EXPLORING THE ROLE OF ACCREDITED SOCIAL HEALTH ACTIVIST (ASHA): A STUDY OF KAMRUP DISTRICT, ASSAM

Dissertation Submitted to Jawaharlal Nehru University in partial fulfilment of the requirements for the award of the degree of

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DECLARATION

I declare that the dissertation entitled **"Exploring role of Accredited Social Health Activist (ASHA): A study of Kamrup District, Assam"** submitted by me in partial fulfilment of the requirement for the award of the degree of **Master of Philosophy** of Jawaharlal Nehru University is an original work. This dissertation has not been submitted for any other degree of this University or any other University.

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CERTIFICATE

We recommended that this dissertation be placed before the examiners for evaluation.

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For My Father

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LIST OF ABBREVIATIONS

NRHM	:	National Rural Health Mission
ASHA	:	Accredited Social Health Activist
ANM	:	Auxiliary Nurse Midwife
AWW	:	Anganwadi workers
PHC	:	Primary Health Center
CHC	:	Community Health Center
BPM	:	Block Program Manager
DCM	:	District Community Mobilser
ADCM	:	Assistant District Community Mobilser
NHSRC	:	National Health System Resource Center
RRC	:	Regional Resource Center
SHRC	:	State Health Resource Center
TOT	:	Training of the Trainers
AIR	:	All India Radio
PRI	:	Panchayati Raj Institution
VHSC	:	Village Health and Sanitation Committee
GMC	:	Guwahati Medical College
RTI	:	Reproductive Tract Infection
STI	:	Sexually Transmitted Infection
BCC	:	Behaviour Change Communication
RNTCP	:	Revised National Tuberculosis Program
NVBDCP	:	National Vector Borne Disease Control Program
MOHFW	:	Ministry of Health and Family Welfare
TB	:	Tuberculosis

Introduction

The newly independent India was left with a big task of revamping its health service system. As a major portion of the population of the country live in rural areas one of its biggest tasks was to address the issues of health care in rural parts of the country. The planners have followed the recommendations of Bhore Committee and have envisaged stronger primary health care (Banerji, 2005).

The significance of primary health care has been reiterated in the Alma –Ata declaration. There was also much emphasis on the need of ensuring community participation in this process not only in terms of availing the services but also assuming responsibility for their own welfare and participating in primary health care in priority setting, assessment of situation and monitoring of community. The involvement of community health volunteer has been counted as very important in the context of primary health care.

The community health volunteer program found its presence in the primary health care program in India but however primarily failed to ensure community participation owing to much concentrated activities mainly circled around preventive health care and family planning (Mankad, 2005). There is change in the ideas in conceptualising community health volunteers in which the ideas of creating a change agent and better community participation through these members of community emerged. The experiments in Maharashtra, and in Chhattisgarh of involving more and more local community members in health care through experiments like Shaheed hospital found significance. (Scn, 1994, p.4).

The evolution of Mitanin also found its place along the line of the ideas of involving a woman volunteer who would act as a catalyst for change in the community. The ideas of people's movement also had influenced the National Rural Health Mission, the program which aimed at creating architectural correction in the health service system. It claims to ensure equitable accessibility to the health service system specifically to the marginalised section of the society (MOHFW, 2006). The NRHM has adopted the strategies of decentralisation, up-gradation of PHC, CHC and sub-center, strengthening of human resources, Accredited Social

Health Activist (ASHA) to overcome the flaws of country's rural health service system. The program entrusted a significant amount of importance to the process of ensuring decentralisation with an idea of involvement of the local self governance in health care planning. The Accredited Social Health Activist (ASHA) is a member of the community who would voluntarily come forward and take part in village health planning along with members of Panchayati Raj Institution and would act as the link between the health services and the community. She is termed as activist who would ensure rightful access to quality health care for her community members and would work as the missing change agent to bring changes in the health status of the community through collective action. In this context she is also supposed to work in coordination with Auxiliary Nurse Midwife (ANM) and Anganwadi workers (AWW) for community mobilisation (MOHFW, 2006). Thus ASHA is envisaged as major way to achieve rural health care that would ensure equitable accessibility to Healthcare and also ensure representation of need of the community in the health planning through her participation in village health planning. Thus in conceptualisation of the program ASHA is termed as an activist, her role in communitization has been referred as vital.

The very design of the program creates concern if the principles of activism, communitization and volunteerism have been applied. As the program is majorly engaged in its efforts of creating a skilful ASHA who would help in delivering services primarily those of immunization, RCH and other health program namely Malaria and Tuberculosis. ASHA though started with an aspect of creating an activist out of her but there is vaguely any scope for her to organise collective action amidst her incentive based activities. There is a question if an ASHA can organise collective action in a situation where she is dependent on the health service system for incentives. In many of the literature she is termed as the escort who is primarily bringing pregnant woman to health facilities for institutional delivery and other pregnancy related care (Ashtekar, 2008). The prime concern whereas she can act as the volunteer who would act for no profit when the foundation of the program is built on performance based incentives for certain listed activities from NRHM. The communitization aspect in ASHA also raises question in terms of seriousness

of the committees formed, the response of the Panchayati Raj Institution towards the program and whether ASHAs PRI, representatives and other members have been able to involve these committees as platform for community participation in health planning or these have been so far only working for management of the bank accounts as indicated in the finding of a study (Ashtekar, 2008) .

The primary need is look whether NRHM has been orienting ASHA to meet its goal of volunteerism, social health activism and communitization. The study sets out to look at the roles of ASHA as an activist, agent of communitization and if NRHM has endeavoured to orient ASHA in the direction of achieving her role in this context. It looks at the program on the level of functions delivered by ASHA. The selection of the field has been Kamrup district in Assam as it is one of the Empowered Action Group states and implementation of ASHA program received prime importance in the state.

Chapter 1

A review of framework of ASHA in National Rural Health Mission

This chapter traces the conceptualisation of ASHA as it comes as an important strategy in NRHM in its effort of revamping rural health care. The program expands the idea of community involvement and also has the zeal to bring poor and marginalised section of the society in closer connection to the health service system both in terms of availing health services and creating community ownership. The chapter also discusses the NRHM's strategies to ensure quality care to rural population and how it tends to incorporate ASHA to achieve NRHM goals.

Conceptual understanding of ASHA:

Keeping in view the above mentioned discussion on programmatic aspect of NRHM and ASHA the formulation of the program can be analysed in terms of the governing ideas in the conceptualisation of the program. ASHA can be seen as important part of the program for bringing changes in the community, engaging community in health planning, ensuring equitable accessibility of all to health services. The evolution of ASHA as a voluntary worker who would help to establish better link between community and health service system derives from its precursor Mitanin program.

Chhattisgarh has had witnessed very poor health indicators in terms of health infrastructure and also in terms of human resources. The PHCs located in tribal areas specifically had no doctors and it was also difficult for the state to ensure appointment of more doctors as it was difficult to find doctors to go in remote areas and also the link between the health service system and the community has broken (http://www.shsrc.org)

The state health service system thus focussed on creating a public health system where local people can themselves tackle their health problem and in this context the participation with civil society organisation and other bodies also have been emphasised and also the community health workers has emerged(http://www.shsrc.org). The Mitanin program which was conceptualised paid importance to the following factors as far as selection and training of Mitanin is concerned (http://www.shsrc.org)

1. A trained facilitator need to play an important role in selection of Mitanin and would also ensure that the views of all the sections of the community specifically vulnerable and backward section of the community before coming to final selection of Mitanin.
2. The program also chooses Mitanin from each hamlet. People from different caste live in different hamlets and hence it is chosen as the unit for selection of Mitanin to ensure equal participation of women from all the caste in the program.
3. Thirdly a process of social mobilisation was designed through which the community can be mobilised to own the program and take part largely in the selection of Mitanin. The program has involved Kalajatha a very popular artiste group to mobilise about the program and plays, songs were written in this context keeping in view the local cultural idioms.
4. As far as preventive and curative care is concerned she is given training both in preventive and curative care. The training in curative care is later then preventive care and Mitanin is also given a 12 drug kit and a guide book to act as first contract for curative care.
5. The Mitanin program has made no provision for honorarium keeping in view that Miatnin should not lose on daily livelihood opportunities on account of her workload and hence the program has designed in a way that it does not take more than 3 to 4 hours per day. Secondly the designer of the program also considers that if compensation is paid to Mitanin than the entire burden of work would fall on her and community participation would be missing.
6. Mitanin learning from the past training formats for Community Health Worker which lasted for a longer time nut followed no continuing program or support has adopted the strategy of 20 days camp based training and 30 days on job training which is expanded over a year and last maximum for 4days each time. This has been strategy to ensure that Mitanins did not have to withdraw from family lives.

Thus while formulating the Mitanin program the policy makers identified the needs of having community participation and also ensuring participation from all sections of the society. The idea of community participation is further understood in terms of acceptance of the community towards government programs, and thus make policies and programs which are best suited for them, and secondly understanding the concept as demand generation for government programs amongst the

community and thirdly , community can be entrusted with the responsibility and the idea that community could be entrusted with power which does not indicate withdrawal of the state but rather partnership between the two (http://www.shsrc.org). The Mitanin program as discussed in the policy documents is built on these ideas of community empowerment who would work in close coordination with PRI (http://www.shsrc.org). Volunteerism also has been an underlying idea while formulating the concept of Mitanin as she is visualised as a volunteer belonging from the community who would not be given any salary or honorarium (http://www.shsrc.org). However she is considered as someone who would have great acceptance in the community; the word Mitanin itself means a female friend who would be there for the other people specifically women of the community (http://www.shsrc.org). She also need to have adequate competency as health professional and hence would be provided with necessary training and drug kit (http://www.shsrc.org). The Mitanin program came as pre-cursor to ASHA and hence some of the concepts also reflect in the creation of ASHA.

ASHA are women volunteers selected from the community who would be daughter in law of the village and would mark her presence for any health related events for poor and vulnerable and specifically women and children. One of the most important concepts of having ASHA workers at community level is to address the issue of availability of critical manpower which is to be addressed through the voluntary community health workers (MOHFW, 2006) in every village of 18 high focus states. Her role is emphasised at the level of sub centers which caters to 5000 population at periphery also recognising the fact that the ANM are overburdened and only 50% of the MPWs are functional (MOHFW, 2006, p1). The policy makers also recognise the fact of Anganwadi workers being involved much in ICDS which does not allow her to engage with the community as change agent and hence ASHA is also envisaged as the missing change agent for the community (MOHFW, 2006, p1).

Her role is also envisaged as an activist who would be responsible for mobilizing the people for accessing health services as their right (Shukla A, 2006). She is considered as community mobiliser for local health planning and accountability to existing health services (Dasgupta and Qadeer, 2005, p139). ASHA, in policy

guidelines is considered as the interface between the community and the health service system and would ensure accessibility to health care system (MOHFW, 2006).

Creation of female health activist (ASHA) also comes as part of the process of ensuring community participation in health planning. Moreover it can be accounted as NRHM strategy to create partnership between the community and the peripheral health staff along with formulation of VHSC, involvement of PRI in health planning (Gill, 2009).

The concept of volunteerism has been associated with creation of ASHA as well. She is expected to work as volunteer and is expected to work for incentives which would be granted in completion of tasks related to national health programs (Shukla A, 2005). ASHA is considered also a health facilitator of the community who would be responsible for basic health care of the community and will also be provided with a drug kit (Shukla, 2005, p128).

Thus ASHA in NRHM is envisaged as women volunteer who would be an activist ensuring community mobilisation for local health planning. She would be filling the gap for lack of health workforce at periphery and would be trained to act upon as the first port of contract and also deliver basic health care services. She is the change agent who would promote healthy lifestyle in the community, specifically amongst vulnerable population.

The evolution of NRHM:

The National Rural Health Mission has come in to picture in India amidst the health sector reforms. There was shift of focus from the urban centric health care to the disadvantaged section of the rural India. The ideas of community involvement, upgrading of primary health care found importance in the discussion of NRHM. In the context of falling rural health service system (Banerji, 2006, p113) some political parties have considered it a major concern and under United Progressive Alliance, following the commitment to Minimum Needs Programme NRHM was introduced. Drawing from Minimum Needs Program introduced in 5^{th} five year plan the NRHM has dwelled on the ideas of equitable access to health care. It seeks to establish architectural correction to the health service system. It aims to establish

functional health service system with re-utilisation of the existing health service system and renovation whenever required (MOHFW, 2006, p5). As a part of its architectural correction the Mission aims to improve service delivery by putting an enabled health service system at all levels which involves simultaneous correction of human resource planning and infrastructure strengthening (MOHFW, 2006, p5).

One of the primary focuses of NRHM has been infrastructure development specifically in the EAG states. It aims for renovation of not only the physical structure of the health service system but also desired for architectural renovation in terms of human resources as well. Up gradation of health facilities is considered an utmost need in NRHM. As discussed in NRHM framework, the central government has only worked for up gradation of sub centers and hence the state governments have only been spending a very meagre amount in constructing of PHCs and CHCs (MOHFW, 2006, p6). The NRHM has opted for expenditure of fund for construction subjected to the condition that it should not be more than 33% in case of high focus states and 25% in case of non high focus states (MOHFW,2006, p6). This up gradation also includes the improvement at the level of district hospital as well. The application of Indian Public Health Standard has been put as mandatory for all the layers of public health deliverance for achieving better health outcomes.

The endeavour of revamping the picture of rural health services system has not only been restricted to up-gradation of PHCs, CHCs and Sub-Centres but also to create health service system better accessible to all the community members without any discrimination and establishing link between health service system and the community. ASHA has been envisaged as very significant in this context. The NRHM has adopted some major approaches for the program as well as has drawn a framework for implementation of which ASHA figures as an integral part.

The approaches of NRHM:

a) The architectural correction of manpower:

Human resource in rural health service system has been in major crunch. The mission has adopted certain strategies to overcome the issue which have been to increase the number of health functionaries. The NRHM proposes to increase the number of ANM to two at sub-center and appoint three ANMs in PHC for round the clock services (MOHFW,2006, p33). The introduction of community health

volunteer comes as an important response to the issue from NRHM.Th NRHM also aims to increase availability of human resources by making a provision of more than 4 lakhs (MOHFW, 2006, p 33) women trained as ASHAs. The NRHM wants to create a brigade of human resources of ANM and ASHA who would be always present in the community for delivering health services and promoting better health practices.

b) Monitoring of the health service system:

Thirdly there is also a discussion on rights- based approach and also ensuring of accountability of the health service system and hence have laid an importance in monitoring at the level of community, external surveys carried out by ASHA and also process of internal monitoring through an Management Information System (MIS) and application of IPH standard to the health facilities (MOHFW, 2006, p9). The community involvement has been given massive importance in this context. The right to access health care gains significance in NRHM framework and it also talks about the role of citizen's charter in making people aware about their health rights. (MOHFW, 2006, p9)

c) Involvement of voluntary bodies:

NRHM also envisages the involvement of voluntary bodies such as NGOs and community organisations for creating a suitable environment for more and more community participation and also to ensure more accountability. The framework entails involvement of voluntary section in all the aspects of the program viz capacity building, training as discussed in the framework "it is proposed to provide people friendly regulatory framework that promotes ethical practice through accreditation, standard treatment protocols, training and skill up-gradation of non-governmental health provider " (MOHFW , 2006, p9)

The implementation framework of NRHM:

The NRHM has created an implementation framework through which it can implement the program throughout the country. The implementation framework has focussed on processes to ensure community participation specifically from the marginalised section of the society. In this aspect of implementation framework the role of ASHA is also given significance.

a) Community led action for health:

The NRHM has visualised for an empowered community which will only be possible if there are mechanisms adopted to ensure their participation in the planning process. It seeks to enable the community to undertake leadership ability for health related issues and creation ownership in public health deliverance by involving Gram Sabha to Zila parishad at district level. The NRHM has visualised for formation of Village Health Sanitation Committe (VHSC) at the Panachayat level with the concept of creation of accountability and leadership at community (MOHFW, 2006) level which was continued also at the level of block with the formation of Rogi kalian Samitis. (MOHFW, 2006) These endeavours were also targeted for addressing the social determinants of health viz, issues of drinking water, sanitation facilities. (MOHFW, 2006) The creation of these bodies brought together members from the community, ASHA as an activist who would ensure participation of community for local health planning and the representative of local governance. A bottom up approach has also been adopted for health planning which implies creation of village health plan at the level of VHSC which will be integrated in district health action plan. (MOHFW, 2006)

b) Capacity building at community level**:**

The NRHM framework for implementation also discusses capacity development at community level also it adopts decentralisation as a strategy and hence the need of newer skills was discussed. In this context it was realized that newer bodies were required for and hence the National Health Systems Resource Center was visualised as the new body to pool all technical assistance from the development partners. (MOHFW, 2006, p 35) The NHSRC is supposed to function at center level and Regional Resource Center for the north –eastern region. A state resource center is planned for the EAG states. (MOHFW, 2006, p 35) Apart from that NRHM also has envisaged the involvement of voluntary sector, medical institutions and hospitals in capacity building through training in rural health sector.

c) Equity in health:

One of the important aspects in NRHM framework for implementation is to ensure equity in health care. The NRHM has put importance in its framework to the aspect

of giving priority to the vulnerable population and empowering them through education and health education. The involvement of volunteers from vulnerable and marginalised communities have also been given as a solution to greater participation and accessibility for the marginalised and vulnerable section (MOHFW 2006, p 30).The involvement of ASHA as volunteer in NRHM comes as major response to the participation of marginalised section of the society specifically women and children.

The visualisation of ASHA in NRHM:

The evolution of Accredited Social Health Activist needs to be seen in the context of this effort of NRHM to bring changes in the health status of rural population. The ASHA has been considered a flagship program and a significant part in the process of decentralisation, ensuring accessibility to health services to the community, health promotion and ensuring better health outcomes. She is a woman who is selected from the community and would act as a catalyst in bringing changes to the health status of the community working in close coordination with PRI and other health workers at the periphery.

a) ASHA's role and responsibility:

The NRHM guidelines (MOHFW, 2006) have identified ASHA as a woman health activist who would be selected in for every 1000 population, a norm which can be relaxed in tribal and hilly districts. The guidelines for ASHA has entailed the following as her major responsibilities (MOHFW, 2006, p2)

1. ASHA is entrusted with the responsibility of imparting information to the community on the issues related to determinants of health viz, basic sanitation, hygiene, nutrition, better living condition and forth.
2. She would also act as counsellor in cases of birth preparedness, breastfeeding, nutrition during pregnancy, institutional delivery, contraception, complementary feeding, RTI , STI etc.
3. ASHA would mobilize community for availing health services mainly at sub center , PHC, viz, immunization, ANC check up , ICDS, sanitation and so forth.
4. She will work in close coordination with Village Health Sanitation Committee for developing village health plan.

5. She will accompany pregnant woman, children to nearest FRUs, PHCs and CHCs.
6. She will administer first aid in case of diahorrea, fever and minor injuries.
7. She would also act as DOTS provider under RNTCP.
8. She will be given drug kit which will comprise of essential drugs such as ORS, iron folic tablets, chloroquine, oral pills, condoms, disposable delivery kit. The kit will be prepared on the basis of recommendation from expert group set up by government of India.
9. Her role as service provider also is desired to be explored by NRHM in terms of provisioning of new born care and management of childhood diseases.
10. She will inform at the level of sub center and primary health center in terms of births and deaths, unusual health problems , disease outbreaks happening in her village
11. She would be responsible for promotion of construction of household toilets under total sanitation campaign.
12. The ASHAs needs to be trained for enhancing her skills spread over two years or more for fulfilment of her roles.

The functioning of ASHA as further has been discussed in the guideline (MOHFW,2006) is dependent on many factors such as institutional arrangement, her coordination with PRI, her interaction with ANM, AWW and also the training arrangements.

The participation process in the functioning of ASHA is described at the village level where she would work in coordination with self help groups, women groups, village health sanitation committee and ANM and AWW. In this context the role of PRI is immense in extending institutional support to ASHA. The support system at the district level would be extended through the District Health Society which would have members from the Panchayati Raj Institutions, and one of the main tasks of this committee would be to ensure participation of Gram Sabha and Gram Panchayat in the selection process of ASHA and also to facilitate training of the trainers as per the guideline. (MOHFW, 2006) Even at block level institutional arrangement has been made for ASHA in the form of Block Coordination committee which will ensure participation of PRI and civil society. (MOHFW, 2006, p4) Indeed the role of civil society has also been emphasised and the

guidelines entail in case of availability of any suitable organisation the selection process should be handed over to civil society organisation. (MOHFW, 2006)

Interaction with the health functional at periphery:

The ASHAs are supposed to work in co-ordination with ANM and AWW. The interaction with Anganwadi Center is envisaged in terms of organising of VHND in which case the AWW will also act in co-ordination with the ANM, guiding of ASHA for undertaking activities of health promotion.

a)Interaction with AWW:

The guideline (MOHFW, 2006, p5) has entailed following activities as the necessary level of interaction between the Anganwadi workers and ASHA

1. Acting as trainer for ASHA
2. Organising of IEC activities through display of posters, on village health and nutrition day
3. AWW will also be responsible for marinating drug kit and issuing it to ASHAs.
4. AWW will be responsible for updating the list of eligible couples and also children less than a year with the help of ASHA.
5. ASHA would act as mobilser and would bring beneficiaries to the health services on the day of immunization and other health related events.

The ASHA is also supposedly to work in coordination with the ANM in terms of enhancing skills, community mobilisation. The NRHM guideline has given the following as expected role of ANM as far as extending support to ASHA is concerned

b) Role and integration with ANM:

The ANM acts as one of the important functional who extends on job training to ASHAs and also helps her in day-to -day functioning. The ANM extend support to ASHA in terms of organising of Village Health and Nutrition Day, in extending support to ASHAs in terms providing services related to reproductive and child health, family planning and mobilising community for accessing services (MOHFW, 2006, p6)

The training process of ASHA also needs to be discussed. The ASHA in NRHM is termed an activist and is expected to take part in communtization process. Thus it is important to understand how NRHM has framed its training module for capacity building of these new set of women volunteers from the community.

