Summer Training at
National Rural Health Mission,
Odisha
(April - June, 2013)

IMPACT OF ASHA TO BRING CHANGE IN HEALTH SEEKING BEHAVIOR AT COMMUNITY LEVEL, DHENKANAL DISTRICT, ODISHA

By
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Under the guidance of
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CERTIFICATE

This is to certify that **Dr.Adish Kumar** student of the 17th batch of the Post graduate Diploma in Health and Hospital Management (PGDHM) at Institute of Health management and Research, Jaipur underwent the summer internship at **National Rural Health Mission, Odisha** from April 8th to June 8th 2013 and performed study on **Impact of ASHA to bring change in Health seeking behavior at Community Level, Dhenkanal district,Odisha**

The candidate successfully carried out the study assigned to him during summer training and his approach to the study was sincere, scientific and analytical.

We wish him success in all his future endeavours.

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Finally , most importantly, I would like to express my heartful thanks to my beloved parents for their blessings and my friends for their help and wishes for the successful completion of this training.

Dr. Adish Kumar

ABBREVIATIONS

ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWC	Anganwadi centre
AWW	Anganwadi Worker
AYUSH	Ayurveda, Yoga and Naturopathy, Unani, Siddha, SowaRigpa and Homeopathy
BCC	Behavior Change Communication
BPM	Block Project Manager
CHC	Community Health Center
CPRC	Community Processes Resource Center
DDK	Disposable Delivery Kits
DH	District Hospital
DLHS	District Level Health Survey
DOTS	directly observed treatment, short-course
DPM	District Project Manager
EDD	Expected Date of Delivery
FGDs	Focus Group Discussion
FRU	First Referral Unit
GIS	Geographic Information System
GPS	Global Positioning System
HMC	Health monitoring and planning Committee
HMIS	Health Management Information System
HRMIS	Human Resources Management Information System
ICDS	Integrated Child Development Services (ICDS)
IEC	Information education and communication
IFA	Iron and folic acid tablet
IMR	Infant Mortality Rate
IPHS	Indian Public Health Standards
IT	Information technology
JSSK	Janani Shishu Suraksha Karyakram
JSY	Janani Suraksha Yojana
MHU	Mobile health unit
MMR	Maternal Mortality Ratio
NGO	Non-governmental organizations

NHSRC	National Health Systems Resource Centre
NIPI	Norway - India Partnership Initiative
NRHM	National rural health mission
NSV	No-scalpel vasectomy
OAS	Orissa Administrative Service
ORS	Oral Rehydration Solution
OSMIS	ODISHA STATE MALARIA INFORMATION SYSTEM
OVLMS	Orissa Vaccine Logistic Management System
PHC	Primary health centre
PNC	Post natal care
PPP	public–private partnership
PRI	Panchayati Raj Institutions
RGH	Rourkela Government Hospital
RKS	Rogi Kalyan Samiti
SC	Sub-center
SHRSC	State Health Systems Resource Centre
SPSS	Statistical Package for the Social Sciences
ST	Schedule tribes
TFR	Total Fertility Rate
TT	Tetanus Toxoid
VHND	Village Health & Nutrition Day
VH&SC	Village Health &Sanitation Committee
V-1,2,3,4 Sub center	Vulnerability graded subcentres

OVERVIEW

Summer internship is an integral part of the PGDHM currriculum. As a part of the course; students of the first year are required to undergo summer training at an organization to get in depth exposure of various departmenrs in the organization and better understanding of the health care delivery system.

The major objectives of the summer training programs are as follows:

1) To better understand the existing health delivery system including public and private sectors.
2) To observe the implementation of various National Health Programmes at National/ State/ District levels.
3) To understand various functions of health systems by interactions with key stakeholders, policy makers, programme managers, academicians and researchers
4) To work on the project/task assigned by summer training organizations.

During my training period I had an overview of various programmes undertaken in National Rural Health Mission,Odhisa including the current status of the programmes. I also carried out a small study on **"**Impact of ASHA to bring change in Health seeking Behaviour at Community Level.A case study of Dhenkanal,odhisa"

Part A: The Organization Profile

1.1. Introduction

The Hon'ble Prime Minister of India Dr. Manmohan Singh launched NRHM on April 12th2005 in the country, with special focus on 18 states including Orissa. It is the Biggest ever health project in the health sector in the last 50 years. It recognizes the importance of health care in the process of economic and social development and improving the quality of lives of our citizens. It provides effective health care to rural population throughout the country with focus on 18 states, which have weak public health indicators and weak infrastructures.

The Hon'ble Chief Minister of Orissa, Shri Naveen Patnaik in presence of the Union Minister Health & Family Welfare, Shri Anbumani Ramadoss launched the NRHM programme throughout the state on 17 June 2005 with goal of "Healthcare to All".

The state of Odisha has an area of 155,707 km² and population of 41,947,358. Odisha is the ninth largest state by area in India, and the population. There are 30 Districts; each district is subdivided into sub-divisions 58 therefore into blocks 314. Blocks consist of Panchayats (village councils) & town municipalities. The state has population density of 270/km^{2} (as against the national average of 382 per square kilometer).the decadal growth rate of the state is +15.94 % (against 21.54% for the country) and the population of the state is growing at a slower rate than the national rate.

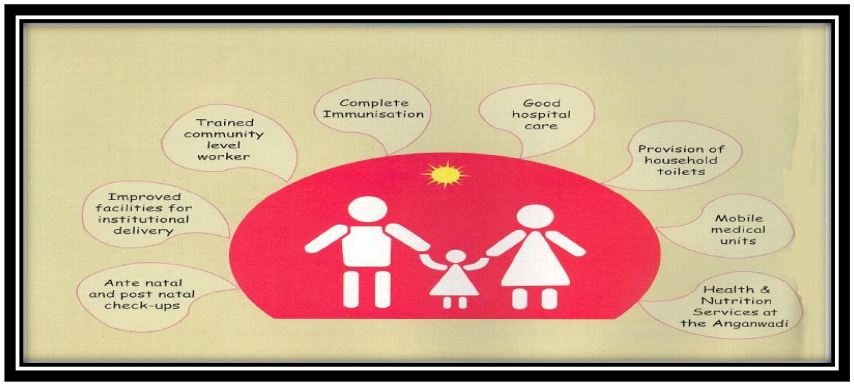


Figure No. 1: Functions of NRHM

In Orissa, more than 85% of the population live in rural areas and depend mostly on agriculture. The percentages of SC & STs constitute 16.53 & 22.13 respectively of the total state population. Nearly 45% of the state area in as many as 13 districts has been declared as Scheduled Areas.

