To What Extent Are ASHAs Able to Perform Their Assigned Roles?

A Study of Muzaffarpur District in Bihar

7 CHAPTER

Alok Lodh,* M Haque,* Pranita Singh,*
Dinesh Singh Dipu,* Sushil Kumar*
and Gitanjali Priti Bhatia**

INTRODUCTION

The Government of India (GoI) launched National Rural Health Mission (NRHM) to improve the availability of and access to quality healthcare services, especially for the poor, women and children residing in rural areas. One of the specific goals of the mission is the reduction in Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR). And, to achieve this, one of the core strategies adopted is to promote access to improved healthcare services at household level through the female health activist, commonly referred to as ASHA in most of the states of India.[1] Within NRHM it was felt that due to the very nature of the job responsibilities of the ANMs and AWWs, they cannot take up the responsibility of being a change agent in the village. Thus, a new band of community-based functionaries, the ASHAs, was proposed to fill this void. The ASHA is supposed to be the first point of contact for any health-related demands of deprived sections of the population, especially women and children. She is supposed to counsel women on matters considered important

* Movement Against AIDS
** Centre for Health and Social Justice

Some of the roles & responsibilities of the ASHA within Ante Natal Care service provisioning as mandated by NRHM are-

- Early registration of pregnant women.
- Ensuring certification of BPL/APL.
- Conducting four Ante Natal Check ups/home visits for ANC and counselling.
- Detection of high-risk pregnancies with appropriate management.
- Mobilization of pregnant women to access institutional health services.
- Counsel women on birth preparedness, contraception, infection control & RTI.
- Depot holder for essential products and services like I&FA, contraceptives, ORS, DDK and OTC drugs.
- Escort pregnant women to pre-identified institutions.
- Organizing health days.
- Bringing the women to the community-based centres on predesignated days.
- Updating registers.

from the viewpoint of maternal health. Along with her other responsibilities, she is also supposed to mobilize the community and help them in accessing health-related services. It is envisaged that ASHA, ANM and AWW will work in close coordination with each other.

The Janani Suraksha Yojana (JSY) is a safe motherhood intervention under NRHM, which is being implemented with the objective of reducing maternal and neonatal mortality by promoting institutional delivery among the poor in rural areas. The scheme provides for cash assistance along with antenatal, delivery and post-delivery care. The Yojana has identified ASHA, as an effective link between the government and the poor pregnant women in l0 low performing states,

i.e., EAG (Empowered Action Group; EAG states are states with very poor health indicators) and few other states.[2] ASHA is supposed to identify pregnant woman, provide or assist in ANC, INC and PNC services, motivate and help in institutional delivery. Work of the ASHA associated with Yojana is assessed based on the number of pregnant women she has been able to motivate to deliver in a health institution and the number of women she has escorted to the health institutions.[3] It is thus evident that in providing maternal healthcare services to women in a village, ASHA is supposed to play an important role along with ANM and the AWW.

THE CONTEXT

Bihar is one of the EAG States in India as evident from its poor indicators on health and health infrastructure. The health infrastructure in Bihar is inadequate with a shortfall of 6,050 sub-centres, 841 Primary Health Centres and 552 Community Health Centres.[4] The Maternal Mortality Ratio in Bihar is 312, which is higher than the national ratio 254.[5] Only 5.8 percent women received all recommended types of antenatal care (the rate is second lowest in India) and only 34.1 percent women had at least one ANC visit, which is lowest among all states in India.[6]

Muzaffarpur district is situated on the Indo-Gangetic plain of North Bihar, and therefore is prone to recurrent flood, natural disasters and disease outbreaks. The population of the district is usually agricultural labour and has generally low socio-economic status. The female literacy of the state is as low as 35.8 percent. The district has significant proportion (15.9%) of SC population with negligible (0.09%) ST population.[7] Chamar and Dusadh are the two main Scheduled Castes residing in the district. These groups usually live on the fringes of habitations and are largely left out from mainstream development. They are bereft of social security schemes, which are often the last, and only

Table 1: Health Services Indicator

Indicators	Muzaffarpur	Bihar	India
% of women receiving at least 3 visit for ANC	20.8	19.6	50
% of women receiving full ANC	5.3	5.4	16.4
% of institutional delivery	19.4	23.0	40.5
% of delivery attended by skilled personnel	24.2	29.5	47.6

Source: http://www.mohfw.nic.in/NRHM/PIP_08_09/Bihar/RCH_Text.pdf

recourse of many families living below poverty line. Health programmes like NRHM are yet to bring in positive change in their health situation.

