to the PHC, she helps in the identification and referral of the LBW babies, she helps in filling and disbursement of the JSY incentives.

- **Family planning**

❖ Almost all of the ANMs / FHWs feel that the ASHAs have a positive role to play in family planning. Only some of the ANMs / FHWs in Kawant, Naswadi and Pavi Jetpur block feel that the ASHAs do not contribute much in the field of family planning. More than half of the ANMs / FHWs are of the opinion that ASHAs keep a record of the beneficiaries for family planning. They register all the eligible couples who need to be counseled and motivated to adopt the different family planning methods. She counsels them about the different permanent , temporary methods of family planning and the importance of birth spacing with their disadvantage being negative effect on the health and nutrition of the mother and the newborn, LBW baby and complications during pregnancy. At the time of visit the ASHAs explain to the newly married woman or women with no child to go in for oral contraceptives like Mala-D, Nirodh etc. In case of woman with one child she counsels the woman for Copper-T insertion. Women with more than two children she counsels them to go in for sterilization operation. Also more than one third of them have said that accompanies the beneficiary to the health facility to avail family planning services. This component of accompanying the beneficiaries to the helath facility was found to be highest in Naswadi (96%) and lowest in Kawant (20%).

❖ Maximum number of ANMs / FHWs have voiced their opinion on the fact that though the ASHA has knowledge about the family planning methods but there is a lot of resistance on the part of the community towards family planning. One of the major component which receives a lot of negative or no response from the communities side is the insertion of Copper-T. They say that community does not understand the importance

and use of Copper-T insertion. They fear that this will cause pain, bleeding, can get displaced from its position or will remain inside the body forever. Due to these reasons motivating the women for Copper-T insertion becomes very difficult. Also there has been a trend seen that once a woman in a village gets ready for Copper-T insertion others also seeing her will fall in line. People in these tribal blocks agree much more easily for sterilization operation but much lot of efforts go in to motivate them for Copper-t insertion. They reason as to why should they go for this as after 2 or 3 children they can go for operation. Due to these reasons ANMs / FHWs voiced their concern that though the ASHAs have about average knowledge base with reference to the different family planning methods that can be adopted but still they need to get much more knowledge about Copper-T insertion so that they can motivate and counsel the women much more easily and effectively with a much more positive response. Also they have said that it is only the females who take part in family planning and not the males. As in these communities they feel that family planning is the responsibility of the woman and the man is only responsible to earn money. He fears that as he has to work in the farms everyday and has long working hours with the operation his effectivity and output in work might decrease. Thus, sterilization operation of the males and motivation for condoms is seen rarely.

- **Immunization**

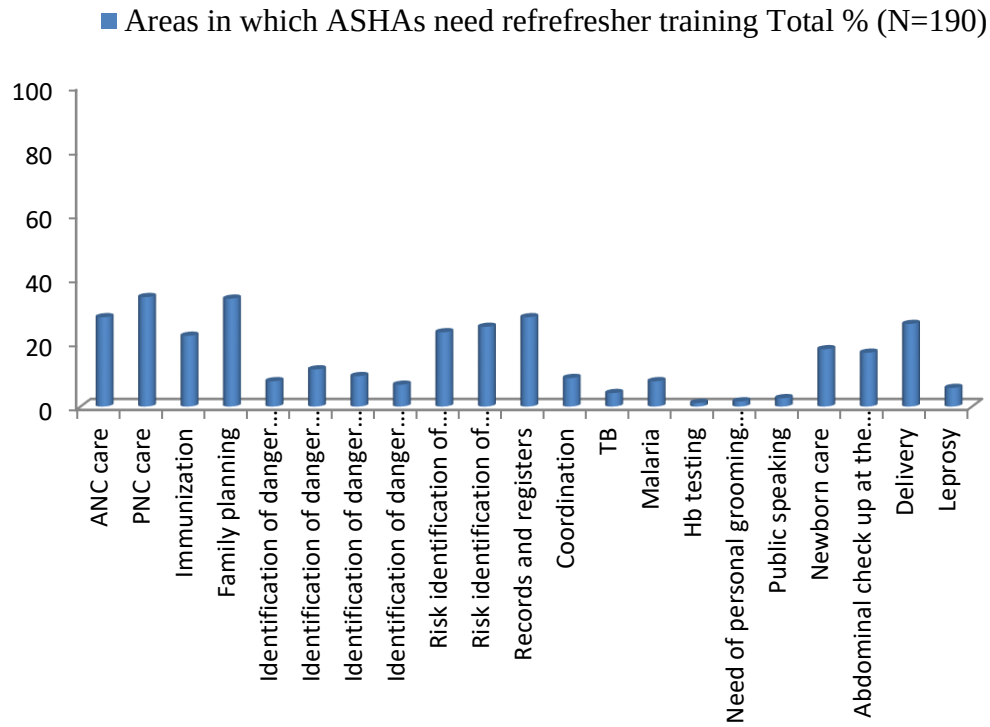
❖ Almost all of the ANMs /FHWs feel that ASHAs do contribute positively in ensuring complete immunization of the child. Only a handful of them in Naswadi, Kawant and Pavi Jetpur are of the opinion that the ASHAs don't contribute much regarding immunization. More than three fifth of them have said that the ANMs / FHWs inform the ASHAs about the immunization day / Mamta divas. The ASHA has a list of all the beneficiaries. Once the day of the immunization session is fixed she pre-informs all the beneficiaries about the session so as to ensure that all the beneficiaries who need to be vaccinated are present on the day of the session and do not go to some other place etc. On the day of the session the beneficiaries who do not show up she goes to their homes and call them to the SC / AWC so as to ensure proper follow-up of the cases and also that there is not chances of missing dose or drop-out cases. At the SC / AWC or at the time of home visit she motivates and counsels the pregnant women, mothers of the children to be vaccinated and adolescent girls about the importance of vaccination and the different diseases against which these vaccines protect. More than one third of them have said that the ASHAs take the weight and height of the beneficiaries. More than four fifth of agree to the fact that the ASHAs help in registering the beneficiaries and helps them in filling the Mamta card. Around one sixth of them said that she does the gradation of the child depending on their height and weight and comparing it with the gradation chart. Alost around one fifth of them agreed that ASHAs play a supporting role with the ANM.

- **Problems faced while working in coordination with the ASHAs**

❖ Most of the ANMs / FHWs have said that they do not face any problems while working in coordination with the ASHAs but still there are around one sixth of them who have said that they do face some problems while working with the ASHAs. Some of the most striking problems that have come across are that the ASHAs do not coordinate properly with the ANMs / FHWs and they do not receive the calls. At the time of meetings and session they do not report to the SC / AWC on time and delay in calling the beneficiaries to the centre due to which the timing of the session becomes much longer then what it is supposed to be. Also on the day of the session she does not stay at the centre till the time she is supposed to stay instead leaves it before time. She does not help the ANM / FHW to get the information of the village due to which there are time when the ANM / FHW does not come to know about the new cases of fever, diarrhea, delivery and other diseases in the village on time. The ASHA also does not maintain proper records and registers and ultimately goes in for false reporting of the cases; which the ANM / FHW comes to know at the time of home visits.

❖ **Refresher trainings**

% Areas in which ASHAs need refrefresher training according to the ANMs /FHWs (Fig 11:)



Almost all the ANMs/FHWs feel that the ASHAs need refresher trainings in different components. As cen be seen from the figure given above around two fourth of them feel that they need training in ANC care, PNC care, Risk identification of pregnant women and newborns. Around one fifth of them feel that the ASHAs require training in the field of knowledge of delivery, immunization, family planning and identification of the danger signs of pregnancy, at the time of delivery, in post partum women and newborns. A handful of the ANMs/FHWs have agreed that the ASHAs do require training in TB, Malaraia and Hb testing. Some of them also feel that a training in how to maintain proper coordination is very essential for them. There have been certain other strikingly different opinions wherein the ANMs/FHWs have said that the ASHAs should be given training in personal grooming, how to boostup their confidence levels, how to keep themselves self-motivated and on public speaking. These areas were highlighted as the ANMs / FHWs feel that as the educational qualification of the ASHAs is comparitively lesser than their expected roles and responsibilities because of which they are not a bit shy at time especially when talking about the topics of family planning and in case of VHSC meetings when she as a voice of the villagers when she needs to voice the issues of concern she is not able to put forward her areas of concern very confidently as she does feel intimidated in the presence of people with a higher post and designation than her. Also interestingly it has been seen that more than one fifth of them have said that there at times that 108 is not able to reach in the interior areas and on hill tops , in which case the woman needs to be brought down on a stretcher to the ambulance which becomes difficult as the woman is in labour and the distance is large and also in these areas there is a problem of communication due to this reason the ASHAs should be given certain primary training on the delivery especially on the abdominal checkup of the pregnant woman at the time of labour pains.

3.) MO

ANALYSIS OF IN-DEPTH INTERVIEW WITH THE MO'S

- **Coordination meetings**

❖ Almost all the MO's meet the ASHAs working in coordination with them. Almost all the MO's (90.4%) meet the ASHAs working in coordination with them once a month, at the time of the sector meeting / monthly meeting at the PHC. About one tenth of the MO's meet the ASHA's two to three times a month. The rest of the one tenth of the MO's said that they meet the ASHA's around three to five times a month during their field visit in their respective villages. Some of the MO's have also said that they call the ASHA's randomly at any time of the month so as to review their work and to give them any important message related to counseling or follow-up of the beneficiaries. Almost all of the MO's have found the coordination meetings with the ASHAs to be beneficial. Some of the most prominent benefits that have been highlighted in the In-depth Interviews are to review the work of the ASHAs and to subsequently assess their monthly reports, to identify their problems and to provide solutions for the same. As the MO's cannot reach all the villages they acknowledge that with the coming in of the ASHAs their work has

become easier. ASHA being a local resident o the village she can immediately identify and refer the cases of fever, diarrhoea etc to the PHC/SC or any primary treatment. As compared to the earlier times when a MPHW / ANM /FHW could reach their respective villages only two times a month, now their reach has increased. The MO's rely on these coordination meetings to get information from the ASHAs about the new developments in the village about the new cases of fever, delivery, diarrhoea etc. During these meetings trainings are given to the ASHAs about the ANC / PNC / TB / Leprosy / Family planning/ certain new programmes or initiatives emerged during the block level meetings and trainings etc. Also discussion about the target achievement in relation to the Immunization, Family planning, ANC, PNC etc is a major area of concern at this time. Some of the other benefits that have come across are the preparation of the incentive sheets of the ASHAs to make them aware about the new diseases or epidemic in their area. The rest one tenth of the MO's are of the opinion that there is no benefit of these coordination meetings as the ASHAs do not come to attend these meetings so there is a low contact between the MO's and the ASHAs due to which the information that had to be passed on to them is not possible.

- **Institutional deliveries, ANC & PNC care and newborn care**

❖ All the MO's feel that these meetings are helpful in improving institutional deliveries, ANC & PNC care of the mothers and newborn care. They acknowledge the fact that the ASHAs have a significant role to play in it. According to them ASHAs play a supporting role with the ANM / FHW. As soon as they come to know a woman is having labour pains she refers the pregnant woman to the PHC, calls 108 and accompanies her to the PHC. In cases where 108 cannot reach due to the difficult terrain or due to the lack of communication in very interior / remote areas; she refers her to have her delivery by a SBA with proper care with respect to the hygiene and not by the local Dai / Bhuva. She also refers all the high risk cases of pregnancy / Post partum woman / newborns to the PHC. She counsels and motivates all the pregnant women to come for regular ANC checkup (100 IFA tablets, 2 TT injections etc.) at the SC. She also makes home visits to the post partum women. She counsels the mothers about different attributes of newborn care like KMC, cord care, not bathing the newborn for the initial 7 days, importance of immunization, exclusive breastfeeding, colostrum feeding etc. The basic problem that has been felt by the MOs is the lower knowledge levels of the ASHAs about the risk identification of pregnancy, post partum women and newborns. Due to this reason they are not able to identify and refer the mothers and newborns at high risk to the PHC on time; leading to higher maternal and infant mortality rate.

- **Family planning**

❖ Around four fifth of the MO's believe that ASHAs have around 60 percent to 70 percent role to play in the promotion of family planning. The ASHAs are provided with a list of eligible couples. At the time of their home visit they counsel them about the importance of adopting family planning and birth spacing. They counsel the beneficiaries about the different permanent and temporary methods of family planning. They advice the newly

married couple to adopt temporary methods like Mala-D, Nirodh, Oral pills etc. in case of couples with one child the mother can go in for IUCD insertion. Couples having two or more than two children can go in for sterilization. Certain problems have been observed in relation to family planning especially in these tribal areas. Firstly, there is hardly any male participation seen in family planning. In these tribal areas it is said that it is the duty of the females to go in for sterilization operation as the men are too buzy in their faming job and the operation will cause them pain and hamper the effectivity of their work. Secondly, Copper-T insertion is one major area where there is hardly any positive response from the community. This is because there is resistance on the part of the community as they believe that the insertion of Copper-T will cause bleeding, pain and will move up at the time heavy work activities. A general trend has been noticed by the MO's that once a woman gets the IUCD insertion done in a village seeing her others might show interest in going in for Copper-T insertion. According to the MO's ASHAs lack the proper knowledge about the importance of Copper-T insertion because of which at the time of their home visits they are not able to properly convince and motivate the women for it. Also, in case of family planning targets are given to ANM, MPHW AWW and ASHAs. Problem occurs in cases where the identification and motivation for adopting family planning methods is done by the ASHA but if the ANM / AWW / MPHW registers this beneficiary first at the PHC then, the ASHA does not receive any incentive.

- **Immunization**

❖ All the MO's agreed to that ASHAs are effective in influencing mothers for complete immunization of the child. They are provided with a list of beneficiaries (pregnant women, infants and adolescent girls). They are in regular touch with the ANMs. Once the date of the immunization day /Mamta Divas has been decided the ASHA pre informs all the beneficiaries about it. She counsels the mothers about the importance of vaccination. On the day of Mamta Divas she calls all the beneficiaries from their homes and records their weight. She plays a supporting role with the ANM and helps her in registration and filling in the Mamta card. About one fifth of the MO's said that the ASHAs also do the grading of the children on the basis of their weight and height.

- **Problems faced by the MOs while working in coordination with the ASHAs**

❖ Almost four fifth of the MO's said that they do not face any problems while working in coordination with the ASHAs. The rest one fifth of them agreed that they do face certain problems. The different problems that have emerged out of these interviews are that:-

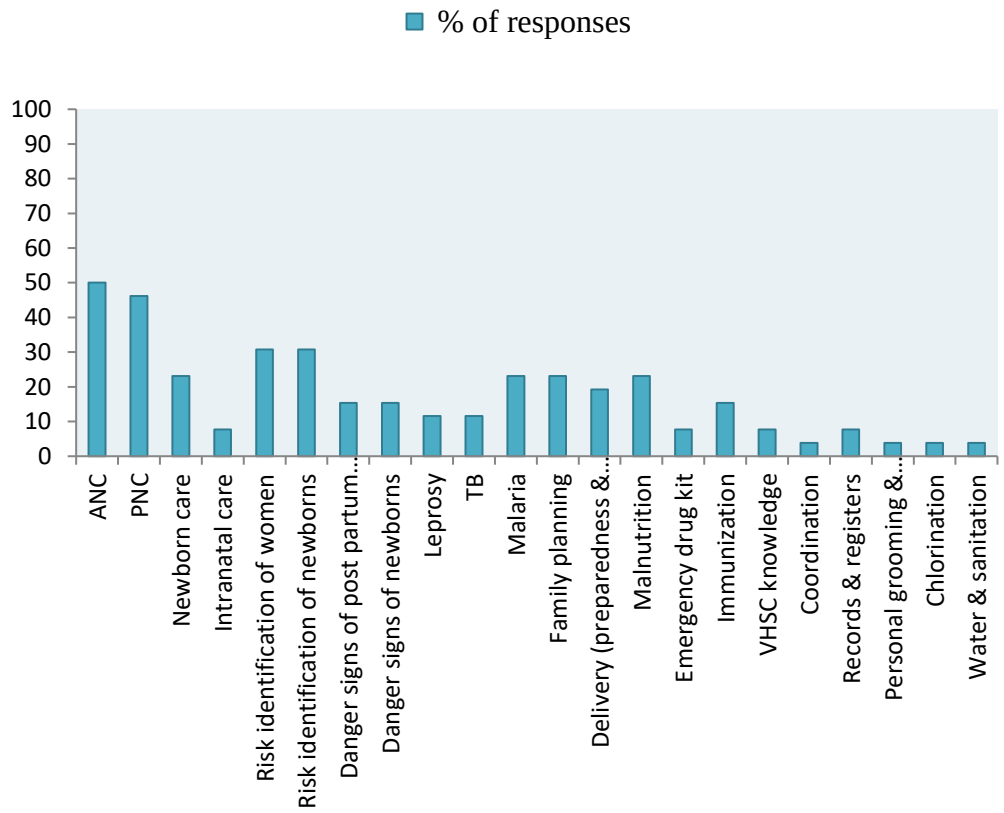
- The ASHAs are not regular
- They do not attend the PHC meetings on time
- They do not maintain their incentive diaries properly which creates a problem at the time of their salary payment calculation, due to the barrier of low coverage network and lack of transportation communication does become a barrier as they cannot contact the

ASHAs directly instead have to pass on the information to the ANM and then have to depend on them for the delivery of message to the ASHA

- Due to their low educational levels they are not able to understand and communicate well the right messages at the right time with the community due to which the targets of the PHC are not met.

