EVALUATION OF ASHA SCHEME UNDER NRHM IN UTTAR PRADESH

Research Study Conducted by:

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SEPTEMBER, 2013

Sponsoring Agency:

सिफ्सा SIFPSA

State Innovations in Family Planning Services Project Agency (SIFPSA)
Om Kailash Tower,
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ACKNOWLEDGEMENTS

One of the key components of the NRHM launched in 2005 is creating a band of trained female health activists, appropriately named 'Accredited Social Health Activist' (ASHA) in each village. These ASHAs act as a 'bridge' between the rural people and health service outlets and plays a central role in achieving national health and population policy goals. The mission has been successful in putting in place large voluntary community health workers which has contributed in a major way in improving the utilization of health facilities and increased health awareness.

ASHA mobilizes the community and facilitate them in accessing health and health related services available at the sub-centre/Primary health centers, such as immunization, Ante Natal Care (ANC), Post Natal Care (PNC) supplementary nutrition, sanitation and other services being provided by the government.

A rapid assessment has been conducted to assess the ground implementation status of ASHA scheme including issues and challenges and understand factors and barriers to the uptake of the ASHA scheme in the state of Uttar Pradesh.

The study 'Evaluation of ASHA Scheme under NRHM in Uttar Pradesh' has been undertaken by Vimarsh, Gurgaon on behalf of SIFPSA, Lucknow, Uttar Pradesh. SIFPSA has been doing tremendous job in the ongoing efforts for improving health care in the state.

We are grateful to Mr.Amit Kumar Ghosh (IAS), Executive Director, SIFPSA for reposing trust in our organization and assigning this study.

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There are certain areas that need attention with regard to better uptake of the scheme and ASHA being motivated at all levels so that she remains an effective first port of call for health systems delivery. There is a need to address these issues in right perspective so as to achieve the objectives and goals set in NRHM guidelines.

It is hoped that learning and recommendations shared in this study will help in addressing issues related to the provision of quality services to rural communities and making an effective contribution to their health.

Udit Bhandari,
Director, Vimarsh, Gurgaon

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ACRONYMS

ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ACMO	Additional Chief Medical Officer
AHS	Annual Health Survey
ARI	Acute Respiratory Infection
ASHA	Accredited Social Health Activist
BCC	Behavior change communication
BCG	Bacillus Calmette Guerin
BPHC	Block primary health centre
CCSP	Comprehensive Child Survival Programme
CHC	Community health centre
CMO	Chief Medical Officer
DCM	District Community Mobilizer
DDK	Drug Delivery Kit
DH	District Hospital
DIV PM	Divisional Project Manager (SIFPSA)
DLHS	District Level Household Survey
DLT	District Level Trainer
DM	District Magistrate
DPM	District Program Manager (NRHM)
Dy.CMO	Deputy Chief Medical Officer
EW	Eligible Women
HEO	Health Education Officer
IDI	In-depth Interview
IEC	Information education & communication
IFA	Iron & Folic Acid
JSSK	Janani Shishu Suraksha Karyakram
JSY	Janani Suraksha Yojana
MCP Card	Mother Child Protection Card
MOIC	Medical Officer In Charge
NBCC	New Born Care Corner

NFHS	National Family Health Survey
NRHM	National Rural Health Mission
PHC	Primary health centre
PNC	Postnatal Care
RCH	Reproductive child health
RFP	Request for Proposal
SC	Sub Centre
SIFPSA	State Innovations in Family Planning Services Project Agency
SNCU	Sick New Born Care Unit
SRS	Sample Registration Survey
TB	Tuberculosis
TT	Tetanus Toxoid
VHIR	Village Health Index Register
VHSNC	Village Health Sanitation & Nutrition Committee
VHND	Village Health Nutrition Day

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EXECUTIVE SUMMARY

Background of the Study

The Government of India and Government of Uttar Pradesh have launched National Rural Health Mission to address the health needs of rural population, especially the vulnerable sections of the society. The sub center is the most peripheral level of contact with the community under the public health infrastructure. This caters to the population norm of 3000 - 5000. The worker in sub center is an ANM who is directly involved in all the health issues of this population, which is spread over the wide area of many kilometers and covering 5 to 8 villages. Many a times the villages are not connected by public or private transport system making her more difficult to achieve the objectives and goals of providing quality health care for the poor and oppressed sections of the society. So the new band of community based functionaries, named as Accredited Social Health Activist (ASHA) has been proposed who serves the population of 1000. under NRHM

ASHA is the first port of call for any health related demands of deprived sections of the population, especially women, children, old aged, sick and disabled people. She is the link between the community and the health care provider.

ASHA is looked at as a change agent who will bring the reforms in improving the health status of oppressed community in rural areas. The investment on ASHA will definitely result in to better health indicators of state and at large the country.

ASHA is the first port of call for any health related demands of deprived sections of the society, especially women and children who do not have easy access to health services. ASHA mobilizes the community and facilitate them in accessing health and health related services available at Sub Centre/Primary Health Centers, such as immunization, Ante Natal Care (ANC), Post Natal Care (PNC) supplementary nutrition, sanitation and other services being provided by the government.

ASHA is a woman resident of the village from where she is selected, trained and supported to improve the health status rural community through improved health care practices, behavior change and through health care provision as is essential and feasible at the community level. There are about 8.50 ASHAs in the country and in Uttar Pradesh, there are approximately 1.30 lacs ASHA workers and as per prescribed norms, there should be one ASHA per 1,000 population in the rural areas.

Government of Uttar Pradesh desired to conduct a rapid assessment of ground implementation status of ASHA scheme including issues and challenges and understand factors and barriers in uptake of ASHA scheme.

Vimarsh has undertaken the 'Evaluation of ASHA Scheme in Uttar Pradesh' on behalf of SIFPSA, Lucknow, Uttar Pradesh. The time line of the study was three months which comprised of formulating comprehensive tools for data collection, undertaking the data collection followed by analysis of it and presentation of findings.

SIFPSA seeks to facilitate, through innovative means and partnerships with government and other agencies, the goal of health for all by improving the quality, demand, access and delivery of family planning and MCH services and also improving related quality of life parameters including the status of women.

The study has been conducted in 15 Districts of Uttar Pradesh with the following objectives:

- To ascertain the acceptability of the ASHAs by the community.
- To estimate the status of support given by ASHAs to community at the time of immunization, ANC, delivery, PNC, Family Planning, Referral Services, Blindness Control to Adolescents & TB Control.
- To study the appropriateness and timeline of payment of compensation money on performance based incentives to be paid subsequently.
- To assess the participation of ASHAs in attending block level meetings/maintaining Village Health Index Register (VHIR)/ complete training (23 Days).
- To assess the implementation of the guidelines in ASHA Scheme by MOIC/HEO/ANM
- To assess the record keeping on ASHA Scheme at Block PHC/CHC & district Level.
- To assess the existing ASHA Support system by superiors i.e. HEO/ANM

Sample Size

The total sample of the study was 5715 which is spread across 225 villages of 15 districts where the research study has been undertaken. The sample comprised of 4970 eligible women, 460 ASHAs, 225 ANMs, 45 MOICs/HEOs from block PHC/CHC, 15 CMOs and 6 DMs and ACMOs/Dy. CMOs and 15 District Community Mobilizers.

Methodology

The methodology comprised of secondary data review and primary data collection through survey with the eligible women, ASHAs and ANMs and in depth interviews with DMs, CMOs, ACMOs/Dy. CMOS, DCMs and MOICs/HEOs. The study took place in 15 districts of Uttar Pradesh which were selected by SIFPSA comprising of all regions of Uttar Pradesh. Out of 15 Districts, 6 districts from Western Region, 2 Districts from Central Region, 5 Districts from Eastern Region and 2 Districts from Bundelkhand Region were covered.

Key Findings

The key findings of the study have been:

- ASHA is accepted as a part of the society and is looked upon as one who promotes health in the village community. She is considered as an opinion leader and well wisher of the village community as far as health services are concerned.

- The implementation of ASHA scheme has resulted in a shift in vital health indicators such as increase in immunization levels, decrease in IMR and MMR and increase in the rate of institutional deliveries.

- Even though there has been a shift in the vital health indicators, there are some bottlenecks in the uptake of the scheme. Drugs are not supplied on time and drug kits are also not replenished timely. ASHAs are not supported by the superiors which is also a major hurdle in her success.

- The payment of incentives is not done timely. When payment is transferred electronically (subject to availability of funds), the list of such transfers are not displayed on the notice board, resulting to inconvenience to ASHA to find out the status of her dues. She faces a lot of hardships while claiming for her payments and they get invariably delayed due to non availability of funds.

- There are minimal efforts for ongoing capacity building of ASHAs for better results and also lack of efforts to resolve the conflicts between ASHAs and ANMs. It has further been observed that meetings at block level many times end up with no discussions taking place to redress the grievances and the problems being faced by ASHAs in their day to day working.

- The prescribed process for selection for ASHAs is usually not followed. Huge gap in numbers of ASHA also exist as majority of ASHAs cater to population of more than 1000 as against norm 'One ASHA per 1000 population'. Further gap is attributed to 'less performing' ASHAs (15 to 20%) in all the districts. Further posts for ASHAs have been sanctioned on the basis of Census 2001 and need to be reassessed in light of Census 2011.

Recommendations

Based on the field survey, discussions with various officials and data analysis, recommendations have been made for improving the implementation of ASHA scheme.

The recommendations have been made in line with the findings of the study and they are as follows:

- **Training Quality and Schedule:** Quality of training to ASHAs call for improvement in terms of equipping them to effectively provide all the services in their charter. Refresher training should be planned on regular interval. Under the cascade training model adopted for ASHAs, training programme be made more comprehensive, with focus not only on imparting information but acquisition of knowledge and skills to efficiently perform their designated functions. No compromise may be made on this front.
- **Communication Strategy:** A well designed and comprehensive and targeted Communication Strategy may be designed to create awareness about ASHA scheme, the services provided by ASHAs and the benefits that are available to the community. The Communication Strategy may suitably target PRI members and other opinion leaders in the community for better acceptance and utilization of all the services that ASHAs are trained to provide. This will boost the demand side, which at present is mostly restricted to immunization services. Awareness generation programmes for PRIs and opinion leaders should be organized at regular intervals for one-two years in order to strengthen the role and functioning of ASHAs. One off communication is not likely to have a sustainable impact.
- **Timely Payment to ASHAs:** In order to avoid delays in compensation money, the existing mechanism prescribed by the state may be strictly followed. Self-explanatory, specific financial guidelines should be made available within time to the programme managers. Funds flow should be monitored on a monthly basis as part of the monthly review agenda at State, District and Block levels. This one step will lead to a sea change in the work environment of ASHAs in the State.

Essential Supplies of Medicines and Stationery: It has been revealed during the study that there are frequent shortages and irregularity in replenishment of drugs on time and lack of timely replenishment of drug kits to ASHAs, Village Health Index Register (VHIR) has not been supplied during financial year 2012-13 to ASHAs. It is necessary to improve the supply chain and logistics management system to overcome reported shortages and lack of supplies. Appropriate number of VHIRs may be supplied and training should be imparted to ASHAs on its maintenance. These could become the basis of their work planning, community based monitoring and supervision by ANMs and others.

- **Strengthened Supportive Processes:** Processes of Community Level Monitoring, problem solving by ASHA supervisors in support of ASHAs' work, and skill up-gradation of ASHAs may be strengthened and institutionalized as early as possible. This will escalate the results from ASHA scheme manifold, without additional costs.
- **Integration of ASHA Scheme into Mainstream Primary Health Care Services:** Appropriate guidelines may be made and implemented to fully integrate ASHAs as strong and integral community based arm of the Health Department. Small but effective steps may be taken in this direction such as ANMs may be asked to ensure participation of all ASHAs working under them in the block level meetings. These meetings should have a proper agenda related to ASHAs performance with the objective of extending them support and monitoring their performance. Minutes of such monthly meetings may be kept and acted upon with action taken reports becoming part of the next meeting agenda. Certain measures could be adopted to ensure full attendance of ASHAs at these meetings and if possible token participation fee could be provided to the ASHAs to ensure their participation.
- **Health Promotion Group Meetings at AWCS:** Group meetings at the Aanganwadi centers of the ASHAs with the village women of all age groups may be institutionalized so that behavior change and adoption of good child bearing and rearing practices among village communities are reinforced from time to time. This way an institutionalization of the health promotion role of ASHAs would be strengthened amongst the community and would lead to uptake of the multiple services provided by ASHA.
- **Selection of ASHAs:** The process of selection of ASHAs may be made more transparent in keeping with the guidelines and community acceptance as well as willingness to work amongst all community groups within the assigned area may be made as the touchstones of the selection process.

CHAPTER 1

INTRODUCTION AND BACKGROUND

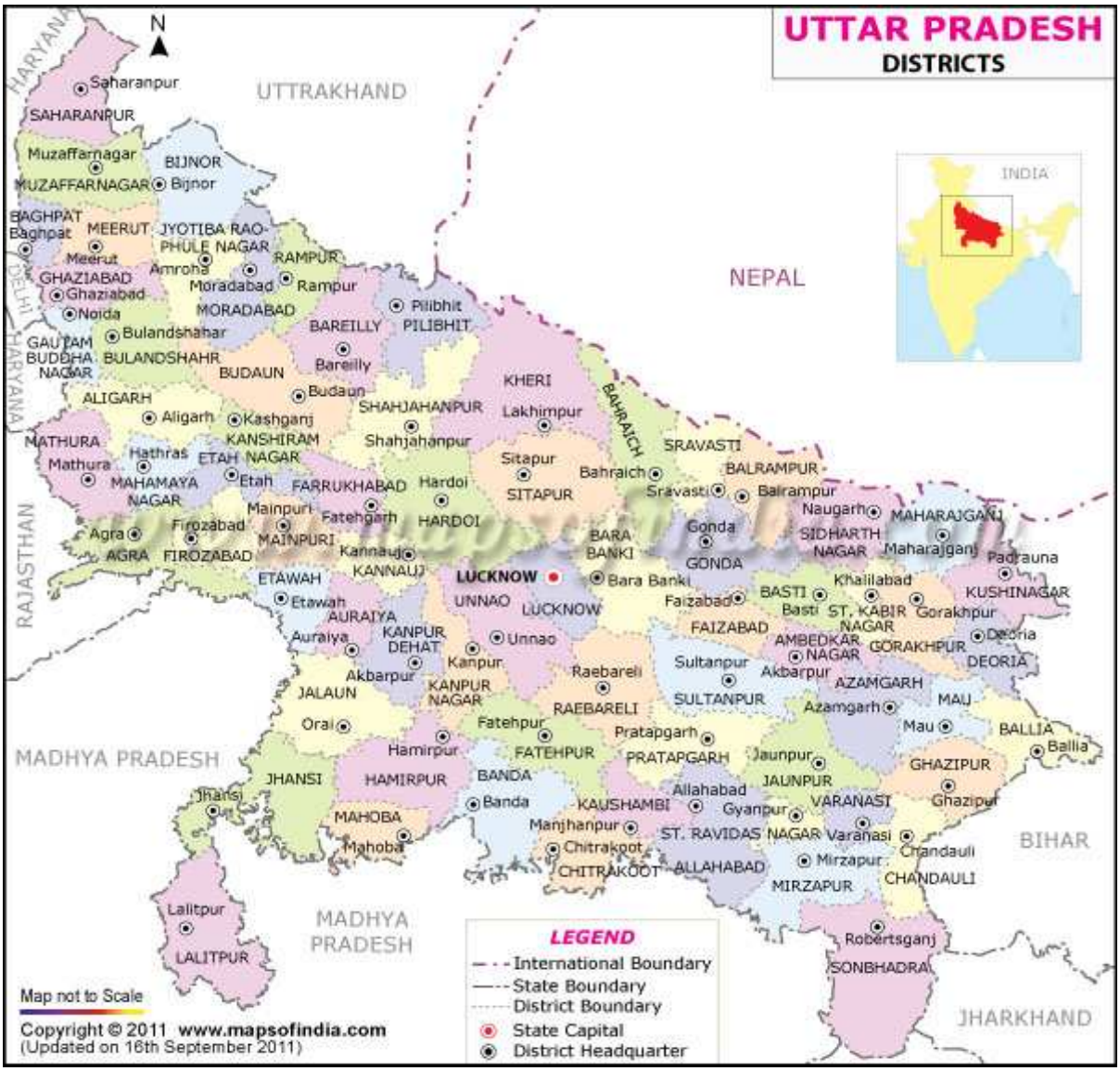
Demography of Uttar Pradesh

Uttar Pradesh is the most populous state in India accounting for 16.49 per cent of the country's population and occupies 6.88 percent of the India's land surface area. It borders with Nepal and the Indian States of Bihar, Jharkhand, Chhattisgarh, Madhya Pradesh, Rajasthan, Haryana, Uttarakhand and National Capital of Delhi. It is also the fourth largest state in geographical area covering 9.0 per cent of the country's geographical area, encompassing 240,928 square kilometers. Uttar Pradesh is divided into 75 districts under 18 divisions and as per census data 2011, the total population of Uttar Pradesh is 199,581,520. Uttar Pradesh is home to 16.49 percent of the India's population. Its rural population is 131,658,339 and urban population is 34,539,582. The density per km is 828. The sex ratio of the state is 908 as compared to India's sex ratio of 940 as per Census 2011. The Himalayas lies in the north of the state and the Deccan Plateau is at the south. In between them the river Ganges, Yamuna, Ghaghra flow eastwards. Uttar Pradesh can be divided into two distinct regions, Southern hills and Gangetic plain.

The latest population figures are based on data from the 2011 census of India. Uttar Pradesh has both a large population and a high population growth rate. During the decade from 1991 to 2001 its population increased by over 17.8%.

The state's 2001–2011 decennial growth rate (including Uttrakhand) was 20.09% which is higher than 1991–2001 rates of 17.8% and also higher than the national rate of 17.64%.

Figure-1: Map showing districts of Uttar Pradesh



Health Indicators of the State

As per SRS 2012 the Infant mortality rate (IMR) in the state is 53 per 1000 live births. Maternal Mortality Ratio (MMR) is 300 per lakh live births as per AHS 2011-12.

About ASHA

National Rural Health Mission launched on 12th April 2005, seeks to provide effective, efficient and affordable health care to rural population in 18 states with weak public health indicators and/or weak infrastructure. The NRHM operates as an omnibus broadband programme by integrating all vertical health programmes of the Departments of Health and Family Welfare including Reproductive & Child Health Programme and various diseases control Programmes. National Rural Health Mission has emerged as a major financing and health sector reform strategy to strengthen States Health systems. The mission has been successful in putting in place large voluntary community health workers in the programme, which has contributed in a major way to improve the utilization of health facilities and increased health awareness.

One of the key components of the mission is creating a band of trained female health activists, appropriately named 'Accredited Social Health Activist' (ASHA) in each village. These ASHA acts as a 'bridge' between the rural people and health service outlets and plays a central role, in achieving national health and population policy goals.

She is selected from the village itself and accountable to rural community, she counsels women on birth preparedness, importance of safe delivery, breast-feeding, immunization, contraception and prevention of common infections. ASHA is the first port of call for any health related demands of deprived sections of the population, especially women and children, who find it difficult to access health services. ASHA mobilizes the community and facilitate them in accessing health and health related services available at the sub-centre/Primary health centers, such as immunization, Ante Natal Care (ANC), Post Natal Care (PNC) supplementary nutrition, sanitation and other services being provided by the government.

Roles and Responsibilities of ASHA:

It is expected that ASHA should provide support services to village community as under:

1. Address any health related demands of deprived sections of the population, especially women and children, who find it difficult to access health services.

2. Create awareness on health and its social determinants and mobilize the community towards local health planning and increased utilization and accountability of the existing health services.

3. Counsel the women on birth preparedness, importance of safe delivery, breast-feeding and complementary feeding, immunization, contraception and prevention of common infections including Reproductive Tract Infection/Sexually Transmitted Infections (RTIs/STIs) and care of the young child.

4. Mobilize the community and facilitate them in accessing health and health related services available at the Aanganwadi/sub-centre/primary health centers, such as immunization, ANC, PNC, supplementary nutrition, sanitation and other services being provided by the government.

5. ASHAs act as a depot holder for essential provisions being made available to all habitations like Oral Rehydration Therapy (ORS), Iron Folic Acid Tablet (IFA), chloroquine, Oral Pills and Condoms etc.

6. To be a promoter of good health practices and will also provide a minimum package of curative care as appropriate and feasible for that level and make timely referrals.

7. To provide information to the community on determinants of health such as nutrition, basic sanitation & hygienic practices, healthy living and working conditions, information on existing health services and the need for timely utilization of health & family welfare services.

Target Beneficiaries:

The target beneficiaries of the ASHA scheme are rural population especially women, adolescent girls and children from poor families who do not have access to health facilities.

Stakeholders:

The stakeholders of this scheme are rural community especially women, children and deprived section of society. These are the ones who are likely to get benefits of health services at their doorstep through support services of ASHA.

Rationale of the Research Study:

The role and responsibilities of ASHAs indicate that she has a significant role in the achievement of the objectives set by NRHM. Looking at this massive plan of selection, training, and provision of payments to the ASHAs on the one hand and their success in mobilizing the community to access the quality healthcare on the other and assess the ground implementation of the scheme along with the challenges faced and factors and barriers responsible for uptake of the scheme, Government of Uttar Pradesh desired to conduct the evaluation study.

The present study has been envisaged to understand and analyze all the issues with the objectives given below:

➢ General Objective:

The general objective of the study is to conduct a rapid assessment to assess on the ground implementation status of ASHA scheme including issues and challenges, and understand factors and barriers in uptake of ASHA scheme.

➢ Specific Objectives of the Study:

- To ascertain the acceptability of ASHA by the community.
- To estimate the status of support given by ASHA to community at the time of Immunization, ANC Delivery, PNC, Family Planning, Referral Services, Blindness Control to adolescents & tuberculosis treatment.
- To study the appropriateness and timeliness of payment of compensation money on performance based incentives to be paid subsequently.
- To assess the participation of ASHA in attending block level meetings/maintaining Village Health Index Register (VHIR)/ complete training (23 days).
- To assess the implementation of the guidelines in ASHA scheme by the MOI/C/HEO/ANM
- To assess the record keeping of ASHA scheme at Block PHC/CHC and district level.
- To assess the existing ASHA Support system by superiors i.e. HEO/ANM.

Scope and the Deliverables of the Study

The scope of the study was to address all the objectives as mentioned above. This report includes present scenario of performance of ASHA and support services provided by her to village community in her service area. This report further includes major findings from the field survey, interviews with health officials and also includes recommendations listed after analysis of the data collected from field. These recommendations may help in removing the bottlenecks in implementation of the scheme so as to further bring improvements in the scheme.

Expectations of SIFSPA from this Study

SIFPSA has empanelled 7 research agencies for evaluation of various schemes. This particular assignment titled ‘Evaluation of ASHA Scheme’ has been assigned to Vimarsh after competitive bidding among the empanelled agencies of SIFPSA. SIFPSA expects from the agency hired for this purpose to submit them report based on Field Survey in 225 villages from 15 Districts of UP. It is further expected that Research Agency submits Major Findings from Field Survey and also submits recommendations that would help in removing the bottlenecks in implementation of the scheme so as to bring further improvements in health services.

CHAPTER 2

METHODOLOGY

Study Design:

The study entitled 'Evaluation of ASHA Scheme under NRHM in Uttar Pradesh' has been conducted to assess the ground implementation status of ASHA scheme including issues and challenges and understand factors and barriers in uptake of ASHA scheme.

This study examines the acceptability of ASHA in the community, status of support given to rural community by ASHA as far as health services are concerned, assessment of record keeping and timeliness of payments to ASHA using survey method and in depth interview techniques.

As a part of the study, 225 villages from 15 districts have been covered for collecting data.

The study used the social science mixed approach with use of survey (structured questionnaires) for EW, ASHA and ANM and In Depth Interviews with the Senior Health Officials and District Magistrates/Chairman, District Health Society.

Sample and Sampling Technique:

The total sample covered for the study is 5715. The sample comprises 4950 Eligible Women, 450 ASHAs, 225 ANMs, 45 MOI/Cs, 15 CMOs/DMs and 15 ACMOs/Dy.CMOs and 15 District Community Mobilizers.

In order to achieve the objectives of the study, multi stage random sampling design has been used. The districts have been selected through random sampling technique. From each district three blocks (best, average and poor performing) have been selected through systematic random sampling and five villages from each block have selected through random sampling technique.

Study Districts:

The study districts selected for the study are given below:

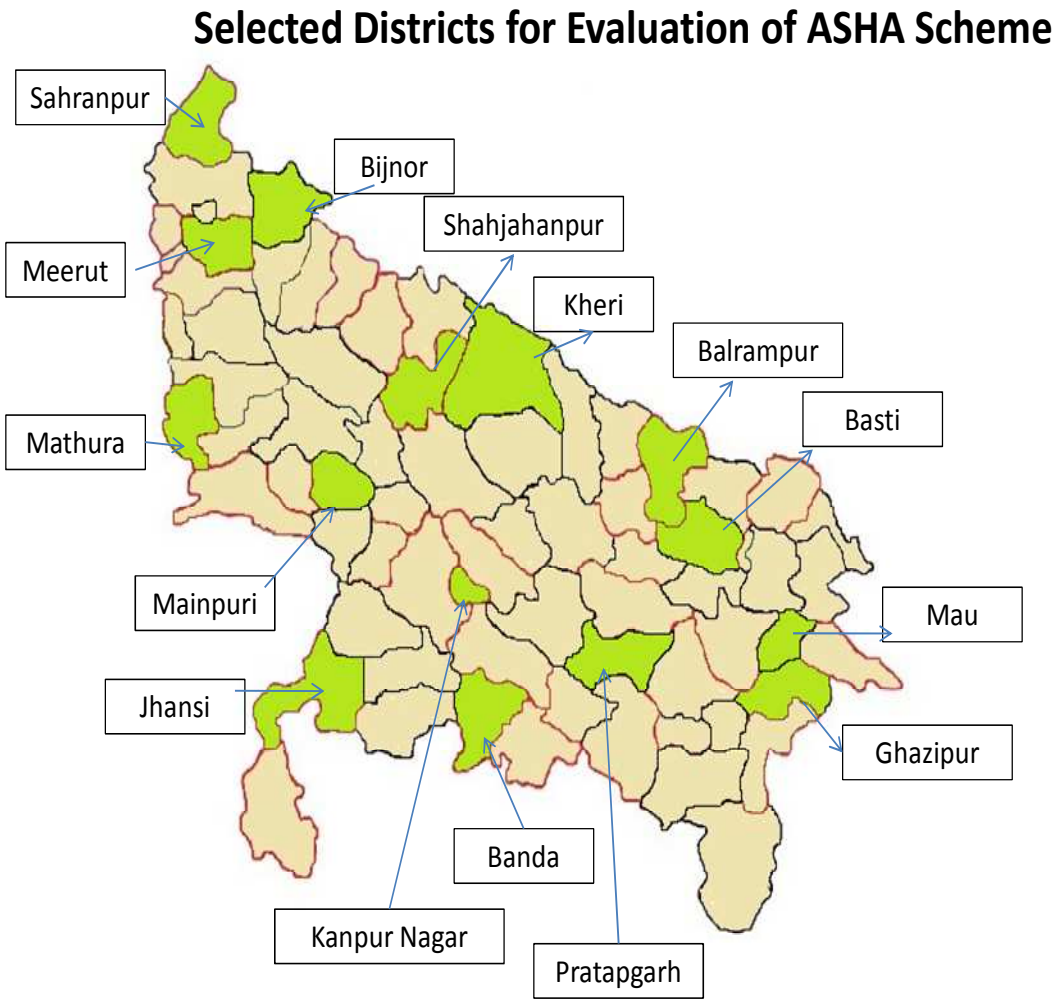


Figure-2: Map showing selected districts for study

Region	No. of Districts	Names of the Districts
Western Region	6	Bijnor, Meerut, Saharanpur, Mainpuri, Mathura, Shahjahanpur
Central Region	2	Lakhimpur Kheri, Kanpur Nagar
Eastern Region	5	Pratapgarh, Gazipur, Basti, Balrampur, Mau
Bundelkhand Region	2	Jhansi, Banda

Table No.1

Region wise Distribution of Sample Districts for Evaluation of ASHA Scheme

Total Sample Size of the Study:

Sl. No.	Interviews	Total as per RFP	Sample Actually Covered
1	20 HH selected will be interviewed from all eligible women in a HH per village from 225 villages of 15 districts 9with one or more eligible woman from same household).	4500*1.1 =4950	4970
2	All ASHAs of concerned selected 225 villages will be interviewed.	450	460
3	All ANM of concerned selected 225 villages will be interviewed.	225	225
4	45 MOIC/HEOs of concerned Block PHCs/CHCs of selected 15 districts will be interviewed.	45	45
5	All concerned 15 CMO/DM and ACMO/Dy. CMO will be interviewed from selected districts.	30	36*
6	All concerned 15 Community Mobilizers will be interviewed from selected districts.	15	15
	Total No. of Interviews	**5715**	**5751**

*Six DMs interviewed

Table No.2

Table Showing Distribution of Sample Size of the Study

Respondents of the Study:

The respondents of the study are Eligible Women in the age of 15-49 years who have given birth to live or still child during reference period 1st April, 2012 to 31st March, 2013, ASHAs and ANMs of the villages where the study was conducted. The MOIC/HEOs of concerned Block PHC/CHC, CMOs/DMs and ACMOs/Dy. CMOs and District Community Mobilizers of selected districts were also covered.

Research Tools and Techniques used for the Study:

Both qualitative and quantitative data collection techniques were used. Data collection tools were developed, pre tested, and administered. The information from the study districts were collected through mapping and listing of the households in the village, structured formats for Eligible Women, ASHAs and ANMs and IDIs with MO I/Cs/HEOs of concerned block PHC/CHC, CMOs/DMs and ACMOs/Dy. CMOs and District Community Mobilizers were also covered.

Description of the Research Tools and Techniques

i) Mapping and Listing

Mapping and listing is a research technique which is done to map and list all the households in a village. This research technique is very helpful when the universe from which the sample is to be selected is large. This technique helps in covering all the houses of the coverage area, be a village or a town where

the data collection activity takes place. Mapping helps the researcher to make landmarks from where the eligible women were identified so as no time is wasted in data collection.

The idea behind using this technique in the research study was to identify and cover all the respondents and list them in the format prepared specifically. After doing the listing the respondents, Eligible Women in the age group of 15-49 years were selected by random sampling.

ii) Structured Questionnaires

A structured questionnaire is a means of gathering information about the characteristics, actions and opinions of people.

The structured questionnaires used in this study have been used for three types of respondents, Eligible Women, ASHA and ANM. Three separate structured questionnaires have been developed to cover the sample target group. The structured tools mainly collected information on indicators like acceptability of ASHA in the community; estimation of the status of support given by ASHA to the community at the time of immunization, ANC, delivery, PNC, referral services, blindness control to adolescents and TB treatment. ASHAs and ANMs structured schedules also focused on the timelinesss and appropriateness of the payments made to the ASHAs, their participation in the block level meetings, maintenance of the VHIR and attending complete training of 23 days. Structured schedules for ANM also included the assessment of implementation of guidelines in the ASHA scheme and assessment of support provided to her by her superiors.

iii) In Depth Interviews

In-depth interviewing is a qualitative research technique that involves conducting intensive individual interviews with a small number of respondents to explore their perspectives on a particular idea, program, or situation.

These interviews have been conducted with MOICs/HEOs, CMOs/DMs, ACMOs/Dy.CMOs and District Community Mobilizers. This research technique mainly collected information on themes; acceptability of ASHA in the community, estimation of support services provided by ASHA on immunization, ANC, delivery, PNC, tuberculosis and blindness control. In addition to this, questions covered the objectives like assessment of implementation of guidelines of ASHA scheme, appropriateness and timeliness of payments of compensation money on performance based incentives to be paid subsequently, assessment of participation of participation of ASHAs in the block level meetings/maintenance of VHIR and completing the 23 days training, assessment of record keeping on ASHA scheme at Block PHC/CHC and district level and the support system by superiors.

Data Collection

In order to collect data from the selected 15 districts, 12 teams had been deployed in the field. The team comprised of two field investigators (female) and one field supervisor (male). The main responsibility of the field investigators was to conduct interviews of the Eligible Women after mapping and listing, while that of the field supervisor was to conduct interviews with the ASHA and ANM. Additionally, the field supervisors also held one to one discussions with the ASHA and the ANM. In addition to field investigators and the field supervisors, the team also comprised of quality checkers who monitored the field teams and also conducted the IDIs with MOICs. In addition to them, the field coordinators coordinated the field activities and also held IDIs with CMOs, ACMOs/Dy CMOs and DCMs.

The data collection exercise was spread across a period of two months from May 26th, 2013 to July 7th, 2013.