Training of ASHA:

The training strategy of ASHA is framed in terms of type of training, material of training. This needs to be discussed in the context of evolution of the program of ASHA as to understand what had been the primary focus of these trainings and how these training modules have been orienting ASHA. As discussed above the role of ASHA has been envisaged for ensuring better linkages between health service system and community and also to ensure the process of community participation in health planning. However as discussed in roles and responsibilities of ASHA the attention is majorly paid to her role as community mobiliser and counsellor for reproductive and child health. Hence there is a need to understand if the training module has put emphasis on infusing the ideas of volunteerism, communitization and activism or has only been a process to orient her as skilled health worker to perform the duties as a counsellor, community mobiliser and a link worker.

a)Training material:

The training material to be prepared for ASHA is desired to be in co-ordination with the envisaged roles of ASHA. The training materials are to be prepared at central level which will then be modified in the states in accordance to their local needs. (MOHFW, 2006, p 7)

Table No1: Training Modules:

Module	Topic
1 Introduction	The module 1 for the training process of ASHA concentrates on orienting ASHA to the NRHM. It details the roles of ASHA and also the need of undertaking a village health plan. It gives an idea in the beginning about how the people of the villages can be incorporated through PRA

	technique in mapping of the village. The module also discusses the Behaviour Communication change as a technique. It entails how ASHA can build better negotiation skill through BCC and impart knowledge to the villagers in health related issues. It also emphasises the use of BCC material while interacting with the people in the village. It also discusses about the roles of AWW, TBA and ANM and how they would their role as far as functioning of ASHA is concerned. The module also entails ASHA's roles in terms of RCH and vertical health care programs. It details her role as link worker and depot holder. The module also details about ASHA's need of understanding the issues of personal hygiene, drinking water safety, disposal of waste water and carry out health promotion activities for adoption of better health practices.
2. Maternal and Child Health	The second module of training for ASHA gives information related to reproductive health, issues related to menstruation and care during pregnancy in terms of ANC. It talks about the seriousness of conditions like anaemia during pregnancy. The module imparts technical knowledge in terms of post –partum care, unsafe abortion and also the critical

	conditions during and after pregnancy. It prescribes the roles of ASHA in terms of ANC, post partum care and also born new care. It details about ASHA's role in terms of imparting information about care during pregnancy, and also to mobilise community to visit health care services. The ASHA also needs to impart information related to nutritional need during and after pregnancy and the need of visiting health care facility after delivery. She also needs to motivate women for safe institutional delivery. The module details about the immunization needs of the child and gives knowledge to ASHA in terms of immunization schedule of the children.
3. Family Planning, RTI HIV/ STI	The module 3 of program gives information in terms of Family planning issues and the benefits of small family norms. The module details about each and every method of family planning and also how ASHA would motivate community for family planning. It also imparts information related to STI and RTI, and HIV and the ASHA's role in this context.
4. National Disease Control programs, minor illness	The module four entails information related to vertical health programs viz TB and malaria and other health conditions such as burns and wounds. The main two programs which have found significance

	is Revised National Tuberculosis Program and Malaria. The module has aimed at enhancing the clinical knowledge of ASHA in terms of providing its symptoms. The module imparts information about vulnerable population, the suitable environment for Tuberculosis. The role of ASHA in prevention and treatment is also entailed. The role of ASHAs as DOTS provider under RNTCP is also detailed in the module. The other vertical program that has been detailed here is malaria, its symptoms and the role of ASHA in this context. The module incorporates the strategies of National Vector Borne Disease Control Program. The ASHA's roles are earmarked in prevention, early detection and treatment of malaria. The module also gives information about wounds, animal bites and what ASHAs can do in these cases. There is also a section given on home remedies.
5 Leadership , women empowerment	The module 5 in NRHM has talked about ASHA's role as an activist. The module discusses the gender inequality that exists in a patriarchal society. It also discusses the need of empowering self and hence prescribes few steps for ASHA to achieve self empowerment. It talks about enhancing self esteem by realising one's self worth. It elaborates the need of ASHA to be self confident, recognise and

	value own achievement and also give respect to herself as a woman and ASHA. It gives the following steps for understanding one's self worth for ASHA Understanding the meaning of self esteem which involves the following concepts It is about being confident about oneself It is about reasonable sense of your self worth It is about having faith in one self Being pleased with one's self achievement Secondly it also entails what self esteem is not about. It gives the following ideas Convincng oneself that they are of value \ Having beautiful features Feeling confident when somebody praises It also entails the characteristics of a person who has a healthy self esteem which are Self confidence Ability to express true feelings To value and recognize own accomplishment Ability to forgive others Ability to welcome change Secondly it also gives a format for self development plan for ASHA in which she can evaluate her strengths and

	weaknesses. It is given as a format for ASHA to understand her daily performance by analyzing what she has achieved and what difficulties she has faced. The module also gives examples of people's movement carried out in many places to bring changes. The module talks of the need of understanding the situation first and to solve it through concerned authority first. However the module has suggested for ASHA to opt for protest whenever the situation demands change and large number of people are affected by the issue. The third aspect that is entailed in the module is that of fundamental rights and directive principles of state policy. There is also description of the rights associated with health care and the significance for an ASHA to know about these rights. The module gives the following as right to health care The availability of public health services in the community with adequate structure, drugs and equipments Accessibility to health services without any discrimination and no one should be refused health care on the ground of caste, religion and economic status and gender The health services should be at

	proximity The health care available should be free of cost Information about the services available should be given to the community without any discrimination in terms of caste/ religion/ class/ gender The health services needs to be gender sensitive The health services should be medically and scientifically appropriate. The module thus gives a detailed list of what constitutes rights for the community members. Though it emphasises the need of ASHA knowing about health care as a right, it gives very less information on how to deal with violation of such rights.
Module 6 : Skills that Saves Lives	The module 6 and 7 covers the area which had been already discussed in earlier modules. The module 6 reiterates the activities of ASHA in the community and also the measurable outcomes of ASHA. It entails the roles of ASHA in social mobilisation, her involvement with VHSC.
Module 7: Skills that Saves Lives -	The 7th module of ASHA entails about child health and nutrition and ASHAs role to ensure better child health. It also gives a detail of the supportive supervision structure and reiterates the roles of ASHA in maternal health care.

Source: http://mohfw.nic.in/NRHM/asha.htm

c) On job Training:

The importance of on job training is discussed in NRHM for maintaining a support system for ASHAs while carrying out functions in the community specifically at the beginning phase and in the later phase. (MOHFW,2006, p7) The primary responsibility of on job training falls on the ANM who will keep on providing inputs in ASHA's work while conducting community visits or in meetings with ASHAs. The NGOs also can be involved in the on job training for the ASHAs. (MOHFW, 2006, p 7)

c) Training of the trainers:

As far as training of the trainers is concerned the NRHM has lad importance to create block level training units who are primarily women and would also spend as much time as ASHAs acquiring knowledge and skills same as ASHAs. (MOHFW, 2006, p7) The duration of training of district level and state level TOT will be finalised by the state as per the kind of trainers selected.

d)The agency of providing training:

The state will identify an NGO as the resource agency for continuing up gradation of skills for ASHA. The resource agency will also create materials with the help of open schools and other distance education system. (MOHFW, 2006)

Conclusion:

The discussion of the framework of NRHM starts with the concept of creating an activist , involving ASHA in communitization process through formation of committees in co-ordination with Pancahayti Raj Institutions. The ASHA is also visualised as the person who would ensure rightful access to health care. The 5th module of training also talks about her role as an activist. However on the other hand there is also much emphasis on the issue of learning skills for ASHA specifically for motivating women for availing reproductive and child health services, family planning, nutrition and immunization. Hence it becomes important to understand how these concepts of volunteerism, activism and communitzation

can be understood and how those can be applied to the program. There is also a need to understand how various literature have review work of ASHA in the context of these roles of volunteer, communitization agent and activist perceived by NRHM. Hence a review of literature is conducted to understand the concepts and how literature has reviewed the ASHA program in terms of her roles.

Chapter 2

Review of literature, understanding the concepts and the perception of the program

The previous chapter has detailed about the framework of NRHM, and the main concepts related to the conceptualisation of ASHA program. In this context volunteerism, communitization and activism have emerged as most important ideas in the conceptualisation of ASHA. Hence this chapter entails a review of how the concepts are understood in literature. The chapter also extends a review of the evaluation processes of ASHA and to what extent her role as an agent of communitization, activist and a woman volunteer have been evaluated. A section of this chapter will also look at a section of literature which would give an account of the how other literature have entailed the program of ASHA.

The discussion on strengthening of primary health care in rural areas have found its place in the Bhore committee recommendations of many committees since first five year planning before NRHM but had remained largely unrealised (JSA, 2007,p1). Apart from this, the discussions on community participation have also found its place in earlier discussion for strengthening rural health care. The country has already endeavoured for community participation through Community Health Worker in 1977(Leslie C, 1989). The importance of community involvement also has been stated in the Alma Ata declaration of 1978. The National Rural Health Mission has reiterated these ideas of community participation in health care planning which has been also reflected in the conceptualisation of ASHA. It is important to note that ASHA is defined as female health activist who is selected from the community and act as catalyst that would ensure equitable access to health care services and also would lead to creation of better health practices in the community. The ASHA has been envisaged as one of the important pillars of NRHM to fulfil its goal of communitization and empowerment of the community towards health planning and implementation. It is important review the concepts through available literature to analyse the roles of ASHA and activist, agent of communitzation and a volunteer.

Volunteerism:

The ASHA workers have been envisaged as women volunteers from the community who would mark her presence in the community for any health related events specifically for the vulnerable and the poor (MOHFW, 2006, p1). It is identified as one of best way to address the lack of human resources at peripheral level of health care system. To understand the conceptualisation of ASHA along the line of volunteerism and what does it indicate for strengthening of delivery of health care services at periphery, it is important to understand the concept itself. The primary themes which are discussed in literature on volunteerism are motivation of the people who come forward for volunteering. Secondly a set of literature also reviews women acting as volunteers and what has motivated them to do so. The understanding of volunteerism is also tried to be formulated along the lines of involvement of human resources and its implication towards the program. Some of the literature also put forth a critical review of volunteerism.

Volunteerism specifically women volunteering in the community can be understood in the context of lack of human resources in the community (Petrzelka and Mannon , 2006 p237). The concept of women volunteerism is defined in literature as an activity in which time is freely given to benefit another person, group or organisation (Petrzelka and Mannon, 2006, p238). Secondly it also tries to understand along the line of women accounting as nurturers and carers of the society and conceptualising volunteerism along the line of domestic labour which falls into category of unpaid labour (Petrzelka and Mannon, 2006, p238).

A set of literature also tries to understand the concept of volunteerism in relation to why volunteerism becomes an option for the individuals. A study (Clary and Snyder 1999) looks into volunteerism through interviewing American adults. The study tries to explore what motivates individuals to join unpaid helping activities known as volunteerism (Clary and Snyder, 1999, p156) what are the motivation factors It seems that values like humanitarianism, seeking to exercise skills that are often unused, to gain career related experiences, strengthening of social relationships reducing negative feelings are some psychological factors

that leads human being to volunteer for an activity as indicated by a study (Clary and Snyder, 1999, p 157) . The perception of women as volunteers have been understood as expression of maternal nature, as a way of building social connection and as way to contribute to development of the society (Petrzelka and Mannon,2006, p 239) .

Volunteerism is understood in some of its literature as a concept which assumes the idea that individuals are better suited for solving social problems than the state and also that causes of social problems are rooted in the individual behaviour (Petras, 1997, p 1587). It therefore hints at individual or private citizen initiatives to solve the problems of society rather than state programs (Petras, 1997, p 1587) This (Petras 1997, p1587) study has indicted that no businessman or politician would want to serve as unpaid labour and hence volunteerism is only restricted as an option for low income groups (Petras 1997, p1587). The corporate interest would never pay heed to the idea of social service for the low income group (Thus the poor will have to pool the non-existent resources to solve the issues which have been neglected by this powerful corporate houses (Petras 1997, p1587) Volunteering has been considered a core element for achieving community participation in primary health care to reach the goal of health for all (Akintola 2011, p 54).However literature also discusses that volunteerism do not turn out to be effective always and have its own challenges. To cite an example Volunteers engaged for care of HIV patients had to help their patients with meagre resources as they were not remunerated which have created problem for the volunteers to involve actively in the program (Akintola , 2011,p55). The credibility of volunteerism has been also debated in some of the literature as an adequate way to ensure effective implementation of the program. As argued volunteerism might have the following crucial problems. (Petras , 1997, p 1588)

- Social problems are located at the moment and in particular circumstances.
- Projection of private resources and willingness to share profit which does not correspond to the reality

- Substitution of symbolic emotive relation in place of delivering substantive pay off
- Focus on local projects rather than comprehensive policies
- Assumption that untrained and unpaid individuals engaged in sporadic activities are equivalent to full time trained professionals.

The scope of volunteerism is also doubted on the grounds of limited commitment owing to the limited resources focussing on small scale projects.

Communitization:

Communitization had been one of the important processes under NRHM. The conceptualisation of ASHA has been an outcome of the same process, hence the need of understanding what the very concept of communitization implies. It is considered as third way of governance in the South Asian countries and it comes as a process which calls for strengthening and empowering the social capital of the communities (Pandey,2010, p15). It is argued that when the system of streamlining the government system fails and the intervention of private bodies seems inevitable there is a third way of governance whereby the government can harness the social capital of the user community rather than handing over the responsibility to NGO or charitable organisation(Pandey,2010, p16) . This indicates making community responsible for day to day management (Pandey 2010 p16.) This process of privatisation (Pandey, 2010, p 16) in the hands of the community is called communitization. It is further argued in that communitization the government stands as an active partner, assister and supervisor. (Pandey, 2010, p16) Thus it implies transferring of stronger roles to community. The process of communitization calls for maximum participation of poorer community for ensuring that impact of any development in the community remains sustainable (Lokho,2009). It implies transferring of ownership powers and resources to the communities (Pandey , 2010,p16). Hence the concept of communitization implies an active participation of the community in planning, managing the aspects related to its development. Communitization has been adopted as a policy response in health care planning

with enhanced role of local governing bodies, involving members from the community in health care planning, management and service delivery.

a)The importance of community in primary health care:

The literature on primary health has put immense interest in centrality of community in health care delivery. As argued by Waylend and Crowder (2002) the community participation has come as most desired aspect in terms of development, implementation and evaluation.

Alma Ata-WHO defines (Waylend and Crowder, 2002, p32) community as having spatial, social and political dimension and also uses these characteristics to understand participation of community in terms of primary health care. A community is considered here somewhat as unit which share similar social characteristics such as class, race and ethnicity or economic status and hence would also share similar health problems and hence the common primary health care approach can be adopted here. Secondly the spatial element which caters to the idea that the community is a unit sharing common geographical space and hence would need a similar approach. The third characteristic is that of political nature of a community which is comprehended in terms of common social characteristics and hence would have common problems and there would be a tendency to work together for solution. However the major problem remains as further discussed in the article is that the significance is not much laid on the aspect of differential power status within the community lacking an emphasis on the fact that the socio economic commonalities may be overcome by another issue as in for instance a community sharing a common geographical space might not share common problems and have differential status in terms of ethnicity, religion or other variables. (Waylend and Crowder, 2002)

b)Decentralisation as way of sharing power:

The process of decentralisation comes as a response to ensure equity in decision making process. As argued by the theory of decentralisation (Johnson, 2003, p vi) is based on the notion of democratisation and empowerment of local political bodies which will be more accountable to local people and also would understand their needs better.

The aspect of decentralisation can be understood in terms of passing of power to the lower ranks of bodies. It is a way of governance where responsibilities are transferred to NGOs, private institutions, and community based organisations. A conceptual differentiation can be made in following ways

- Deconcentration, in which political, administrative and fiscal responsibilities are transferred to lower units within central line ministries or agencies
- Devolution, in which sub-national units of government are either created or strengthened in terms of political, administrative and fiscal power
- Delegation, in which responsibilities are transferred to organisations that are 'outside the regular bureaucratic structure and are only indirectly controlled by the central government
- Privatisation, in which all responsibility for government functions is transferred to nongovernmental organisations (NGOs) or private enterprises independent of government. (Johnson, 2003, p4)

Decentralisation has found a recent place in the administration of the developing nations.It is also argued that centralised administration does not have connection with the local community and hence lacks understanding of local needs(Johnson, 2003, p4) Thus in this context decentralisation comes as a response to ensure infusion of local ideas and optimum utilisation of resources. There are few roles that can be identified for the government in such rural areas which are provisioning of public goods such as universal education and health care, provision of divisible goods such as irrigation and agricultural credit and thirdly determination and enforcement of laws and fourth is recognition and protection of rights allowing organisations and associations to grow (Johnson, 2003, p6). In this context the importance of distribution of resources has gained an utmost importance and hence also the idea of reaching out to poor and marginalised specifically. The argument is that decentralisation can lead to an effective and efficient use of resources through a process of devolution or privatisation entrusting use of resources on local users (Johnson, 2003, p7). However as again argued in literature that decentralisation is only effective only when the local empowered actors are accountable. The Indian government also has made its

effort to reach out to the poor and marginalised section through 73rd and 74th amendment. (Johnson, 2003, p7) However as further discussed in the literature that decentralisation effort has not been able to lend much power to local authorities or people (Aggarwal, Ribot,2001). Thus the question that needs to be raised whether the decentralisation has resulted in an outcome where participation in decision making has not been a distant dream for the local people specifically the marginalised and the poor and secondly if the state apparatus is lending adequate freedom to these bodies to act on own initiatives.

c) Empowerment:

The evolution of ASHA also needs to be understood along the line of empowerment of the community. The concept of empowerment originated from the debates on education in Latin America specifically in works of Paulo Friere who proposed that poor could be enabled to challenge the power structure through conscious raising (Hust 2004, p 45)..

"The term government refers to a range of activities from individual self assertion to collective resistance, protest and marginalisation that challenge the basic power relations. For individuals and groups where class, caste, ethnicity and gender determine their access to resources and power their empowerment begins when they not only recognise the systematic forces that oppress them but to act to change existing power relationships. Empowerment is a process that aims at changing the nature and direction of systematic forces which marginalise women and other disadvantaged groups" (Hust, 2004, p45)

The concept of empowerment indicates the ideas of making someone powerful, facilitating the weak to attain strength, to increase one's self esteem and to support someone fight for rights (Kumar and Varghese, 2005, p55).The concept of empowerment is also linked to growing emphasis on participative systems of governance and management at multiple levels (Jumani , 2006, p3).The concept of empowerment however is also not simple process of sharing , distribution and re-distribution of power. It is indeed a larger process of change in social, economic and political ideologies and even change in the minds of marginalised section through conscentisation (Jumani, 2006, p6) Empowerment of the underprivileged had been considered now an important function of the

government and hence programs have been formulated along the line of participative processes.

Activism and change agent:

The concept of activism draws from the ideas of community action for bringing change that promotes social and economic justice (Shragge, 2003, p 44).The idea of activism can be understood in the context of collective action, capability to bring change in the existing structure which has been oppressive. It also caters to the idea of availing what rightfully belongs to individuals.

a)Sociological theory of activism:

Thus concept of activism in the literature has been very much associated with collective action towards bringing social change. The concept of activism has been associated with sociological theories that concerns social change. The strain theory explains activism as a response in terms of strains or major structural changes which creates grievances leading people to organise for collective action (Vallochi 2010, p 15). The other theory of resource mobilisation however states that activism does not always occur as response to major structural changes in the society (Vallochi, 2010, p16). It believes that socially caused grievances are always present and it is important that how these grievances are harnessed for collective action. Here the activist focuses more on dynamics of mobilising people for addressing these grievances always present in the society.

b) Political activism:

The aspect of political activism implies the way citizens participate in the governing process. The research associated with political activism tends to look at various dimensions of political activism. There are few major themes that have emerged in last decade amongst which are the revival of interest in voluntary associations and social trusts and expansion of various forms of cause oriented activism including demonstrations and protests. It further analyses the way political participation is achieved in democracies which is majorly found in the form of voting followed by a minority being involved in campaigning and other processes and finally the form of protest politics. However as indicated by

literature (Norris, 2009 , p629) the participation of people in such cases depends on indicators such as hold over resources, educational status, class, caste and ethnicity leading to active participation of those who are informed about the processes. Thus it leads to an activism highly restricted to elitism.

Activism also needs to be understood in the context of people's health movement with an idea of application of long lost concept of application of human right to local health problems. The aspect of right has been given due importance as is health as argued in is centrality to all human rights (Turiano and Smith, 2008 p1). The right to health and health care comes as an uniting forum for all the health activists as they make demands at local, national and international level which has also been launched in India to re-install the deteriorating public health service system (Turiano and Smith 2008, p4).As further argued it has come majorly in close participation of civil society participation in community planning and monitoring under NRHM with an expectation of direct involvement with community to identify issues.

The ASHA has also been identified as the missing change agent at the periphery who would promote healthy life style in the community specifically among vulnerable population. The concept of change agent has been present in health programs of other developing nations as well. At present health has been identified as not only associated with illness but having a greater connotation. In this context the community health workers have been considered as not only people delivering health care but also to support community identify their health problems and find solutions for them (Heckert and Connor, 1999, p332). The concept of change agent is associated with bringing positive changes to the community. In health planning it also indicates the importance of health promotion leading to healthy lifestyle.