- **Refresher trainings**

% Areas in which ASHAs need trianing according to the MOs (Fig 12:)



- All the MO's believe that ASHAs require more training to improve their effectivity and efficiency. With reference to the figure given above it can be said that some of the major areas needing training that have been agreed upon by more than half of the MOs are ANC care, PNC care, Risk identification of the pregnant women, Risk identification of post partum women, Risk identification of newborns. Around one fourth of them said that the ASHAs need trainings in case of Malnutrition, Newborn care, Family planning and Malaria. About less than one fourth of them agreed that training for ASHAs is required in case of Delivery; here delivery refers to both delivery preparedness and the importance of

the need to counsel about institutional deliveries. Less than one fifth of them felt that the ASHAs need of training about the knowledge of the Danger signs of post partum women and newborn, Immunization, Leprosy and TB. Some of the other components that have come to light are need for training in intranatal care, records and registers, coordination, water and sanitation, emergency drug kit, chlorination and the need for personal grooming and to boost up their confidence levels.

❖ **Focussed Group Discussion with the VHSC members**

As a part of the study focus group discussions were conducted with the members of Village Health and Sanitation Committees[2] (VHSCs). The VHSCs consist of 11-13 members inclusive of:

- Gram Panchayat members from the village
- Frontline health functionaries such as Accredited Social Health Activist (ASHA), Anganwadi Worker, Auxiliary Nurse Midwife (ANM)
- Leader of Self Help Group (SHG) and , community gate keepers

Primarily the FGDs were conducted to solicit the perception of VHSC members regarding the role of ASHAs in:

- The social mobilization and voicing the health concerns of the community
- Availing and accessing the public health services
- Coordination with various government stakeholders to address the health concerns

[2] As decentralizations and community participation have been considered key strategies for making health services effective, the NRHM launched the concept of formation of Village Heath and Sanitation Committees (VHSCs) in all villages.

Demographics:

The each focus group was consisting of 8-10 participants from VHSCs. Seventy-two VHSC representatives participated in the focus groups out of which around two third were male participants. A third of the total participants had no formal education. More than half of them were associated with the agriculture. The detailed participant profile is attached as annexure-I.

Highlights of Findings:

The following findings are from a series of eight (8) focus groups conducted with members of the VHSCs of four tribal blocks of Vadodara district.

The discussion was initiated by soliciting the VHSC members' views regarding the health and sanitation condition of their villages. They were asked about the prevalence of generic health and sanitation problems of their villages.

I. Prevalent Health & Sanitation Problems of the Village:

There was widespread similarity in all groups when asked about the major health and sanitation problems of their villages. The common responses were related to:

- The prevalence of anemia, diarrhea, malaria, vomiting, fever, TB, and diabetes.
- The lack of toilet facility, water, cleanliness and hygiene, and health awareness.
- The distance between the health facility and the village, and
- Irregular visits of Auxiliary Nurse Midwives (ANMs)

In context of the prevalent health issues and concerns, the discussion was followed where the participants were asked to list down the functions of ASHAs.

II. Functions of ASHAs as Perceived by VHSCs:

ASHA is a health activist in the community who creates awareness on health and its social determinants and mobilizes the community towards the existing local health services. She is a promoter of good health practices. She also provides a minimum package of curative care as appropriate and feasible for that level and makes timely referrals. During the discussion, the participants were asked to list the roles of ASHAs. Her roles and responsibilities as perceived by the representatives of VHSC were as follows:

- Providing immunization services
- Accompany pregnant women to hospital for delivery
- Providing mother & child care information to pregnant & nursing women through home visits & during 'Mamta Clinics'(Maternal & Child health clinics)
- Arranging emergency transport (108)

- Attending VHSC meetings and helping to sort out the health and sanitation issues of village with VHSC
- Measures the weight of mother and infants
- Referring high risk mothers and children to hospital
- Helping people to get the benefit of JSY[3] & CY[4]
- Attending 'Mamta Day' & Birthday celebration at AWC
- Testing the quality of drinking Water[5]
- Providing primary medical care for minor ailments such as diarrhoea, fevers, and first aid for minor injuries

After the listing of responsibilities, the discussion was further carried out by asking the group that apart from the listed tasks, what all other tasks an ASHA should perform.

In response to that all participants appreciated the role of ASHA and her contribution in the village, however, some of the participants (2 out of 8 groups) raised concerns about the ability of ASHA in comprehending the problem of hygiene and sanitation of the village. They expressed that ASHA should conduct *faliya* (cluster) meetings with the use of appropriate examples.

One group also reported that some of the ASHAs are not equipped with the thorough knowledge about the existing government health schemes and benefits, the group was of the opinion that ASHA should have detailed knowledge about the schemes, benefits, and the procedures so that the community can maximum avail the timely benefits.

The participants were also asked that have they found any improvement in their villages because of ASHAs presence. In response to that, all the groups were in same opinion.

[3] 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, by the Hon'ble Prime Minister, is being implemented in all states and UTs with special focus on low performing states.

[4] The Chiranjeevi Yojana **(CY)** implemented by the Government of Gujarat aims at encouraging the BPL families to improve access to institutional delivery. This is done by providing financial protection to these families and covering their out-of-pocket costs incurred on travel to reach the healthcare facility.

[5] ASHA has been trained and provided with the water testing kit by Water and Sanitation Management Organization (WASMO). It is a facilitating organization working towards drinking water security and habitat improvement by empowering communities to manage their local water sources, drinking water supply and environmental sanitation.

III. Perceived Improvements in Health Services due to ASHAs' Performance:

There was agreement in all groups that ASHAs have contributed significantly in improvement of their villages is, in fact, she is important and because of her, changes took place in their villages related to:

a) Maternal and Child health
   a. High risk identification & referral
   b. Improved immunization
   c. Increased institutional deliveries
   d. Reduction in infant and maternal mortality
b) Government Health Service Delivery
   a. Awareness and accessibility of DOTS[6]
   b. Accessibility of emergency transport facility
   c. Awareness and access of JSY & CY
   d. Regular visits by ANMs

> *"pehla nurse gaam ma niyamit aavta nahota, pan ASHA bahen ne kaarne have niyamit aave chhe ane rasikaran thaay chhe" ("*Earlier Nurse was not visiting the village regularly, but with the ASHA's efforts she has started visiting the village regularly and now regular immunization is carried out.") **: VHSC participant from Pavi Jetpur Block**

c) Change in Knowledge, Attitude & Practice
   a. Improved health awareness
   b. Started trusting the medicines
   c. Acceptance of family planning methods

IV. Perceived Role in Providing Integrated Health Services:

When asked about ASHA's integration with others, all groups have appreciated her integration with various stakeholders like, PRIs, ANMs, AWWs, local traditional birth attendants (TBAs) and VHSCs. As perceived by participants, she also coordinates to sort out health and sanitation issues of the communities.

[6] The WHO-recommended Directly Observed Treatment, Short Course (DOTS) strategy was launched formally as Revised National TB Control programme in India in 1997 after pilot testing from 1993-1996. Since then DOTS has been widely advocated and successfully applied. DOTS is the most effective strategy available for controlling TB.

The discussion was further taken ahead with the challenges and difficulties faced by ASHAs as perceived by the participants.

V. Challenges and Difficulties Faced by ASHA as Perceived by VHSC Members:

The main challenges/ difficulties perceived across all groups were:

- **Presence at the time of Delivery:**
  Accompanying pregnant women for the delivery was served as the main responsibility of ASHA. To fulfill this responsibility, sometime ASHA has to be remained present with the patient 24x7, and this creates issues in her married and social life, reported by most of the groups.
- **Updated Knowledge and Information:**
  Sometime lack of knowledge about the subject matter creates challenge for her, as bought out by one group.
- **Massive Coverage:**
  One group mentioned that it is difficult for ASHAs to ensure continuum of care of all ANC, PNC and infants of the village such as immunization, checkups, weight monitoring and other nutrition and health care services. There are several *faliyas* (clusters) (about 10-15) in the village. It is difficult for ASHA alone to ensure that beneficiaries of all these *faliyas* (clusters) take all the necessary health and nutrition services.

> *"Amara gam ma toh amara falia ni javabdari VHSC member ni hoy chhe ke beheno ane balako seva leva aave…balwadi par"* (In our village, a VHSC member is responsible for ensuring that women and children of beneficiaries of that *faliyas* (clusters) take the services at the *anganwadi*): **VHSC participant from Chhota Udepur Block**

One group also mentioned that ASHA is not able to make the required home visits PNC women and infants especially during the 42 days post delivery. When probed about the reason behind the same, they mentioned that at a time there are 20-25 women and infants or even more in the village dispersed in various *faliyas* (clusters). Considering her other responsibilities related to ANC and intra-partum care, she is not able to pay the necessary attention.

> *"ASHA ben ekala pohchi na vale badhi behanone and balako ne, VHSC sabhyo ane temni gharwali madad thi behanone and balako ne salah suchan ane sarvar leva mate saath sangat apay"* (ASHA alone is not able to reach all women and children, VHSC members and their wives should help in giving necessary advise and accompany/support for referral): **VHSC participant from Chhota Udepur Block**

- **Incentives:**
  Incentives is always a motivational factor especially when it comes to the providing services to the community, thus, delay in giving incentives and inadequate incentives results in compliance the functioning of ASHA.
- **Community Support:**
  Rigid customs and non compliance to advice, and scattered settlements were also pointed out as barriers in role of ASHA as change agent. Sometimes it becomes difficult for her to explain the *'uneducated'* who don't listen to her health advice.

> *"Raat na 2 vaagye pan suvavad maate javu pade tyare bechari ne gharwala and saasu nu sambhadavu pan pade…. ("*The poor lady has to accompany the pregnant women at 2:00 a.m. also for delivery, which makes her listen taunts from Husband and Mother In-Law.") **: VHSC participant from Pavi Jetpur Block**

The discussion was further preceded with the suggestions of the participants to improve the performance of ASHAs.

VI. Suggestions to Improve ASHA's Performance:

Many participants (3 out of 8 groups) acknowledged the need for timely paid incentives for the improved performance of ASHA. Training has a positive impact on the performance of ASHA, thus, she should be provided with the timely training.

One group suggested that, VHSC member should take the responsibility of their faliyas (clusters) and ensure that the beneficiaries take the services especially on Nutrition-Health Days and other days when ANM visits the village.

They also suggested that women VHSC members and wives of male VHSC members to be involved in ensuring PNC and infant care. VHSC members to support in identification of at risk mothers and infants and support in their referral as done for delivery

Another group recommended that *'the local NGO (Deepak Foundation)'* [7]should monitor the activities of ASHA so that she consciously keeps improving herself. A few of the participants (2 out of 8 groups) also suggested that ASHA should have stock of basic medicines ready with her so that people don't have to go to PHCs for the general illnesses.

"kaamgiri ghani saari chhe, pan jo samayantare taalim malti rahe to vadu saari kaamgiri kari shake chhe. Ane taalim saathe saathe jo Deepak dwara emnu monitoring thatu rahe to ghana saara parinaam aavi shake chhe …."("The work is very good; however timely trainings will enhance their work. If Deepak Foundation keeps monitoring her activities that will also result in much better results can be achieved."): **VHSC participant from Naswadi Block**

d.) <u>Indepth Interview with the beneficiaries</u>

- **Background characteristics**

The beneficiaries chosen for the interview were four pregnant women and four post partum women one from each of the block in both the cases. It was found that the mean age of the beneficiaries came to around 25. Out of these eight beneficiaries four of them could not read or write, two of them studied upto class class 5th, one of them was 8th pass and one was graduate. Four fifth of the beneficiaries were of the ST caste and the rest of them were SC. In terms of the socio-economic status depending upon the availability of the card it was found that half of them were belonged to the APL category and half of them were in the BPL category. The mean of the number of years since marriage came to around four years. There were two beneficiaries whose years since marriage was less than one year. The mean of the average age of their husbands were found to be 28 years with a range of minimum of 25 and a maximum of 37. The educational status of their husbands came as upto 8th class for one third of the cases, for the rest of one third it was found that they were upto 12th class pass and the rest one third included men who were graduate and who could not either read or write. Majority if the beneficiaries work in their farms during the day and during the rest of the day do the household chores. Some of them also do tailoring business and the work at their own grocery shops besides their daily household activities. Only two of the beneficiaries were housewives. The mean of the number of live births of these women came to around two, that of the still births was 3 and in case of miscarriages it was 1. None of these beneficiaries had an abortion. Out of these eight beneficiaries two of them were not aware of the name of the ASHAs in their village.

- **Roles and responsibilities**

When asked to whether the ASHAs made a visit to their homes at the time of ANC, delivery or during PNC period it was found that majority of them agreed that the ASHA made them a visit except one. The mean of the number of times an ASHA made an ANC visit was 2 times, for visits at the time of delivery it was one time and in case of visits at the time of PNC period it came to around 2 times. The messages which were given to the beneficiaries at the time of home visit were delivery preparedness, nutrition and immunization.

❖ **Birth and Death registration**

In all the cases of the beneficiaries they said that the ASHA had guided them as to where and when to get the birth and death certificate. In case the beneficiaries faced certain problems or were unable to somehow get the certificate the ASHAs in these cases helped and assisted them to get the certificate. All of them gad got their certificates from the 'Talati' or the Gram Panchayat.

❖ **Health facilities**

In terms of the knowledge of the beneficiaries about the different health facilities available in their vicinity the beneficiaries could identify and relate with the SCs, PHCs and private hospital in their village. The facilities they were aware of were that the doctor sits at the centre and treats the fever, diarrhoea and cases and does operation.

- **Antenatal care**

When asked about as to how did the ASHA come to know that the woman was pregnant it was seen that in three fifth of the respondents they had themselves informed ASHA about that they had missed their periods for the last month or for the last few months. In the rest two fifth of the cases the ASHA came to know either from the AWW / ANM / she herself came to know at the time of home visit. As soon as the ASHA came to know about the pregnancy of the woman she confirmed the pregnancy of the woman through a urine pregnancy strip (UPT) or in certain cases she also referred them to the PHC. The issues discussed by the ASHA at the time of ANC visit were mostly IFA tablets, importance of nutrition and a proper balanced diet comprising of green leafy vegetables, milk and iron rich foods. She also explained to the beneficiary about the importance of institutional deliveries over home deliveries. Some of them even mentioned thet in case of any complication the woman should get herself checked at the PHC by the MO. When asked to the woman as to what are the minimum number of antenatal checkups a woman should ideally receive more than half of the responses received referred to the fact that the woman should have ANC checkups as many number of times as needed by the woman and two of them did say that they did not have an idea about it. When asked about the antenatal checkup received by the beneficiary at the time of her last pregnancy half of them said that they had got the checkup by the local Dai / Bhuva, one fourth of them had got their checkup from MO at the PHC and the rest one fourth of them had got it from a private doctor. The mean of the number of times she had received checkup at the time of the last pregnancy it was found that it fell in the range of two to three times. In all the cases it was found that at the time of ANC visit they had got their blood tested, urine tested, abdominal examination done, BP checked, weight taken, TT injections were administered, IFA tablets and deworming tablets were given. When asked as to know as to whether ASHA helps them in getting ANC checkup all of them said agreed to this

and said that the ASHA informs them about the session at the SC a day in advance and also calls them from their homes for ANC checkup. She reminds them about their due date of vaccination even if the woman forgets about it. In case of the two women who did not have ANC checkup the reasons for this was that they did not know as to where to go, whom to contact and they did not feel the need for going in for the checkup as their mother-in-laws also did not go in for such checkups.