Considering that good health is an important asset of livelihood and illness a major cause of impoverishment, the health and allied sector in the state has made noticeable improvements in leprosy control, Polio eradication, Infant

Mortality Rate (IMR), Maternal Mortality Ratio (MMR), Malaria, Crude Birth Rate, Crude Death Rate, Life Expectancy at Birth, Nutritional Status, Literacy, drinking water supply and sanitation.

NRHM has an important role in the provision and administration of health services and in order to raise the quality, extend accountability and deliver the services fairly, effectively and courteously.

The NRHM primarily seeks to provide preventive, promotive, curative and rehabilitative health services to the people through primary health care approach that has been accepted as one of the main instruments of action for development of human resources, accelerating the socio-economic development and attaining improved quality of life. Primary health care is essential health care for all citizens, easily accessible and at cost, which citizens and community can afford.

In the rural areas services are provided through a network of integrates health and family welfare delivery system. The primary health care infrastructure has been developed as a three tier system-sub-centers, Primary Health centers and Community Health Centers. Sub-Centers is the most peripheral contact point between the Primary health care system and the community and is manned generally by Multi- Purpose Health Workers(Male & Female), AWW and ASHA. Medical Officer supported by Para-Medical and other staff operates primary Health center. Some of the PHCs are running under PP model.

1.2. Objectives of National Rural Health Mission:

i. To bring IMR to less than 28
ii. To bring MMR to less than 100
iii. To achieve TFR of 2.1
iv. To strengthen the existing infrastructure
v. Appointment of contractual staff
vi. To increase community participation with help of Rogi Kalyan Samiti at all hospitals and Village health and sanitation committees.

1.3. Objectives of State Health Society:

1.3.1. RCH Objectives

i. To reduce Total Fertility Rate from 2.47 to 2.1 by 2010 in the State of Orissa
ii. To reduce Infant Mortality Rate from the present level of 71 /1000 live births to 50/1000 live births by 2010 in the State of Orissa
iii. To reduce Maternal Mortality Rate from the present level of 358/100,000 to 250/100, 000 by 2010 in the State of Orissa.

1.3.2. NRHM Initiatives General Objectives:

i. Reduction in child and maternal mortality.
ii. Universal access to public services for food and nutrition, sanitation and hygiene, and universal access to public health care services with emphasis on services addressing women's and children's health and universal immunization.
iii. Prevention and control of communicable and non-communicable diseases, including locally endemic diseases.
iv. Access to integrated comprehensive primary health care.
v. Population stabilization, gender and demographic balance.
vi. Revitalization of local health traditions and mainstream AYUSH.
vii. Promotion of healthy life styles.

1.3.3. Objectives of ASHA:

i. Create awareness on health and its social determinants.
ii. Mobilize the community towards local health planning.
iii. Increase utilization and accountability of the existing health services.
iv. Promote good health practices.
v. Provide a minimum package of curative care as appropriate and feasible for that level.
vi. Undertaking timely referrals.

1.3.4. Board Objective of Mainstreaming of AYUSH:

i. Mainstreaming of AYUSH in the health care service delivery system to strengthen the existing public health system.

1.3.5. Objectives of United Fund For Sub Centers:

i. To increase functional, administrative and financial resources and autonomy to the field units.
ii. To develop the physical infrastructure and centre specific activities for PHCs.

1.3.6. Objectives of RSK:

i. Ensure compliance to minimal standard for facility and hospital care and protocols of treatment as issued by the Government.
ii. Ensure accountability of the public health providers to the community.
iii. Introduce transparency with regard to management of funds.
iv. Upgrade and modernize the health services provided by the hospital and any associated outreach services.

v. Supervise the implementation of National Health Programmes at the Hospital and other institutions that maybe placed under its administrative jurisdiction.
vi. Organize outreach services/ health camps at facilities under the jurisdiction of the hospital Display a Citizen's Charter in the Health facility.
vii. Generate resources locally through donations, user fees and other means.
viii. Establish affiliations with private institutions to upgrade services
ix. Undertake construction and expansion in the hospital building
x. Ensure optimal use of hospital land as per govt. guidelines
xi. Improve participation of the society in the running of the hospitals
xii. Ensure proper training for doctors and staff
xiii. Ensure subsidized food, medicines, drinking water and cleanliness to the patients and the attendants.
xiv. Ensure proper use, timely maintenance and repair of hospital building equipment and machinery.

1.3.7. Objectives of Mobile health Units:

i. Every district will have at least operational mobile medical unit for delivering health services in terms of preventive, promotive, curative and effective to rural population especially to poor woman, children & old.

1.3.8. Objectives of Strengthening of PHC/CHC/UGPHC to Indian Public Health Standard:

i. To provide optimal expert care to the community.
ii. To achieve and maintain an acceptable standard quality care in terms of Assured Services.
iii. To make the services more responsive and sensitive to the needs of the community.

1.3.9. Objectives of Immunization:

Districts will provide equitable, efficient and safe immunization services to all infants and pregnant women. Aim is to achieve 100% full immunization status by 2009-2010 and to maintain it for long.

2005-06---------50%

2006-07---------60%

2007-08---------75%

2008-09---------95%

2009-10---------100%

i. Contribute global eradication of Polio by 2007.
ii. Elimination of Neonatal Tetanus, Diphtheria and Pertussis by 2009.

iii. Measles mortality and morbidity reduction to 80% by 2010, compared to 2000 estimates.

iv. Achieve and maintain vitamin A supplementation coverage >80% under the age of 3 yrs

v. Establish sufficient sustainable and accountable fund flow at all levels.

vi. Ensure there is sustained demand and reduced social barriers to access immunization services.

1.3.10. Objectives of the NIDDCP:

i. Assess the magnitude of IDD by periodic surveys.

ii. Re-survey after every 5-years to assess the extent of IDD and the impact of Iodized Salt.

iii. Laboratory Monitoring of Iodized Salt and Urinary Iodine excretion.