A section of review already has established the primary concepts in the evolution of the program have been volunteerism, activism, communitzation. The review is also extended to analyse if ASHA is designed and evaluated further in the program reflecting her role as a woman volunteer, a social health activist and agent of communitization**.**

ASHA as depicted in the evaluation reports :

The program of ASHA also has been also reviewed several times since its implementation. It is indeed important to understand how these reports have seen the program in terms of its success and failure. The evaluation reports of ASHA need to be looked at to understand how the process of communitization, her role as social health activist has been evaluated.

The concurrent evaluation (NHSRC, 2011) of the ASHA at its introduction recognises her as social health activist, link worker and agent of communitization. The report gives an immense importance to effectiveness of the program in terms of coverage, service delivery and whereas ASHAs have adequate skills for delivering her services as community health worker.

The evaluation (NHSRC,2011) framework primarily dwells upon the programmatic components of the ASHA. The analysis of the program gives significance to the questions such as selection process of ASHA, how much time she spends on field, how many persons and families have been provided service. The evaluation further analyses effectiveness of ASHA in terms of her coverage, her task of getting a user to a health facility or a professional service provider. Secondly it again looks at role of ASHA in terms of providing counselling, health promotion for better health practices. The last question that the evaluation takes in to account is the activist role of ASHA in terms of promoting collective action for accessibility to services, holding of meetings, reaching of services to the marginalised section.

The NHSRC evaluation (NHSRC, 2011) has looked at the functionality of ASHA in terms of her knowledge regarding care in pregnancy, new borne care, her involvement in Village Health and Nutrition Day, child health and also her role in terms of prevention and cure of malaria and tuberculosis. Her functionality in these aspects is emphasised vehemently to the extent of ASHA's knowledge regarding nutritional needs and complication during pregnancy, her role in increasing institutional delivery. The activist role of ASHA is discussed very little as a part of community mobilisation in which ASHA's action as activist are measured through mobilisation activities, action against domestic violence, anti-alcohol campaign, ensuring accessibility to ANM and AWW for

the marginalised section. The key findings from the evaluation study reflects that the majorly emphasised activities of ASHA has been promotion of institutional delivery, new borne care and immunisation has been quite high owing to the incentivised nature of the work .However it also notes that effectiveness of ASHA is very low in such cases as they possess very low knowledge and skills and also resources to provide care and support herself. The evaluation recommends for enhancing knowledge base and skill base of ASHA through training along with ensuring adequate supply of resources and timely response from the health service system.

Another set of documents which have reviewed NRHM is Common Review Missions which are set up as National Rural Health Mission's steering group's effort to conduct concurrent evaluation of the program (NHSRC, 2007). The Mission conducts state level studies which are then compiled. There are five such compilations which look at program across states. The components of ASHA have also been looked at intrinsically in these mission reports. The first review mission evaluates the program in terms of her selection, training, incentive of ASHA, supply of drug kit, the support structure of ASHA, role of VHSC, the involvement of PRI and also role clarity and monitoring of ASHAs. The fifth common review mission (NHSRC, 2011, p6) reinforces the findings of the previous common review mission that ASHA is seen both by the providers and community members as the person who has enabled access to health services for mothers and children. The fifth Common Review Mission like the previous reports has also reiterated that the role of ASHA is more pronounced as facilitator of services; however it gives report of much strengthened support system for ASHA which have been indicated as major problem in previous reports.

The First Common Review Mission (2007) brought forth the problems associated with delayed payments of incentives to ASHA and also the problem associated with incentives mechanism in terms of mere concentration of ASHAs on incentivised issues and leaving out issues such as counselling on child health. It also refers to conflicts between AWW and ASHA in terms of who gets the incentives for facilitating JSY to pregnant women. The review further notes that

the roles of ASHAs have been primarily restricted to immunization and JSY also owing to overemphasis on the aspects of incentivised programs and weak support system for ASHA. The role of VHSC is also minimal owing to the fact that most of them are non-functional. The review adds that the VHSCs need to be more functional and more involvement of ASHA program and sub-center is required in improving the functions of VHSC along with imparting of skills for village health planning which also should involve ASHA. The Second Common Review Mission (2008) also discusses the challenge of ensuring PRI participation which is only proactive in Tripura and Nagaland. The need of elaborate training in planning, implementation and monitoring of various components is emphasised. The Second CRM emphasises on strengthening of PRI participation in the program, however the review majorly focuses on strengthening ASHA's role increasing strength of the support system for ASHA. The Common Review Mission second review (2008) has extended the discussion on ASHA mainly in terms of service delivery. The review discusses primarily the strong roles that ASHAs have played in delivering services such as JSY. Secondly it also brings out the issues related to drug kit and the need of addressing the issues of replenishment. The third Common Review Mission (2009) and fourth Common Review Mission(2010) also gives similar recommendations for the program and emphasises the need of strong support structure for a better functioning ASHA. The fourth common review mission reiterates how ASHAs have been considered very significant in mobilising women for institutional delivery and immunization and diseases. The fifth common review Mission (2011) has again talked about institutional delivery and immunization as two most important functions of ASHA. It however puts the finding that the incentive mechanisms are more or less streamlined in most of the states. The Common Review Mission (2011) also extends discussion on ASHA's roles in other programs such as malaria surveillance, DOTs, new borne home based care. The incentive based work also evolved as an important notion amongst the health functionaries as opposed to the concept that an ASHA can work voluntarily without any interest in monetary gain. The CRM report (2011)

cites an example from Chhattisgarh where ASHAs who are not taking incentive with a willingness to work voluntarily has been dismissed as non-functional ASHAs. As pointed out by the report this has been a lost concept that any community health worker would work only on the grounds of volunteerism. Indeed Chandigarh also has started with an initiative of making regular payments to ASHA.

Indeed the training materials for supportive structure of ASHA at state level have been also built in the line of monitoring skills of ASHA in terms of RCH, immunization and family planning(RRC ,2011). There is also a need to look at a set of literature that critically reviewed the program. These have tried to look at work of ASHA and understand her contribution to the program. This section also looks at the driving principles in the formulation of community volunteers in the health program.

Perception of the program in other reviews:

As argued in many of the literature the community health volunteer program has been one of the most important components of primary health program. The VHWs as perceived in literature is considered as primarily related to preventive aspect of treatment and woman primarily had been considered fitting the bill most (Mankad, 1991). However as further argued the idea of community health volunteer has gone under the screening process keeping in view the failure of the community health volunteer programs in India. The whole approach was looked at not just through the perspective of involvement of these volunteers for preventive care but as change agent autonomously working outside the health service system in the context of ongoing people's movement (Mankad,1991). Community based approaches have found its tremendous importance in people's movement forming one of its important base in Chhattisgarh. The Community based approaches have found its importance in the people's movement to ensure control over livelihood and access to natural resources. The Shaheed hospital came as a great example of people's movement and creating a health facility with active participation and contribution from the mine workers in Chhattisgarh

(Sen, 1999). The main purpose of this movement and active contribution of the community was garnered towards creating a people friendly health facility (Sen, 1999).The Mitanin was designed with similar ideas of having a woman volunteer from the community who would help in incorporating community participation and empowering of the community (http://www.shsrc.org)The Accredited Social Health Activist had found its conceptualisation in the midst of this discussion of redefining community health volunteers as change agent and also a part of the process of community involvement in health planning. However in many of the literature the issue of very less attention paid to the roles of ASHA as an activist, agent of communitization have found its place. The primary focus of ASHA has deviated from these roles and has laid a major focus on ASHA's role as taking pregnant woman for institutional delivery under JSY and collecting children at sub-center for immunization (Ashtekar, 2008, p25). This overemphasis on institutional delivery has created a resentment amongst the Traditional Birth attendants (Sharma,2009, p177) and much talked about co-ordination between TBAs and ASHAs is missing and secondly also the ASHAs have been concentrating more on this activity considering the monetary gain and demands for employment from ASHA has been raised. Secondly the other concern also remains that there is resentment amongst ASHAs owing to the delay in payment of incentives. The present ASHAs are also loaded with immense number of works many of which is related to MCH. As indicated in Hota (2006, p193) the work of ASHA has been primarily focussed on her responsibilities as community health workers who would " reinforce community action for universal immunization, safe motherhood , institutional delivery, and reproductive health related services, new-borne care, prevention of water borne diseases, nutrition and sanitation" (Hota, 2006, p193)

Such an incentive and skill oriented approach towards ASHA is much emphasised by NRHM in its training process. As indicated in Hota (2006, p194) the primary focus of the capacity building of NRHM is to enhance skills and increase number of health staff.

The limitation of ASHAs in terms of her functionality is also a big concern as ASHAs are facing difficulties at every level of functioning, the meagre amount of incentives and the inadequate drug kit which has very few numbers of drugs and also has been undergoing the problem of insufficiency in supply (Ashtekar, 2008, p 25). As further argued the ASHA is often denied a meaningful role in curative care with granting of such meagre resources. In conceptualisation the ASHAs are visualised as the activist but the NRHM has never have equipped ASHA to undertake complex social roles (Ashtekar, 2008, p25). The study also further extends that when the health service system is not adequately able to tackle issues of lack of doctors and other human resources it also becomes difficult for an ASHA to work efficiently and ensure quality health care to community members in such an institutional setting which has not been able to overcome its own flaws (Ashtekar, 2008 , p 25)

The other concern that rises in NRHM is its approach towards communitization. As discussed in literature the communitization process in NRHM is devoid of any innovation, scope for mobilisation of local resources and it only has restricted itself to the process of fund allocation (Ashtekar, 2008, p 24). The PRI participation also has been very minimal with most of the PRIs paying importance to other development activities than health (Sharma, 2009, p177) .In the context of this lack of seriousness the committees such as VHSCs only caters to the work of management of a bank account (Ashtekar,2008).

The question remains whereas ASHA has the freedom and scope of ensuring community ownership in health planning, collective action of the community and availing of health services as a right. As indicated by reports (JSA, 2007) her functioning had been restricted to delivering of specific health services like RCH and immunization. The biggest challenge had been her obligation towards health service system and the fact that her work is constantly supervised and credited by ANM and ASHA facilitators

Though the NRHM has planned for adequate training for them inadequacy in training and also that ASHA has not been able to understand even her roles

properly have been reported (Bajpai and Dholakia, 2011). NRHM also draws the concept of ASHA as an activist who would mobilise people for local health planning and also would facilitate accessibility to health care as their right. However the question here arises is whereas the ASHA workers have freedom to act as an activist and make health care accessible as a right. She is also part of the health service system in terms of reporting of events and also is dependent on the ANM for compensations (Shukla, 2005). The right to health care is hardly practised and a control of the health service system remains on the ASHA workers through the performance indicators (Dasgupta and Qadeer, 2005).

Conclusion:

The review leads to the question that whereas the concepts of volunteerism, communitization and activism has found its place in the program or the design of ASHA. This also needs to be measure empirically through an understanding of ASHA's functions in the community.

Chapter 3

Research Methodology

Conceptualisation framework:

The NRHM has forayed into revamping of rural health service system with an aspiration of providing affordable and quality health care to rural population specifically to poor and vulnerable section. The program also sought to ensure community participation and ensure accountability of health service system to community. Thus there was an ingrained idea of ensuring constant engagement between health service system and the community. The program envisaged of Accredited Social Health Activist who would act as an interface between the health service system and the community. She has been visualised as a woman volunteer from the community who would act as an ASHA with an approval from the community. Her role is that of a health activist who would create awareness on social determinants of health in community and secondly would mobilise community towards participating in local health planning (MOHFW,2006). As an activist her role is also to ensure increased utilisation of the health services as well as ensuring that it is accountable to the community. The NRHM also has entailed ASHA's role in its process of involving bodies of local self governance through formation of quasi governmental bodies. While understanding the ideas of activism, communitization and volunteerism has found prominence in the conceptualisation of ASHA, it is also important to analyse how these concepts are explained theoretically. The concept of volunteerism in theoretical review has been considered as the core element in in achieving community participation to reach the goal of health for all (Akintola 2011, p54). Volunteerism has been given importance in various programs and is often looked as way to solve the issues of crunch in human resources (Petrzelka and Mannon, 2006). The conceptualisation of ASHA as the woman volunteer who is entitled to pay special attention to woman and children of the community can be looked to the perception of woman volunteerism as an expression of maternal nature (Clary and Snyder 1999, p157) . The very idea of ASHA being intricately connected to the community can also be linked to the theoretical understanding of woman building social connection and contributing to the

development of the society (Clary and Snyder 1999, p 157). The NRHM has envisaged creation of VHSC which would have an active participation from ASHA and PRI and would be responsible for village health planning (MOHFW, 2006). This idea of involving ASHA a woman volunteer from the community and the PRI can be linked to the concepts of communitization which is seen as the way of transferring of ownership over resources to the community (Pandey, 2010, p16). This endeavour can also be linked to the concept of communitization, the third way of governance which offers an alternative approach to governance which is to improve public delivery system at the grassroots and empowering communities harnessing social capital at grassroots (Pandey 2010). Thirdly the activist role of ASHA for ensuring accessibility to health care as a right can also be linked to theoretical understanding of people's movement. In this theoretical understanding health activism is explained with right based approach and health as centrality to all rights (Turiano and Smith 2008, p1). One needs to look at how NRHM facilitated ASHA to fit in these roles through its program components and through the training process. There is also a need to look at the association of ASHA with VHSC in fulfilling the roles of an activist and agent of communitization. Apart from this the supervisory structure is also influencing the functioning of ASHA which needs to be explored.

Firstly the training modules designed for ASHA circles around enhancing ASHA's knowledge about the program components of NRHM with which are Reproductive and child health, Vertical disease programs and family planning. The 5th module although has elaborated on the concepts of leadership, rights and activism much of the training is emphasised on building ASHA as a skilled worker as reflected from the other training modules. Secondly the training process of ASHA is also linked to functionality of ASHA. The roles and responsibilities entailed in NRHM framework most of her responsibilities are that of counsellor for pregnancy related care , acting as an escort to the health services facility , promotion of institutional delivery and increasing coverage of immunization, her role in vertical health programs (MOHFW, 2006, p1). ASHA is considered as an honorary volunteer and would not receive any salary so that her work as ASHA would not interfere with her normal work however ASHA would be compensated for her performance in national programmes.

Most of these activities performed by ASHA such as immunization, institutional delivery, family planning, collection of blood slides for malaria (NVBDCP) have been incentivised to motivate ASHA. The supervisory structure of ANM and ASHA supervisors also monitors ASHA's performance in delivering these services. ANM extends support to ASHAs for mobilising community to avail these services offered by the health service system. ASHA supervisor has also been added as a layer in Assam for direct supervision in field that primarily would cover the areas of reproductive and child health, family planning. Thus the entire network of services built around ASHA and the supervision conducted on her plans to fortify her performance in deliverance of these aforesaid services. Hence one needs to analyse at the if amidst being the link between health service system and community for delivering the services related to reproductive and child health, immunization, family planning, vertical disease programs and institutional delivery ASHAs have scope to act as an activist and contribute towards building community ownership in NRHM.

Broad Objective of the study:

The broad objective of the study is to understand if the much envisaged ideas of communitization, activism and volunteerism in the NRHM framework have been given importance in the design of the ASHA or she merely is oriented to work as community level health worker.

Specific objectives:

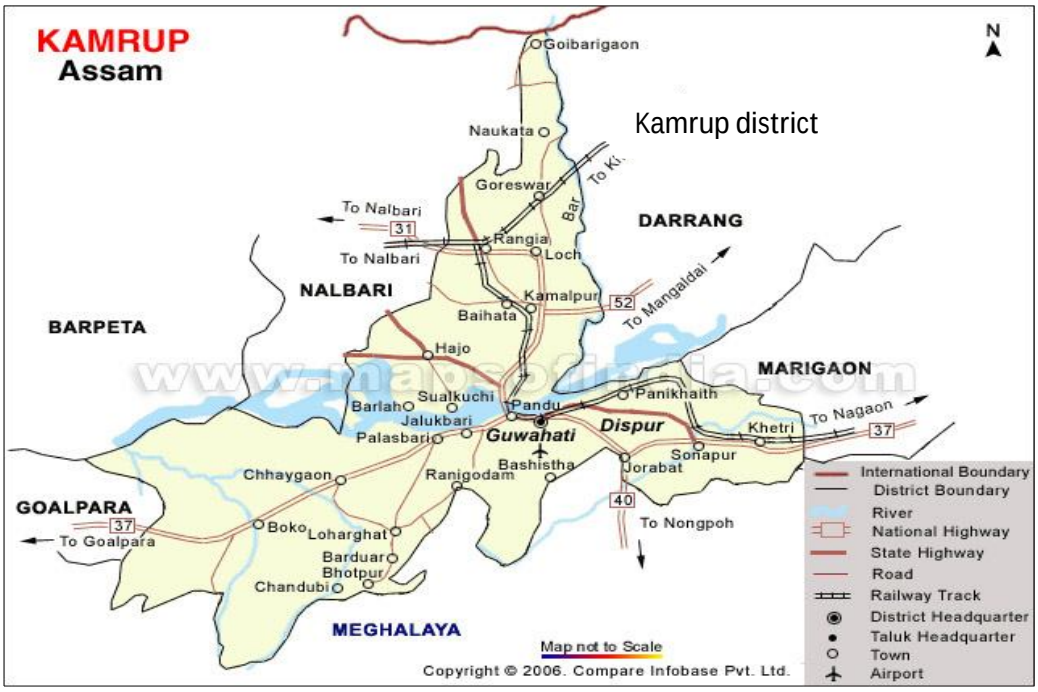
- To explore the role of ASHA as an activist, agent of communitization and volunteer through her functioning.
- To analyse how the training process of ASHA has oriented her as an agent of communitization, activist and a volunteer.
- To explore the roles of ANM in the functioning of ASHA.
- To understand the co-ordination of ASHA with PRI in the communitization process.

For the purpose of understanding the implementation of the ASHA program and to explore the duties performed by ASHA, the monitoring mechanisms and her co-ordination with the PRI, ANM and ASHA supervisors, fieldwork was conducted in Kamrup district of Assam which is one of the EAG states which has seen an earliest implementation of ASHA.

MAP 1: ASSAM

Source: http://www.censusindia.gov.in/maps

MAP NO. 2: KAMRUP DISTRICT



Source: http://www.mapsofindia.com

The study area selected is Kamrup district . It is an administrative district located in the western part of Assam. It derives its name from the ancient name of Pragjyotishpur. The district is now divided into two administrative sections which are Kamrup rural and Kamrup Metropolitan division. As per this division the Kamrup rural is expanded in an area of 344 sq km and Kamrup Metroplitan covers an area of 627 sq km (http://www.kamrup.nic.in/glancefr.htm). The urban section of Kamrup has its local administrative units which are Guwhati Municipal Corporation, North Guwahati Town Committee and Narangi (OG) and the rural Kamrup has panchayat bodies for local self administration (http://kamrupmetro.nic.in/distadm.asp).The Kamrup rural has total of 14 blocks a .The total population of Kamrup district is 1,517, 202 (http://www.census2011.co.in/census/district). In this total population the kamrup rural has a population of 157202 and Kamrup metro has a population of 1260419 (http://www.census2011.co.in/census/district).

The district has a variation amongst its inhabitants in terms of religion and caste. There are also tribal groups such as living in the area. The languages primarily spoken are Assamese and also Bengali in some parts of the district. Some other tribal languages are also spoken in some of the areas. As far as health status is concerned the health status of the district is give below in terms of health infrastructure and human resources.

The kamrup metropolitan has 1 block PHC, 1 CHC 8 MPHCS and 281 sub-centers. The kamrup rural has 12 block PHCs, 9 Community Health Centers , 19 MPHCs and 52 sub- centers (http://www.nrhmassam) . The total number of First Referel Unit in Kamrup district is seven out of which five are in administrative division Kamrup rural and two are located in Kamrup metropolitan. The FRUs are namely Bako, Rangiya, Sualkuchi , Bezera, Hajo (Kamrup rural) and Dhirenpara MCW Hospital and Pandu (.http://www.nrhmassam.in/dlhs3) The district(Kamrup metropolitan) has one medical college, one Ayurvedic college and one homeopathic college. The total numbers of district hospitals located in Kamrup are three one of which are located in Kamrup rural division and two in kamrup urban division (http://www.assam.gov.in).

Selection of block:

Hajo block was selected for field study on the ground of convenience for the researcher and also keeping in view the fact that the area has varied representation of different social groups in terms of caste and religion. Hajo block is located in Kamrup rural division. The information of the block is obtained from the compilation collected from Hajo block PHC. The detail of the block in terms of its population, health infrastructure, and human resources is given below.

The Hajo block has total population of 1, 79, 325 out of which Mulsim population is 87,696 and Hindu population is 91,629.The Hajo block also has variation in population in terms of belonging to scheduled and general category. The Hajo block has total 23,5 83 SC, 2,157 ST and 15,440 population belonging to other category. The block also has section of Bengali speaking Muslim population who shares a different identity in terms of origin and culture from the Assamese ethnic group.

The health structure of the block:

The Hajo block has one community health center, seven mini PHCs and 32 sub-cneters. As far as the human resources are concerned the Hajo block has total 16 ASHA superviors, 74 ANMs and 171 ASHAs.

Sampling technique:

The sampling technique used is purposive and the sampling included 18% of the total ASHAs from the block. As the NRHM also has talked about support system an ASHA has to work in close co-ordination with PRI representative ANM and ASHA supervisors. Hence the researcher also has included president of VHSC who are members of PRI, ANM and ASHA supervisors in the sampling. Apart from that the sampling also included Program Managers at PHC and block PHC level to form an understanding of their perception of ASHA's role and how they have been extending support to the ASHA program. There was also key respondents selected from DONBOSCO, (ASHA state Resource Center) and a

key institute for capacity development of ASHA and ASHA supervisors and also regional co-ordinator at Regional Resource Center which is for the entire north eastern states and is responsible for providing technical input under NRHM (http://rrcnes.gov.in/about.html).