- **Delivery**

Almost all of them said that the ASHA informed them about the steps they should ideally take for delivery preparedness. Some of these being saving money, preparing a delivery kit. She also informed the beneficiaries to inform her as soon as she comes to know about the fact that the woman is in labour. She also told them that in case of any emergency or complication call 108. She had counseled all the beneficiaries about the importance of institutional deliveries over home deliveries. She had counseled them that in case of institutional deliveries the doctor could immediately identify and treat her on the spot besides there are lesser chances of getting infection by the mother or the newborn. Almost all the beneficiaries had delivered in the hospital either PHC / private hospital only two of them delivered at home. The reason for their delivery at home was that the transport facility could not reach their homes on time due to which they had to deliver at home and in one case there was no facility available nearby. In the case of two third of the beneficiaries who had delivered in the institution the ASHA had accompanied them to the health facility for delivery and in only about one third of the cases she could not accompany the beneficiaries to the health facility. The reason for not being able to accompany to the health facility was due to certain personal reason or when the call was made late at night. When the ASHA accompanied the pregnant woman to the health facility she generally stayed there either till the time of registration (in one third of the cases) or till the time of delivery (in two third of the cases).

- **Postnatal care and newborn care**

With reference to the visit of the ASHAs after delivery it was found that two third of the ASHAs had made a visit to the woman and the newborn soon after the delivery. Only in cases where home deliveries took place ASHA could not make a visit either to the post partum woman or to the newborn. As in these cases the pregnant woman usually migrates to another place that means to her maternal home for delivery. On an average the ASHAs made around 2 visits to the postpartum woman after delivery. At the time of post natal visit the ASHA usually advised the women about the need for regular checkups at the PHC, importance of taking proper care of their health and medicines, she also explained the importance of taking a proper balanced nutritious diet and rest for the proper health of the mother and the newborn. In terms of the counseling

related to the newborn care she advised the woman about the need and importance of exclusive breastfeeding, importance of colostrum feeding and the different breastfeeding techniques. Only in one fifth of the beneficiaries had the ASHA informed them about cord care. In these one fifth of the cases she had informed them as to not to apply anything on the cord and to refer to the nearby doctor in the PHC in case of any problem. Only in one sixth of the cases had she informed about the time at which the newborn needs to the bathed. Coming on to KMC it was found that in only one fifth of the cases she had informed the beneficiaries about KMC. She had informed them that in case of KMC the mother should put the newborn for as long as possible to as close as possible to the chest; so that the child gets the warmth of the mother and the weight and health of the newborn remains in control.

- **Risk identification**

When the beneficiaries were asked as to whether the ASHA had informed them about the identification of the risk in case of pregnant, postpartum and newborns only two of them said that they had been informed about these complications and danger signs. These beneficiaries knew that at the time of delivery the danger sign is the excessive pain and blood loss. About the danger signs in the newborn they were aware that these comprised of the inability of the newborn to breathe properly, when the child is not able to take the feed properly and in case the child has some breathing problems and turns pale. In case of any complications and danger signs observed they are advised to refer immediately to the PHC or any other private hospital.

- **Birth spacing**

All of the beneficiaries agreed that they had been counseled and informed about the different family planning methods. They had knowledge about the temporary and permanent methods of family planning like Mala-D, Nirodh etc. They also knew that they can get an operation done after they have two children. Half of the beneficiaries voiced that the ASHA had explained to them the importance of birth spacing, which was improved health status of the mother and the child and that a small family is much more manageable for a good living. These counseling sessions were held at the time of home visits and at the time when the ASHA came to know about a new married woman in her village.

- **Immunization**

All of the beneficiaries had got themselves (pregnant women) and the children were vaccinated. All of them said that their Mamta card had been made in which all their details were recorded. They said that at the time of Mamta divas the activities undertaken included administration of injections, weight and height is taken, blood is tested and the Mamta card is filled.

- **Other diseases**

Out of eight of the beneficiaries only one third of them knew about malaria. They said that the symptoms of malaria are high fever, joint pains and feeling cold. They also knew that if one has malaria it can be confirmed by blood test. None of them had any clue about TB and Leprosy. They could not identify with these diseases even on probing.

- **National programmes**

Only two out of eight beneficiaries were aware about the JSY. They knew that this is a government scheme under which the pregnant woman gets some money in case she delivers in the hospital. As of now none of them had received the money of JSY. None of them had ever heard about the Chiranjeevi Yojana.

- **Transport facility**

In case of women who had delivered in the hospital all of them had called either 108 and in two of the cases they had called the private hospital vehicle. The overall response of these emergency transport facility was good and satisfactory.

Chapter 4

DISCUSSION

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

Infant and child mortality rates did show declining trends during the decade of 1980 and early 1990s, but maternal mortality ratio continues to remain high. The pace of decline of IMR, especially neo -natal mortality rate, has slowed down during the period of 1995 -2005. Introduction of the CSSM in 1992 and the RCH in 1997 by the Government of India marked as a paradigm shift in the provision of maternal and child care. But these attempts could produce limited results in the absence of sustained commitments, clear implementation strategies, and supportive supervision especially during the first phase o f the RCH. The objective of the NRHM is to strengthen healthcare delivery system with a focus on the needs of the poor and vulnerable sections among the rural population. The NRHM has prioritized on low performing States to reduce regional imbalances in the health outcomes. The NRHM is also attending to the determinants of good health, like, sanitation, nutrition, and safe drinking water. Its architectural corrections include integration of different organizational structures, optimization of health manpower, decentralization and community participation, and extension of effective referral hospital care at community levels as per the Indian Public Health Standard in each block of the country. One of the main tenets of the programme is to identify one ASHA per 1000 population in the rural areas with the purpose of supporting community to access the public health services. Framework of the NRHM underlines ASHA as a health activist in the community. She is expected to create awareness on health and its determinants, mobilize the community towards local health planning, and increase the utilization of the existing health services. The GoI issued certain guidelines to all the States to ensure that women with required capacity may only take the assignment as ASHA. The 23-day training in four phases was proposed to enhance the knowledge and skills of ladies identified as ASHAs. To make her functional in an appropriate manner, she is trained for seven day in the first instance on a set curriculum developed by the GoI. Also significantly, since ASHA receives a fixed honorarium as compensation money in lieu of each activity performed, the timely flow of this money is of paramount importance for her commitment and motivation.

The knowledge of ASHAs on the nature of the activities and job responsibility is the pre -requisite for effective service delivery. Most of the ASHAs have comprehended accompanying pregnant mother to hospital and counselling community on safe delivery, ANC/PNC, breastfeeding, immunization, contraception and prevention of RTIs/STIs as their role and responsibility. As regards their job responsibilities like creating community awareness on determinants of health, mobilising the community to access healthcare services at different facilities, depot holder of medicine and DOTS provider and motivating the community for

construction of household toilets, nearly half couldn't specify. Most of the ASHAs also fail to specify the two other job responsibilities namely assisting VHSCs to develop village health plan and informing AWWs/ANMs about birth and deaths. With reference to the current study on the competency assessment of the ASHAs in the four tribal blocks of Vadodara district it was found that the maximum response of the ASHAs was received in context to their escorting function of the beneficiaries to the nearby health facility (40%) and gathering information about the new developments in the village (25%). The activities which were shadowed were their role in the VHSC, the activities related to the BCC of the village community and the linkages with the government officials like the ANM, AWW, MO and others.

The ASHA programme has been successful in terms of promotion of institutional deliveries and in immunization. Even here the last mile, namely reaching the marginalized, is yet to be covered, with between 15% to 50% of women in some districts have not been reached. The ASHA is not as effective in influencing critical health behaviours such as three ANC check ups, breastfeeding, adequacy in complementary feeding, with the same intensity, which undermines her effectiveness in bringing about changes in health outcomes. According to the results obtained from the present study the motivational level of the ASHA for institutional deliveries is high. Home deliveries are more in those cases where there is infrastructural problems like there might not be proper road facility, 108/ambulance cannot reach the interior most areas or the houses situated on the hill top or might be due to communication problem. In such cases it becomes difficult either to bring the woman from the top of the hill to the ambulance or to the health facility tied to a wooden plank or in a stretcher. As in such cases the woman either dies on the way or delivers till the time she reaches the foot of the hill. So, in such cases people prefer to go in for home deliveries. In case of ANC checkups though the ASHAs do counsel and motivate the women about regular ANC checkups through a qualified doctor but due to high migration rate problem occurs.

According to a study done in Gorakhpur of ASHAs and ANMs have a good co-ordination. ASHA is acting as a supporting hand to the ANM and AWW and they in turn act as a guide to the ASHA that strengthens the delivery of services. The MOs also stated that they have control over ASHA and they monitor their work. All of them have felt that the ASHA and ANM, ASHA and AWW work in coordination with each other mostly in the registration of pregnant women, ANC/PNC, immunization and safe delivery. According to the present study though the coordination of the ASHAs with the MO's has been reported to be good but problems are still prevalent in the areas of coordination activities between the ANM and ASHA. The basic problem that has emerged is that there is lack of clarity on the part of the ASHAs about their exact expected roles and responsibilities due to which at a number of instances it happens that they end up doing much more work than they are expected to do and in the end they are not being paid accordingly.

Chapter 5

CONCLUSION AND RECOMMENDATIONS

CONCLUSION

Deepak foundation started an intervention project on SMCS with the Department of Health and Family Welfare, government of Gujarat, aiming to reduce the infant and maternal mortality in the district through the existing government health delivery systems in line with the goals of NRHM and State Population Policy. Based on the extensive experience in training of VLHW's in the past, the District Health Society chose Deepak Foundation as a Training Resource Centre. In January 2007, Deepak Foundation initiated training with 852 ASHAs in these four tribal blocks of the district. About 577 ASHAs have completed all four phases of the training as per the NRHM guidelines.

The present study reveals the impact of these trainings on the work performance and knowledge of ASHAs regarding various health related activities, which have been initiated by Deepak Foundation in the four tribal blocks, Kawant, Naswadi, Pavi Jetpur and Chhota Udepur. The aim of this study was to assess the competencies of the ASHAs and to understand the post-training work performance of the ASHAs and the realities and challenges encountered by them in successful implementation of the various health related activities. The impact has been mainly measured through self administered questionnaires for ASHAs on knowledge, awareness, and practice. However, to assess effective activity and coordination with the government officials raking of the ASHAs was done by the ANMs/FHWs and MOs and in-depth interviews of the ANMs/FHWs, through FGDs.

Based on the findings and observations as stated above, the work performance of ASHAs appears clearly. It can be seen that the ASHAs almost have a good knowledge base regarding their awareness pertaining to their expected job related roles and responsibilities. They have a fair understanding of the steps taken for the identification of the pregnancy, issues related to the ANC/PNC checkup and their counselling. They know about the topics of delivery preparedness and motivate the beneficiaries for institutional deliveries, they themselves call 108 in case she comes to know that the labour pain of the woman has started. Most of the ASHAs escort the woman to the nearby health facility and remain there till the time of delivery. Most of them counsel to the beneficiaries regarding the important issues like colostrum feeding, exclusive breastfeeding of the newborn and complimentary feeding. The ASHAs on the whole are very good in case of immunization sessions. They call the beneficiaries beforehand for the session and do proper follow-up of the drop out cases.

In case of family planning though they counsel the beneficiaries about the different family planning methods available (both temporary and permanent methods) but still they face problems**.** It was found that the ASHAs had a hard time in convincing the women for Copper-T insertion as a number of myths and misconceptions were related to it. Besides there was a lot of societal pressure on the woman, as she was the only person who was said to be responsible for family planning. Majority of men in these communities did not want to take in the onus of family

planning. Because of these reasons the ASHAs could not refer the desired cases either to the PHC / SC.

It has been seen that ASHAs lack knowledge on the identification of the danger signs and complications in the pregnant women, during delivery, in case of post partum women and in newborns. They cannot recognize the signs and symptoms of the identification of the beneficiary at risk because of which the referral either gets delayed or may not even happen. Also, they have a very sketchy knowledge about the diseases like Malaria (where majority of the ASHAs referred to the cause of Malaria when asked to state the symptoms of malaria), in case of TB and Leprosy they were not very well versed with the symptoms and treatment of these diseases. Though most of the ASHAs are members of the VHSC nad have a fair idea about its functioning but still they lack the confidence and the skill to put forth the demands of the community infront of them.

Interviews and rankings from the ANMs/FHWs and MOs have revealed that on the whole they are pretty satisfied with the work of the ASHAs working in coordination with them. Though as revealed from the above result they also feel that ASHAs should be imparted trainings in risk identification of the pregnant women and newborn, danger signs in case of pregnant women, post partum women and newborn and also in diseases like malaria, TB and leprosy. Though most of the MOs were happy with the coordination activities they had with the ASHAs but problems were seen at the time of coordination of the ASHAs with the ANMs/FHWs. The reason was this being that the ANMs feel that the ASHAs don't listen to them, do not cooperate and do not attend the meetings on time. But, during this research activity it was found that firstly the ANMs do not go for the home visit on regular basis. They only go for visits when there are issues pertaining to target fulfillment. Besides the ANMs pass of their job responsibilities to the ASHA and as the ASHAs are not fully aware about their expected roles and responsibilities they end up doing all the work without being duly paid for it.

Incentives is a major problem for the ASHAs as they are not being paid the desired amount in accordance with the quantum of work they do. There have been instances stated wherein the MOs and ANMs have asked for their commission in between so as to release their incentives. Also an issue that had come to light was that that all the health functionaries get targets from their respective PHCs. If a particular beneficiary has been identified and motivated by the ASHA but at the time of referral and disbursement of the payment the ANM comes forward claiming that 'This is my target'. In this case the ANM gets the money for referral and the ASHA even looses the money for motivation. Also is cases where there are more deliveries in a month the ASHA is not paid the same amount in that month. And when in the subsequent month there is no delivery she is neither paid the pending payment nor does she have any other payment for the other wok she has done.

In the view of the VHSC members the outcome of all the eight FGD groups revealed that the ASHA is the first choice of grassroots health providers for any health related demands of the community, especially women and children. There was an established rapport of the ASHA with the communities which was attested with the participants rating as *"Good"* for ASHA's work. The main responsibilities of ASHAs were mainly revolves around the pregnant and nursing mothers with their infants. Training and mentoring has always been a very strong component of

providing health services, the responses verifies the same as majority of participants were in opinion of timely training and mentoring of ASHA should continue for enhanced knowledge attitudes and practices.

Also from the indepth interviews of the beneficiaries it was seen that on the whole the beneficiaries were happy that they had someone from their village whom they could contact and tell their health related problems at anytime of the day or night. They laid a lot of trust on the responsible ASHAs of their village. Keeping the literacy levels of the beneficiaries in mind they did have a respectable knowledge base regarding their health facility in the vicinity, ANC checkup, immunization, breastfeeding, colostrum and importance of institutional deliveries. The areas they lacked information was risk identification of the mother an newborn, malaria, TB, leprosy, JSY, Chiranjeevi Yojana and few in case of family planning.

It can be said that the level of knowledge of the ASHAs vary according to the complexity of the problem. From the responses it appears that general information related questions are easily understood by ASHAs as compared to the situation where the information is complex or technical.

In the end it can be said that the ASHA as supposed to her role of an Accredited Social Health Activist has been reduced to the perform the role of a social mobilizer. Though expectations from the ASHAs are high but there issues and areas of concern are not being taken into consideration. In the end the responsibilities of the other officials are passed on to them but still they are not paid their due incentives on time leading to a feeling of resentment in the minds of the ASHAs. This makes the ASHAs feel exploited at times. Though the ASHAs have a potential and capacity of being a service provider but they are not being able to do so successfully instead end up being a social mobilizer. The outcomes expected from the ASHAs can show many fold results if the ASHAs are given a good blend of refresher trainings at shorter intervals of time and more frequently and some substantial motivational factors to keep their spirits high towards their work, so that this crucial link between the public health delivery system and the community strengthens manifold in the right direction.