Data Analysis

The information collected by field survey was synthesized and analyzed in statistical software SPSS and the IDIs were subjected to detailed content analysis. They were analyzed according to the objectives of the study. The data collected and analyzed has further been corroborated using field surveys like AHS and SRS.

Report

Based on survey findings, comments received from various health officials and DMs the report comprising of field findings, analytical synthesis and suggestions for improving the outreach services to rural community through ASHA is being submitted.

CHAPTER 3

RESEARCH FINDINGS

The study titled 'Evaluation of ASHA Scheme under NRHM in UP' assessed the ground implementation of the scheme in the state of Uttar Pradesh with its focus area on issues and challenges faced by ASHAs and understanding the factors and barriers in uptake of the scheme. It also examined the utilization of the scheme by village community and the factors impeding utilization. In addition to these, this study also focused on the assessment of implementation of the guidelines of the scheme and incentive activities.

This chapter of the report deals with the findings of the study reported by various stakeholders, after synthesis and analysis of data.

The findings have been given in the order of interviews with Eligible Women, ASHAs and ANMs and subsequently findings from the discussions held with the Senior Health Officials; MOICs/HEOs, CMOs, ACMOs, DCMs and DMs.

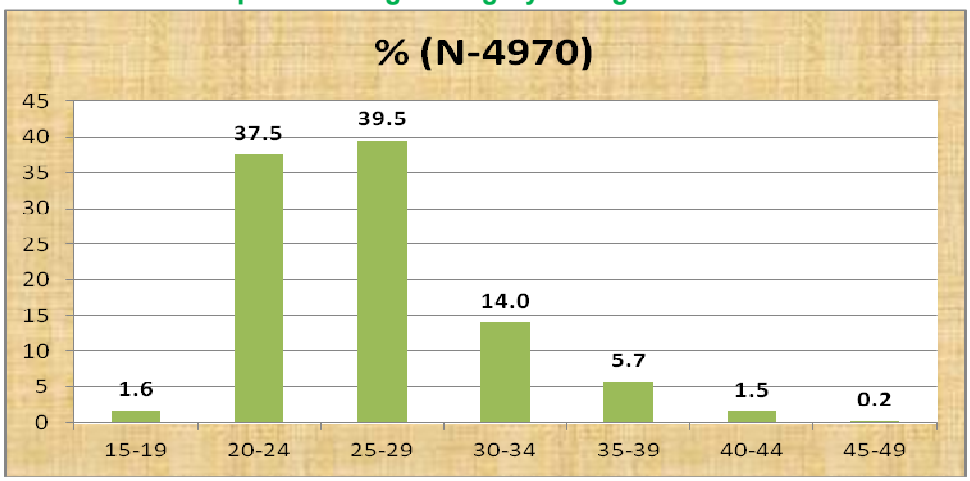
- **RESPONDENTS: Eligible Women**
- **Sample Size: 4970**

Special characteristics of respondents

Age Category

The main respondents of this study are Eligible Women who are direct beneficiaries of ASHA scheme. The women interviewed, belonged to the age group of 15-49 years, with maximum being in the age group of 20-29 and the minimum being in the age group of 45-49 years. The following graph clearly depicts the age category of the Eligible Women interviewed.

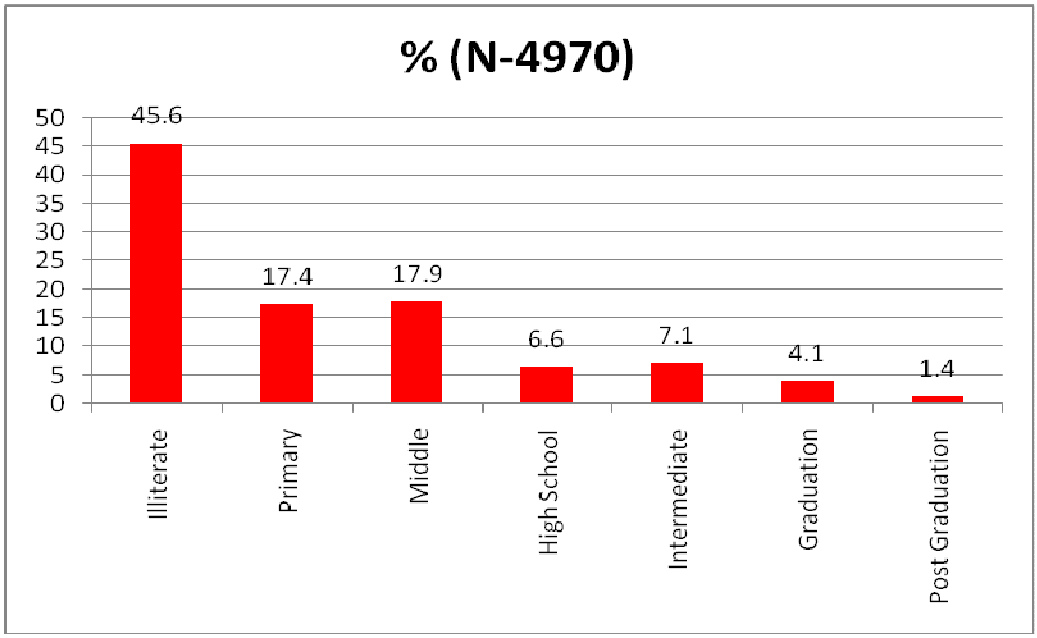
Graph No.1: Age Category of Eligible Women



Educational Profile

A high percentage of women interviewed were found to be illiterate, while a considerable percentage had a formal education. 45.6% respondents were illiterate, whereas 41.9% of them have got formal education up to high school. A minimal percentage of 12.6, have completed education up to post graduation level.

Graph No.2: Educational Profile of Eligible Women



Median age of EW

Median Age at the time of marriage (% N-4970)	Average
Median age at the time of marriage of Eligible Women interviewed	18.27 years

Table No.3

Average age of women who were interviewed is 18.27 years.

Live/still Birth

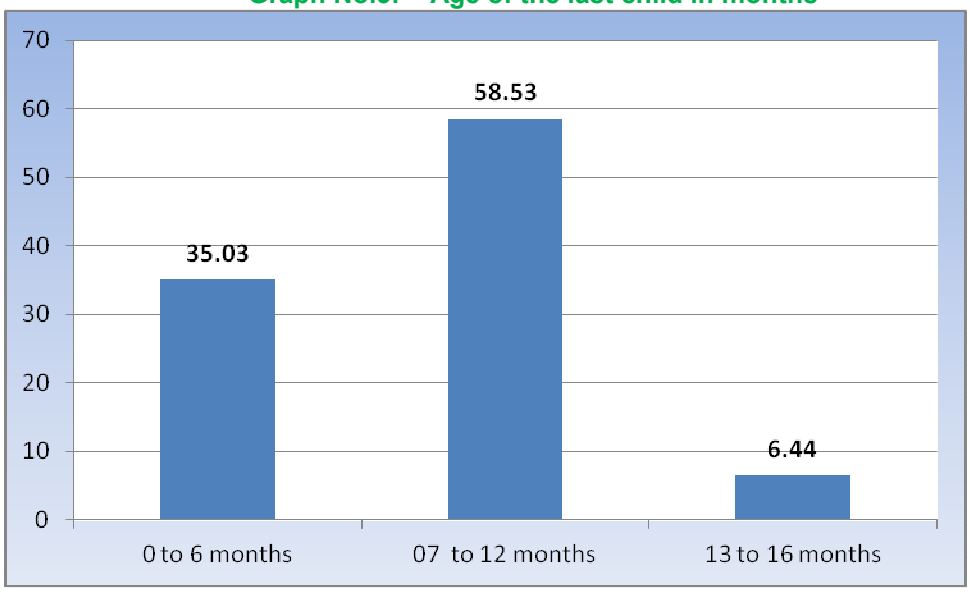
Birth of child	% (N-4970)
Live	97.91
Still	2.09

Table No.4

As per field survey, 97.91% respondents reported to have delivered live child.

EW who were interviewed reported that 58.53% of children were in the age group of 7-12 months and 0-6 months reported to be 35.03% and only small margin i.e. 6.44% were in the age group of 13-16 months.

Graph No.3: – Age of the last child in months



Sex of the child

Sex ratio of male and female child is 53.32 **:** 46.68 respectively.

Sex of the child	% (N-4970)
Male	53.32
Female	46.68

Table No.5

Knowledge about ASHA

Sr. No.	Findings	N	%
1.	Heard of ASHA	4970	100
2.	ASHAs visiting all the houses of all religions and castes	4970	98.97
3.	Understanding the role of ASHA	4970	99.65
4.	Knowledge about ASHA working in the village	4970	99.4
5.	**Knowledge about number of ASHAs working in the village**	4942	
	One		70.6
	Two		19.0
	Three or More		6.4
	Do Not Know		4.0

Table No.6

It has emerged from field survey that 100% of Eligible Women have heard of ASHA and 98.97% reported that ASHAs visit all the houses belonging to all religions and castes in the village. 99.4% of Eligible women reported that they are aware of ASHAs working in their village. 70.6% of EW reported that only one ASHA is working in their village, 19% reported that two ASHAs are working in their village and 6.4% reported that 3 or more ASHAs are working in their village. However, only 4% respondents informed that they are not aware of number of ASHAs working in their village.

Frequency of meetings with Eligible Women by ASHA

Sr.No.	ASHA meeting Eligible women	N	%
1	ASHA meeting Eligible women	4970	98.4
	As per need	4888	99.9
	Never		0.1

Table No.7

98.4% of respondents reported that ASHA meets them. However 99.9% Eligible Women reported that ASHA meets them as and when needed.

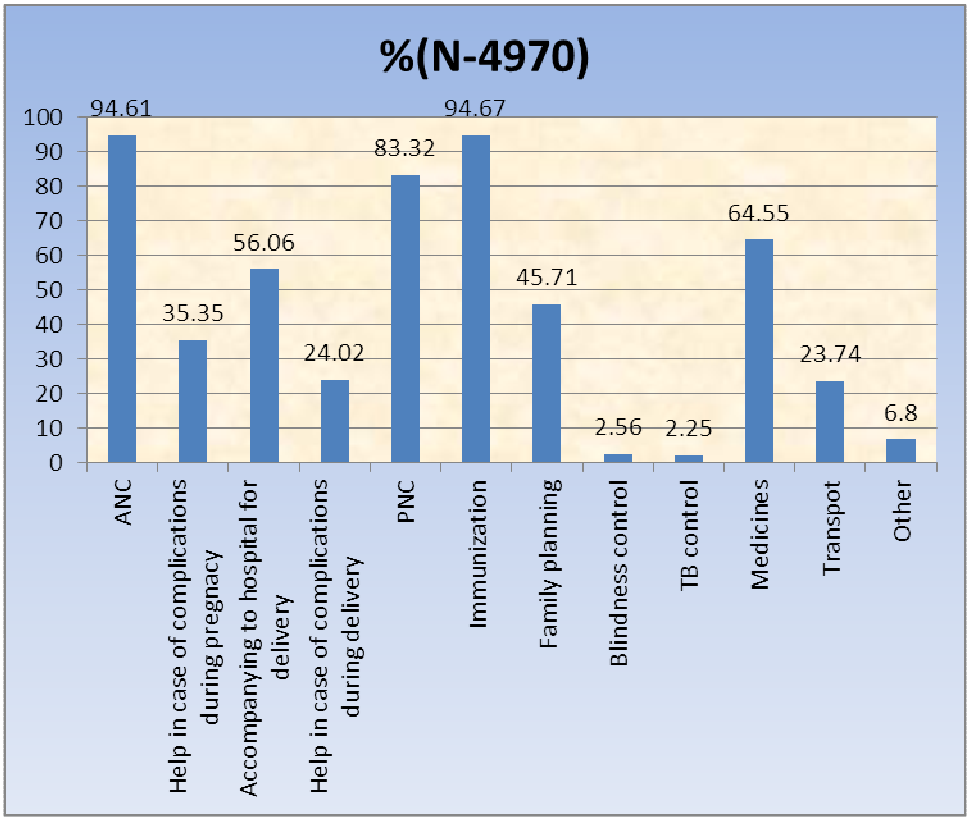
As far as the acceptance of ASHA in the community is concerned, she has widely been accepted by the village community and she shares very cordial relations with them. 99.8% respondents reported positive to this query.

ASHAs relation with village community

Sr.No.	Statement	N	%
1	ASHA sharing cordinal relation with village community	4970	99.8

Table No.8

GraphNo.4: Support Services
Support Services received through ASHA as mentioned by Eligible Women



It was informed by 94.61% of the eligible women interviewed that they have received support services from ASHAs in registration of ANC and in immunization, support received is 94.67%. Help in case of complications accounted for 35.35%, accompanying women to hospital for delivery 56.06%, help in case of complications during delivery 24.02%, in PNC support received is 83.32%, family planning 45.71%, Blindness control and TB control 2.56% and 2.25% respectively, supply of medicines accounted for 64.55%. Transport and others (Birth preparedness, awareness generation, escort services etc.) accounted for 23.74% and 6.80% respectively.

Availing of ANC

Availing of health services for ANC	N	%
Undergoing ANC at health facility	4970	95.93

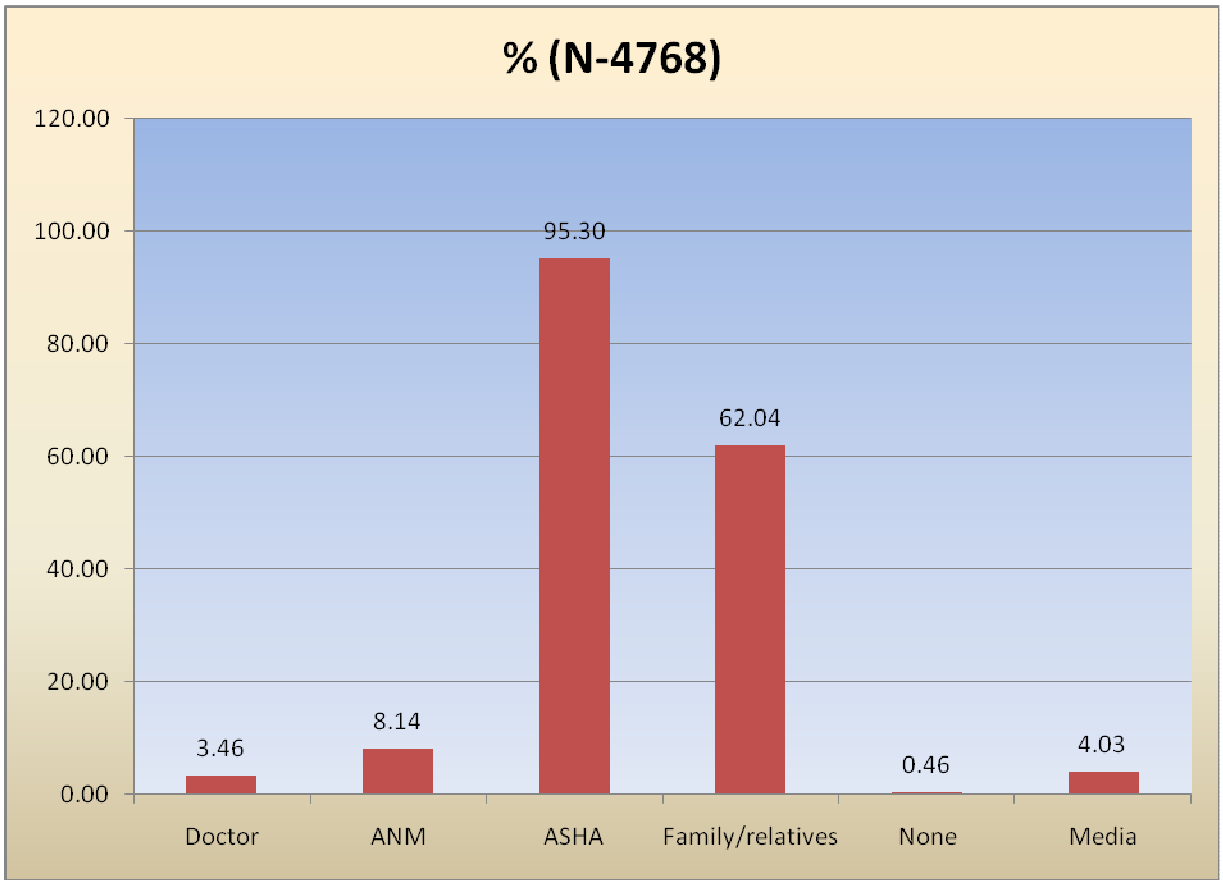
Table No.9

95.93% EW reported that they have availed of ANC.

Motivation for ANC

As high as 95.3% of women reported that they have been motivated by ASHAs for ANC while 62.04% of them reported they were motivated by their family members. The ANM, doctors and media accounted for a small percentage in this regard, with a total of 15.63%, while a few eligible women (0.46%) reported that they knew about it of their own. Even on being motivated for ANC, certain women did not prefer going for such check up.

Graph No.5 Source of motivation for ANC



Help by ASHA for ANC

Sr.No.	Help by ASHA for ANC	N	%
1	Support services received by EW for ANC from ASHA	4768	
2	Once	4768	6.04
3	Twice		45.97
4	Thrice		44.21
5	None		3.78

Table No.10

With regard to support services for ANC through ASHA, 6.04% EW responded that that they received support only once, support given twice accounted for 45.97%, thrice 44.21% and only 3.78% EW reported that they did not get any support for ANC through ASHA.

Reasons for not visiting Antenatal Care

On being asked, 53.7% respondents informed that they did not feel the need for ANC and lack of knowledge in this regard accounted for 24.5%. 3.4% of respondents informed that it was not customary, no transport was the reason cited by 4.1% respondents, poor quality of service accounted for 2%, family did not allow accounted for 6.8%. Only 0.8% respondents reported that ANC visits cost too much and 2% of the respondents reported that behavior of hospital staff was not good.

The following table clearly depicts the reasons for not having ANC sessions:

Reasons for not availing ANC	% (N-202)
Not needed	39.11
Not customary	2.48
Cost too much	0.50
Too far / no transport	2.97
Poor quality of services	1.49
No time to go	1.98
Lack of knowledge	17.82
Family did not allow	4.95
Behavior not good of hospital staff	1.49

Table No.11

Birth Preparedness

Counseling on birth preparedness

On being probed, it was reported by EW (84.42%) that ASHA counseled them for birth preparedness and they also counseled on complications before delivery (43.66%).

40.32% EW reported that ASHA helped them in taking to hospital during complications before delivery. 9.54% EW reported that ASHA helped them in taking them to hospital, others accounted for help in complications before delivery accounted for 58.20%

Sr.No.	Counseling by ASHA on birth preparedness	N	%
1.	Counseling from ASHA on birth preparedness	4970	84.42
2.	Complications before delivery	4970	43.66
3.	If so, ASHA helped in taking to hospital	2170	40.32
4.	If so, ASHA helped in arranging transport for taking to hospital	2170	9.54
5.	Others helped in complications during delivery	2170	58.20

Table No.12

Consideration for place of delivery

The table below states 64.4% EW considered place of delivery at govt. run hospital and 9.4% in private hospital/nursing home. 26.2% EW reported that they considered for delivered at home.

Consideration for place of delivery	% (N-4970)
Government Hospital	64.4
Private Hospital/Nursing Home	9.4
At Home	26.2

Table No.13

Place of Delivery

The table below indicates that 50.1% of the respondents of this category reported that their place of delivery was government hospital while 16.5% and 33.4% reported that their place of delivery was private hospital/nursing home and their house respectively.

Child Delivered at	% (N-4970)
Government Hospital	50.1
Private Hospital/Nursing Home	16.5
At Home	33.4

Table No.14

ASHA Accompanying EW to hospital for delivery

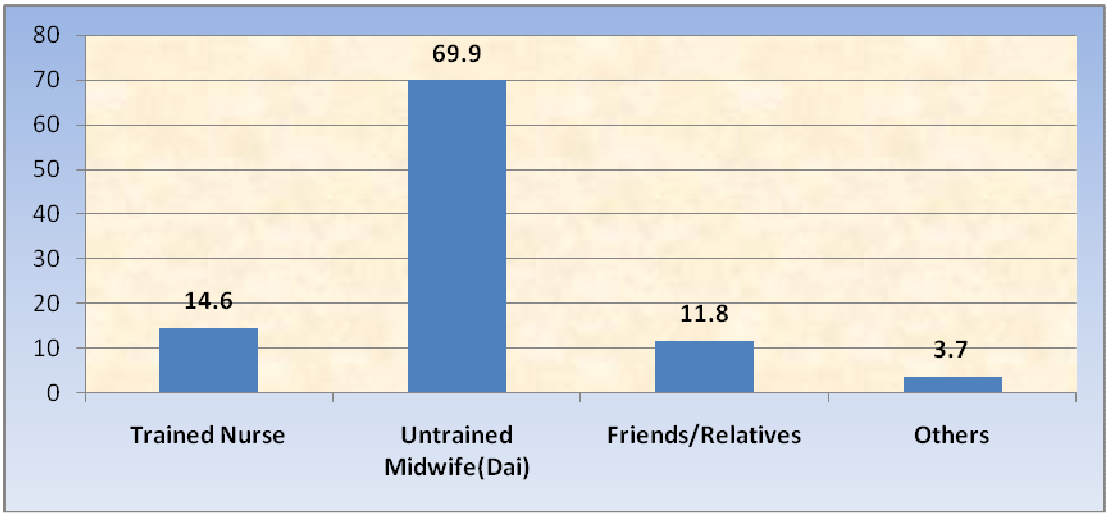
	Accompanying EW to hospital for delivery	N	%
1	I. ASHA	4970	77.2
	II. Family members/relatives		84.9
	III. Others		4.5
	IV. Planning in advance for transport to be used	4970	44.6
2	**Planning for donating the blood in case of emergency**	4970	
	1. Family members/relatives		86.2
	2. Friends/Neighbors		1.0
	3. Others		19.7

Table No.15

77.2% EW reported that ASHA supported them accompanying EW to hospital for delivery, family members/relatives accounted for 84.9% and others accounted for 4.5%. On being probed with regard to planning in advance for transport to be used for going to hospital for delivery, 44.6% EW reported that they had planned in advance in this regard. With regard to query for planning who would donate blood in case of emergency, 86.2% EW reported that they had planned that family members/relatives would donate blood, friends/neighbors and others accounted for 1% and 19.7% respectively.

Who would conduct delivery, in case of delivery at home?

Graph No.6 - Eligible women 4970



As the above graph depicts, in case of delivery at home, 69.9% reported that they had planned that delivery would be conducted by untrained midwife *(dai),* 14.6% by trained nurse, 11.8% by friends/relative and others accounted for 3.7%.

Birth preparedness

Sr.No.	Birth preparedness	N	%
1	ASHA asked for keeping certain items ready in case of delivery at home	4970	72.6

Table No.16

72.6% EW reported that they were asked by ASHA to keep certain things ready in case of delivery at home.

ASHA counsels the women for birth preparedness and also briefs her about the clean items to be used during birth. The following table indicates that ASHA has been able to counsel the eligible women for birth preparedness on following items. 71.9% of the respondents reported that she counseled them on clean room for delivery.

Counseling on items to be kept ready for birth preparedness

Items	% (N-3608)
Clothes	99.7
Soap	98.1
Thread	97.4
Blade	98.6
Clean room for delivery	71.9

Table No.17

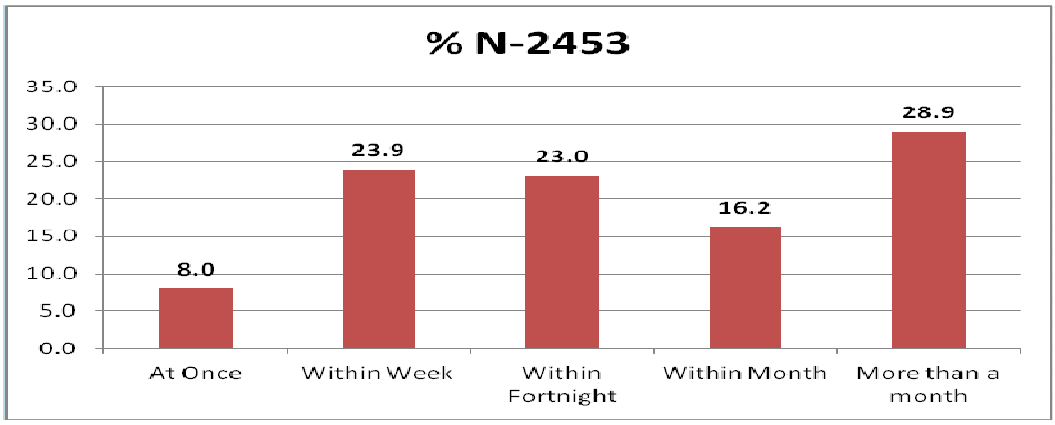
Benefits under JSY

EW reported (93.6%) that they were given information by ASHA about benefits under JSY. With regard to query for mode of payment, 97.8% reported that they received monetary benefit by cheque and only in case of 2.2%; they reported that they received monetary benefit in case. 100% EW reported that ASHA assisted them in getting benefits under JSY. Only 49.36% availed benefits under JSY.

Sr.No.	**Benefits under JSY**	N	%
1.	ASHA informing about JSY to EW	4970	93.6
2.	Receipt of monetary benefit under JSY after delivery	4970	49.36
3.	**Mode of payment**		
	Cheque	2453	97.8
	Cash		2.2
4.	ASHAs assistance in getting benefits under JSY	2453	100

Table No.18

Graph No.7 - Time gap for receipt of benefit under JSY

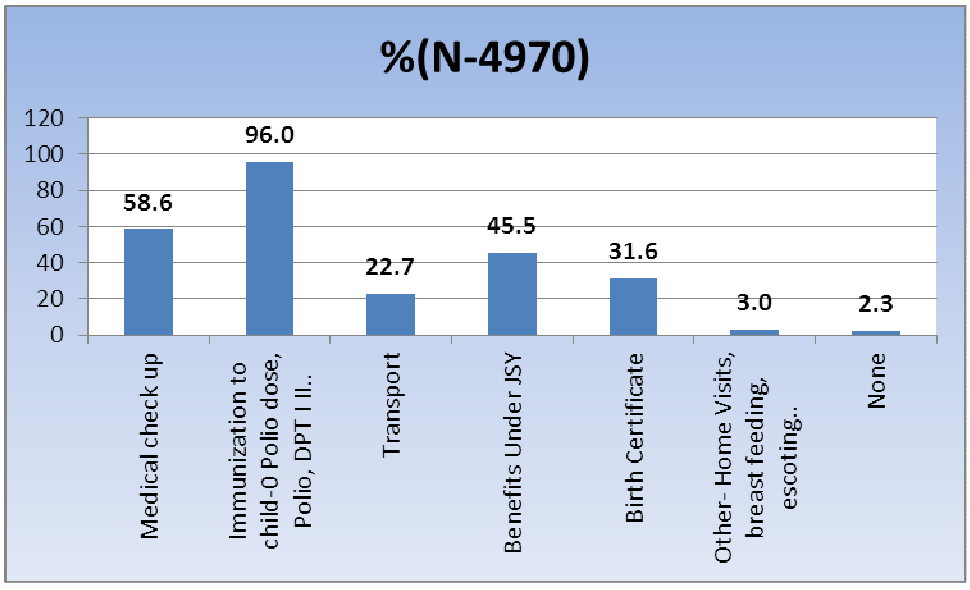


The above graph depicts the time it took for EW to receive benefits under JSY. 28.9% EW reported that received benefit after a month, 23.9% reported that they received benefits within a week, 23% within fortnight, 16.2% within a month respectively. Only 8% EW reported that they received benefits under JSY at once.

Delivery Support from ASHA

ASHA has played a significant role in providing post delivery support to the village community with 96% of the sample reporting that they were supported in providing immunization to their child. About 58.6% reported that they were provided support in medical checkup as well. It also came into light that benefits under JSY were also communicated to the village women by ASHAs with 45.5% of sample reporting this. The role of ASHA in providing support in getting a birth certificate is 31.6%; it is highly insignificant in the case of transport (22.7%) and very small percentage reported that (3%) she paid them home visits and counseled them on breastfeeding, malnutrition etc. No support was provided by her post delivery as reported by 2.3% of the respondents.

Graph No.8



Counseling provided by ASHA

In addition to the support provided, ASHAs also counseled Eligible Women on various health issues. The following table depicts the issues on which counseling is provided. Survey findings reveal that her role in promoting family planning is 60.8%, in malnutrition it is 55.9%, in diarrhea management 77.8%, ARI 91.1% and in immunization it is as high as 96.5%.

The following table reveals the major issues where counseling was provided by ASHA:

Counseling provided by ASHA	% (N-4970)
Family Planning	60.8
Information about Malnutrition and its symptoms	55.90
Counseling by ASHA for prevention of malnutrition	53.62
Child suffered from Diarrhea	77.8
Information about Immunization	96.5
Knowledge about Acute Respiratory Infection	91.1

Table No.19

ASHAs support to EW for ARI, Diarrhea, malnutrition, immunization, complications after delivery, complications to child

32.4% EW reported that ASHA supported them in treatment of ARI/Diarrhea, 42.4% EW reported that they received support from ASHA regarding child suffering any kind of complications during delivery. 21.7% EW reported that they provided information to ASHA about complications and only 6.3% reported that ASHA accompanied them to hospital for treatment.

Sr.No.	Statement	N	%
1	ASHAs support for treatment of ARI, Diarrhea, Malnutrition, Immunization	4970	32.4
2	Child suffering any kind of complications after delivery	4970	42.4
3	Information to ASHA by EW about complications to child	2108	21.7
4	ASHA accompanied you and child to health facility	4970	6.3

Table No.20

FAMILY PLANNING AND POST DELIVERY SUPPORT:

94.54% EW reported that they were counseled by ASHA for institutional delivery. As per following table, it is reported by only 18.7% EW that they were supplied condoms, pills etc. for family planning. 89.4% EW reported that they were escorted by ASHA for ANC, for delivery 53.3% reported that ASHA escorted them for delivery, PNC (70.2%), family planning (17.4%) and others (11%) escorted them to health facilities for other ailments.

97.6% of EW reported that they were called by ASHA for immunization on vaccination day, only 16.5% reported that attended meeting with ASHA on health awareness.

Sr. No.	Findings	N	%
1.	Counseling by ASHA for institutional delivery	4970	94.54
2.	Supply of condoms, pills etc. for family planning by ASHA	4970	18.7
3.	**Escorting by ASHA for**		
	I. ANC	4970	89.4
	II. Delivery		53.3
	III. PNC		70.2
	IV. Family planning		17.4
	V. Others		11.0
4.	ASHA calling EW for immunization on vaccination day	4970	97.6
5.	Attending meeting with ASHA on health awareness camps	4970	16.5

Table No.21

Issue of MCP card, Discharge slip, birth certificate

75.4% EW reported that they were issued MCP card, 48% reported that they were issued discharge slip by hospital after delivery and 43.7% reported that they were not issued any discharge slip, 6.8% reported that discharge slip was not available with them and 1.5% EW could not recall whether discharge slip was issued to them or not. Only 32.4% reported that they were issued birth certificate, 63.8% reported that they were not issued birth certificate for baby, only 3.7% reported that birth certificate is not available with them.

On being asked whether they are currently practicing any family planning method, 36.3% EW responded positive and on further probed, they reported that they are using 89% and 11% spacing and limiting methods respectively.

Sr. No.	Findings	N	%
1.	**Supply of MCP card**	4970	
	Yes		75.4
	No		18.3
	Not available		6.3
2.	**Issue of discharge slip after delivery in the hospital**	3310	
	Yes		48
	No		43.7
	Not available		6.8
	Cannot say		1.5
3.	**Issue of birth certificate of baby**	4970	
	Yes		32.4
	No		63.8
	Not available		3.7
4.	Currently practicing any family planning method	4970	36.3
5.	If so, Limiting	1803	11.0
	Spacing		89.0

Table No.22

ASHAs role and behavior with EW

As per survey findings, 97.6% EW reported that ASHAs are very cooperative and approachable to them. 96.4% EW reported that ASHAs are visiting them regularly. With regard to perception of EW on ASHAs role, it was reported 98.2% that ASHAs are promoting health related issues amongst community.

On being asked, where they would go (if not ASHA), 65% EW reported that they would go to govt. health facility, 45.6% reported that they would go to private health facility, ANM (1.5%). Local health care providers and others accounted for 7.4% and 3.9% respectively. Only 2.9% EW reported that they had incurred any exp. for services and support provided by ASHA.