In Muzaffarpur, institutional deliveries are limited to 19.4 percent. Government outreach of healthcare services is poor: only 57.6 percent children received the BCG and only 8.4 percent women ever used government health facilities[8] and only 2.5 percent women are ever contacted by ANM.[9] One of the reasons for low outreach health services may be due to the prevalence of untouchability among different castes in the state. Anecdotal evidence have shown that frontline service providers, selected from the upper middle castes, do not provide regular services to the women from the lower castes and these women are therefore denied of the existing healthcare/preventive/promotive services if any. When families from the lower castes access the formal health systems, they are often subjected to harassment, delays and non-cooperation, which further aggravate their already compromised situations. With nowhere else to go, these poor communities try to avail commercially available services from the unregulated private sector, which is beyond their economic means and therefore end up with compromises against their meager land holding, family assets etc.

Given this context, it was decided by Movement against AIDS (MAA),[10] a grassroots-level voluntary organization, to

conduct a short-term rapid appraisal to assess the provisioning of antenatal care by ASHAs in Muzzaffarpur district.

The Objective

To assess the difference in the level of ANC service provisioning by ASHAs to women from different social groups and the level of their coordination among ANMs and AWWs in the delivery of these services in Muzzaffarpur district.

METHODOLOGY

The study was conducted in Muraul block of Muzzafarpur district. This block was chosen for study as it has significant proportion (20%) of SC population and also in this block the selection of ASHAs is said to be complete with one round of training.[11] The study was carried out from October 2008 to November 2008. The study used both qualitative and quantitative methods.

Sample Selection

From the Muraul block 12 ANMs, 16 AWWs and 15 ASHAs were selected for the study. For studying the response of the beneficiaries, two villages with high SC population were selected from the block. Twenty women, 10 from general category and 10 from SC category, who had delivered in the last 6 months preceding November 2008, were randomly selected from each village for the FGD.

Data Collection

The research team conducted in-depth interviews with the ANM, AWW and ASHAs. The interview schedule was prepared keeping the ANC service provisioning of the ASHA under NRHM in focus.

FGDs were conducted with potential beneficiaries. A total of four FGDs were conducted, two in each village. From each selected village one FGD was held with women from general and one with the SC population, each group containing 10 women.

A survey with 234 women who had delivered within the last 1 year in the block was also interviewed using a questionnaire about their perceptions on ASHAs.

Limitations

The rapid assessment was designed to have an overview of the process, which were taking place at grassroots level and was not designed to be a study in exactitude. The study did not take into account other external factors such as flooding, socio-political upheavals and the issue of radical naxalism, which may have affected health service provisioning.

FINDINGS

Profile of Study Participants

The study shows that majority of the frontline health providers were from higher castes, especially with regard to ANMs. With regard to economic status also majority of the providers, especially ANMs and ASHAs, were from APL category. It is surprising to find that all of the ASHAs selected were at least matriculates. Table 2 gives details of socio-economic profile of the participants of the study.

Awareness about ASHA

From among the women surveyed only 55 (23.5%) of the total 234 women surveyed stated that they know about the

Table 2: Profile of the Participants

Characteristic		ANM	AWW	ASHA	Women
Social status	General	7	6	7	28 (12%)
	OBC	5	4	4	61 (26%)
	SC	0	3	3	101 (43%)
	ST	0	1	2	10 (4%)
	Muslim & Christians	0	0	0	34 (15%)
Economic status	Above Poverty Line	10	8	14	56 (24%)
	Below Poverty Line	2	7	2	178 (76%)
Education	Non-literate	0	0	0	141 (60%)
	Less than matriculation	0	6	0	63 (27%)
	Matriculation	2	0	7	16 (7%)
	Intermediate	8	9	5	14 (6%)
	Beyond Intermediate	2	0	4	0 (0%)
Work experience	0-1 years	0	1	6	-
	1-2 years	2	4	1	-
	More than two years	10	9	9	-
Total		12	16	15	234

ASHA as an "ASHA." The rest 76 percent women were not really aware about the ASHA as a concept or her physical presence in the community even though some have actually received some of the services by the deputed ASHA of her village without knowing her actual designated identity. Among the women not aware, only 5 percent belonged to the General Castes as compared to a shocking 47 percent belonging to the OBC category, 44 percent belonging to the SC and 4 percent to the ST community.