The villages for the study were selected keeping in view the following context:

- To include villages with mix of Hindu and Muslim population
- To include villages which is entirely inhabited by Muslim population
- To include villages inhabited with majority of SC population
- To include villages which have population inhabited entirely by people from Hindu religion.
- To include villages with ethnic variation.

The number of villages inhabited entirely by Muslim population is 12 and entirely by Hindu population is also 12. There are 6 villages selected with a mixed population from both the religion. The number of villages inhabited by majority of Hindu SC population is 5 and majority Hindu(other) is 10. As far as the ethnic identity is concerned 5 villages in Kho Puni Kuchi sub-center has been inhabited by Bengali Muslim population. This would be seen in relation to religious and caste background of ASHA and whether these women selected as ASHA belong to marginalised section and ensure their accessibility to fellow marginalised section.

Selection of respondents:

The primary respondents for the study were ASHA who were selected from 30 villages falling under 6 sub-centers under Hajo block PHC. The selection of the villages from which ASHAs were selected for the study was identified in the context of composition of population in terms of caste, religion and ethnic identity. One ANM and one ASHA supervisor was selected from each sub-center and VHSC presidents from two villages under each sub-center were selected for the study. Program Managers from 5 PHCs and one from Block PHCs were also interviewed.

Table No 2. Sample Size and Area

PHC	Sub-Centre	No. of ASHA	No.ofANM supervisor	NO. of programme Manager	No. of VHSC
Ramdia	**Koibortala**	**5**	**1**	**1**	**2**
Boromboi	**Ukhura**	**6**	**1**	**1**	**2**
Dadara	**Dalibari**	**5**	**1**	**1**	**2**
Hajo	**Duparguri**	**5**	**1**	**1**	**2**
Buragohaithan	**Japia**	**4**	**1**	**1**	**2**
Saniadi	**Khapanakuchi**	**5**	**1**	**1**	**2**
Total		**30**	**6**	**6**	**12**

Selection of key informant

The State co-ordinator and district Community Mobiliser from the ASHA DONBOSCO were selected for the study as they have been playing crucial role in imparting training to ASHAs and the ASHA supervisors and the regional co-ordinator at regional resource centre. The state Programme from NRHM was also included.

Table No 3 Key Informants

institute	District Community Mobiliser	State ASHA Programme Coordinator	State Programme Officer
Don Bosco Institute	1	1	
NRHM			1

Tools for Data Collection:

The researcher collected both secondary and primary data. The secondary data was collected from reports available with National Health Resource Center, State ASHA resource center, evaluation reports of ASHA, Common review missions of NRHM and other articles related to ASHA program. The primary data was collected through semi-structured interview schedule for the ASHAs, ANM, ASHA supervisor, presidents of VHSC, Program Manager, key informant at Donbosco which is State ASHA Resource Center. Observation list was made in terms of how ANM and ASHA interact on immunization day organised in the village and also to

observe VHSC president's response in meetings with ASHA supervisors and ASHAs. Only two of such meetings could be observed in village Sakumtali in Koibortotola sub center and in village Mokhonia in Ukhura sub-center.

Data collection process:

Phase 1:

Preliminary visit to Hajo Block:

The researcher has conducted a preliminary visit to Hajo block to build an understanding of the ASHA program and the supportive structure built around her. The researcher has also has visited the office of Director General of Health

Services(Kamrup rural) for obtaining permission to work in the Hajo block. After obtaining permission the researcher has visited the block PHC and few other few sub-centers. A compilation was also gathered from the block PHC in regarding health infrastructure, population composition, human resources available in the Hajo block. The researcher also collected information regarding training bodies. This helped the researcher to select villages for the study and also to create tools.

2nd phase:

In the second phase the researcher started with an interview process with the officials at NRHM(Assam) and key informants at DonBosco which was the state ASHA resource Center and was entrusted with the responsibility of capacity building of ASHA and the ASHA supervisors. The purpose was to understand the perspective of the institutes responsible for capacity building of ASHA towards her roles.

The second task was to conduct interview with the ASHAs, VHSC presidents, ASHA supervisors, ANM and the Program Managers.

Observation:

The researcher also used observation as a technique to understand the interaction between the ANM and ASHA at the level of sub-center and also to understand the interaction of ASHAs with the VHSC presidents.

Methods used for data analysis:

The researcher has planned for both quantitative and qualitative analysis. The common themes were identified from the responses and then were organised under emergent domains. These emergent domains were then analysed to create a summary.

Problems faced during the data collection process:

- The researcher faced problems mainly in terms of conducting meetings with the members of Panchayati Raj institutions who were not available and also in most cases reluctant to give an interview.
- The second problem faced by researcher was the notion of few ASHAs that the researcher can help to regularise their incentive which had to be broken at the very onset of the interviews.
- Researcher also could not meet any district level trainer as they were not available.

CHAPTER 4

PROFILE OF THE ASHA PROGRAM IN ASSAM AND PROFILE OF RESPONDENTS

This chapter firstly gives an account of the health infrastructure under NRHM , the status of ASHA program, the innovations in Assam .Secondly It entails socio-economic and political context of Hajo block where the fieldwork for the study has been conducted, as these aspects have influenced the functioning of ASHA in the block. Secondly the chapter also deals with the profile of ASHAs followed by the supervisory structure (ASHA supervisors, ANM, Program mangers, Training body of the program)

The health infrastructure of Assam:

As per state report 2010 Assam has 4604 HSCs, 856 PHCs including block PHCs and 108 CHCs, 25 district hospitals, 13 sub-divisional hospitals, four medical colleges and one ayurvedic hospitals. As far as health infrastructure is concerned the state is lagging behind and has witnessed stagnation in terms of functioning of sub-center since the inception of NRHM in 2006. Presently one sub-center is catering to 6,770 populations as opposed to norm of 5,000 and only 61% of the sub centers are functioning in buildings owned by government (NHSRC, 2011,p37) . As far as the human resource is concerned the state is lagging behind from the set IPHS standard which can be derived from the following table.

Table No 4

Stock of Human Resources in Assam:

	Available	IPHS standard	% of coverage
Medical officer	3154	3787	83%
Specialist	914	1303	70%
Staff Nurse	5539	9854	56.2%
Lab technician	1299	2635	49%
Pharmacist	1383	2447	56.5%
ANM	10110	10422	97%

Source: 5th common review mission, Assam (www.mohfw.nic.in) Page no9

Decentralisation and supporting structure at periphery:

The Assam Panchayati Raj Act enacted in 1994 which incorporated the features of 73rd amendment and the Panchayat election were held in the year 2007 (NHSRC 2011, p12). The NRHM has talked about co-ordination of PRI in planning and implementation of health related activities in community through bodies such as VHSC. Assam has 26,312 VHSC formed till the year 2011(NHSRC 2011,p 12).VHSCs are given Rs, 10,000/- for provisioning of safe drinking water, organisation of VHND, construction of sanitary facilities and arranging money for emergency referel(NHSRC, 2011, p12). All the VHSC members are trained about roles and responsibilities in the year 2009-2010, in 2010-2011and in 2011-2012 (NHSRC, 2011,p 12)

The supportive structure for ASHA:

As far as supportive structure is concerned under NRHM the state needs to put in place ASHA mentoring group, State ASHA Resource Center and, support structure available at block level is Block program management unit (RRC, 2011, p12) .At the sub-center level the AWW , ANM , ASHA supervisors act as supportive mechanism for ASHA. The state has created State ASHA Resource Center for creating support mechanism for ASHA. Along with creation of State ASHA training Resource Center the state has added a layer of ASHA facilitators in 2009 for direct field level supervision and on job training (RRC, 2011, p13). One ASHA facilitator is appointed for every ten ASHAs and are supposed to carry out 20 days of field work for which Rs.150 is dispersed along with an honorarium of Rs 500/. Currently the state has appointed 2700 of ASHA supervisors (RRC, 2011, p13).The details of the bodies formed for capacity development is given below

a) Regional Resource Center :

The capacity development process in Assam has also been entrusted with the Regional Resource Center which has been looking after the entire region of North – East. The Regional Resource Center was created in the year 2006 and is located in Guwahati (http://rrcnes.gov.in/index.html). It has been constructed keeping in view that the region has been showing a low performance as per as health indicators are

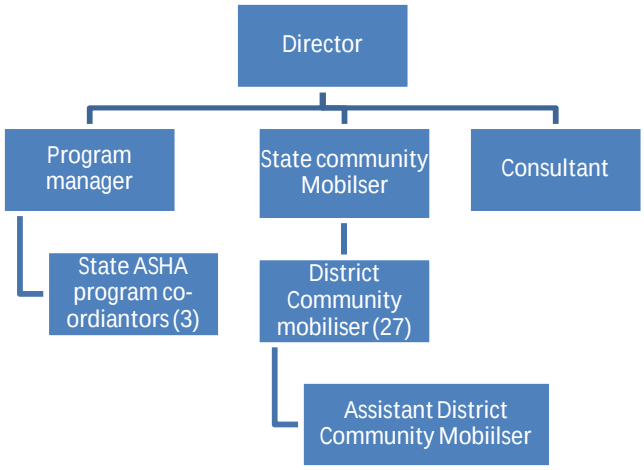
concerned specifically in terms of maternal and child death. The main work of Regional Resource Center is to provide technical assistance in planning, implementation and also monitoring of the program NRHM in the states falling under north-eastern region (http://rrcnes.gov.in/index.html).

b)The State ASHA Resource Center:

As far as training of ASHA is concerned a State ASHA Resource Center comes as state's initiative of public private partnership. Through a memorandum of understanding between Don Bosco Institute and state government on February 21, 2009 the State ASHA Resource Center was built for capacity building of ASHA and ASHA supervisors. The vision of this body is primarily is to keep ASHAs and ASHA supervisors motivated to work towards enabling the community to access health care.

The State ASHA Resource Center is also entrusted with the responsibility of developing materials such as ASHA diary, and materials for ASHA supervisors. The State ASHA Resource Center has appointed District Community Mobiliser stationed at District Program Management Unit (DPMU) who would mobilise ASHA facilitators and would hold discussion with them for strengthening their capabilities. TheState ASHA Resource Center works with the following structure to provide support to the ASHA program

Figure 3 Structure of State ASHA Resource Center



Source: http://dbisarc.org/

Special innovations:

The state has innovated a special program called community radio in order to enhance knowledge of ASHA in aspects of health. This was initiated in the year of 2007 in collaboration with the All India Radio majorly keeping in view the role of ASHA in Mother and Child Health program and the need of negotiating with the mothers and the family member (http://www.nrhmassam.in/asharadio.php). The program also tries to extend ASHA's knowledge in relation to importance of immunization, family planning, safe drinking water, information on Tuberculosis and malaria, organisation of the Village Health and Nutrition Day (VHND) along with ANM , AWW (http://www.nrhmassam.in/asharadio.php) . The collaboration between the NRHM and All India Radio was extended to UNICEF, Assam with a specific importance given to content development for the program. The program also has developed a feedback mechanism from the ASHAs which is through letters from the ASHAs. The planners of the program have spoken about post cards for the ASHAs which would be stamp free and 20 such postcards would also be given to ASHAs (http://www.nrhmassam.in/asharadio.php). However it has not been implemented yet and the address of All India radio is given at the end of the program so that the ASHAs can write to the AIR. As far as individual queries are concerned the program caters to through actions taken by mission directorate and the queries which concern most problems of the ASHAs are answered through the program itself (http://www.nrhmassam.in/asharadio.php).

Resources for ASHA:

The NRHM has made provisions for providing resources to ASHA which mainly are drug depot, bicycle, radio, ASHA bag and an umbrella (http// www.nrhmassam .com) The drug kit of ASHA has the following drugs.

Figure 4 Drugs of ASHA

ASHA Drug Kit as per guidelines and manuals
ORS
Paracetamol
Oral Contraceptive Pills
Condoms
IFA
Cotrimoxazole
Chloroquine
Dicyclomine
Albendazole
Nischay Kit
Thermometers
Bandages
Cotton Swab
Betadine
Gentian Violet

Source: NHSRC (2011) p . 29

The socio-economic and political characteristics of Hajo:

The block has two legislative constituencies and variation exists within the block between these two constituencies in political, economic and social context. The further division which was observed was between villages inhabited by Assamese population of Hajo constituencies and the villages inhabited by Bengali Muslim Community in terms of their socio-economic condition and political power.

The political context of the block Hajo:

The block is divided into two legislative constituencies and has members from two different political parties. The legislative constituencies are namely the Hajo legislative constituency and Jalukbari legislative constituency. The current Jalukabari constituency has a member of legislative assembly from the ruling party Congress. The Member of Hajo Legislative Constituency is from Trinamool Congress. The political context has been discussed here as the political power of PRI member is also influenced by this political leadership. All five Gram Panchayat in Jalukbari Constituency has representation from Congress party and Hajo constituency has 11 gram panchayat with representation from congress, 7 from AGP and 7 with mixed representation of congress, AGP and independent candidates.

The ethnicity:

The ethnic difference exists in terms of the language spoken between the two communities which are Bengali and Assamese. The entire block Hajo has around 40% of Bengali Muslim population as told by one of the members of a village inhabited by Bengali Muslim population in Hajo constituency. This section of population is a part of migrant population from eastern Bengal and shares a different cultural identity than the Assamese population. This ethnic group also faces discrimination on the ground of existing history of Bangladeshi migration who shares similar cultural identity. Thus this puts a divide between the Assamese and Bengali Muslim population and leads to the phenomena of considering section of Bengali Muslim population as not belonging to the larger Assamese identity.

The economic context:

The economic context of the place is different in terms of occupation within the Hajo block the data for which is derived from the discussion held with ASHAs. The villages that fell under Jalukabari constituency whereas has majority of population belonging to an agricultural community, small business, there is also large section of population working in tertiary sector owing to the closeness to Guwahati city. This section of population also owns agricultural land. In Hajo constituency around 52% of the villages have population who have been involved in agricultural activity but also some of them are working in tertiary sector. The Hajo constituency has

population from the SC community and the Bengali Muslim population who earn their livelihood mainly by trading fish in nearby areas and also in the city. Amongst total villages selected under the study in Hajo legislative constituency around 26% of the villages are engaged in fish rearing as a major livelihood activity.

As the researcher finds differences within this group of section of population in terms ethnic differences and political leadership in terms of two legislative constituencies the profile of the ASHA will be discussed within the division of Bengali Muslim population and Hajo legislative constituency and the Jalukbari legislative constituency.

Profile of ASHA:

The profile of ASHA is elaborated in the context of her age , marital status, her educational status , economic status , social background, the reasons for selection cited by ASHA and also the selection process itself.

a)Age structure of ASHA:

The following table give an account of the ASHAs in terms of her age. The table gives a detail of age of ASHAs in Jalukbari Constituency , Hajo constituency and the villages inhabited by Bengali Muslim Population

Table No 5: Age structure of ASHA

	30-40	40-50	50-60	Total no of ASHAs interviewed
Jalukbari constituency	5	--	--	5
Hajo constituency	14	4	2	20
Villages with Bengali Muslim pop	5	-	--	5
Total	24	4	2	30

As discussed earlier the normative age group from which ASHAs are to be selected is 25-45 years. This norm is mostly followed in all the villages selected under the study with majority of ASHAs belonging to an age group of 30-40 years. There is an exception witnessed only in case of very few villages in Hajo legislative constituency where the ASHAs selected were more than forty five years old or even were in late sixties. The ASHA who is 60 years old was appointed as ASHA as she had experience of working as CHW. The ANM thought she would be benefited also financially as she is from a very poor family who is somehow living hand to mouth.

b) Educational qualification of ASHA:

The framework for ASHA entails that an ASHA needs to have good communication skills and expects her to be educated at least up till standard eight. This criterion of selecting a literate woman is met everywhere. The trend shows that majority of women have studied at least till eighth and ninth standard (16 out of total 30 ASHAs), and a few have passed matriculation.

c) Marital Status of ASHAs:

The following table gives a data of marital status of ASHAs across all the three sections, Jalukbari constituency, Hajo Constituency and Villages with Bengali Muslim population.

Table No 6: Marital status of ASHA

	Married	Widowed	Single	Total no of ASHAs interviewed
Jalukbari	2	3	0	5
Hajo	10	9	1	20
Bengali Muslim pop	5	--	--	
Total	17	12	1	30

The majority of ASHAs selected were married, few were widowed and one ASHA had single status. Majority of ASHAs in the Jalukbari constituency were widowed. Most of these ASHAs both married and widowed had more than two children.

1.4 Economic Status of the ASHAs:

The economic status of ASHA is measured through her family through her total family income and also through figures for who is the earning head.

d) Family income:

The following table gives an account of who is the breadwinner in the family of women who are working as ASHA. The income interval is drawn on the basis of the responses of ASHA to the question of their family income. Many of ASHAs has a family income between Rs 2,000/--Rs.4,000/- per month and only a few ASHAs cited income more than Rs. 7,000

Table No 7: Income of ASHA

	2,000-4,000	More than 7,000	Total
ASHA as a sole breadwinner	16	----	16
Dependent on other members in the family	10	4	14
Total	26	4	30

The family income was taken as a variable for understanding the economic condition of ASHA. The income here referred to the total income of her entire family including her and any other earning member of the family who bares family expenditures. As the findings suggest that the ASHAs who belonged to lower category of income (Rs 2,000/4,000) had been those who are the sole breadwinner of the family. However as reflected from the table 4 only a few ASHAs have family income which is more than Rs. 4,000 per month.

Social and community identity of ASHA:

The NRHM has spoken about the participation of marginalised and disadvantaged in the health planning process. Hence it is important to have ASHAs from marginalised sections of the community as the ASHAs are supposed to play an important role in the planning process through participation in bodies like VHSC.

This was looked through the religious and caste background of ASHA. As far as the social structure of the villages is concerned in many cases the entire village was inhabited by people belonging to same caste group or religion. Hence in such case the ASHA belongs to the same caste or religious group to which the rest of the community belong.

a) Religious background of ASHA:

The following table gives a detail of ASHAs in terms of religion between Hajo and Jalukbari constituency.

Table No 8: Religion of ASHA

Constituency	Hindu	Muslim	Total no of ASHAs
Hajo	12	13	25
Jalukbari	3	2	5
Total	15	15	30

As depicted in the table no 5 women from both Hindu and Muslim religion have a good representation as ASHAs in the health service system. As already have been mentioned the villages have its unique social characteristics. Majority of the villages, are either inhabited entirely by Hindu or Muslim population except in few villages where population from both the community dwell. In such villages with mix population in most cases the ASHA is selected from the religious group which is more in number in the area. As perceived by the minority section of the group of ASHAs their religion has not been an issue in their interaction with the community.

b)SC/ OBC/ General status of ASHA

Table No 9 : SC / OBC/ General status of ASHA

	SC	OBC	General	Total
Jalukbari			5	5
Hajo	8	4	8	20
Bengali muslim population	---		5	5
Total	8	4	18	

As the number of ASHAs selected from SC and OBC categories is concerned it is evident that the ASHAs have been represented well from these communities. Many of such villages have been inhabited majorly by SC population and hence have an ASHA from the same category. However as reflected even in few of the villages in Hajo constituency the ASHAs selected belong to SC and OBC category despite the fact that majority of population are from general category. The data reflects that majority of ASHAs are SCs followed by ASHAs from general category and very few ASHAs from OBC category.

The selection of ASHA:

a)The reasons given by women for wanting to be ASHA:

The following table gives an account of the reason for which women from the community chose to be ASHAs.

Table No 10: The reason that motivated to be ASHA

The reasons as given by ASHAs	Number of women who selected to be ASHA (total no of ASHA -30)
Financial reason	12
Wish to build career	5
Urge to serve the community	11
Social interaction	2
Total	30

The ASHAs were enquired about the main reason they have chosen to be an ASHA and the major reasons cited were financial reasons, the urge to serve the community, as way to be busy, the wish to have a career growth in health sector.

The first and foremost reason as stated by many of the ASHAs is that of financial reason. As already have been discussed a majority of women are sole bread winner of the family, they considered it to be help for running her household. It is also noteworthy that some of the women were also motivated by the ANMs citing that it would help them financially or may act as an opportunity to acquire a government job in future.

The second reason as cited by ASHAs is the wish to serve the community. As a matter of fact almost all the ASHAs have cited the idea of serving the community as a motivation behind her being an ASHA. However it has been cited as the primary reason by some of the ASHAs and for them financial gain did not count and also earning for family did not come as urgency.

The third reason cited is the expectation that persists amongst ASHAs to build or develop a career in health sector. The urge of developing a career in health sector is present amongst many of ASHAs who have had earlier experiences in the health sector.

There is a section of ASHA who also have opted for ASHA work as a way to interact with other people from the community. This has come as way for few of them to keep them busy in some task or way to take a break from household task.

b)The selection process of ASHA:

An ASHA as envisaged in NRHM needs to be selected by the community. The NRHM has paid importance in its guidelines for ASHA (MOHFW 2006) that a woman from the community is selected as an ASHA who would have her acceptance in the community and would have social mobilization, promotion of healthy lifestyle as her primary duties. Hence the selection process of ASHA was to be tackled by the gram panchayat, Village health sanitation committee as they are the key representation of the community. The selection process of ASHA involves participation of facilitator selected at block level who would organise focus group discussions with the community to ensure their participation and also would put forth

the choices of the community to the gram panchayat for final selection of ASHA (MOHFW, 2006).The majority of the ASHAs selected in the study have been appointed around 2005-2006, only a few being appointed in 2007.

