ROLE OF ASHA WORKERS IN RURAL DEVELOPMENT WITH REFERENCE TO KOTTAYAM DISTRICT

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By

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Certificate

This is to certify that the Minor Research Project entitled**ROLE OF ASHA WORKERS IN RURAL DEVELOPMENT WITH REFERENCE TO KOTTAYAM DISTRICT"**MRP(H)-1274/13-14/ KLMG031/ UGC-SWRO DATED 28THMarch-2014 is a bonafide work done by **Ms.TISSY ERUTHICKAL**, **Assistant Professor, Post-Graduate Department of Commerce, Baselius College, Kottayam.** Also the project is completed by duly adhering to the rules and regulations laid down by the *University Grant Commission*

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DECLARATION

I **Mrs. TISSY ERUTHICKAL**, hereby declare that the dissertation entitled "**ROLE OF ASHA WORKERS IN RURAL DEVELOPMENT WITH REFERENCE TO KOTTAYAM DISTRICT**" has been prepared by me and also declare that this is a bonafide record of research work done by me during the course of minor research project allotted to me byThe University Grant Commission, New Delhi and no part of this study has been submitted earlier or elsewhere for any similar purpose.

Kottayam

Date:

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Acknowledgement

I am very much delighted to present the Minor Research project work entitled ***"Role of ASHA Workers in Rural Development with reference to Kottayam District".***

I bow my head ***God Almighty*** *for giving me the required strength and courage to complete this humble project. Without his grace nothing would have been possible.*

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Tissy Eruthickal

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The World Bank defines rural development as, ”Rural development is a strategy to improve the economic and social life of a specific group of people , the rural poor, including small and marginal farmers ,tenants and the landless.

Thus rural development means to the process of improving living conditions, providing minimum needs, increasing productivity and employment opportunities and developing potentials of rural resources through integration of spatial, functional and temporal aspects. In the process of rural development rural society as a whole moves from one step of the economic status. A target group-the rural poor-has been identified for programmes of rural development.

Rural development is basically concerned with improving the standards of the mass of the low income population residing in rural areas and making the process of their development self-sustaining. Rural development involves changes in attitudes, customs, beliefs and values, output-both quantitatively and qualitatively, utilization of natural and human resources, employment patterns and magnitudes, technology, institutional and organizational frameworks, incomes, both spatial and social relationships, rural lifestyle, and policy initiatives related to land and water, forest, inputs, supporting services, prices, backward areas and deprived sections of society, organization and administration, resource generation, self-sufficiency and self-sustenance, gender issues, sustainability, and management/ conservation, government intervention, people’s involvement, and the nature and levels of planning (including decentralized planning in a multi-level frame work).

Policy for rural development has become a major preoccupation of the government of poor countries since on the successful tackling of rural development problems depend the pace and tone of development of the economies of the poor countries. The rural development programmes occupy significant position in India’s economic planning, as nearly three-fourth of its population lives in villages. In fact villages represent real India. Hence without uplifting rural masses, we cannot think over accelerate the pivot of overall economic development. In order to ensure that there should be balanced economic development of the country and the fruits of the development should percolate to the grass-root levels, rural development gets the top most priority in our planned efforts.

Health is not the mere absence of disease; it is a requisite for defining a person's overall wellbeing. Article 39(e) (f) 42 and 47 on part IV of the Indian constitution clearly define a state's responsibility to guarantee a healthy life to the people of its country. The state's obligation towards the health of its people is beyond social reasons. It is more because healthy people can only contribute productivity towards nation building and high economic growth. It expected that the state with high economic growth will be able to allocate more towards providing basic health facilities. The long standing ailments of the health system are being addressed at length inside along with some field cases. For ages people in the rural areas have been using traditional knowledge innovations and practices embodying traditional life style to take care of the day to day health requirement. The need to rely on this traditional/ knowledge is fast gaining ground as never diseases are sprouting mainly due to extra dependence on traditional sources of health care. Primary health centers play an important role in local effects to implement natural health. However the main problem include the failure to integrate health service with - economic & social development. Union budget for 15-16 allocates 33152crores to the health sector and take the initiatives further in the direction of universal health care. But India still spends only about 1 per cent of gross domestic

The launch of NRHM is the much dreamt program which can make health for all and placing people's health in their hand a reality. NRHM aims to improving rural health by targeting phased increase in the funding for the health up to 2-2% of GDP.The strategy of NRHM encompasses the principles of health for all. Such as equitable distribution community participation, inter-sectorial co-ordination and appropriate technology etc. decentralized planning ,community ownership of health service system and inter- sectorial collaboration are the pillars on which the super structure of the mission has been built. Health management are part of the core strategy of the mission. Government of India launched the National Rural Health Mission (NRHM) on 12thApril 2005 throughout the India with special focus on 18 states which have weak public health indicators and/or weak infrastructure. The NRHM was launched with a view to bring about dramatic improvement in the health system and health status of the people, especially those living in rural areas by the end of 2012. The NRHM has a clear objective of providing quality health care in the remotest rural areas by making it accessible, affordable and accountable. Under NRHM, financial assistance has been provided to the states, UTs for the health systems strengthening which include augmentation of infrastructure human resources and programme management ,emergency responses services ,Mobile Medical units, community participation .

Even though the state of Kerala has advanced as compared to the other states of India in terms of critical health indicators are concerned, the state is facing challenges that are unique and specific. The people are now facing the problem of high morbidity both from re-emergence of communicable diseases and the second generation problems like the ageing population and non-communicable diseases. Moreover, there remains the challenge of sustaining the privileged health indicators. Further, improving the quality of health care where the health seeking behaviour is very high is of utmost importance. The resources of National Rural Health Mission came in an opportune time when the state was finding it difficult to find resources matching the demand. During the last three years the State has been able to initiate many programmes suiting to its specific requirements and considering its health issues that need immediate intervention. These initiatives correspond to the Key Performance areas outlined by NRHM like a) Institutional Strengthening b)Improving access to better health care and quality services and c) Accessibility of health care to the under privileged and marginalised

The Govt. ofIndia has decided to launch a National Rural Health Mission (NRHM) to addressthe health needs of rural population, especially the vulnerable sections of society.One of the key components of the National Rural Health Mission (NRHM) is toprovide every village in the country with a trained female community healthactivist ASHA. The full form of ASHA is AccreditedSocial Health Activist.

ASHA will be trained to work as an interface between the community and thepublic health system. ASHA will be the first port of call for any health relateddemands of deprived sections of the population especially women and childrenwho find difficult to access health services. ASHA caters to a population normof 5000 but is effectively serving much larger population at the sub center levelespecially in EAG states with only about 50% MPW (M) being available in thesestates the Auxiliary Nurse Midwife is heavily over work which impacts outreach services in rural areas.

In order to create awareness among the rural people about this problem and this problem and to help them Accredited Social Health Activist [ASHA] was formed. Now a day's Accredited Social Health Activist [ASHA] is becoming popular among rural population with its Reproductive and Child Health [RCH] activities and other health care programs. Therefore an attempt is made to study the role of Accredited Social Health Activist [ASHA] in improving the health needs of rural population. The study is carried out in order to determine the effectiveness of the plan and to create more

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CHAPTER – I

INTRODUCTION

Since the role of the community health worker was re-emphasized during the Alma Ata conference in 1978, there have been several variations and definitions of this term. Globally, they are called by a variety of names including Health Auxiliaries, Barefoot Doctors, Health Agents, Health Promoters, Family Welfare Educators, Health Volunteers, Village Health Workers, Community Health Aides, Community Health Volunteers and Community Health Workers. With the varying demands and differing levels of health within countries, regions, districts, and villages, each community has its own version of the community health worker.

According to WHO, "CHWs are men and women chosen by the community, and trained to deal with the health problems of individuals and the community, and to work in close relationship with the health services. They should have had a level of primary education that enables to read, write and do simple mathematical calculations" (WHO 1990).1

Witmer et al (1995) define community health workers as "Community members who work almost exclusively in community settings and who serve as connectors between health care consumers and providers to promote health among groups that have traditionally lacked access to adequate care. By identifying community problems, developing innovative solutions, and translating them into practice, community health workers can respond creatively to local needs".