RECOMMENDATIONS

Areas of concern	Actions recommended
Background characteristics	
The mean age of the ASHAs in the four tribal blocks comes to about 30. This is an important determining factor which affects the functional effectivity and efficiency of the ASHAs. As most of them fall in the late twenties category this has a bearing on their mobility in the field and service delivery.	**More focus should be laid on the selection of the ASHAs. Age is an important deciding factor for the proper expected outcome of the programme. It can become the major strength as the young can be made to deliver service with motivation and capacity building support.**
Population Coverage	
Majority of the ASHAs are catering to a population of more than the stipulated norm of 1,000. It was found that the mean of the population coverage in the four tribal blocks came to around 1549. In case of Kawant it was 1468, in Chhota Udepur it was 1608, in Naswadi it was 944 and in Pavi Jetpur it was 1639. These tribal villages sit in the hamlets spread over large areas and intercepted by hills and small rivulets. Due to these natural barriers, the ASHAs at times even fail to visit certain areas and certain sections of the population remain unserved and unreached at times. Even if the ASHAs makes a visit to these interior most areas the frequency of the number of visits made is low.	**An assessment of the population catered to by each ASHA should be made at the PHC and sub-centre level under the guidance of district NRHM office and redistribution of areas should be made among the ASHAs so as to keep the population norms limited to 1000 or less. In sparsely populated areas intercepted by hills and rivers, the norm should be relaxed.**
Roles and responsibilities	
The ASHAs are very keen on some of their job responsibilities like registration of pregnant women (ANC registration), motivating the women for institutional deliveries, accompanying the pregnant woman to the hospital, ANC/ PNC care related activities, immunization, organization of Mamta Divas but the neglected areas are risk identification of	**There is a need to firstly train the ASHAs in the areas needing referral and risk identification. She should then be sentised towards the impact of these activities on the health indicators of the state and then ultimately on the country. She then needs to be motivated to perform these activities of referral, identification of beneficiaries and**

the pregnant women, postpartum women and newborns, identification of the leprosy and TB cases, participation in VHSC and development of comprehensive village health plan, adolescent education, family planning motivating the people for construction of toilets etc. From the above pattern of the activities it can be seen that all these activities are the ones linked to the financial incentives. Thus, the ones related to the incentives receive highest priority and other activities are given less importance by the ASHAs.	**counseling them. This motivation can be done through an improved incentive based system so, that the ASHA herself feels like getting associated with these activities and does not take it as a burden.**
Trainings required	
Risk identification	
It has been seen that ASHAs lack knowledge on the identification of the danger signs and complications in the pregnant women, during delivery, in case of post partum women and in newborns. They cannot recognize the signs and symptoms of the identification of the beneficiary at risk because of which the referral either gets delayed or may not even happen.	**According to NFHS -3 the MMR and IMR in Gujarat is . Thus, there is an urgent need being felt for the ASHAs to be able to identify and refer the cases showing danger signs at the time of either ANC, during delivery or in case of newborns. For this the ASHAs need to be given regular refresher trainings at short intervals of time so that during these sessions the ASHAs get to revise the knowledge gained and can share their experiences in the field. These sessions should be interactive so that the ASHAs can voice their opinion and can state their problems and subsequently can get a solution for the same.**
Other diseases	
It was found that ASHAs have a very sketchy knowledge about the diseases like Malaria (where majority of the ASHAs referred to the cause of Malaria when asked to state the symptoms of malaria), in case of TB and Leprosy they were not very well versed with the symptoms and treatment of these diseases.	**According to NFHS-3 the . Malaria being a disease which is much more prevalent in during the summer months and in case of open uncovered source of water (like in the agricultural fields) it is important that the ASHA counsels the families about the precautions they can take and the place for referral in case if the individual has high fever especially during the evenings, chills and severe headache. The ASHA needs to educate the beneficiaries about the signs and**

	symptoms they can look for in case of TB or Leprosy. Since both these diseases can be treated by taking proper medication like Direct Observed Treatment Short course and Multi Drug Treatment respectively; timely identification and referral of these cases is very important. The ASHA thus, requires proper training with reference to the identification of the signs and symptoms, prevention strategies and their treatment.
Family planning	
Family planning emerged as a major issue during the performance evaluation of the ASHAs. It was observed that the ASHAs did posess a respectable knowledge about the different family planning methods available. At the time of home visit they used to advise the beneficiaries to go in for oral contraceptives like Mala-D, Nirodh etc in case of a newly married couple. In case of one child they counseled them about Copper-T insertion and they advised sterilization operation in case of women with more than two children. It was found that the ASHAs had a hard time in convincing the women for Copper-T insertion as a number of myths and misconceptions were related to it. Besides there was a lot of societal pressure on the woman, as she was the only person who was said to be responsible for family planning. Majority of men in these communities did not want to take in the onus of family planning. Because of these reasons the ASHAs could not refer the desired cases either to the PHC / SC.	**Because of a lot of resistance from the society regarding family planning the ASHAs had problems in communicating the importance of family planning effectively to the beneficiaries. It was seen that though she could counsel and motivate the women regarding oral contraceptives and sterilization operation. But, the main problem area remains the Copper-T insertion therefore, training is required for the ASHAs especially in Copper-T insertion so that they can motivate and counsel the beneficiaries more effectively and can answer their questions of doubt in a more affirmative manner. Also, the male participation in terms of family planning is very poor. So, there is a need of imparting training to them so that they can adopt the required skill sets for the inclusion of the males also.**
Role in VHSC	
It was seen that a good number of ASHAs were aware of the VHSCs in their village. Majority of them were also members of the Village Health and Sanitation Committees but they could not play a very substantial role in their VHSCs. They had a problem in delivering their role of being a spokesperson of their	**There is felt need of the ASHAs being imparted full knowledge about the role of VHSC and her contribution in it. She should be equipped with the required skill sets to get information from the VHSC members about the VHSC funds and the areas in which it is utilized. She should be equipped**

village health and sanitation issues. They could not effectively communicate in a large crowd with people with high designations and posts. Some of them even said that they get intimated in their presence.	**with all the required skill sets so that she can put forth the demands of the community in relation to the health and sanitation related issues of the village without any threat or scare.**
Infrastructural developments	
The ASHAs have voiced their concern on the fact that in these hilly and the interior most areas transportation of expectant mothers in labour, emergency or accident cases becomes a major problem. In the interior most villages, the transport services are not available especially at night time. Even in case if 108 comes to their place there is either a delay on their part or the 108 cannot reach to the hill top so the mother has to be hanged to a wooden plank and brought to the foot of the hill because of which at times either the mother or the baby dies or at time the mother even either delivers on the way or has to deliver at home. Since ASHA is a link between community and health service, any delay in transportation may lower her credibility in the community which may decrease her effectiveness.	**There is a need to improve the infrastructural and transport facilities in these areas so that the ASHAs can deliver their expected roles effectively and can refer the cases to the nearby health facility timely. So that the desired impact and outcome is achieved.**
Incentives	
The entire compensation received by ASHAs per month is very low which is quite inadequate for their sustenance. The members working in ccordination with the ASHAs like the ANMs, MOs and VHSC members have indicated the inadequacy of the compensation to the ASHAs. Also, it had been reported by some of the ASHAs that during the months there were more delivries they were not given the desired compensation as per the number of deliveries for which they had accompanied the pregnant woman to the health facility. As in this case the MO told the ASHAs that he cannot release such a huge amount in one go so only a part payment was given to the ASHAs. In the next month the ASHAs were still not	Compensation for ASHAs should be suitably increased. There is a need that certain amount of money should be fixed for the ASHAs as their salaries. The rest can depend upon their work and the targets met which can be incentivized. Payment should be done at the work site without any delay through cheque. Flow of fund should be regular and on time.

given the incentive carried forward from the last month. Also, in months when there was not even a single case of ANC the ASHA did not get any money for that whole month inspite of the fact that she had been working in a number of other activities for that month. Further majority of the ASHAs are not getting incentives in time. This thus becomes a negative motivational factor for the ASHAs which needs to be tackled.	
Another operational problem is when ASHA provide all the approved services of ANC and immunization but fail to get the incentive if she missed the opportunity to accompany the mother to the health facility due to some reasons. The most important reason for such incidence is lack of communication on that critical moment, or due to the unwillingness of the beneficiaries to inform her. Besides, she also loses the incentive if the client opted for the delivery in private hospital or nursing home.	**As the other health officials have a CUG mobile network in Gujarat this possibility can also be explored for the ASHAs. Even if the mobile phones cannot be given individually to the ASHAs but still they can be given village wise. This step might be crucial in the long run as this could lead to better connectivity with the community and health facility, transport vehicles, without any hassles. The ASHAs can be trained to equip herself with the apt communication skills so that she can convince the family members of expectant mothers the importance of ASHAs as an accompany because she is the best link between the pregnant mother and service providers regarding her history and condition.**
Logistics – Medicine kit	
All the ASHAs involved in this study in the four tribal blocks of Vadodara district did not have a medicine kit. A majority of the ASHAs have said that they lacked proper knowledge about the different medicines and their dosage. A number of ASHAs voiced their concern towards the fact that they need trainings about certain basic medicines so that they can give certain primary treatment to the village people as and when required.	**A need is felt firstly to give trainings to the ASHAs with regard to the basic medicines and their dosage. Then, all the ASHAs should be provided with a basic medicine kit as approved by the NRHM. This step is crucial so that the ASHAs can fufill their roles and responsibilities of being a 'primary depot holder' more effectively and so that there till the time a patient is referred to the nearby health facility they have already received certain basic primary treatment.**

Communication and Coordination	
During the study it was observed that there was a lack of proper coordination of the ASHAs with the ANMs. A number of internal conflicts were observed between them which affected the effectivity of their work. Also it was seen that at the end of the day most of the work of the ANMs was pushed as a responsibility towards the ASHAs and in the end the incentives for this was taken up by the ANM.	**As the ASHAs are being unduely exploited at times there is a need of proper monitoring and supervision so that they are not taken for a ride unnecessarily. During their training process they should be informed about the exact roles and responsibilities they are supposed to perform while working in coordination with their ANMs.**
Community mobilization	
More than a quarter of the ASHAs are unable to conduct meetings in the community because they are unable to motivate the target group effectively.	**The technique for community mobilisation should be incorporated in their future training curriculum.**

APPENDIX 1

TOOLS OF DATA COLLECTION

CONFIDENTIAL

(For research purpose only)

Date

PERFORMANCE EVALUATION OF ASHAs

ASHA QUESTIONNAIRE ON KNOWLEDGE, AWARENESS & PRACTICES

Serial Number

District	
Tehsil / Tahluka	
Village Name	
Name of the ASHA (Respondent)	
Name of the PHC	
Name of the SC	

INFORMED CONSENT

My name is Gursimran Alagh. I am a student of International Institute of Health Management Research (IIHMR; New Delhi). I am carrying out a study to evaluate the trainings given to the

ASHAs. Findings of the study will be used to design different trainings and refresher courses in the future.

Everything that you report during this interview will be kept strictly confidential and your name will not be recorded on the questionnaire. You may decline to answer any question, or stop the interview at any time in case you feel uncomfortable. The interview will take approximately 10-15 minutes. Participation is completely voluntary.

I would like to ask for your consent to be interviewed on this topic.

I have read the above considerations regarding my participation in the study. I understand that all the records will be kept private and that I can leave the study at any time.

I agree to be in this study.

Signature **Place**
Date

Section A : BACKGROUND INFORMATION

Sno.	QUESTIONS	CODING CATEGORIES	CODES	SKIP TO
1	Age (in completed years)	☐☐		
2	Educational Qualification	Std. 1 to 7 Std. 8 to 1o Std. 11 to 12 College	1 2 3 4	

3	Caste	SC & ST Others	1 9	
4	Marital status	Unmarried Currently Married Separated Divorcee Widow	1 2 3 4 5	
5	Socio-economic status (as per availability of card)	APL BPL Do not have card	1 2 3	
6	Since when did you become the ASHA of this village?	Day ☐ Month ☐ Yea☐		
7	What is the name and number of you provide services to?	Village ☐ Populatio☐		
8	What is the number of households you are covering ?	☐		
9	Trainings of how many modules have you completed till date?	☐		
10	When was the last training undertaken? Specify	Day ☐ Month ☐ Yea☐		

Section B : ROLES & RESPONSIBILITIES

Sno.	QUESTIONS	CODING CATEGORIES	CODES	SKIP TO
11	Mention 5 main responsibilities of ASHA? **Enlist**	1. _____ 2. _____ 3. _____ 4. _____ 5. _____		
12	**What activities do you undertake for:-**			
12.1	The identification of pregnancy	1. _____ 2. _____		

		3. _____ 4. _____ 5. _____		
12.2	The ANC care	1. _____ 2. _____ 3. _____ 4. _____ 5. _____		
12.3	At the time of delivery	1. _____ 2. _____ 3. _____ 4. _____ 5. _____		
12.4	PNC care	1. _____ 2. _____ 3. _____ 4. _____ 5. _____		
12.5	The newborn care	1. _____ 2. _____ 3. _____		

		4. _____ 5. _____		
13	Mention 5 important messages that you provide to women and others in the family as an educator and counselor. **Enlist**	1. _____ 2. _____ 3. _____ 4. _____ 5. _____		
14	Mention 5 important roles you play at the PHC/SC. **Enlist**	1. _____ 2. _____ 3. _____ 4. _____ 5. _____		

Section C : BIRTH & DEATH REGISTRATION

Sno.	QUESTIONS	CODING CATEGORIES	CODES	SKIP TO
15	**What do you do when you come to know about:-**			

<table>
<tr><td>15.1</td><td>Pregnancy</td><td>1. _____
2. _____
3. _____</td><td></td><td></td></tr>
<tr><td>15.2</td><td>Birth</td><td>1. _____
2. _____
3. _____</td><td></td><td></td></tr>
<tr><td>15.3</td><td>Maternal death</td><td>1. _____
2. _____
3. _____</td><td></td><td></td></tr>
<tr><td>15.4</td><td>Infant death</td><td>1. _____
2. _____
3. _____</td><td></td><td></td></tr>
<tr><td>16</td><td>How many did you get registered?</td><td><table><tr><th>Sno.</th><th>CATEGORY</th><th>No. OF BIRTHS/DEATHS</th><th>Nos. REGISTERED</th></tr><tr><td>1</td><td>Births (last 3 months)</td><td></td><td></td></tr><tr><td>2</td><td>Maternal deaths (last 1 year)</td><td></td><td></td></tr></table></td><td></td><td></td></tr>
</table>

		3	Infant deaths (last 3 months)			

Section D : HEALTH FACILITIES

Sno.	QUESTIONS	CODING CATEGORIES	CODES	SKIP TO
17	What are the number of health facilities available in your block?	**Sno.** / **HEALTH FACILITY** / **NAME (location)** / **Nos.** 1 SC 2 PHC 3 CHC /CEmONC 4 Private /NGO hospital		
18	**What are the health services which should be available at?**			
18.1	PHC	1. _____ 2. _____ 3. _____ 4. _____ 5. _____		
18.2	SC	1. _____ 2. _____ 3. _____ 4. _____ 5. _____		
18.3	CHC			

		1. _____ 2. _____ 3. _____ 4. _____ 5. _____		
18.4	CEmONC (if any)	1. _____ 2. _____ 3. _____ 4. _____ 5. _____		
19	Do you accompany the beneficiaries to the health facility?	Yes No Sometimes	1 2 3	**If 2 skip to 21**
20	At which health facility do you accompany them? Specify			

Section E : ANTENATAL CARE

Sno.	QUESTIONS	CODING CATEGORIES	CODES	SKIP TO
21	How do you identify the pregnant women in your area? **Enlist**	1. _____ 2. _____		

		3. _____ 4. _____ 5. _____		
22	Mention 5 important key messages that you give to the pregnant woman at the time of visit? **Enlist**	1. _____ 2. _____ 3. _____ 4. _____ 5. _____		
23	**What are the issues that you discuss with the beneficiaries during the visit?**			
23.1	ANC check up	1. _____ 2. _____ 3. _____ 4. _____ 5. _____		
23.2	Delivery	1. _____ 2. _____ 3. _____ 4. _____ 5. _____		
23.3	PNC check up	1. _____		

		2. _____ 3. _____ 4. _____ 5. _____		

Section F : DELIVERY

Sno.	QUESTIONS	CODING CATEGORIES	CODES	SKIP TO
24	Do you accompany the pregnant woman to the health facility for delivery?	Yes most of the times No Sometimes only	1 2 3	**If 2 skip to 26**
25	When you accompany a woman to the facility for delivery, for how long do you generally stay there? **Specify**	1. _____ 2. _____ 3. _____		
26	What are the circumstances under which you have been generally unable to accompany women to the health facility? **Specify**	1. _____ 2. _____ 3. _____		

Section G : POSTNATAL CARE

Sno.	QUESTIONS	CODING CATEGORIES	CODES	SKIP TO
27	Do you make home visits to examine postnatal women?	Yes No Sometimes	1 2 3	**If 2 go to 32**
28	How often do you visit the postpartum women?			