Sr.No.	Relevant findings	N	%
1.	ASHA cooperative and easily approachable	4970	97.6
2.	ASHA visiting community regularly	4970	96.4
3.	EWs perception about role of ASHA in promoting health amongst community	4970	98.2
4.	**In case of health related problems where would EW go, if ASHA not available**	4970	
	1. Govt. health facility		65.0
	2. Private health facility		45.6
	3. ANM		1.5
	4. Local health care provider		7.4
	5. Others (unqualified doctor)		3.9
5.	Any exp. incurred for services and support received from ASHA	4970	2.9

Table No.23

RESPONDENTS: ASHA

- **Sample:** 460

Special characteristics of respondents

Median age: 33 years
Religion

Sr.No.	Religion	% (N-460)
1	Hindu	0.952
2	Muslim	0.043
3	Sikh	0.004

Table no.24

Caste

Sr.No.	Caste	% (N-460)
1	General	0.24
2	OBC	0.51
3	SC/ST	0.25

Table No.25

Educational Qualification of ASHA

Since the ASHA is the main stakeholder of the scheme, and the study is also primarily focused on her therefore this set of findings includes her perspective and knowledge about various issues.

The pie chart depicts the educational qualification of the ASHA. It is observed that 43.2% ASHA are middle pass and 25% are matriculate. Graduate and post graduate account for only 8.3% and 1.5% respectively.

Graph No.9: Educational Qualification of ASHA

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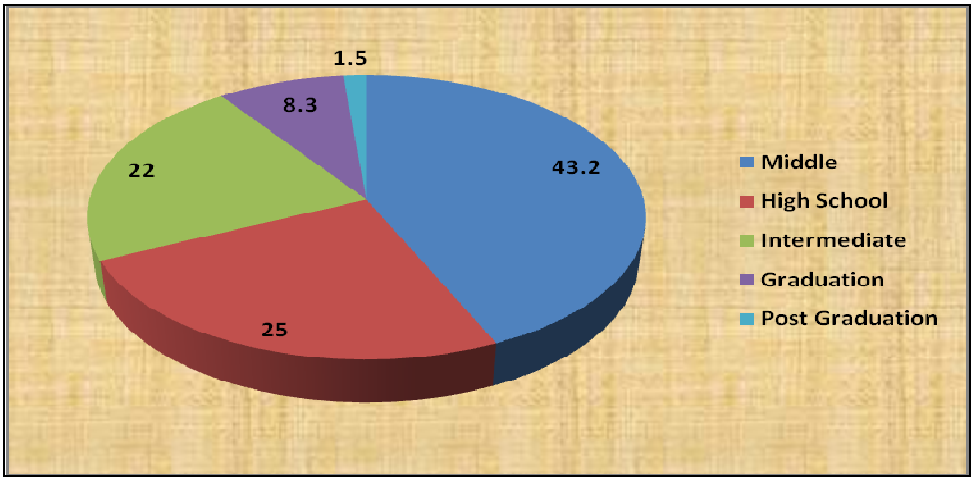


Selection Process of ASHA and availability of relevant documents

As far as the selection process of ASHA is concerned, 70.9% informed that they were selected through Gram Sabha. 96.7% stated that they have photo identity cards issued by the health department. In order to corroborate this fact, 89.7% of the ASHA showed their photo identity card on being asked. 21.96% ASHA stated that before selection as ASHA, they were engaged with some other job. Out of 3.2% ASHAs who have lost their photo identity card, 0.36% ASHA only reported that they have applied for fresh photo identity card.

Selection process of ASHA	**%**
Selection of ASHA through Gram Sabha **% (N-460)**	70.9
ASHA having photo identity card issued by Health Department **% (N-460)**	96.7
Photo identity card seen on the spot **% (N-445)**	89.7
Photo identity card applied, if lost **% (N-15)**	3.37
Doing any Job before selection as ASHA **% (N-460)**	21.96

Table No.26

Place of Residence of ASHA

The table below depicts that 87.6% of ASHA belonged to the same village where they worked and in 99.3% cases, they have been residing in the same village for more than three years and only 0.7% are residing for less than 3 years.

Place of residence	**%**
ASHA belongs to the same village (N-460)	87.6
ASHA residing in the same village for less than 3 Yrs (N-403)	0.7
ASHA residing in the same village for more than 3 Yrs (N-403)	99.3

Table No.27

Trainings and Awareness

Sr.No.	Trainings and Awareness	N	%
1.	Trainings completed by ASHA	460	98.3

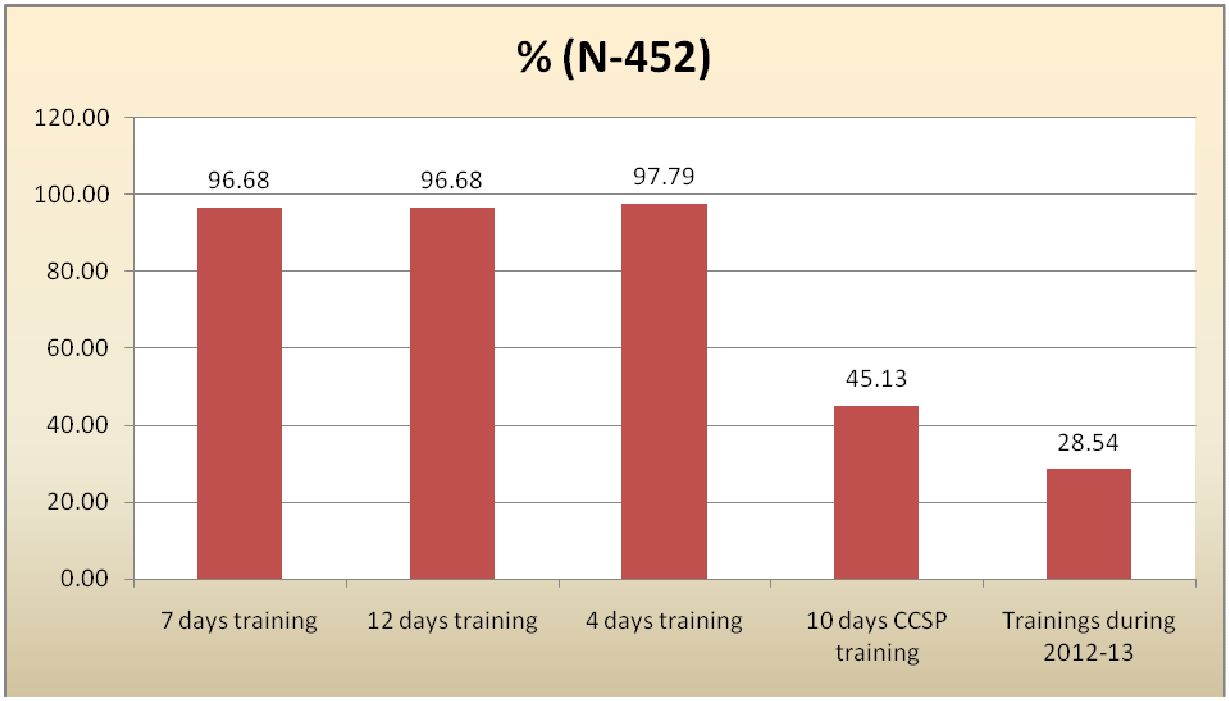
Table No.28

98.3% of ASHAs have reported that they have completed trainings.

Trainings Received by ASHA

98.3% of ASHAs had undergone training. 96.68% have undergone 7 days and 12 days training and 97.79% have undergone 4 days training. 45.13% of ASHAs in study districts had undergone CCSP training and 28.54% of ASHAs had undergone other trainings as well such as Malaria, Filaria, TB control, Blindness control training, filling VHIR etc.

Graph No.10: Trainings Received by ASHA



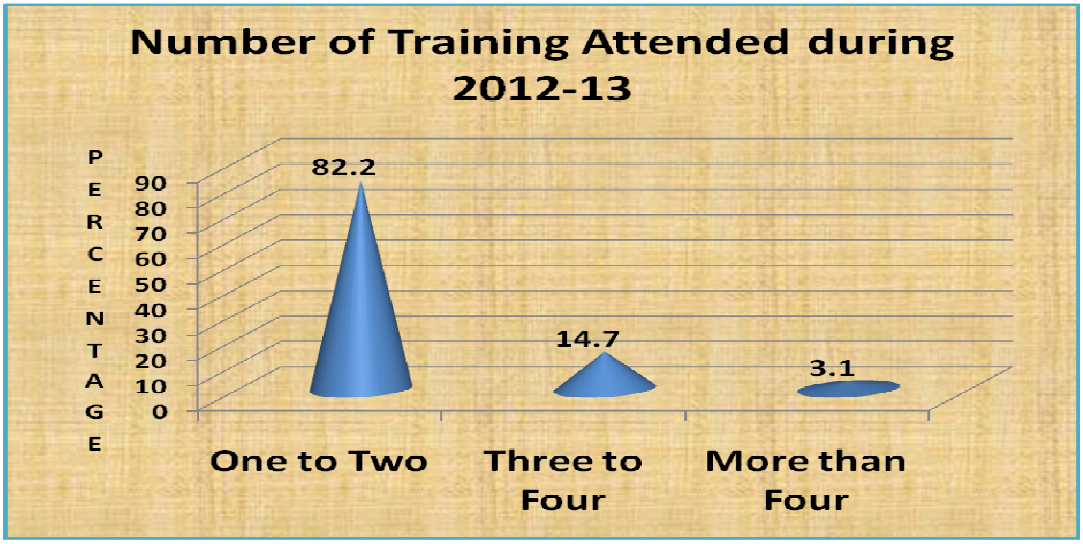
Generating awareness on malnutrition and complications during delivery

Sr.No.	Generating awareness on malnutrition and complications during delivery	N	%
1	Generating awareness about malnutrition and its symptoms	460	97.0
2	Awareness about complications during pregnancy	460	100

Table No.29

97% ASHAs reported that they generated awareness amongst rural community on malnutrition and complications during delivery and 100% ASHAs reported that they also made aware of Eligible Women of the complications during pregnancy.

ASHA % (N-129) - Graph No.11



During 2012-13, 82.2% of ASHAs have received one to two trainings, 14.7% respondents received three to four trainings and only 3.1% respondents received more than four trainings during this period.

Trainings received by ASHA during 2012-13

Sr.No.	Trainings received during 2012-13	N-129	%
1.	CCSP	93	72.0
2.	Measles	36	27.9
3.	T.B	20	15.5
4.	Immunization	47	36.4
5.	Pregnancy related	16	12.4
6.	HIV & AIDS	2	0.77
7.	Malaria	4	3.10
8.	Blindness control	3	2.32
9.	Family Planning	4	3.10
10.	Care to expecting mothers	25	19.37
11.	Diarrhea	10	7.75
12.	Health related	82	63.35

Table No.30

The above table details the type of of trainings received by ASHA on various health related issues.

Population being covered by ASHA

As per NRHM 'One ASHA per 1000 population' is norm. The table given below reveals a huge gap in this regard as 74.13% of ASHAs covered population of more than 1000.

Population	% (N-460)
Less than 1000	25.0
1000 – 2000	68.48
2000 – 4000	5.65
More than 4000	0

Table No.31

ASHAs understanding of her role

Sr.No.	Understanding role and responsibilities	N	%
1.	Understanding role and responsibilities	460	100

Table No.32

100% of ASHAs reported that they are fully aware of their role and responsibilities and on being asked to list the responsibilities, they could mention 100% for ANC registration, care during pregnancy and institutional delivery, general awareness about family planning accounted for 32.8%, 88.4% for immunization, birth/death registration only 2.39%, Leprosy, Blindness control and TB accounted for meager 7.17%. PNC accounted for 7.39%, home visits for child care 18% and supply of medicines accounted as little as 3.26%.

List of responsibilities as mentioned by ASHAs

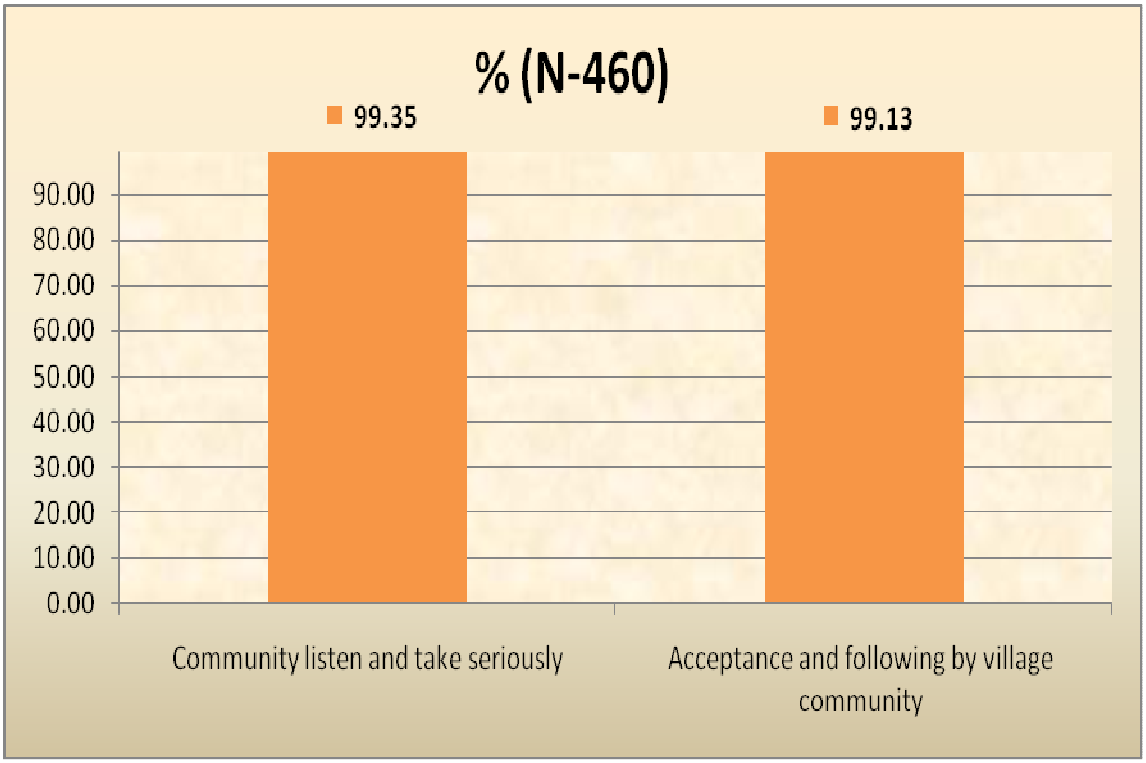
Sr.No.	List of responsibilities	N-460	%
1.	ANC registration, care during pregnancy, institutional delivery,	460	100
2.	Generating awareness about family planning	151	32.8
3.	Complete immunization to child	407	88.4
4.	Birth/death registration	11	2.39
5.	Leprosy, T.B, Blindness control	33	7.17
6.	PNC	34	7.39
7.	Home visits for child care, awareness generation amongst village community	83	18.0
8.	Supply of necessary medicines to women and children	15	3.26

Table No.33

Acceptance and Cooperation from village community

The acceptability of the ASHA and the cooperation she receives from the village community would lead to greater awareness in the community. The study reveals that acceptance of ASHA by village community is as high as 99.35% and they take her work very seriously and give attention to her as reported by 99.13% of the respondents.

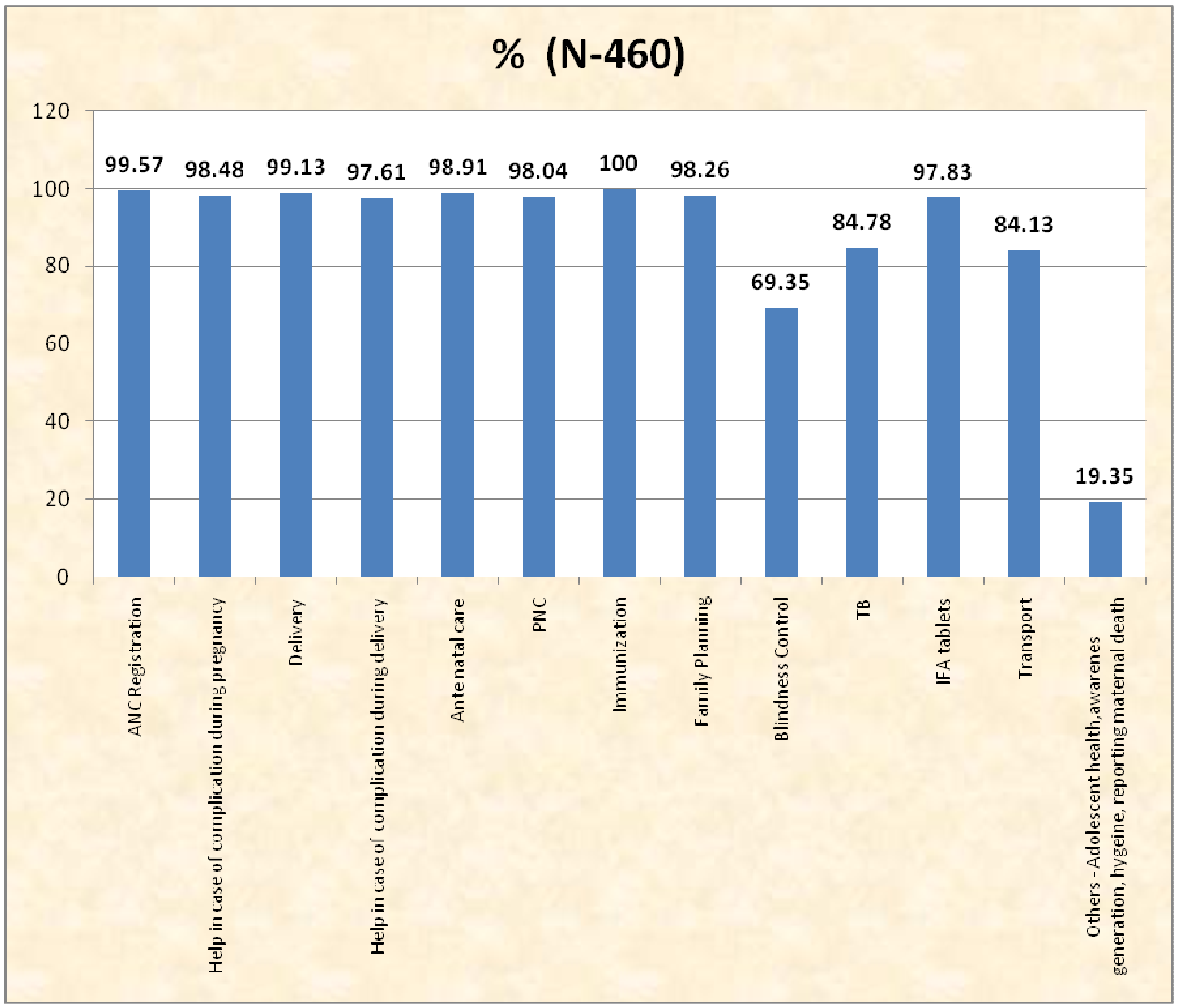
Graph No.12: Acceptance and Cooperation from the Village Community



List of support services to village community as mentioned by ASHA

ASHAs were asked about the services they provide to the community. There was 100% positive response for immunization, followed by support provided for ANC registration (99.57%). It is further evident that help was also extended in case of complications during pregnancy is 98.48%. Help in case of delivery accounted for 99.13%, ANC (98.91%), PNC (98.04%), IFA tablets (97.83%) and family planning (98.26%). Blindness control accounted for (69.35%), TB control (84.78%), transport (84.13%), and other issues like adolescent health, hygiene, reporting maternal death, awareness generation on health issues were 19.35%.

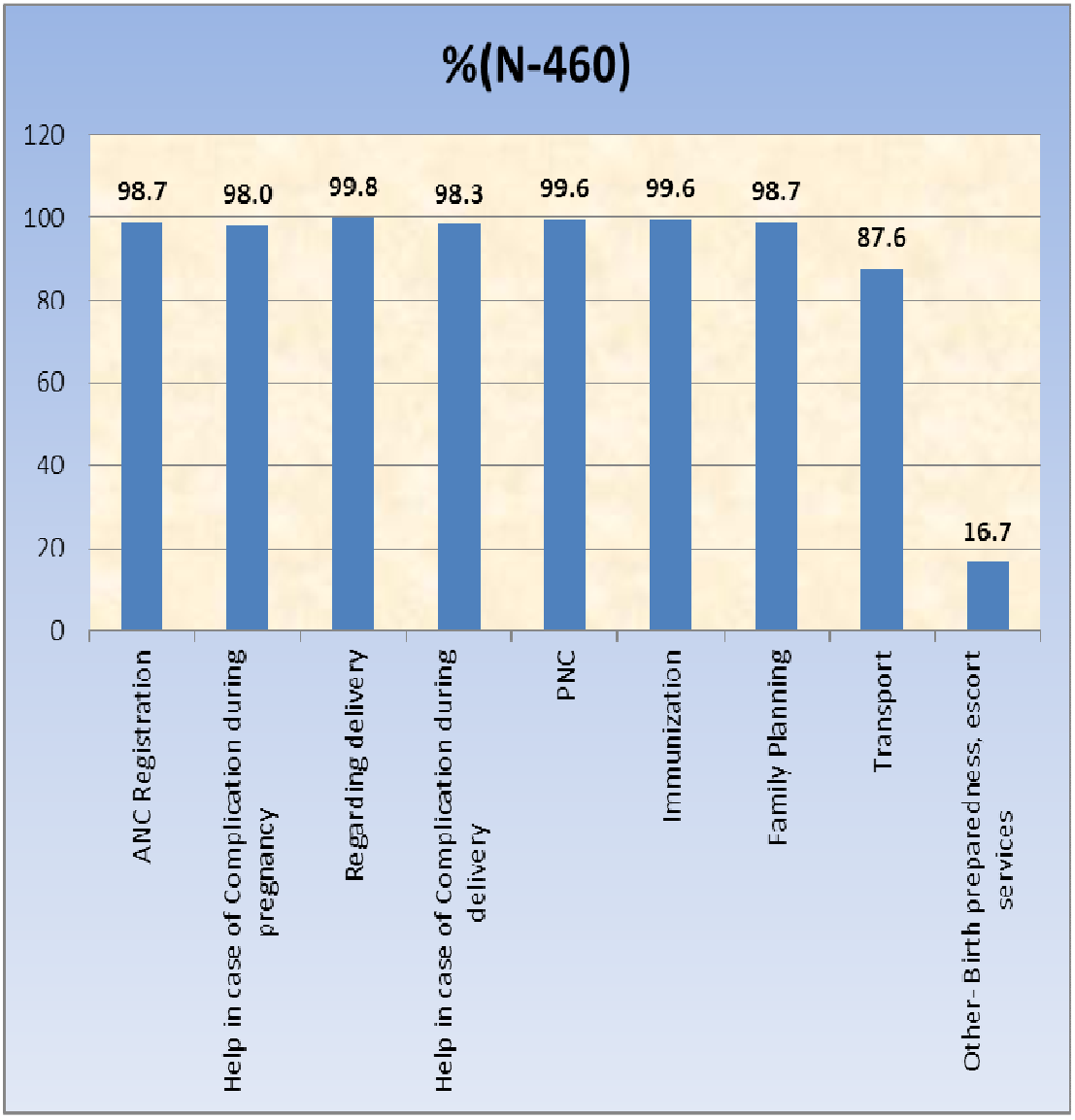
Graph No.13: Services Provided by ASHA



Counseling provided by ASHA during pregnancy

ASHAs counseled Eligible Women on various health issues. The chart below depicts the counseling provided during pregnancy. It was reported during the survey with ASHAs that 98.7% of them provided counseling on ANC registration, 98% responded that they counseled on complications during pregnancy, regarding delivery they counseled 99.8%, 98.3% reported that they provided counseling on complications during delivery, for PNC counseling, they reported 99.6%, for immunization 99.6%, counseling on family planning accounted for 98.7%, transport 87.6%, and others such as birth preparedness and giving escort services accounted for 16.7%.

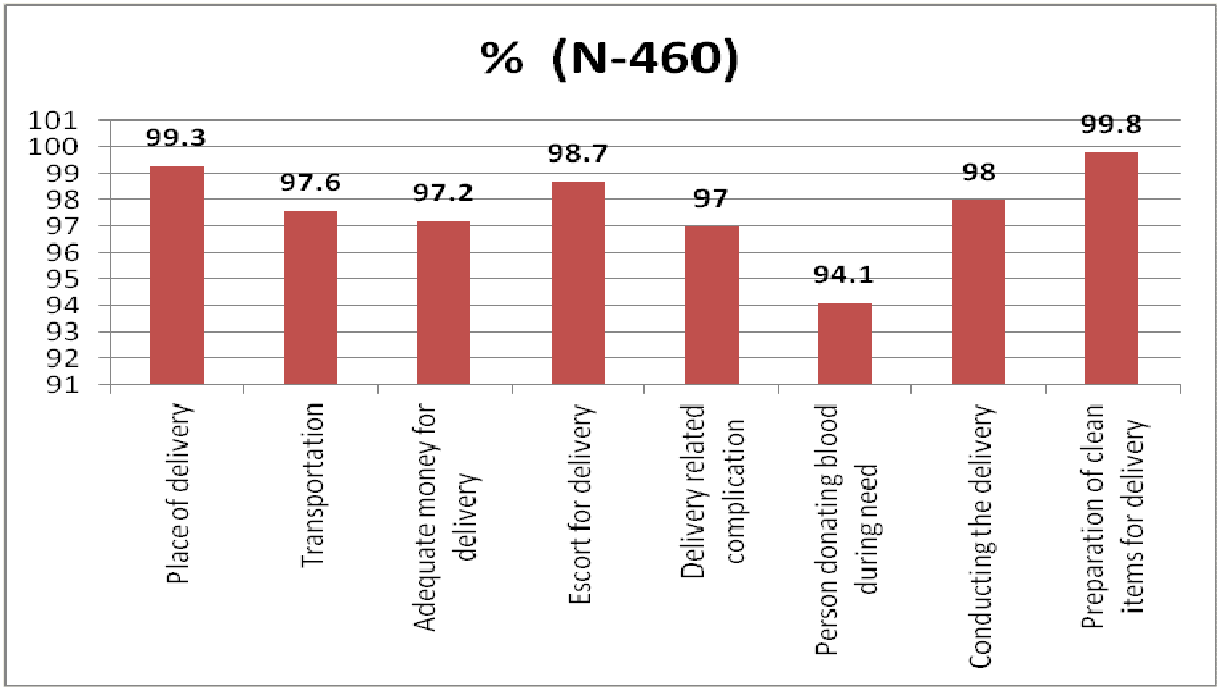
Graph No.14: Counseling Provided by ASHA during Pregnancy



Counseling provided by ASHA during delivery

ASHAs also reported that they provided counseling to village women on delivery, 99.8% on preparation of clean items for delivery followed by counseling on place of delivery (99.3%). About 98.7% of them escorted the women for delivery and arranged the provision of transport (97.6%). ASHAs also reported that they provided counseling to the village women for delivery related complications (97%) and need for person who would donate blood during need (94.1%) and in conducting the delivery (98%) and arranging adequate money for delivery (97.2%).

Graph No.15: Counseling Provided by ASHA during Delivery



Counseling on birth preparedness and Awareness Generation on Health Services

It was reported that about 100% counseling was done by the ASHAs on birth preparedness and 76.96% of them reported that they were provided IEC material for awareness generation. Out of that 99.7% reported that they generated awareness amongst village community after receipt of training material.

Sr.No.	Statements	N	%
1	Counseling on birth preparedness	460	100
2	IEC material provided to ASHA	460	76.96
3	Generating awareness , If training material provided,	354	99.7

Table No.34

Village Health Sanitation & Nutrition Committee Meetings

ASHAs were probed about the Village Health Sanitation and Nutrition meetings (VHSNC) to which it was reported that 72% attended the VHSNC meetings, 99.7% of them briefed the community about the discussions. It was further reported that bank account of VHSNC had been opened in case of 78.26%. Only 8.8% of ASHAs were offered any designation in VHSNC.

VHSNC Meetings	% (N-460)
ASHA attending meetings of VHSNC	72
ASHA briefing community of the discussions taken place in the meetings of VHSNC	99.7
Offered any designation in VHSNC	8.8
Bank account for VHSNC opened	78.26

Table No.35

No. of VHSNC meetings attended by ASHA during 2012-13

No. of meetings attended during 2012-13	Nos.(Average)
No. of meetings of VHSNC attended by ASHA (135 out of 331 i.e 40.7% during 2012-13)	3.9

Table No.36

On being asked, ASHA reported the details of discussions taken place during VHSNC meetings. Their response to topic relating to clean environment in village surroundings, toilets etc accounted as high as 95.4%, about immunization 51.66%, balanced diet accounted for 33.8%, regarding potable water 20.5%, steps to check prevention of infectious diseases accounted for 37.1% and benefits about govt. schemes only accounted for 15.10%.

Topics discussed during these meetings

Sr. No.	Topics discussed during these meetings	N-331	%
1.	Clean environment in village surroundings, toilets etc.	316	95.4
2.	About immunization	171	51.66
3.	Balanced diet and nutrition	112	33.8
4.	Potable water	68	20.5
5.	Steps to be taken for prevention of infectious diseases such as lime powder, bleaching powder, spray etc	123	37.1
6.	Benefits about govt. schemes	50	15.10

Table No.37

Designation of ASHA at VHSNC

Sr.No.	**Designation at VHSNC**	N-29	%
1.	Secretary	7	24.1
2.	Joint secretary	19	65.5
3.	President	3	10.3

Table No.38

Only 29 ASHAs have been offered any designation in VHSNC and the details of designations being held by them are given in above table.

Operation of account of VHSNC

Sr. No.	Operation of account of VHSNC	N-371	%
1	ANM and village pradhan	300	80.8
2	Village pradhan	34	9.16
3	MOIC	7	1.88
4	ANM	30	8.08

Table No.39

80.8% ASHAs reported as mentioned in the above table that operation of bank account of VHSNC is jointly by ANM and village pradhan and in case of operation of account by others accounted for 19.2% (9.16% village pradhan, MOIC 1.88% and 8.08% by ANM)

Reasons for not attending the VHSNC Meetings

It was reported that 48.8% of ASHAs were not called in the meeting and other 2.3% were not interested in going to the meeting and 49.9% ASHA cited some other reasons for not attending the meetings.

Reasons for not attending	**% (N-129)**
Was not called in the meeting	48.8
Was not Interested	2.3
Others	49.9

Table No.40

Counseling on malnutrition provided by ASHA on symptoms of malnutrition:

It was found from the survey that, ASHAs provided counseling to women of the village on malnutrition (98.5%), diarrhea management (99.6%) and acute respiratory infection (95.4%) and creating awareness about symptoms of malnutrition accounted for 95.2%.

Findings	% (N-460)
Counseling on Malnutrition and symptoms	98.5
Diarrhea	99.6
Acute Respiratory Infection	95.4
Creating awareness about symptoms of malnutrition	95.2

Table No.41

Awareness Levels of ASHA about JSY

It was found that 100% of ASHA have heard of JSY and have provided information to eligible women about the benefits of it. 97% ASHAs informed that they received feedback from ANMs on JSY. On being asked to state the benefits under JSY, 100% ASHAs reported that EW would get monetary benefit of Rs.1400 for institutional delivery, 80.4% further reported that transport facility is one of the benefits under JSY, 100% ASHA reported that making available medicines and food to EW as one of the benefit, 93.9% ASHA reported that they are satisfied with the benefits EW are getting under JSY.

JANANI SURAKSHA YOJANA

Sr. No.	Benefits under JSY as listed by ASHA	N-460	%
1.	ASHA heard of JSY	460	100
2.	If yes, state benefits under JSY Monetary benefit of Rs.1400 after institutional delivery to eligible women	460	100
	Making available Medicines and food to EW	460	100
	Transport facility for institutional delivery for EW	370	80.4
3.	ASHA providing information to Eligible Women of the benefits under (JSY)	460	100
4.	ANM giving information to ASHA on JSY	460	97
5.	Satisfied with benefits women are getting from JSY	460	93.9

Table No.42

Reasons for not being satisfied for benefits under JSY

On being asked from EW who reported that they were not satisfied with the benefits EW are getting under JSY, 67.8% cited less payment, bribe at the time of payment, not good behavior of hospital staff with patients accounted for 35.7% and 67.8% respectively as mentioned in the following table:

Sr. No.	Reasons for not satisfied for benefits under JSY	N-28	%
1.	Less payment after institutional delivery	19	67.8
2.	Gratification at the time of payment of incentive	10	35.7
3.	Not good behavior with patients at hospital	19	67.8

Table No.43

ASHAs help to EW under JSY

Janani Suraksha Yojana	% (N-460)
ASHA helping beneficiary in getting incentive under JSY	98.0
ASHA knowing benefits under JSY in case of delivery at home	65.4

Table No.44

65.4% of ASHA knew about the benefits under JSY in case of delivery at home and 98% ASHA reported that they have helped beneficiaries in getting benefits under JSY as mentioned in above table.