The National Rural Health Mission (NRHM) was launched on 12th April 2005 with an objective to provide effective health care to the rural population with emphasis on poor women & children. One of the key components of the NRHM is to provide every village in the country with a trained female community health activist i.e. Accredited Social Health Activist (ASHA). ASHA is a health activist in the community, who will create awareness on health and its determinants and mobilize the community towards local health planning and increased utilization and accountability of the existing health services. The ASHA is expected to be an interface between the community and the public health system. NRHM is envisaged as a horizontal program with emphasis on initiatives and planning at local level.3,4 ASHA being the grass root level worker the success of NRHM depends on how efficiently is ASHA able to perform but the efficiency of ASHA or efficiency of performance of ASHA depends on their awareness & perception about their roles & responsibilities in health care provision

ORIGIN OF THE RESEARCH PROBLEM

Earlier there were no such health care activities for the needs and wants of the rural people. These health care activities were formed when the government realized the fact that majority of the rural people died because of improper medical treatment. The people in those areas did not know how to take treatment if they are affected by disease like Malaria, Chikungunia, and Cholera. And they didn't have an easy access to the hospitals. The birth rate decreased because he woman did not get proper care and treatment while they were pregnant.

In order to create awareness among the rural people about these problems Accredited Social Health Activist [ASHA] was formed. ASHA works as an interface between community and the public health system. Now a day's Accredited Social Health Activist [ASHA] is becoming popular among rural population with its health care programmes. Therefore an attempt is made to study the role of Accredited Social Health Activist [ASHA] in improving the health needs of rural population.

IMPORTANCE OF THE STUDY

Earlier there were no such health care activities for the needs and wants of the rural people. These health care activities were formed when the government realized the fact that majority of the rural people died because of improper medical treatment. The people in those areas did not know how to take treatment if they are affected by disease like Malaria, Chikungunia, and Cholera. And they didn't have an easy access to the hospitals. The birth rate decreased because he woman did not get proper care and treatment while they were pregnant.

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The development of industry leads to development of economy .The development of the health is very importance since they are promising factor of tomorrow. The government adopted many strategies for providing health education. Till date more than 8.85 lakhs ASHA workers have been selected, trained and deployed across the country. ASHA is a first port of any health related demand of deprived section of the population especially women and children which finds it difficult to access health services in rural areas. It increases the utilisation outpatient services, diagnostic facilities which enhance the wealth through health which provides a channel for financial inclusion for the total population.

REVIEW OF RESEARCH AND DEVELOPMENTS IN THE SUBJECTS

Arima Mishra conducted a study about the role of the Accredited Social Health Activists in effective health care delivery in South Orissa finds that there should be more involvement of community in recruiting and discussing responsibilities of the ASHAs. This will enable ASHAs to effectively act as a bridge between the community and the formal healthcare services

Planning commission, Government of India conducted study of National Rural Health Mission (NRHM) In 7 States Programme Evaluation Organisation about role of ASHA turns out to be extremely important in promoting utilization of public health care facilities for MCH care, Family Planning and treatment of Chronic Diseases. ASHA's home visits and counseling promotes utilization of family planning services primarily from public health facilities.

An evaluation study in Madhya Pradesh and Uttarakhand has been pointed out that there is a great urgency to speed up establishment of support structures and implementation of the programme. All these states will benefit a great deal while having a skilled ASHA at the community level to promote maternal, new born and child health and family planning

Gosavi SV and Raut AV ASHAS' awareness & perceptions about their roles&responsibilities: a study from rural wardha Comments that though the NRHM focuses on reducing the maternal & child mortality & morbidity, creation of functional infrastructures & up gradation of services. We found out that the public health machinery is not successful in

generating awareness and creating a cadre of functional frontline workers in the form of ASHA. ANC services at the village level were affected because of lack of participation of ASHA in village health & nutrition day (VHND) & because of lack of clarity in their roles in health care provision.

A study by Bajpai et al (2009) found that the introduction of ASHAs has had a positive impact in increasing the proportion of women taking at least three antenatal check-ups and immunisation institutional deliveries. It should also be kept in mind that the scheme requires the volunteers to play an activist role in communities which are often characterised by religion and caste politics, conservative attitudes and where women are still looked down upon.

Gopalan SS, et al.(2010)conducted Cross-sectional study assessing community health workers' performance motivation: a mixed-methods approach on India's Accredited Social Health Activists (ASHA) programme in Orissa. By using multistage stratified sample 386(10%) community health workers were selected. **Result revealed that** the level of performance motivation was the highest for the *individual l*and the *community level* factors (mean score 5.94–4.06), while the *health system* factors scored the least (2.70–3.279). Those ASHAs who felt having more community and system-level recognition also had higher *levels of earning* as CHWs (p=0.040, 95% CI 0.06 to 0.12), a *sense of social responsibility* (p=0.0005, 95% CI 0.12 to 0.25) and a feeling of *self-efficacy* (p=0.000, 95% CI 0.38 to 0.54) on their responsibilities. There was no association established between their level of dissatisfaction on the incentives (p=0.385) and the extent of motivation.

Sharma P, et al.(2008-2009) conducted a Comparative study to find out the difference in utilization of Janani Suraksha Yojana in rural areas and urban slums Dehradun, Uttarakhand. The study was carried out among 227 married women in reproductive age (15-49 years), who delivered in government hospital were considered for the study out of which 88 women belonged to rural areas and 139 women were from urban slums. The study concluded that JSY utilization was found to be low in rural areas i.e. 38.7% .Thus, IEC activities should be strengthened and ASHA's work should be properly monitored.

Manish K Singh, et al. (2007-08) conducted a cross-sectional study on factors influencing utilization of available services under NRHM in relation to maternal health in rural Lucknow. 350 Recently Delivered Women (RDW) were considered as those who

delivered a newborn at PHC Sarojininagar within a week of interview and belonged to villages within the confines of the PHC being served by the ASHA. Sample was selected by simple random sampling technique. Study was conducted in two stages, in the first Recently Delivered Women were interviewed at their bed side and 2nd stage after 6 weeks of delivery. The result concluded that utilization of health services for early registration significantly associated with age and religion of Recently Delivered Women.

Darshan K Mahyavanshi, et al. (2011) conducted cross sectional study on knowledge, attitude and practice regarding child health (under five years of age) of ASHA workers in Surendranagar district. 130 samples were selected by simple random sampling at 5 PHCs of Surendranagar district. Data has been collected by using predesigned and pretested proforma. The result reveals that about 68.46% and 68.47% had lack of knowledge about measles and pneumonia respectively. Approximately 80.77% knew about signs and symptoms of malaria but 59.23% .

Sushama S Thakare, et al. (2011),conducted cross sectional study on effectiveness of the training course of ASHA on feeding practices at a rural teaching hospital: at the Rural Health Training Centre, Saoner, District Nagpur, India. 94 ASHAs & 5 supervisors were the sample of the study. A predesigned, pretested and structured schedule was used for the data collection. Effectiveness of training programme was done by posttest assessment by using same questionnaire. Study reveals that the mean pretest score was 15.11$\pm$ 1.89, which had risen significantly (p=0.001) posttest to a mean of17.30$\pm$ 1.59. Study concluded that ASHA worker and their supervisors gained the knowledge and skills on breast feeding and complimentary feeding after the training.

Srivastava SR,et al.(2011).conducted a cross sectional study to evaluate the knowledge, attitude and practices of ASHA workers in relation to child health at Palghar Taluk in Thane district of Maharastra for a period of 3 months. 150 ASHA workers were selected from the area of which 4 workers were untrained and thus excluded from the study. Each ASHA workers interviewed using questionnaire by face to face interaction. Results showed that a total of 67.1% of ASHA were not aware of the correct preventive measures for vitamin A deficiency, 29(19.9%) of ASHA s did not feel the need for referral for a child with diarrhoea who is unable to drink or breast feed. Similarly in acute respiratory tract infection 35(23.9%) of ASHAs did not know to refer child with fast breathing. 59 ASHA s (50.4%)

considered a baby crying more than 3 hours following immunization not worth referring to a first referral unit.

P Stalin, Anand Krishnan, et al. (2008-09).conducted a study on ASHA's involvement in newborn care at Primary Health Centre (PHC) Haryana. All the 33 ASHA of Primary Health Centre were trained in providing newborn care by community physicians at Civil Hospital. This was followed by two refresher training at three months interval and supportive supervision. The study result showed that the knowledge did not increase immediately after training. This could be attributed to the induction trainings under routine program and working experience for more than 2 years. In addition, this could be due to shorter duration of training. Three months after training, there was significant increase in the knowledge of ASHAs. This could be attributed to learning by doing and indicates the need for practical training for ASHAs.