As reflected from the data however it is evident that the formal procedure of selection as laid down in NRHM framework has not been followed. Most importantly in every part of the block ANM has been one of the most influential people to select the ASHA. The opinion of the ANM stood out in majority of the cases even if the committee for selection had other stakeholders from the community and secondly most of women selected had either been a relative of ANM or shared a close friendship with her. The process of selection has however seen a variation even within the block which is based on the cultural perception of the health functional, her stakeholders' role in the selection and also the perception that have existed among the stakeholders regarding suitable criteria for women to be selected as ASHA. The features associated with the selection process are found to be slightly different in three different zones within the block which are viz Jalukbari constituency , Hajo constituency and villages inhabited with Bengali The selection process of ASHA in Jalukbari constituency happened through a meeting organised with the stakeholders of community viz village head, ANM, AWW and teachers. The information was passed on majorly by ANM and Anganwadi workers. A desired criteria that was put forth from the health service system (as reported by ANM) was women who were poor and also who have ample free time to devote towards community. Though the concept of considering relatively poor women from the community is ingrained in the idea of ensuring participation of disadvantaged section of women in health service system, it is noteworthy that the information was passed on to only a few selected women who were related to ANM and AWW. Muslim population.

The selection of ASHA in Hajo constituency did not happen through convening of a community meeting. The ANM has played a pivotal role and have identified women from the community who are in her perception suitable to work as an ASHA. In this context the ANM has selected women mostly who were either engaged with health service system or has been part of self help group or any other community organisation. Few of the ANMs have explained it as a mechanism to ensure appointment of ASHA who are better acquainted with the health service

system and also have better experience in negotiating with the community. The other stakeholders of the community have participated in the process of selection through consenting on application filed by the women identified by ANM suitable as ASHA.

The villages with Bengali Muslim population the selection procedure adopted was similar to the other parts of Hajo legislative constituency. However a difference occurred in terms of the perception preserved by the health functional about suitability of women for being an ASHA. The characteristics preferred for selection of women as ASHA differed here from the other parts of block. The health functional has given preference to women who have themselves adopted family planning techniques. It comes as a family planning strategy specifically for this area.

Conclusion:

The understanding of the profile of ASHA is important in the context of analysing her socio economic background and if she has been selected considering the NRHM principles of ensuring equitable accessibility to health services for marginalised section. Though an ASHA is envisaged as a woman who is widely recommended by the community , the community participation in this process has not been present. The selection process has been primarily based on the decision of ANM and sees very less participation of PRI which is desired in the NRHM framework. In this context one needs to look at the function of ASHA and what are the services she has been delivering.

Chapter 5

Functionality of ASHA

The envisaged roles of ASHA as an agent of commuinitization, activist and volunteers also need to be explored through the functions delivered by ASHA. There is also a need to understand what ASHAs have learnt from the training process. This would explain if the training process under NRHM has been able to transfer the concepts of communitization, activism and volunteerism. Hence the chapter attempts to look at both the training process and functions of ASHA. First it looks at the training process that has happened in Kamrup district through an analysis of interviews conducted with the resource person for training and also experiences shared by ASHA. Secondly it looks at functioning of ASHA. In this section it analyses what she has been told about her roles when she joined as ASHA and the services she has delivered. It also looks at the role of supervisory structure and their perception regarding ASHA. The challenges faced by ASHA is also analysed to understand if it has impacted her functioning. The last section of this chapter looks at ASHA's functioning with VHSC.

Training of ASHA:

The component of capacity development and training of ASHA is contracted out by NRHM to Don Bosco Institute in Assam. As has been discussed in the previous chapter ASHA State Resource Center was created through a memorandum signed between NRHM and the missionary organisation in the year 2009. It has been entrusted with the responsibility of training of trainers. The State Training Resource Center has also defined a staff structure which has been explained in the previous chapter. The interviews were conducted with District Community Mobiliser who holds meetings with ASHA and ASHA supervisor at the community level and secondly with State ASHA Program Co-ordinator to whom the District Community Mobiliser reports. The training process of ASHA in Kamrup district has completed all training till 5th module both at TOT and block level.

As reflected from the interview with State Co-ordinator, Don Bosco has been imparting training to ASHA primarily to build skills for mobilising community. She gives the following account in this context

> "Don Bosco is primarily acting as a body who would do TOT to finally imparts to ASHAs to work with community. The main task we have been doing is primarily to create skills in ASHA for mobilising her community to access health services and follow better health practices" Anna, State ASHA Program Co-ordinator (name changed)

It was further explored how these training officers have perceived these concepts of volunteerism, activism and communitization and whether they see a scope for imparting these to ASHAs through the training process. In this context volunteerism is explained as motivation to work for the society by the State Program Co-ordinator. It is expressed that the woman are joining as ASHAs with the motivation to work for the community and Don Bosco also works towards keeping their moral high through the training process. The following account is given in this context

> "Volunteerism is the motivation to work for the community and most of women have joined as ASHA with the same motivation. So they are very much volunteers. Motivation only has kept them going even in a condition when they get no timely incentive. We as a training institute try to keep this morale high by motivating them to continue working with the same spirit" Anna , State ASHA Program Co-ordinator (name changed)

The State Program Co-ordinator has explained that ASHAs have not even been able to obtain her rightful incentives on time. Moreover the health service system itself is not responsive to the needs of the community and do not attend them properly when they visit health services. Thus it is difficult to expect that ASHA would be able to ensure right full access to health services for community members as a health activist.

> "ASHA has to face many challenges for herself only and cannot have much scope to be an activist. The ASHAs have reported that they would not work as they don't even get their incentives on time. Moreover they also face difficulties at the health services when they bring pregnant women and they are not paid heed to. They are also questioning about what profits they get from being ASHA as what they have to all face is challenges and even are deprived of incentives. ASHAs are struggling with their own rightful incentive and there is not much scope for them to be an activist" Anna, State ASHA Program Co-ordinator (name changed)

She further explains that hence it is not also possible for Don Bosco Institute to train her as an activist. As further stated the components of activism in 5th module are also considered not practically possible to be implemented by ASHA. It is also added that the work profile ASHAs is much circled around her responsibility as community health worker. The following account is given in this context

> " The component of 5th module which talks about ensuring rights to access health care by ASHA is not possible for an ASHA to implement. These ideas only look good in books. The profile of ASHA is more of a community health worker. She is working well as a community mobiliser which is also possible for her. The other training modules of ASHA also pay immense importance to her role for mobilising community for using health services." Anna, State ASHA Program Co-ordinator(name changed)

The concept of volunteerism and activism is defined by the state program officer who is not part of Don Bosco Institute and is appointed by NRHM to look in to the overall aspect of training in the state along with State ASHA Resource Center. He has explained the concept of volunteerism as the option of having a choice. It explained that the concept of voluntarism is much present as all the woman working as an ASHA had chosen to be an ASHA. He gives the following account in this context

> "She (ASHA) is a voluntary worker who had been working her own choice. She has been never forced to work with NRHM and now she has been performing all her tasks as ASHA willingly " Gaurav Ranjan, State Program Officer , NRHM , Assam (name changed)

As far as the aspect of activism it was again asserted as difficult to impart the theoretical ideas of building leadership, right to health care to ASHAs who are not highly educated women. In this context the following account is given

> "It is difficult to impart the theoretical concepts given in the 5th module at the level of ASHA who have completed education only till High School. So the training mostly imparts how she has to inform community about the services available for them. She is basically told about her roles and responsibilities in terms of telling her community about the free services available at PHC, inform BPL families about various schemes for them" Gaurav Ranjan , Program Officer , NRHM, Assam (name changed)

Thus the training process as reflected from the data collected at the level of training institutes primarily concentrates on ASHA's capacity development as community mobilise. She is imparted the skills of building communication with the community for availing services from the health service system.

The process of capacity development from the State ASHA Resource Center further involves ASHA supervisors. The District Community Mobiliser (DCM) appointed hence is given the responsibility of overall supervision of work of ASHA supervisor and ASHA. This task of supervision is done primarily through holding meetings with ASHA supervisors and ASHAs. However this process of supervision also does not involve the ideas of helping ASHA to realise her roles of a Health Activist, agent of Communitization and volunteer. The supervisory inputs are more in terms of motivating and mobilising ASHA and ASHA supervisors for connecting more and more people from the community to health service. In this context the following account is given

> " I hold meetings both with ASHAs and ASHA supervisors .My task is to motivate them to work in co-ordination with each other.I also try to enhance their negotiation skills to mobilise community for availing health services" Sanjeev Basumatary , DCM (name changed)

Thus it can be understood that the capacity development of ASHA is mostly circles around the idea of building her skills for mobilising community for health services. This aspect also needs to be corroborated with the experiences of ASHA and what they have learnt from the training. This would explain if ASHAs have imbibed the ideas of activism, communitization and volunteerism through the training process.

Perception of ASHAs about the training:

The training in the district has been completed till 5th module. The interviews with ASHAs reflect that mostly the learning of ASHAs has been related to programmatic components in NRHM. The most important component which has remained with all the ASHAs after the training process is Services related to pregnant woman that starts from registration of pregnant woman, ANC, imparting information to pregnant woman about nutritional needs, importance of institutional delivery for safety of mother and Child. All the ASHAs have stated two to three services related to pregnant women as what they have learnt from the training.

> " I basically remember talking mostly about health of pregnant women and how ASHAs are supposed to help them in the training. We were told that our duty as an ASHA is to register woman who are pregnant in our community. We also have to conduct home visits to the houses of pregnant woman and advise them about the care they have to take during pregnancy. We are also told to explain the importance of institutional delivery to the woman and specifically to their family members" Salima Begum, ASHA , Sub-center Ukhura, Hajo constituency (name changed)

Secondly majority of ASHAs also have stated that they have gained knowledge of vertical health programs viz National Vector Borne Disease Control Program, RNTCP and HIV. Firstly many (17 out of 30 ASHAs) of the ASHAs have stated learning her importance in NVBDCP program in terms of collection of blood slides for fever detection from the training.

> "We have been also told about our importance in Malaria program. We have been told about the symptoms of malaria and how our district might have more malaria cases. We are told to collect blood slides from my community for fever detection. It is informed to be very important to detect fever for prevention of malaria" Namita Das, Sub-center Koibortola , Hajo constituency (name changed)

Many of the ASHAs also have included in the interview (15 out of 30 ASHAs) that they have learnt from the training the need of promotion of healthy hobbits in community for prevention of malaria .One of the ASHAs states as follows:

> "My (ASHA's) role in Malaria program was given importance in the training process. We were told to inform community about promotion of healthy habits such as using of mosquito nets, not storing water for prevention of malaria. We also have to collect blood slides for which we get Rs 20 per slide. " Leena Begum,Sub-center Khopanikuchi, Hajo Constituency (name changed)

Apart from Malaria program some of the ASHAs (13 out of 30 ASHAs) also have stated deriving information on RNTCP and her role as DOTs provider. The following account has been given by an ASHA in this context

> "We have been also given information regarding symptoms of Tuberculosis and also the role of ASHA in DOTs program. We were told that we can identify TB patients in my community and refer them for treatment. We are also supposed to act as provider of medicine visiting (DOTs) patients suffering from Tuberculosis " Sunita Barman , Sub-center Dalibari, Jalukbari Constituency (name changed)

The second aspect enquired was that of co-ordination with VHSC. Many of the ASHAs (10 out of 30 ASHAs) have understood her role in VHSC in terms of co-ordinating with

PRI members for planning development activities for community. An ASHA has given the following account in this context

> "We are told that the VHSC has been built for undertaking activities for community development. It is supposed to improve the conditions of the village in terms of safe drinking water and sanitation. We have been said to co-ordinate with PRI members to plan for such activites . They (trainer) have also told about giving sanitation facilities for BPL families" Karuna Kalita, ASHA, Sub-centre Dalibari,Jalukbari Constituency (name changed)

Another set of ASHAs (10 out of 30 ASHAs) have built an understanding that the role of the VHSC is mainly to manage the expenditure of the untied fund. In this context one of the ASHAs gives the following account

> "In the training we have been told about the untied fund the VHSC committee has to maintain. In this case we are told that we (ASHAs) have to manage a bank account. We are also told that the co. mmittee won't be able to withdraw money from the account without my sign as I have to act as a secretary. The PRI member is also important as who is also has given the signatory authority as President of the committee" Mazida Begum , ASHA Sub-center Japia, Hajo Constituency (name changed)

There are other few ASHAs (10 out of 30 ASHAs) however who were not able to respond in terms of role of VHSC.

The third aspect that is emphasised in the functioning of ASHA is the co-ordination with AWW, ANM and ASHA supervisor. As far as co-ordination with ANM is concerned a majority of the ASHAs (14 out of 30 ASHAs) have understood it in terms of reporting. This includes primarily reporting in terms of immunization, registration of pregnant women, ANC as has been cited by these 14 ASHAs. The following account has been given in this context

> "We have been oriented in the training process that the main person that ASHA has to report about all her functions is ANM. We are told in the training that we have to give her the number of pregnant women registered by us in the community. The reporting in terms of immunization and ANC also has been given much importance in the training process. The ANM has to be reported every week about the target we have covered as far the services delivered by us is concerned" Mallika Begum, ASHA Sub-center Ukhura (name changed)

Apart from this a section of ASHA (6 out of 30) also has cited that they have been oriented in the training to establish co-ordination with ASHAs in terms of community mobilisation. The other set of ASHA (5 out of 30) also have recalled learning ANM's significance in terms of providing services after they are referred or escorted by ASHAs

to sub center. There is also a section of ASHA (5 out 30 ASHAs) who could not respond to how they have been oriented in terms of co-ordination with ANM.

As far as the co-ordination with AWW is concerned a majority of ASHAs have mentioned that they have been trained to involve AWW in VHND for mobilising community in health related issues (14 out of 30 ASHAs) . Secondly a section of ASHA also has cited that AWW (12 out of 30 ASHAs) has to be necessarily involved in the meetings of VHSC. A very few of ASHAs (2 out of 30 ASHAs) also cited being oriented in training to report AWW in matters related to nutritional status of children of community. A very few number of ASHAs (2 out of 30) also had not been able to recall how they have been oriented in training as far as working in co-ordination with AWW is concerned.

The perception ASHAs have built in terms of her roles on the basis of training indicates that majority of ASHAs have associated their roles to mobilisation and linking community to sub – center and PHC in reproductive and child health and vertical disease programs for Malaria and Tuberculosis. Indeed even as far as ASHA's co-ordination with ANM is concerned the above discussion reflects that ASHAs mainly perceived role of ANM's role in mobilising community for availing services or providing services to the community members at the sub-center. The ASHAs also have created a perception from the training that they are responsible for reporting to ANM regarding how many people from the community has been reached out by ASHA and linked to sub- center. The perception amongst majority of ASHAs regarding her co-ordination with AWW has restricted to only involving them in VHND and VHSC meetings. The perception that is built amongst ASHAs in terms of co-ordination with VHSC has although been explained in terms of community development, it only refers to water and sanitation issues. Moreover a major section of ASHA also has built a perception that her role is primarily restricted to maintenance of fund in VHSC. Thus it can be seen that the ideas of village health planning has not been stated by any of the ASHAs as a component in which they were oriented during training.

Perception of ASHA Supervisor and ANM about their role:

As reflected from the interviews all ANM have stated that their role as far as ASHA is concerned in to take reports and visit community with them whenever there is a difficulty. ANMs also has stated that imparting on job training is also part of their

responsibility. Majority of them (5 out of 6) had accounted their role in terms of providing clinical support to ASHA .In the context of reporting an ANM states as follows

> "ASHA supports me in collecting reports. This is also necessary so I can sign her papers for incentive. She is given a target on account of how many children are left in the immunization process. I also alert her whenever there is gap in performance in any of the health indicators primarily immunization, institutional delivery and ANC. I check her reports on weekly basis on Saturday when we have meetings with the ASHA. I also telly her report with the data I have in terms of immunization and other services. The main aspects in which we collect data are Diarrhoea cases, registration of pregnant women, report of institutional delivery, VHND meetings, ANC. I also visit community with her on regular basis. A day has been fixed for that purpose." Nirupoma Deka, ANM, Sub-center Dhoparguri, Hajo Constituency

As far as role of ASHA supervisors is concerned they also have stated her role as collecting reports from ASHA. The ASHA supervisors in Hajo Constituency also have been supervising ASHAs in organising VHSC meeting. Some of the ASHA supervisors (3 out of 6) also have stated helping ASHA regarding organisation of VHND. One of the ASHA supervisors gives the following statement in this context

> "ASHA supervisors' role is to collect reports from ASHA. She is not much literate so my task is to collect report from her so that there is good documentation of the work happening at the community level. I have been given formats in which I have to collect reports on immunization, number of home delivery, diahorrea cases, ANC, and how many women have opted for institutional delivery.I also help ASHA in organising VHSC meeting. I have been able to ensure now that these meetings are conducted regularly. I also give suggestions to ASHA for VHND meetings sometimes physically and sometime over telephone" Namita Malakar, ASHA supervisor, Sub-center Koibortotola, Hajo constituency (name changed)

There is a conflict as well in some cases between ANM and ASHA supervisor. Some of the ASHA supervisor (2 out of 6) have stated ANM not being responsive whenever she enquires for any data which she needs to tally with the data given by ASHA. Again there is problem from the side of ANM as some of them (3 out of 6) have stated that ASHA supervisors never do as much hard work as them and ASHAs and keeps on asking for reports. One of the ANMs has given the following statement in this context

> "ASHA supervisors are appointed unnecessarily. The supervisor here never visit community. She only collects reports from ASHA visiting sub-center one day. She sometimes takes reports from ASHA over telephone only. She troubles me as well asking for reports from me so that she could fill her reporting formats " Benu Deka, ANM, Sub-Center Dhoparguri, Hajo Constituency

Information about the work profile given when they joined:

One also needs to look at the work profile that has been given to ASHA in the time of her selection. This would explain in what ways health service system wanted to involve ASHA. A majority of the ASHAs (26 out of 30 ASHAs) were informed by ANM that their main duties are to mobilise women for institutional delivery and secondly to bring them to hospital for availing the service. The other important function that has been conveyed to ASHAs was that of immunization. Majority of the ASHAs(26 out of 30) also have asserted being told that they have to motivate mothers to immunize their children at sub-center. In this context one of the ASHAs gives the following account reflecting that these are the two areas which found prominence in orientation of ASHA

> "The ANM told me in the beginning, when I was informed about the profile of ASHA that mainly my functions will be to encourage I women and their family members for institutional delivery. I was supposed to explain to them how it is important for safety of mother and child both. The ANM also told me that I have to promote immunization and motivate mothers to immunize their children" Reema Das, ASHA , Sub-center Dhoparguri , Hajo constituency (name changed)

Secondly as reflected from the interviews some of the ASHAs (6 out of 30) facilitating pregnant women of the community for ANC has also found importance along with institutional delivery and immunization in her initial orientation.

> " I was told by the ANM of the sub- center that my responsibilities as ASHA will be to motivate women from my community for institutional delivery. I am also told to motivate mothers to bring their children to sub-center for immunization. I also told to ensure that women who are pregnant have been regularly visiting health services for Ante Natal Check Up" Samiara, ASHA, Sub-centre Dalibari (name changed)

The discussion above indicates that ASHAs were primarily oriented as health worker for promoting and facilitating the services of immunization, institutional delivery and care in pregnancy to the community.

Service delivery by ASHA:

The functionality of ASHA has been one of the major questions in recent times. Hence it is important to understand the services delivered and the activities focussed most in the deliverance of her duties. The other associated factors with functionality of ASHA

are her interaction with the layer of health functionaries at the periphery viz, AWW ANM and ASHA supervisor who are supposed to extend supportive supervisory inputs to ASHA and also assist ASHA in deliverance of her functions.

a) Institutional Delivery:

It is one of the primary activities which have gained utmost significance in NRHM. All the ASHAs interviewed have talked about it as their primary function in Hajo block. The number of home deliveries is higher in low lying areas of the Hajo constituency inhabited by Bengali Muslim population. The ASHAs from these villages have been also strictly conveyed from the BPM to ensure that no home delivery takes place in their area. One of the ASHAs from these villages states as follows:

> "Home delivery is a big problem in my village. People are not ready to opt for institutional delivery. They say that there is no point in going to hospital when our dai can conduct delivery. And also the babies born at home are also healthy . We have told BPM ma'am about this problem and also have complained about the dai. But we are the one who always end up being questioned by BPM ma'am about the low rate of institutional delivery. Our ma'am says that we have to be more and more active in mobilising community and also need to involve ANM or ASHA supervisor often for conducting home visits" , Zinab, ASHA, Sub-center Khopanikuchi (name changed)

The enabling of JSY thus comes as one of the major task of ASHA. The ASHAs themselves consider this as an activity of major significance due to incentivised nature of the task. Some of the ASHAs (13 out of 30 ASHAs) pointed out that it is also one of the activities where the beneficiaries can be motivated for the monetary gain received from the health service system. Hence it has become easier for ASHAs to motivate people from the community for institutional delivery and earn incentives herself along with the community member. So much so that in many instances it has become an issue of conflict between the ASHAs and Dai in some villages of Hajo constituency. As one of the ASHAs from Hajo constituency has said

> "The BPM madam asks to bring more institutional delivery cases, but the dai in my area is already contacted by the community members. She is easily available in the area and also they do not have to go the health service system. But this creates problems for me as I lose my incentive and also it affects my performance. I have explained to my community members about the incentive they get but yet the local dai try to take away my cases. I have even complained against her to the Block Program Manager." Roja ,ASHA Sub-center Khopanikuchi (name changed,)

There are also instances of conflict between ASHAs as far as coverage under JSY is concerned. The following account is given by an ASHA in this context

> "The ASHA from nearby village has also been mobilising women for institutional delivery from the village which falls under me. The village she lives in adjacent to mine and she keeps on coming to my village. Recently she has also taken a pregnant woman from my community to hospital for delivery. This is not tolerable as she is taking away my cases and I am losing my incentive. I have also informed Block Program Manager about this incident" Hamida, ASHA, Sub-center Dalibari Jalukbari Constituency (name changed),

Thus the issue of institutional delivery has found an excessive importance. The health service system is pressurizing ASHAs to ensure more and more institutional delivery in her community. The ASHAs are also working for increasing institutional delivery as it involves incentives.

b) Ante natal Care and post natal care:

NRHM has paid a huge amount of importance to safe motherhood and safety of new borne. Ante natal care and post natal care comes as one of the major tasks for ASHA. Majority of the ASHAs are quite aware about importance of Ante natal care and have been concentrating immensely on mobilising pregnant women for ante-natal checkups. However the announcement of Mamoni Scheme has acted as one of the key instrument for ASHAs to motivate community members. The scheme is introduced in Assam under the aegis of National Rural Health Mission. It aims at reducing Maternal Mortality Ratio and encourages women to go for three ante natal check-ups to detect the danger signs of pregnancy at earliest and treatment can be sought. It provides a booklet of safe motherhood and new borne care to pregnant women. It also gives an amount of Rs 1000 in the second and third ante natal check-ups for meeting the expenses of nutritional food and supplements for pregnant women. Some of the ASHAs (14 out of 30 ASHAs) have reported that this incentive based mechanism has been helpful for them to mobilise women from the community for ante-natal check up. One of ASHAs gives the following account in this context

> "Whenever I do home visits in my community I go along with my booklets of Mamoni scheme. It is also influencing the mother-in laws of the community for sending their daughter-in – laws for availing ANC to sub-center . Many of the pregnant women also keep on asking me when would they get money under the scheme" Poonam , ASHA, Sub-center , Ukhura, (name changed)

Although Ante natal care has gained importance as reflected from the interviews with ASHA the post natal care has not been given due attention. Not all the ASHAs have mentioned it as one of her important functions. Interestingly even the supervisory structure that exist for ASHA did not much deliberate upon post natal care and only a few ASHAs (only 10 out of total 30 ASHAs) have reported undertaking follow up visits after delivery has taken place.

c) Immunization:

The aspect of immunization has gained a large amount of significance in the functioning of ASHA. The intervention of ASHA has been proved very useful for fulfilling immunization coverage. Indeed days have been fixed by the health service system for organising vaccination camps for each ASHA and the entire health functionaries at periphery is working towards increasing of immunization coverage. However seemingly in some context it has remained majorly an issue of compulsion for meeting targets of immunization and the aspect of mobilisation of community to realise it as a felt need is missing in some of the villages in Jalukbari constituency. Some of the ASHAs (2 of the ASHAs out of 5 in Jalukbari constituency) have stated the community members are mostly not willing for immunization. But as the health service system is really concerned about fulfilling of coverage the ASHAs visit those households much frequently .As reflected from the interviews with these two ASHAs when the community members are not willing to avail the services even after constant efforts both by ANM and ASHA.