	Specify			
29	How many women did you visit in the last month?	☐☐		
30	How many visits did you make to these women in the last month?	☐☐		
31	When you make home visits for postnatal checkup what advice do you give to the mothers on postnatal care of women? **Explain**	1. _____ 2. _____ 3. _____ 4. _____ 5. _____		
32	Do you counsel women about new born care?	Yes No Sometimes	1 2 3	**If 2 skip to 34**
33	What all do you tell them about new born care? **Explain**	1. _____ 2. _____ 3. _____ 4. _____ 5. _____		

Section H : RISK IDENTIFICATION

Sno.	QUESTIONS	CODING CATEGORIES	CODES	SKIP TO
34	Do you identify post partum women at risk?	Yes No Sometimes	1 2 3	**If 2 skip to 37**
35	What are the signs to look for in a post partum woman? **Specify (min 3)**	1. _____ 2. _____		

		3. _____ 4. _____		
36	Where do you refer a post-partum mother needing treatment? **{NOTE: MULTIPLE ANSWERS ARE POSSIBLE CIRCLE ALL THE POSSIBLE CORRECT OPTIONS}**	SC PHC CHC Private / NGO hospital Quack / Bhuva Others (specify)……	1 2 3 4 5 9	
37	Do you identify newborns at risk?	Yes Sometimes No	1 2 3	**If 2 skip to 40**
38	What are the signs to look for in a newborn at risk? **Specify (min 4)**	1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____		
39	Where do you refer a newborn needing treatment? **{NOTE: MULTIPLE ANSWERS ARE POSSIBLE CIRCLE ALL THE POSSIBLE CORRECT OPTIONS}**	SC PHC CHC Private / NGO hospital Quack / Bhuva Others (specify)…….	1 2 3 4 5 9	

Section I : BIRTH SPACING

Sno.	QUESTIONS	CODING CATEGORIES	CODES	SKIP TO
40	What are the dangers of closely spaced births you know about? **Explain (min 3)**	1. _____ 2. _____ 3. _____ 4. _____ 5. _____		
41	Do you promote family planning method for the couples?	Yes No Sometimes	1 2 3	**If 2 go to 45**
42	Where do you do the counseling?	PHC SC At the time of home visit Others (specify)……..	1 2 3 9	
43	When do you do the counseling?	ANC period PNC period Others (specify)……..	1 2 9	
44	What are the 4 key messages that you give regarding family planning to pregnant and postpartum women? **Explain**	1. _____ 2. _____ 3. _____ 4. _____		

Section J : IMMUNIZATION & MAMTA DIVAS

Sno.	QUESTIONS	CODING CATEGORIES	CODES	SKIP TO
45	What activities do you undertake at the time of immunization? **Enlist**	1. _____ 2. _____		

		3. _____ 4. _____		
46	What activities do you undertake at the time of Mamta Divas? **Enlist**	1. _____ 2. _____ 3. _____ 4. _____		

Section K : OTHER DISEASES

Sno.	QUESTIONS	CODING CATEGORIES	CODES	SKIP TO
47	What should be the minimum level of Hb for pregnant women? **(Encircle the correct answer)**	7% 11% 12% Above 12%	1 2 3 4	
48	What are the 4 main symptoms of anemia? **Specify**	1. _____ 2. _____ 3. _____ 4. _____		
49	Mention 4 ways by which anemia be prevented? **Enlist**	1. _____ 2. _____ 3. _____ 4. _____		

50	What are the 2 main symptoms of TB? **Specify**	1. _____ 2. _____		
51	What is the treatment of TB? **Specify**	1. _____ 2. _____ 3. _____		
52	What are the 3 main symptoms of malaria? **Specify**	1. _____ 2. _____ 3. _____		
53	What are the 3 main symptoms of leprosy? **Specify**	1. _____ 2. _____ 3. _____		

Section L : RECORDS & REGISTERS

Sno.	QUESTIONS	CODING CATEGORIES	CODES	SKIP TO
54	Do you maintain any records and registers?	Yes No	1 2	**If 2 skip to 67**
55	What all registers do you maintain? **Enlist**	1. _____ 2. _____ 3. _____ 4. _____		

		5. _____		
56	Why is the MIS register of Deepak Foundation filled? **Explain**	1. _____ 2. _____ 3. _____ 4. _____		
57	What all information do you record in this register? **Specify (broad categories)**	1) 1 **FORM A –**_____ 2) 2 **FORM B –** _____ 3) 3 **FORM C –** _____ 4) 4 **FORM D –** _____		
58	What all information do you record about the ANC/PNC checkup? **Enlist**	1. _____ 2. _____ 3. _____ 4. _____ 5. _____		
59	Do you collect information from ANM/FHW?	Yes No Sometimes	1 2 3	**If 2 skip to 61**
60	What all information do you receive from ANM/FHW? **Enlist**	1. _____ 2. _____ 3. _____ 4. _____ 5. _____		

61	Do you record the birth weight of the newborn?	Yes No Sometimes	1 2 3	**If 2 skip to 64**
62	Do you identify Low birth Weight babies?	Yes No Sometimes	1 2 3	**If 2 skip to 64**
63	How do you record Low Birth Weight Babies? **Specify**			
64	Where do you record maternal deaths?			
65	Where do you record infant deaths?			
66	Are you satisfied with the MIS training?	Very satisfied Satisfied Somewhat satisfied Not satisfied	1 2 3 4	

Section M : COMMUNICATION & COUNSELLING

Sno.	QUESTIONS	CODING CATEGORIES	CODES	SKIP TO
67	Give information about the meetings in your village.			

Sno.	NAME OF THE MEETING	No. OF MEETINGS ATTENDED	ISSUSES DISCUSSED
1			
2			
3			
4			
5			

Section N : VILLAGE HEALTH & SANITATION COMMITTEE (VHSC)

Sno.	QUESTIONS	CODING CATEGORIES	CODES	SKIP TO
68	Are you a member of VHSC?	Yes No		**If 2 skip to 75**
69	How often do you meet the VHSC meetings?	Once a month Once in 15 days Once a week When I have time	1 2 3 4	
70	What is the role of VHSC? **Explain**			
71	How has the untied fund utilized in the last 1 year?	Fully used Not used Partially used	1 2 3	**If 2 skip to 73**
72	In which all activities is the VHSC fund utilized? **Enlist**	1. _____ 2. _____ 3. _____ 4. _____ 5. _____		
73	Has your VHSC prepared a Village Health Action Plan (VHAP) for 2009-10 or 2010-11?	Yes No Somewhat	1 2 3	**If 2 skip to 75**
74	What issues have emerged in the VHAP? **Explain**	1. _____ 2. _____ 3. _____ 4. _____ 5. _____		

Section O : NATIONAL PROGRAMMES

Sno.	QUESTIONS	CODING CATEGORIES	CODES	SKIP TO

75	Are you aware of any National Health Programmes of the state/country?	Yes No Somewhat	1 2 3	**If 2 skip to 77**
76	Mention the National Health Programmes you are aware of? **Enlist**	1. _____ 2. _____ 3. _____ 4. _____ 5. _____		
77	Do you know about Janani Suraksha Yojana (JSY)?	Yes No Somewhat	1 2 3	**If 2 skip to 79**
78	What role do you play in JSY? **Explain**	1. _____ 2. _____ 3. _____ 4. _____		
79	Do you know about Chiranjivi Yojana ?	Yes No Somewhat	1 2 3	**If 2 skip to 80**
80	What role do you play in Chiranjivi Yojana? **Explain**	1. _____ 2. _____ 3. _____ 4. _____		

Section P : TRANSPORT FACILITY

Sno.	QUESTIONS	CODING CATEGORIES	CODES	SKIP TO
81	What mode of transport do you	a) Walk	1	

	use to take beneficiary to the health facility?	b) Cycle c) Bus d) Ambulance e) Private f) Other (specify)……	2 3 4 5 9	
82	Have you heard about 108?	Yes No	1 2	**If 2 skip to 85**
83	How many times did you call 108 in the last 1 month?			**If have not called 108 even once in the last 1 month then, skip to 86**
84	What was the type of cases for which you called 108?			
85	What was the response of 108?			

Section Q : COORDINATION

Sno.	QUESTIONS	CODING CATEGORIES	CODES	SKIP TO
86	In the last 1 month how many times have you had the coordination meetings?	**Sno.** / **MEETING** / **No. OF MEETINGS** 1 / ANM 2 / AWW 3 / Government agencies 4 / Others		
87	Do you think there are any benefits of having coordination meeting?	Yes No Somewhat	1 2 3	

Section R : TRAINING

Sno.	QUESTIONS	CODING CATEGORIES	CODES	SKIP TO
88	Do you feel confident that you have the required skills or will you like more training with respect to your job roles and responsibilities?	1) I feel confident 2) Want more training 3) Cannot say	1 2 8	
89	In which area do you think more training is required? **Explain**	1_____ 2_____ 3_____ 4_____ 5_____		

MENTION ANY PROBLEMS IF ANY YOU FACE IN DELIVERING YOUR ROLES & RESPONSIBILITIES

CONFIDENTIAL

(For research purpose only)

Date

PERFORMANCE EVALUATION OF ASHAs

ANM RANKING LIST

Serial Number

District	
Tehsil / Tahluka	
Name of the ANM (Respondent)	
Name of the Cluster	
Name of the ASHAs working under you	**1** **2** **3** **4** **5** **6** **7** **8** **9** **10**
Name of the SC	

INFORMED CONSENT

My name is Gursimran Alagh. I am a student of International Institute of Health Management Research (IIHMR; New Delhi). I am carrying out a study to evaluate the trainings given to the ASHAs. Findings of the study will be used to design different trainings and refresher courses in the future.

Everything that you report during this interview will be kept strictly confidential and your name will not be recorded on the questionnaire. You may decline to answer any question, or stop the interview at any time in case you feel uncomfortable. The interview will take approximately 10-15 minutes. Participation is completely voluntary.

I would like to ask for your consent to be interviewed on this topic.

I have read the above considerations regarding my participation in the study. I understand that all the records will be kept private and that I can leave the study at any time.

I agree to be in this study.

Signature **Place** **Date**

BACKGROUND INFORMATION

Sno.	QUESTIONS	CODING CATEGORIES	CODES	SKIP TO
1	Age (in completed years)	☐☐		
2	Educational Qualification	Upto 10th class Upto 12th class Graduate Post-graduate Others (specify)	1 2 3 4 9	
3	Caste	SC ST Others	1 2 9	
4	Marital status	Unmarried Currently Married Separated Divorcee Widow	1 2 3 4 5	
5	Socio-economic status (as per availability of card)	APL BPL Do not have card	1 2 3	
6	Since when did you become the ANM?	Day ☐ Month ☐ Year ☐		
7	Since when are you the ANM at this SC?	Day ☐ Month ☐ Year ☐		
8	What is the population size that you are covering?	☐		
9	What is the number of households you are covering?	☐		
10	Where did you undergo your ANM training?			
11	When did you undergo your ANM training?	Day ☐ Month ☐ Year ☐		

INSTRUCTIONS

GIVE RANKS TO ALL THE CATEGORIES MENTIONED BELOW FOR THE ASHAs ON A SCLAE OF 1-5. STARTING FROM THE LOWEST AT 1 AND THE HIGHEST AT 5.

RANKING LIST

Sno.	PARAMETER / CRITERIA	NAME OF ASHA 1	NAME OF ASHA 2	NAME OF ASHA 3	NAME OF ASHA 4	NAME OF ASHA 5
1	**Behaviour**					
1.1	At the SC					
1.2	With the ANM					
1.3	With the beneficiaries					
2	**Knowledge about:-**					
2.1	Her roles and responsibilities as an ASHA					
2.2	The facilities available at the SC					
2.3	ANC care					
2.4	Care at the time of delivery					
2.5	PNC care					
2.6	Family planning					
2.7	Immunization					
3	**Awareness about:-**					
3.1	Identification of the beneficiaries					
3.2	Risk identification of pregnant women					
3.3	Risk identification of post partum women					
3.4	Risk identification of newborn					
4	**Practice**					
5	**Efficiency in service delivery to the beneficiaries**					
6	**Maintaining records & registers**					
7	**Coordination with the ANM**					
8	**Training of ASHAs**					

INSTRUCTIONS

GIVE RANKS TO ALL THE CATEGORIES MENTIONED BELOW FOR THE ASHAs ON A SCLAE OF 1-5. STARTING FROM THE LOWEST AT 1 AND THE HIGHEST AT 5.

RANKING LIST

Sno.	PARAMETER / CRITERIA	NAME OF ASHA 1	NAME OF ASHA 2	NAME OF ASHA 3	NAME OF ASHA 4	NAME OF ASHA 5
1	**Behaviour**					
1.1	At the SC					
1.2	With the ANM					
1.3	With the beneficiaries					
2	**Knowledge about:-**					
2.1	Her roles and responsibilities as an ASHA					
2.2	The facilities available at the SC					
2.3	ANC care					
2.4	Care at the time of delivery					
2.5	PNC care					
2.6	Family planning					
2.7	Immunization					
3	**Awareness about:-**					
3.1	Identification of the beneficiaries					
3.2	Risk identification of pregnant women					
3.3	Risk identification of post partum women					
3.4	Risk identification of newborn					
4	**Practice**					
5	**Efficiency in service delivery to the beneficiaries**					
6	**Maintaining records & registers**					
7	**Coordination with the ANM**					
8	**Training of ASHAs**					

Date

PERFORMANCE EVALUATION OF ASHAs

MO RANKING LIST

Serial Number

District	
Tehsil / Tahluka	
Name of the MO (Respondent)	
Name of the ANMs working under you	**1** **2** **3** **4** **5** **6** **7** **8**
Name of the PHC	

INFORMED CONSENT

My name is Gursimran Alagh. I am a student of International Institute of Health Management Research (IIHMR; New Delhi). I am carrying out a study to evaluate the trainings given to the ASHAs. Findings of the study will be used to design different trainings and refresher courses in the future.

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I agree to be in this study.

Signature **Place** **Date**

BACKGROUND INFORMATION

Sno.	QUESTIONS	CODING CATEGORIES	CODES	SKIP TO
1	Age (in completed years)	☐☐		
2	Educational Qualification			
3	Caste	SC ST Others	1 2 9	
4	Marital status	Unmarried Currently Married Separated Divorcee Widow	1 2 3 4 5	
5	Socio-economic status (as per availability of card)	APL BPL Do not have card	1 2 3	
6	Since when did you become the MO at this PHC?	Day ☐ Month ☐ Yea☐		

RANKING LIST

INSTRUCTIONS

GIVE RANKS TO ALL THE CATEGORIES MENTIONED BELOW FOR THE ASHAs ON A SCLAE OF 1-5. STARTING FROM THE LOWEST AT 1 AND THE HIGHEST AT 5.