SajiSaraswathyGopalan, SatyanarayanMohanty and Ashis Das (2012) Assessing community health workers' performance motivation: a mixed-methods approach on India's Accredited Social Health Activists (ASHA) programme. The CHW programme could motivate and empower local lay women on community health largely. The desire to gain social recognition, a sense of social responsibility and self-efficacy motivated them to perform. The healthcare delivery system improvements might further motivate and enable them to gain the community trust. The CHW management needs amendments to ensure adequate supportive supervision, skill and knowledge enhancement and enabling working modalities.

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

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

(100%) and Uttar Pradesh (98%) registered pregnant women for ANC were visited only once for ANC.

SMSMC, (2008) undertook a study to assess the quality of institutional deliveries in Jaipur District, Rajasthan. The study found that ASHAs create awareness on the need for skilled attendance at birth, on danger signs during pregnancy, counsel pregnant mothers for 26birth preparedness, motivate them for ante n atal check –ups and accompany them to health institutions at the time of institutional delivery, in addition to other roles and responsibilities

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

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

OBJECTIVES

The main objective of the study is to determine the health awareness among rural population. The specific objectives of the study include the following

- to know the health development of rural population through the implementation of ASHA
- to know the level of awareness among public
- to identify the satisfaction of rural population in getting the services through ASHA
- to know the role of ASHA in maintaining financial inclusion

HYPOTHESIS

1. There is no significant relationship between gender and awareness about ASHA

2. There is no significant relationship between economic category and types of information provided
3. There is no significant relationship between number of home visit and savings of money for meeting contingencies

METHODOLOGY OF THE STUDY

The study about role of Accredited Social Health Activist [ASHA] in improving health needs is both analytical and descriptive. The following methodology was used for this study

- Data used – both primary and secondary data was used. Primary data was collected from 150 respondents of through structured interview schedule from Kottayam District using multi stage sampling technique. The Kottayam District consists of 5 taluk, from each taluk one panchayat is selected at random. Thereafter from each panchayat a sample of 30 respondents is selected. Secondary data for the purpose of study was collected from published sources such as books, journals, and internet.
- Tools for presentation – For the presentation of the collected and classified data statistical tools such as tables
- Percentage analysis – is calculated by summing up the frequencies of each particular class of intervals and taking it as cent percentage. Find out the composition of each class interval to the total cent percentage.
- Likert's scaling technique**:** Likert's sale is a psychometric sale commonly involved in research that employs questionnaires. It is the most widely used tool to measure the positive and negative responses. In a Likert's sale the respondent is asked to respond to 5 each of the statements in terms of several degrees such as highly satisfied-5 satisfied-4 neutral-3 dissatisfied-2 highly dissatisfied-1

LIMITATIONS

A study of this nature of course faces limitations and entails constraints and snags. Physical constraints, to a great extent, have compelled the researcher to reduce the size of the research canvas. So too has been the question of time constraints. The impending deadline has compelled the researcher to rush through many stages of the research. The

hesitation of the respondents to divulge factual information regarding some of their personal state of affairs has affected the reliability of the data in some respects. In spite of all these constraints, the researcher feels that modest but sincere and serious attempt has been made in this study to make it meaningful one.

CHAPTERISATION OF THE STUDY

For a lucid presentation the report is divided into four chapter.

Chapter I :- Introduction

Chapter II :- Theoretical overview of ASHA workers

Chapter III :- Data Analysis and Interpretation

Chapter IV :- Findings, Suggestions and conclusion

CHAPTER II

THEORETICAL OVERVIEW OF ASHA WORKERS

Rural Development is a complex phenomenon covering a wide spectrum of activities meant to ameliorate the condition of people, living in rural areas. Rural development has been defined by different authorities in different ways. Rural development may also be defined as a systematically organised process which results into sustained higher levels of income, of people living in rural areas, over a pretty long period of time.

In the Indian context, "Rural Development" can be defined as "integrated development of area and the people through optimum development and utilization (and conservation where necessary) of local resources- physical, biological and human and by bringing about necessary institutional, structural, and attitudinal changes by delivery of a package of service to encompass not only economic field, i.e. agricultural, allied activities, rural industries, but also establishment of required social infrastructure and services in the area of health and nutrition, sanitation, housing, drinking water and literacy with ultimate objective of improving quality of life of "rural poor" and the "rural weak".

The World Bank defines rural development as, "Rural development is a strategy to improve the economic and social life of a specific group of people , the rural poor, including small and marginal farmers ,tenants and the landless.

According to Robert Chambers, "Rural development is strategy to enable a specific group of people, poor rural women and men, to gain for themselves and their children more of what they want and need. It involves helping the poorest among those who seek a livelihood in the rural areas to demand and control more of the benefits of rural development.

Thus rural development means to the process of improving living conditions, providing minimum needs, increasing productivity and employment opportunities and developing potentials of rural resources through integration of spatial, functional and temporal aspects. In the process of rural development rural society as a whole moves from one step of the economic status. A target group- the rural poor-has been identified for programmes of rural development.

Rural development is basically concerned with improving the standards of the mass of the low income population residing in rural areas and making the process of their development self-sustaining. Rural development involves changes in attitudes, customs, beliefs and values, output-both quantitatively and qualitatively, utilization of natural and human resources, employment patterns and magnitudes, technology, institutional and organizational frameworks, incomes, both spatial and social relationships, rural lifestyle, and policy initiatives related to land and water, forest, inputs, supporting services, prices, backward areas and deprived sections of society, organization and administration, resource generation, self sufficiency and self sustenance, gender issues, sustainability, and management/ conservation, government intervention, people's involvement, and the nature and levels of planning (including decentralized planning in a multi-level frame work).

Policy for rural development has become a major preoccupation of the government of poor countries since on the successful tackling of rural development problems depend the pace and tone of development of the economies of the poor countries. The rural development programmes occupy significant position in India's economic planning, as nearly three-fourth of its population lives in villages. In fact villages represent real India. Hence without uplifting rural masses, we cannot think over accelerate the pivot of overall economic development. In order to ensure that there should be balanced economic development of the country and the fruits of the development should percolate to the grass-root levels, rural development gets the top most priority in our planned efforts.

India was one of the pioneers in health service planning with a focus on primary health care. In 1946, the Health Survey and Development Committee, headed by Sir Joseph Bhose recommended establishment of a well structured and comprehensive health service with a sound primary care infrastructure. In 1952 as a consequence of the Bhose Committees recommendation, Primary Health Care Centre were established to promote, prevent, curate and rehabilitate the services to entire rural population, as an integral component of wider Community Development Programme. The convulsive political changes that took place in the 1970s impelled the Central Government to implement the vision Sokhey Committee of having one Community Health Worker for every 1000 people to entrust 'people health on people's hand'.

India has come quite close to Alma Ata Declaration on Primary Health Care made by all countries of the world in 1978. The Declaration included commitment of governments to

consider health as fundamental right; giving primacy to expressed health needs of people; community health reliance and community involvement; Intersectoral action in health integration of health services; coverage of entire population; choice appropriate technology; effective use of traditional system of medicine and use of only essential drugs. Health Policy was formed in 1982 to make architectural corrections in health care system. National Health Policy gave a general exposition of the policies which require recommendation in the circumstances then prevailing in health sector. Universal Immunization programme (UIP) was launched in 1985 to provide universal coverage of infants and pregnant women with immunization against identified vaccine preventable diseases. In 1997, Reproductive and child Health (RCH-Phase) programme was launched which incorporated child health, maternal health, family planning, treatment and control of reproductive tract infections and adolescent health. RCH Phase-2 (2005-2001) aims at sector wide, outcome oriented programme based approach with emphasis on decentralization, monitoring and supervision which brings about a comprehensive integration of family planning into safe motherhood and child health.

Health is influenced by a number of factors such as adequate food, housing, sanitation, healthy lifestyle, protection against environmental hazards and communicable diseases. The various issues related to tribal health are:

1. Health and culture-including the traditional belief in the super nature.
2. Health, food habits and environment-covering the sanitation, water supply, settlement pattern, the total physical environment affecting health and food during socio-religious occasions.
3. Medicine, health and community-the traditional health practitioners, their position in the society, concept and treatment of diseases, nature and use of medicine-traditional and modern.
4. Fertility and mortality variations and reasons, use of traditional and modern practices of birth control.
5. Interaction of traditional and modern systems of medicine at various levels, reasons for non-adoption of modern practices.
6. Traditional medicine –its use and application with certain modifications and change, study of indigenous methods of treatment.