Basis for payment to beneficiaries for delivery at home under JSY

Sr. No.	If yes, basis for payment to beneficiaries for delivery at home	N-301	%
1	BPL family	301	100
2	Not more than 2 children	298	99
3	Age of woman should be above 18	184	61.12

Table No.45

On being asked the basic criteria for payment under JSY, 100% ASHA reported that BPL member would get benefit, not more than two children 99% and age of woman should be above 18 was reported by 61.12%.

Benefits to JSY beneficiaries for institutional delivery and delivery at home

Sr. No.	Benefits to beneficiaries	N-301	%
1	Medicines	92	30.5
2	ANC, PNC	48	15.9
3	Incentive of Rs.500 for delivery at home	205	68.1
4	Incentive of Rs.1400 for institutional delivery	181	60.1
5	Free transportation	79	26.2
6	Birth certificate	15	4.9
7	Immunization to woman and child	46	15.2

Table No.46

To list the benefits under JSY for institutional and delivery at home, ASHA reported various benefits as mentioned in the above table.

No. of beneficiaries under JSY

No. of beneficiaries under JSY during 2012-13	7924

Table No.47

No. of beneficiaries under JSY are 7924 as reported by ASHAs as mentioned in the above table.

Source for information of receipt of benefit by EW

Sr. No.	Source for information of receipt of benefit by EW		%
1	From MOIC/ANM	N-451	31.0
2	From records at BPHC/CHC		8.0
3	From beneficiaries		36.0
4	Others		25.0

Table No.48

On being probed 31% ASHA reported that they got information regarding source of payment to JSY beneficiaries from MOIC, from records at BHPC/CHC accounted for 8%, they got to know from beneficiaries (36%) and 25% ASHA got information regarding payment to ASHA under JSY from other sources.

Reporting birth/death and maternal death reporting

Statement	%
ASHA recording birth/death in VHIR (N-460)	97
ASHA reporting maternal death (**N-441)**	95.9
i) At once	73.4
ii) Within 24 hours	23.1
iii) After 24 hours	3.4

Table No.49

The study reveals that 97% respondents recorded births and deaths in the VHIR, whereas 95.9% ASHAs reported on maternal deaths. The maternal deaths reported at once accounted for 73.4%, while those reported within 24 hours accounted for 23.1% and after 24 hours were accounted for 3.4%.

Entries of women and children in VHIR

Sr.No.	Statement	% (N-460)
1	ASHA making entries of pregnant women and children up to 1 year in the VHIR after survey	96.5
2	ASHA escorting pregnant woman to Hospital/CHC/PHC for ANC	99.3

Table No.50

In addition to this, 96.5% ASHA reported that they had made entries in VHIR of pregnant woman and children up to one year and 99.3% of them escorted the pregnant woman to hospital or sub health center for ANC.

During 2012-13, ASHA reported 35 maternal deaths.

Maternal deaths reported during 2012-13	Nos.
Maternal deaths reported	35

TableNo.51

Sr.No.	Knowledge about symptoms relating to for complications of expectant mothers (complications during pregnancy)	% (N-460)
1	Knowledge about symptoms	100.0

TableNo.52

With regard to knowledge about symptoms relating to complications of expectant mothers, 100.0% ASHA reported that they have knowledge of the same and on being asked; they mentioned the symptoms as mentioned in the following table:

List of symptoms relating to complications during pregnancy

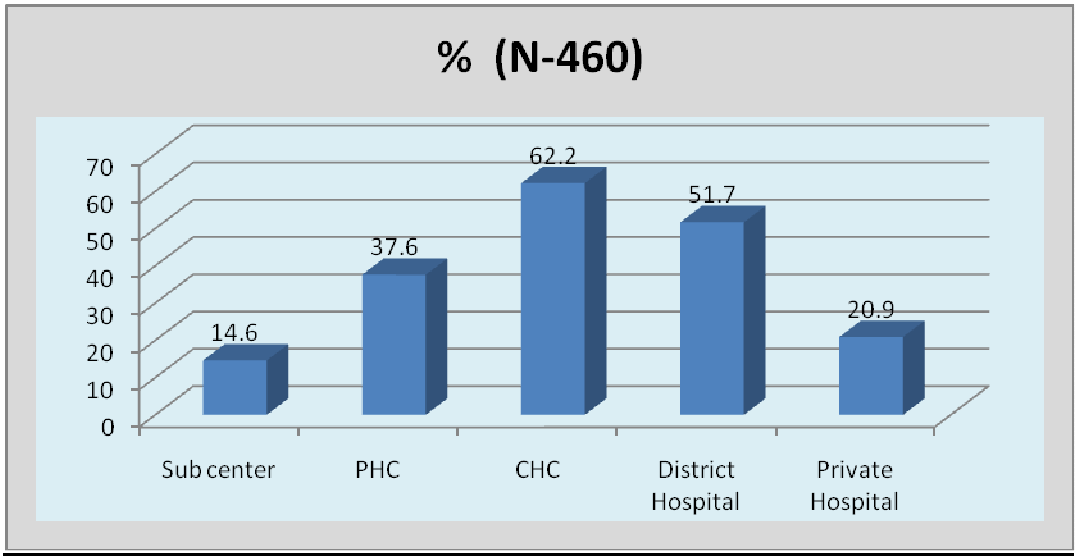
Sr. No.	List of symptoms relating to complications during pregnancy as described by ASHA	N-460	%
1.	Jaundice	182	39.5
2.	Low weight and weakness	48	10.4
3.	Blood pressure	76	16.5
4.	Swelling in hands and feet	384	83.4
5.	Leucorrhea	27	5.86
6.	Feeling giddiness	221	48.0
7.	Excessive vomiting	194	42.1
8.	Fever	37	8.0
9.	Excessive bleeding and anemic	242	52.6

Table No.53

If yes, preference of Health Facility in case of complications during pregnancy

The following graph depicts the preference of the ASHAs of the health facility while dealing with the complications during pregnancy. About 62.2% of them preferred community health centers, followed by district hospitals (51.7%), followed by primary health centers (37.6%) and sub centers (14.6%). The primary hospitals accounted for 20.9% as far as the preference of ASHA is concerned.

Graph No.16



Support Services provided by ASHA

It was reported from the survey held with ASHAs that 98.5% of them escorted the women to the health facility, 92.4% of them arranged transport for the pregnant women and 94.1% ensured immunization of the child.

Services	% (N-460)
Escort to the Health Facility for delivery	98.5
Arranging transport for pregnant woman	92.4

Table No.54

Immunization to child before discharge from hospital

Sr.No.	**Immunization to child**	N	%
1.	Immunization to child before discharge from hospital	460	94.1
2.	**If so, details of immunization**		
	1. Polio 0 dose	433	99.8
	2. BCG		98.8

Table No.55

The above table depicts that 94.1% of children were immunized before discharge from hospital and on further being asked, 99.8% and 98.8% reported that Polio 0 dose and BCG were administered to children before discharge from hospital.

No. of institutional delivery and deliveries at home

Sr.No.	**Deliveries**	**Nos.**	**Avg. per ASHA**
1	Institutional deliveries	10450*	22.72
2	Deliveries at home	4271	9.28

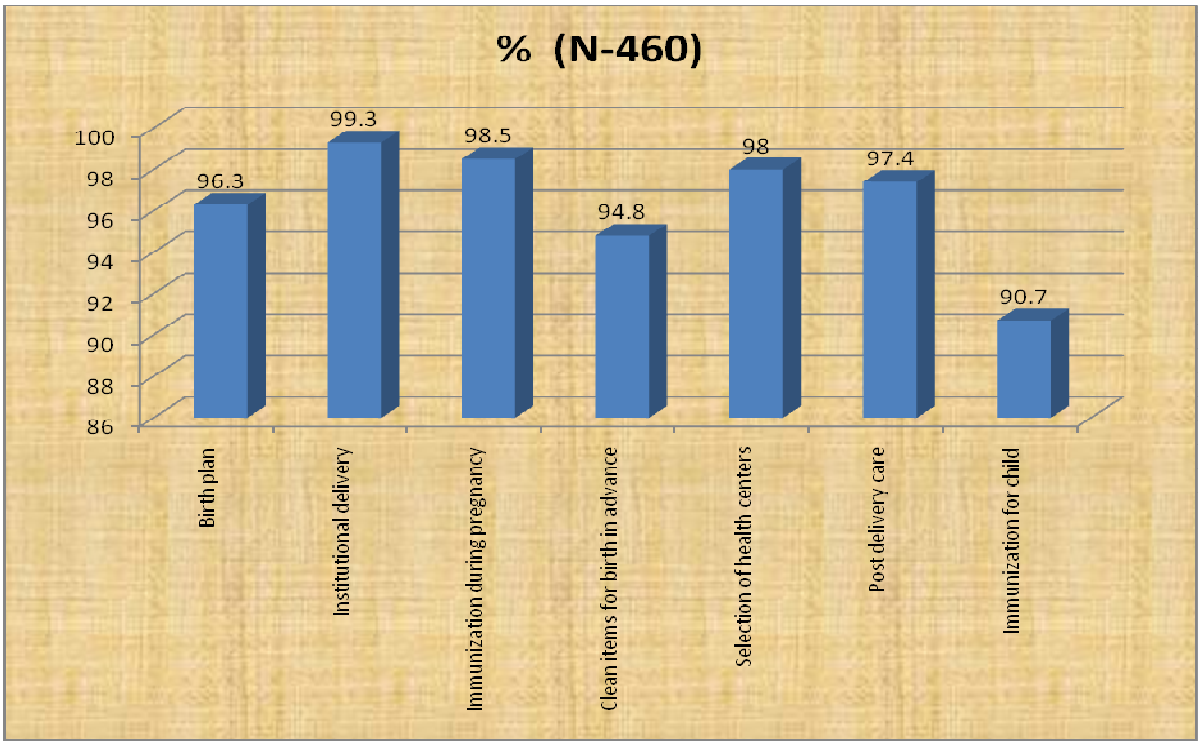
Table No.56

*Note: ASHAs reported that they referred 189 delivery cases to private hospitals, nursing homes.

Support Services related to Birth Preparedness

ASHAs were probed for the various support services they provide to the village women, with 96.3% ASHA reported that they counseled the stakeholders for birth plan. 99.3% of them counseled the women for institutional delivery, immunization during pregnancy accounted for 98.5%. The selection of health centers accounted for 98%, while clean items for birth in advance, post delivery care and immunization for child accounted for 94.8%, 97.4% and 90.7% respectively.

Graph-17: Support Services related to Birth Preparedness



Precautions suggested during delivery at home

It was reported from the survey that almost 100% ASHAs created awareness among the women for clean room, clean sheet, unused blade, thread and soap as precautions to be taken during delivery as mentioned in the following table:

Items	% (N-460)
Clean Room	98.5
Clean sheet	99.6
Unused blade	99.8
Thread	99.6
Soap	99.6

Table No.57

Assisted in delivery during 2012-13

Statement	Nos.	Average per ASHA
No. of deliveries assisted by ASHAs	8393	18

On an average, ASHA assisted in 18 deliveries during 2012-13.

Table No.58

Visits to Eligible Women after delivery

ASHAs visited eligible women after delivery. 55% of them reported that they made twice a week visits to the women after delivery while 42.4% of them made visits immediately after delivery. 2% and 0.6% made visits after a week and within a month respectively.

Time of meeting	% (N-460)
Immediately after delivery	42.4
Twice in a week	55.0
After a week	2.0
Within a month	0.6
Not at all	0.0

Table No-59

ASHAs pay visits to the new born and monitor the growth. ASHA reported that 38.3% of them paid visits up to 6 to 7 times while more than 7 times visits were reported by only 4.6% of them. Further it was reported that in total 57.2% paid visits either once, twice, thrice or four to five times.

Home visits to new born	% (N-460)
Once	10.4
Twice	24.6
Thrice	12.4
4 to 5 times	9.8
6 to 7 times	38.3
More than 7 times	4.6

Table No.60

Care to new born in case of complications and PNC

Other Relevant findings	% (N-460)
Escorting infant to health facility in case of complications within 42 days	71.3
Counseling to mothers for PNC	100%

Table No.61

New born was escorted to the health facility in case of complications within 42 days was reported by 71.3% of ASHA and counseling to mothers for PNC accounted for 100%.

In case of need, Eligible women are referred to following health facilities:

Sr.No.	Statement		%
1.	Referring to District Hospital	**N-460**	61.5
2.	CHC		67.2
3.	PHC		43.9

Table No.62

In case of need, EW are referred to above facilities, 61.5% ASHA reported that they were referred to District Hospital, CHC and PHC accounted for 67.2% and 43.9% respectively.

Relevant Findings related to Services Provided by ASHA

Counseling on family planning after delivery

Sr. No.	Statement	N	%
1	Referring women to hospital after delivery, if needed	460	100
2	Counseling on family planning after delivery during 2012-13	460	100

Table No.63

Counseling on family planning after delivery and referring to women to hospital after delivery accounted for 100%.
No. of cases of family planning as reported by ASHAs are mentioned below:

If so, numbers of cases during 2012-13 (Family planning cases)

Sr. No.	No. of cases	**Nos.**	**Avg. per ASHA**
1	Male sterilization	26	0.06
2	Female sterilization	1707	3.71
3	Temporary methods	9214	20.03
4	Others	491	1.07

Table No.64

Male sterilization is only 26 whereas female sterilization is on higher side i.e.1707, temporary methods and other methods accounted for 9705.

Supply of drug kits during 2012-13

Sr.No.	Statement	% (N-460)
1	Received Drug Kit during last financial year 2012-13	24.35
2	Regularly getting medicines from hospital	23.70

Table No.65

With regard to query regarding drug kit received during 2012-13, 24.35% nodded positive and only 23.70% responded that they are getting regular medicines from hospital.

On further being asked, ASHAs reported that they received following medicines during 2012-13: Only paracetamol, Betadine and ORS were mainly received which accounted for 83%, 55.3% and 58% respectively by ASHA.

Details of medicines received during reference period 2012-13

Sr. No.	Medicines received during reference period 2012-13	N-112	%
1.	Paracetamol,	93	83.0
2.	Vitamin A	4	3.57
3.	Betadine	62	55.3
4.	ORS	65	58.0
5.	Mala D	23	20.5
6.	IFA	38	33.9
7.	Pneumoslide	3	2.67
8.	Septron	2	1.78

Table No.66

Village Health Index Register

The table below creates an understanding that about 97.39% of the ASHAs have heard about VHIR and have made entries in it (94.78%). It was further reported that 88.26% said to have received training to make entries in VHIR, 97.6% ASHAs are updating the list of children and report to ANM regularly, 58.26% of 98.1% ASHA reported that they have received incentive of Rs.500 for updating the register and 1.9% respondents reported to have received less than Rs.500 for updating VHIR.

Village Health Index Register	**% (N-460)**
Aware of Village Health Index Register (VHIR)	97.39
Making entries in Village Health Index Register (VHIR)	94.78
Imparted training to make entries in VHIR	88.26
Update the list regularly of children and report to ANM	97.6
Got any incentive for updating the register	58.26
If yes, Rs. 500 amount received for updating the register	98.1
Received amount less than Rs. 500	1.9

Table No.67

Payment of Incentives

Got any ASHA Payment voucher from Hospital	82.2

Table No.68

82.2% ASHAs reported that they got payment vouchers from Block PHC/CHC.

ASHA reported as under that they are receiving incentive for following services and the amount of incentive against each service is mentioned below as mentioned by them

Provision for incentive for services provided and the amount of incentive as reported by ASHA

Sr. No.	Services	Amount
1.	Complete immunization	100
2.	Routine Immunization	150
3.	Polio	75
4.	**Sterilization** Male Female	 200 150
5.	TB control (complete)	250
6.	Blindness control	20
7.	Institutional delivery	200
8.	Escorting women to hospital in case of complications during pregnancy	200
9.	Birth/death registration	20
10.	Attending Block level meetings	50
11.	Maternal death reporting	50
12.	Leprosy (complete)	500
13.	VHIR writing	500
14.	Home visits to new born and mothers (6-7 visits)	250

Table No.69

AMOUNT CLAIMED AND AMOUNT RECEIVED DURING 2012-13

Sr.No.	Amount	Average per ASHA
Amount claimed	4151393	9025
Amount received	4115823	8947

Table No.70

Incentive while assisting ANM in vaccination

Contents	% (N-225)
Got incentive voucher while assisting ANM in getting women and children vaccinated in the village on immunization day	91.1

Table No.71

The tables above depicts the payment of incentives to the ASHAs during 2012-13 and 91.1% of them reported that they got incentive voucher while assisting the ANMs in getting women and children vaccinated on immunization day.

Submission of claim for Incentive

It was reported that 54.89% of ASHA submitted their monthly claim form for incentive, while 45.10% (26.25% within 7-10 days and 18.85% within 10-20 days respectively) of them reported that they submitted the claims between 7 to 20 days.

Within	% (N-460)
7-10 days	26.25
10-20 days	18.85
More than 20 days	54.89

Table No.72

Reasons for not getting full payment

ASHAs were probed for not getting full payment and they faced hardships faced accounted for a larger percentage of 73% while 21.6% reported that funds were not available and 2.7% each reported that forms were not filled properly and rules were not followed.

Reasons for not getting full payment	% N 74
Funds not available	21.6
Forms not filled properly	2.7
Rules not followed	2.7
Others (various hardships faced) such as abnormal delay, bribery etc.	73.0

Table No.73

Incentive in cash for services provided

Sr. No.	**Incentive received in cash for services provided**	N 460	%
1.	Sterilization	403	87.3
2.	Polio	418	90.80
3.	Filaria	51	11.08

Table No.74

ASHA reported that they are getting incentive in cash for above services. Sterilization accounted for 87.3%, Polio 90.80% and Filaria accounted for 11.08%

Difficulties faced while receiving incentive in cash

Sr. No.	**Incentive received in cash for services provided**	% (N-460)
1	Facing hardships for getting incentive	48.26

Table No.75

Time Gap between Submission of Claim Form and Receipt of Incentive

It was revealed in the survey findings that 72.2% of ASHA got their claims after 20 days from the date of submission of claims. 27.8% ASHA informed that 7-20 days was the time gap between form submission and receipt of incentive.

Within	**% (N-460)**
7-10 days	12.6
10-20 days	15.2
More than 20 days	72.2

Table No.76

Receipt of travel exp. for attending Block PHC/CHC meeting

Receipt of travel exp. for attending Block PHC/CHC meeting	**% (N-460)**
Receipt of travel exp.	84.35

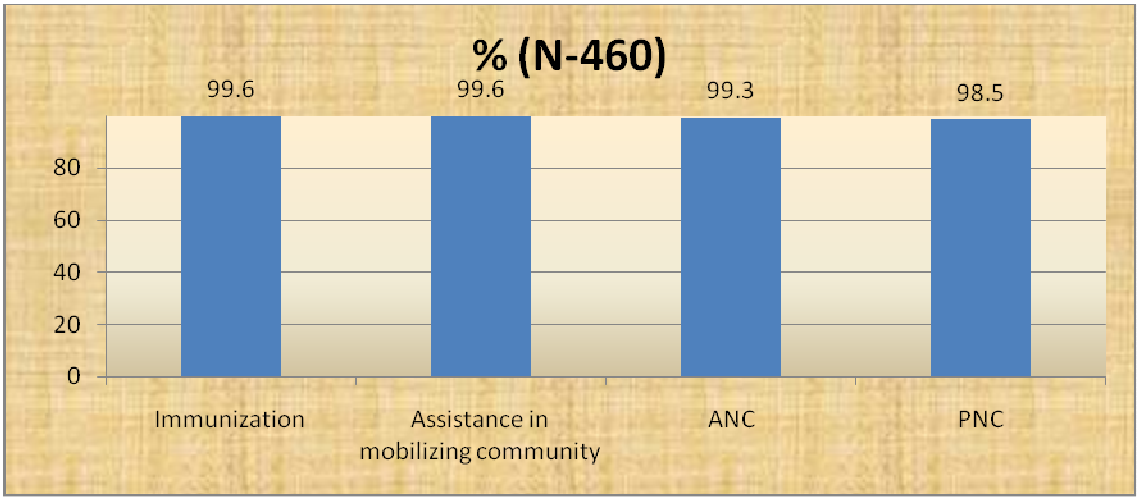
Table No.77

84.35% ASHA reported that they are getting travel exp. for attending meeting at Block PHC/CHC

Cooperation given by ASHA to ANM:

It was revealed during the survey that ASHA cooperated with ANM maximum during immunization and provided assistance in mobilizing the community (99.6%). Cooperation has also been provided in ANC and PNC (99.3 and 98.5% respectively).

Graph No.18: Cooperation given by ASHA to ANM.



Frequency of Meeting with ANM in connection with work

In order to understand, the frequency of meetings of ASHAs with ANMs in connection with work, it was reported by 53.9% of ASHAs that they met ANMs only when it was required while 3.5% informed that they met daily, the other 36.5% met either once or twice in a week, whereas another section of 1.5% and 4.6% met once in a fortnight and monthly respectively.

Frequency of Meeting	% (N-460)
Daily	3.5
Twice in a week	23.0
Once in a week	13.5
Once in fortnight	1.5
Monthly	4.6
As and when feel the need	53.9

Table No.78

Help to ANM to bring women and children to vaccination site

Help to ANM to bring women and children to vaccination site	% (N-460)
Bringing women and children for vaccination to vaccination site	100%

Table No.79

100% of ASHAs reported that they are bringing women and children to vaccination site for vaccination.

Cooperation received by ASHA from her superiors

It was found out from the survey that the cooperation received from ANM by ASHA, was 98.7%.

Statements	% (N-460)
Cooperation received from ANM	98.7

Table No.80

Cooperation received from ANM on following issues

Statements	% (N-454)
Information on JSY and other schemes	91.85
Home visits with ASHA	89.20
Help in maintaining the books	94.27
Others	3.08

Table No.81

It was further reported by 91.85% ASHAs that they get information on JSY and other govt. schemes and 89.20% ASHAs reported that ANMs make home visits with them. 94.27% ASHAs reported that ANMs are helping them in maintaining the books and others in this regard accounted for only 3.08%.

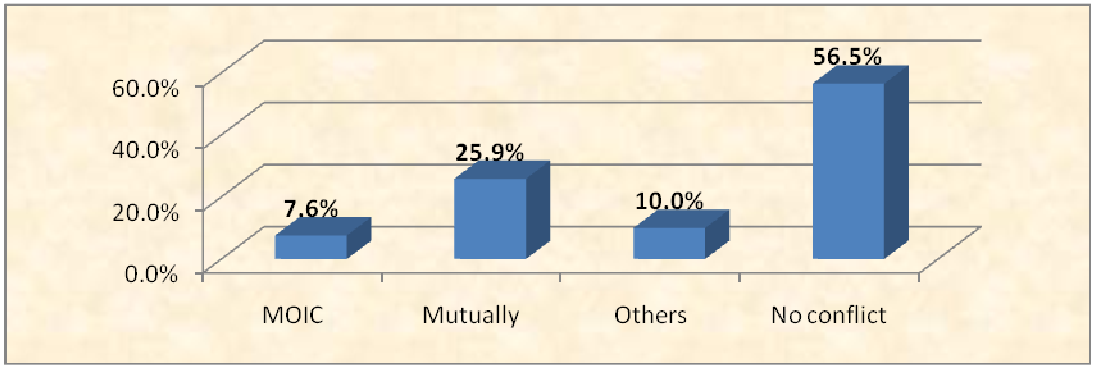
Conflict with ANM

Conflict with ANM % (N-460)	13.48

Table No.82

Only a minimal percentage of 13.48% reported that they had a conflict with the ANM in the past one year.

Conflict with ANM - Conflict resolution between ASHA and ANM – Graph No.19



As the above graph depicts, in case of conflict with ANM and how it is resolved, 7.6% reported that they bring the same to the knowledge of MOIC, they resolve the conflict mutually accounted for 25.9% and help of others accounted for 10%. 56.5% ASHA reported that they do not have any conflicts.

Difficulties being faced in performing her duties

Sr. No.	**Difficulties being faced in performing the duty**	N-460	%
1	Lack of awareness for immunization	220	47.8
2	Administration of polio drops	57	12.39
3	For institutional delivery	111	24.13
4	Family planning method	32	6.95
5	Less payment of incentive after work	117	25.4
6	Sterilization	9	1.95
7	Lack of transport	132	28.6
8	No timely payment	103	22.3
9	Extracting money by hospital staff from beneficiaries	43	9.34
10	Late payment of incentive under JSY	15	3.26
11	Non availability of medicines	150	32.6
12	More population coverage in the service area and non availability of VHIR	10	2.17

Table No.83

As per above table, on being asked, ASHAs reported their difficulties as mentioned in the above table. Lack of awareness for immunization accounted for 47.8% followed by lack of transport (28.6%) and non availability of medicines at 32.6%. No timely payment of incentive accounted for 22.3%, less payment of incentive accounted for 25.4%. 9.34% ASHA reported that money is being demanded for clearing her dues. 3.26% ASHA reported less payment under JSY and 2.17% reported more population coverage as one of the difficulties being faced by them during her day to day work. 12.39% ASHA reported that they in administration of polio drops, they find difficulties in villages, 24.13% reported difficulties in institutional deliveries and family planning methods accounted for 6.95%. Difficulties with regard to sterilization accounted for 1.95%.

Meetings at Block level PHC/CHC

Sr. No.	Meetings at Block level PHC/CHC	N	%
1	Meetings at block level – monthly as reported by ASHAs	396	
	i) One meeting		85.35
	ii) Two meetings		11.11
	iii) Three meetings		1.26
	iv) Four meetings		2.27
2	**No. of attendance of meetings during 2012-13**	455	
	i) Less than 12 meetings		35.38
	ii) 12 meetings		53.41
	iii) More than 12 meetings		11.21

Table No.84

85.35% ASHAs reported that on an average, one meeting per month is being held,11.11% respondents reported that 2 meetings are held every month, 1.26% respondents reported that 3 meetings per month and 2.27% respondents reported that they 4 meetings are being held per month at Block PHC/CHC. On further being asked, ASHAs reported that they attended less than 12 meetings, % reported that they attended 12 meetings, and % reported that they attended more than 12 meetings during 2012-13.

Meetings with pregnant women and adolescent girls during Financial Year 2012-13

ASHA has a mandate to hold discussions and meetings with the adolescent girls and women on reproductive and health issues. On probing the same, it was found that 28.48% of them did not hold any meetings, while 2.39% of them had held at least one to five meetings, while 46.2% of them had held six to 15 meetings. Nearly, 31.7% of them had held 11-15 meetings and 2.8% held 16-20 meetings in the last financial year.

Average number of meetings with pregnant women & adolescent girls during last financial year	**% (N-460)**
0	28.48
1 – 5	2.39
6 – 10	14.5
11 – 15	31.7
16 – 20	2.8
21 and above	20.22

Table No.85

Topics discussed during these meetings

ASHAs reported that the following topics are discussed in the above meetings: PNC and immunization are on top agenda i.e. 87.82 followed by hygiene 69.5% ASHA reporting, 40.6% on balanced diet and malnutrition, breastfeeding only 16.30% ASHA reporting and others accounted for very small percentage. 13.4% ASHA reported that Family planning issue is also discussed and on AIDS, it is only 10.8%.

Sr. No.	Topics discussed during these meetings	N-460	%
1.	Hygiene	320	69.5
2.	Institutional delivery	65	14.13
3.	Breastfeeding	75	16.30
4.	Balanced diet and malnutrition	187	40.6
5.	PNC and immunization	404	87.82
6.	Ideal age of marriage	4	0.86
7.	Menstruation	35	7.6
8.	Family planning	62	13.4
9.	AIDS	50	10.8

Table No.86

Type of registers carried to these meetings

Sr. No.	**Type of registers carried to**	N-460	%
1.	ANC registration	175	38.0
2.	Adolescents register	126	27.3
3.	Immunization	119	25.8
4.	VHIR	35	7.6
5.	Proceeding book	204	44.3
6.	JSY register	10	2.17
7.	Birth/death register	50	10.86

Table No.87

On being asked the registers carried by them to above meetings, ASHA reported as above. Proceeding book accounted for 44.3% followed by ANC registration 38.0%, adolescents register 27.3%, immunization 25.8%, VHIR 7.6%, JSY register 2.17% and birth/death register accounted for 10.86%.

Cooperation from MOIC/HEO

Sr.No.	Relevant findings	N	%
1.	Cordial attitude of MOIC/HEO	460	97.0
2.	Facing any difficulty in dealing with MOIC/HEO	460	3.0
3.	**If so, approaching whom**		
	I. Senior officers		69.2
	II. Mutually		15.4
	III. Others		15.4

Table No.88

97% of the ASHA shared a cordial relations with the MOIC and HEO. Only 3% ASHA reported that they faced any difficulty with MOIC/HEO and incase of difficulties, they approached their seniors (69.2%), others 15.4% and they mutually resolved the issues also accounted for 15.4%.

Cooperation from MOIC/HEO and Redressal of grievances

Statement	%
Cooperation from MOIC/HEO and Redressal of grievances	95.86

Table No.89

95.86% ASHA reported that they are getting cooperation from MOIC/HEO and redressal of their grievances.

Nomination for any award

Statement	N	%
Nominated for any award in connection with your services as ASHA	460	15.9
If yes, details 1st prize	73	41.10
2nd prize		20.55
3rd prize		38.36
If not so, feeling of ASHA that her work is not recognized	460	79.9
Satisfied with job	460	100

Table No.90

15.9% of them were nominated for any award in connection with services they have provided as ASHA. Out of 73 ASHAs, 41.10% got 1st prize, 2nd and 3rd accounted for 20.55% and 38.36% respectively. On being probed, 79.9% ASHA reported that they have the feeling that their services are not recognized, though 100% of them responded that they are satisfied with their job.

In addition to above findings, followings are the problems that have been reported by the ASHAs during one to one discussion held with them and suggestions given by them:

- **Irregular supplies of medicines/no replenishment of drug kit/no Medicines at hospitals**

The majority of ASHAs stated that the medicines are not being supplied on time. Few of ASHAs informed that they have not been provided with the medicines since last year. They feel embarrassed when people ask for medicines for illnesses, e.g. fever, diarrhea, polio vaccines etc. While few of ASHAs reported that there is a problem of replenishment of drug kits and drugs have not been replenished at all. A large number of ASHAs also reported that the medicines & other relevant materials, used during delivery are, generally, not available in SHC/PHC or even CHC. The concerned people are compelled to purchase these things from the open market.

- **Poor Conditions of Health Facilities**

It was reported by some of the ASHAs that many health facilities are running in poor health conditions. They reported that there is no regular supply of electricity, no availability of drinking water, no proper sitting arrangements, unhygienic toilets, dusty & dirty rooms & galleries etc. Some health facilities are running in the rented buildings, which are in bad conditions & need repair work. Poor infrastructure is one of the major reasons why people do not prefer to conduct delivery at government health facilities.

- **Less Incentives and No Provision of Fixed Salary**

Most of ASHAs feel that the incentives being given under ASHA scheme are very less in some activities, such as sterilization, pulse polio, routine immunization. Even some ASHAs complained that no incentive is being given in case of TB patients, delivery at CHC, for attending the meetings at BPHC. A few of them told that no incentive is paid to them for delivery at home even after receiving full ANC by the concerned women. In addition, to this some of them reported that their services are being taken for 24 hours without any leave or rest, and then also they are not paid a fixed salary. Number of ASHAs stated that present system of payment is defective. They are being paid less amount for filling VHIR & some other activities.

- **Difficulty in convincing people on health issues**

  Some ASHA stated that they face difficulty in convincing people for polio, immunization, institutional delivery & sterilization. People especially Muslim women & of lower strata of society do not cooperate in this matter. They also do not show any interest for having the TT injections during the time of pregnancy. People are not aware on health issues. They believe in superstitions and follow some old practices or customs. They do not know why to get the benefits of health programmes, since they do not take the counseling of ASHA seriously. Few of ASHAs reported that casteism also hampers the progress of work.

- **Problems related to Transportation**

One of the major problems faced by the ASHA is lack of transportation. They face the problem in taking the pregnant women & infants in case of complications to health facilities especially at night. Apart from this, there is no facility of transportation in case of sterilization. A significant number few also reported that a large area has allotted to them, therefore they are facing the problem of mobility within the village. Though they have to move to many sub hamlets, yet no vehicle (cycle) has been provided.

- **Bribe Demanded by Health Officials**

Some ASHAs reported that health officials & staff members demand money before getting their cases clear, i.e. Rs. 2000/- per annum by doctors, Rs.250/- per delivery by ANM, Rs. 100/- for issuing JSY cheques by clerical staff. The money is also demanded for getting the birth certificates or immunization cards etc. Rs. 500/- is taken from ASHA, who obtains 1st prize in ASHA *Sammelan*. Nurses demand Rs.500 to 700/- per delivery from beneficiaries. Rs. 200/- is taken for 108 ambulance from beneficiaries.

- **No night halt facility**

Many ASHAs reported that they face the problem for night halt, when they take patients to the health facilities. There is no room for taking rest a while or night halt. Even there is no facility of night halt for the lactating mothers for staying there for 48 hours.