Sno.	PARAMETER	RESPONSE
1	**Behaviour:-**	
1.1	At the PHC	
1.2	With the MO	
1.3	With the beneficiaries	
2	**Knowledge about:-**	
2.1	Her roles and responsibilities as an ASHA	
2.2	The facilities available at the PHC	
2.3	ANC care	
2.4	Care at the time of delivery	
2.5	PNC care	
2.6	Family planning	
2.7	Immunization	
3	**Awareness about:-**	
3.1	Identification of the beneficiaries	
3.2	Risk identification of pregnant women	
3.3	Risk identification of post partum women	
3.4	Risk identification of newborn	
4	**Practice**	
5	**Efficiency in service delivery to the beneficiaries**	
6	**Maintaining records and registers**	
7	**Coordination with the MO**	
8	**Training of ASHAs**	

CONFIDENTIAL

(For research purpose only)

Date

PERFORMANCE EVALUATION OF ASHAs

BENEFICIARIES QUESTIONNAIRE

Serial Number

District	
Tehsil / Tahluka	
Village Name	
Name of the Respondent	

INFORMED CONSENT

My name is Gursimran Alagh. I am a student of International Institute of Health Management Research (IIHMR; New Delhi). I am carrying out a study to evaluate the trainings given to the ASHAs. Findings of the study will be used to design different trainings and refresher courses in the future.

Everything that you report during this interview will be kept strictly confidential and your name will not be recorded on the questionnaire. You may decline to answer any question, or stop the interview at any time in case you feel uncomfortable. The interview will take approximately 10-15 minutes. Participation is completely voluntary.

I would like to ask for your consent to be interviewed on this topic.

I have read the above considerations regarding my participation in the study. I understand that all the records will be kept private and that I can leave the study at any time.

I agree to be in this study.

Signature **Place** **Date**

Section A : BACKGROUND INFORMATION

Sno.	QUESTIONS	CODING CATEGORIES	CODES	SKIP TO
1	Age (in completed years)	☐☐		
2	Educational Qualification	Illiterate Upto 5th class Upto 8th class Upto 10th class Upto 12th class Graduate Post-graduate Others (specify)	1 2 3 4 5 6 7 9	
3	Caste	SC ST Others	1 2 9	
5	Socio-economic status (as per availability of card)	APL BPL Do not have card	1 2 3	
4	Marital status	Unmarried Currently Married Separated Divorcee Widow	1 2 3 4 5	
5	For how long have you been married?	1 year or less than 1 Years since marriage ☐☐	1 2	
6	What is the age of your husband?	☐☐		
7	What is his educational qualification?	Illiterate Upto 5th class Upto 8th class Upto 10th class Upto 12th class Graduate Post-graduate Others (specify)	1 2 3 4 5 6 7 9	
8	Are you presently doing any work?	Yes No Sometimes	1 2 3	
9	What kind of work do you do?			

10	What is the number of:-	**Live births** | **Still births** | **Miscarriages** | **Abortions** | | | | | | | | | |		
11	Do you know the name of the ASHA of your village?	Yes No		**If 2 the questionnaire will not be applicable**
12	What is her name?			

Section B : ROLES & RESPONSIBILITIES

Sno.	QUESTIONS	CODING CATEGORIES	CODES	SKIP TO
13	Did the ASHA visit you?	Yes No Sometimes	1 2 3	**If 2 skip to 17**
14	When did the ASHA visit you?	ANC period At the time of delivery PNC period Others (specify)……	a b c d	
15	How many such visits did the ASHA make?	Sno. | ANC period | At the time of delivery | PNC period | Others | | | | | | | | | | | |		
16	At the time of visits on what all topics did the ASHA tell you about? **Enlist**	1_____ 2_____ 3_____ 4_____ 5_____		

Section C : ANTENATAL CARE

Sno.	QUESTIONS	CODING CATEGORIES	CODES	SKIP TO
17	When did the ASHA come to know that you are pregnant?			
18	How did the ASHA come to know that you are pregnant?			
19	What was the first thing the ASHA did when she came to know about your pregnancy?			
20	What issues did the ASHA discuss with you during her visit about ANC? Enlist	1_____ 2_____ 3_____ 4_____ 5_____		
21	What is the minimum number of antenatal checkups that a woman should receive?	1 2 3 More than 3 Any number as per need Do not know	1 2 3 4 5 8	
22	At any time during your last pregnancy, did you receive antenatal checkup by any healthcare provider?	Yes No	1 2	**If 2 skip to 29**
23	Where did you receive your ANC checkup?	Home by visiting ANM AWC PHC CHC Private clinic in the village Private hospital in the nearby village / town Others (specify)……	1 2 3 4 5 6 9	

<table>
<tr><td>24</td><td>How many times during pregnancy you received medical checkup by the healthcare provider?</td><td>Once
Twice
Thrice
More than three times
Do not remember</td><td>1
2
3
4
5</td><td></td></tr>
<tr><td>25</td><td>Who was the healthcare provider from whom you had received ANC checkup?
{NOTE: MULTIPLE ANSWERS ARE POSSIBLE CIRCLE ALL THE POSSIBLE CORRECT OPTIONS}</td><td>PHC doctor
Qualified Private Doctor (MBBS)
ANM
ASHA
Trained Birth Attendant (TBA)
Untrained Dai
Quacks / Bhuva
Religious persons
Others
(specify)……</td><td>a
b
c
d
e
f
g
h
i</td><td></td></tr>
<tr><td>26</td><td>At the time of ANC visits was your:-

CIRCLE THE CORRECT ANSWER</td><td>
<table>
<tr><th>Sno.</th><th>QUESTION</th><th>YES</th><th>NO</th><th>DON’T REMEMBER</th></tr>
<tr><td>1</td><td>Blood tested</td><td>1</td><td>2</td><td>8</td></tr>
<tr><td>2</td><td>Urine tested</td><td>1</td><td>2</td><td>8</td></tr>
<tr><td>3</td><td>Abdominal examination done</td><td>1</td><td>2</td><td>8</td></tr>
<tr><td>4</td><td>BP checked</td><td>1</td><td>2</td><td>8</td></tr>
<tr><td>5</td><td>Weight taken</td><td>1</td><td>2</td><td>8</td></tr>
<tr><td>6</td><td>TT injections given</td><td>1</td><td>2</td><td>8</td></tr>
</table>
</td><td></td><td></td></tr>
<tr><td>27</td><td>Did the ASHA help you in any way in getting ANC checkup?</td><td>Yes
No
Sometimes</td><td>1
2
3</td><td></td></tr>
<tr><td>28</td><td>In what way did the ASHA help you in getting ANC checkup?
Explain

(RECORD VERBATIM)</td><td>Advised me for ANC
Helped me in registration for ANC
Reminded me my due dates
Accompanied me for ANC checkup
Helped me in getting JSY card
ASHA did nothing
No ASHA was there at that time in the village
Others
(specify)…….</td><td>a
b
c
d
e
f
g
h</td><td></td></tr>
</table>

29	Why did you not go for any ANC checkup during your last pregnancy? **{NOTE: MULTIPLE ANSWERS ARE POSSIBLE CIRCLE ALL THE POSSIBLE CORRECT OPTIONS}**	Pregnancy was normal No one informed me where to go Elders in the family did not support Did not get time for ANC No one was to accompany Do not know where to go Unsure of quality of ANC service Unsure of availability of provider Only IFA tablets are provided Facility too far No transportation Costs too much Others (specify)……	a b c d e f g h i j k l m	

Section D : DELIVERY

Sno.	QUESTIONS	CODING CATEGORIES	CODES	SKIP TO
30	Did the ASHA advise you on delivery preparedness?	Yes No Somewhat	1 2 3	**If 2 skip to 32**
31	What advise did she give you regarding delivery preparedness? **Explain**			
32	Did she advise and motivate you to go for institutional deliveries?	Yes No	1 2	**If 2 skip to 34**
33	What did she tell you about the advantages of the institutional deliveries? **Explain**			
34	Where did you have your delivery?	Home Hospital	1 2	
35	Name the health facility at which you delivered.			
36	Did the ASHA accompany you to the health facility for delivery?	Yes No	1 2	**If 2 skip to 38**
37	When she accompanied you to the facility for delivery, for how long did she stay there?			

38	What reason did she give for not accompanying you to the health facility?			
39	What reason did she give for leaving early from the health facility?			
40	Why did you not deliver at the nearby health facility?			

Section E : POSTNATAL CARE & NEWBORN CARE

Sno.	QUESTIONS	CODING CATEGORIES	CODES	SKIP TO
41	Did the ASHA make visits to your home after your delivery?	Yes No	1 2	**If 2 skip to 45**
42	When did she make the visit after delivery? **Specify**	Soon after delivery Within 7 days if delivery After seven days of delivery Don't remember	1 2 3 8	
43	How many visits did the ASHA make?	☐☐		
44	When the ASHA made home visits for postnatal checkup what advice did she give you? **Explain**	1_____ 2_____ 3_____ 4_____ 5_____		
45	Did the ASHA take you the nearby health facility for PNC check up?	Yes No	1 2	**If 2 skip to 46**
46	Did she counsel you about new born care?	Yes No	1 2	**If 2 skip to 48**

47	What all did the ASHA tell you about new born care? **Explain**	1_____ 2_____ 3_____ 4_____ 5_____		
48	Did she counsel you about cord care?	Yes No		**If 2 skip to 50**
49	What did she tell about cord care? Explain	1_____ 2_____ 3_____ 4_____		
50	What was applied on the cord stump?	Oil Ghee Ash Turmeric Talcum powder Nothing Others (specify)……	1 2 3 4 5 6 9	
51	Did the ASHA tell you about when the child should be bathed?	Yes No	1 2	**If 2 skip to 54**
52	When was your child bathed?	Immediately After 1 hour Within 2-4 hours After 12 hours After 24 hours After a week Others (specify)……	1 2 3 4 5 6 9	

53	What was done to clean your child?	Cleaned with dry cloth Cleaned with water (sponge bath) Others (specify)……	1 2 9	
54	Did she tell you about KMC?	Yes No	1 2	**If 2 skip to 56**
55	What did she tell you about KMC? Explain	1_____ 2_____ 3_____ 4_____		
56	Did the ASHA tell about breastfeeding and feeding practices?	Yes No	1 2	**If 2 skip to 58**
57	What did the ASHA tell about breastfeeding and feeding practices? **Explain** **(Record Verbatim)**	Colostrum Exclusive breast feeding for the first 6 months Breastfeeding techniques Complementary feeding Others (specify)……	1 2 3 4 9	

Section F : BIRTH & DEATH REGISTRATION

Sno.	QUESTIONS	CODING CATEGORIES	CODES	SKIP TO
58	Did you get a birth certificate for your child?	Yes No	1 2	
59	Did the ASHA help you in getting your child registered?	Yes No	1 2	

Section G : HEALTH FACILITIES

Sno.	QUESTIONS	CODING CATEGORIES	CODES	SKIP TO
60	Did the ASHA inform you about the health facilities available in your nearby area?	Yes No	1 2	**If 2 skip to 63**
61	Which are the health facilities she told you about? **Enlist**	1_____ 2_____ 3_____ 4_____ 5_____		
62	What did she tell you about the facilities available there? **Explain**	1_____ 2_____ 3_____ 4_____ 5_____		

Section H : RISK IDENTIFICATION

Sno.	QUESTIONS	CODING CATEGORIES	CODES	SKIP TO
63	Did she inform you about the danger signs during pregnancy?	Yes No	1 2	**If 2 skip to 64**
64	What were the danger signs she told you about?	1_____ 2_____ 3_____		

		4_____ 5_____		
65	Did she tell you about complications during pregnancy or delivery?	Yes No	1 2	**If 2 skip to 68**
66	What were the complications she told you about?	1_____ 2_____ 3_____ 4_____ 5_____		
67	Where did she tell you to go for treatment when required with those danger signs and complications? **{NOTE: MULTIPLE ANSWERS ARE POSSIBLE CIRCLE ALL THE POSSIBLE CORRECT OPTIONS}**	SC PHC CHC Private / NGO hospital Quack / Bhuva Others (specify)……	a b c d e f	
68	Did she inform you about the danger signs to look for in a newborn?	Yes No	1 2	**If 2 skip to 71**
69	What were the danger signs she told you about?	1_____ 2_____ 3_____ 4_____ 5_____		

70	Where did she tell you to go for treatment when required with those danger signs and complications? **{NOTE: MULTIPLE ANSWERS ARE POSSIBLE CIRCLE ALL THE POSSIBLE CORRECT OPTIONS}**	SC PHC CHC Private / NGO hospital Quack / Bhuva Others (specify)……..	a b c d e f	

Section I : BIRTH SPACING

Sno.	QUESTIONS	CODING CATEGORIES	CODES	SKIP TO
71	Did the ASHA counsel you about family planning and birth spacing?	Yes No	1 2	**If 2 skip to 76**
72	What did she tell you about family planning? Explain	1_____ 2_____ 3_____ 4_____ 5_____		
73	Where did the ASHA do the counseling?	PHC SC At the time of home visit Others (specify)……..	1 2 3 9	
74	When did the ASHA do the counseling?	ANC period PNC period Others (specify)……..	1 2 3	

75	Did she involve your husband as well in these counseling sessions?	Yes No Sometimes	1 2 3	

Section J : IMMUNIZATION & MAMTA DIVAS

Sno.	QUESTIONS	CODING CATEGORIES	CODES	SKIP TO
76	Did you get your child vaccinated?	Yes No Don't remember	1 2 8	**If 2 skip to 78**
77	What all vaccines has your child received? **Specify**	1_____ 2_____ 3_____ 4_____ 5_____ 6_____		
78	Did the ASHA maintain an immunization card of your child?	Yes No Don't know	1 2 8	
79	Have you ever attended Mamta Divas	Yes No Sometimes	1 2 3	**If 2 skip to 81**
80	What activities did you see at the time of Mamta Divas? **Enlist**	1_____ 2_____ 3_____ 4_____		

Section K : OTHER DISEASES

Sno.	QUESTIONS	CODING CATEGORIES	CODES	SKIP TO
81	Did the ASHA inform you about any other disease?	Yes No	1 2	**If 2 skip to 83**
82	What are the diseases she told you about?			

Sno.	DISEASE	SYMPTOMS	PREVENTION	TREATMENT
1				
2				
3				
4				
6				

Section O : NATIONAL PROGRAMMES

Sno.	QUESTIONS	CODING CATEGORIES	CODES	SKIP TO
83	Have you ever heard about Janani Suraksha Yojana (JSY)?	Yes No Somewhat	1 2 3	**If 2 skip to 86**
84	Who told you about JSY?			
85	What do you know about JSY? **(RECORD VERBATIM)**	Govt. incentives to women for delivery at health facility Appointment of ASHA to promote ANC and institutional delivery JSY provides money to women for transportation ASHA accompanies mother to the facility for delivery ASHA helps in complete immunization of children Aware about JSY but not in detail Others (specify).....	a b c d e f g	

86	Did the ASHA inform you about the incentive money you will get if you deliver at a health facility?	Yes No	1 2	
87	Did you receive incentive money under the JSY scheme?	Yes No	1 2	**If 2 skip to 90**
88	When was the payment made?	Before discharge from facility Within one week 1-2 weeks 3-4 weeks More than one month Have not received as yet	1 2 3 4 5 6	
89	How much total amount were you paid under JSY?	| | | |		
90	Did the ASHA help in getting payment?	Yes No	1 2	
91	Do you know about Chiranjivi Yojana?	Yes No Somewhat	1 2 3	**If 2 skip to 93**
92	What do you know about Chiranjivi Yojana? **Explain**	1_____ 2_____ 3_____ 4_____ 5_____		

Section P : TRANSPORT FACILITY

Sno.	QUESTIONS	CODING CATEGORIES	CODES	SKIP TO
93	What mode of transport did you use to go to the health facility for delivery?	Walk Cycle Bus Ambulance (108) Private Other (specify)……	1 2 3 4 5 9	**If 4 answer 95 also**

94	Who arranged for the transportation?	Self Husband Other family members Neighbours/friends ASHA ANM Panchayat Pradhan Village Health Committee Other(specify)……	1 2 3 4 5 6 7 10 9	
95	What was the response of 108?			

MENTION ANY PROBLEMS / FEEDBACK ABOUT THE EXPERIENCES YOU HAVE HAD WITH THE ASHAs WORKING IN YOUR AREA

DATE :	IDI Number :

PERFORMANCE EVALUATION OF ASHA's

Indepth Inteviews Guidelines for ANM's

NAME OF THE RESPONDENT:
NAME OF THE INTERVIEWER:
PLACE OF INTERVIEW:
START TIME:
END TIME:

- **OBJECTIVE OF THE STUDY :** The broad objective of the study is to evaluate the knowledge, awareness and practices of the ASHAs and impact of the trainings imparted to the ASHAs under standard NRHM module on in the four tribal blocks of the Vadodara district and subsequently assess the need for refresher trainings for ASHAs on the basis of the perceptions of different stakeholders at different levels.