> "Some people of my village are not willing to go for immunization especially for second dozes of injection saying their children fall ill after the immunization process. Though I try to explain them that having fever after immunization is a not a very major issue they are often not convinced. I report ANM at sub-center who also has visited those households. The ANM has after repeated efforts have written down their refusal to access the services , so that BPM ma'am doesnot question our sincerity " Bhairavi kalita , ASHA, Sub-center Dalibari, Jalukbari Constituency (name changed)

d) Family Planning:

Family planning is another activity which has been undertaken by the ASHAs. The family planning program started with the norm of small family and reduction of country's total fertility rate. The ASHAs in NRHM also has been given the task of promoting the small family norm in their community. They are also provided

contraceptives and condoms in the drug kit. The family planning is also an incentive driven activity in which ASHAs and both the beneficiary are paid incentive for availing tubectomy. The majority of ASHAs (19 out of 30 ASHAs) seem to have concentrated on this activity and it also come as major target for her from the health service system. However the family planning activity has not been a priority in most sections of the community as stated by many of the ASHAs.

e) Drug kit maintenance:

The drug kit is another important aspect of ASHAs functioning in the villages. Majority of the ASHAs have reported receiving of drug kit from the health service system. But the major issues that emerge are that of its timely replenishment, the demand of newer medicines from ASHA and lastly quantity and quality of medicine. Although NRHM hints at replenishment of the drug kit at an interval of three months , interviews with all the ASHAs reveals that PHC has distributed drug kits to ASHA in a gap of three years. Some of them (16 out of 30 ASHAs) also have added that there has not been any stock register has been maintained for the usage of drugs. The ASHAs have stated collecting medicine from sub-center. They also refer community members to sub-center whenever they are not able to provide medicines to them. One of the ASHAs gives the following account in this context

> "The drug kit we have is not sufficient for population coverage of 1,000. The PHC also has supplied the kit to me three times in last three years. I have been taking medicines from the sub-center whenever I do not have sufficient medicine. In many cases I also refer my community members to visit sub-center if the medicine they are asking for is not available with me" Kanchan Deka, Sub-center Ukhura (name changed)

The refilling of medicine for the ASHAs has not happened as per demands put forth by them rather whenever PHC receives a medical stock. In such cases the ASHAs have opted for the measure of referring the patient to the sub center. A number of (approximately 26%)ASHAs indeed have resented this issue and even considers inability to provide medicine when asked by the community members an erosion of faith in her.

> " I feel bad whenever I am unable to provide medicine to any of my community members when they come asking for it. I feel it causes an erosion of faith in me as I am supposed to help them in matters related to health and drug kit is a way to do that and if I won't have medicines with me then how anyone would consider me

> an effective ASHA. Moreover some might think as well that I have sold some of the medicines as well. ASHA Seema, Sub-Center Koibortola (name changed)

The second issue associated is that of quality and quantity of medicine. While most of the ASHAs consider the quality of the medicine given to them is good many of them had complaints about quanitity. Most of them are of the view that the quantity of medicine falls far shorter than the demands of 1000 population they have to cover. One of the ASHAs gives the following account

> " I am given only 100 crocin tablets whereas I have to cover 1000 population. It is a highly demanded from my community and almost everyday somebody comes to my house asking for crocin. I think that the amount of crocin should be increased by PHC. This is not only a problem faced by me but many other ASHAs would also give the similar account", Seema ASHA Sub-center, Koibortola, Hajo Constituency (name changed)

Many of the ASHAs also raise demands for certain newer medicine which are for general ailments as the community comes asking for those and every time they have to refer them to the sub center. Many of them (20 out of 30) has stated the need of keeping medicines for diarrhoea for older people. The pregnancy kit is also not part of the drug kit and some of the ASHAs also have raised demand for the same.

f) Child health:

The issue of child health seems to be neglected in Hajo block. The involvement of ASHAs in child health is limited to immunisation only. The health service system also has given an immense importance to fulfilling of immunization coverage. Very few ASHAs (6 out of 30 ASHAs) have associated themselves with issues related to child nutrition and other major disease of childhood. In fact only a few (2 out of 30 ASHAs) ASHAs have stated participating in the school health program in Jalukbari constituency .

g) Communicable diseases:

The aspect of communicable diseases has also remained restricted to detection of malaria cases as reflected from the interview with many of the ASHAs(22 out of 30 ASHAs). The ASHAs in the block receives an incentive for collecting blood slides form their community for detection of malaria. Only a few ASHAs (5 out of 30) have spoken about informing community about symptoms of Tuberculosis and the need of maintaining cleanliness.

h) Coordination with the supervisory structure in delivering services (ANM, AWW, ASHA supervisors)

Co-ordination of ASHA with AWW and ANM and ASHA supervisors has been indicated by NRHM as important aspect. As far as social mobilisation is concerned a majority of ASHAs have reported co-ordinating with the ANM. Almost all the ASHAs have reported that they have taken help from ANMs in case of problems faced in the community for mobilisation for availing of health services. One of the ASHAs gives the following account

> " ANM didi visits our village along with me. I inform her mainly whenever I am not able to convince my community members for availing any service. Recently I have not been able to convince women of my community for family planning, she (ANM) has visited those households with me." Nazira Begum , ASHA Sub-center Koibortola, Hajo Constituency (name changed)

The ASHAs have maintained a regular connection with the sub-cneter and also have kept ANMs updated about the services delivered. All the ASHAs have stated providing report to ANM as crucial task of ASHA. An ASHA states as follows

> "We have to report to ANM for each and every services given by us. She asks for birth and death registration, registration of pregnant women, number of institutional delivery,number of ANC, immunization coverage, details of family planning. Sometime it seems that ANM's work is only to take report from us for the plenty of functions we do" Sagarika, ASHA Sub-center, Japia, Hajo Constituency (name changed)

A meeting is organised on every Saturday at sub-center where ASHA's performance is discussed. Many of the ASHAs have informed that ANM gives training but it has not been a formal process. One of the ASHAs states as follows

> " I ask ANM about any clinical aspect I do not understand about care in pregnancy, immunization. ANM has been immensely contributed to increase my knowledge. We are also oriented on Saturday about any new clinical aspect, for example she had oriented us about the Ante Natal check up for pregnant women. Except Saturday also she keeps on updating and informing us about programs under NRHM. We can approach her any time we do not understand something about a program." Benu Das, ASHA sub-center Dhoparguri , Hajo Constituency (name changed)

As far as co-ordination with ASHA Supervisor is concerned a majority of the ASHAs have stated her role is in terms of providing reports. However many of the ASHAs (12 out of 30 ASHAs) have stated appointment of ASHA supervisor only has created

additional responsibility for her in terms of reporting. One of the ASHAs states the following

> " I am not sure why I have to report about the same things to ASHA supervisor when I am already giving details to ANM. The supervisor is also not helping me in any context. She hardly comes to the sub-center and does not visit my community. She would only ask for data from me over telephone." Minati Rajbongshi , ASHA, Sub-center Dhoparguri, Hajo Constituency , (name changed)

There are other few ASHAs (10 out of 30 ASHAs) who however feel that ASHA Supervisor has helped them in organising regular meetings of VHSC and also ensure expenditure of VHSC fund. One of the ASHAs give the following statement

> "The Supervisor atleast has helped me to organise VHSC meetings. Earlier I never had any clue how to spend the fund given, but atleast for last one year I have been buying equipments as told by ASHA supervisor. This is helping me a lot when the VHSC presidents and other members of the committee hardly pay importance to work of VHSC" Uruphia Khatoon, ASHA, Sub-center Ukhura, Hajo constituency (name changed)

There are other few ASHAs (8 out of 30 ASHAs) who states that they can not do anything about appointment of ASHA supervisor. They also add that if the government has added this layer to health functionaries then they cannot do anything to change it. Hence it is better to concentrate on one's own work and co-ordinate with ASHA supervisor he way government wants it.

The least co-ordination is maintained with AWW who mostly is involved with ASHA on vaccination day and VHND. Many of the ASHAs (19 out of 30 ASHAs) have talked about difficulty in building coordination with AWW as she hardly comes to the sub-center. Some of the ASHAs also have stated that AWW interacts with ASHA only on VHND and meetings of VHSC.

Perception of supervisory structure about quality of work of ASHA:

There is an appreciation from both the health service system and VHSC presidents of the contribution of ASHA in promoting institutional delivery, providing reproductive and child health services, services related to malaria and distribution of drugs kits. The Block Program Manager states as follows

> "ASHAs have been immensely helpful in linking community to health service system specifically women of the community. Some of the active ASHAs also have been able involve male members of the community in VHND.She has been performing well in terms of care in pregnancy and immunization. The incentive driven activities have also been helpful in motivating ASHAs to work." Manju Haloi, Block Program Manager, Hajo BPHC (name changed)

Many of the VHSC presidents also has agreed that the women who were selected ASHA have been contributing to betterment of health of the community specifically for woman of *the community. One of the VHSC presidents states as follows*

> " The selection of ASHA has been good. I have attended vaccination day and many women have brought their children for vaccination. So I think she has been able to bring women and children to sub-center for availing services. The community members I have spoken also are aware of ASHA and the services she delivers" Vinay Das , VHSC president, Sub-center Dhopargur , Hajo constituency , (name changed)

However many of the program managers and PRI representative in VHSC have an opinion that minimum educational criteria for being an ASHA (which is any woman who have studied till eight standards) should be at least completion of matriculation and not less than that. The opinion that prevails is that an educated ASHA would act more diligently and intelligently when it comes to delivering health and health related services. She will be more capable of management of fund with VHSC and facilitate treatment of patients at health services without unnecessary dependence on other health functionaries specifically GNMs and would be more proficient in maintaining her records without much intervention from ANM. One of the VHSC presidents have emphasises the need of ASHA being more educated to perform her duties without being dependent on others unnecessarily. He states as follows

> "An ASHA should be at least educated enough to do her own work. It is also a problem for her when she has to take help of nurses for filling forms for which she also has to give away some money. So ASHAs needs to have good education level" Suleman Hussain, VHSC president, Sub-center Ukhura, Hajo Constituency, (name changed)

This is also corroborated by staff from supervisory level that ASHA at least should complete her high school to handle the ever increasing duties of ASHA and the pressure of enhancing her skills. One of the program managers gives the following account

> "At present an ASHA needs to be more skilled as the numbers of duties they perform have increased the aspects of maternity health services also have widened. It is difficult for an ASHA who have just passed eight standards. If in any case there needs to be a minimum limit it should be matriculation as that much education an ASHA at least needs to acquire the kind of skills imparted in the training".Nava Sharma ,Program Manager, PHC Ramdia (name changed)

Many of the health functionaries give an opinion that the appointment of ASHA supervisor have been helpful for ASHA as now they are able to maintain records efficiently. The ASHA supervisors also have been helpful in community mobilisation. One of the Program Managers has given the following account

> " As facilitators are more educated than ASHA, community mobilisation specially for family planning have been easier for her. She can accompany ASHA and mobilise community better as she has more education level people also listen to her. She is also have been very helpful for her in terms of reporting" Nava Sharma , Program Manager, PHC Ramdia , Hajo constituency (name changed)

Challanges as perceived by ASHA:

Majority of ASHAs (26 out of 30 ASHAS) have discussed about various forms of challenges that she faces while functioning in the community and also working in coordination w6ith the health service system.

a)From Community:

Many of the ASHAs from villages inhabited by Bengal Muslim population has stated the problem of delivering services which are not in consonance with cultural beliefs of the community. One of the ASHAs states as follows

> " I have to face challanges in terms of motivating women from the community to opt for institutional delivery. The people in my village only favour home delivery. They fear that the women will be touched by male doctor if taken to hospital for delivery. This is believed not to be a good thing" (ASHA Samina Begum, Sub-center, Khopanikuchi, Hajo Constituency (name changed)

Similarly for few more ASHAs the deterrence from family planning in Muslim community comes as a challenge in terms of her functioning. One of the ASHAs from a village inhabited by Muslim population gives the following account

> "I have been able to mobilise community for institutional delvery, immunization and also to attend VHND. I conduct home visits atleast thrice in a week. The community members also have built faith in me and seek advice from me in any health related matter. But as far as family planning is concerned they are not much willing to adopt family planning measures. Especially mother in laws consider it against the principles of our community. Even if a woman is willing it is difficult for her to break these notions. It becomes difficult for me to facilitate the services

of family planning. However some of the women do come seeking contraceptives from me." Salima Begum , ASHA, Sub-center Koibortotola, Hajo Constituncy (name changed)

The preference for private hospital for treatment and the much ingrained belief that PHCs do not provide good health service in few villages where population is better off also comes as hurdle for ASHA to work as link worker between the community and health service system. It is prevalent in the villages covered under Dhoparguri sub- center in Hajo constituency and Dalibari sub-center in Jalukbari constituency which is at proximity to Guwahati city where most of the private hospitals are located. One of the ASHAs have given the following statement

"In my village the people don't want to visit government health facilities . They tell me that there are not even adequate facilities in PHC for conducting delivery of baby. They want to have fully facilitated health services and hence prefer private hospitals. Mostly they take their own vehicle to Maligaon(a place in Guwahati) or hire one. I am anyways contacted by them as I am very much accepted in the community" Minati Rajbongshi , ASHA, Sub-center Dhoparguri, Hajo constituency ,(name changed)

Many of the ASHAs (almost 23% of ASHAs) consider her image as a government personnel also has created challenges for her in functioning . A perception exists among the community members that she is paid by the government for the services rendered to them and hence considers that ASHA is mobilising community for using health services only for her own benefit.

Secondly mobilising community for VHND has come as a major challenge for some of the ASHAs specifically in terms of involving the members of VHSC in the meetings. The challenge also comes in terms of low presence in the VHND in case of few ASHAs in Jalukabari constituency. One of the ASHAs gives the following narration in this context

" The VHND organised have a very low presence. It is difficult to convince the community members. They would say that they would come when I go to invite them but later they don't arrive. There is a problem with the people of this village; they all think I will get money if they come for my VHND." Munmi Begum ASHA, Sub-center Dalibari ,Jalukbari Constituency (name changed)

b)From the health services

<u>Problems at CHC and other referral centres</u>:

The functioning of ASHA comes as a challenge also because of the problematic functioning of the health service system. A majority of the ASHAs have reported

facing some challenges with the health service system that has come as a hurdle for ensuring quality health care to the community members. One of the challenges that comes for ASHA is the referral services in Hajo block. The places of referral from Hajo PHC are Guwahati Medical college, Panbazar Medical College. The major problems in Hajo block PHC is referral as claimed by ASHA even in cases of normal delivery. This comes as challenge for ASHA to explain it to the family members who are already annoyed with the running around and delay happening in availing of services. As narrated by one of the ASHAs

> "It is very difficult to explain to family members why I have brought her to Hajo PHC when the services are not available here. It also comes as a problem for me to explain why the case was referred to GMC from Hajo when a normal delivery takes place. They believe that Hajo as a PHC should be able to tackle at least the cases of normal delivery" Anju Barman , ASHA, Sub-center Dalibari , Jalukbari Constituency (name changed)

So much so is the annoyance with this referral process that in some of the villages in Jalukbari constituency which is at proximity to the other referral center prefers to go directly to Guwahati Medical College or Panbazar Medical College rather than availing services from the block PHC.

> " There have been many instances when the Hajo PHC has referred cases to GMC. The family members of the pregnant women often gets annoyed with the commuting they have to do from our village to Hajo PHC and then again to GMC in case of referral. This takes atleast three to four hours whereas if one goes directly to GMC or Panbazar Medical College directly then it takes one and half an hour. Hence many people from my community prefers to go directly to GMC or Panbazar Medical College rather than going through referral process of Hajo PHC" Anju Barman, Sub-center Dalibari , Jalukbari Constituency (name changed)

The other issue associated with the health service system is unassisted deliveries which have happened while taking referred cases on 108 ambulances to Guwahati Medical College by few of the ASHAs. Such negligence at the end of health service system also comes as challenge for the functioning of ASHA.

The other issue that remains pertinent for some of the villages is the distance from the PHC. It comes as a major problem for the people living in villages lying in the riverbank that have reported not having a well equipped PHC at proximity and resented the necessity to run to Hajo block PHC for availing health services. A story narrated by an ASHA can probably give a better insight into the issue

"It is very difficult for me to bring pregnant women for delivery to Hajo hospital specifically when the whole area is submerged with water. Once a child was born in boat itself as we could not finally reach hospital. In another case I convinced a family to go for institutional delivery and also have arranged for a boat. I tried to contact an 108 ambulance for taking us to the hospital after we reach the main road but could not get through one. Therefore once we crossed the flooded area I tried to look for an auto on the main road. I went a little far to look for an auto leaving the family in the boat itself. Though I got an auto when I came back I found out that the family has returned to the village. I somehow reached back to my village and found the dai is already conducting the delivery." Sameera , ASHA, Sub-center Khopanikuchi, Hajo Constituency (name changed)

The other problems as cited by some of the ASHAs is the ill treatment they receive from the nurses specifically at Guwahati Medical College. As one of the ASHAs has given the following account

"The nurses at GMC does not respond to us properly. Sometimes they also misbehave with us and shouts if I ask something related to condition of the patient. Once when I asked a nurse about condition of a woman I had taken to GMC she refused to reply and misbehaved with me shouting ask doctor not me "Indira Das, ASHA , Sub-center Koibortola , Hajo constituency (name changed)

Secondly the ASHAs also have stated that the nurses at Hajo Block PHC also demands for a share in the incentives the ASHAs are supposed to receive under JSY scheme. One of the ASHAs has stated as follows

"The nurses at Hajo Hospital (Block PHC) takes money from me whenever I am escorting a pregnant women. They say that as we will get some incentive it is better that I give them a little money. She says that she should have sahre as she is also helping by facilitating the birthing process and issuing documents which will help her to gain incentive" Ranu Baegum, ASHA, Sub-centre Ukhurasub center Hajo constituency (name changed)

Problems with payment of incentives towards ASHA and beneficiary:

The irregular and late payment of incentive comes as the most uttered grievance from ASHAs. Many of the ASHAs (27 out of 30 ASHAs) state that incentive of the beneficiaries as far as JSY is concerned the payment under JSY has been quite a regular affair.

However the major concern lies with the irregular and delayed payments of the incentive based schemes such as Mamoni which has gained quite popularity in the community. The ASHAs consider delayed payment of this form of incentive under this scheme has been affecting her relation with the community. As an ASHA states as follows

> " I have been mobilising women of the community for availing ante-natal care by telling them about the Mamoni scheme. But now as they have not received the money under the scheme even after completion of all ante-natal check ups it has created problems for me to visit those households. The program manager has told us that not all the beneficiaries would get the money. Now it would a very big problem as I have told everyone about the schems and many have availed the services also. If I am not able to ensure that they get the incentive then they would also really not believe me for anything in future" Indira das , Sub-center Koibortola Hajo constituency (name changed)

The other issue is definitely that of irregular payment of incentive to ASHA. All the ASHAs have resented the irregular payments of incentives under JSY , immunization and family planning. As stated by majority of the ASHAs (17 out of 30 ASHAs) incentives paid for collecting blood slides are regular.

d)From the supervisory structure:

Seemingly the ASHAs share a cordial relation with the ANM. Indeed they also have expressed ANMs not creating much problem for facilitating the payment of incentive. The major difference of opinion comes between ASHA and ASHA supervisor. A 40% (12 out of 30 ASHAs) of the ASHAs have stated that she now has to give report both to ASHA supervisor and ANM about her work and thus it has only created an additional responsibility for her. The other issue is that of the supposed coordination with AWW who are both in the opinion of ANM and ASHA is not coming forward to support ASHA for social mobilisation.