- **Non Cooperation of the Health Staff with the ASHA**

Many ASHAs reported that health staffs at SC/PHC/CHC/DH do not cooperate with them. ANMs do not conduct the routine immunization regularly in the village. Even ANMs do not inform about routine immunization. ANMs do not provide & verify the ASHA payment vouchers on time. In some health facilities, Doctors & nurses are very careless about patients. They do not care for patients. Some nurses torture the patients. Most of times, Doctors are found absent from hospitals. Nurses refer the cases to District Hospital. In some SC, ANM is not appointed for long time. Keeping in view, people do not prefer to go to Government health facilities. They also pointed out that the Pradhans of the village also do not cooperate with them in promoting the health programmes.

- **Unavailability of Lady Doctor**

Few ASHAs reported that there is no lady doctor in some health facilities, thus people do not prefer to have a delivery at government facilities.

Therefore in view of above, ASHAs suggested that remedial steps in these regard may be taken to redress their grievances and problems and difficulties being faced by them in their day to day work should be redressed.

- **RESPONDENTS: ANM**
- **Sample: 225**

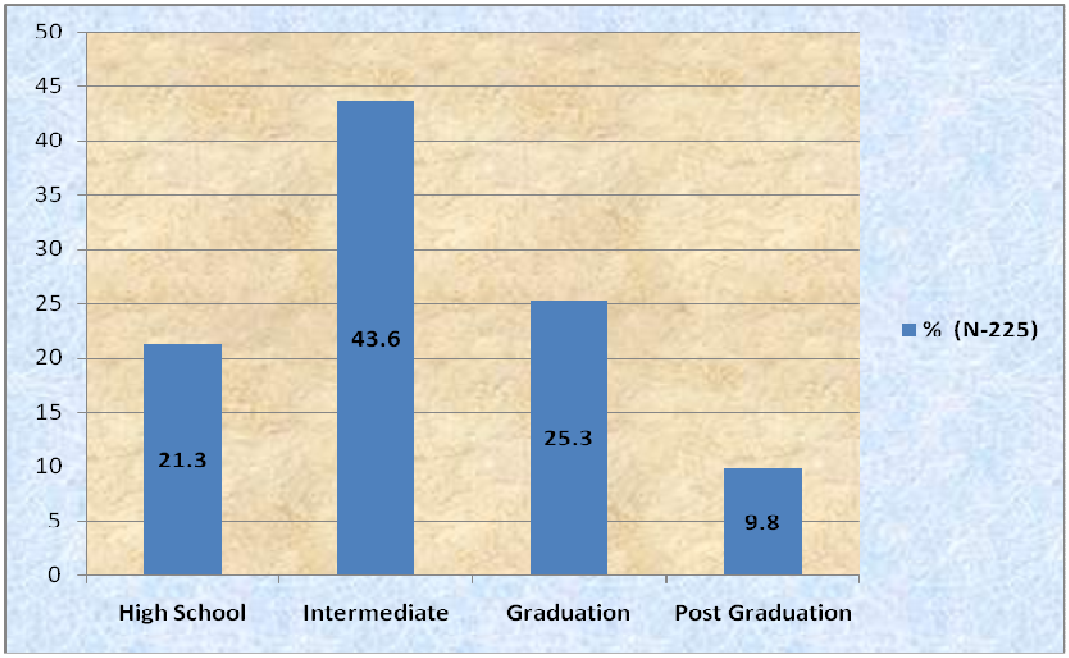
Selected characteristics of respondents

- **Median age = 44 years**
- **No. of years of service – 17 years (average)**
- **No. of ASHAs working under ANM – 5**

Educational Profile of ANM

It was found out from the survey that 43.6% of ANMs had their intermediate cleared, while 25.3% of them were graduate and 21.3% of them had passed high school. Only 9.8% of them were post graduates.

Graph No.20: Educational Profile of ANM



ANM working in her respective centre

1.	ANM working in her centre (average service period)	10 years

Table No.91

Sr. No.	Statements	N	%
1.	ANMs residing in the same village where sub centre is located	225	14.70
2.	ANM residing in the same village for less than 3 years	34	3.0
	ANM residing in the same village for more than 3 years	34	97.0
3.	ANM getting report from ASHA on birth/death	225	96.4
4.	**Time Taken to reach sub centre**	**N**	**%**
	Less than One hour	186	81.72
	One hour	186	16.13
	Two hours+	186	2.15

Table No.92

During field survey, it has revealed that only 14.70% of ANMs are residing in the village where their respective sub centres are located and large number of ANMs (85.30%) are not residing in the villages where their respective sub centres are located. Out of 34 ANMs, 97% ANMs are residing in the village for more than 3 years and only 3% of ANMs are residing in the same village for less than 3 years. 96.4% ANMs reported that they are getting report on birth/death from ASHA. They further reported (81.72) that it takes less than one hour to reach to their sub centre, 2.15% respondents reported that it takes more than 2 hours to reach her respective sub centre while 16.13% respondents reported that it took them one hour to reach their respective sub cetnre.

Population Covered by ANM

NRHM seeks to provide minimum two ANMs (against one at present) at each Sub-Centre, as one ANM at a sub-centre has not been found adequate to attend to the complete needs of maternal and child care in any village.

In order to understand the component of the population covered by the ANM, they were probed on this issue. It was reported that large number of ANMs (57.8%) of them covered population between 5,000 to 10,000, while 26.6% covered more than 10,000 population and 15.6% of them covered between 3,000 to 5,000 segment of population. The following table points out to huge gap.

Population	% (N-225)
3000 – 5000	15.6
5000 – 10000	57.8
More than 10,000	26.6

Table No.93

Average number of villages covered by ANM

1.	Average number of villages catered by ANMs	N-225	6.38

Table No.94

Average villages covered by each ANM is 6.38 villages

Roles and Responsibilities as specified by ANM

1.	ANM understands her role and responsibility	225	99.6%

Table No.95

On being asked, 99.6% ANMs reported that they understood their roles and responsibilities as mentioned above.

Role and responsibilities of ANM as reported by them

Sr. No.	**Role and responsibilities of ANM as reported by them**	N-224	%
1.	Immunization	224	100
2.	Family planning	150	66.9
3.	ANC registration	176	78.5
4.	PNC	55	2.23
5.	Institutional delivery – awareness generation of JSY benefits	193	86.1
6.	Birth/death registration	46	20.5
7.	Taking care of infant	49	21.8
8.	Leprosy treatment	24	10.7
9.	TB control	25	11.16
10.	Blindness control	9	4.01
11.	Cooperation to ASHA	30	13.39
12.	Village sanitation	45	20.08

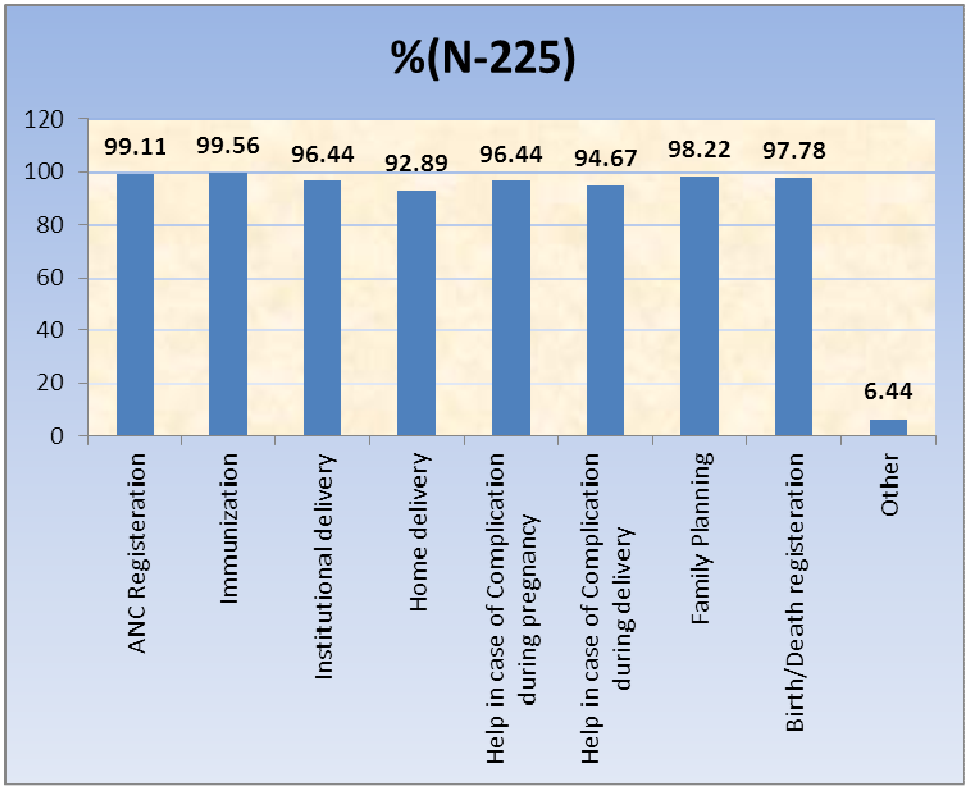
Table No.96

On being probed, ANMs listed their role and responsibilities as above. Immunization, Family Planning, ANC registration, Institutional delivery accounted on top i.e 100%, 66.9%, 78.5%, 86.1% respectively). PNC accounted only 2.23%, birth/death registration 20.5%, taking care of infant 21.8%, leprosy, TB Control, Blindness control accounted for 10.7%, 11.16%, 4.01 respectively, Village sanitation accounted for 20.08% and cooperation to ASHA accounted for only 13.39%.

Support received by ANM from ASHA

As far as the support received from ASHA by ANM is concerned 99.56% of them reported that ASHA provided support for immunization, 99.11% provided support for registration for ANC, 98.22%, of them get support in family planning and reported birth and death (97.78%), 96.44% reported that support was provided in case of complications during pregnancy and delivery and institutional delivery accounted for 96.44, help in case of delivery accounted for 94.67%, others 16.44%, home delivery 92.89%.

Graph No.21: Support Received by ANM from ASHA



Janani Suraksha Yojana

Sr.No.	Janani Suraksha Yoyana (JSY)	% (N-225)
1.	ASHA helping ANM in JSY cases	99.6
2.	ANM satisfied with incentive women are getting under JSY	96.4

Table No.97

With regard to JSY, it was reported by 99.6% ANMs that they are getting cooperation from ASHAs and 96.4% of ANMs reported that they were satisfied with the incentive eligible women are getting under JSY.

No. of women who have benefitted under JSY with cooperation from ASHA

Sr. No.	Institutional deliveries	Nos.	Average per ASHA
1	No. of institutional deliveries	10263	22.31
2	ANM assisted in deliveries at home	1641	3.57

Table No.98

No. of institutional deliveries are 10263 and ANM has assisted in 1641 deliveries at home.

Delivery of cheques towards incentive under JSY

On being probed, it was reported delivery of cheques to beneficiaries are delivered through followings: 71.6% ANMs reported that MOIC delivered the cheques while others accounted for 28.6%.

Sr. No.	Delivery of cheques towards incentive under JSY through	% (N-225)
1	MOIC	71.6
2	ANM	4.0
3	ASHA	13.8
4	SELF	1.8
5	Others	16.4

Table No.99

ASHA reporting birth/ death to ANM

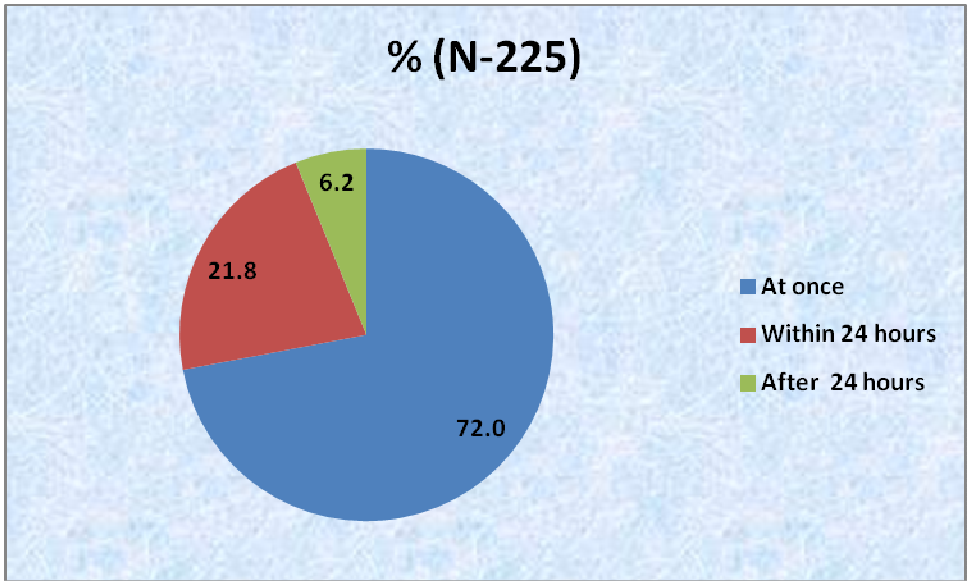
Sr.No.	Statement	% (N-225)
1	ASHA reporting birth/ death to ANM	96.24

Table No.100

ANMs getting report from ASHA on maternal death

ANMs reported that in 72% cases, they get report for maternal death from ASHA at once, 21.8% accounted for within 24 hours and after 24 hours reporting on maternal death accounted for only 6.2%.

Graph No.22



Maintenance of VHIR

On being probed about the VHIR, the ANM informed that 95.56% of the registers were updated by ASHA, help provided by ANM in maintaining VHIR also accounted for 95.56% and 92.00% of them provided help in verification of VHIR. 96% ANMs reported that ASHAs are maintaining VHIR.

Village Health Index Register	% (N-225)
Maintaining of VHIR by ASHA	96.00
Updating of VHIR by ASHA	95.56
Verification of VHIR by ANM	92.00
Help provided by ANM in maintaining VHIR	95.56

Table No.101

(Note: Entries are being made in some other register as VHIR has not been supplied in the last financial year).

ASHAs performance and support to ANMs

ANMs further reported that they get 100% support from ASHAs in immunization and ASHAs bring women and children to vaccination centres.

Sr. No.	Statement	N	%
1	ANM getting support in immunization from ASHA	225	100
2	**Tracking of immunization status of children by ANM**		
	MCP	225	88.4
	Others	225	11.6
	ANM satisfied with ASHAs performance in the field	225	98.7

Table No.102

On being asked how they track immunization status of children, 88.4% ANMs reported that they keep a track from MCP card and others accounted for 11.6% (information provided by ASHAs in the absence of MCP).

Number of deliveries

Sr. No.	**Deliveries**	Nos.	Average per ANM
1	Institutional deliveries	10538	47
2	At home	3589	16

Table No.103

Institutional and deliveries at home are 10538 and 3589 respectively as reported by ANMs.

Institutional deliveries – support from ASHA

Sr. No.	**Institutional deliveries - through ASHA**	**N**	%
1	Institutional deliveries	197	93.40

Table No.104

ASHAs have assisted in 184 cases in institutional deliveries as reported by ANMs.

Frequency of meetings with ASHA

The meetings of ASHAs and ANMs take place as and when needed was reported by 56.4% of the respondents (ANMs). 29.8% of them reported that they met ASHAs twice in a week, 7.1% reported more than a week and 6.7% of them reported that they met them in a month.

Time Interval	% (N-225)
Twice in a week	29.8
More than a week	7.1
In a month	6.7
As and when needed	56.44

Table No.105

ANM supporting ASHA

Sr.No	Statement	N	%
1.	ANM visiting eligible women along with ASHA	225	99.1
2.	ANM organizing meeting with ASHAs in her cluster	225	94.7
3.	ASHA sharing her problems with ANM	225	97.8

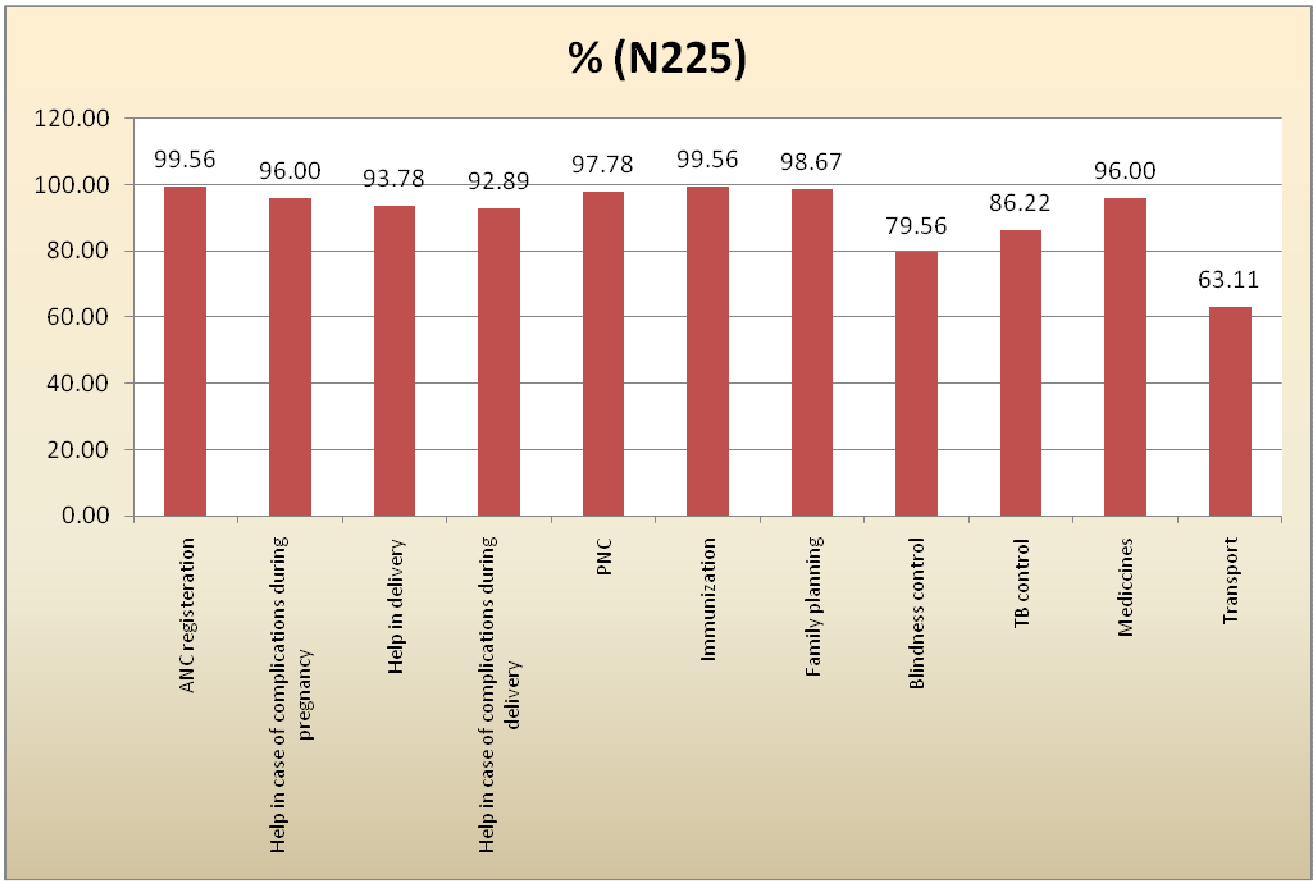
Table No.106

99.1% ANMs reported that they are making home visits along with ASHA. ANMs (94.7%) further reported that they organize meeting in her respective cluster. On being probed, 97.8% ANMs reported that ASHAs share their field related problems with them.

Support provided by ANM to ASHA

ANM was probed about the support she provided to ASHA and 99.56% respondents informed that support was provided for registration for ANC for immunization each, while 96% of them reported that support is also provided by her in medicines and 96% of complications during pregnancy. In addition to that, support is also provided by ANM in blindness control (79.56%), TB (86.22%) and transport (63.11%). 93.78% ANMs reported that they helped in delivery, 92.89% reported that they helped in complications during delivery, 97.78% for PNC, family planning accounted for 98.67%.

Graph-23: Support provided ANM to ASHA



Help from ASHA in bringing women and children to vaccination centre

Sr.No.	Statement	N	%
1	Help from ASHA in bringing women and children to vaccination centre	225	100

Table No.107

100% respondents reported that ASHA are helping them in bringing women and children to vaccination centre.

Attendance of ASHA and ANM at Block Level Meetings

99.56% of the ANM informed that they attended the block level meetings with ASHA and ensured the verification of their performance before meetings. Further, 90.67% of them informed that ASHA accompanied them for meetings. ANMs reported that in 98.22% ASHAs attended block level monthly meetings.

Block level monthly Meetings	% (N-225)
Verification of ASHA's performance before meetings	99.56
Attendance of ASHA at the meetings regularly	98.22
Accompanying ASHA for the meetings	90.67

Table No.108

Rating by ANM of ASHAs performance

Sr.No.	Rating of ASHAs performance by ANM	N	%
1	ANM found ASHAs performance satisfactory during field visit	225	98.66
2	**Rating by ANM of ASHAs performance** Very good	225	40.04
	Good		56.94
	Average		1.85
	Bad		1.15

Table No.109

As per survey findings, 98.66% ANMs reported that they found ASHAs performance satisfactory during their field visit. Out of them, ANMs rated their performance as very good, good, average and bad respectively at 40.04%, 56.94%, 1.85%, 1.15%.

Relevant findings

Sr. No.	Relevant findings	N	%
1	ASHA regularly preparing the list of pregnant women and shown to ANM	225	97.3
2	**ASHA behavior with village community**	225	
	Good		98.2
	Average-		1.3
	Bad		0.4
3	ANMs attending VHSNC	225	91.1
4	ASHA attending VHSNC	225	89.77

Table No.110

97.3% ANMs reported that ASHAs are preparing list of pregnant women on regular basis. 98.2% ANMs reported that ASHAs behavior with village community is good and only 1.3 and 0.4% reported that it is either average and bad respectively. 91.1% ANMs reported that they are attending VHSNC, 89.77% ANMs reported that ASHAs also attend VHSNC.

Services for which ASHA gets Incentives in Cash

96.4% ANMs also reported that they are verifying payment vouchers submitted by ASHAs. In response to query for what activities ASHA gets incentive, response was positive. Their response was 90.2% and 86.66% for Polio and sterilization respectively. 24.88% and 15.55% ANMs reported Filara and measles as other services for which cash is received.

Incentive received in cash by ASHA for support services provided by her

Sr. No.	Incentive to ASHA and verification of vouchers	N	%
1.	ANMs verifying payment vouchers submitted by ASHAs	225	96.4
2.	**Incentive to ASHA in cash for services**		
	Polio	203	90.2
	Sterilization	195	86.66
	Filaria	56	24.88
	Measles	35	15.55

Table No.111

Details of works taken up for utilization of amount received under VHSNC

Sr. No.	Details of works	N-225	%
1.	Sanitation	146	64.8
2.	Bleaching powder, diesel, spray	98	43.55
3.	Medicines	28	12.44
4.	Meeting exp.	22	9.77
5.	IEC	16	7.11
6.	Weighing scale	5	2.22
7.	Repair of sub centre	11	4.88
8.	Stationery	6	2.66
9.	Maintenance of sub centre	95	15.55

Table No.112

On being probed how the amount received at VHSNC is being spent, ANMs reported as above. While 64.8% is being spent on sanitation, on bleaching powder 43.55%, medicines at 12.44%, maintenance of sub centres at 15.55%. Repair at sub centre accounted for 4.88%, IEC 7.11%, meeting exp. 9.77%, purchase of weighing scale 2.22% and stationery accounted for 2.66% of the total funds received at VHSNC.

In addition to above findings, followings are the problems that have been reported by the ANMs during the one to one discussion held with them:

- **Problem of Transport**

The biggest problem being faced by ANMs is the problem of transportation. One third of them reported that they face problem in carrying out their daily activities like during field visits, while immunization, bringing vaccines from block level to the sub centre due to lack of transportation. ANMs that do not stay at the SC due to the poor condition of centre also have to commute from their place of residence to the concerned sub centers. Due to lack of transport, their work is interrupted.

- **Supply of Medicines, FP methods and Drug kits to ASHA**

An overwhelming majority of ANMs stated that most of the times medicines and FP methods are not available at CHCs, PHCs and even at District Hospitals. Since the supply and logistics of drugs is not managed properly, the beneficiaries have to purchase the medicines from outside. Many of ANMs reported that the ASHAs from their areas either do not have the drug kits at all or they are not replenished regularly. Other supplies like immunization cards are also not available. This causes problems in operation of the programme.

- **Poor condition of Sub Centre and Lack of basic facilities at SC**

Most of the ANMs reported that the Sub center is inhabitable and needs repair. The building of the sub centre is very old and dilapidated. Sub centre do not have boundary wall. Some of the sub centers leak during rainy season. Many sub centers are dirty and unsanitary. Apart from the physical infrastructure ANMs state that there are no basic facilities available at the sub center like potable water, toilets and electricity. Some ANMs also reported that the SC is very far away from village or outside the village. Safety and security of the SC is also an issue. Few ANMs reported thefts from their Sub centers.

- **Problems in Immunization**

Many ANM reported that people do not bring their children for immunization or do not cooperate in immunization. Some ANMs also reported that the mothers do not come to the booths even if they are repeatedly called or informed. Few ANMs also report that due to cases of Adverse Events Followed by Immunization (AEFI) like fever and rashes, people fear from vaccination. Many members from Muslim community do not cooperate in polio immunization.

Incentive of ASHA

Many ANMs stated that the incentives of ASHA is very less and is not in accordance to the amount of the work they do. Some ANMs also reported that money is demanded by clerks, accountants and other officials for payment of incentives to ASHA. Their payment is also delayed due to unavailability of funds. This discourages ASHAs and their performance is also affected due to this very reason.

- **Delay in Payment of Salaries**

Many ANMs reported that they do not receive their salaries on time. Some ANMs reported that they did not get salaries in months and this affects their work.

- **VHSNC Joint account of ANM and Pradhan**

A significant majority of ANMs reported that the joint account of ANM and Pradhan poses many problems to them. In many cases the Pradhan demands money for any amount to be taken out of the account for VHSNC activities. The Pradhan does not sign the vouchers. Few ANMs reported that since the Pradhan is uncooperative the VHSNC fund has not been utilized since long time.

- **Lack of Awareness Regarding Health Issues Among People**

Many ANMs stated that there is lack of awareness among people regarding health issues. They do not utilize the services being provided by the government. It was also reported that people especially from lower caste do not get NSV done even after having more than two children. They do not practice hygiene and keep their surroundings dirty.

In order to cover all the objectives of the study, the senior health officials MO I/Cs/HEOs, DCMs, ACMOs/Dy.CMOs, CMOs and DMs were interviewed for this study and their perspective on ASHA scheme was taken. The following section details the perspective of each senior official on the implementation of the scheme, improvements in the health sector and the barriers which prevail in the uptake of the scheme.

DISCUSSION WITH MEDICAL OFFICER IN CHARGE / HEALTH EDUCATION OFFICER

- **Estimation of Support given by the ASHA to the Community**

Many MOICs / HEOs reported that some ASHAs are not performing their duties up to the mark or their performance is poor. Since ASHA payment is completely incentive based, control over them is limited. Some MOICs/HEOs recommended that poor performing ASHAs should be suspended and efficient ASHA should be appointed. However, one MOIC stated that the process of suspending inactive ASHA is very complex. Few MOICs indicated that there should be a block level/district level committee to monitor the work of ASHAs and their performance. Some of them also suggested that a person should be appointed to monitor the activities of ASHA.

- **Timeliness and Appropriateness of Payments made to ASHA**

This set of respondents reported that the budget is generally not available on time which delays the payment of incentives to ASHA. This delay of payment discourages the ASHA.

"…there is scarcity of budget in time. Payment is delayed due to this and the program faces problems…" **–** HEO, Block – Bhoodbaral, Meerut

"For timely payment of incentives, availability of budget in time should be ensured…" **–** MOIC**,** Block **–** Bilhaur, Kanpur Nagar

"…some ASHA are not working properly, despite they are trained. Due to this the program is facing problems" **–** MOIC**,** Block **–** Mohammadpur (Sadar), Bijnor

"ASHA's work is not satisfactory…" **–** MOIC**,** Block-Bhadaura, Gazipur

"…less performing ASHA should be expelled and new ASHA should be appointed" **–** MOIC**,** Block – Bidhnu, Kanpur Nagar

"There should be committee at block level under NRHM to monitor the work of ASHA. Those ASHA whose work is not satisfactory should be suspended immediately and new ASHA should be appointed…" **–** MOIC**,** Block – Nigohi, Shahjahanpur

DISCUSSION WITH THE DISTRICT COMMUNITY MOBILIZERS

- **Estimation of Support given by the ASHA to the Community**

Many respondents of this category agreed to the fact that ASHA scheme has augmented institutional deliveries. The adoption of family planning methods have seen unprecedented surge. Routine Immunization and mass immunization campaigns have been very successful due to ASHA scheme. Many DCM reported that ASHA scheme has a major contribution in generation of awareness regarding health issues among people. They also stated that the there has been a decline in Infant Mortality Rate and Maternal Mortality Rate.

"Institutional deliveries have increased significantly which has led to decline in Infant Mortality Rate and Maternal Mortality Rate - DCM, District – Basti

"*Family Planning has been successful due to ASHA scheme and the ratio of immunization has increased significantly"*- DCM, District – Banda

"Due to ASHA scheme, the awareness regarding health issues has increased. Since ASHA is from the same village, her reach is good" - DCM, District – Mainpuri

- **Assessment of the Implementation Guidelines of the ASHA Scheme**

It is observed from this interview that ASHAs are selected for awards according to the guidelines issued by government which are performance in institutional delivery, performance in immunization and performance in family planning (sterilization). Many DCMs also stated that one of the criteria of evaluation of ASHA for awards is the population covered by ASHAs.

"ASHA is evaluated for award on the basis of their performance in JSY, Routine Immunization, family planning and the population covered by them. On these criteria, the percentage is calculated and 1st, 2nd and 3rd prize is distributed" - DCM, District – Meerut

- **Timeliness and Appropriateness of Payments made to ASHA**

Most of the DCMs reported that they ensure timely payment to ASHA by ensuring timely verification and timely submission of payment vouchers by ASHA. ANM is instructed to take ASHA with their vouchers to block PHC and verify them so that payment is done on time.

"…submission of vouchers in time is ensured. This helps in timely payment of incentives to ASHA…" – DCM, District – Bijnor, Kanpur Nagar

"…ANM is instructed that the ASHA under her should bring their vouchers with them and they should be verified and submitted on the same day…" – DCM, District – Basti

- **Assessment of the Existing Support System to the ASHA by the Superiors**

It has been reported that the problems faced by the ASHA are raised in the meetings of ASHA Mentoring Group and District Health Society. It came into light that DCMs of certain districts attend the monthly meetings and record the problems which are reported at the same platform of mentoring and health society meetings. It was further informed that the problems are also solved by providing the feedback to the DM who further takes a decision. The same respondents also stated that sometimes the CMO & ACMO solves problems by discussing with the concerned MOICs and the meetings are conducted with MOIC & HEO at BPHC.

DISCUSSION WITH ADDITIONAL CHIEF MEDICAL OFFICERS (ACMO - RCH) / DY. CMO

- **Estimation of Support given by the ASHA to the Community**

All ACMOs / Dy. CMO unanimously agreed that the ASHA scheme has augmented institutional deliveries, both routine and mass immunization and adoption of Family Planning methods to a great extent. It has been reported that the scheme has a major contribution in generation of awareness regarding health issues among people. ASHA is acting as a link between Health department and rural people and is helping them avail health facilities provided by government. It was also observed that the awareness among people regarding health issues has increased and ASHA has a major contribution in this.

"…due to ASHA's contribution the health status has shown improvement which includes increase in institutional deliveries, increase in immunization and family planning as well as the awareness among people has increased - Dy. CMO, District – Lakhimpur Kheri

"…is a good scheme. This scheme has led to increase in Health Awareness due to which, institutional deliveries, immunization, NSV has increased to a great extent…" - ACMO, District – Saharanpur

"…through ASHA scheme, institutional deliveries have increased and Family Planning has showed unexpected increase…" - ACMO, District – Mathura

"…due to increase in institutional deliveries, IMR and MMR have declined. Routine Immunization is constantly increasing. ASHA has a big contribution in this…" - Dy. CMO, District – Lakhimpur Kheri

"…ASHA have motivated people to avail health services and have created awareness regarding health issues among them…" ACMO, District – Shahjahanpur

- **Assessment of the Implementation Guidelines of the ASHA Scheme**

It is reported by some of the ACMOs/ Dy. CMOs that the selection process of ASHAs is unfair and biased. Due to political influence, the Pradhan appoints ASHAs from among his acquaintances or from dominating families in the village. Due to this, the work is not being done properly. This statement made by the ACMOs is in line with one of the objective of this study that states assessment of the implementation of the guidelines.