BACKGROUND INFORMATION OF THE RESPONDENT

Age:

Educational Qualification:

Marital status:

SECTION 1 – COORDINATION MEETINGS

1.1 Do you meet the ASHAs working in coordination with you?
1.2 How many ASHAs are working under you? (include all the ASHAs at that SC)
1.3 How often do you meet the ASHAs working in coordination with you?
1.4 Do you feel there are any benefits of having coordination meetings with the ASHAs?
1.5 What are the benefits of having coordination meetings with the ASHAs? **Probe for answers**

SECTION 2 – INSTITUTIONAL DELIVERIES, ANC, PNC & NEWBORN CARE

2.1 Do you feel that ASHAs contribute towards improving institutional deliveries, ANC, PNC and newborn care?
2.2 What is their contribution in these areas? **Explain**

SECTION 3 – FAMILY PLANNING

3.1 Do you think that ASHAs have a role to play in family planning?
3.2 What is their role and how effective is the ASHA in influencing a couple for family planning? **Explain**

SECTION 4 - IMMUNIZATION

4.1 According to you does the ASHA contribute at the time of immunization sessions?
4.2 How effective is the ASHA in influencing mothers for complete immunization of the child? **Explain**

SECTION 5 – PROBLEMS FACED

5.1Do you face any problems while working in coordination with the ASHAs?
5.2 What are the kind of problems you face while working in coordination with them? **Elaborate**

SECTION 6 – TRAINING

6.1 According to you think that ASHAs need further refresher training in the near future?
6.2 What more trainings should be given to the ASHAs to improve their effectivity and efficiency?

SECTION 7 – FEEDBACK & SUGGESTIONS

7.1 Briefly mention about any feedback, experiences or suggestions you have had while working with ASHAs. **Probe for answers**

DATE :

IDI Number :

PERFORMANCE EVALUATION OF ASHA's

Indepth Inteviews Guidelines for MO's

NAME OF THE RESPONDENT:

NAME OF THE INTERVIEWER:

PLACE OF INTERVIEW:

START TIME:

END TIME:

- **OBJECTIVE OF THE STUDY :** The broad objective of the study is to evaluate the knowledge, awareness and practices of the ASHAs and impact of the trainings imparted to the ASHAs under standard NRHM module on in the four tribal blocks of the Vadodara district and subsequently assess the need for refresher trainings for ASHAs on the basis of the perceptions of different stakeholders at different levels.

BACKGROUND INFORMATION OF THE RESPONDENT

Age:

Educational Qualification:

Marital status:

SECTION 1 – COORDINATION MEETINGS

1.4 Do you meet the ASHAs working in coordination with you?
1.5 How many ASHAs are working under you? (include all the ASHAs at that SC)
1.6 How often do you meet the ASHAs working in coordination with you?
1.4 Do you feel there are any benefits of having coordination meetings with the ASHAs?
1.5 What are the benefits of having coordination meetings with the ASHAs? **Probe for answers**

SECTION 2 – INSTITUTIONAL DELIVERIES, ANC, PNC & NEWBORN CARE

2.1 Do you feel that ASHAs contribute towards improving institutional deliveries, ANC, PNC and newborn care?
2.2 What is their contribution in these areas? **Explain**

SECTION 3 – FAMILY PLANNING

3.1 Do you think that ASHAs have a role to play in family planning?
3.2 What is their role and how effective is the ASHA in influencing a couple for family planning? **Explain**

SECTION 4 - IMMUNIZATION

4.1 According to you does the ASHA contribute at the time of immunization sessions?
4.2 How effective is the ASHA in influencing mothers for complete immunization of the child? **Explain**

SECTION 5 – PROBLEMS FACED

5.1Do you face any problems while working in coordination with the ASHAs?
5.2 What are the kind of problems you face while working in coordination with them? **Elaborate**

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6.1 According to you think that ASHAs need further refresher training in the near future?
6.2 What more trainings should be given to the ASHAs to improve their effectivity and efficiency?

SECTION 7 – FEEDBACK & SUGGESTIONS

7.1 Briefly mention about any feedback, experiences or suggestions you have had while working with ASHAs. **Probe for answers**

Focus Group Discussion Guide

FGD with VHSC members to evaluate performance of ASHAs under the NRHM in four tribal blocks

INSTRUCTION: Please make sure that ASHA is not included in the group

Sl. no. of FGD ☐☐ Date of FGD: __ __/__ __/ __ __ __ _

Block: _____ Run By: _____

Place of FGD: _____ Time: _____

Total Participant: ☐☐ No. of Male: ☐☐ No. of Female: ☐☐

Name of the FGD Moderator: _____

Name of the FGD Facilitator: 1._____

2._____

Mode of Recording: Electronic mode ☐ Written ☐ Both ☐

Background information

Profile of members participating in FGDs

Sr. #	Name	Gender	Age	Marital Status	Education	Caste	Occupation	Position in VHSC/Membership Status
1								
2								
3								
4								
5								
6								
7								
8								

1. What are the general health and sanitation problems in your village?
   (Probe: Probable issues like Anaemia, Malaria, Diarrhoea etc)

2. Have you seen the film Sahiyaro Saath anytime?

3. Have you heard about ASHA in your village?
   (Probe using terms like Aarogya Karyakarta, etc)

4. What are the major roles of ASHA in the community?
   (Probe: Maternal and Newborn care/General Health)

5. Do you feel ASHA do all the activities that she should do? Yes / No

   If yes, list activities:
   …….
   …….
   …….
   …….
   …….

6. Could you list the functions that you expect her to perform?
   …….
   …….
   …….
   …….
   …….

7. Is there any change in the villages since the recruitment of ASHAs in your village? If yes, what changes?

8. With whom ASHAs coordinate in the village?

Probe:

- What does she do in VHSC meeting?
- Coordination with AWW, ANM, Sarpanch, VHSC members

9. How do you rate the performance of ASHA in the VHSC meetings?

    - Good
    - Average
    - Poor
    - Don't Know/ Can't say

10. Do you think the ASHA could contribute any way in improving the health status of people in your community? If yes; How?

11. What are the challenges faced by ASHA?
    Probe: Lack of rapport, lack of knowledge, lack of monitoring and supervision, lack of supplies, lack of incentives/approvals etc.

12. What are your suggestions to improve the performance of ASHAs in your village?

Signature of the moderator: _____; Date: __ __/ __ __/ __ __ __ __
Signature of the facilitator: 1._____;
2. _____;

APPENDIX 2

TABELS OF QUANTITAIVE DATA

COMPETENCY ASSESSMENT OF ASHAs ON KNOWLEDGE, AWARENESS & PRACTICES

Table 1: Background characteristics of the ASHAs

Percent distribution of the ASHAs in the tribal blocks of the Vadodara district

	Kawant	Chhota Udepur	Naswadi	Pavi Jetpur	Total
Demographic characteristics					
Mean age	28.2	29.3	29.9	30.5	29.8
Marital status					
Unmarried	17.3	19.6	27.3	8.3	25.3
Currently married	78.2	76.1	69.7	81.5	78.0
Others *	4.5	4.3	3.1	10.2	5.8
Socio-economic characteristics					
Ethnicity					
SC / ST	96.1	94.2	90.3	88.8	95.3
Others	3.9	5.8	9.7	11.3	8.9
Socio-economic status					
APL	35.8	42.5	41.5	44.1	40.2
BPL	58.0	52.7	52.1	51.4	53.2
Do not have card	6.2	4.8	6.3	4.5	5.6
Educational Qualification					
Std. 1 to 7	28.4	9.0	35.2	15.3	28.6
Std. 8 to 10	40.1	51.5	50.7	55.9	52.4
Std. 11 to 12	27.2	35.9	13.4	20.7	28.7
College	4.3	3.6	0.7	8.1	4.5
Average duration (years) as ASHA	3.2	4.2	3.6	3.2	4.0
Average population covered	1464.7	1608.3	943.6	1639.2	1508.9
Average number of households covered	227.9	242.6	166.5	235.5	243.8
Average number of villages covered	1.1	1.0	1.5	1.1	1.2
Average number of training module completed	4.9	4.9	4.8	4.6	4.5

Table 2. AWARENESS ABOUT ROLES OF ASHA
Percent ASHA aware about eight roles of ASHA's as per NRHM in Tribal Blocks of Vadodara, GUJARAT

Role of ASHA's	Kawant	Chhota Udepur	Naswadi	Pavi Jetpur	Total
Knowing village people	25.5	26.7	28.5	25.6	25.2
Help and assist in making VHAP	12.3	14.5	15.7	14.8	13.9
Conduct BCC	10.8	15.9	12.8	10.4	12.6
Linkages with Govt. staffs	8.7	5.6	4.7	6.8	7.5
Counseling	40.9	42.5	45.7	45.8	46.9
Escorting patients to the hospital	35.6	37.8	38.9	36.8	36.8
Act as PMC and depot holders	3.4	4.5	3.2	2.7	3.8
Maintain Records & Registers	19.8	23.2	22.6	20.8	20.5
PMC=Primary medical care					

Table 3. AWARENESS ABOUT ROLES OF ASHA
Percent ASHA aware about eight roles of ASHA's as per NRHM in Tribal Blocks of Vadodara, GUJARAT

What activities ASHA do	Kawant	Chhota Udepur	Naswadi	Pavi Jetpur	Total
To identify pregnant women					
Ask during home visit	24.5	26.8	29.6	28.5	26.5
Woman herself informed me	45.7	45.8	40.2	43.6	44.5
ANM informs me	12.8	10.6	9.8	10.2	10.9
Ask dai	0.2	0.4	0.5	0.1	0.4
I came to know from other women	5.7	6.8	4.7	5.4	5.8
The ANC care					
Registration of pregnant woman	25.5	20.8	28.7	24.9	23.6
Ensure all 3 ANC checkups	35.8	38.9	32.6	30.5	32.4

Ensure all requisite examinations	23.9	20.1	24.6	27.8	25.8
Inform about the date and time of availability of the ANM	39.5	40.4	40.2	43.4	40.7
Counsel about nutrition	28.6	26.8	23.6	28.9	27.5
Inform about the nearest health facility	20.9	19.8	17.5	16.4	19.7
Delivery preparedness	44.7	42.8	43.7	44.8	45.8
At the time of delivery					
Counsel about institutional deliveries	32.9	33.4	35.6	30.9	32.1
Inform about nearest health facility and call 108	40.2	35.8	45.3	42.7	44.6
Escort / accompany	40.5	38.9	37.8	36.9	40.2
Counsel to go in for SBA in case of home delivery	22.9	22.8	23.5	27.8	28.9
Refer to the health facility for emergency	20.9	23.4	24.8	25.6	22.4
Delivery preparedness	38.7	36.5	37.9	34.5	35.9
PNC care					
Advise woman for atleast 1 checkup within 2 weeks of delivery	25.6	24.3	27.8	28.5	27.8
Counsel about contraceptives	20.3	22.5	24.6	24.3	22.8
Advise about registration of birth	25.8	26.5	27.5	28.9	26.8
Counsel about the importance of nutrition	24.3	22.8	23.5	25.1	24.8
The newborn care					
Breastfeeding	40.9	42.3	41.4	43.5	42.3
Advise the woman about various complimentary foods	20.6	23.4	22.8	24.5	21.9
Advise on vaccinations	35.6	32.8	34.7	32.9	34.7
Advise the mother on KMC	25.3	24.7	28.9	23.6	25.8
Weigh the child within 24 hours, 3rd day and 7th day	20.9	19.8	17.4	15.6	17.8
Advise to wrap the newborn in a clean, dry cloth	18.4	17.9	18.0	17.3	17.5
Do not bathe the newborn for the first	10.9	9.8	7.8	5.8	6.8

seven days					
Make visits to the newborn	12.4	11.8	10.9	8.7	10.9
roles you play at the PHC/SC					
Help in registration / admission	20.7	22.3	24.5	19.8	22.3
Helping families to get medicines and other supplies	25.2	24.7	23.8	21.9	22.9
Helping in getting JSY money	15.6	12.5	14.2	13.8	14.9
ASHA= ; PMC=Primary medical care					

Table 4. ACTIVITIES RELATED TO BIRTH AND DEATH REGISTRATION
Percent ASHA aware about eight roles of ASHA's as per NRHM in Tribal Blocks of Vadodara, GUJARAT

What activities ASHA do	Kawant	Chhota Udepur	Naswadi	Pavi Jetpur	Total
Pregnancy					
Take information about the LMP	30.9	32.4	35.6	28.9	32.4
Performs the pregnancy test	80.3	79.8	74.5	76.5	73.6
Calculates EDD	60.3	59.8	57.9	64.5	59.8
Registers the pregnant women	70.2	69.4	65.9	64.3	67.6
Birth					
Make visit to the newborn	50.9	52.5	54.5	52.4	51.8
Weigh the newborn	60.2	59.8	58.7	61.2	60.8
Refer the newborn to the health facility in case of LBW	24.5	23.4	22.7	22.6	24.5
Register the newborn	20.3	19.8	18.7	16.5	18.7
Help to get the birth certificate	30.8	24.5	28.9	27.6	29.8

Maternal death					
Make visits to the home	35.4	32.3	30.9	37.8	32.6
Gather information about the cause of death	20.9	19.6	19.8	17.6	19.5
Register the death	62.3	60.4	59.8	57.6	59.3
Help to get the death certificate	25.8	24.5	25.8	24.6	24.8
Infant death					
Make visits to the home	20.9	22.3	24.5	26.3	24.3
Gather information about the cause of death	15.7	16.3	12.7	14.8	15.2
Register the death	55.4	52.3	50.9	51.4	52.8
Help to get the death certificate	30.9	32.5	36.7	27.6	30.2

RANKING OF ASHAs BY THE MOs

Table 5 : BACKGROUND CHARACTERISTICS

Percent distribution of the background characteristics of the MO's in the four tribal blocks of Vadodara district

	Kawant (N=8)	Chhota Udepur (N=7)	Naswadi (N=5)	Pavi Jetpur (N=6)	Total (N=26)
Age (in years)					
Mean age	34.25	26.86	34.40	33.83	32.19
Minimum age	26	24	26	27	24
Maximum age	58	34	41	51	58
Educational qualification					
MBBS	37.5	57.1	80.0	66.7	57.5
BAMS	37.5	28.6	0.0	33.3	26.9
BHMS	25.0	14.3	20.1	0.0	15.4
Caste					
SC	0.0	28.6	0.0	16.7	11.5
ST	37.5	28.6	20.0	33.3	30.8
Others	62.5	42.9	80.0	50.0	57.7
Marital status					
Unmarried	12.5	42.9	20.0	16.7	23.1
Currently married	87.5	57.1	80.0	83.3	76.9
Socio-economic status					
APL	100.0	85.7	100.0	100.0	96.2
BPL	0.0	14.3	0.0	0.0	3.8
Mean Duration as a MO at the PHC	2.4	1.9	1.6	2.8	2.2
No. of ASHAs working under MO					
Mean	20.25	25.14	28.20	21.67	23.42
Minimum	10.0	24.0	15.0	11.0	10.0
Maximum	25.0	28.0	29.0	20.0	29.0