1.4. NRHM Approach: NRHM is working under following five main approaches.

1.4.1. COMMUNITIZE

i. HMC/RKS / PRIs at all levels
ii. Untied grants to community/PRI Bodies
iii. Funds, functions & functionaries to local community organizations
iv. Decentralized planning, VH&S Committees

1.4.2. MONITOR,PROGRESS AGAINST STANDARDS

i. Setting IPHS Standards
ii. Facility Surveys
iii. Independent Monitoring Committees at Block, District & State levels

1.4.3. FLEXIBLE FINANCING

i. Untied grants to institutions
ii. NGO sector for public Health goals
iii. NGOs as implementers
iv. Risk Pooling – money follows patient
v. More resources for more reform

1.4.4. IMPROVED MANAGEMENT THROUGH CAPACITY

i. Block & District Health Office with management skills
ii. NGOs in capacity building
iii. NHSRC / SHSRC / DRG / BRG
iv. Continuous skill development

1.4.5. INNOVATION IN HUMAN RESOURCE MANAGEMENT

i. More Nurses – local Resident criteria
ii. 24 X 7 emergencies by Nurses at PHC. AYUSH
iii. 24 x 7 medical emergency at CHC

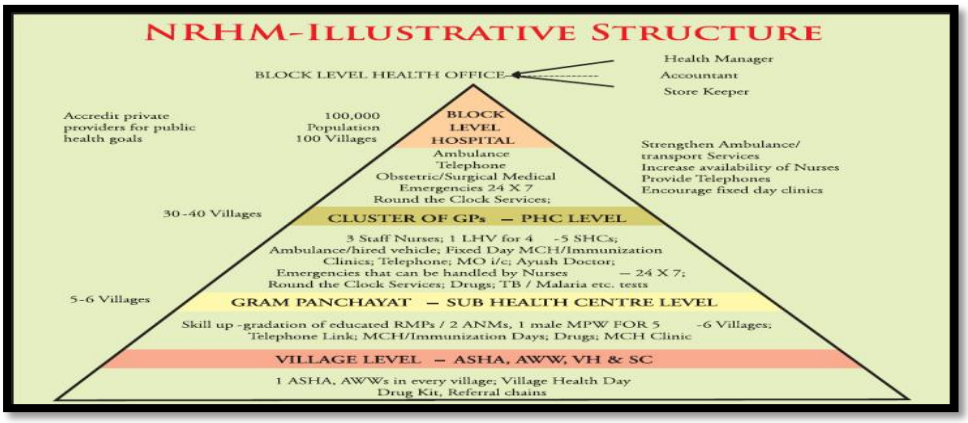


Figure No.2: NRHM-Illustrative structure

1.5. State Initiatives:

1. *Swasthya Kantha Campaign:* To provide health related communication information to rural population by writing the information on specific walls meant for the purpose. The walls are located at strategic points in most villages.
2. *ASHA PNC:* Home based post natal care for mother and infant by ASHA
3. Bicycles provided to ASHA for greater mobility so as to reach difficult and distant areas. Cycle is preferred in many villages due to lack of proper infrastructure of roads in those areas
4. ASHA Fixed day payment (10^{th} of every month) to address grievances related to payment of ASHA incentives in time and encouraging performance based incentive motivation
5. The Government of Odhisa has started the 108 Ambulance Service this year.
6. ASHA Gruha providing help desk cum rest shed for ASHA in hospitals
7. Gramsat to promote health provisions
8. *Public- private partnership:*

   i. *Urban Slum Health Project:* Targeted for outreach and vulnerable areas. Provides services for health, hygiene, sanitation and nutrition.

   ii. *AROGYA Plus project:* Specially targeted at Naxalite areas for providing health services to these areas. This project functions similarly as mobile health units

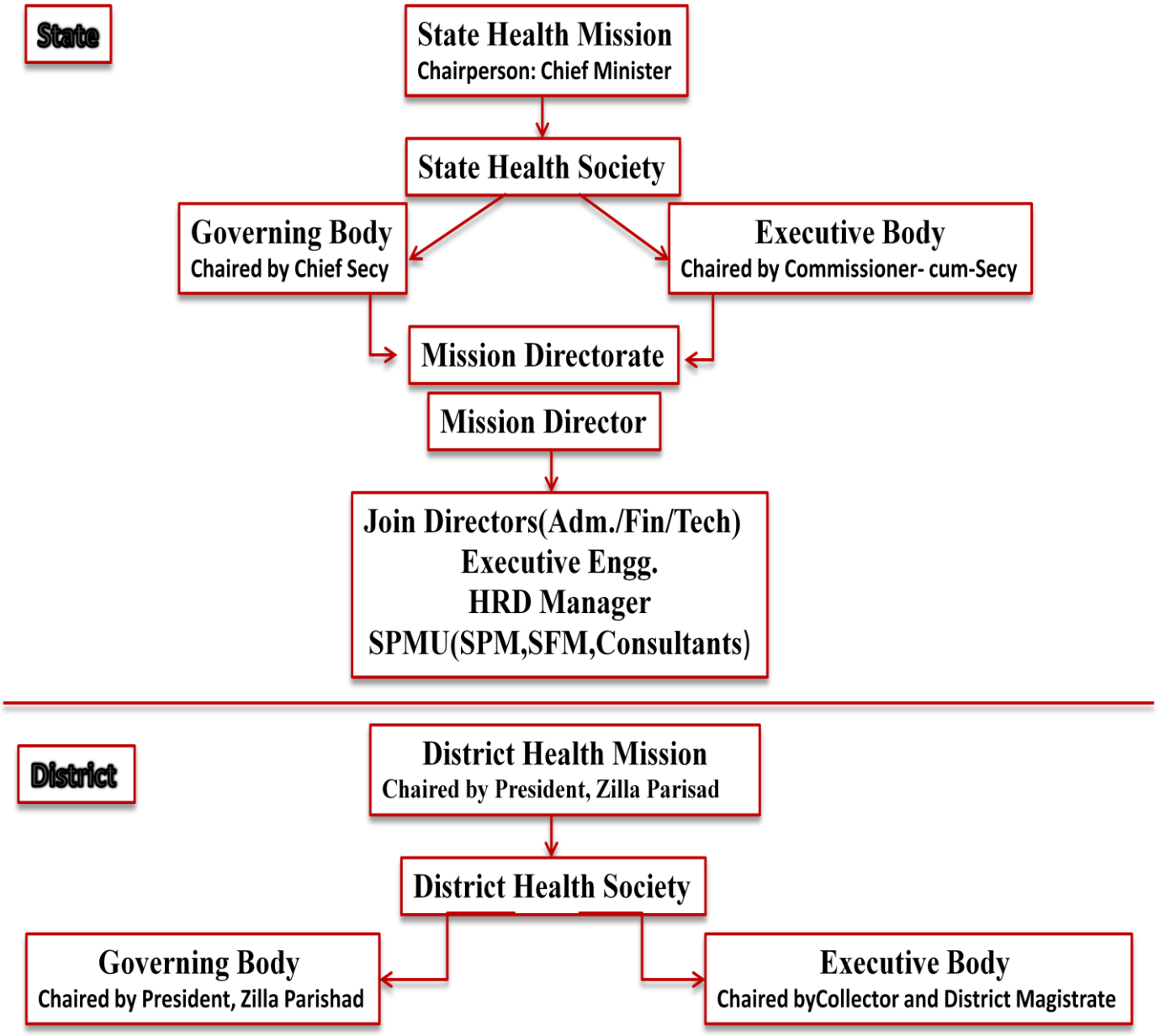
   iii. *PHC New project:* 32 PHC (New) in very outreach areas