"…because political pressure and Pradhan appoints ASHA from dominating families in the hope that ASHA would become permanent salaried employee of the government. Forty percent of such ASHA are less performing, if we pressurize them for work, 10-15 people in a group come to beat us and threaten us…" - Dy. CMO, District – Jhansi

- **Assessment of the Existing Support System to the ASHA by the Superiors**

It was reported by most of the CMOs / Dy. CMO problems are solved at block level by MOIC / HEO and ANM in their meetings. If it is needed, the problem is taken to district level and solved by Nodal Officer and DPMU officers in a meeting. The respondents also stated that the problems have been raised in writing in the meetings of ASHA mentoring group, CMO, ACMO and District Health Societies. An ACMO also reported that ASHA Redressal Cell has been constituted to address the issues faced by ASHA.

"…problems of ASHA are solved in the meeting with MOIC and HEO at block level…" - ACMO, District – Jhansi

"…if block level authorities are not able to solve their problems, these issues are raised in ASHA Mentoring Group and District Health Society meeting in written…" - ACMO, District – Mainpuri

DISCUSSION WITH CHIEF MEDICAL OFFICERS

- **Estimation of Support given by the ASHA to the Community**

Most of the CMOs described ASHA scheme as a successful scheme which is helping people avail health services. One CMO also described ASHA as the backbone of Health department. Many CMOs stated that ASHA scheme has augmented institutional deliveries to a great extent. People have become more aware and conscious regarding health issues especially mother and newborn care. Similarly, many CMOs reported that ASHA scheme has positively contributed towards increase in Immunization and adoption of Family Planning methods.

> ***"…ASHA is an important link and has a big contribution towards creating awareness among people…"*** - CMO, District-Shahjahanpur

> ***"…ASHA is playing an important role in Health. People are becoming more aware. There is an abrupt surge in institutional deliveries due to which maternal deaths have declined. ASHA had an important role in Routine Immunization and polio immunization. ASHA has also contributed in Family Planning…"***CMO, District-Lakhimpur Kheri

> ***"…ASHA's performance is good, institutional deliveries, immunization and family planning are showing better results…"***- CMO, District- Meerut

- **Assessment of the Implementation Guidelines of ASHA**

Some of the CMOs reported that the selection process of ASHA is highly flawed and biased due to political pressure. In few cases ASHA has been selected from dominating families but these ASHA do not work. It was also reported that if they are pressurized for work, political influences protect them. This is a major hurdle in proper implementation of ASHA scheme.

> ***"…selection process of ASHA is wrong. Due to political pressure and Pradhan's favoritism ASHA is selected from influential families…"*** - CMO, District- Jhansi

> ***"…most of inactive ASHA are either associated with local politics or are from influential families. They themselves do not work and advise other ASHA also not to work…"*** - CMO, District- Mathura

DISCUSSION WITH DISTRICT MAGISTRATES

- **Estimation of Support given by the ASHA to the Community**

The number of Institutional deliveries, Immunization rate, ANCs, PNCs etc has improved, thus focusing on the objective of the support services provided to the community by the ASHAs. In order to support this objective, the respondents also said that these community health workers are creating awareness among communities related to health issues & are mobilizing them. The people have accepted ASHAs & follow what ASHA counsels to them. Though the scheme has been appraised, it has also been remarked that it is not working as per expectations and is lacking somewhere. It was also notified by the same set of respondents that ASHA are less active, since they get fewer incentives for their work except JSY.

CHAPTER 4

RESULTS AND FINDINGS

These results & findings are derived from field survey and in depth interviews with District Magistrates from 6 Districts, CMOs, ACMOs, DCMs from all 15 Districts, MOICs from 45 Block PHC/CHC.

1. Acceptability of ASHA in the Community

It is reported by ASHA that she has been widely accepted by the village community and she shares a cordial relationship with them. This fact was further supported by majority of the eligible women who reported that ASHA is cooperative and easily accessible to them in the hours of need. They also reported that she shares a cordial relationship with them. She plays a significant role in promoting health services in the village community. She pays regular visits to them and is considered as their well wisher. An overwhelming majority of the ANM stated that ASHA had a good behavior with the village community, thus making her widely acceptable. The senior health officials interviewed for this study, Medical Officer in Charge / Health Education Officer, District Community Mobilizers, Additional Chief Medical Officers (ACMO - RCH) / Dy. CMO, Chief Medical Officers and District Magistrates further supported this, by stating that ASHA scheme has been instrumental in improving the health status of the village community, as there has been a remarkable improvement in the rate of immunization and institutional delivery.

It is observed that ASHA has been widely accepted by the village community and are a backbone of support health services under NRHM. She is easily accessible to them and is available as and when needed. She shares a cordial relation with the community and is considered as an opinion leader as far as promotion of health services is concerned. She is a regular visitor in the community and creates awareness among the community people on health related issues.

2. Estimation of the Status of Support Provided by ASHA to the Community

During the discussions with ASHA, it came into light that she supports the community on various related health issues such as immunization, ANC, delivery and PNC. She also stated that she extends her support in blindness control, TB management and family planning etc. This fact was further corroborated by the eligible women who reported that ASHA has been instrumental in providing support to them for immunization, ANC, delivery and PNC. She is also reported to provide support in meeting their needs for medicines, as and when required by them. She is also reported to provide support for arranging transport during health related emergency. She also extends support in blindness control, TB management and leprosy control and also helps in referral cases. The ANM interviewed for this study stated that support has been provided in the same area as above. The senior health officials interviewed are also of the same opinion and have praised the scheme and the support provided. The CMO of district Lakhimpuri appreciated the work being done by ASHA saying that ***"…ASHA is playing an important role in health. People are becoming more aware. There is an abrupt surge in institutional deliveries due to which maternal deaths have declined. ASHA has an important role in Routine Immunization and polio immunization. ASHA has also contributed in promotion of Family Planning"***

The data analysis reveals that the ASHA is providing support to the community as far as health services are concerned. Due to the support provided by her, the rate of institutional deliveries, immunization, and family planning has gone up. This statement can be further supported by the fact that the rate of MMR of Uttar Pradesh has seen a downward trend, with the state recording 345 MMR in 2010-2011 and improvement has been seen in the year 2011 – 12 with the latest MMR being 300 (source: AHS 2010-11 and 2011-12). She is an important link in the community. People have become more aware and conscious regarding health issues especially mother and newborn care. The scheme has positively contributed towards an increase in the awareness of people as far as health services are concerned.

3. Appropriateness and Timeliness of Payment of Performance based Compensation Money

Majority of ASHA feel that incentives being given to them under various activities such as sterilization, pulse polio, routine immunization are very less. Few of them have reported that no incentive is being given in case of TB management, delivery at CHC, for attending meetings at block PHC for some reason or other. A few of them told that no incentive is paid to them for delivery at home even after providing services for full ANC to the concerned women. Few of them even reported that their services are being utilized for 24 hours without any rest, and then also they are not paid a fixed amount towards salary. Despite putting efforts all the times, they reported that incentives being paid to them are very less and it should be increased. Some of them also stated that their payments should be released on time. Majority of ASHAs stated that present system of payment towards incentive is erratic and quite disturbing to them.

On the contrary, it also came into light that payments are delayed either because ASHA does not submit the payment vouchers on time or the payment vouchers filled are incomplete in nature. They also reported that they want training on accounts keeping.

An overwhelming majority of ANMs advocate that ASHAs should be paid a fixed monthly salary. Due to the incentive being less, they feel de-motivated to work. A fixed salary would not only increase their efficiency but will also make them more accountable for their work. It has also been reported by many senior officials that the ASHA receives less incentives and this affects their performance of work. It has also come into light that the budget is not generally available and this delays the payment to ASHA, as reported by most of the MO I/C interviewed. Majority of MO I/C further reported that on their part the payments are not delayed, but at the same time they informed that payments get delayed if funds are not received from the district. On further being probed, they informed that in case of any dues to ASHA, they do not send any funds requirement to CMO's office.

It is important to note that, most of the DCM interviewed in study districts reported that they ensure timely payment to ASHA by ensuring timely verification and timely submission of payment vouchers by ASHA. ANM is instructed to take ASHA with their vouchers to block PHC and verify them so that payment is done on time. This fact can be supported by the statement given by the DCM of Bijnor district who said that "***"…submission of vouchers in time is ensured. This helps in timely payment of incentives to ASHA…"*** which is in contrary to what ASHA and ANM have been reporting.

It is observed that the ASHA payments are delayed beyond considerable time for the reasons, funds not available or payment vouchers are incomplete .It is felt that fixed payments are a demand of many including the ANMs advocating this fact. Since the ASHAs are not paid for their dues they feel that work is being taken for granted. Even though all the payments are transferred electronically (subject to availability of funds), no such lists are displayed on notice boards which results to ASHA running from pillar to post, to get to know the status of her dues. The payment to ASHA invariably gets delayed due to non availability of funds and there is no provision of making payments to them on submission of their dues. It

is further observed that MO I/C's do not forward any payment requests. Not only this, it also came into picture that, ASHA faces lot of hardships in getting the payments released.

4. Assessment of Participation of ASHA in attending Block Level Meetings/Maintaining VHIR and Attending Complete Training for 23 Days

An overwhelming majority of ASHA reported that many of them have undergone 23 days training. In six districts namely, Saharanpur, Shahjahanpur, Kanpur Nagar, Lakhimpur Kheri, Jhansi and Pratapgarh, majority of ASHA reported that they have also undergone ten days CCSP training. It was stated by only few of them that they attended VHND meetings and addressed the community about health and nutrition issues after it. A majority of ASHA reported that they did not attend the VHND meetings as they were not called for it.

It has been reported that many of them maintained VHIR and have received trainings to update it. This fact was further corroborated by majority of ANM that VHIR registers were maintained by ASHA and in this regard they also helped ASHA in maintaining VHIR. In addition, it was also stated by majority of ANM that they verified VHIR before block level meetings so that ASHA get her dues on time. Many ANM also verified the performance of ASHA before block level meetings. Majority of ANM also reported that they accompanied ASHA to the block level meetings and during such meetings their attendance are duly recorded. Most of ASHA reported that there are no proper arrangements for seating during these meetings.

Meetings at Village Health & Nutrition Day:

NRHM assures better health outcomes for village community especially those belonging to marginalized and vulnerable section of the society. VHND promises to be an effective platform for providing first contact primary health care. Role of ASHA is well defined as per guidelines for VHND. As per ASHAs own admission, 28.5% of ASHAs are not attending VHND and few of them have attended only 1 to 5 meetings during a year.

Village Health Index Register:

VHIR has not been supplied to ASHA during last financial year 2012-13. Entries are being made in some other register. It is observed that the ASHA has been attending meetings at block level and also updates this register regularly. It is also revealed from the analysis that in most of the cases ANMs also help ASHA in updating the register and verifies it, so that problems are not posed while ASHAs claim for incentives. Few of ASHA are facing difficulties in updating the register.

Block Level Meetings:

It is observed that no guidelines are being followed during block level meetings. In some of the cases, it has been observed that only attendance is being recorded and there is no reference to discussions made in the meetings. Protocol for conducting meetings is not being followed as per the guidelines for block level meetings. No burning issues, such as prevention of seasonal diseases (malaria, filaria, dengue and water borne diseases etc) are discussed at all in these meetings. It is further observed that as per guidelines meetings at block level do not address the problems being faced by ASHA on her day to day duties/performance. These meetings invariably end with only discussions on payment status of incentives to ASHA. There are no proper seating arrangements for ASHA during these block level meetings.

Meetings of VHND:

The role of ASHA in VHND is not visible and she needs to be oriented on health and nutrition issues. ASHA's attendance in these meetings is very poor and if they attend these meetings, hardly any issues are discussed as per guidelines for VHND. Field survey reveals that VHND meetings are only on paper. ASHAs and ANMs are unaware and clueless how to conduct the meetings, what are the requirements for holding such meetings, what are the issues that need to be addressed and need urgent attention relating to nutrition? It is further observed that these meetings end up in a casual way and there are almost no efforts made for counseling on various issues such as Maternal Health, Child health, family planning, RTI & STI, sanitation, health promotion, gender issues, communicable diseases, counseling on importance of nutrition, various facilities available under NRHM. No record of VHND meetings have been updated at block PHC/CHC.

Trainings to ASHAs:

Though ASHAs have undergone 23 days training, yet need is felt to reorient them on various health related issues and on accounts keeping. Trainings/orientation should be a regular feature. They also need to be trained on sharing the issues discussed at VHND with village community. Majority of ASHAs interviewed have undergone trainings from 1st to 5th schedules and trainings on 6th schedule is continuing, it has not resulted to dissemination at village community level for want of follow up at block and District level.

5. Implementation of Guidelines in ASHA Scheme

It has been an observation that the guidelines for ASHA are not being followed strictly. There has been a number of instances at every level that the guidelines are not given due importance. During detailed discussions with MOIC, CMO, ACMO, DCM, it has been observed that monthly block level meetings for ASHA are not taken seriously. No agenda is chalked out for discussions during the meetings. Discussions do not take place to get the status of performance of ASHA. ASHAs also do not submit the list of their requirements such as stationery, registers, medicines, drug kits etc nor MOICs/HEOs ask them for the same.

Assessment of implementation of Guidelines at following levels:

a) At Sub Centre:

There has been very less intervention by ANMs with regard to follow up of ASHA's work. Only in very few cases, ANMs visit ASHAs service area and interact/guide them. Neither ASHAs bring their needs viz. medicines, drug kits etc nor ANMs ask for. ASHAs payment vouchers are not checked in most of the cases before Block Level monthly meetings. Majority of ANMs do not attend VHND meetings along with ASHAs.

b) ***At Block Level:***

At Block level, there have been no efforts made for Capacity Building programs for ASHA, creating enabling environment for her, to promote and help in building cordial relations between ANM and ASHA, discussions on problems being faced by ASHA in performing her day to day duties, resolving the issues, to get appraisal of monthly progress of ASHA. In case of any problems being faced by ASHA, the same are not brought to the knowledge of District officials.

c) ***At District Level:***

Detailed discussions have been made at District level with CMO, ACMO and DCM; it has been observed that they hardly attend block level monthly meetings for ASHA. In most of the cases, they are unaware of difficulties being faced by ASHA. ASHA mentoring Group meetings are held quarterly in the District which is chaired by District Magistrate. There also some suggestions are made and sent to CMO's office for implementation for improvement of health services in rural areas by seeking help of ASHA. Redressal of grievances of ASHAs such as payment to them towards their dues, replenishment of drug kits etc are being paid attention and efforts are made to resolve the same. However it is observed that more efforts are needed in respect to Orientation programs for ASHA, timely payment to them, creating enabling environment for them, timely replenishment of drug kits and make them available of required stationery.

Selection Process/Recruitment of ASHA:

Key selection criteria such as education level and representativeness of the local community are extremely critical if ASHAs are to be retained and communicate information to their community members. However, the findings indicate that selection processes and criteria are not being met in several areas, which leads to the recruitment of ASHAs who may not be able to perform to the level necessary.

a) **Less performing ASHA:**

During discussions with CMOs, they expressed that selection of few of ASHAs is flawed and the selection sometimes are biased. In few of cases ASHAs are either recruited from dominating families or they are acquainted village Pradhan who recommends their names to Block Nodal officer for final approval. With the result, health services in rural area get affected.

It has been observed in this study that in all the districts, 10 to 15% ASHAs are less performing and their work is highly unsatisfactory. They should be replaced with new one by adopting rigorous process of selection involving various community groups, self help groups, ICDS, Block Nodal Officer, District Nodal Officer, Village Health Committee and Gram Sabha as mentioned in the guidelines for selection of ASHA. This would help in improving the health services in rural area.

Huge gap of ASHA as per population norms:

As per NRHM norms 'One ASHA per population of 1000' should be there. *However study reveals that 82.7% of ASHAs are catering to health needs of rural community having population of more than 1000. This huge gap should be filled by recruiting more ASHAs as per requirements. This will further strengthen the health services in rural area. The following table shows that as against sanctioned post of 29435 for ASHA, filled post are 28002 i.e. 95.14% of sanctioned post are filled. It is further observed that sanctioned posts for ASHA are based on census 2001.*

Sl. No.	Name of Districts	Status of ASHA	
		Sanctioned Posts	Working ASHA
1	Bijnor	2244	2195
2	Meerut	1431	1419
3	Saharanpur	2005	1854
4	Mathura	1544	1439
5	Mainpuri	1458	1453
6	Shahjahanpur	2014	1902
7	Lakhimpur Kheri	3141	3117
8	Kanpur Nagar	1486	1423
9	Jhansi	1230	1165
10	Banda	1257	1217
11	Pratapgarh	3092	2618
12	Balrampur	1496	1463
13	Basti	2128	2028
14	Mau	1751	1746
15	Ghazipur	3158	2964
Total		**29435**	**28003**

Table No.113

6. Assessment of record keeping on ASHA Scheme at Block PHC/CHC and District level

At block level: MOIC/HEO on being asked informed that they are maintaining all the books relating to ASHA scheme and they further informed that these are updated on regular basis.

However study reveals that these books are not being updated on regular basis. ASHA Payment Master Register was not shown on being asked in most of the blocks. ASHA monthly meeting register was found to be incomplete as it only mentioned the names and signatures of ASHAs who attended these meetings. In majority of the blocks, minutes of monthly meetings have not been recorded properly. It is further observed that these meetings are not taken seriously by block PHC/CHC as there is no agenda for meetings circulated. In few of cases, it has been noticed that minutes of the meetings have properly been recorded and in certain cases, only few health related topics in routine have been mentioned every

month. Dues to ASHAs are electronically transferred (subject to availability of funds) to the respective accounts of ASHAs but list of such transfers are not displayed on notice board as per guidelines. These results to inconvenience to ASHAs who have to find out the status of their dues.

At District level:

District Health officials and DCMs informed that they are maintaining all the records pertaining to ASHAs and these are updated from time to time. They are maintaining books regarding payments, numbers of ASHAs in the district, record keeping of drugs and other material supplied to ASHAs. Register for ASHAs Mentoring Group is also being maintained at District Level. They also maintain proceeding book for the meetings conducted by District Health Society.

It is observed that these registers are not maintained at District level properly and these are not updated from time to time.

7. Support provided by the Superiors ANM, MOIC/HEO

It has been informed by majority of ANMs and MOICs/HEOs that they extend support to ASHAs as and when needed by them. They further informed that ASHAs also cooperate with them. It was further informed that they not only support ASHAs in their day to day activities but also help them in updating VHIR. In addition to these, majority of senior health officials also apprised that the problems being faced by ASHA are taken up in the block level monthly meetings and their issues are resolved there and then.

However it has been observed that in practical sufficient support is not given. Trainings, replenishment of drug kits, follow up to trainings, supply of stationery, IEC material, timely payments to ASHAs are some of the areas where support from seniors are to be provided but in majority of the cases, it is not adequate. ASHAs are not given feedback towards further improvement. More support is needed to assist ASHA so that she performs better in her service area and caters to health needs of village community. Periodic survey of ASHA's performance in her service area and her usefulness in providing health services to village community is not being carried out by ANM and MOIC/HEO. It has further been observed that referral cases brought by ASHA are not given due importance and she feels neglected.

CHAPTER 5
RECOMMENDATIONS

ASHA has been instrumental in promoting health services in rural areas and has proved to be very useful with regard to outreach of these services; still it is felt that there has not been optimum use of her potentials. There are certain areas that need attention with regard to better uptake of the scheme and ASHA being motivated at all levels so that she remains an effective first port of call for health systems delivery. There is a need to address these issues in right perspective so as to achieve the objectives and goals set in NRHM guidelines.

Therefore based on results and findings, the following recommendations are given keeping in view of key indicators (objective wise) for 'Evaluation of ASHA Scheme under NRHM in the state of Uttar Pradesh:

Objective 1: Acceptability of ASHA by the Village Community

The study reveals that ASHA is acceptable by the community members, but in order for better uptake of the scheme and to make it more enabling, it is felt that a communication strategy needs to be designed to create awareness on the ASHA scheme for at community levels and for PRI members better acceptance for of the ASHAs. This shall help in improvement of the health status at the community level and would lead to success of the ASHA scheme as planned.

Objective 2: Estimation of the Status of Support Provided by ASHA to the Community

ASHA has been providing constant support to the community members which have resulted in improvement of the health status of the community with indicators like institutional delivery and family planning rates have gone up. She is an important link in the community & is an important source of health related awareness. Even though she is an important source of awareness she is sometimes unheard by the community members and thus a barrier exists to the uptake of the scheme. It is recommended that collective meetings at the aanganwadi center with the village women of all age groups should be held so that behavior change among them is reinforced time to time and improvement in the health status of the community is given a platform forward.

Objective 3 : Appropriateness and Timeliness of Payment of Performance based Compensation Money

The study reveals that the ASHA workers face a lot of hardships as far as their payments is concerned. There are several key issues regarding incentives and compensation for ASHAs, which, if mitigated, would greatly contribute to an improvement in ASHAs motivation and performance... Keeping the above in mind a career progression for the ASHAs to become a part of the formal health system should be considered.

It is also recommended that her payment of the compensations should be done on timely basis and no payment voucher should be kept pending unnecessarily at Block PHC/CHC. The process of disbursement of payments should be made transparent. It should be ensured that the payment vouchers are immediately verified by the ANM and soon after sent for further processing.

It is also proposed that the system of payments to ASHA should be made more transparent and more accountable. ASHA should be informed well in advance about the payment procedures and should be

given a firm date as and when she should collect her payments, thus saving her time and money spent in enquiring about her payments.

In order to ensure timely payment to ASHA for her dues, her superior ANM/DM/MOIC should send requests for funds on time. This shall ensure timely disbursement of payments to ASHA, thus maintaining her motivation to create awareness among the community members, which would lead to improved effectiveness of the scheme.

Objective 4: Assessment of Participation of ASHA in attending Block Level Meetings/Maintaining VHIR and Attending Complete Training for 23 Days

As far as the participation of ASHA in the block level meetings is concerned, it is important to reorient/re-brief the ANMs and the ASHAs about the meetings. Guidelines should be made in which the ANM must ensure the participation of all those ASHAs who works under her. The meetings should have a proper agenda and the minutes of meetings should be noted properly and disbursed among the participants.

The superiors in the block level meeting should take feedback from the ASHA and the ANM about their work and extending support to the community. They should also be asked about the problems faced and measures should be taken to address them. At these meetings innovative ways to use the IEC material in the community, already supplied to the ASHA & the ANM, should be taught and facilitated. This would help in uptake of the scheme and help remove the barriers.

Measures should be taken to ensure 100% attendance at these meetings and if possible monetary help should be provided to the ASHA so that it ensures their attendance.

The study reveals that VHIR was not supplied to the ASHA workers during the year 2012-2013 and ASHAs are maintaining these records in some other register, It is recommended that appropriate number of village health index registers should be supplied to them and proper trainings should be imparted on how to update them. Requisite stationary should be replenished from time to time. The ASHA should be monitored rigorously as far as the updation of these registers is concerned and the ANMs on regular basis should check these registers,

This would ensure timely updation of the register and would help in uptake of the scheme as the ASHA would dutifully visit the community members and motivate them.

Under the cascade model of training to the ASHA, trainings should provide complete knowledge and skills to the trainees within the stipulated time. Quality of training should be enhanced and refresher trainings should be planned regularly. In specific to improving programme, a medicine kit to ASHA must be provided & she should be trained on first aid at the earliest to help the community serve better and promptly.

Objective 5: Implementation of Guidelines in ASHA Scheme

In order for better implementation of the guidelines of ASHA scheme at all the levels certain steps need to be taken which would help in the success of the scheme. The payments made to ASHA should be done on timely basis which would help ASHA to retain her motivation to work, The PRI members should help the ASHA to create awareness among the community members on health issues, The Pradhan should be supportive of her and should take measures to help her in improvement of the health status of the village community. It is suggested that regular meetings at the Sub Center be organized with the

ANMs so that the issues being faced by ASHA are solved. A process of community level monitoring, regular problem solving, and skill up-gradation should be developed as early as possible.

As far as the recruitment of ASHA is concerned, the study shows there are gaps in that crucial step. The gaps should be filled as soon as possible. The recruitments of ASHA should be a non bias affair and they should be chosen transparently from the community. A committee should be formed for the selection of the ASHA. The process of selection should be rigorous. The replacement of non performing ASHA should also be done on priority basis,

It is also recommended that the newly recruited ASHAs should be helped by the ANM in order to get familiarized with the community and the latter should introduce the community members to the newly recruited ASHA.

Objective 6: Assessment of record keeping on ASHA Scheme at Block PHC/CHC and District level

A monitoring system with specific and self explanatory guidelines should be developed as far as the record keeping on ASHA scheme is concerned. It is proposed that measures should be taken to assess whether the records are being updated or not. The record registers should be sent to the CMO of the district twice in a month as a part of the monitoring process. Guidelines should also be issued at the district level to make surprise visits and check record keeping at all levels.

Objective 7: Support provided by the superiors ANM, MOIC/HEO

The success of the ASHA Scheme depends on regular and reliable supervision by her superiors. Monthly meetings at block level for ASHAs should be used as a platform for the reinforcement of various health issues. Clear strategies and procedure for supervision should to be defined along with a list of supervisory activities. The supervisors should be oriented on how to supervise and offer help to the ASHA in order to address the community better, Emphasis should be on the feedback to be provided to the ASHA worker on her performance in the village. The funds of RKS should be utilized to incur expenses towards replenishment of drug kits, supply of stationery etc, in case of non availability of funds for these purposes. The ASHA should be motivated to introduce any innovative methods of motivating the community and such ASHA should be encouraged during the block level meetings.

RECOMMENDATIONS FROM OBSERVATIONS

- There is potential for ASHAs to take on some additional roles outside those originally prescribed, such as helping develop village health plans, registration of vital events with the ANM/AWW, and community based new born care. Inclusion of these additional activities would increase associated financial incentives.
- Present system of electronically transferring payment to ASHA towards her dues is appreciable and it should continue. It should be ensured that amount thus transferred should be displayed on notice board so that ASHA comes to know the actual status of her dues.
- It is recommended that instead of paying honorarium, ASHA should be given additional incentive based on her performance. She should be judged based on her past performance and number of cases she manages. The minimum criteria for promoting health services in this regard should be fixed. Quarterly target should be fixed for each ASHA so as to make her accountable.
- Despite low incentive, ASHAs face all sorts of hardships for getting their dues. This is great cause of concern and this cause must be removed as it leads to discontentment amongst them. It should be ensured that no payment voucher is kept pending unnecessarily at Block PHC/CHC.

- The meeting of minutes should be recorded in a proceedings book, and it should include all the points discussed in the meetings as per agenda items or any other issues raised and discussed during these meetings

- For continued support from the superiors to the ASHA clear strategies and procedure for supervision need to be defined along with a list of supervisory activities and the skills for supervision to be taught to the superiors who will conduct these activities.
- There should be help desk established at Block PHC to address the problems of ASHAs and redress the same.

Support Mechanisms Required

It is felt that the following support mechanisms are required:

- **Selection of ASHA:** Through rigorous process of selection as per guidelines.
- **Familiarizing ASHA with the village:** ANM to assist to newly recruited ASHA to familiarize her with the health status of the villagers and facilitate her adoption to village conditions.
- **Maintenance of VHIR:** Updating by ASHA and verifying by ANM.
- **Organization of VHND:** VHND should be observed every month to discuss health related issues. ASHA to mobilize village community to attend VHND.
- **Coordination with community groups:** Develop rapport with community based groups to develop work force for jointly conducting health camps.
- **Meeting with ANM:** ANM to hold meeting with ASHA once in a month.
- **Monthly meeting at BHPC/CHC:** ANM to ensure participation of ASHA. MOIC to review health status of villages and conduct the meetings as per guidelines.
- **Monthly meetings of ASHAs:** MOIC/HEO to organize meeting on same day when BHPC monthly meetings are held.
- **Community Monitoring:** Social audit by village community by themselves on health related issues
- **Role of District Health Society:** Assessment of the progress of ASHA, selection process, their training and orientation, usefulness to village community.
- **Linkage with health facility:** Due recognition to ASHA and give priority of referrals made by her.

In order to achieve the goals and objectives of the ASHA scheme under NRHM, it is essential that the strengths of the program are sustained and consolidated, and the shortcomings as recognized are properly addressed. Suitable corrective actions are taken to minimize their adverse effects on the program.

ANNEXURE

1. QUESTIONNAIRES FOR

i. Questionnaires for Eligible Women

ii. Questionnaires for ASHA

iii. Questionnaires for ANM

2. SCHEDULES FOR IN DEPTH INTERVIEWS WITH

i. MOIC/HEO

ii. ACMO/DY.CMO

iii. DISTRICT COMMUNITY MOBILIZERS

iv. CMO/DM

उत्तर प्रदेश में एक्रीडेटेड सोशल हैल्थ एक्टिविस्ट (आशा) योजना का मूल्यांकन

उप मुख्य चिकित्साधिकारी/अपर मुख्य चिकित्साधिकारी के लिए आई0डी0आई गाइड

सन्दर्भ अवधि 1 अप्रैल, 2012 से 31 मार्च, 2013

[सभी प्रश्न पढ़िये, तथा जिन प्रश्नों का उत्तर न प्राप्त हुआ हो उन प्रश्नों पर जोर देकर निकालने का प्रयास करें]**

राज्य– उत्तर प्रदेश

जनपद–

(क) आशा के कार्यो की समीक्षा

1 जनपद में आशा द्वारा सामना की जाने वाली समस्याओं को दूर करने के लिये कौन से कदम उठाये जाते है?

2 क्या इससे सम्बन्धित मुद्दो को सी0एम0ओ0, ए0सी0एम0ओ0 तथा आशा मेन्टारिंग ग्रुप, जिला स्वास्थ्य समितियों में होने वाली बैठकों में लिखित रूप से उठाया गया?

(ख) आशा योजना को और भी सुद्धढ़ बनाने हेतु उठाये गये कदम (कृपया अलग से पृष्ठ संलग्न करें)

3 आशा योजना के बारे में आपके विचार (कृपया अलग से पृष्ठ संलग्न करें)

4 क्या आशायें अपेक्षित परिणाम को प्राप्त करने में सहायक हुई है?

5 यदि हॉ, कृपया विस्तार से बताइये।

6 यदि ऐसा नहीं है तो उनकी कार्य प्रणाली को सुधारने के कौन–कौन से सुझाव देना चाहेगे?

नोटः जहॉ पर आवश्यक हो वहॉ के लिये कृपया एक नया पृष्ठ संलग्न करें।

उत्तरदाता का नाम

दिनॉक

(उत्तरदाता को धन्यवाद के साथ (साक्षात्कार) बातचीत को समाप्त करें)

उत्तर प्रदेश में एक्रीडेटेड सोशल हैल्थ एक्टिविस्ट (आशा) योजना का मूल्यांकन

मुख्य चिकित्सा अधिकारी/जिलाधिकारी के लिए आई0डी0आई गाइड

सन्दर्भ अवधि– 1 अप्रैल, 2012 से 31 मार्च 2013

[** सभी प्रश्न पढ़िये तथा जिन प्रश्नों का उत्तर न मिल रहा हों उन पर जोर देकर सही उत्तर निकालने का प्रयास करें)]

राज्य– **उत्तर प्रदेश**

जनपद–

(क) परिचय तथा सामान्य प्रश्न

1. नाम––––––––––––––––––––

(ख) आशाओं के कार्य की समीक्षा

- अपके जनपद में आशा योजना के सम्बन्ध में आपके क्या विचार है?
- आपके जनपद में आशा योजना को सृदढ एवं प्रभावी बनाने हेतु आप के कया विचार है?

(जहॉ भी आवश्यकता हो कृपया अलग से पृष्ठ संलग्न करें)

उत्तरदाता को धन्यवाद के साथ साक्षात्कार को समाप्त करें।

उत्तर प्रदेश में एक्रीडेटेड सोशल हैल्थ एक्टिविस्ट (आशा) योजना का मूल्यांकन

जिला कम्युनिटी मोबलाईजर (District Community Moblizer) के लिये आई0डी0आई

सन्दर्भ अवधि–1 अप्रैल 2012 से 31 मार्च 2013

[** सभी प्रश्न पूछिये तथा जिनके उततर न मिल पा रहें है उन पर जोर देकर निकालने का प्रयास करें]

राज्य– **उत्तर प्रदेश**

जनपद–

(क) परिचय एवं सामान्य प्रश्न

1. शैक्षिक योग्यता ————————————————————
2. नाम ————————————————————
3. पद ————————————————————
4. जनपद में स्वीकृत आशाओं की संख्या ————————————
5. जनपद में कार्यरत आशाओं की वर्तमान संख्या ————————————
6. कमी के अन्तराल को भरने के लिये और अधिक आशाओं की भर्ती योजना

(ख) आशा के कार्यो की समीक्षा

7 आशाओं के द्वारा किये गये कार्यो की समीक्षा के लिये जनपद में कौन सी प्रक्रिया अपनायी जाती है।

8 2012–2013 में आशाओं द्वारा सामना की गयी समस्याओं को दूर करने के लिये जनपद में कौन–कौन से कदम उठाये जा रहे है। क्या इससे सम्बन्धित मुद्दों को सी0एम0ओ0, ए0सी0एम0ओ0, आशा मेनटारिंग ग्रुप एवं जिला स्वास्थ्य समितियों की बैठकों में लिखित रूप से उठाया गया?