Table 6: RANKING LIST						
Percent distribution of the rankings of ASHAs done by the MO						
Sno.	**Rank**	**Kawant (N=8)**	**Chhota Udepur (N=7)**	**Naswadi (N=5)**	**Pavi Jetpur (N=6)**	**Total (N=26)**
1.	**BEHAVIOUR**					
1.1.	**At the PHC**					
	Bad	0.0	0.0	0.0	0.0	0.0
	Fair	0.0	0.0	0.0	0.0	0.0
	Average	0.0	71.4	20.0	0.0	23.1
	Good	62.5	14.3	40.0	33.3	38.5
	Very good	37.5	14.3	40.0	66.7	38.5
1.2.	**With the MO**					
	Bad	0.0	0.0	0.0	0.0	0.0
	Fair	0.0	0.0	0.0	0.0	0.0
	Average	0.0	14.3	20.0	16.7	11.5
	Good	37.5	71.4	40.0	16.7	42.3
	Very good	62.5	14.3	40.0	66.7	46.2
1.3.	**With the beneficiaries**					
	Bad	0.0	0.0	0.0	0.0	0.0
	Fair	0.0	0.0	0.0	16.7	3.8
	Average	25.0	14.3	0.0	16.7	15.4
	Good	25.0	57.1	80.0	0.0	38.5
	Very good	50.0	28.6	20.0	66.7	42.3
1.4.	**In totality**					
	Bad	0.0	0.0	0.0	0.0	0.0
	Fair	0.0	0.0	0.0	0.0	0.0
	Average	25.0	42.9	20.0	33.3	30.8
	Good	37.5	57.1	60.0	0.0	38.5
	Very good	37.5	0.0	20.0	66.7	30.8
2.	**KNOWLEDGE ABOUT**					
2.1.	**Her roles & responsibilities as an ASHA**	0.0	0.0	0.0	0.0	0.0
	Bad	0.0	0.0	0.0	0.0	0.0
	Fair	50.0	42.9	40.0	16.7	38.5
	Average	50.0	28.6	20.0	16.7	15.4
	Good	0.0	28.6	20.0	16.7	15.4
	Very good					
2.2.	**Facilities available at the PHC**					
	Bad	0.0	0.0	0.0	0.0	0.0
	Fair	0.0	0.0	0.0	0.0	0.0
	Average	25.0	28.6	20.0	16.7	23.1
	Good	62.5	57.1	20.0	66.7	53.8
	Very good	12.5	14.3	60.0	16.7	23.1

2.3.	**ANC care**					
	Bad	0.0	0.0	0.0	0.0	0.0
	Fair	0.0	0.0	0.0	16.7	3.8
	Average	12.5	14.3	0.0	16.7	15.4
	Good	75.0	28.6	100.0	50.0	61.5
	Very good	12.5	42.9	0.0	16.7	19.2
2.4.	**Care at the time of delivery**					
	Bad	0.0	0.0	0.0	0.0	0.0
	Fair	0.0	0.0	0.0	0.0	0.0
	Average	25.0	57.1	40.0	33.3	38.5
	Good	37.5	28.6	40.0	33.3	34.6
	Very good	37.5	14.3	20.0	33.3	26.9
2.5.	**PNC care**					
	Bad	0.0	0.0	0.0	0.0	0.0
	Fair	0.0	0.0	0.0	0.0	0.0
	Average	25.0	42.9	40.0	50.0	38.5
	Good	62.5	28.6	20.0	16.7	34.6
	Very good	12.5	28.6	40.0	33.3	26.9
2.6.	**Family planning**					
	Bad	0.0	0.0	0.0	0.0	0.0
	Fair	0.0	28.6	0.0	0.0	7.7
	Average	25.0	14.3	20.0	33.3	23.1
	Good	37.5	14.3	40.0	33.3	30.8
	Very good	37.5	42.9	40.0	33.3	38.5
2.7.	**Immunization**					
	Bad	0.0	0.0	0.0	0.0	0.0
	Fair	0.0	0.0	0.0	0.0	0.0
	Average	0.0	42.9	40.0	16.7	23.1
	Good	62.5	57.1	40.0	50.0	46.2
	Very good	37.5	0.0	20.0	50.0	26.9
2.8.	**In totality**					
	Bad	0.0	0.0	0.0	0.0	0.0
	Fair	0.0	0.0	0.0	0.0	0.0
	Average	62.5	42.9	60.0	33.3	50.0
	Good	37.5	57.1	40.0	50.0	46.2
	Very good	0.0	0.0	0.0	16.7	3.8
3.	**AWARENESS ABOUT**					
3.1.	**Identification of the beneficiaries**					
	Bad	0.0	0.0	0.0	0.0	0.0
	Fair	0.0	0.0	0.0	0.0	0.0
	Average	12.5	28.6	0.0	33.3	19.2
	Good	50.0	42.9	20.0	50.0	30.8
	Very good	37.5	28.6	40.0	50.0	38.5

3.2.	**Risk identification of the pregnant women**					
	Bad	0.0	0.0	0.0	0.0	0.0
	Fair	0.0	0.0	0.0	16.7	7.7
	Average	12.5	42.9	20.0	50.0	30.8
	Good	62.5	0.0	80.0	16.7	38.5
	Very good	25.0	42.9	0.0	16.7	23.1
3.3.	**Risk identification of newborn**					
	Bad	0.0	0.0	20.0	0.0	3.8
	Fair	0.0	14.3	0.0	50.0	15.4
	Average	25.0	57.1	40.0	16.7	34.6
	Good	75.0	14.3	40.0	16.7	38.5
	Very good	0.0	14.3	0.0	16.7	7.7
3.4.	**In totality**					
	Bad	0.0	0.0	0.0	0.0	0.0
	Fair	0.0	14.3	0.0	33.3	11.5
	Average	25.0	42.9	60.0	33.3	38.5
	Good	75.0	42.9	40.0	16.7	46.2
	Very good	0.0	0.0	0.0	16.7	3.8
4.	**Practice**					
	Bad	0.0	0.0	20.0	0.0	3.8
	Fair	0.0	0.0	0.0	0.0	0.0
	Average	25.0	14.3	20.0	16.7	19.2
	Good	62.5	71.4	40.0	50.0	57.7
	Very good	12.5	14.3	20.0	33.3	19.2
5.	**Efficiency in service delivery to the beneficiaries**					
	Bad	0.0	0.0	0.0	0.0	0.0
	Fair	0.0	0.0	20.2	16.7	7.7
	Average	12.5	14.3	80.0	0.0	23.1
	Good	75.0	42.9	60.0	33.3	53.8
	Very good	12.5	14.3	20.0	33.3	19.2
6.	**Maintaining records and registers**	0.0	0.0	0.0	16.7	3.8
	Bad	0.0	14.3	0.0	0.0	3.8
	Fair	12.5	14.3	80.0	0.0	23.1
	Average	87.5	57.1	20.0	66.7	61.5
	Good	0.0	14.3	0.0	16.7	7.7
	Very good					
7.	**Coordination with the MO**					
	Bad	0.0	0.0	0.0	0.0	0.0
	Fair	0.0	0.0	0.0	16.7	3.8
	Average	25.0	0.0	0.0	0.0	7.7
	Good	62.5	57.1	60.0	50.0	57.7
	Very good	12.5	42.9	40.0	33.3	30.8

8.	**Training of ASHAs**	0.0	0.0	0.0	16.7	3.8
	Bad	0.0	0.0	0.0	0.0	0.0
	Fair	25.0	14.3	40.0	33.3	26.9
	Average	50.0	71.4	60.0	16.7	50.0
	Good	25.0	14.3	0.0	33.3	19.2
	Very good					

RANKING OF THE ASHAs BY THE ANMs

Table : BACKGROUND CHARACTERISTICS

Percent distribution of the background characteristics of the ANM's in the four tribal blocks of Vadodara district.

	Kawant (N=52)	**Chhota Udepur (N=45)**	**Naswadi (N=41)**	**Pavi Jetpur (N=52)**	**Total (N=190)**
Age (in years)					
Mean age	39.2	40.0	37.8	38.5	38.9
Minimum age	23.0	23.0	23.0	19.0	19.0
Maximum age	53.0	56.0	53.0	54.0	56.0
Educational qualification					
Up to 10th class	59.6	37.8	48.8	51.9	50.0
Up to 12th class	25.0	35.6	46.3	32.7	34.2
Graduate	15.4	24.4	4.9	15.4	15.3
Post graduate	0.0	2.2	0.0	2.2	0.0
Caste					
SC	19.2	35.6	22.0	11.5	21.6
ST	57.7	35.6	56.1	57.7	51.6
Others	23.1	28.9	22.0	30.8	25.3
Marital status					
Unmarried	21.2	13.3	12.2	9.6	14.2
Currently married	75.0	80.0	70.7	90.4	79.5
Others	3.8	6.6	17.1	0.0	5.8
Socio-economic status					
APL	63.5	91.1	70.7	96.2	80.5
BPL	3.8	4.4	26.8	3.8	8.9
Do not have card	32.7	4.4	2.4	0.0	10.5
Since when did you become ANM?					
Since when did you join as ANM at this SC?					
What is the population size you are covering?	4075.0	4734.08	3094.61	4137.23	4041.51
Mean	1985	1879	500	600	500
Minimum	5600	7891	5088	6000	7891
Maximum					

What is the number of households you provide services to?	575.40	556.31	472.66	522.98	561.73
Mean	225	250	75	237	75
Minimum	935	935	935	1200	1200
Maximum					
What is the number of ASHAs working under you?					
Mean	3.13	3.41	3.71	3.67	3.48
Minimum	1	1	2	1	1
Maximum	7	6	6	7	7

Table 10: RANKING LIST ANM						
Percent distribution of the rankings of ASHAs done by the ANM						
Sno.	**Rank**	**Kawant (N=52)**	**Chhota Udepur (N=45)**	**Naswadi (N=41)**	**Pavi Jetpur (N=52)**	**Total (N=190)**
1.	**BEHAVIOUR**					
1.1.	**At the SC**					
	Bad	0.6	0.0	11.2	1.4	3.3
	Fair	3.8	2.0	6.9	12.6	6.6
	Average	19.4	22.2	20.7	13.1	18.7
	Good	49.4	48.0	33.0	32.7	40.3
	Very good	26.9	27.8	28.2	40.2	31.2
1.2.	**With the ANM**					
	Bad	3.8	0.0	10.1	1.4	3.7
	Fair	1.9	2.5	6.9	5.6	4.3
	Average	14.4	21.2	16.0	9.8	15.3
	Good	43.1	41.4	36.2	33.2	38.2
	Very good	36.9	34.8	30.9	50.0	38.6
1.3.	**With the beneficiaries**					
	Bad	3.1	0.0	9.6	1.9	3.6
	Fair	2.5	3.5	8.0	3.3	4.3
	Average	21.9	17.7	16.0	15.0	17.4
	Good	36.9	39.9	34.0	30.4	35.1
	Very good	35.6	38.9	32.4	49.5	39.5
1.4.	**In totality**					
	Bad	3.1	0.0	11.2	0.9	3.7
	Fair	3.1	1.5	8.5	12.1	6.6
	Average	31.3	28.8	23.4	16.4	24.5
	Good	43.1	53.0	36.7	41.1	43.6
	Very good	19.4	16.7	20.2	29.4	21.7
2.	**KNOWLEDGE ABOUT**					
2.1.	**Her roles & responsibilities as an ASHA**	2.5	0.0	10.1	0.9	3.3
	Bad	6.3	2.0	9.6	7.5	6.3
	Fair	20.6	18.7	21.8	18.7	19.9
	Average	36.3	43.4	34.6	36.0	37.6
	Good	34.4	35.9	23.9	36.9	32.9
	Very good					
2.2.	**Facilities available at the SC**					
	Bad	5.0	3.0	12.2	0.0	4.9
	Fair	0.6	2.5	12.2	6.5	5.7
	Average	15.6	30.8	19.1	21.0	22.0
	Good	43.1	39.9	34.0	29.0	36.1
	Very good	35.6	23.7	22.3	43.5	31.4

2.3.	**ANC care**					
	Bad	1.9	0.0	10.6	0.9	3.3
	Fair	6.9	3.5	9.0	9.8	7.4
	Average	25.0	20.2	22.3	13.1	19.7
	Good	30.6	40.4	34.6	31.8	34.5
	Very good	35.6	35.9	23.4	44.4	35.1
2.4.	**Care at the time of delivery**					
	Bad	3.1	0.0	12.2	0.9	3.9
	Fair	11.3	2.5	10.1	5.6	7.1
	Average	23.8	30.3	20.7	20.1	23.7
	Good	32.5	35.4	31.9	33.2	33.3
	Very good	29.4	31.8	25.0	40.2	32.0
2.5.	**PNC care**					
	Bad	3.1	0.5	12.2	1.9	4.3
	Fair	11.3	7.1	9.0	7.5	8.6
	Average	25.6	24.7	21.8	19.2	22.6
	Good	33.1	37.9	33.0	34.6	34.7
	Very good	26.9	29.8	23.9	36.9	29.7
2.6.	**Family planning**					
	Bad	6.3	0.0	13.3	1.4	5.0
	Fair	8.1	8.1	17.0	14.5	12.1
	Average	15.0	31.3	21.3	20.1	22.2
	Good	40.0	36.4	17.0	24.3	28.9
	Very good	30.6	24.2	31.4	39.7	31.7
2.7.	**Immunization**					
	Bad	3.8	0.0	11.2	0.9	3.8
	Fair	2.5	7.1	5.9	5.1	5.3
	Average	18.1	15.2	10.6	12.1	13.8
	Good	30.0	32.3	33.5	22.0	29.2
	Very good	45.6	45.5	38.8	59.8	47.9
2.8.	**In totality**					
	Bad	3.8	0.0	13.3	1.4	4.5
	Fair	8.8	7.1	9.0	10.3	8.8
	Average	34.4	40.9	37.8	26.2	34.6
	Good	39.4	40.9	31.9	46.7	40.0
	Very good	13.8	11.1	8.0	15.4	12.1
3.	**AWARENESS ABOUT**					
3.1.	**Identification of the beneficiaries**					
	Bad	3.8	0.0	11.2	0.9	3.8
	Fair	5.0	9.1	5.9	4.2	6.1
	Average	21.3	18.7	14.4	18.2	18.0
	Good	28.1	37.9	44.1	26.6	34.2
	Very good	41.9	34.3	24.5	50.0	37.9

3.2.	**Risk identification of the pregnant women**					
	Bad	3.8	1.5	15.4	1.9	3.3
	Fair	7.5	7.1	15.4	10.3	6.1
	Average	25.6	31.3	28.2	20.6	18.0
	Good	25.0	37.4	22.3	30.8	34.2
	Very good	38.1	22.7	18.6	36.4	37.9
3.3.	**Risk identification of newborn**					
	Bad	8.1	0.0	14.9	3.7	6.4
	Fair	10.0	9.1	12.8	8.9	10.1
	Average	24.4	34.3	27.7	27.1	28.6
	Good	32.5	34.3	30.9	29.0	31.6
	Very good	25.0	22.2	13.8	31.3	23.3
3.4.	**In totality**					
	Bad	5.0	0.0	16.0	2.3	5.7
	Fair	13.8	11.1	11.7	13.1	12.4
	Average	26.9	40.4	38.8	27.6	33.6
	Good	36.9	36.4	23.9	43.0	35.3
	Very good	17.5	12.1	9.6	14.0	13.2
4.	**Practice**					
	Bad	5.6	0.0	10.6	1.4	4.2
	Fair	8.1	9.6	4.3	3.3	6.2
	Average	15.6	19.7	17.0	15.4	17.0
	Good	29.4	44.9	34.6	36.4	36.7
	Very good	41.3	25.8	33.5	43.5	35.9
5.	**Efficiency in service delivery to the beneficiaries**					
	Bad	3.8	0.0	10.6	2.8	4.2
	Fair	8.1	8.6	6.9	3.7	6.7
	Average	22.5	25.8	17.0	21.5	21.7
	Good	27.5	42.4	38.3	35.5	36.3
	Very good	38.1	23.2	27.1	36.4	31.1
6.	**Maintaining records and registers**	4.4	2.5	10.1	0.9	4.3
	Bad	10.6	10.1	9.6	5.1	8.7
	Fair	19.4	21.7	19.1	16.4	19.1
	Average	35.6	35.4	35.1	36.9	35.8
	Good	30.0	30.3	26.1	40.7	32.1
	Very good					
7.	**Coordination with the ANM**					
	Bad	5.0	0.0	9.6	0.5	3.6
	Fair	4.4	1.5	4.8	1.9	3.0
	Average	15.6	25.8	17.6	15.0	18.6
	Good	34.4	44.9	32.4	22.4	33.3
	Very good	40.6	27.8	35.6	60.3	41.6

8.	**Training of ASHAs**	5.0	0.5	13.8	1.9	5.1
	Bad	3.1	2.5	9.6	5.6	5.3
	Fair	20.0	14.6	23.4	17.3	18.7
	Average	31.9	44.9	29.8	29.4	34.1
	Good	40.0	37.4	23.4	45.8	36.8
	Very good					