Woman made provisions for the basic necessities like food, fuel, medicine, housing material etc. from the forest produce. Food was obtained from shifting cultivation and from minor forest produces (MFP) like flowers and fruits collected from the forest. Extraction from herbs, roots and animals were used for medicine. All these efforts incurred an excessive workload on women. Because of extensive cutting of trees by vested interest, the distances between the villages and the forest area had increased, forcing the tribal women to walk longer distance in search of minor forest produce and firewood. In this rapidly changing milieu, tribal women were confronted with an extraordinary workload.

Health is a function, not only of medical care but also of the overall integrated development of society, cultural, economic, educational, social and political; each of these aspects has a deep influence on health, which in turn influences all these aspects. Hence, it is not possible to raise the health status and quality of life of people unless such efforts are integrated with the wider efforts to bring about the overall transformation of a society. Good health and society go together.

One of the key components of the National Rural Health Mission is to provide every village in the country with a trained female community health activist ASHA or **Accredited Social Health Activist**. Selected from the village itself and accountable to it, the ASHA will be trained to work as an interface between the community and the public health system.

ASHA will be chosen through a rigorous process of selection involving various community groups, self-help groups, Anganwadi Institutions, the Block Nodal officer, District Nodal office, the village Health Committee and the Gram Sabha.

SELECTION AND TRAINING OF ASHA

- 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 3ASHAs 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 primarily be a women resident of the village
- Married/widowed/divorced, preferably in the age group of 25 to 45 years.
- She should be a literate woman with formal education up to class eight. This may be relaxed only if no suitable person with this qualification is available.
- She will counsel women on birth preparedness, importance of safe delivery, breast feeding and complementary feeding, immunization, contraception and prevention of common infections.
- Capacity building of ASHA is being seen as a continuous process. ASHA will have to undergo series of training episodes to acquire the necessary knowledge, skills and confidence for performing her spelled out roles.
- The ASHAs will receive performance-based incentives for promoting universal immunization, referral and escort services for Reproductive & Child Health (RCH) and other healthcare programmes, and construction of household toilets.
- Empowered with knowledge and a drug-kit to deliver first-contact healthcare, every ASHA is expected to be a fountain head of community participation in public health programmes in her village.
- ASHA will be the first port of call for any health related demands of deprived sections of the population, especially women and children, who find it difficult to access health services.
- ASHA will be a health activist in the community who will create awareness on health and its social determinants and mobilise the community towards local health planning and increased utilisation and accountability of the existing health services.
- She would be a promoter of good health practices and will also provide a minimum package of curative care as appropriate and feasible for that level and make timely referrals.
- ASHA will 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 utilisation of health & family welfare services.

Selection Process

The selection of ASHAs would have to be done carefully. The District Health Society envisaged under NRHM would oversee the process. The Society would designate a District Nodal Officer, preferably a senior health person, who is able to ensure that the Health Department is fully involved.

She would also act as a link with the NGOs and with other departments. The Society would designate Block Nodal Officers, preferably Block Medical Officers, to facilitate the selection process, organizing training for Trainers and ASHA as per the guidelines of the scheme.

✓ The Block Nodal Officer would identify 10 or more Facilitators in each Block so that one facilitator covers about 10 villages. The facilitators should preferably be women from local NGOs; Community based groups, MahilaSamakhyas, Anganwadis or Civil Society Institutions. In case none of these is available in the area, the officers of other Departments at the block or village level/local school teachers may be taken as facilitators.

✓ These facilitators should be oriented about the scheme in a 2-day workshop which should be held at the district level under supervision of the District Nodal Officer. During this meeting, the Block Nodal Officers should also be present. The District Nodal Officer will brief the facilitators and Block Nodal Officers on the selection criteria and importance of proper selection in effective achievement of the objectives of the same and also the role of facilitators and Block Nodal Officers are required to play in ensuring the quality of the selection process.

✓ The facilitators would be required to interact with community by conducting Focused Group Discussions (FGDs) / workshops of the local self help groups etc. This should lead to awareness of roles and responsibilities of ASHA and acceptance of ASHA as a concept in the community. This interaction should result in short listing of at least three names from each village.

✓ Subsequently a meeting of the Gram Sabha would be convened to select one out of the three shortlisted names. The minutes of the approval process in Gram Sabha shall be

recorded. The Village Health Committee would enter into an agreement with the ASHA as in the case of the Village Education Committee and Sahayogini in SarvaShikshaAbhiyan. The name will be forwarded by the Gram Panchayat to the District Nodal Officer for record.

State Governments may modify these guidelines except that no change may be done in the basic criteria of ASHA being a woman volunteerwith minimum education up to VIII classand that she would be a resident of the village. In case any of the selection criteria or guidelines is modified, these should be widely disseminated in local languages. 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.

National ASHA Mentoring Group

The national ASHA mentoring Group (NAGM) was constituted by the Ministry of Health & Family Welfare in july 2005 to serve as a Technical and advisory body for the ASHA programme and to extend support to the Central and State Governments in overall implementation, mentoring and monitoring of the programme .

Objectives:

- Provide Technical Guidance and inputs for Policy to the Ministry of Health & Family Welfare on overall implementation and development of the ASHA Programme.
- Identify one or few states and provide on-site mentoring through periodic supportive supervision visits.
- Meet on a bi-annual basis to share the major observations and provide assessment reports related to programme progress, challenges, and innovations across different states.
- Identify constraints; provide feedback and strategic recommendations to the Ministry of Health & Family Welfare and state officials for appropriate interventions.
- Support in undertaking programme evaluation at regular intervals, to enable evidence based understanding of programme effectiveness and propose strategies for improved outcomes.
- Facilitate scale of ASHA trainings through- serving as training sites, supporting in identification or selection of trainers, assisting in training curriculum design and providing inputs for developing training material.

- Identify the emerging priorities and support in planning future goals to enable long term sustenance of programme.

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 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 up gradation**: 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.

- **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 TO ASHA

- ✓ ASHA would be an honorary volunteerand 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.

One of the key strategies under the National Rural Health Mission (NRHM) is having a Community Health Worker i.e. ASHA (Accredited Social Health Activist) for every village with a population of 1000. Detailed guidelines have been issued by the Government of India in matter of selection and training of ASHA. The States have been given the flexibility to relax the population norms as well as the educational qualifications on a case to case basis, depending on the local conditions as far as her recruitment is concerned.

2. The above said guidelines also clearly bring out the role of ASHA vis-vis that of Anganwadi Worker (AWW) and the Auxiliary Nurse Midwives (ANM). The non-ASHA States (including the NE) have been advised that they could provide for similar link workers at the village level in the revised Project Implementation Plan for RCH-II in the current year. States like Andhra Pradesh and Haryana are already having the link workers. The 10 states where ASHA scheme is presently in place can select ASHAs in urban areas also as link workers subject to similar provisions being made in the State PIP for RCH-II in the current financial year.

3. The reports received from the States indicate that over 1, 20,000 ASHAs have been selected in the year 2005-06 and that they are being provided with orientation training as envisaged in the guidelines issued on ASHA. Now, a careful strategy needs to be devised for providing the necessary management support to ASHA so that she is not left alone in the village without having any linkage with the health system.The group includes experts and practitioners in the field of Community Health representing NGOs, training and research institutions, academic and medical colleges.

4. The following set of guidelines are issued to enable the States to develop and put in place a proper support mechanism for ASHA.

(1) ASHA Mentoring Group:

The Government of India has set up an ASHA Mentoring Group comprising of leading NGOs and well known experts on community health. Similar mentoring groups at the State/District/Block levels could be set up by the States to provide guidance and advise on

matter relating to selection, training and support for ASHA. At the District level, MNGOs and at Block level, FNGOs could be involved in the mentoring of ASHA. The State Govt. may utilize the services of Regional Resource Centre (RRC) and include them in the Mentoring Group at the State level.

(2) Selection of ASHA

As ASHA will be in the village on a permanent basis, she should be selected carefully through the process laid down in the first set of ASHA guidelines. It is possible that the selected ASHA drops out of the programme. It is, therefore, necessary to keep a record of such cases at Sub-Centre/ PHC level. In the above circumstance, a new ASHA could be selected from the panel of three names previously prepared on the recommendation of the Gram Sabha.