(कृपया 2012–2013 में आशाओं द्वारा किये गये कार्यो की सूची लगायें)

(ग) भुगतान प्रक्रिया :

9 क्या जनपद में आशा के कार्यो एवं उसको किये गये भुगतान का कभी आपने सत्यापन किया है।

10 वर्ष 2012–2013 में आशा को भुगतान करने के लिये कौन सी प्रक्रिया अपनायी गई हैं?

11 आप आशाओं को शीघ्र भुगतान दिलाने में क्या प्रयास करते हैं?

12 2012–2013 में जनपद स्तर पर आशाओं के लिये आपको कितनी धनराशि प्राप्त हुई?

13 वर्ष 2012–2013 में आशा योजना पर जनपद में कितनी धनराशि का व्यय किया गया?

(घ) आशा को प्रशिक्षण :

14 उन आशाओं का प्रतिशत दीजिये जिन्होंने जनपद में 23 दिन का प्रशिक्षण प्राप्त किया?

15 क्या जनपद में आशाओं को 10 दिन का सी0सी0एस0पी0 प्रशिक्षण दिया गया यदि हाँ तो कितने प्रतिशत?

16 क्या आप कभी ब्लाक स्तर पर आशा की बैठकों में सम्मिलित हुए है?

(ड0) आशा योजना को सुदृढ़ बनाने के लिये उठाये गये कदम :

आशा योजना पर आप का दृष्टिकोण

17 क्या आशा योजना अपेक्षित परिणाम प्राप्त करने में सहायक हुई है?

18 यदि हॉ, कृपया विस्तार से बताइये।

19 यदि नहीं, तो उनके कार्यो में सुधार के सुझाव दीजिये।

20 वर्ष 2012–2013 में कितने आशा मेन्टारिंग ग्रुप की बैठके की गई?

21 इन बैठकों का क्या परिणाम रहा? बैठक का कार्यवृत्त की प्रति उपलब्ध करायें।

(च) आशा सम्मेलन :

22 क्या आशा सम्मेलन प्रतिवर्ष किये जा रहे है?

23 प्रथम, द्वितीय एवं तृतीय सम्मानो को चुनने की प्रक्रिया क्या रहती है?

उत्तरदाता का नाम ————————————————

हस्ताक्षर ————————————————

दिनॉक ————————————

कृपया जहॉ आवश्यकता हो नया पृष्ठ संलग्न करें)

(उत्तरदाता को धन्यवाद के साथ साक्षात्कार समाप्त करें)

उत्तर प्रदेश में एक्रीडेटेड सोशल हैल्थ एक्टिविस्ट (आशा) योजना का मूल्यांकन

MOIC/HEO के लिए IDI गाइड

सन्दर्भ अवधि 1 अप्रैल 2012 से 31 मार्च 2013

[** सभी प्रश्न पूछे तथा जिन प्रश्नों के उत्तर न मिल पा रहे हो उन पर जोर देकर उत्तर निकालने का प्रयास करें]

राज्य – उत्तर प्रदेश

जनपद ————————————————

ब्लाक————————————————

PHC/CHC का नाम————————————

(क) परिचय एवं सामान्य प्रश्न

1. आपके ब्लाक में स्वास्थ्य केन्द्रों की संख्या :

उपकेन्द्र	अन्य (स्पष्ट करें)

2. शैक्षिक योग्यता _____
3. नाम _____
4. पद _____
5. मोबाइल नं0 _____
6. ब्लाक में स्वीकृत की गई आशाओं की संख्या _____
7. ब्लाक में कार्यरत आशाओं की संख्या _____

(ख) आशा के कार्य

8. आशा की समस्याओं के समाधान के लिये कौन–कौन से कदम उठाये गये है?

(ग) भुगतान प्रक्रिया :

9. वर्ष 2012–2013 में आशा को प्रोत्साहन राशि के भुगतान करने की कौन सी प्रक्रिया अपनायी गई।
10. वर्ष 2012–2013 के दौरान आपको आशा योजना के लिये कितनी धनराशि प्राप्त हुई?
11. वर्ष 2012–2013 के दौरान आपने आशा योजना पर कितनी धनराशि खर्च की?
12. क्या आप ब्लाक स्तर पर बैठक करने के लिये आशा को कोई भुगतान करते है? यदि हॉ, तो कितना ?

(घ) वह कार्य जिनके अन्तर्गत आशा को प्रोत्साहन राशि दी जाती है–

(कृपया उन कार्यो को स्पष्ट करें जिनके लिये आशा को प्रोत्साहन राशि दी जाती हो)

क्रम. सं.	कार्य का नाम	प्रोत्साहन राशि (रू0 में)

क्रम. सं.	कार्य का नाम	प्रोत्साहन राशि (रू0 में)

(ड0) अभिलेखों का रखरखाव :

13. क्या VHIR रजिस्टर नियमित रूप से अद्यतन (update) किये जाते है?
14. इन प्रविष्टियों का सत्यापन कौन करता है?
15. जननी सुरक्षा योजना (JSY) की लाभर्थियों को प्रोत्साहन राशि का भुगतान कैसे किया जाता है?

(च) आशा से सम्बन्धित मुद्दे :

क्रम.सं.	आशा का प्रकार	संख्या
1	उन आशाओं की संख्या जिन्होंने प्रशिक्षणें में भाग लिया (जैसे– 23 दिन, 7 दिन, 12 दिन एवं 4 दिन वाले प्रशिक्षण)	
2	उन आशाओं की संख्या जिन्होने 7 दिवस एवं 12 दिवस का प्रशिक्षण प्राप्त किया	
3	उन आशाओ की संख्या जिन्होने 7 दिवसीय प्रशिक्षण प्राप्त किया	
4	उन आशाओ की संख्या जिन्होने 10 दिवसीय प्रशिक्षण प्राप्त किया	
5	नवनियुक्त (अप्रशिक्षित) आशाओं की संख्या	

16. क्या आप अपने PHC/CHC में आशा के कार्यो के निष्पादन से संतुष्ट हैं?
17. औसतन कितने प्रतिशत आशा मासिक बैठकों में भाग लेती हैं?
18. आशा और ANM के बीच किसी भी प्रकार के विवाद के मामले को कैसे सुलझाते है?
19. मासिक बैठकों के दौरान किन–किन मुद्दों पर विचार विमर्श होता है?
20. क्या आप आशा के कार्यो में आने वाली समस्याओं का पूरे तौर पर निस्तारण करते है?
21. क्या आशा को प्रोत्साहन राशि का भुगतान शीघ्रतम कर दिया जाता है?
22. 23 दिवस के प्रशिक्षण के अलावा, क्या आशा को और भी प्रशिक्षण दिये गये है, कृप्या अन्य प्रशिक्षण का नाम बताएँ?

(छ) आशा का मासिक बैठक रजिस्टर :

23. आशा की मासिक बैठकों का आयोजन कौन कराता है तथा यह बैठके कहॉ आयोजित की जाती हैं?
24. स्वास्थ्य कार्यकर्ताओं के लिये आयोजित बैठकों के कौन–कौन से उद्देश्य होते है?
    (दवा की किट की आपूर्ति एवं भुगतान के बारे में अवश्य पूछें)
25. क्या इन बैठकों के कार्यवृत्त को तैयार किया जाता है?

(छ) आशा का भुगतान एवं मास्टर रजिस्टर :

26. मासिक तौर पर आशा को किये हुए भुगतान का लेखा–जोखा कौन तैयार करता है?
27. मास्टर रजिस्टर (प्रपत्र–2) कौन तैयार करता है?
28. भुगतान करने का तरीका क्या है। जैसे मासिक या पाक्षिक इत्यादि।

(ज) आशा द्वारा किये गये कार्य

29. ब्लाक में कितने VHIR पूर्ण है?
30. वर्ष 2012–2013 में आशाओं को पुरस्कृत करने के लिए कौन सी प्रक्रिया अपनाई गई?

(झ) योजना के कार्यान्वयन में समस्यायें या किन समस्याओं का सामना करना पड़ा)

31. NRHM द्वारा ब्लाक स्तर पर आशा योजना के कार्यान्वयन में आपको किन–किन समस्याओं का सामना करना पड़ा?
32. क्या आप योजना के कार्यान्वयन में सुधार के बारे मे कोई सुझाव देना चाहेगें?
    (प्रत्येक प्रश्न के उत्तर के लिय अलग से पृष्ठ संलग्न करें)

उत्तरदाता का नाम ——————————————————

दिनॉक –

आपके द्वारा दिये गये समय के लिये धन्यवाद
(उत्तरदाता को धन्यवाद के साथ साक्षात्कार को समाप्त करें)

उत्तर प्रदेश में एक्रीडेटेड सोशल हैल्थ एक्टिविस्ट (आशा) योजना का मूल्यांकन

ANM (आक्सलरी नर्स मिडवाईफरी) के लिये सर्वेक्षण प्रश्नावली

सन्दर्भ अवधि 1 अप्रैल 2012 से 31 मार्च 2013

राज्य	उत्तर प्रदेश			
जनपद		कोड		
ब्लाक		कोड		
गॉव		कोड		
गॉव की जनसंख्या				
PHC का नाम				
CHC का नाम				
उपकेन्द्र का नाम				
ANM की सेवावधि (वर्षो में)				
इस केन्द्र के आधीन आशा की संख्या				
इस केन्द्र के आधीन गॉवों की संख्या				
उस आशा का नाम जिसका साक्षात्कार लिया गया हो तथा जिनके कार्य का मूल्यांकन इस केन्द्र द्वारा किया गया हो	आशा के नाम	योग्यता	आशा का नाम	योग्यता

ANM का नाम	आयु	शैक्षिक योग्यता	इस केन्द्र पर कब से कार्यरत	
			महीना	वर्ष

फील्ड अन्वेषक (सर्वेक्षक) का नाम हस्ताक्षर

पर्यवेक्षक का नाम हस्ताक्षर

साक्षात्कार की तिथि दिनॉक———————— महीना———————— वर्ष

भाग–1 :

क्रम0 सं0	प्रश्न	श्रेणी	सही उत्तर पर गोला बनाये	..... पर जायें
1.	इस केन्द्र में आप कितने दिनों से काम कर रही हैं	वर्षो की संख्या		
2.	क्या आप इस उपकेन्द्र वाले गॉव की ही निवासी है?	I. हॉ II. नहीं	1 2	
3.	यदि हॉ, तो आप इस गॉव में कब से रह रही है?	I. तीन वर्ष से कम II. तीन वर्ष से अधिक	1 2	
4.	यदि नहीं, तो आप कहॉ रहती है?	गॉव का नाम		
5.	आपके गॉव की इस केन्द्र से दूरी	कि0मी0 में		
6.	आपके घर से उपकेन्द्र तक पहुॅचने में कितना समय लगता है?	I. एक घण्टा II. दो घण्टा III. दो घण्टे से अधिक	1 2 3	
7.	आप कितनी आबादी की देखरेख (कवर) करती है	I. 3000 से 5000 II. 5000 से 10000 III. 10,000 से अधिक	1 2 3	
8.	कितने गॉवों तक आपकी पहुॅच है आपके कार्य या क्षेत्र में कितने गॉव आते है?	गॉवों की संख्या		
9.	क्या आप अपनी भूमिका और दायित्वों को समझती हैं?	I. हॉ II. नहीं	1 2	
10.	यदि हॉ, तो अपने दायित्वों को सूचीबद्ध कीजिये (कृपया स्पष्ट करें)	I. II. III. IV. V. VI.		

भाग–2 :

आशा द्वारा सहयोगी सेवाए :

क्रम0 सं0	प्रश्न	श्रेणी	सही उत्तर पर गोला बनाये	..... पर जायें
1.	आप आशा से किस प्रकार का सहयोग प्राप्त करती है?	I. प्रसव पूर्व देखभाल का पंजीकरण II. टीकाकरण III. संस्थागत प्रसव IV. घर पर प्रसव V. गर्भवास्था के दौरान जटिलता होने पर सहायता VI. प्रसव के दौरान जटिलता होने पर सहायता VII. परिवार नियोजन VIII. जन्म एवं मृत्यु IX. अन्य (स्पष्ट करें)	1 2 3 4 5 6 7 8 9	
2.	क्या आशा ने जननी सुरक्षा योजना में आपकी सहायता की।	I. हॉ II. नहीं	1 2	
3.	क्या आप जननी सुरक्षा योजना (JSY) से संतुष्ट है, जिसका लाभ महिलाएं आशा के सहयोग से प्राप्त कर रही हैं।	I. हॉ II. नहीं	1 2	
4.	उन महिलाओं की संख्या बताइये जिन्होने जननी सुरक्षा योजना (JSY) का लाभ आशा के सहयोग से पाया हो?	I. संस्थागत प्रसव की संख्या II. घर पर ए.एन.एम. द्वारा प्रसव की संख्या		
5.	जननी सुरक्षा योजना की लाभार्थियों को प्रोत्साहन का चेक किसके द्वारा प्रदान किया गया	द्वारा : I. MOIC II. ANM III. आशा IV. स्वयं V. अन्य (स्पष्ट करें)	1 2 3 4 5	
6.	क्या आशा आपको जन्म/मृत्यु की सूचना देती है?	I. हॉ II. नहीं	1 2	

क्रम0 सं0	प्रश्न	श्रेणी	सही उत्तर पर गोला बनाये	..... पर जायें
7.	क्या आशा आपको मातृ मृत्यु की सूचना देती है?	I. तुरन्त (तत्काल) II. 24 घण्टे के अन्दर III. 24 घण्टे के बाद	1 2 3	
8.	क्या आशा VHIR तैयार करती है?	I. हॉ II. नहीं	1 2	
9.	क्या आशा VHIR को अद्यतन (update) नियमित करती है?	I. हॉ II. नहीं	1 2	
10.	क्या आप VHIR नियमित रूप से सत्यापित करती है?	I. हॉ II. नहीं	1 2	
11.	क्या आप VHIR बनाने में आशा की मदद करती है?	I. हॉ II. नहीं	1 2	
12.	क्या टीकाकारण कार्यक्रम में आशा आपका सहयोग करती है?	I. हॉ II. नहीं	1 2	
13.	आशा द्वारा तैयार बच्चे के रिकार्ड द्वारा आप टीकाकरण की स्थिति का पता कैसे लगाती है?	I. टीकाकरण कार्ड (MCP) II. अन्य (स्पष्ट करें)	1 2	
14.	संस्थागत प्रसव एवं घर पर प्रसव की संख्या बताइये	I. सस्थागत (सं0) II. घर पर (सं0)	1 2	
15.	क्या आप उन महिलाओं की संख्या बता सकती है जो संस्थागत प्रसव के लिये आशा द्वारा लायी गई हों?	I. हॉ II. नहीं	1 2	
16.	काम के सिलसिले में आशा कितने–कितने दिन बाद आपसे मिलती है?	I. सप्ताह में दो बार II. एक सप्ताह से अधिक III. महीने में IV. जब आवश्यकता होती है	1 2 3 4	
17.	क्या आप पात्र महिलाओं से आशा के साथ मिलने जाती है?	I. हॉ II. नहीं	1 2	
18.	क्या आप अपने क्षेत्र की समस्त आशाओं की कलस्टर में बैठक करती है?	I. हॉ II. नहीं	1 2	
19.	क्या आशाये अपनी परेशानियों को आपसे चर्चा करती है?	I. हॉ II. नहीं	1 2	

भाग–3 :

ANM का आशा के साथ सम्बन्ध

क्रम0 सं0	प्रश्न	श्रेणी	सही उत्तर पर गोला बनाये	पर जायें
1	आशा को उसके कार्यो में आपने किस प्रकार सहयोग किया है।	1 प्रसव पूर्व देखभाल का पंजीकरण	1	
		2 गर्भावस्था के दौरान होने वाले खतरों के सम्बन्ध में सहायता	2	
		3 प्रसव कराने में	3	
		4 प्रसव के दौरान होने वाले खतरों में सहायता	4	
		5 प्रसवोपरान्त देखभाल	5	
		6 टीकाकरण	6	
		7 परिवार नियोजन	7	
		8 अन्धापन नियन्त्रण	8	
		9 क्षय रोग टी0बी0	9	
		10 दवाइयां	10	
		11 यातायात का साधन	11	
		12 अन्य (स्पष्ट करें)	12	
2	क्या आशा टीकाकरण दिवस पर टीकाकरण के लिए बच्चों/महिलाओं को टीकाकरण केन्द्र पर लाती है और आपकी सहायता करती है?	I. हॉ II. नहीं	1 2	
3	क्या ब्लाक स्तर बैठकों से पहले आप आशा द्वारा निष्पादित कार्यो का सत्यापन करती हैं	I. हॉ II. नहीं	1 2	
4	क्या आशा नियमित रूप से ब्लाक स्तर पर होने वाली बैठकों में नियमित रूप से शामिल होती है?	I. हॉ II. नहीं	1 2	
5	क्या ब्लाक स्तरीय बैठकों में आशा आपके साथ रहती है	I. हॉ II. नहीं	1 2	
6	वर्ष 2012–2013 में ब्लाक PHC/CHC कितनी बैठकें सम्पन्न हुई	संख्या		
7	अप्रैल 2012 से मार्च 2013 तक आप ब्लाक PHC/CHC पर कितनी बैठकों में शामिल हुई हैं?	संख्या		
8	फील्ड भ्रमण के दौरान आपने आशा के कार्य को कैसा पाया	संतोषजनक / असंतोषजनक		
	ASHA 1			
	ASHA 2			

क्रम0 सं0	प्रश्न	श्रेणी				सही उत्तर पर गोला बनाये	पर जायें
	ASHA 3						
9	आशा द्वारा कार्यो के निष्पादन को आप किस तरह ऑकती है–	बहुत अच्छा	अच्छा	औसत	खराब		
	ASHA- 1						
	ASHA-2						
	ASHA-3						

भाग–4 :
अभिलेखों का पर्यवेक्षण

क्रम0 सं0	प्रश्न	श्रेणी	सही उत्तर पर गोला बनाये	..... पर जायें
1.	क्या आशा बच्चो और गर्भवती महिलाओं की सूची नियमित रूप से बनाकर आप को दिखाती है?	I. हॉ II. नहीं	1 2	
2.	गॉव के समुदाय के साथ आशा का व्यवहार कैसा है?	I. अच्छा II. औसत III. खराब	1 2 3	
3.	क्या आप VHSNC की बैठकों में सम्मिलित होती है?	I. हॉ II. नहीं	1 2	
4.	क्या आशा इन बैठकों में सम्मिलित होती है?	I. हॉ II. नहीं	1 2	

भाग–5 :
भुगतान की प्रक्रिया

क्रम0 सं0	प्रश्न	श्रेणी	सही उत्तर पर गोला बनाये	..... पर जायें
1.	क्या आप आशा द्वारा दिये गये भुगतान वाउचर की पुष्टि करती है?	I. हॉ II. नहीं	1 2	
2.	किन सेवाओं के लिये आशा नकद भुगतान प्राप्त करती है?(कृपया स्पष्ट करें)	1 2 3		
3.	वित्तीय वर्ष 2012–13 में ग्राम स्वास्थ्य स्वच्छता एवं पोषण समिति में प्राप्त धनराशि रू0 10,000 किन किन कार्यो में व्यय किया गया ?	1 2 3 4 5		

भाग–6 :

ANM द्वारा सामना की जाने वाली समस्याएं एवं कठिनाइयॉ तथा सेवाओं में सुधार के सुझाव

क्रम सं0	**ANM** द्वारा सामना की जाने वाली समस्याएं एवं कठिनाइयॉ	सेवाओं में सुधार हेतु **ANM** द्वारा सुझााव
1.		
2.		
3.		
4.		
5.		

उत्तरदाता का नाम ————————————————

हस्ताक्षर ————————————————————

दिनॉक ————————————————————

भाग–7 :

साक्षात्कारकर्ता का प्रेक्षण/विचार :

सामान्य टिप्पणी :

किसी विशेष प्रश्न पर प्रेक्षण/विचार /टिप्पणी

कोई अन्य टिप्पणी/प्रेक्षण

पर्यवेक्षक का प्रेक्षण

सामान्य टिप्पणी :

उत्तर प्रदेश में एक्रीडेटेड सोशल हैल्थ एक्टिविस्ट (आशा) योजना का मूल्यांकन

ASHA (मान्यता प्राप्त सामाजिक स्वास्थ्य कार्यकत्री) के लिये सर्वेक्षण प्रश्नावली

सन्दर्भ अवधि 1 अप्रैल 2012 से 31 मार्च 2013

राज्य	उत्तर प्रदेश					
जनपद				कोड		
ब्लाक				कोड		
गॉव				कोड		
गॉव की जनसंख्या						
PHC का नाम						
CHC का नाम						
उपकेन्द्र का नाम						
ANM का नाम						
ASHA का नाम	आयु	धर्म	जाति	शैक्षिक योग्यता	कार्यावधि	
					महीना	वर्ष

आपके कार्यक्षेत्र में अधिकांश लोग किस धर्म एवं जाति के है? धर्म———— जाति ————————

फील्ड अन्वेषक (सर्वेक्षक) का नाम हस्ताक्षर

पर्यवेक्षक का नाम हस्ताक्षर

ASHA का नाम हस्ताक्षर

साक्षात्कार की तिथि दिनॉक————————— महीना———————————— वर्ष

भाग–1 :

सामान्य जानकारी :

फील्ड अन्वेषक (सर्वेक्षक) द्वारा ASHA को अपना परिचय देकर बैठक के उद्देश्य के बारे में बताया जाय तथा उससे साक्षात्कार हेतु थोड़ा समय निकालने का आग्रह किया जाय)

क्रम0 सं0	प्रश्न	श्रेणी	सही उत्तर पर गोला बनाये	..... पर जायें
1.	आपका चयन कैसे हुआ?	I. ग्रामसभा की खुली बैठक द्वारा II. अन्य (स्पष्ट करे)	1 2	
2.	क्या आपके पास स्वास्थ्य विभाग द्वारा जारी फोटो पहचान पत्र है?	I. हॉ II. नहीं	1 2	
3.	यदि है, तो कृपया दिखाइये	I. देखा गया II. नहीं देखा गया	1 2	
4.	यदि आपका फोटो पहचान पत्र खो गया है या आपके पास नहीं है, ऐसी स्थिति में क्या आपने इसके लिये आवेदन किया है?	I. हॉ II. नहीं	1 2	
5.	ASHA के लिये चयन से पहले क्या आप कोई और व्यवसाय (नौकरी) कर रही थी?	I. हॉ II. नहीं	1 2	
6.	क्या आप इसी गॉव की रहने वाली है?	I. हॉ II. नहीं	1 2	
7.	आप इस गॉव में कितने समय से रह रही है?	I. तीन वर्ष से कम से II. तीन वर्ष से अधिक से	1 2	
8.	क्या आपने प्रशिक्षण लिया है?	I. हॉ II. नहीं	1 2	
9.	यदि हॉ तो	I. 7 दिन का II. 12 दिन का III. 4 दिन का IV. 10 दिन का	1 2 3 4	
10.	क्या वर्ष 2012–2013 में आपने कोई प्रशिक्षण प्राप्त किया है?	I. हॉ II. नहीं	1 2	
11.	यदि हॉ तो, आप विगत वर्ष कितने प्रशिक्षण में सम्मिलित हुई है?	संख्या		
12.	वर्ष 2012–2013 में आपने किस प्रकार के प्रशिक्षण लिये।	I. II. III.		
13.	आप लगभग कितने बड़ी आबादी को सेवाएं प्रदान करती है?	I. 1000 से कम II. 1000 से 2000	1 2	

क्रम0 सं0	प्रश्न	श्रेणी	सही उत्तर पर गोला बनाये	..... पर जायें
		III. 2000 से 4000 IV. 4000 से अधिक	3 4	
14.	क्या आप अपनी भूमिका एवं जिम्मेदारियों को जानती है?	I. हॉ II. नहीं	1 2	
15.	यदि हॉ तो, अपनी जिम्मेदारियों को सूची बद्ध करें। (कृपया स्पष्ट करें)	I. II. III. IV.		
16.	क्या गॉव के समुदाय के लोग आपकी बात को सुनते है तथा गम्भीरता से लेते है?	I. हॉ II. नहीं	1 2	
17.	क्या वह आपकी बातों को स्वीकार करते है और अपनाने में योगदान देते है।?	I. हॉ II. नहीं	1 2	

भाग–2 :

<u>गॉव समुदाय को ASHA द्वारा दी जाने वाली सेवाएं :</u>

क्रम0 सं0	प्रश्न	श्रेणी	सही उत्तर पर गोला बनाये	..... पर जायें
1.	गॉव समुदाय को आप किस प्रकार की सेवाओं में सहयोग प्रदान करती है।	1 प्रसव पूर्व देखभाल पंजीकरण	1	
		2 गर्भावस्था के दौरान होने वाली जटिलताओ/खतरों में सहायता	2	
		3 दप्रसव कराने में	3	
		4 प्रसव के दौरान होने वाली जटिलताओं/खतरो में सहायता	4	
		5 जांचे	5	
		6 प्रसवोपरान्त देखभाल	6	
		7 टीकाकरण	7	
		8 परिवार नियोजन	8	
		9 अन्धापन नियन्त्रण	9	
		10 क्षय रोग (टी0बी0)	10	
		11 आयरन की गोली	11	
		12 यातायात उपलब्ध कराने में	12	
		13 अन्य (स्पष्ट करें)	13	
2.	क्या गर्भावस्था के दौरान आपने इनमे किसी के बारे में परामर्श दिया?	1 प्रसव पूर्व देखभाल पंजीकरण	1	
		2 गर्भावस्था के दौरान होने वाली जटिलताओ/खतरों में सहायता	2	
		3 प्रसव कराने के बारे में	3	
		4 प्रसव के दौरान होने वाली जटिलताओं/खतरो में सहायता	4	
		5 प्रसवोपरान्त देखभाल	5	
		6 टीकाकरण	6	
		7 परिवार नियोजन	7	
		8 यातायात का साधन उपलब्ध कराना	8	
		9 अन्य (स्पष्ट करें)	9	

3.	क्या आपने प्रसव के दौरान इनमे से किसी के बारे में परामर्श दिया?	1 प्रसव का स्थान	1	
		2 यातायात की व्यवस्था	2	
		3 प्रसव के लिये प्रचुर धन की व्यवस्था	3	
		4 प्रसव के लिये ले जाना	4	
		5 प्रसव से सम्बन्धित जटिलताओं/खतरों के बारे में	5	
		6 आवश्यकता पड़ने पर रक्त दानकर्ता को तैयार रखना	6	
		7 प्रसव करवाना	7	
		8 प्रसव के दौरान प्रयोग आने वाली वस्तुएं तैयार रखना जैसे–सूती कपड़ा, साबुन, धागा, ब्लेड, प्रसव के लिये साफ कमरा	8	
		9 अन्य (स्पष्ट करें)	9	
4.	क्या आपने गर्भवती महिला को बच्चे के जन्म की तैयारियों के बारे में बताया था?	I. हॉ II. नहीं	1 2	
5.	क्या आपको महिलाओं में जागरूकता लाने के लिये प्रचार प्रसार (IEC) वस्तुऐ उपलब्ध करायी गई है?	I. हॉ II. नहीं	1 2	
6.	यदि हॉ तो, क्या आप समुदाय को इस सम्बन्ध में जागरूक करती है?	I. हॉ II. नहीं	1 2	
7.	क्या आप ग्रामीण स्वास्थ्य स्वच्छता एवं पोषण समितियों (VHSNC) की बैठकों में भाग लेती हैं?	I. हॉ II. नहीं	1 2 →	Q.11
8.	यदि हॉ तो, वित्तीय वर्ष 2012–2013 में आपने कितनी बैठको में भाग लिया है?	संख्या		
9.	यदि हॉ तो, इस प्रकार की बैठकों में किन–किन विषयों पर विचार विमर्श किया गया?	I.		
		II.		
		III.		
		IV.		
		V.		
10.	क्या आप VHSNC बैठकों में की गई चर्चा के बारे में समुदाय को संक्षेप में बताती है।	I. हॉ II. नहीं	1 2	

11.	VHSNC मै आपकों कोई पद दिया गया हैं ?	I. हॉ II. नहीं	1 2	
12.	यदि हां तो कौन सा (स्पष्ट करें)			
13.	क्या VHSNC का खाता खुला हुआ है ?	I. हॉ II. नहीं		
14.	यदि हा तो इसका संचालन किसके द्वारा होता है ?			
15.	आपने बैठकों में भाग नहीं लिया है तो कृपया कारण स्पष्ट करें।	I. बुलाया नहीं गया II. रूचि नहीं थी III. अन्य (स्पष्ट करें)	1 2 3	
16.	क्या आपने समुदाय को इन सब के बारे में सलाह दी है?	I. कुपोषण II. दस्त III. श्वसन संक्रमण IV. अन्य (स्पष्ट करें)	1 2 3 4	
17.	क्या आपने कुपोषण एवं इसके लक्षणों के बारे में लोगों को जागरूक किया है?	I. हॉ II. नही	1 2	
18.	क्या आपने जननी सुरक्षा योजना के बारे में सुना है?	I. हॉ II. नहीं	1 2	
19.	यदि हॉ तो, जननी सुरक्षा योजना के अन्तर्गत होने वाले लाभों के बारे में बताइये	I. Rs. II. III. IV.		
20.	क्या आप पात्र महिलाओं को जननी सुरक्षा योजना (JSY) के अन्तर्गत मिलने वाले लाभों के बारे में बताती हैं?	I. हॉ II. नहीं	1 2	
21.	क्या ANM आपको जननी सुरक्षा योजना के बारे में जानकारी देती है?	I. हॉ II. नहीं	1 2	
22.	क्या जननी सुरक्षा योजना के अन्तर्गत महिलाओं को मिलने वाले लाभों से आप सन्तुष्ट है?	I. हॉ II. नहीं	1 2	
23.	यदि नही तो, कारण बातइये?	I. II. III.		