The study found that the ANMs and AWWs were aware about the existence of the ASHA in their respective work areas. A few AWWs even stated the exact number of ASHAs selected and working in their respective areas, particularly where the village size is large and multiple ASHAs have been selected within the same revenue village.

But the FGDs with women revealed that majority (75%) of the women were not aware about the presence of ASHA as health worker.

Registration of Pregnancy under JSY

Out of the total of 234 women surveyed, only about 28 percent (65 women) had registered themselves under the JSY scheme. Table 3 reveals how the reach of JSY is eluding the marginalized sections of the society.

A majority of the ANMs expressed that the ASHA has been registering pregnancies through them. Most ANMs gave a figure between 30–70 registrations in the last 6 months per ASHA. This figure could not be corroborated from the ASHA or the AWW.

Five of the 16 AWWs said that the ASHA had registered between two to twelve pregnant mothers. The rest of the AWWs were not very sure about the number or the process that the ASHAs undertake to register pregnancies under JSY.

As compared to the above, most of the ASHAs said that they had registered anywhere between three to twenty five pregnancies each along with the ANM. Only one ASHA said that she is yet to register any pregnancy under JSY as she is not aware about it. ASHAs said that they have recorded about 25 percent of the total registered pregnancies within the first trimester, 69 percent in the second trimester, while the rest 6 percent pregnancies were registered in the seventh month.

This contradiction among different frontline level health providers and with the reality (as revealed by women) with regard to registration under JSY shows the quality of implementation of NRHM.

Table 3: Registration of Pregnancies by Social Status of Women

Social status	Registration of pregnancies		Total
	Registered	Non-registered	
General	24 (86%)	4 (14%)	28
OBC	5 (8%)	56 (92%)	61
SC	22 (22%)	79 (78%)	101
ST	3 (30%)	7 (70%)	10
Muslims & Christians	11 (32%)	23 (68%)	34
Total	65 (28%)	169 (72%)	234

Counselling Services by ASHA

Out of the total women surveyed, only 26 percent women stated that they had been counselled by the ASHA for availing institutional delivery and related services. Twenty-two percent stated that they have been intimated about the EDD, 30 percent reported that they had been advised about the financial benefits available, while 26 percent stated that they have been intimated about the travel-related benefits available to a registered pregnant woman under JSY. If we analyse the rest 73 percent (172 women) who have stated that the ASHA had not provided any such service it is seen that less than 1 percent of the General Castes had been left out as compared to an overwhelming 4 percent of the STs, 48 percent of the SCs and 47 percent of OBCs.

Most of the ANMs reported that the ASHAs counsel the "would be" mothers, particularly with reference to their diet and cleanliness. Three ANMs stated that the ASHAs in their area do not provide any type of counselling services.

As far as AWWs are concerned, half of them said that the counselling by ASHAs are mostly limited, with two specifically stating that it was only related to TT immunizations. Other AWWs said they are not sure if the ASHAs in their area counsel pregnant woman for institutional delivery or for any other services. They said that they only counsel pregnant woman and not the ASHAs.

With regard to the ASHAs themselves, only one of the fifteen ASHAs interviewed stated that she counselled on institutional delivery.

Home Visits by ASHA for Providing ANC

The study found that ASHAs had made home visit to only 22 percent (51 women) in the study area. Table 4 gives more detailed information about the outreach of ASHAs to different social groups of the community.

Table 4: Home Visits by ASHA by Social Status of Women

Social status	Home visit		Total
	Yes	No	
General	22 (79%)	6 (21%)	28
OBC	8 (13%)	53 (87%)	61
SC	22 (22%)	79 (78%)	101
ST	3 (30%)	7 (70%)	10
Muslims & Christians	7 (21%)	27 (79%)	34
Total	62 (26%)	172 (74%)	234

Half the ANMs interviewed stated that the ASHAs visit the houses of pregnant women, and few of them say that it is specifically for completing the TT immunization schedule and not for home visits *per se*. The rest of the ANMs disclosed that the ASHA does not do home visits.

Only a few AWWs reported that the ASHA conducts home visits for providing ANC care. Three AWWs said that the ASHAs in their area do not conduct home visits. Few AWWs were of the opinion that sometimes the ASHA goes to the homes of pregnant women but those visits are part of her social life and not specifically for providing ANC care.