(3) Training of ASHA

The guidelines already issued on ASHA envisage a total period of 23 days training in five episodes. However, it is clarified that ASHA training is a continuous one and that she will develop the necessary skills & expertise through continuous on the job training. After a period of 6 months of her functioning in the village it is proposed that she be sensitized on HIV / AIDS issues including STI, RTI, prevention and referrals and also trained on new born care.

(4) Familiarizing ASHA with the village:

Now, that ASHAs have been selected, the next step would be to familiarize her with the health status of the villagers and facilitate her adoption to the village conditions. Although, ASHA hails from the same village, she may not be having knowledge and information on the health status of the village population. For this purpose, she should be advised to visit every household and make a sample survey of the residents of village to understand their health status. This way she will come to know the villagers, the common diseases which are prevalent amongst the villagers, the number of pregnant women, the number of newborn, educational and socio economic status of different categories of people, the health status of weaker sections especially scheduled castes/scheduled tribes etc. She can be provided a simple format for conducting the surveys. In this she should be supported by the AWW and the Village Health & Sanitation Committee.

The Gram Panchayath will be involved in supporting ASHAs in her work. All ASHAs will be involved in this Village Health and Sanitation Committee of the Panchayath either as members or as special invitees (depending on the practice adopted by the State). ASHAs may coordinate with Gram Panchayaths in developing the village health plan. The untied funds placed with the Sub-Centre or the Panchayat may be used for this purpose. At the village level, it is recognized that ASHA cannot function without support. The SHGs, Womans Health Committees, Village Health and Sanitation Committees of the Gram Panchayat will be major sources of support to ASHA. The Panchayat members will ensure secure and congenial environment for enabling ASHAs to function effectively to achieve the desired goal.

(5) Maintenance of Village Health Register:

A village health register is maintained by the AWW which is not always complete. ASHA can help AWW to complete and update this register by maintaining a daily diary. The diaries, registers, health cards, immunization cards may be provided to her from the untied funds made available to the Sub-Centres.

(6) Organization of the Village Health and Nutrition Day:

All State Governments are presently organizing monthly Health and Nutrition day in every village (Anganwadi centres) with the help of AWW/ANM. ASHA along with AWW should mobilize women, children and vulnerable population for the monthly health day activities like immunization, careful assessment of nutritional status of pregnant/lactating women, newborn & children, ANC/PNC and other health check-ups of women and children, taking weight of babies and pregnant women etc. and all range of other health activities. The ANM and the AWW will guide the ASHA during the monthly health days. The organization of the monthly Health and Nutrition Days ought to be jointly monitored by the CDPO, LHVs, and the Block Supervisor of the ICDS periodically.

(7) Co-ordination with SHG Groups:

ASHA would be required to interact with SHG Groups, if available in the villages, along with AWW, so that a work force of women will be available in all the villages. They could jointly organize check up of pregnant women, their transportation for safe institutional

delivery to a pre-identified functional health facility. They could also think of organizing health insurance at the local level for which the Medical Officer and others could provide necessary technical assistance.

(8) Meeting with ANM:

ANM should have a monthly meeting with the ASHAs stationed (5-6 ASHAs) in the villages of her work area at the Anganwadi Centre during the monthly Health and Nutrition Day to assess the quality of their work and provide them guidance.

(9) Monthly meetings at PHC level:

The Medical Officer In-charge of the PHC will hold a monthly meeting which would be attended by ANM and ASHAs, LHVs and Block Facilitator. During this period, the health status of the villages will be carefully reviewed. Payment of incentive to ASHAs under various schemes could be organized on that day so that ASHA need not visit the PHC many times to receive her incentives. States may ensure that payment to ASHA are made promptly through a simplified procedure. During these meetings, the support received from the Village Health and Sanitation Committee and their involvement in all activities also should be carefully assessed. The ASHA kits also could be replenished at that time. Replenishment of kit should be prompt, automatic and through a simplified procedure.

(10) Monthly meetings of ASHAs:

A meeting of ASHA could be organized on the day monthly meetings are organized at the PHC level to avoid unnecessary travel expenditure and wastage of time. The idea is that apart from the meeting with officials they should be given opportunity to share sometime of their own experience, problems, etc. They will also get an opportunity to independently assess the health system and can bring about much needed changes.

In addition to monthly meetings at PHC, periodic retraining of ASHAs may be held for two days once in every alternate month where interactive sessions will be held to help then to refresh and upgrade their knowledge and skills, as provided for in the original guidelines for ASHA.

(11) Block level management:

At the block level, the BMO will be in overall charge of ASHA related activities. However, an officer will be designated as Block level organizer for the ASHA to be assisted by Block Facilitators (one for every 10 ASHAs). Block Facilitators could be appointed as provided for under the first set of guidelines on ASHA already issued to the States. The Block Facilitator may be necessarily women. However, male members if any, who may have already been appointed earlier as Block Facilitator may continue. The Block Facilitators would provide feedback on the functioning of ASHAs to the BMO & Block level organizers. They shall also visit the ASHAS in villages.

(12) Management Support FOR ASHA:

Officials in the ICDS should be fully involved in ASHAs activities and their support should be provided for at every level i.e. PHCs, CHCs, District Society etc. The management support which would be provided under RCH/NRHM at the Block, District & State level should be fully utilized in creating a network for support to ASHA including timely disbursement of incentives, at various levels. This support system should have full information on the number of ASHAs, quality of their out put, outcomes of the Village Health and Nutrition Day, periodic health surveys of the villages to assess her impact on community etc.

(13) Community monitoring:

Periodic surveys are envisaged under NRHM in every village to assess the improvement brought about by ASHA and other interventions. The funding for the survey will be provided out of the untied funds provided to the Sub-Centre. The first survey would provide the base line for monitoring the impact of health activities in the village.

(14) Role of District Health Missions:

The District Health Mission in its meetings will specially assess the progress of selection of ASHAs, their training and orientation, usefulness to the villages etc. They should also have a Cell in the DPU to collect all information related to ASHA and the community which should be available on the computer network. This information should be accessible by the State Health Missions as well as the Mission at the national level.

(15) Linkage with Health Facility:

The success of NRHM to great extent depends on performance of ASHA and her linkage with functional health system. The health system has to give due recognition to ASHA and take prompt action on the referrals made by her; otherwise the system cannot be sustained. Every ASHA must be familiar with the identified functional health facility in the respective area where she can refer or escort the patients for specific services. The persons manning these health facilities should be sensitized to effectively respond to the instant needs of the local people. Funds available under IEC-programme may be used for education and publicity in respect of above services. The role of the State & District level Missions would be to provide support to ASHA from village to the district level without any blockage on the way. The States may take appropriate steps to locally adopt these guidelines and make the ASHA scheme a complete success.

Funding for Support Mechanism of ASHA

One of the key strategies under the National Rural Health Mission (NRHM) is a community health worker i.e., Accredited Social Health Activist (ASHA) for every village at a norm of one per thousand population. Right after the launch of the Mission, detailed guidelines were issued by the Government of India for selection and training of ASHAs. The above guidelines clearly brought out the role of ASHA vis-vis that of Anganwadi Worker (AWW) and Auxiliary Nurse Mid-wife (ANM). The guidelines also gave break up of the expenditure on selection, training and provision of drug kits to ASHAs. The scheme for providing performance linked compensation and the methodology of payment of compensation was also delineated in those guidelines.

2. In view of the selection of large number of ASHAs, a need for providing a support mechanism for ASHAs has been acutely felt. A set of guidelines was therefore issued to the States to facilitate putting in place a mechanism for this purpose. These guidelines provided for inter-alia ASHA mentoring group at State level, Block Level Facilitators at the rate of one per ten ASHAs, a system of monitoring meetings of ASHAs at the PHC level, coordination with Self-Help Groups etc.

4. The implementation framework for the NRHM has recently been approved. The scheme of ASHA has now been extended to all the 18 high focus States. Besides, the scheme

would also be implemented in the tribal districts of the other States. In the new implementation framework, a provision has been made for an expenditure of Rs. 10,000 per ASHA during a financial year. This ceiling does not include the performance-based compensation, which the different programme divisions would disburse from their own funds. The earlier ASHA guidelines had visualized an expenditure of Rs. 7,415/- per ASHA. The increased outlay gives a valuable opportunity to further strengthen the support mechanism.