   iv. *VG project:* Meant for primitive tribe groups

   v. *Maternity Waiting Home:* Providing PNC support to pregnant women in outreach areas. Providing temporary home for expectant mothers living in hard to reach tribal areas, where they come 5-7 days before EDD and can wait for delivery

9. *Mobile Health Unit:* To provide preventive, promotive & curative health services in the inaccessible areas & difficult terrains which are un-served /underserved under usual circumstances
10. *Janani Express:* Free referral transport system to promote institutional delivery and reduce out of pocket expenditure by providing nonstop free transport facility and contributing in reduction of infant and maternal mortality
11. *Mobile Boat Clinic:* To provide basic health services to people of most inaccessible and difficult areas of Malkanagiridistrict (Naxalite area)
12. *Tika Express:* An alternate vaccine delivery system for children of difficult and tribal dominated pockets
13. *Sick New Born Care Unit:* To improve neonatal survival and provide special level- II care to neonates including low birth weight and sick neonates
14. *Single Window:* Janani Sewa Kendra for JSY beneficiaries to reach upto a mark of 100% birth registration and to provide all major MCH related benefits at facility level
15. *IT initiatives:* e-Swasthya Nirman, e-Blood Bank, e-Sanjog (GPS based MHU tracking system), HRMIS, Grievance Redressal System for JSSK scheme, OSMIS, OVLM

1.6. Organogram:



Part B: My Summer Training Project

Executive Summary:

The project is to assess the Impact of ASHA to bring change in Health Behaviour at Community Level especially among the ANC/PNC beneficiaries in Odisha.

In 2007, before implementing of ASHA, MMR was 300, IMR was 65 & TFR 2.3 and it is gradually showing decline trends .however, it is still a matter of great concern that this change is occurring due to presence or after implementation of ASHA or some other factors are responsible. Since creating behavioral changes and awareness among the communities about the facilities provided by government for better health of people is main job of ASHA. A descriptive cross-sectional study carried out among the ANC/PNC beneficiaries to assess whether ASHA is responsible for these changes among these beneficiaries in Odisha.

The study covered two blocks of Dhenkanal district of Odisha with sample of 117 selected from the sub- centers of Blocks. Their knowledge and awareness was assessed with the help FGDs and semi-structured questionnaires. Data was analyzed using SPSS and content analysis.

The finding showed that the ASHA is acting as a catalytic agent to bring positive health behavior change in the community more than 97 percent of people willing to have institutional delivery and 94 percent preferred government infrastructure and facilities for ANC care. ASHA is playing major role to enhance institutional delivery significantly as a result decrease in MMR & IMR rapidly.

2. 1 Introduction

The National Rural Health Mission (NRHM) is a strategy for integrating ongoing of Health & Family Welfare, and addressing issues related to the determinants of Health, like sanitation, Nutrition, Safe Drinking water. The NRHM seeks to adopt a sector wide approach and aims at systematic reforms to enable efficiency in health service delivery. One of the key components of the National Rural Health Mission is to provide every village in the country with a trained female community health activist – 'ASHA' or Accredited Social Health Activist -who would serve as a link between community and the rural health system.

As a health activist in the community ASHA would create awareness on health and its social determinants, mobilize the community and facilitate them in accessing health and health related services available at the village/sub-center/primary health centers, such as Immunization, Ante Natal Check-up (ANC), Post Natal Check-up (PNC), ICDS, sanitation and other services being provided by the government. She will counsel women on different issues including birth Preparedness & importance of safe delivery. She will arrange escort/accompany pregnant women & children requiring treatment/ admission to the nearest pre- identified health facility i.e. Primary Health Centre/ Community Health Centre/ First Referral Unit (PHC/CHC /FRU).

Despite the skepticism of the early years, influenced partly by the memory of the country's not very successful past Community Health Worker efforts, today the ASHA programme has 850,000 ASHAs across the country, and can confidently claim to have contributed in no small measure to the achievements of the NRHM.

ASHAs have moved from promoting institutional delivery and immunization to providing home based care and counseling for pregnant women, newborns and children. The portfolio of services that the ASHA offers also includes the promotion of products such as sanitary napkins and spacing contraceptives not as commercial commodities but as behavior change delivery vehicles.

A primary resident of the same village with formal education up to VIII and preferably in the age group of 25-45 she would be selected by following intensive community level processes. However, she would not be paid any monthly fixed honorarium, but would be entitled for performance-based compensation for the contribution that she makes at the community level.

Each of the ASHAs is provided with drug kits, which she uses for the treatment of the common minor ailments. Besides, she also share information and mobilizes action around good health

care practices. Fulfillment of these roles are envisaged through continuous skill up gradation and providing required adequate support system.

In Odhisa state, ASHA called as *"ASHA didi"*. ASHAs are selected coterminous with Anganwadi Centers. 34252 ASHAs have been selected in the state. ASHAs have been provided with induction and thematic Training to act as "Agents of Change".

40594 ASHAs positioned in the state (by December 2010), 41102 to be completed by Jan 2011. 608 ASHAs positioned in 11 urban slum locations to address the health issues in urban slums. Selection of 365 ASHAs who have left, resigned and died is in progress. Selection of ASHA in hard to reach habitations (V3 and V4 sub centre areas) is in progress with an objective to ensure the presence of ASHA in the habitations with having a minimum of 100 population in V3 and V4 sub centre areas. These trainings have sensitized ASHAs on their role and improved knowledge on different health issues and disease control measures. Guideline issued for conducting the Thematic training on a public private partnership mode with the support of the NGOs. Improving the quality of training has been the thrust of the program.