Contrary to what was reported by the ANMs and AWWs, all the ASHAs said that they do home visits with three specifically stating that they do so because they have to ensure the immunization (TT), though none of them said that they complete all the three ANC visits per pregnant woman. Some said that they go to those homes that are nearby. Few of them said that they encourage consumption of Iron tablets during these home visits. Few ASHAs said that they undertake home visits because after delivery they get their money.

Most of the ASHAs usually perceive their primary ANC responsibility as that relating to ensuring timely immunization (TT), informing about the expected date of delivery, telling women about the need to go to the PHC, providing and ensuring consumption of iron tablets, counselling the

women on cleanliness of their surrounding, eating nutritious food and helping them to make contact with the ANM.

With regard to the type of women who should receive their services, most of the health providers said that it is the poor women who really need free health services irrespective of their class and caste. But in the reality it was a different picture.

In the FGDs women revealed that for their health-related needs during pregnancy they are served by either the informal service providers like the village *dai* or their own families and neighbours for delivery related needs or the village compounder and the untrained medical practitioners for injection or medicine related requirements. They said that only occasionally they get help from the ANM, who charges for her services. A few reported that the ASHA sometimes comes, but usually to the upper class houses where there is more money available. They said that she does not visit the marginalized ("*garib*")[12] households. A few said that taking help from the village dai is more suitable for them because if they are unable to pay her by cash for her services, she can be paid by kind like giving grains.

Referral for Institutional Delivery

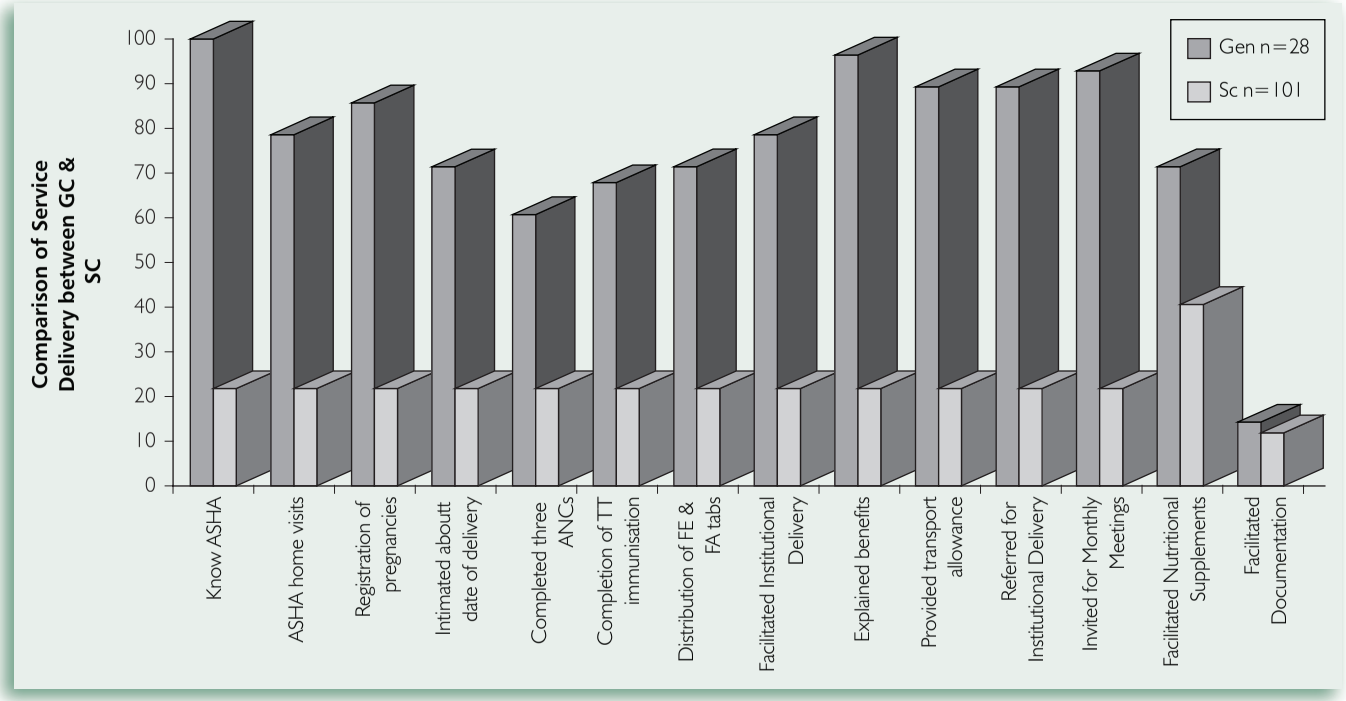
Out of the twelve ANMs interviewed, most reported that the ASHAs do not refer any expectant mother either to institutions for check up or for institutional delivery. Some cited poor knowledge of the ASHAs in understanding the various complications of pregnancy as the cause of not referring women to institutions. ANMs said that it is they who are instrumental in sending the patients for institutional delivery.