5. Over the last one year, the States have selected more than 200,000 ASHAs. The number of ASHAs is likely to be increase very rapidly over the next two years. As a matter of fact, a district alone is expected to have more than 1,000 ASHAs. Obviously, a very strong support mechanism is required at block, district and State level to ensure that the scheme of community health worker meets the objectives, which the Mission has envisaged for it. The support functions which would have to be carried out at these levels include inter-alia, preparation of training calendar for the trainers as well as for ASHAs, monitoring the implementation of the training programmes, adapting the training modules (provided to the States by the GoI) to suit the local conditions, translation in local language, printing and distribution of these manuals, developing ASHA monitoring forms and monitoring her performance, developing IEC materials, addressing grievances of ASHAs if any etc.

5. In order to provide adequate support to the ASHAs, the following has been provided:

- **<u>At State Level:</u>**

In the implementation framework of the NRHM a provision has been made for a State Health System Resource Centre (SHSRC) in every State. It is envisaged that once this centre is set up they would provide the leadership and support to the ASHA scheme at the State level. However, setting up of SHSRC may take a year. Since the support mechanism for ASHAs at the State level cannot wait for that long, a provision is being made for ASHA resource centre on the lines of the set up in Rajasthan. In the State having more than 20,000 ASHAs, a resource Centre would comprise a Project Manger (MBA), a Deputy Project Manager (MSW), one Statistical Assistant (Graduate in Statistics), a Data Assistant and Office Attendant.

In the smaller States (other than North Eastern States) having less than 20,000 ASHAs, three persons are being provided at the State level i.e. one Project Manager, a Statistical Assistant, and one Office Attendant. These functionaries together would comprise an ASHA Resource Centre which would ultimately get subsumed in the State Health Resource Centre (SHRC) as and when the SHRC gets off the ground.

In the detailed cost estimates (annexured), adequate provisioning has been done for office expenses and other contingent expenditure. This amount will be provided as a lump sum so that the States have the flexibility to use the amount as per their needs.

- **At District level:**

In the existing ASHA guidelines, at the district level a District Nodal Officer has been provided. The District Nodal Officer is to be an officer nominated by the Civil Surgeon. Since the guidelines do not provide for additional human resources, it is expected that he/she would be doing the work with the existing human and financial resources. However, as has been mentioned above, managing the various aspects of the functioning of more than 1,000 ASHAs will not be a simple task without adequate human and financial resources. It is, therefore, now proposed that each District Nodal Officer would be supported by a Community Mobiliser who would have the qualification of MSW. A Data Assistant may also be provided to satisfactorily discharge the work.

- **At Block Level:**

At the block level, as per the existing ASHA guidelines, the Block Nodal Officer is to be nominated by the Block Medical Officer. The Block Nodal Officer will have the services of a number of Block Facilitators @ 1 per 10 ASHAs. Even though a need has been actually felt for the services of a Block Coordinator, looking to the large number of blocks in the States, the outgo in providing for an additional Block Coordinator at the block level would be considerable. It may not, therefore, be possible to provide for the services of a Block Coordinator without overshooting the norm of Rs. 10,000 per ASHA. However, in the earlier guidelines, a provision of one Facilitator for ten ASHAs has already been made. It is expected that this arrangement would suffice. However, a flexibility would be available to the Block Nodal Officer to utilize the services of the Facilitator posted at the block or any

other Facilitator for other administrative work in his office relating to ASHAs. For this purpose a small honorarium could be permissible to the Facilitators.

- **At PHC level:**

  There would be considerable workload at PHC level as many of the bills for payment to ASHA would be processed in that office. Since no additional manpower is provided at this level, a suitable honorarium for LHV and the Block Supervisor for ICDS is being provided in the guidelines.

Present status of ASHA

- The total Number of ASHAs engaged by States/UTs increased from 7.06 Lakhs in 2009 to 8.90 lakh in 2013

- To further enhance the skill of ASHAs, they are now being trained on the Home Based New Born Care and have been provided HBNC kits. This is to improve new born care practices at the community level and the early detection and referral of sick new born babies in first 42 days of life.

- For career progression of ASHAs, States have been asked to give priority to ASHAs in ANM/GNM schools, subject to their meeting the eligibility criteria. Five states have already implemented this initiative.

- A proposal for certification of ASHAs to enhance competency and professional credibility of ASHAs by knowledge and skill assessment has been approved recently. The certification will be done by National Institute of Opening Schooling (NIOS).

- The cost norms for ASHAs have been enhanced from Rs.10,000 per ASHA to Rs.16,000 per ASHA

- The rates of existing performance based incentives for ASHAs have been enhanced and fresh incentives have also been introduced including those for routine activities so as to ensure that each ASHA workers can work properly.

No. of ASHA selected during (including ASHA in tribal areas in Non-High Focus States including kerala state.)	**2005-06**	**130315**
	2006-07	**300636**
	2007-08	**171327**
	2008-09	**105176**
	2009-10	**93890**
	2010-11	**47987**
	2011-12	**5837**
	Total	**855168**
No. of ASHAs who have received training	**1st module**	**807897**
	2nd module	**736956**
	3rd module	**713096**
	4th module	**690423**
	5th module	**573127**
	6th module	**93147**
	7th module	**92747**
No. of ASHAs in position with drug kits		**741502**
Total No. of Monthly Village Health & Nutrition Days held in the state	**2006-07**	**3505902**
	2007-08	**4962883**
	2008-09	**5819410**
	2009-10	**5870961**
	2010-11	**6925116**
	2011-12	**3153572**
	Total	**30237844**

(Data as on 30th September 2011)

CHAPTER III

DATA ANALYSIS AND

INTERPRETATION

This Chapter deals with the Analysis and interpretation of the Data Collected. As has been stated earlier, in this study 15o sample respondents are selected from 5 taluks of Kottayam district. Their responses collected and tabulated with the help of statistical tables. Appropriate statistical measures are computed using various statistical tools for analysing and interpreted data and reaching and meaningful conclusions.

Table 3.1

Gender wise classification

Gender	No .of respondents	percentage
Male	90	60
Female	60	40
Total	150	100

Source: Primary data

Interpretation: From the above table it is clear that the respondents covered under the survey are grouped according to their gender . Out of the 150 respondents, 90(60%) are male and 60(40%) are female. In this study, majority of the respondents are male.

Table 3.2
Age Wise Classification

Age	No .of respondents	percentage
Below 18	1	1
18-30	10	6
31-45	64	43
46-60	51	34
Above 61	24	16
Total	150	100

Source: Primary data

Interpretation: The above table shows age wise classification of respondents. It shows that 43% are in the age group 31 to 45, 34% are in the age group 46 to 60. Out of 150 respondents 16% are from age group above 61.6% are in the age group 18 to 30 and 1% are from age group below 18.

Table 3.3

Education wise classification

Education	No .of respondents	percentage
SSLC	59	39
plus two	56	37
Graduation	26	18
PG	9	6
Total	150	100

Source: Primary data

Interpretation: It is interpreted that 39% of the respondents have an educational qualification of SSLC, 37% of the respondents have plus two qualification, 18% of the respondents are graduated and remaining 6% of the respondents have an educational qualification of post graduation.

Table 3.4

Occupation wise classification

Occupation	No .of respondents	percentage
Private employee	46	31
Govt. employee	13	8
Business	22	15
Farmer	21	14
Daily workers	48	32
Total	150	100

Source: Primary data

Interpretation: while considering the occupational status of the respondents,32% are daily workers, 31% are private employees , 15 % engaged in business, 14% constitute of farmers and remaining 8% are government employees.

Table 3.5

Monthly income

Income	No .of respondents	percentage
Less than 10000	56	37
10000-20000	52	35
20000-40000	29	19
Above 40000	13	9
Total	150	100

Source: Primary data

Interpretation : it is evident that 37% of the respondent having a monthly income of less than 10000, 35% of the respondents having an income between 10000 to 20000, 19% of the respondents having an income between 20000 to 40000 and remaining 9% having an income above 40000.

Table 3.6

Economic category

category	No .of respondents	percentage
BPL	54	36
APL	96	64
Total	150	100

Source: Primary data

Interpretation: From the above table it is clear that 64% of the respondents belongs to APL category (above poverty level) and remaining 36% of the respondents belongs to BPL category(below poverty level)

Table 3.7

Awareness about ASHA workers

Level	No .of respondents	percentage
Fully	52	35
partly	82	54
not aware	16	11
Total	150	100

Source: Primary data

Interpretation: it is interpreted that 54% of the respondents are partly aware about ASHA, Only 35% of the respondents are fully aware about ASHA and remaining 11% of the respondents are not at all aware about ASHA workers.