ASHAs have contributed significantly for the implementation of **Janani Suraksha Yojana (JSY)** under NRHM. Out of the total 411774 number of institutional deliveries conducted during the year 2007-08, ASHAs have accompanied 226265 numbers of pregnant women to the health institutions for delivery that is around 55% of the total number of cases. Besides, they have also motivated number of cases for promoting institutional delivery. This has increased the Institutional Delivery in the state by 40% (HMIS).

Though primarily involved in promoting institutional delivery to begin with, at present ASHA is a multi-faceted community health worker acting as a link person between community and the health facility.

2.1.1. Roles & Responsibilities:

ASHA is responsible for creating Awareness on Health including

i. Providing information to the community on nutrition, hygiene and sanitation
ii. Promoting universal immunization
iii. Providing information on existing health services and mobilizing and helping the community in accessing health related services available a health centers.
iv. Registering pregnant women and helping poor women to get BPL certification.
v. Counseling women on birth preparedness, safe delivery, breast feeding, contraception RTI/STI and care of young child.
vi. Arranging escort/accompanying pregnant women and children requiring treatment/admission to the nearest health centre.

vii. Providing primary medical care for minor ailments. Keeping a drug kit containing generic AYUSH and allopathic formulations for common ailments.

viii. Promoting construction of household toilets.

ix. Facilitating preparation and implementation of the Village Health Plan through AWW, ANM, SHG members under the leadership of village health committee.

x. Organizing Health Day once/twice a month at the Anganwadi with the AWW and ANM.

xi. ASHA is also a depot holder for essential services like IFA, OCP, condoms, ORS, DDK etc issued by AWW & ANM.

2.1.2. Capacity Development:

i. Induction and modular training (module 1 – 4) completed for all the ASHAs except for the newly ASHAs selected in recent past. 100% completion by end of January 2011.

ii. All the ASHAs completed Module 5 training except the newly selected ones, 100% completion by March 2011.

iii. Around 21000 ASHAs trained in First Aid, 100% completion by March 2011.

iv. 21452 completed FTD training, NISCHAYA training completed for all ASHAs, PNC training completed in three districts by NIPI, DOTS and Leprosy training completed.

v. Refresher training of ASHAs on going in districts. Four modules to be completed by March 2011.

vi. Training of ASHA on module 6 and 7 initiated. 12 State Master trainers trained in National TOT. Selection of District Master Trainers completed in 10 districts. Up gradation of State Training Site is in process.

vii. Training of ASHAs regarding their role in flood situation management is completed in 14 flood-affected districts.

2.1.3. Incentive payment

i. Fixed day incentive payment on 10th of every month, which is declared as "ASHA Incentive Payment Day". All payment through e-transfer and AC payee cheques.

ii. Clearance of backlog payment through special drives and no backlog in incentive payment is ensured. Grievance redressal mechanisms at various levels.

iii. Scope of incentive payment is expanded with a total 22 incentive provisions in place.

2.1.4. Support provisions

i. Drug kit has been provided to all the ASHAs who have completed the induction and modular training. Drugs have been replenished for ASHA Drug Kit. Drug kit use manual provided to each ASHA to facilitate effective use of ASHA Drug kit.

ii. First Aid kit is being provided to the ASHAs who have completed training in First Aid Kit.

iii. Monthly ASHA sector meeting has been institutionalized as a forum for programme strengthening.

iv. 88 ASHA Gruhas has been made operational at health facilities, which include DHH, Capital Hospital, RGH, Medical Colleges and L3 institutions. Completion of ASHA Gruha in all L3 institutions by March 2011.

v. Award for best performance to ASHAs has been institutionalized at different levels.

vi. District and Block level ASHA Diwas is organized for activity planning, monitoring and grievance redressal.

vii. Uniform provided to all ASHAs, comprehensive Diary given to ASHAs. Bi cycle provided to facilitate mobility provision.

viii. ASHA Conventions organized at the district level to facilitate peer learning and sharing of experience.

ix. Community Processes Resource Center (CPRC) is functional in Mission Directorate, NRHM to provide facilitation and handholding support for community processes implementation in the state.

2.1.5. The following are the key focus areas of ASHA programme implementation :

i. Strengthen support system to promote "Each ASHA as effective and empowered"

ii. Need based capacity building of ASHAs in hard to reach habitations with a focus on language, culture and educational background.

iii. Specific plans to facilitate support provisions for the ASHAs located in difficult to reach habitations.

iv. Establish and strengthen sub-block level facilitation support through the positioning of Block Community Mobilizer and Community Facilitator

v. Ensure supportive supervision mechanism and in field facilitation support based on the capacity and specificity of each ASHA.

vi. Improve functional effectiveness of each ASHA by proper tracking of the knowledge base, skills, activity performance and providing need based handholding support.

vii. Expanding the scope of incentive provisions, maximizing amount of incentive to ASHAs, timely payment, grievance redressal mechanisms.

viii. Tracking the contribution of each ASHA, attrition rate and mechanism for ensuring performance of each ASHA as per the bench mark/criteria.

The Notebook provided to ASHA for entry of their beneficiaries and services them/ has to provide.

2.2. Aim of the study:

To assess the impact of ASHA to bring change in health behavior practices at community level.

2.3. Objectives:

i. To evaluate the impact of ASHAs on health seeking practices of pregnant women's.
ii. To evaluate the increased percentage of utilization of family planning measures (methods of contraception)

Indicators:

i. Percentage of women to attend VHNDs in Village.
ii. Percentage of pregnant women utilizing Antenatal Care from public health care facilities. (TT inj. ,IFA Tablets)
iii. Increased knowledge about the colostrums feeding of beneficiaries.
iv. Percentage of increased Permanent methods users.
v. Percentage of increased Temporary method users.

Finding is compared with the DLHS 2007-08 data to know how much percentage of change is seen in perception of community towards health seeking behavior.

2.4. Research Question:

i. Is there any increased trend in health behavior regarding maternal and child health after introduction of ASHA in Gondia & Kamakhyanagar block of Dhenkanal district, Odhisa, India?
ii. Has there been any percentage increase in sterilization methods after introduction of ASHAs?