Most of the AWWs stated that the ASHA definitely does not refer any delivery case to the institutions, though a few of them reported that may be some ASHAs have referred some women for institutional delivery, as they get money for such referrals, but were not sure of how many such referrals have happened in their area.

The ASHAs, on the other hand, stated that they have referred delivery cases to institutions, but the numbers average between one to three cases per ASHA during the entire study period. They said that though they want to take women for institutional delivery, most of the times for various reason the delivery takes place at home only. One ASHA stated that though she sends cases for review by the doctor, the doctor does not properly check the woman and this discourage them to go again. Another ASHA said that she takes delivery cases to the ANM, and if the ANM refers her to the PHC then only the expectant mother goes to the hospital/ PHC for availing institutional services. Also the fact that even in a government health facility they have to incur high expenses for institutional delivery, compels poor and marginalized families to seek healthcare from unqualified and informal private practitioners (like *Bengali* doctor). Harassment by PHC staff, inadequate infrastructure, lack of transportation were said to be the other causes that discourage women to go for institutional delivery at government facilities, as reported by another ASHA. She said that then she had to coax and take them by spending her own money. Such instances of spending their own money were reported by few other ASHAs also. This has stopped other ASHAs from taking women for check-ups or institutional delivery with their own money. One ASHA recounted how she had to spend her own money while escorting a pregnant woman for availing health check-up services and that she could not recover her dues as the woman delivered at home later and she was refused the benefits on grounds of home delivery.

During the FGDs, women said that ASHA rarely takes women for delivery to the PHC. One woman said that ASHA is the one who apparently registers their name and facilitates release of money from the hospital, but she also said that the ASHA does not come to her area as it belongs to a lower caste section (See Figure 1).

Figure 1: Comparison of Service Delivery between General Castes and Scheduled Castes



Perception about ASHAs Roles and Responsibilities

Most of the ANMs perceive the ASHA as one who has the primary duty to identify the women in the village, register her through the ANM, help her in the immunization, look after her nutrition and take her to the hospital whenever required especially for availing institutional delivery. Few ANMS were also of the opinion that ASHAs should be involved in child healthcare activities also. Most of them expect her to assist her in all the immunization events taking place in the village. They said, since she is from the village most of them feel that she is best suited to roam about in the village and keep on bringing the new cases which they usually miss out on.

Most of the AWWs described the primary function of the ASHA as identifying pregnant women in the village and providing ANC care. They feel all the other workers such as the ANM or the immunization volunteers (Polio) only serve partially and do not provide comprehensive services. They feel that ASHAs are able to reach out to people better than them as they are based in the centre. Some of the AWWs desired that the ASHA assist her in bringing the women and children to the centre, since they are busy working at the centre and cannot go for calling the beneficiaries from their homes. AWWs said that they feel that the ASHAs are not properly fulfilling their duties related to ANC care and they take interest only in institutional delivery as they get money for that. Most of the AWWs cannot distinguish the separate functional areas of their respective services in the village.

When ASHAs were asked about their views on their own roles, some said that they feel their main responsibility is to facilitate institutional delivery by spending their own money. One of them said that she helps the woman through the local Self-Help Group by giving their money to the needy. Few of the ASHAs informed that family planning is a part of their responsibility and that one of them assists the women in accessing IUD-related services. One of them reported that

she helped in the regional polio immunization programme. Overall, the findings revealed that most of them were not clear about their roles and responsibilities, though they expressed a sense of pride in their job. They expressed their unhappiness too that in spite of doing a good job they do not get a regular income and thus gets disheartened.

FGDs revealed that most of the women could not differentiate the functions of the different frontline workers with only a few of them saying that the ASHA is supposed to help the pregnant women in the village while the ANM provides immunization, twice during a pregnancy.