Thus it can be drawn from the data that many of the ASHAs do not see ASHA supervisors as a support system. Secondly AWW also has not been extending support to ASHAs as reflected from the interviews with ASHAs(As derived from some of the interviews the ANM and ASHA supervisor have tussle in terms of sharing of information related to health related issues in the community. Secondly a problem with AWW and ANM also exist on account of the claim made that AWW is detaching herself from sub center and is more engaged with ICDS.

The ASHAs also face challenges at the front of their family because of the other roles she has play as earner of money and taking care of household duties. Some of the ASHAs (11 out 30 ASHAs) have stated that it is difficult to manage both household duties and her work as ASHA.

Conflict with domestic responsibilities:

The interaction with the ASHAs also reveals their concern over the dual nature of her obligation both towards her home and community. Some of them asserted the fact that being a woman it has become a difficult job for them to step out of the house whenever there is a call from the community or the health service system.

An ASHA from Jalukbari constituency who is a widow and have three children has expressed her difficulties in following ways,

> "ASHA has so much to do for the community specifically for pregnant woman. I have to be there anytime they call me in case of labour pain, even if it is late at night. Few days back, I was called by a family in the village and I had to run leaving my daughter studying in ninth standard all alone as my sons were also not in the house. Though I usually tell my neighbours to look after my house, whenever I have to rush to hospital at midnight, I still can't stop being tensed for my children, specifically my daughter." Salima ,Sub-center Dalibari, Hajo Constituency (name changed)

A strong perception also exists amongst many of the ASHAs that the health service system will hold her responsible if incidents such as child death and outbreak of disease. An ASHA in whose villages a new borne baby died states the follows

> "Deaths in home delivery have occurred in my village. Today only a baby died while birthing. I was not able to attend this pregnant woman as I had to escort another woman from my village yesterday morning for delivery and stayed at the hospital.I have visited house of this woman whose baby died several times . But despite my effort the baby died. The sad part is that BPM ma'am would question me why the family had opted for home delivery when I had already visited their house."Indira Das, Koibortola , Sub-center hajo constituency (name changed)

As being an ASHA she has been carrying out many responsibilities, she also complains of not being able to give much time to her family. An ASHA gives the following account

> "I have to be fully alert about my community, as I am given the responsibility to take care of people's health. I know I will be the person who will be held responsible most, if a disease breaks out in the community or in cases of home delivery by ANM and our BPM ma'am. So I have to be on guard every time and it keeps me very busy. Many times I stay whole day and all night in the hospital if I have to accompany someone to the hospital for delivery. Now I feel working as ASHA a lots of additional responsibility has come for me and I don't get much time for my family" Jamila , ASHA, Sub-centre Japia Hajo Constituency (name changed)

ASHA as a sole breadearner:

Though NRHM wants to give out certain amount of incentive for ASHAs as a sign of appreciation of her dedication, it is more often regarded as a source of income by the ASHAs. Majority of them do not have any alternative option of livelihood. For many of them it has also been difficult to pursue any other source of earning as the health services already demand huge number of services and time from her. Some of them who were engaged in other activities have also been displaced from any earlier sources they were engaged. A major number of ASHAs in the Hajo legislative constituency have been engaged in some activities before being an ASHA. Two of the ASHAs from the area give the following account,

> "I have been a teacher in a local Lower Primary school; I was also secretary of Sarbasikshya Mothers' group and member of managing committee in my school. However as I started working as an ASHA I had very little time to devote to anything else. I had to leave my earlier job as being an ASHA, one is loaded with immense number of duties." Nazira Begum, Sub- center Koibortotola , hajo constituency (name changed)

Another ASHA from Hajo constituency who was pursuing weaving as a profession also had not been able to continue with her earlier work. She gives the following account,

" I was a member of weaver's association in my village. I also was involved very significantly with the group. It was a small business initiative. When joined as an ASHA I was told that there is not much work so I thought it to be an opportunity to have an added work. However as slowly it turned out to be I was not able to give much time to my earlier work nor could attend meetings of the group. Though now I visit the group I am no longer actively involved." Minu Das, ASHA, Sub- center Japia , Hajo constituency (Name changed)

Thus majority of ASHAs views her work of ASHA as a source of income and also urges for a regular earning rather than incentives. This relates to the demand of a salaried system for the ASHA program.

Community Mobilisation:

Community mobilisation has been one of the most important duties of ASHA. The process of community mobilisation for health promotion and availing of health services by the community members happens primarily through home visits conducted

by ASHAs and the organisation of village health and nutrition day. The ASHAs experience with the community also has influenced their functioning in terms of community mobilisation..

a)Organisation of VHND :

The Village Health and Nutrition Day had been organised by each ASHA in her village and days for it already had been fixed from PHC above. The VHND guidelines issued by NRHM instruct that VHND has to be organised in AWC once in a month and especially in those villages which have been left out. The VHND as suggested in these guidelines needs to be seen as "platform for interface between the community and the health system". The VHND is considered an event which would see coordinated effort amongst AWW, ANM, and VHSC in terms of organising and mobilising of community and also can have presence of other health personnel. The VHND can act for the community as ground for interaction with health service system and gain information on issues related to health and its determinants. As further discussed in the guidelines the major portion of the services to be delivered on VHND encircles around Reproductive and child health. The other suggested issues are discussion and rendering of services related to TB, Malaria and other communicable diseases and on some social determinants of health viz water and sanitation.

The organisation of VHND had been quite a regular affair in the villages happening once in a month. As reported by most of the ASHAs in Jalukabari and Hajo constituency the VHND is organised mainly as told by ANM. An ASHA gives the following statement as far as organising VHND is concerned

> " Health day (VHND) is organised on the day that has been already decided by the Block PHC. I organise my on 3rd Wednesday of the moth. We have been organising VHND regularly and the ANM tells me what I have to do on that day. I also organise for tea or grams for the women who come for the VHND. The AWW and ANM and I discuss about the various health needs for pregnant women. I also discuss issues related to adolescent health" Aqsa, ASHA, Sub-center Khopanikuchi, Hajo constituency (name changed)

As far as involvement of other health functionaries are concerned the participation of AWW and sometimes ASHA supervisor is also cited by the ASHAs. However only in case of a very few ASHAs the involvement of PRI members have been possible in VHND. In this context an ASHA states as follows

"Mainly AWW, ANM and ASHA supervisors are only present. I also invite VHSC president but he hardly comes for VHND. He says he is very busy. I also do not expect that he would come. He is not even present often in VHSC meetings which is compulsory for him, so it is useless to expect him to attend VHND" Jamila , ASHA, Sub-centre Japia , hajo constituency(name changed).

The ASHA is mainly handles the responsibility of mobilisation of the community. However the planning related to organisation of the VHND varied from one week before to two days before the event as told by different ASHAs. The planning of the VHSC also has happened as in many occasions as instructions given from the block PHC. The issues discussed in the VHND mostly encircle around immunization, and RCH services. As far as involvement of the community is concerned the mostly mobilised population has been women in reproductive age and in very few cases adolescent girls.

b) Home visits:

As NRHM suggests home visits is one of the most important functions of ASHA. A majority of ASHAs visit houses in the community at least four times in a week. A very few ASHAs have stated they regularly go for home visits. Most of these home visits conducted mainly focuses on pregnancy counselling, counselling of mother, mother in-law and husband for institutional delivery, identification of eligible couples for registration, mobilisation of mother and other family members for immunization of children and also for collection of blood slides. The discussion on maintenance of hygiene and healthy habits also arises in the home visits as indicated by the ASHAs.

c)ASHAs previous experiences with the community:

The prior experiences of ASHA is significant to understand her level of interaction with the community and also to analyse if the prior experiences have helped her to reach out to the community more. Significantly a large number of ASHAs in Hajo legislative constituency have been involved with the community in various ways. A majority of the ASHAs were engaged with the community as health workers on various events such as polio day, filarial duties and a few of them even were working as dais and CHVs before. A few more ASHAs within the same constituency were members of self help groups and cooperative societies. A very small number of

ASHAs also have acted as panchayat member in the past and very few as worker of political party. A link can be established between ASHA's experiences with the community and her functioning. The ASHAs who have been involved have been able to establish better link with the community because of their earlier experiences. As one of the ASHAs who were also a dai gives the following account,

> "I have been involved with my community as dai from long before know it pretty well how a pregnant woman needs to be taken care of. I act like mother to all the new borne babies and explain how they should be taken care of to their mother. I was approached by the villagers before as well and now as ASHA my prior experiences have helped me to understand medical issues better, especially issues related to pregnancy and child care." , Maneswari , ASHA, Sub-centre Koibortotola, Hajo constituency (name changed)

The ASHAs who were members of self help group also have considered it as helping ground for them to discuss issues specifically related to maternal and child health, nutrition and hygiene and build better connection with women of the community. On e of the ASHAs from Hajo constituency who had worked community health worker also states that her experience has helped her in building acceptability in the community as ASHA. Her statement is as follows

> " I did not have to work hard to be accepted by the community as ASHA. People in my village already recognise me since the time I worked as CHW. Being a CHW I also had knowledge about family planning program. As I already had experience of interacting with community members it was easier to mobilise community as ASHA." Kavita, ASHA, Sub-center, Dhparguri, Hajo Constituency (name changed)

Thus the past experiences of ASHA has also influenced their stake in the community and also better mobilization skills.

Interaction with VHSC:

The VHSC in the block has been formulated in the year of 2009.The VHSCs have been trained in terms of guidelines and also the utilisation of united fund. This section would try to analyse the role of ASHA in VHSC and whether it has been able to extend support to functioning of ASHA, formulate health planning and also take health related action for the community

Organising meetings with VHSC:

The ASHA has the main role of organising meetings with VHSC. She has to inform all the members of the VHSC why the meeting is being held. The main purpose of the meeting as stated by majority of the ASHAs (25 out of 30 ASHAs) is to discuss the expenditure of the fund. Though a majority of the ASHAs have been organising meetings regularly for last one year the participation of the members of the VHSC is questionable. It is stated by majority of ASHAs that it has been a very difficult for her to ensure engagement of PRI members in the meeting. It has been a problem stated by all the five ASHAs in Jalukbari constituency and also some other ASHAs (10 out of 25) in Hajo constituency. An ASHA gives the following account in this context

> "First of all it seems to be a very huge responsibility to organise VHSC meeting also when I already have ample of tasks to complete. I generally convene a meeting once in a month as instructed by ASHA supervisors. I inform all the members of the committee. The other members of my committee come to meeting regularly but it is very difficult to ensure the presence of VHSC president. He would say that he would come but often is not present in the meetings. Later whenever asked by ASHA supervisor he would say that he has some work from the panchayat or some work of his own." Karabi Das, ASHA, Sub-center Dalibari, Jalukbari constituency (name changed)

Utilisation of fund:

a) Process of decision making for utilisation of fund:

The VHSC is entrusted with an amount of 10,000 which is an untied fund that is supposed to be utilised for development of the community. The ASHA and PRI member work as joint signatories. The absence of the VHSC president creates a major hurdle for utilisation of untied fund as the president also acts as another signatory authority along with ASHA. The major hurdles ASHA faces in terms of her functioning with VHSC is the hindrance created from the PRI member in withdrawing money by refusing to sign. The ASHA is also not able to tackle the situation as she does not hold as powerful position as the PRI members. She has reported it to the health services system but they also have not been able to streamline PRI participation. The Block Program Manager gives the following account in this context

> "It has been difficult for ASHA to co-ordinate with PRI members. The members take very less interest in working with ASHAs. They hardly attends meetings and also asks for money for signing to withdraw money. The ASHA supervisor is also supporting ASHA now to organise meeting and therefore meetings are at-

> least held now. As far as participation of PRI is concerned we are trying to build a serious connection with PRI members. Training is imparted to PRI members and ASHA about account utilisation. But still I would say the PRI members are not showing any interest. They often do not want to come for these training sessions." Manju Haloi, Block Program Manager. Hajo BPHC (name changed)

This is also rooted into the fact that these PRI representatives are powerful entities and sharing of equal decision making power is a challenge for ASHA. This power equation although is present in the entire block it is stronger in Jalukbari constituency which is legislative constituency of one of the state minsters and the bodies of gram panchayat who belong to the same political party holds significant decision making power in the community. An ASHA from the area gives the following account in relation to her power at par with the PRI representative

> "The VHSC president is a very powerful person and it is very difficult for me to have any tussle of opinion with him. I have lots of problem in convincing him to sign documents as he asks for money every time I go to him for signing papers. I wish I had ANM as co-signatory authority with me rather than the PRI representative." Karabi Das ASHA, Dalibari Sub-center, Jalukbari Constituency (name changed)

Thus with this unequal power position the issue of demands raised from the VHSC president for share in the fund also comes as a challenge for ASHAs. The ASHA supervisor also has not been able to intervene in Jalukabari constituency and does not participate in meetings of VHSC. She only stated giving instructions related to expenditure of VHSC fund to ASHAs. She gives the following statement

> " I do not participate in meetings with VHSC. The ASHA also has never approached me in any matters related to VHSC. I pass on any information given to me by BPM about expenditure of VHSC fund to ASHA but I neither interact wth AWW or VHSC presidents in matters related planning of activities of VHSC" Mitali Baishya , ASHA supervisor Dalibari Sub-center ,Hajo Constituency (name changed)

The political power shared by the PRI in the villages inhabited by Bengali Muslim population however is not as strong as compared to other parts of the block. The ASHAs in these villages also do not have problems in terms of involving them in VHSC meetings. The problems of The VHSCs formed have reported having many grievances in terms of equitable accessibility to health service system. They resented that they are being isolated from the rest of the community and also is discriminated in terms of provision of health services. One of the VHSC presidents has given the following account

> "The major concern is not the strength of VHSC for undertaking community action but also the condition we are living in. Our community is isolated from the rest of others and also a very less efforts for development have taken place for us. Even as PRI we are not very strong and we have not been able to ensure much development action for the community" Salim Ali, VSHC president, Sub-center , Khopanikuchi Hajo constituency(name changed)

As drawn from the interviews of the VHSC presidents it turns out that a few of them also consider the utilisation of fund have been only been as per wish of ASHA rather than being spend for the development of community. Thus though the VHSCs have been organised and have been utilising the untied fund to some extent it is hard to say that community ownership for the body have emerged and it has been able to deliver as platform for community action.

d) Activities initiated by ASHA in coordination with VHSC:

The activities that majority of the VHSC (all the VHSCs have used the fund in that manner) have been engaged with is purchasing of clinical equipments as instructed from the PHC which often ends up lying in ASHAs houses. It is noteworthy that the need of buying of equipments has never come out from the discussion held in VHSC in terms of need of the community but because of the instruction given from the PHC. The total sanitation campaign comes as another kind of activity for which an amount of Rs. 300 is distributed for each BPL family by some (36%) of the VHSCs. However there is a very few number of VHSCs in which the ASHA herself has taken an initiative and the other members of the VHSC has extended support. This group of ASHA has better influential position in the community and also shares a better power equation with other members of the VHSC as some of them had been member of gram panchayat and also involved in other political processes. To cite an example an ASHA from this group of ASHAs have organised anti-alcohol campaigns in the community and also have been able to raise the issues of taking action on the vendors of local alcohol. One of the ASHAs states as follows

> "There was a problem in my community of a local vendor of alcohol. It was major problem as many other community members also were having problem him selling alcohol. It was creating chaos and there were many young boys getting alcoholic. I have talked to the VHSC president Vibha maam and few other community members. We had a meeting and then decided to make the vendor stop selling alcohol. We had called him in that meeting as well and told him that if he does not stop selling alcohol he would have to leave the village. He had stopped selling alcohol now but I have heard that he is again selling alcohol again secretly" Rabita Das, ASHA, Sub-center Dhoparguri, Hajo constituency (name changed)

c)Village Health planning :

The village health planning has been a missing component in the functioning of ASHA. All the ASHAs stated not creating any village health plan along with other members of VHSC. The BPM of the block also have confirmed not adopting any such practice by any of the VHSCs in the block.

d)ASHAs interaction with health functionaries in functioning of VHSC :

The other health functionaries such as AWW and ASHA supervisors are also taking part in the functioning of VHSC . The major level of interaction in terms of functioning of VHSC comes from ASHA supervisors in Hajo constituency. She participates in the VHSC meeting and provides instructions to ASHAs in relation to expenditure of VHSC. However it is noteworthy that the ANMs shares a minimum level of interaction with the VHSC in terms of decision making though they are present in every meeting organised by the ASHA for discussion of utilisation of fund. A very few of the ASHAs reported sharing data related to health with any other members of VHSC. The AWW though also is a member of VHSC has also showed very less involvement in the activities of VHSC. As drawn from the discussion with the program manager it is evident that the PHC themselves have found interaction with PRI a difficult affair. Some of the PRI members also have showed discomfort with the intervention from Hajo block PHC in terms of utilisation of fund. They have considered it as too much intrusion from the health service system. Thus another hurdle that comes into ensuring credibility of VHSC is the lack of coordination between the health service system and panchayati raj institution.

Conclusion:

The functioning of ASHA as can be derived from the above analysis of data primarily circles around her work as community mobiliser for availing services available with the health service system. She is seen as the person who would help NRHM to spread information on its programs of immunization, Reproductive and Child Health, JSY and Disease control programs. She has been delivering her roles to bring community members to avail services to sub-center and PHC. It is also important to note that the

entire focus has been on performance based incentive. The ASHAs are concentrating on those activities which have incentives. The health service system is also emphasised on a target oriented approach and is focussing on increasing number of beneficiaries for immunization, ANC, institutional delivery and family planning. The role of ASHA in VHSC also has been restricted to expenditure of fund as per suggested by Hajo Block PHC and no village health planning is present. Thus the envisaged roles of ASHA as an activist , agent of communitzation and volunteer has not been translated in to the functioning of ASHA. Rather ASHA work has been limited to that of health worker or helper for ANM at the level of community

Chapter 6

Discussion and Conclusion

The NRHM has envisaged for community ownership in the program and volunteerism from amongst community members to participate in the planning process. The framework for NRHM entails that as AWW has been engrossed in ICDS and has not been able to act as change agent on health ASHA would fill her role. However the major difference between an ASHA and AWW comes in terms of her identity of being from the community and voluntarily coming forward to take action for the betterment of her community. The ASHAs are also considered a vehicle for community involvement who would act in close coordination with support system (PRI, AWW and ANM). She is supposed to play immense role in village health plan along with PRI members and other stakeholders of the community. However the incentivised nature of the program, stringent monitoring for fulfilling coverage of vertical programs, the emphasis on skill building of ASHA in the training modules specifically for functioning as community mobiliser for JSY, immunization, family planning has restricted her role only to a health worker at periphery. This chapter discusses the role of ASHA which has been restricted to community level health worker, through the emergent trends from the analysis of data. This is also linked to conceptual understanding of volunteerism, activism and communitization to support the argument that the training process , programs associated with ASHAs and the supervisory inputs at field level has limited her scope to act as a volunteer, health activist and agent of communitization

The emergent trends in the findings:

In this section the finding of this study is linked to literature review to explore the role of ASHA as a volunteer. The emergent trends of the data are as follows

Reason women are working as ASHA:

As a set of literature have reviewed the concept of volunteerism in terms of the reason one opts to involve in voluntary activities the data from this study is seen vis-a

vis finding of these studies. The main reasons women have chosen and working as ASHA are as follows

a) ASHA as a livelihood option:

Majority of the ASHAs (12 out of 30 ASHAs) as reflected from the finding chose to be an ASHA for financial reasons. As discussed in the previous section most of the ASHAs belong to poor financial background and the incentives paid to ASHA becomes very important for running her household. This is also corroborated by other studies (Sharma, 2009) that ASHAs have been concentrating more on incentive based activities as similar to the finding of our study. The expectation of monetary gain also comes from her family members too. Hence it definitely leads to a question if the financial compulsion to run a household has played an upper hand for the ASHAs as a motivating factor to join the program rather than voluntary zeal to serve the community. This status of ASHA also has led to major significance put in the incentive driven activities by ASHA.

b)The urge to serve the community:

There are few women (11 out of 30) who have joined and are working as ASHA mainly because of their urge to contribute to the society and not for any financial gain. The finding from our study corroborates the finding of other studies (Petrzelka and Mannon, 2006) in which volunteerism is considered by women as a way of contributing to development of society. It can also be linked to finding of other studies which explains volunteerism as activity freely given to another person , group or organisation (Petrzelka and Mannon, 2006)

c)The career perspective of ASHA:

Some of the ASHAs (5 out of 30) also have stated that they have joined as ASHAs in expectation of a career in health sector. The finding of our study corroborates the finding of other study which explains that volunteering has been also adopted as a way to gain career related experiences .Some of the literature review also reflects that volunteers adopt it as an option so that an experience is built in the field they want to explore further (Clary and Snyder,1999).

The target based image of ASHA:

The second aspect discussed is targeted approach adopted in the implementation of the program. As the concept of volunteerism indicates that cause of social problems are rooted in individual behaviour and individuals themselves and thus issues of society would be better solved with private initiative than state programs (Patres 1997) .The ASHAs are given targets from the health services system in which she has to function in a restricted setting refutes the idea of building community ownership in the program through volunteers from the community. Although the ASHAs have been immensely working towards fulfilling the targets of the health service system but it has restricted her role only to a helping hand of ANM at peripherry. Moreover it also lays the ground for question if it is creating high amount of pressure on ASHA and depleting her motivation.