Table 3.8

Source of information about ASHA workers

Source	Number of respondents	percentage
Media	40	27
Friends	39	26
Relatives	22	14
Awareness classes	49	33
total	150	100

Source: Primary data

Interpretation: The above table shows the source of information about ASHA workers. It is clear that 49 respondents got awareness about ASHA workers from awareness classes, 40 respondents are from media, 39 respondents got awareness about ASHA workers through friends and remaining 22 respondents from relatives.

Table 3.9

visit of ASHA workers

Visit	No .of respondents	percentage
Yes	149	99
No	1	1
Total	150	100

Source: Primary data

Interpretation : From the above table it is clear that 99% of the respondents houses are visited by ASHA workers and only 1% of the respondents comments that house visit is not conducted by ASHA workers

Table 3.10

Type of Visit of ASHA workers

Frequency	No .of respondents	percentage
Once	93	62
Twice	46	31
Thrice	5	3
More than that	6	4
Total	150	100

Source: Primary data

Interpretation : The above table shows the frequency of visit of ASHA workers among the houses. it is evident that 62% of the respondents houses are visited only once, 31% of the respondents houses are visited twice.3% of the respondents' houses are visited thrice and only 6 respondents opined that ASHA workers visited more than thrice.

Table 3.11

Assistance provided by ASHA workers

Diseases	No .of respondents	percentage
Fever	99	66
Diarrhea	22	15
Delivery	30	20
Others	28	19
Total	150	100

Source: Primary data

Interpretation: the above table shows the types of diseases assisted by ASHA workers. 66% of the respondents opined that ASHA workers assisted them in fever,20% of the respondents opined that ASHA workers assisted them in delivery, 19% of the respondents opined that ASHA workers provide assistance in other diseases and remaining 15% of the respondents gets assistance for diarrhoea from ASHA workers.

Table 3.12

Information regarding health

Information	No .of respondents	percentage
Yes	145	97
No	5	3
Total	150	100

Source: Primary data

Interpretation : The table 3.12 interprets about the provision of information provided by ASHA workers regarding health. it is clear that 97% of the respondents getting information regarding health from ASHA workers, and remaining 3% of the respondents does not get any information regarding health from ASHA workers.

Table 3.13
Type of information provided

Type of information	No .of respondents	percentage
Nutrition	45	30
basic sanitation	61	41
Hygenic practices	95	63
Total	150	100

Source: Primary data

Interpretation : the above table depicts the type of information provided by ASHA workers regarding health. it shows that 95 respondents received information regarding hygienic and health practices, 61 respondent s gets information regarding basic sanitation facilities and remaining 45 respondents received information regarding nutrition.

Table 3.14

Opinion about ASHA workers

	Factors	very good(5)	Good(4)	Neutral(3)	Bad(2)	very bad(1)
1	minor health injuries/first aid	39	79	23	8	1
2	Nutrition	66	66	13	5	0
3	Sanitation	69	68	11	1	1
4	minor health problems	39	64	37	8	2
5	ANC	8	40	76	21	5
6	Delivery	42	54	44	6	4
7	PNC	12	27	82	26	3
8	Immunisation schedule of new born babies	93	36	17	1	3
9	Prevention from sexually transmitted diseases	20	44	58	20	8

Source: Primary data

Interpretation: All the nine options have been considered for analysis and composite index number have been calculated. It is clear from the above table that ‘immunisation schedule of new born babies’ is the most preferable service provided by ASHA workers, which scored 665 points. The services regarding ‘sanitation’ and ‘nutrition’ come second and third with 653 points and 643 points. ‘Minor health injuries/first aid’ comes fourth with 597 points, while ‘minor health problems’ and ‘delivery’ come fifth and sixth with 580 points and 574

points. ‘Prevention from sexually transmitted diseases’ and ‘ANC’ come seventh and eighth with 498 points and 475 points. The least preferable service of SHA worker is ‘PNC’ comes ninth with 469 points.

Table 3.15

Group meeting in their localities

Response	No .of respondents	Percentage
Yes	78	52
No	72	48
Total	150	100

Source: Primary data

Interpretation: From the above table it is clear that 52% of the respondents opined that ASHA workers conducting Group meetings in their localities regarding the health problems. And remaining 48% of the respondents opined that ASHA workers does not conducting any group meetings in their localities.

Table 3.16

Services rendered by ASHA workers

Services	No .of respondents	percentage
Minor health injuries	38	7
Nutrition	98	18
Sanitation	118	22
Minor health problems	54	10
ANC	20	4
Delivery	76	14
PNC	12	2
Immunisation schedule of new born babies	106	20
Prevention from sexually transmitted diseases	13	3
Total	535	100

Source: Primary data

Interpretation : The table 3.16 shows the services received by the community from the ASHA workers. Out of 150 respondents 22% of the respondents got services about sanitation, 20% about immunisation schedule of new born babies, 18% about nutrition, 14% about delivery, 10% about minor health problems, 7% gets information about minor health injuries, 4% about ante natal checkup (ANC), 3% about prevention from sexually transmitted diseases and remaining 2% about post natalcheckup (PNC) .

Table 3.17

Satisfaction level

Level	No .of respondents	Weighted sum
Highly satisfied(5)	23	115
Satisfied(4)	81	324
Neutral(3)	42	126
Dissatisfied(2)	3	6
Highly dissatisfied(1)	1	1
Weighted Total	150	572
Weighted Average		3.81

Source: Primary data

Interpretation: This table contains the data relating to the level of satisfaction of respondents towards the performance of ASHA workers. The table shows a weighted average of 3.81 which indicates a satisfied level of performance of ASHA workers.

Table 3.18

Effectiveness of ASHA workers

Statement	Excellent	Good	Average	Below average	Poor
The dedication of ASHA workers in your locality	40	71	36	3	0
Publicity measures of ASHA	31	52	59	8	0
Health development through ASHA workers	26	82	37	5	0

Table 3.18(a)

Effectiveness of ASHA workers

Statement	Excellent (4)	Good (3)	Average (2)	Below average (1)	Weighted total	Weighted average
The dedication of ASHA workers in your locality	160	213	72	3	448	2.98
Publicity measures of ASHA	124	156	118	8	406	2.70
Health development through ASHA workers	104	246	74	5	429	2.86

Source: Primary data

Interpretation: The table 3.18 and 3.18a shows the degree of agreement by the respondents about the statement related to their effectiveness to the society. Likert's scaling technique is

used to quantify the degree of agreement. All the 150 respondents have opinion about the statement.

a) Dedication of ASHA workers in your locality: Out of 150 respondents 71 opinioned good to the statement. The computed value of Likert's scaling technique is 448 and score in the 4 point scale is 2.98. Since the score is 2.98 it is concluded that respondents are opinioned as good.
b) Publicity measure of ASHA: 39.33% of the respondents opinioned that publicity measures of ASHA is average. The computed value as per the scaling technique is 406, which lies between 350(150 x 3) and 600 (150 x 4).The average value as per the scale is computed to be 2.70. Hence the rating of the respondents lies between Good and Average.

c) Health development through ASHA workers: Out of 150 respondents 82 opinioned good to the statement. The computed value of Likert's scaling technique is 429 and score in the 4 point scale is 2.86. it is suggested that health development through ASHA worker is good.

Table 3.19

Saving of money for meeting contingencies

Savings	No .of respondents	Percentage
Yes	78	52
No	72	48
Total	150	100

Source: Primary data

Interpretation: The above table shows the ability of respondents to save money for meeting contingencies related to health, by providing services through ASHA workers. It is clear that 52% of the respondents are saving money for meeting contingencies and remaining 48% of the respondents are not saving money for meeting contingencies after the service of ASHA workers.