Collaboration between ASHA and the Frontline Workers

Most of the ANMs expressed their happiness over the support they receive from the ASHA during the immunization events in the village. They feel that with the support of the ASHA none of the beneficiaries are left out of the schedule. They said that now that the ASHA is working they have a fair idea about how many pregnant women are there in their jurisdictional areas. Interviews with ANMs also revealed the fact that class and caste differences between ANM and ASHAs sometimes create animosity between them, though no one was explicit about it.

The study found that ASHAs and the AWWs coordinate between each other with regard to village level surveys, organizing immunization camps and Muskaan days or the Mothers days and filling up the schedule for immunization. Some of them stated that they take the help of the ASHA in distribution of the ration and weighing of the babies. Few AWWs reported that it so happens sometimes that when they go to meet a woman at her home after closing the anganwadi centre, many times the woman is not available at that time. In that case they expect the ASHAs to go and meet the woman at the time when she is at home which coincides with the opening hours of the anganwadi centre.

Both the AWW and ANMs reported that ASHAs are better placed to ensure geographical coverage of the services that they provide.

Most of the ASHAs are clear about their positioning in the chain of services; that they are supposed to visit the houses in the village, whereas the ANM and the AWW are supposed to provide services from certain fixed points. They also noted that they are not equipped to provide services directly to the women unlike the ANM and the AWW who either gives injections or makes available nutrition respectively directly to the beneficiaries. Their role is to facilitate access to such services. The study found few ASHAs, who were unable to distinguish their role from the ANMs and AWWs.

Most of the ASHAs reported that they are happy with the level of cooperation offered by the ANM and the AWW. They also said that they coordinate with them in various activities like distribution of IFA tablets and supplementary nutrition, immunization, etc. Some ASHAs stated that some ANM asks money for medicines they take for providing services to women in their villages, which hinders their relationship. A few of the ASHAs reported that since they do not get regular incomes they do not maintain regular contacts with the ANM or the AWW.

Most of the women during the FGDs could not identify instances where the ASHA received any support from other health functionaries in providing the ANC services though a few could conversely identify the AWW who is helped by the ASHA in the meetings at the centre. Some of the others could identify her as helping the ANM in giving the polio drops.

VHSC and ASHA

None of the AWWs or the ASHAs could tell anything about the existence of the VHSC or whether it had been formed at the villages.

Training of ASHAs

While few ASHAs were satisfied with the training, others were not. Those who were unsatisfied said that the training was not properly done and that they could not understand anything. One ASHA said that they expected the training to address early childhood care so that she can extend such services to the babies in her community. Some opined that joint trainings with the AWW and the ANM would have ensured that they also know what is to be done and would have helped in future work collaboration. The ANMs and AWWs were also of the same opinion. Few ASHAs said that there should be a periodic training.

With regard to the mode of training one ASHA commented that there should be more demonstrations rather than theoretical trainings. Few ASHAs said that they are yet to get the total training. Like the ASHAs, ANMs and AWWs were also of the opinion that they should be involved in the training process.

Challenges Faced by the ASHA

The study found that the ASHAs face a wide array of challenges and constraints in their work. They are listed as follows:

- Demand of money by the service providers: AWWs reported that when the ASHA takes women for delivery to the PHC, the ANM demands money from her. One ASHA recollected an incident where one of the PHC staff threatened to not register the mother's name unless the ASHA paid up.
- Inadequate compensation: After completion of delivery if the beneficiary does not get her money then she blames the ASHA for taking away all her money. Some AWWs reported that when the beneficiary does not

receive the JSY benefits in time she usually misbehaves with the ASHA.

- Inadequate honorarium: AWWs felt that as the ASHAs do not get regular honorarium they therefore cannot be made accountable for their services.
- Monetary assistance under JSY: ASHAs said that they do not get monetary assistance in advance to pay for the expenditure incurred for taking and getting an institutional delivery done, whereas the women who is about to deliver does not want to spend any money because she feels that institutional delivery at government hospitals are "free" and she is not supposed to pay. ASHAs reported that they should be remunerated at every stage starting from registration itself, which will encourage them to work more.
- Transportation: Both ASHAs and AWWs shared that non-availability of cheap transport at the village level hinders ASHAs in taking a woman for institutional delivery.
- Family resistance and security issues: Some ASHAs said that she faces resistance from her family as she does not get any payment. She also has restriction on her travel, especially during night.
- Lack of awareness: The study found that both ASHAs and women were not aware about the various benefits and requirements under JSY. Many ASHAs also reported that they are not aware what services ANMs are supposed to provide at village or sub-centre level.