2.5. Rationale of the study:

i. The Government of India has launched National Rural Health Mission (NRHM) to address the health needs of rural population, especially the vulnerable section of the society. The sub-centre, which is the peripheral level of contact with the community under the public health infrastructure, caters to a large population of 5000. The ANM is overworked, which influences upon outreach services in rural areas.

ii. To complement the work of ANM, ASHA (the Accredited Social Health Activist) is selected through a selection process to fill the gaps in the health care delivery system. She is a volunteer who acts as a bridge between the community and the available health care system. The ASHA strengthens the link between health sector and community. The role and responsibilities of ASHA indicate that she has a significant role in the achievement of the objective set for the mission. She is working towards catalyzing behavioral change in rural and tribal areas of the state. ASHA is contributing towards enhancing quality of life with focus on health nutrition,

sanitation, drinking water etc. Looking at this it was thought to undertake a study to analyze how much community had a effect of the ASHAs on their health seeking behavior. The present study was planned to understand and analyze impact of ASHAs on the community with the objectives given below.

2.6. Geographical Boundaries:

The study cover 2 blocks Gondia & Khamakhyanagar of Dhenkanal district of Odhisa.

Odhisa is situated on subcontinent's southeast coast, by the Bay of Bengal. It is surrounded by west Bengal to the northeast and in the east, Jharkhand to the north, Chattisgarh to the west and north-west and Andhra Pradesh to the south.

Odhisa having 30 districts. The study conducted in Dhenkanal district of Odhisa.

Dhenkanal district is occupying a central position in the Geo-political map of odhisa. It is the district, which touches the boundary of Keonjhar in the north, jajpur in the east, Cuttack in the south and Angul in the west.

Total population: 11, 92,948

Total Area: 4452 Sq.kms , Blocks: 8

Our proposed study aims was to cover Gondia & Kamakhyanagar block.

Basic Information	Gondia Block	Kamakhyanagar Block
Name of the CHC	Sriramchandrapur	Anlabereni
Area of the Block	692.77 Kms	190 Sq.Kms
Population	1,52,498	1,13,929
Total No's of village	163	116
Total Hamlet	22	
Total Sector	05	04
Total No's of sub-center	23	21

Table No 1: Basic Information of Blocks where surveys conducted

2.7. METHODOLOGY

The following tools were used for carrying out the study; some of the tools were purely used for exploratory research.

i. *Secondary Data:* Documents offered by National rural health mission, Odhisa, Module for ASHA and few research documents were studied in great depth for a better understanding of the projects.

ii. *Primary Data:* Primary research was done in form of interview ASHA & interview schedule & FGDs of Beneficiaries at block Gondia & Kamakhyanagar in Dhenkanal to complete the survey.

2.7.1. Study Type : Cross-Sectional Descriptive Study

2.7.2. Sampling Unit **:** Purposiviely selected Gondia and Kamakhyanagar Block from Dhenkanal District

2.7.3. Study Respondents: Service Provider: ASHA, Beneficiaries: Pregnant women (under ANC) and Women, who have given birth in- last 6 months

2.7.4. Sampling Design: Purposive Sampling

GONDIA & Kamakhyanagar blocks have been selected deliberately considering that selected sample will be representative of the whole district: ASHA: from identified Villages.

Beneficiaries: identified women who having ANC checkups and who has given birth in the last six months

2.7.5. Criteria for selecting the sample:

The sample size selected was based on convenient sampling. Looking into the very short time line of the completion of the report two blocks were chosen from district for the survey. Blocks were close to the district headquarter around 25-50km from the head quarter. Further sub centers were selected from sectors of each block. It was noticed during selection of sub centers that in selected sub centers ASHAs are available.

2.7.6. Sampling Size:

Interview Schedule	117 (Beneficiaries)
In-Depth Interviews	18 (ASHAs)
FGDs	04 (5 beneficiaries per FGD)
Villages survey	19

Table No 2: Total Sample size collected

Gondia Block	Villages Surveyed
JORUNDA Sc	1. Atinda
	2. Natima
MATHENTHULIA Sc	1. Barpa
	2. Mundhubari
	3. Jambu
SARISIPADA Sc	1. Kolha
DEOGAN Sc	1. Deogan
	2. Dagerapali
PINGUA Sc	1. Pingua

Kamakhyanagar Block	Villages Surveyed
TUMUSINGHA Sc	1. Tumasingha
TANGAR Sc	1. Tangar
	2. Chitagarh
	3. Kantajharia
RAINARSINGPUR Sc	1. Sriarampur
	2. Rainarsingpur
BAISINGA Sc	i. Baisingha
	ii. Nausahi

Table No 3: Sub-center and villages visited during scheduled timeline of study

2.7.7. Tools and Techniques:

- ✓ *Tools*

i. FGD: Guideline

ii. in-depth interview: Semi structured Questionnaire for qualitative information

iii. Survey: Survey form for quantitative information

- ✓ *Techniques*

i. FGD:

There was random selection for Women for FGD. FGDs were conducted with potential beneficiaries, women who are in the ANC /PNC periods and benefited from service of ASHAs. Four (4) FGDs are conducted. Two (2) FGDs will be conducted in each block. In each selected village, FGDs was conducted in two different locations in each FGD there was least 5-6 women.

ii. Interview: In depth interview for ASHA has conduct to get relevant information.

iii. Survey: All women who are pregnant and have given birth in the last six months have been surveyed.

2.7.8. Data Analysis Plan:

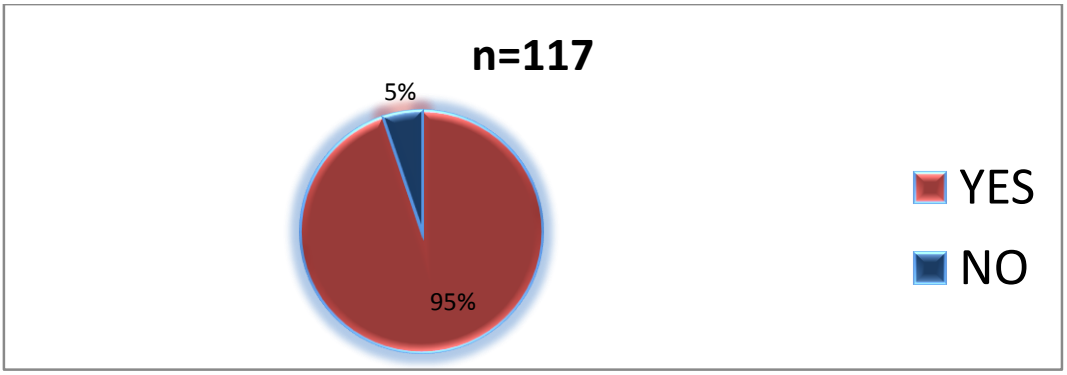
Data entry and its analysis were done by using SPSS software along with Microsoft Excel wherever required.