Table 3.20

Gender and Nature of awareness

Gender	Fully aware	Partly aware	Not aware	Total
Male	33	47	10	90
Female	19	35	6	60
total	52	82	16	150

Source: Primary data

H_0- there is no significant relationship between gender and awareness about ASHA

H_1- there is significant relationship between gender and awareness about ASHA

Result of the test

Test statistics	Level of significance	Degree of freedom	Calculated value	Table value	Accept/Reject
X2	5%	2	.54	5.991	Accept

Interpretation: The above test result shows the computed value of chi square is less than the table value of chi square at 5% level of significance, hence the null hypothesis is accepted which implies that there is a statistically insignificant difference between gender and awareness

Table 3.21

Economic category and types of information provided

Economic category	Nutrition	Basic sanitation	Hygienic practices	Total
BPL	19	18	30	67
APL	26	43	64	133
Total	45	61	100	200

Source: Primary data

H_0- there is no significant relationship between economic category and types of information provided

H_1-there is significant relationship between economic category and types of information provided.

Result of the test

Test statistics	Level of significance	Degree of freedom	Calculated value	Table value	Accept/Reject
X2	5%	2	2.04	5.991	Accept

Interpretation: Above hypothesis is formulated to analysis whether there is any relation between the economic category of the respondents and type of information provided by ASHA workers. The above test result shows the computed value of chi square is less than the table value of chi square at 5% level of significance, hence the null hypothesis is accepted which implies that there is a statistically insignificant difference between the economic category of the respondents and type of information provided by ASHA workers.

Table 3.22

Type of home visit of ASHA workers and saving of money for meeting contingencies

Frequency of home visit	Savings (yes)	Savings (no)	Total
Once	33	60	93
Twice	35	11	46
Thrice	5	0	5
More than thrice	6	0	6
Total	79	71	150

Source: Primary data

H_0- there is no significant relationship between type of visit of ASHA workers and savings of money for meeting contingencies

H_1-there is a significant relationship between type of visit of ASHA workers and savings of money for meeting contingencies

Result of the test

Test statistics	Level of significance	Degree of freedom	Calculated value	Table value	Accept/Reject
X2	5%	3	29.47	7.81	Reject

Interpretation: The above test result shows the computed value of chi square is more than the table value of chi square at 5% level of significance, hence the null hypothesis is rejected which implies that there is a significant relationship between type of visit of ASHA workers and savings of money for meeting contingencies

CHAPTER IV

FINDINGS, SUGGESTIONS AND CONCLUSION

Findings

On the basis of extensive analyses of data collected, classified and tabulated using statistical tables and processed using various statistical tools and put to hypothesis testing using chi-square test. The following findings have been arrived regarding the role of ASHA workers in Rural Development.

- 60% of the respondents are male.
- Majority of respondents belongs to the age group of 31-45.
- 39% of the respondents are SSLC.
- Majority of the respondents are employed in private and other sectors.
- Majority of the respondents belongs to an income group in between less than 10000 and 20000
- 64%of the respondents are above the poverty line [APL].
- Majority of respondents are aware about ASHA plans.
- 33% of the respondents got aware of ASHA workers from awareness classes.
- 99% of the respondent's homes are visited by ASHA workers.
- Most of the respondents homes are visited only once by ASHA workers.
- 66% opined that ASHA assisted them in Fever
- Majority of the respondents opined that ASHA provided information regarding health.
- 63% opined that ASHA provide them information about Hygienic practices.
- 79 respondents have the opinion that ASHA'S service isgood for minor health injuries/ First aid.
- 66% of the respondents opined that ASHA'S service is very good for Nutrition.
- 64% of the respondents are of the view that ASHA'S service is good in curing health problems.
- Majority of the respondents says that ASHA'S service haveneutral effect in Ante Natal Checkup [ANC].
- 54% of the respondents opined that ASHA'S service for delivery is very effective.
- Most of the respondents are of the view that ASHA'S service is effective.

- 93% opined that ASHA'S service for Immunization schedule for newborns is very effective.
- 58% opined that ASHA'S service haveneutral effectin the prevention of sexually transmitted diseases.
- 52% opined that ASHA conducted group discussions.
- 71% opined that ASHA is good in work.
- Majority of the respondents received services regarding the sanitation facility
- Respondents are satisfied with the performance of ASHA workers
- Most of the respondents opined that effectiveness of ASHA workers is good.
- 52% of the respondents save money for meeting contingencies
- Chi-Squre Test reveals that there is a statistically insignificant difference between gender and awareness
- Result of the study concluded that there is no relation between the economic category of the respondents and type of information provided by ASHA workers
- Result of the study concluded that there is a significant relationship between type of visit of ASHA workers and savings of money for meeting contingencies.

Suggestions

- ASHA works on a population size of 1000. The population size should be decreased so that ASHA can care better for the small part
- The role of media should be increased to give publicity among ASHA.
- There should be more of awareness programs and campaigns.
- It should be important to improve the effectiveness of plans through incorporating innovative plans.
- ASHA should conduct more medical camps and seminars to make people more aware.
- Number of training programs for ASHA should be increased.
- Compensation provided to ASHA must increase so that more people will come forward to uplift the rural society.

Conclusion

With the introduction of ASHA there has been an evident development in the health of rural people. ASHA has been successful with its activities like immunisation schedule of new born babies, sanitation and various health care programs. The rural peoples are more aware about

health like nutrition, Basic sanitation and hygienic practices with the commencement of ASHA. The activities of ASHA is supporting the rural peoples, so that there would be an upliftment among the rural society which in turn helps in the improvement of our nation. **“The soul of our nation lies in the village”** The various activities roots from the rural areas. Keeping in mind these facts ASHA was developed and is successful in its endeavors so long it will remain successful in the future in its activities of women and child empowerment.

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APPENDIX

QUESTIONNAIRE

Dear respondent,

I hereby declare that the information supplied by you will be used only for academic purposes and the personal details will be kept strictly confidential

Name : .....

1) Gender : Male ☐ Female ☐

2) Age: Below 18 ☐ 18-30 ☐ 31- 45 ☐ 46-60 ☐

61&Above ☐

3)Education: SSLC ☐ Plus Two ☐ Graduation ☐

Post-Graduation ☐

4) Occupation: Pvt.Employee ☐ Govt.employee ☐ Business ☐

Farmer ☐ Others ☐

5) Monthly income: Less than 10,000 ☐ 10,000-20,000 ☐

20,000-40,000 ☐ above 40,000 ☐

6) In which group do you belong to

BPL ☐ APL ☐ Others ☐

7) State the level of awareness about ASHA

Fully Aware ☐ Partly Aware ☐ Not Aware ☐

8) From where do you know about ASHA Workers?

Media ☐ Friends ☐ Relatives ☐ Awareness classes ☐

9) Whether ASHA workers provided with you any useful information?

YES ☐ NO ☐

If yes which type of information is provided by them.....

10) Do ASHA workers visit your home?

YES ☐ NO ☐

11) How many times ASHA workers visited your house in a month

Once ☐ Twice ☐ Thrice ☐ more than that ☐

12) In which of the following diseases have ASHA workers assisted you

Fever ☐ Diarrhoea ☐ Delivery ☐ Others ☐

13) Whether ASHA workers provided you with any information regarding health?

YES ☐ NO ☐

14) In which area ASHA workers provides information regarding health?

Nutrition ☐ Basic sanitation ☐

Hygienic practices ☐ Other, if any please Specify.....

15) What is your opinion about ASHA Workers for the following services

	Factors	Very Good	Good	Neutral	Bad	Very Bad
1	Minor health injuries/first aid					
2	Nutrition					
3	Sanitation					
4	Minor health problems					
5	Ante natal checkup(ANC)					
6	Delivery					
7	Post natal check up(PNC)					
8	Immunisation schedule for newborn babies					
9	Prevention from sexually transmitteddiseases					

16) Does ASHA conduct any group discussions in your locality?

YES ☐ NO ☐

17) Tick the services you received from the ASHA workers

Minor health injuries/first aid ☐ Nutrition ☐ Sanitation ☐

Minor health problems ☐ Ante Natal Checkup(ANC) ☐

Delivery ☐ Post natalcheck up(PNC) ☐ Immunisation schedule for newborn babies ☐

Prevention from sexually transmitted diseases ☐

18) Are you satisfied with the overall performance of ASHA workers?

Highly satisfied ☐ Satisfied ☐ Neutral ☐

Dissatisfied ☐ Highly dissatisfied ☐

19) State your level of agreement for the following factors,

Statement	Excellent	Good	Average	Below Average	Poor
The dedication of ASHA workers in your locality					
Publicity Measures of ASHA					
Health development through ASHA workers					

20) After the service of the ASHA workers, are you able to save some money for meeting the contingencies related to health

YES ☐ NO ☐

21) Can you provide suggestive measures for improving the publicity and quality of ASHAWorkers.

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