Positive Achievements in Recent Years

Though the study found that there are many aspects in health service delivery that needs improvement, yet one could notice some positives changes being brought by the

implementation of NRHM in the district. Few aspects are listed below:

- Sensitization to a certain extent of the public health machinery, especially the service providers with regard to ANC needs of women, including quality of care concerns.
- NRHM has been able to generate awareness within the frontline workers especially the ANM, AWW and the ASHA about the intention of the government in encouraging and popularizing institutional deliveries.
- Creating a cadre of rural health volunteers who may be eventually successful in improving the maternal and child health.

CONCLUSION

The rapid assessment provided an empirical understanding of the dynamics existing at community level among the frontline health workers and the beneficiaries. Some of the important findings of this report are mentioned below:

- The ASHA who is looked upon as the basis of implementation of NRHM, is still, after 3 years of its launch, struggling to establish her identity both within the community where she is serving, as well as among the formal sector service providers who she is assisting in providing the statutory health services at village level. The health services provided by the ASHA have serious limitations in terms of outreach as well as quality. Even after two to three years of functioning she has not been able to establish a significant relationship with her own community. This is possibly due to the lack of inclusiveness in the planning process at various levels, improper selection procedure, inadequate and poor training process,

lack of clarity on programme objectives and a plethora of socio-economic factors.

- Inadequate health provisioning at PHC level and the subsequent referral units of the government health provisioning further limits the quality and authenticity of services that ASHAs are supposed to provide at village level.
- Inadequate compensation for the services and time volunteered by the ASHA and the reimbursement driven system that is in existence at most of the government institutions have demoralized the ASHA.
- The front line health workers such as the ANM and the AWW are not clear about the roles and responsibilities of ASHA which hampers proper coordination among the different frontline health workers.
- Even though some women are today availing the JSY benefits, yet those belonging to the marginalized lower castes face a strong and significant social exclusion and have been largely left out of the benefits provided by the ASHA at community level. It is due to various socio-economic, religious and cultural issues at both the community level as well as at the level of the service providers where caste, creed and monetary affluence most often decide who will receive what services and when.
- The Village Health & Sanitation Committee as envisioned within the bottom-up planning process of the NRHM was nowhere to be seen. Neither the community members nor the frontline health workers were aware about any such stipulation. This lack of community participation has ensured that such health services are only in the domain of either the service provider or the recipient.

Based on its findings, the study recommends few strategies that can be adopted to improve the functioning of ASHAs:

1. There is a need to establish the presence of ASHA within her community. This can be achieved to a large extent by-
   a) Formation of VHSC at village level.
   b) Proper selection of ASHAs according to NRHM guidelines.
   c) Generating more awareness about the health services she would be providing and the delivery mechanism through village meetings.
   d) Orienting the frontline workers (ANM, AWW and the ASHA) by joint training and collaborative planning.
2. ASHAs need to be made more effective as an instrument of service delivery by —
   a) Ensuring adequate number of quality trainings.
   b) Making available proper service kit.
   c) Encouraging collaborations with the ICDS and sub-centre at community level for service delivery.
   d) Addressing the financial constraints and rethinking the cash delivery models of JSY.
   e) Working out suitable mechanisms for compensation.
3. There is a need for developing community-based mechanisms that press demand for services to ensure adequate provisioning of service. This can be done by-
   a) Proper functioning of VHSC.
   b) Orienting the PRI representatives about the provisions under the NRHM.

NOTES

1. NRHM (2005-12): *Mission Document.*
2. Ministry of Health and Family Welfare, Government of India, NRHM website-JSY as in October 2006.
3. JSY Guidelines downloaded from http://india.gov.in/allimpfrms/alldocs/2384.pdf
4. Ministry of Health & Family Welfare, Government of India (2007): *RHS Bulletin*.

5. http://censusindia.gov.in/Vital_Statistics/SRS_Bulletins/MMR-Bulletin-April-2009.pdf
6. NFHS -3, Bihar.
7. Census 2001.
8. DLHS-RCH round –II.
9. IIPS: Key indicators: RCH Data 2002-2004, Mumbai.
10. MAA works in the area of reproductive health among the marginalized families with a special focus on services in and around the expectant mothers.
11. Medical Officer in charge, Muraul block
12. *Garib* in Bihar is usually referred to those from the marginalized lower caste families living on the fringes of mainstream rural society, usually Harijans, Mushahars and Tulas.