The context of volunteerism in NRHM merely comes as response to address the issue of lack of man power at periphery and the idea of unpaid labour from low income group who will pool scarce and non-existent resources to solve issues which had been neglected due to larger corporate interest (Patres, 1997). However the credibility of such measure is questionable as the resources held by the volunteers in this context is very scanty and also there is very less support system both from the health service system and PRI for enabling ASHA to hold power over resources. The very less resources at the hands of volunteers has been noted as a limitation for the volunteers in other studies as well (Indeed the stake of ASHA in decision making process has been also restricted keeping in view the stringent monitoring from the health service system as far as utilisation of fund of VHSC is concerned. The example of limited drugs and also difficulties faced by ASHAs in replenishment of drug kits can be cited as examples here and as also corroborated by other studies (Sharma, 2009).

Communitization:

The NRHM has talked about a decentralized model in which it talks about participation of the community in health planning. The communitization process has been one of the most desired goal of NRHM. The concept of communitization indicates a partnership between the government and the community. It is seen as third

way of governance in which it calls for strengthening and empowering of social capitals of communities (Pandey 2010).It also talks about sharing of power with the community and ensuring participation of poorer community for sustainable development (Lokho,2009). It also comes as process of building community ownership (Pandey 2010). The NRHM has talked about communitization and has indicated towards immense role to be played by ASHA in this process of communitization (MOHFW, 2006). As far as communitizaton is concerned our finding shows that ASHA has not been able to work in co-ordination with PRI members effectively. As reflected from our study the VHSC s are although utilising fund, the PRI members are often not part of the monthly meetings held for discussion of issues of the community. The challenges of ASHA as far as communitization is concerned the finding related to ASHA's interaction with PRI is given below.

The streamlining of the Program with PRI:

The efforts of NRHM in the process of communitization needs to be seen in the context of inter sectoral coordination with PRI which has been considered the best epitome of community participation. The process of decentralisation has been tried to be incorporated at district level, block level and community level through formation of bodies which would ensure collaboration between health service system and the PRI. This is expected to lead towards community involvement in the program. The data reflects functioning of VHSC, one of the important committees formed to fulfil this purpose. However the question arises whether this has resulted in community participation and to what extent the body has been able to prove its credibility. One of the important finding of our study and as corroborated by other studies (Sharma, 2009) is less attention paid from the panchayati raj institutions to the health developmental activities under VHSC and more towards other activities. Firstly the participation of the most important partner in this committee the gram panchayat member is itself missing. As the data reflects VHSCs meetings are also held regularly as stated by ASHAs participation of the PRI members in meeting is also very less as well as the involvement in developmental planning. The health service system also has been unable to help ASHA to establish co-relation with PRI

members. The Block Program Manager herself says that even they are finding it difficult to ensure presence of VHSC presidents in the training organised at Block PHC for utilisation of fund. The other finding from our study reflects that majority of the ASHAs are holding meetings of VHSC only to discuss the budget of the body and spends it in accordance with the instructions that is give from PHC. The VHSC president is also approached to sign papers for withdrawing money for the same. Thus the task of ASHA in VHSC only has remained as a responsible person for processing of fund as also reflected in other studies (Ashtekar, 2008)

Again as reflected from the data there is also a concern in terms of unequal power shared by the ASHAs with the PRI members and hence it has been difficult for an ASHA to respond to demands for monetary share in the un-tied fund from the PRI members. Specifically as told by ASHAs in Jalukbari constituency it is very difficult for her to convince PRI members in VHSC meetings, or refuse their demands for monetary share from the fund as they are very strong politically and do not pay heed to ASHA's opinion. The ASHA supervisors have continued with a stringent monitoring process for holding of meeting regularly , expenditure of fund. Hence the proposed idea of making community responsible for day to day management in the conceptualisation of communitization(Pandey 2010) has been missing amidst the stringent monitoring from the ASHA supervisors and constant instructions of Block PHC about expenditure of untied fund.

Activism:

The concept of ASHA as an activist founds upon the argument that she would act as the person who would ensure participation for local health planning (MOHFW, 2000) and will also initiate cause oriented protest demonstration . The finding of this study shows that there are only a few ASHAs who have been able to organise community for cause oriented protest demonstration. The example of the ASHA from Dhoparguri Sub-center Hajo who initiated an anti-alcohol campaign to oust local vendor can be cited here. However the role of ASHA for ensuring participation of local community for health planning has not been realized as none of the ASHAs has initiated a village health plan along with other members of VHSC.

Again the activist role of ASHA also demands from her ensuring right to health care but as the following finding shows that ASHAs have not been able ensure quality health care when the health service system is not functioning adequately. The study reflects the following findings as far as irresponsiveness of health service system is concerned.

a)The challenges from health services for ASHA:

The study corroborates the finding of other studies (Ashtekar, 2008) in terms of ASHAs helplessness in delivering services when the health service system is not functioning adequately and undergoing the problems such as of lack of human resources in its own health services.

As the data reflects most of the ASHAs have faced challenges in terms of ensuring quality health care to the community members which also erodes the faith of the community in health service system. Many of the ASHAs have stated the problems with referel system in Hajo Block PHC. The ASHAs from villages inhabited by Bengali Muslim population also has cited the problem they face due to distant health facilities discussed in previous chapter. There are also issues raised in terms of misbehaviour of nurses at GMC one of the referral center and also the issue of GNM asking for share in incentive in Hajo Block PHC. The ASHAs are also not able to take action against such issues as she is also part of the health service system for reporting events for receiving her incentive as argued in literature (Shukla, 2009)

b) The context of power held by ASHA:

The activism becomes a source only for those who have access to information, resources and hence is also more often restricted to elite groups only (Norris, 2009) . The issue of ASHA working as an activist needs to be seen in the light of her socio-economic background and also if she holds enough power over resources to bring adequate changes in the health status. In this context our study corroborates the finding of study (Ashtekar, 2008) that though ASHA is given the role of activist the NRHM has done quite less to equip her to perform such a complex social role with minimal control over resources. The finding of the study regarding drug kit is

applicable here which is often said to be insufficient for the entire population and also contain medicines for selective health problems as also is corroborated in other studies (Ashtekar,2008) . The replenishment of the drugs also has been a major issue in the program. Thus it is difficult to expect ASHA to be an activist when she does not hold enough resources. ASHAs who mostly comes from the low socio-economic background is not capable to hold power over resources in the community. The data corroborates the fact by giving only a few number of ASHAs who were capable of organising action at community level through VHSC on account of capability to mobilise resources.

Thirdly one also needs to understand which sections hold power over the resources and if the marginalised section of the society has any control over decision making process. Factors like political situation and ethnic difference have major role to play in terms of differential hold over resources. The political situation in the Hajo block as discussed in the previous chapter has been diverse. The PRI members in Jalukbari constituency enjoys immense power owing to the fact constituency belongs to a minister of the ruling party and hence also has advantages of having hold over resources first.

Secondly the ethnic differences also create an issue. The Bengali Muslim population has been a discriminated section on account of their origin. In most cases they are considered as a refugee group, not belonging to larger Assamese identity and hence lack rightful power over resources. This differential power status can be linked to idea of activism as only restricted to those who can access information. Hence activism depends highly on indicators such as hold over resources, educational status, class, caste, ethnicity leading to active participation of those who are informed about the processes (Norris, 2009) .

There has been a divergence between what NRHM set out to do and have achieved so far. The problem to many extent lies in the programmatic structure of NRHM which when implemented has only targeted the selective primary health care approach and also the design of the ASHA program also has been extremely performance based and strictly monitored by ANM as also discussed in Dasgupta and Qadeer (2005) .

Indeed the inclusion of ASHA supervisors have made it more stringent in terms of reproductive health, immunisation, diarrhoea , family planning, majority of this being incentivised in a nutshell most of the monitoring being on incentive based program. Most importantly though NRHM had created ASHA and loaded her with responsibilities it could not bring much architectural correction to the health service system. Moreover the emphasis also diverged from building community ownership of the program to a target oriented health delivery system As indicated in Hota (2006) and also found by our study the primary focus the primary focus of NRHM has been to ensure functioning of ASHA for RCH related services , immunization, prevention of water borne diseases and nutrition. Secondly as also reflected in our study and discussed in other literature the ASHA's work has also been much restricted to working as an escort for institutional delivery under JSY (Sharma, 2009) in The functioning of VHSC also have become a problem as the linkages with PRI could never been achieved and also it did not analyse the fact if ASHA would be able to deal with rigid power structure of the community, herself being from a poor and a marginalised section.

Reflection of the ideas in the training modules:

The NRHM has planned out modules for the purpose of training for ASHA. These training modules form the most important part in orienting ASHA about her role in the community. It is needed to be reviewed how these training modules are designed to train ASHAs for communitization process, for activism and for imparting the ideas of volunteerism. However as can be derived from the training modules the training is largely based on building skills of ASHA as a health worker. The first module primarily imparts information to ASHA in terms of vertical health care programs and RCH. It emphasises on imparting information to ASHAs about health promotional activities. The other modules have also extended this concept of orienting ASHA in terms of RCH, building necessary negotiation skills for motivating community for institutional delivery. ASHAs role in Malaria detection and prevention and also as DOTs provider has been emphasised in the third module of training. It is only in the fifth module of the training that the ideas of leadership and right to health care have

been discussed. The module entails about the need of realising self worth by ASHAs and also explains her role as an activist in terms of organising collective action when the issue emerges to be affecting a large number of populations. It also entails the need for ASHA to understand the concept of equity and ensure same while function. ASHA's roles in terms of accessibility to quality health care and ensure that ANM and AWW are functional. It also gives a section on fundamental rights and the need of building leadership amongst ASHAs. However the problem remains that though the instructions for ASHA in terms of realizing herself worth and ensuring of accessibility to health care has been elaborated the program design has not given ASHA the adequate training for the same. The other training modules have put the concept of communitization at one side and have only focused on knowledge enhancement of ASHA. The findings of our study in relation to the training process of ASHA it is evident from the interviews with the trainers of Don Bosco and State Program Officer that the training of ASHAs concentrates on building her skills as community mobiliser (discussed in chapter 5). They also have added that it is difficult for an ASHA to imbibe the roles of an activist as given in the 5th module. The State Program Co-ordinator at Don Bosco also have added that the ASHAs do not hold the capacity of ensuring right to health care as an activist for other members of the community when she herself is not able to ensure receiving their rightful incentives timely. All the training modules have been completed in Assam. However as reflected from the understanding of ASHA of the training process (discussed in chapter 5) it can be derived that ASHA has imbibed the role of skilled health worker.

The evaluation framework for ASHA also seem to have sidelined the ideas of communitization, activism, volunteerism and primarily have measured the outcome of the program in terms of her role in JSY, health promotion activities. The first common review mission though have to some extent discusses the issue of missing link between PRI and ASHA program the programmatic components of ASHA such as drug supply, immunization, JSY and the support structure for ASHA. Thus the evaluation has restricted to ASHA's role in meeting targets for various program components of ASHA and also on how a support structure will be built for the same.

Conclusion:

The concluding arguments can be that Accredited Social Health Activist which has been envisaged by NRHM along the line of activism, communitization and volunteerism ended apparently as health worker at periphery. The concept of volunteerism might have found place as some of the women have started to work as ASHAs with an urge to work towards development of community. However the role of ASHA as an activist and agent of communitization has been very difficult task to achieve. The main loophole itself has remained in the designing of the program. NRHM though has envisaged these roles for ASHA right in the beginning the training process, the programs of NRHM, ASHAs are associated has curved her role as community health worker. The primary orientation ASHA has achieved is from the training process which emphasised on building ASHA's skills as a community mobilser and link worker. The modules also restricted her role mostly to delivering of vertical disease program, health promotion, and community mobilisation for availing the services of reproductive health immunization and family planning. The functioning of ASHA in the community also has mainly restricted to these areas. The constant supervision from NRHM to have better health outcomes in the aforesaid areas has not let ASHA come out of her role as health worker. Her role in VHSC as reflected from this study only has been restricted to fund utilisation and management of fund. Thus it can be summarised that NRHM has been mentoring ASHA towards playing the role of a health worker rather than building her capacity for acting as volunteer health activist and agent of communitzation.

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ANNEXURES

Respondent 1. ASHA

Name

Age:

Sex

Religion: Hindu/ Muslim/ Christian

Category: SC/ ST/ OBC/ Other

Educational qualification:

Family income of ASHA:

Duration of working as ASHA:

Volunteerism:

- Who have selected you as ASHA?
- How did you come to be an ASHA?
- Can you explain your roles as ASHA? Did anyone orient you about your role as ASHA?
- What did motivate you to be an ASHA?
- Who approached you to be an ASHA?
- Were you involved in any other voluntary activities before becoming ASHA?

Service Delivery:

- What are the ranges of functions you carry out in the community as a health worker and mobiliser of the community?

- Do the community approach you time to time , if yes in what kind of matters?
- How do you maintain drug kit provided by NRHM? Do you face any problem regarding the same?
- Are you satisfied with the resources that you are provided from the health functionaries?
- What is your view about incentive based mechanism?

Supervision:

- How are you supervised by ASHA supervisors and ANM?
- How do you perceive your interaction with the ASHA supervisors? How is she is different from ANM in terms of supporting you?
- How do you interact with ANM in terms of supervision, service delivery and incentive?
- How do you view ASHA supervisor's role in facilitating your functioning?
- What are the kind of reporting you do with Supervisors and ANM?

Communitization:

- How do you want to place yourself in the community in terms of ensuring accessibility to health services, health promotion?
- How do you perceive your role in VHSC and what support you get from them?
- How do you plan your activities in the community?

- Do you think you have been able to ensure community involvement in your planning?

Activism:

- What do you think the acronym ASHA stand for and how do you understand the word activism in it?
- How do you view health promotion and what are the activities you perform for health promotion?
- How often do you meet VHSC members and how do you participate in activities of VHSC?
- How do you plan your activities for VHND?
- How do you interact with the health staff in terms of your functioning and monitoring of your work?

Training:

- Have you been trained if yes, till what module?
- What is the significance of training in your view?
- What are the components of the trainings?

Respondent 2 : ANM

Name

Name of the village:

Age:

Sex:

Religion: Hindu/ Muslim/ Christian

Category: SC/ ST/ OBC/ other

Educational qualification:

- How do you perceive role of ASHA as community level health worker?
- What do you understand by acronym ASHA and the concept of activism in it?
- How do you perceive your relationship with ASHA in terms of her functioning?
- How do you view capabilities and skills of ASHA?
- Do you think having ASHA is important for NRHM and she has been able to help in mobilising community?

Supervision:

- What are the level of interaction with ASHA
    - In terms of supervision?
    - In terms of her assisting you in delivering various health services?
    - In terms of her planning and organising VHND?
- How will you define the role of ASHA facilitators in terms of functioning of ASHA?

- Do you also interact with ASHA supervisors in relation to functioning of ASHA and delivering of health services in the community?
- What are the components of on-job training imparted by you time to time to ASHA?
- How do you plan and guide ASHA in terms of VHND and mobilising community for accessing health services?

Incentives:

- Do you think you face challenges in terms of managing payment of incentives to ASHA both from ASHA's end and health structure above you?
- Do you think ASHA's are functioning well under this incentive based scheme?
- Do you think that ASHAs have been able to build up skills and qualities in this process of supervision and training?

Respondent 3: ASHA supervisors

Name:

Name of the village :

Age:

Sex:

Religion: Hindu/ Muslim/ Christian

Category: SC/ ST/ OBC/others

Supervision of ASHA:

- How do you perceive ASHA's role in the community?
- How will you explain your significance in terms of supervising ASHA?
- What are the functions you perform in terms of supervision of ASHA?
- What are the kinds of reports ASHAs provide to you in terms of her functioning?
- How do you interact with the health staff above in terms of reporting about ASHA's functioning?
- Do you think your supervision has been beneficial at the end of ASHA and health structure above? If yes how and why?
- Do you face any challenges in functioning as ASHA supervisor?
- Do you also conduct any meeting with ANM and VHSC in terms of functioning of ASHA? If yes what are the components of those meetings?
- How have you been appointed as ASHA supervisors?
- What are the problems you face in terms supervision of ASHA as you have been introduced in the health service system only recently ?

Training:

- What are the components of the training that is imparted to you?
- How do you execute the training that has been imparted?

Respondent 4: Program Managers (PHC)

Name:

Age:

Sex:

Religion: Hindu/ Muslim/ Christian

Caste: SC/ ST/ OBC / Others

Educational Qualification:

- What is the selection process of ASHA and has it been same since inception of NRHM?
- How do you perceive ASHA's role in the community?
- How would you explain ASHAs role as an activist?
- Do you think ASHA's have been able to connect more people from the community to the health service system?
- What is the process of mechanism that has been followed to ensure that ASHA's are functioning well?
- How will you perceive well functioned ASHA in terms of
  - Service delivery
  - Health promotion
  - Community mobilisation
  - Health planning
- Do you think having ASHA supervisors have been beneficial for the program and better functioning of ASHA if yes why?
- Do you measure ASHAs performance with some pre-defined indicators if yes what are they?
- How will you explain ANMs and ASHAs interaction in terms of service delivery, community mobilisation?
- What are the positives and challenges of having ASHA in the community?
- What is the position ASHA holds in VHSC and what are the level of activities she participates in VHSCs?

Respondent 5: Key informant (SARC, State Program Officer)

Name:

Place of residence:

Age:

Sex:

Religion: Hindu/ Muslim/ Christian

Category: SC/ ST/ OBC/others

Functioning of ASHA:

- What do you think ASHAs should be doing as an activist as the acronym itself suggest?
- The DONBOSCO organisation is a pioneer body in providing assistance in this ASHA program. How do you create or help ASHA to analyse her roles
- What do you think are the challenges of ASHA while meeting these roles? .
- How far is it important for an ASHA to have knowledge about various social schemes and probably also knowledge and skills to make the rightful things available to the community for example , in terms of any issues in context of accessibility to health services or any other schemes, or say pds? Does the ASHA training mark these as important and have imparted those in the training?
- There are components such as leadership and health as a right , fundamental rights in the module for ASHA training which are entailed as core values for ASHA as an activist?
- How far is it important for an ASHA to have knowledge about the local governance and other structure of power and have a participation in the

decision making process? Do you think the existing ASHA's have those kind of stake ?

- Do you think ASHAs have been able to ensure better accessibility of community to the health service system? if yes what are the major ways that the program has been able to achieve this and if not why?
- How will you perceive future of ASHA?

Training of ASHA:

- What do you think are the strengths and weakness of the program?
- Why training is this training conducted for ASHA?
- What are the basic skills that have been imparted through the training conducted with ASHA?
- You have mentioned motivation of ASHA as an important component of the sessions. What does this term motivation imply?
- Does this motivation concept also talk about volunteerism as being motivation based theory? That one needs to have motivation as an utmost important thing to work as ASHA.
- Do you think this aspect of motivating them to work for the community have been imbibed by them as ASHAs are women who also would have family responsibilities? Do you see any tussle in ASHAs these two roles and do you think ASHAs have been able to overcome them?
- Do you consider incentive as a motivation for ASHA if yes do you think it overshadows the concepts of volunteerism and activism?
- How is ASHA facilitators important for functioning of ASHA?
  - In delivering services?
  - Acting as community mobilizer?

- Working as an activist?

- What are the components of her training?
- What motivated his introduction in to the program? What did the MOU suggest?
- What are the methods of the training adopted?
- What are the supports do you get from the health service system while imparting the training?
- What do you think these aspects of training; supervision and monitoring have been able to do with skills of ASHA? Has she been able to act as person who have been able to solve problems of the community, help them access health services as right or involve community in taking actions for their problems?

Respondent 6:

Secretary of VHSC:

VHSC President:

Name:

Name of the village :

Age:

Sex:

Occupation:

Religion: Hindu/ Muslim/ Christian

Category: SC/ ST/ OBC/other

Selection process of ASHA:

- What is the selection process of ASHA and what roles VHSC play in the process?
- Have there been any changes in the selection process of ASHA since NRHM started?
- Do you think VHSC plays an important role in selection process of ASHA if yes how do you think it does?
- Does any other member from the community except VHSC participates in selection of ASHA , if yes who are they?
- What are the grounds does the VHSC believe important for the selection of ASHA?

Participation of ASHA and VHSC in NRHM:

- What are the functions the VHSCs perform in the community?
- How are ASHAs involved in the activities of VHSC?
- How do you support ASHA in preparing health planning for the community?
- Is there any interaction of VHSC with ASHA, ANM and ASHA supervisors in terms of her functioning in the community? If yes what is the process?
- How frequently do you conduct meeting with ASHA and what are the components discussed in these interaction?

Respondent7: District Community Mobiliser

Name:

Name of the village:

Age:

Sex:

Occupation:

Religion: Hindu/ Muslim/ Christian

Category: SC/ ST/ OBC/other

- How do you perceive ASHA as an activist?
- How many times do you conduct meeting with ASHA and ASHA supervisor and what do you discuss in those meetings?
- Do you also conduct any meetings with VHSC and community and what are the topics you discuss in those meetings?
- What kind of support do you get from the health service system and DonBosco in terms of your functioning?
- How do you help ASHA when she faces problems in terms of non accpetence of certain services in the community , or facing problems such as not acceptance of some issues in the VHSC, ill-treatment to ASHA from the health staff, death or any other kind of loss of beneficiaries due to negligence of health staff?
- What are the common complaints of ASHA in terms of her functioning?
- What are the support you extend to ASHA in terms of planning and organising VHND?

- Is there any difference between the way you interact with ASHA and ASHA supervisor?
- What are the kind of support do you extend to ASHA supervisor?
- Do you also monitor both of their functioning, if yes how?
- Whether ASHAs have been facing any difficulties inputting issues in the VHSC if yes what are those?
- What are the kind of support do you receive from health service system in handling issues related to ASHA?
- What are the skills ASHAs have been able to imbibe after training in terms of being health worker?
- Whether ASHAs have been able to deliver those functions in the community? What are the challenges she faces in that context?