2.8. Finding and Analysis:

No of childrens	ANC beneficiaries	PNC Beneficiaries	
0(first time pregnant)	36	0	
1	26	16	
2	4	23	
3	1	8	
4	0	2	
7	0	1	
Total	67	50	117

Table No 4: Total number of Beneficiaries/service provider interacted

a) Beneficiaries know about ASHAs.



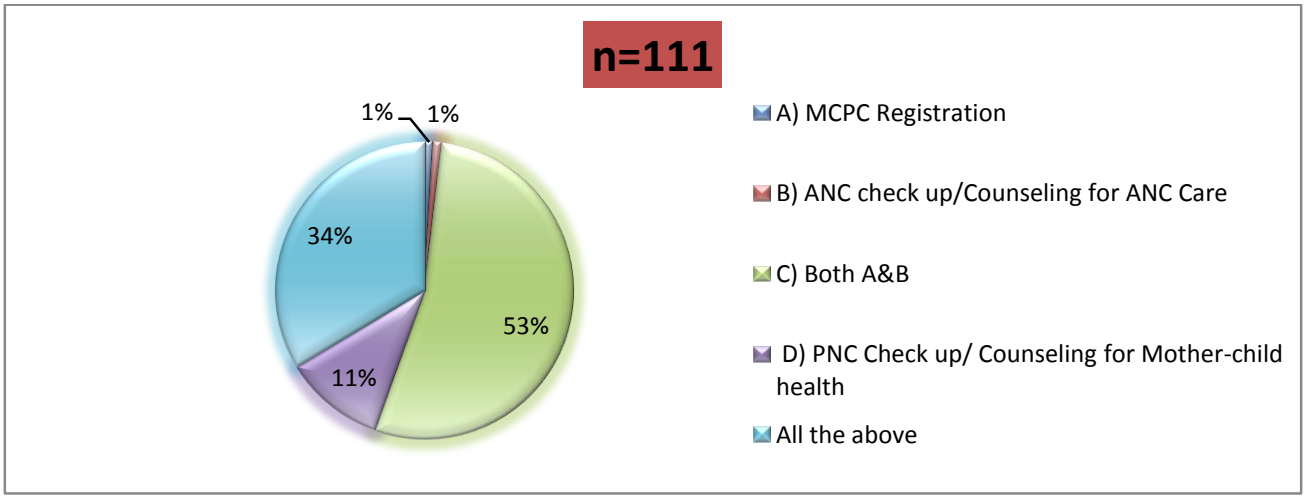
There has been an overwhelming response of the community in stating that the ASHA is playing a critical role in facilitating the process of registration, administration of TT, consumption of IFA, chemoprophylaxis, colostrums feeding, exclusive breast feeding, immunization etc besides giving routine counseling. Further, the intervention of ASHA has resulted in dispelling various blind beliefs and they are able to avail of proper medical counseling and services on time regarding care during pregnancy and newborn care.

..ASHA didi is always ready to help us .she visit to our home regularly, if we have any health problem we share with her including our family problem. she really care the mother and child. She is like one of the family member to us. ..**Munni Behra, 25 yr, mother**

Baisingha village, Khamakhyanagar, Dhenkanal

It was observed that 111out of 117 beneficiaries interviewed know ASHAs of their villages at personal level. The rest 6 people were from the village where still ASHA not appointed or facilitates the services. The six people were receiving the services through ANM of concern sub center.

b) Attending Village Health & Nutrition Day (MAMTA DIVAS).



VHND is conducted on Tuesday and Friday of every week of each month. The ASHA also has played a major role in organizing monthly health days for immunization and other health services. The ASHA collected the names of beneficiaries for the health day and informed them in advance to ensure maximum participation.

The Village Health and Nutrition days (VHND) were observed every month where ASHAs participated in collaboration with the ANMs and AWWs in almost all the villages. In few villages, the SHGs also joined the Village Health and Nutrition Days. The ASHA gets the information of pregnant and lactating mothers, Grade-III and Grade-IV children from the ANM and AWW before the day is observed to have effective coordination. In general, the following activities done in the VHNDs including: a) MCPCard registration of newly pregnant women. b) Weight measurement of pregnant woman and Children with the age group of 0 to 3 years. c) BP and abdominal check up of pregnant women, d) counseling of pregnant women and newly delivered mother regarding cares and measures should be taken. e) Motivation and education for family planning measures.

The study shows that women's are highly motivated and educated regarding the VHND and they know what services they receive on VHND days.

Out of total interviewed beneficiaries 53% told they visit VHND at AWC because they were registered for MCPCard and get medicines and counseling for pregnancy period.34% replied that they received all the medicines(TT.IFA tablets),check-ups(more than 3 times)and counseling for cares during ANC & PNC (colostrums feeding, new born care).

c) Prefernce of public health care facilities for Utilization of ANC Care

Response	Number of Respondents	Acc to DLHS -3 (Dhenaka nl)
Government Facility (AWW,Sc,PHC,CHC)	105 (94%)	74.3%
Private Facility (Nursing homes)	04 (04%)	13.9%
Community based services(Home, Trust)	02 (02%)	4.5%
Total	111	

Table No 5: Preferred of facilities for utilization of ANC care

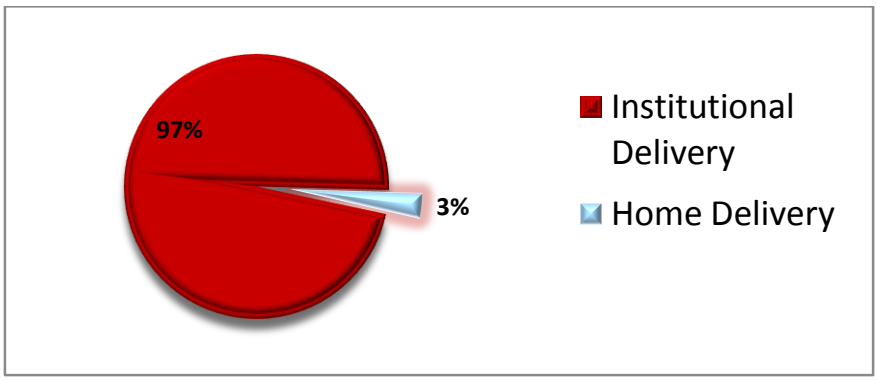
Antenatal care is an important aspect of maternal as well as newborn health. Ideally a pregnant mother should have 3 or more visits during anteantal care.