24.	क्या आप जननी सुरक्षा योजना की लाभार्थियो को प्रोत्साहन राशि दिलवाने में सहायता करती है	I. हॉ II. नहीं	1 2	
25.	क्या आप जानती है कि घर पर प्रसव होने के मामले में जननी सुरक्षा योजना (JSY)के अन्तर्गत लाभ लिया जा सकता है?	I. हॉ II. नहीं	1 2	
26.	यदि हॉ तो, किस आधार पर पात्र महिला को प्रोत्साहन राशि दी जा सकता है?	I. II. III.		
27.	यदि हॉ तो, पात्र महिला संस्थागत प्रसव या घर पर प्रसव के मामले में किस प्रकार लाभ प्राप्त कर सकती है?	I. II. III. IV.		
28.	क्या आप अपने कार्यक्षेत्र के अन्दर महिलाओं की संख्या बता सकती है जिन्होंने JSY के अन्तर्गत वर्ष 2012–2013 के दौरान लाभ प्राप्त किया हो	संख्या_____		
29.	आप किसके द्वारा पता लगाती है कि जननी सुरक्षा योजना की लाभार्थी अपनी प्रोत्साहन राशि प्राप्त कर चुकी है?	I. MOIC/ANM II. अभिलेखों द्वारा III. लाभार्थी द्वारा IV. अन्य (स्पष्ट करें)	1 2 3 4	
30.	क्या आप ग्राम स्वास्थ्य सूचकांक रजिस्टर में जन्म/मृत्यु दर्ज करती है	I. हॉ II. नहीं	1 2	
31.	क्या आप मातृ मृत्यु की सूचना देती है?	I. हॉ II. नहीं →	1 2	Skip to 30
32.	यदि हॉ तो, आप मातृ मृत्यु की सूचना कब देती है?	I. तत्काल II. 24 घण्टे के अन्दर III. 24 घण्टे के बाद	1 2 3	
33.	आपने मातृ–मृत्यु की सूचना पिछले वित्तीय वर्ष कितनी की	संख्या–––––––		
34.	क्या आप VHIR रजिस्टर में गर्भवती महिलाओं तथा 1 साल से कम उम्र के बच्चों की संख्या सर्वेक्षण करने के बाद ही भरती है?	I. हॉ II. नहीं	1 2	

35.	क्या आप गर्भवती महिलाओं को अस्पताल/उपकेन्द्र पर पूर्व प्रसव देखभाल के लिये ले जाती है?	I. हॉ II. नहीं	1 2	
36.	या आप गर्भवती माताओं में खतरे के चिन्हों को जानती है?	I. हॉ II. नहीं	1 2	
37.	यदि हॉ, तो खतरे के लक्षण क्या हैं?	1 2 3 4		
38.	गर्भावस्था के समय किसी भी जटिलता/खतरे के मामले मे आप महिला को कहॉ ले जाती है?	I. उपकेन्द्र II. प्राथमिक स्वास्थ्य केन्द्र III. सामुदायिक स्वास्थ्य केन्द्र IV. जिला अस्पताल V. निजी अस्पताल VI. अन्य (स्पष्ट करें)	1 2 3 4 5 6	
39.	क्या आप प्रसव के लिये गर्भवती महिला को अस्पताल/उपकेन्द्र ले जाती है?	I. हॉ II. नहीं	1 2	
40.	क्या आप गर्भवती महिला को ले जाने के लिये साधन की व्यवस्था करती है?	I. हॉ II. नहीं	1 2	
41.	क्या अस्पताल से छुटटी होने से पहले बच्चे को टीकाकरण किया जाता है?	I. हॉ II. नहीं	1 2	
42.	यदि हॉ तो, टीकाकरण का विवरण दीजिये (कृपया स्पष्ट करें)	I. पेलियो 0 खुराक II. बी0सी0जी0 III. अन्य (स्पष्ट करें)	1 2 3	
43.	संस्थागत प्रसव एवं घर पर प्रसव की संख्या की जानकारी दें।	I. संस्थागत प्रसव की संख्या–– II. घर पर प्रसव की संख्या–––		
44.	आपने पिछले वित्तीय वर्ष में कितनी महिलाओं को प्रसव हेतु प्राईवेट अस्पताल में भेजा?	संख्या————		

45.	जन्म की तैयारियों/तत्परता से सम्बन्धित आपने कौन–कौन सी सेवाएं प्रदान की है?	I. जन्म योजना II. संस्थागत प्रसव III. गर्भावस्था के दौरान टीकाकरण IV. जन्म के समय के लिये पहले से ही स्वच्छ वस्तुओं की उपलब्धता V. स्वास्थ्य केन्द्र का चयन VI. प्रसवोपरान्त देखभाल VII. बच्चे का टीकाकरण	1 2 3 4 5 6 7	
46.	घर पर प्रसव के मामले में क्या आप महिलाओं को सावधानियों के बारे में बताती है?	I. हॉ II. नहीं	1 2	
47.	यदि हॉ तो, घर पर प्रसव के समय के लिये आपने उनको कौन–कौन सी सावधानियों के बारे में बताया।	I. स्वच्छ कमरा II. स्वच्छ चादर III. बिना प्रयोग किया हुआ नया ब्लेड IV. धागा V. साबुन VI. अन्य (स्पष्ट करें)	1 2 3 4 5 6	
48.	वित्तीय वर्ष 2012–2013 आप कितनी महिलाओं को संस्थागत प्रसव के लिये ले गई ?	संख्या		
49.	प्रसव के कितने दिनों बाद आप प्रसूता महिला से उनके घर पर मिलने जाती है।	I. प्रसव के तुरन्त बाद II. सप्ताह में दो बार III. एक सप्ताह बाद IV. एक महीने के अन्दर V. बिल्कुल नहीं	1 2 3 4 5	
50.	आप नवजात शिशु को कितनी बार घर पर देखने जाती है?	संख्या		
51.	जन्म के बाद (42 घण्टों के अन्दर) किसी प्रकार की जटिलता/खतरे की स्थिति में क्या आप शिशु को स्वास्थ्य सुविधाओं तक लेकर गई हैं	I. हॉ II. नहीं	1 2	
52.	क्या आपने प्रसूता महिलाओं को प्रसवोपरान्त देखभाल के बारे में सलाह दी है?	I. हॉ II. नहीं	1 2	

53.	यदि हॉ तो, जरूरत पड़ने पर आप उसे कहॉ लेकर जाती है?	I. II. III.			
54.	क्या आवश्यकतानअुसार प्रसवोपरान्त महिलाओं का संदर्भन (रेफर) किया जाता है?	I. हॉ II. नहीं		1 2	
55.	क्या प्रसव के बाद आप महिलाओं को परिवार नियोजन के बारे में सलाह देती है?	I. हॉ II. नहीं		1 2	
56.	यदि हॉ तो, पिछले वित्तीय वर्ष में कराये गये कार्यो के सम्बन्ध में संख्या भी बताइयें	**तरीके** I. पुरूष नसबन्दी II. महिला नसबन्दी III. अस्थायी विधि IV. अन्य (स्पष्ट करें)	संख्या ------ संख्या ------ संख्या ------ संख्या------		
57.	क्या आपको पिछले वित्तीय वर्ष में ड्रग किट प्राप्त हुई या नहीं?	I. हॉ II. नहीं		1 2	
58.	यदि हॉ तो क्या आप बता सकती है कौन. कौन सी दवाईया दी गयी ?				
59.	क्या आपको नियमित रूप से अस्पताल से दवाईया दी जाती है?	I. हॉ II. नहीं		1 2	

भाग–3 :

अभिलेखों का रखरखाव :

क्रम0 सं0	प्रश्न	श्रेणी	सही उत्तर पर गोला बनाये	..... पर जायें
1.	क्या आप कोई भी अभिलेख (रिकार्ड) बनाती है?	I. हॉ II. नहीं	1 2	
2.	क्या आपको ग्राम स्वास्थ्य सूचकांक रजिस्टर के बारे में पता है?	I. हॉ II. नहीं	1 2	
3.	क्या आप स्वयं VHIR में प्रविष्टियॉ (entries) करती हैं?	I. हॉ II. नहीं	1 2	
4.	क्या आपको VHIR भरने हेतु प्रशिक्षण प्राप्त हुआ?	I. हॉ II. नहीं	1 2	
5.	क्या आप बच्चों की सूची नियमित रूप से अद्यतन करती है और ANM को सूचित करती है?	I. हॉ II. नहीं	1 2	
6.	क्या आपको रजिस्टर पूर्ण करने के लिए कोई प्रोत्साहन राशि दी जाती है।	I. हॉ II. नहीं	1 2	
7.	यदि हॉ तो, कितना ?	रू0		

भाग–4 :

<u>प्रोत्साहन के भुगतान की प्रक्रिया :</u>

क्रम0 सं0	प्रश्न	श्रेणी	सही उत्तर पर गोला बनाये	..... पर जायें
1.	क्या आपको अस्पताल की ओर से आशा भुगतान वाउचर प्रदान किये गये है?	I. हॉ II. नहीं	1 2	
2.	कौन–कौन सी सेवाओं के लिये आपको प्रोत्साहन राशि मिलने का प्रावधान है और कितना ?	सेवाओं का नाम	Rs.	
		I.		
		II.		
		III.		
		IV.		
		V.		
		VI.		
		VII.		
3.	वर्ष 2012–2013 में आपने कौन–कौन सी सेवाओं के लिये प्रोत्साहन प्राप्त किया और कितना।	I.		
		II.		
		III.		
		IV.		
		V.		
		VI.		
4.	क्या आपको गॉव में महिलाओं एवं बच्चों के टीकाकरण में ANM को सहयोग प्रदान करने के उपरान्त भुगतान प्राप्त करने हेतु वाउचर मिलता है?	I. हॉ II. नहीं	1 2	
5.	कितने दिनों बाद आप अपने प्रोत्साहन के लिये आशा भुगतान वाउचर जमा करती है?	I. 7–10 दिन के अन्दर II. 10–20 दिन के अन्दर III. 20 से अधिक दिन बाद	1 2 3	
6.	वर्ष 2012–2013 में आपने लगभग कितने प्रोत्साहन राशि का दावा किया।	रू0		
7.	वर्ष 2012–2013 में आपने कितनी प्रोत्साहन राशि प्राप्त की और कितनी बार में? (कृप्या पास बुक देखें)	रू0	बार ––में	
8.	यदि आपको कम भुगतान प्राप्त हुआ तो पूरा भुगतान न मिल पाने के कारण क्या थे।	I. विधि का न होना II. फार्म का सही	1	

क्रम0 सं0	प्रश्न	श्रेणी	सही उत्तर पर गोला बनाये	..... पर जायें
		से भरा न होना III. नियमों का पालन नहीं किया IV. अन्य (स्पष्ट करें)	2 3 4	
9.	किस प्रकार की सेवाओं के लिये आपको नकद भुगतान किया जाता है (स्पष्ट करे)	I. II.		
10.	क्या आपको अपना प्रोत्साहन राशि प्राप्त करने में किसी प्रकार की कठिनाई का सामना करना पड़ता है?	I. हॉ II. नहीं	1 2	
11.	आपके द्वारा BPHC को कितने - कितने समय पर भुगतान बाउचर जमा किया जाता है ?			
12.	भुगतान बाउचर जमा करने के कितने समय बाद आपको अपने प्रोत्साहन राशि का भुगतान प्राप्त हो जाता है?	I. 7–10 दिन के अन्दर II. 10–20 दिन के अन्दर III. 20 से अधिक	1 2 3	
13.	क्या ब्लाक स्तर पर बैठको में भाग लेने के लिये आपको कोई यात्रा भत्ता मिलता है?	I. हॉ II. नहीं	1 2	

भाग–5 :

ANM तथा MOIC/HEO/DCM के सम्बन्ध :

क्रम0 सं0	प्रश्न	श्रेणी	सही उत्तर पर गोला बनाये	..... पर जायें
1.	ANM को उसके कार्यो मे आप किस प्रकार का सहयोग प्रदान करती हैं?	I. टीकाकरण	1	
		II. समुदाय के जुटाव में सहायता	2	
		III. प्रसव पूर्व देखभाल	3	
		IV. प्रसवो परान्त देखभाल	4	
		V. अन्य (स्पष्ट करें)	5	
2.	काम के सिलसिले में आप ANM से प्रायः कितने–कितने समय बाद मिलती है?	I. प्रतिदिन II. सप्ताह में दो बार III. सप्ताह में एक बार V. एक पक्ष में दो बार V. मासिक VI. जब भी आवश्यकता समझती हैं।	1 2 3 4 5 6	
3.	क्या आप टीकाकरण दिवस पर महिलाओं/बच्चों को टीकाकरण केन्द्र पर लाती है और ANM का सहयोग करती है।	I. हॉ II. नहीं	1 2	
4.	क्या ANM आपका सहयोग करती है?	I. हॉ II. नहीं	1 2	
5.	ANM आपको सहयोग कैसे करती है?	I. JSY तथा अन्य योजनाओं की जानकारी देती है II. परिवारों का भ्रमण करती है III. रजिस्टर/पुस्तक तैयार करवाती है IV. अन्य (स्पष्ट करें)	1 2 3 4	
6.	पिछले एक वर्ष में ANM के साथ कोई मनमुटाव/वाद–विवाद की स्थिति आयी?	I. हॉ II. नहीं	1 2	

क्रम0 सं0	प्रश्न	श्रेणी	सही उत्तर पर गोला बनाये	..... पर जायें
7.	आप और ANM के बीच में कोई बाद–विवाद की स्थिति उत्पन्न होती है तो इसका समाधान कौन कराता है	I. MOIC II. आपसी तौर पर III. अन्य (स्पष्ट करें)	1 2 3	
8.	अपने कार्यो को करने में आप किस प्रकार की समस्याओं का सामना करती है?	I. II. III. IV. V.		
9.	ब्लाक PHC/ CHC पर एक माह में कितनी बैठके होती है?	संख्या		
10.	अप्रैल 2012 से 31 मार्च 2013 के बीच ब्लाक PHC/ CHC स्तर पर आपने कितनी बैठको में भाग लिया है?	संख्या		
11.	आपके द्वारा अपने गॉव में गर्भवती महिलाओं और किशोरियों के स्वास्थ्य पर पिछले वित्तीय वर्ष में कितनी बैठके आयोजित की गई है?	संख्या		
12.	इन बैठकों में किस प्रकार की चर्चा होती है?	I. II. III. IV.		
13.	इन बैठकों में क्या आप कोई रजिस्टर ले जाती है?	I. हॉ II. नहीं	1 2	
14.	यदि हॉ तो, किस प्रकार का रजिस्टर आप अपने साथ ले जाती है?	I. II. III. IV.		
15.	MOIC/HEO का आपके प्रति रूख/रवैया कैसा है।	I. सोहार्द पूर्ण II. सोहार्द पूर्ण नहीं	1 2	
16.	क्या आपको MOIC/HEO के साथ काम करने मे कोई कठिनाई महसूस होती है?	I. हॉ II. नहीं	1 2	
17.	यदि हॉ तो आप इसके लिये किसके पास जाती है?	I. वरिष्ट अधिकारीयों के पास	1	

क्रम0 सं0	प्रश्न	श्रेणी	सही उत्तर पर गोला बनाये	..... पर जायें
		II. आपसी तालमेल सें III. अन्य (स्पष्ट करें)	2 3	
18.	क्या आपको MOIC/HEO द्वारा सहयोग प्राप्त होता है तथा वह आपकी समस्याओं का समाधान करते है।	I. हॉ II. नहीं	1 2	
19.	ASHA के रूप में सेवाएं देने के लिये क्या कभी आपको किसी पुरस्कार/सम्मान के लिये नामित किया गया है?	I. हॉ II. नहीं	1 2	

20.	यदि हॉ, तो आपने किस तरह का पुरस्कार प्राप्त किया?	I. प्रथम II. द्वितीय III. तृतीय	1 2 3	
21.	यदि नही तो क्या कभी–कभी आपको महसूस होता है कि आपके कार्य की सराहना नहीं की गई।	I. हॉ II. नहीं	1 2	
22.	क्या आप अपने कार्यो से संतुष्ट है?	I. हॉ II. नहीं	1 2	
23.	यदि नही तो कृपया कारण बताइये।	(नीचे के भाग में इन बातों को विस्तार से देखा जा सकता है)		

भाग–6 :

ASHA द्वारा सामना की जाने वाली समस्याएं एवं कठिनाइयॉ

क्रम सं0	**ASHA** द्वारा सामना की जाने वाली समस्याएं एवं कठिनाइयॉ	सेवाओं में सुधार के लिए **ASHA** द्वारा दिये गये सुझाव
1-		
2-		
3-		
4-		
5-		

उत्तरदाता का नाम हस्ताक्षर

दिनॉक

भाग–7 :

साक्षात्कारकर्ता का प्रेक्षण (साक्षात्कार पूर्ण होने के बाद भरा जाय)

सामान्य टिप्पणी :

किसी विशेष प्रश्न पर टिप्पणी/प्रेक्षण

कोई अन्य टिप्पणी/प्रेक्षण

<u>पर्यवेक्षक का प्रेक्षण</u>

सामान्य टिप्पणी :

उत्तर प्रदेश में एक्रीडेटेड सोशल हैल्थ एक्टिविस्ट (आशा) योजना का मूल्यांकन

15–49 वर्ष की पात्र महिलाओं के लिए सर्वेक्षण प्रश्नावली

संदर्भ अवधि 1 अप्रैल 2012 31 मार्च 2013

राज्य	उत्तर प्रदेश	
जनपद	कोड	
ब्लाक	कोड	
गॉव	कोड	
गॉव की जनसंख्या (आबादी)		
प्राथमिक स्वास्थ्य केन्द्र का नाम		
सामुदायिक स्वाथ्य केन्द्र का नाम		
उपकेन्द्र का नाम		
ANM का नाम		
मान्यता प्राप्त सामाजिक स्वास्थ्य कार्यकर्ता (आशा) का नाम		

क्षेत्र (फील्ड) सर्वेक्षक का नाम हस्ताक्षर

फील्ड पर्यवेक्षक का नाम हस्ताक्षर

साक्षात्कार (बातचीत,सम्पर्क) की तिथि : दिनांक माह वर्ष

पात्र महिला का नाम

उम्र

शिक्षा

1	निरक्षर	1
2	प्राथमिक शिक्षा	2
3	माध्यमिक शिक्षा	3
4	हाई स्कूल	4
5	इण्टरमीडिएट	5
6	स्नातक	6
7	परा स्नातक	7

विवाह के समय उम्र (आयु)

बच्चे का जन्म : जीवित/ मृत

जीवित बच्चे की उम्र

बच्चे का नाम

बच्चे का लिंग लड़का– 1 लड़की–2

फील्ड सर्वेक्षक के लिए निर्देश :
पात्र महिला को सर्वेक्षक अपना परिचय अवश्य दें।
खुशहाल संवाद स्थापित करें।
पात्र महिला को सम्पर्क (मुलाकात) का उद्देश्य बतायें।
बातचीत के लिए समय निकालने के लिए धन्यवाद दें।

भाग– 1
आशा के बारे में सामान्य जागरूकता

क्रम0 सं0	प्रश्न	श्रेणी	सही उत्तर पर गोला बनाये	..... पर जायें
1	क्या आपने आशा के बारे में सुना है?	1 हॉ 2 नहीं	1 2	
2	क्या आशा आपके गांव में सभी धर्म एवं जाति के घरों में जाती है?	1 हॉ 2 नहीं	1 2	
3	क्या आप आशा के कार्य जानती है?	1 हॉ 2 नहीं	1 2	
4	यदि हॉ, तो कृपया आशा द्वारा प्रदान की जाने वाली कुछ सेवाएं बताइये।	1 प्रसवपूर्व देखभाल 2 प्रसव में हेतु इकाई तक साथ में ले जाना। 3 प्रसवोपरान्त देखभाल 4 प्रतिरक्षा (टीकाकरण) या बचाव के तरीके 5 परिवार नियोजन सेवाएं 6 अन्य (विवरण दे)	1 2 3 4 5 6	
5	क्या आप अपने गॉव में कार्यरत किसी आशा को जानती है?	1 हॉ 2 नहीं	1 2	
6	आप के गॉव में कितनी आशा काम कर रही है?	1 एक 2 दो 3 तीन या अधिक 4 नहीं जानती हैं।	1 2 3 4	
7	क्या आशा आपके यहॉ आती है?	1 हॉ 2 नहीं	1 2 →	**भाग– 2**
8	वह कब–कब मिलती है?	1 आवश्यकतानुसार 2 कभी नहीं	1 2	
9	आशा का व्यवहार कैसा हैं?	1 सौहार्दपूर्ण 2 सौहार्दपूर्ण नहीं	1 2	

भाग– 2

मान्यता प्राप्त सामाजिक कार्यकर्त्री (आशा) योजना के उपयोग

क्रम0 सं0	प्रश्न	श्रेणी		सही उत्तर पर गोला बनाये	..... पर जायें
1	आशा से आप कौन–कौन सी सेवाएं प्राप्त करती है?	1	प्रसव पूर्व देखभाल के लिये पंजीकरण कराना	1	
		2	गर्भावस्था के दौरान किसी प्रकार की जटिलता में सहायता	2	
		3	प्रसव हेतु इकाई तक ले जाना	3	
		4	प्रसव के दौरान किसी भी प्रकार की जटिलता मे सहायता	4	
		5	प्रसवोपरान्त देखभाल	5	
		6	प्रतिरक्षा साधन (टीकाकरण)	6	
		7	परिवार नियोजन	7	
		8	अन्धापन नियन्त्रण (रोकथाम)	8	
		9	क्षयरोग (TB)	9	
		10	दवाइयाँ	10	
		11	यातायात के संसाधन	11	
		12	अन्य (विवरण दें)	12	
2	स्वास्थ्य सुविधाओं के अन्तर्गत क्या आपने प्रसव पूर्व देखभाल सेवा का लाभ उठाया है?	1	हॉ	1	
		2	नहीं	2 →	प्र0सं0 5
3	यदि हॉ, तो प्रसव पूर्व देखभाल के लिये आपको किसने प्रेरित किया?	1	डाक्टर (चिकित्सक)	1	
		2	ए0एन0एम0	2	
		3	मान्यता प्राप्त सामाजिक कार्यकर्ता (आशा)	3	
		4	परिवार के लोग/रिश्तेदार	4	
		5	किसी ने नहीं	5	
		6	प्रचार प्रसार के माध्यमों से	6	
		7	अन्य (स्पष्ठ करें)	7	

4	क्या आशा ने आपको प्रसव पूर्व देखभाल में आपकी सहायता की?	1	एक बार	1	
		2	दो बार	2	
		3	तीन बार	3	
		4	नहीं	4	
5	प्रसव पूर्व देखभाल के लिये ना जाने का क्या कारण था?	1	आवश्यकता नहीं	1	
		2	प्रथा में नहीं है	2	
		3	बहुत खर्चीला है	3	
		4	बहुत दूर है/यातायात संसाधन नहीं है।	4	
		5	सेवाओं की गुणवत्ता बहुत कमजोर है।	5	
		6	समय की कमी	6	
		7	जानकारी की कमी	7	
		8	परिवार वालों की अनुमति नहीं	8	
		9	अस्पताल कर्मी का व्यवहार अच्छा नही है।	9	
		10	अन्य (स्पष्ट करें)	10	
6	क्या बच्चे के जन्म की तैयारी के लिए आपको आशा द्वारा जानकारी दी गई?	1	हॉ	1	
		2	नहीं	2	
7	क्या गर्भावस्था के दौरान आपको किसी प्रकार की जटिलता का सामना करना पड़ा?	1	हॉ	1	
		2	नहीं	2	→ प्र0सं0ण्9
8	यदि हॉ, तो आशा द्वारा आपको किस प्रकार की सहायता प्राप्त हुई?	1	क्या वह आपको स्वास्थ्य सुविधा तक ले गई?	1	
		2	क्या उसने जाने के साधन की व्यवस्था की ?	2	
		3	अन्य (स्पष्ट करे)	3	
9	आपने अपने बच्चे को जन्म देने के लिये कहॉ का विचार बनाया था?	1	सरकारी (अस्पताल/उपकेन्द्र)	1 2	
		2	प्राइवेट (अस्पताल/नरसिंह होम)	3 4	
		3	घर पर		
		4	अन्य (स्पष्ट करें)		
10	बच्चे का जन्म कहॉ हुआ?	1	सरकारी (अस्पताल/उपकेन्द्र)	1 2	
		2	प्राइवेट (अस्पताल/नरसिंह होम)	3 4	
		3	घर पर		
		4	अन्य (स्पष्ट करें)		
11	क्या आपको प्रसव से पहले किसी तरह की जटिलता का सामना करना पड़ा?	1	हॉ	1	
		2	नहीं	2	

12	यदि हॉ, तो आशा से आपको किस प्रकार की सहायता मिली?	1 2 3	क्या वह आपको स्वास्थ्य सुविधाओं तक ले गई? क्या उसने जाने के साधन की व्यवस्था की? अन्य (स्पष्ट करें)	1 2 3	
13	प्रसव के लिये स्वास्थ्य केन्द्र तक कौन साथ जायेगा, क्या इसके बारे में आपने पहले से ही सोच रखा था?	1 2 3	आशा परिवार का कोई सदस्य अन्य (स्पष्ट करें)	1 2 3	
14	क्या आपने जाने के साधन की व्यवस्था पहले से ही तय कर रखी थी?	1 2	हॉ नहीं	1 2	
15	आपातकालीन स्थिति में आपको रक्तदान कौन करता?	1 2 3	परिवार का सदस्य / रिश्तेदार मित्र / पड़ोसी अन्य (स्पष्ट करें)	1 2 3	
16	घर पर प्रसव की दशा में यह कौन करवाता?	1 2 3 4	प्रशिक्षित नर्स अप्रशिक्षित मिडवाइफ (दाई) मित्र / रिश्तेदार अन्य (स्पष्ट करें)	1 2 3 4	
17	घर पर प्रसव की दशा में क्या आशा ने कुछ वस्तुएं तैयार रखने के लिये कही थी?	1 2	हॉ नहीं	1 2	
18	यदि हॉ, तो कौन सी वस्तुए आशा के सुझाव के कारण तैयार रखी गई	1 2 3 4 5	सूती कपड़ा साबुन धागा ब्लेड प्रसव के लिये स्वच्छ कमरा	1 2 3 4 5	
19	क्या प्रसव के बाद आपको जननी सुरक्षा योजना (JSY) के तहत कोई धनराशि प्राप्त हुई?	1 2	हॉ नहीं	1 2	
20	यदि हॉ, तो यह लाभ आपको किस रूप में प्राप्त हुआ?	1 2 3	नकद चेक नहीं मिला	1 2 3	
21	क्या आशा ने लाभार्थी को जे.एस.वाई. धनराशि दिलवाने में कोई मदद की?	1 2	हॉ नहीं	1 2	
22	प्रसव के बाद जननी सुरक्षा योजना (JSY) के अन्तर्गत यह लाभ आपको कब मिला?	1 2 3 4 5	तत्काल एक सप्ताह के अन्दर 15 दिन के अन्दर 1 माह के अन्दर 1 माह के बाहर	1 2 3 4 5	

23	प्रसव के बाद आशा द्वारा आपको किस प्रकार सहायता प्राप्त हुई?	1 2 3 4 5 6 7	चिकित्सीय जाँच शिशु के लिये प्रतिरक्षा (टीकाकरण) 0 पोलियो खुराक, पोलियो, डी पी टी चेचक, हेपाटाइटिस बी पल्स पोलियो यातायात का साधन जननी सुरक्षा योजना के अन्तर्गत लाभ जन्म प्रमाण पत्र अन्य (स्पष्ट करें) कोई नहीं	1 2 3 4 5 6 7	
24	क्या प्रसवोपरान्त आपको आशा द्वारा परिवार नियोजन के बारे में परामर्श दिया गया?	1 2	हॉ नहीं	1 2	
25	क्या आशा द्वारा आपको कुपोषण तथा उसके लक्षणों के बारे में बताया गया?	1 2	हॉ नहीं	1 2	
26	क्या आशा द्वारा आपको कुपोषण की रोकथाम के बारे में बताया गया?	1 2	हॉ नहीं	1 2	
27	क्या आपके बच्चे को कभी दस्त (डायरिया) हुआ है?	1 2	हॉ नहीं	1 2	
28	क्या आशा ने आपको टीकाकरण से सम्बन्धित जानकारियाँ दी ?	1 2	हॉ नहीं	1 2	
29	क्या आप तीव्र श्वसन संक्रमण(ए0आर0आई0) के बारे में जानती है?	1 2	हॉ नहीं	1 2	
30	क्या उपरोक्त बीमारियों के इलाज में आपको आशा का कोई सहयोग प्राप्त हुआ?	1 2	हॉ नहीं	1 2	
31	क्या जन्म के बाद आपका बच्चा किसी प्रकार की जटिलता से बीमार हुआ है?	1 2	हॉ नहीं	1 2	
32	क्या आपने इस जटिलता के बारे में आशा को बताया?	1 2	हॉ नहीं	1 2	
33	क्या आप अपने बच्चे को लेकर आशा के साथ किसी स्वास्थ्य सुविधा के लिये गई है?	1 2	हॉ नहीं	1 2	

भाग– 3

सहयोगी सेवाएं :

क्रम0 सं0	प्रश्न	श्रेणी	सही उत्तर पर गोला बनाये	..... पर जायें
1	क्या आशा द्वारा आपको संस्थागत प्रसव के बारे में सलाह दी गई थी?	1 हॉ 2 नहीं	1 2	
2	क्या आशा ने आपको जननी सुरक्षा योजना (JSY) के बारे में बाताया?	1 हॉ 2 नहीं	1 2	
3	क्या आशा ने आपको किसी प्रकार के परिवार नियोजन के साधनों को उपलब्ध कराया? (जैसे– कन्डोम, खाने की गोलियॉ इत्यादि)	1 हॉ 2 नहीं	1 2	
4	क्या आशा आपको इन स्वास्थ्य सुविधाओं के लिए कभी स्वास्थ्य इकाई पर ले गई?	1 प्रसव पूर्व देखभाल 2 प्रसव के लिए 3 प्रसवोपरान्त देखभाल 4 परिवार नियोजन 5 अन्य (स्पष्ट करें)	1 2 3 4 5	
5	क्या टीकाकरण के दिन आशा ने गॉव में आपको टीकाकरण के लिये बुलाया था?	1 हॉ 2 नहीं	1 2	
6	क्या आप आशा द्वारा गॉव में आयोजित किसी भी स्वास्थ्य जागरूकता सभा में शामिल हुई है?	1 हॉ 2 नहीं	1 2	

भाग– 4

<u>लाभार्थियों के पास प्रासंगिक प्रपत्रों की उपलब्धता</u> :

क्रम0 सं0	प्रश्न	श्रेणी	सही उत्तर पर गोला बनाये	..... पर जायें
1	क्या आपको (MCP) कार्ड उपलब्ध कराया गया	1 हॉ 2 नहीं 3 उपलब्ध नही	1 2 3	
2	यदि यह एक संस्थागत प्रसव था, तब क्या आपको प्रसव की डिस्चार्ज स्लिप दी गई ?	1 हॉ 2 नहीं 3 उपलब्ध नहीं	1 2 3	
3	क्या आपने अपने शिशु का जन्म प्रमाण पत्र प्राप्त किया ?	1 हॉ 2 नहीं 3 उपलब्ध नही	1 2 3	
4	क्या इस समय आप कोई भी परिवार नियोजन का साधन अपना रही है?	1 हॉ 2 नहीं →	1 2	भाग–**5**
5	क्या यह एक स्थायी या अस्थायी विधि है?	1 स्थायी विधि 2 अस्थायी विधि	1 2	

भाग– 5

आशा के बारे में धारणा :

क्रम0 सं0	प्रश्न	श्रेणी	सही उत्तर पर गोला बनाये	..... पर जायें
1	क्या आवश्यकता पड़ने पर आशा आसानी से उपलब्ध हो जाती है और आपका सहयोग करती है?	1 हॉ 2 नहीं	1 2	
2	क्या आशा नियमित रूप से समुदाय (सभी लोगों) से मुलाकात (सम्पर्क) करती हैं?	1 हॉ 2 नहीं	1 2	
3	क्या आपको लगता है कि समुदाय में स्वास्थ्य को बढ़ावा देने में आशा की भूमिका महत्वपूर्ण है?	1 हॉ 2 नहीं	1 2	
4	यदि आशा गॉव में उपलब्ध न हो तो, आप किसी भी स्वास्थ्य समस्या को लेकर कहाँ जायेगें?	1 सरकारी स्वास्थ्य केन्द्र 2 निजी अस्पताल 3 ए0एन0एम0; 4 स्थानीय स्वास्थ्य सेवाएं प्रदान कर्ता के पास 5 अन्य	1 2 3 4 5	
5	क्या आशा द्वारा दी गई सेवाओं एवं सहयोग के लिये आपसे कोई खर्च लिया गया?	1 हॉ 2 नहीं	1 2	
6	आशा के पास न जाने का क्या कारण है?			

उत्तरदाता का नाम

उत्तरदाता के हस्ताक्षर/अंगूठा

दिनांक :

अवलोकन

सर्वेक्षक का प्रेक्षण/(विचार) : (बातचीत समाप्त होने के बाद भरा जाय)

सामान्य टिप्पणी :

किसी विशेष प्रश्न पर टिप्पणी/प्रेक्षण/विचार /अवलोकन

कोई अन्य टिप्पणी/अवलोकन

पर्यवेक्षक का अवलोकन विचार

सामान्य टिप्पणी

VIMARSH
THE CONSULTANCY GROUP

उत्तर प्रदेश में एक्रीडेटेड सोशल हैल्थ एक्टिविस्ट (आशा) योजना का मूल्यांकन

सन्दर्भ अवधि 1 अप्रैल 2012 से 31 मार्च 2013

परिवारों का सूचीकरण

जनपद_____ब्लाक_____ गॉव_____ जनसंख्या_____

परिवारों की कुल सं._____उपकेन्द्र का नाम_____

अन्वेषक (सर्वेक्षक) का नाम हस्ताक्षर

पर्यवेक्षक का नाम हस्ताक्षर

दिनॉक _____

क्रम संख्या.	परिवार के मुखिया का नाम	पता	क्या आप के परिवार में किसी विवाहित महिला ने 1, अप्रैल 2012 से 31 मार्च 2013 के बीच किसी जीवित या मृत बच्चे को जन्म दिया है? **हॉ या नहीं (हॉ–1, नहीं–2)**	यदि हॉ, तो पात्र महिलाओं की संख्या	पात्र परिवारों की क्रम संख्या

क्रम संख्या.	परिवार के मुखिया का नाम	पता	क्या आप के परिवार में किसी विवाहित महिला ने 1, अप्रैल 2012 से 31 मार्च 2013 के बीच किसी जीवित या मृत बच्चे को जन्म दिया है? **हॉ या नहीं (हॉ–1, नहीं–2)**	यदि हॉ, तो पात्र महिलाओं की संख्या	पात्र परिवारों की क्रम संख्या

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Sponsoring Agency:
State Innovations in Family Planning Services Project Agency (SIFPSA)
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Lucknow, Uttar Pradesh

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