Visit at on immunization Day at kohla(gondia block)

Prefernce of place for antenatal care was collected.it was observed that almost 94 percent of the respondents got/ willinng to receive there antenatal care from SCs,PHCs,CHCs, SDHs and DH for diagnostic tests and other necessary check-ups. IFA tablets are provided to them and they received reqiured supplements from time to time.all the respondents regularly visit for ANC check-ups during VHND and if missed then on immunization days. There is dramatic fall in preference in private facility and community based services as they receive regular counseling and knowledge about the benefits of utilization of ANC from govt facilites through ASHA(like benefits of cash assesments of 5000/- from ICDS scheme,regular motivated by ASHA , counseling by ASHA regarding benefits under regisrtration for JSSK scheme) . Whwn comparing with the DLHS -3 , there is a huge differnce for utlizing the government facilites

74% to 94% and declining trend for private facilites 13.9% to 4 % . All due to regular conselling by ASHA regarding government free and affordable facilites.

d) Preferred place for delivery.



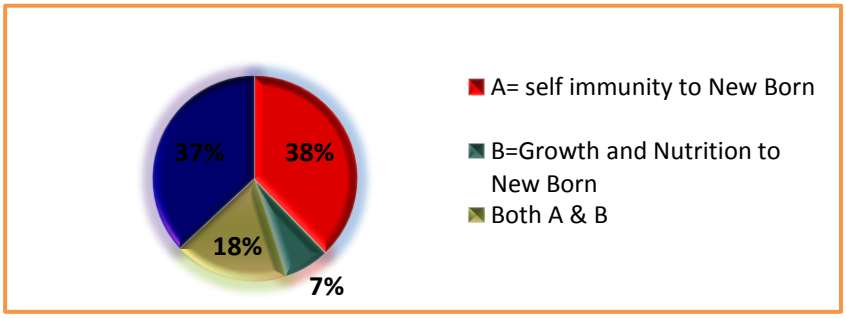
According to DLHS-3, home delivery occurred in Dhenkanal was 51.9%

..Recently I gave birth to my seventh child. The last two deliveries were held at hospital .I heartily thanks to ASHA didi who told me regarding the benefits of institutional delivery. Now I will suggest my surrounding peoples to go for institutional delivery as it is safe and risk free compare to home .me and my child both are healthy.

Paravathi Thodi,35 yrs, Jumbu village, Dhenkanal

Place of delivery is an important determinant for reducing risk off infant and maternal death. ASHA starts rigorous counseling after knowing the Expected Date of Delivery (EDD) of the patient regarding the benefits of institutional delivery. In all the cases, the ASHA accompanies the pregnant women who go for institutional delivery. In most cases, they had to stay with the patient in the hospital for 2-3 days until they are discharged and ultimately returns with the mother. It was found that around 97% of the study population prefer institutional delivery (government hospitals) while only 3 percent preferring home delivery. It is one of the good sign that health systems desires to achieve 100% institutional delivery is about to achieve was found in the study population. Study shows these increased preferences are due to the awareness of the rural masses about the benefit of both good health of mother and child, less risk of infant and maternal death and other complicacy during after the birth of child. It is an undoubted fact that ASHA workers are acting as one of catalytic factors for increasing the preference of institutional delivery as well promotion of maternal health.

e) Knowledge about the benefits of Colostrums Feeding



Baby's first feed: (KHASA KHERRA)

Initiation of breastfeeding early is also an essential component of newborn care. Mother's first milk should be given within half an hour to newborn.

Among the beneficiaries 37 %, responses do not know the benefits of colostrum. The respondent includes both ANC and PNC beneficiaries. This is one of the major issues to be looking out in future.

The reason that respondents given that ASHAs counsel only during one month before the EDD about the benefits of colostrum. After delivery ASHA and ANM make sure that mother feed colostrum to new born until unless any complication (c-section, mother had no milk ,ill health of the new born) doesn't occur. The mothers did not have adequate reason for feeding colostrum.

Services availing	Benefits of colostrums			
	immune to child	growth and nutrition to the child	both 1 & 2	don't know
ANC	13	4	6	38
PNC	29	4	14	3

Table No 6: Knowledge of beneficiaries regarding colostrums feeding

Among 111 respondents 41 beneficiaries having no knowledge about the benefits of colostrum. The main reason behind this was ASHA not counsel during early ANC period.42 beneficiaries responded that newborn child get immune against diseases and 20-said newborn get help in body immune and nutrition.

Why we should not feed colostrum (khasa-kheera) to our newborn. I want my child to be healthy and intelligent and do something for our community and country. I will surely feed him my first milk.

Services availing	Exclusive breast feeding period				
	Upto 2 months	Upto 3 months	Upto 4 months	Upto 6 months	Don't know
ANC	0	2	0	59	0
PNC	0	2	0	48	0

Table No 7: **Knowledge about duration of exclusive breast-feeding**

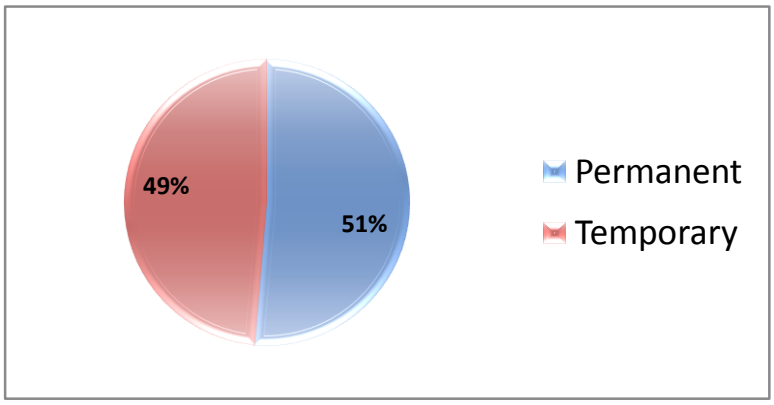
Breastfeeding is ideally continued for the first 6 months of life. Weaning starts from six months onwards when the newborn can be supplemented. The beneficiaries were asked about the exclusive breast-feeding period.97 percent having the knowledge about the exclusive breast-feeding period.3 percent responded only 3 months.

f) Family planning measures used /willing to prefer.

Knowledge of Contraception is almost universal among married women in Orissa. According to DLHS-3 of Dhenkanal, family planning measures utilized were:

Permanent	34.6%
Temporary	21.9%

Table No 8: Family planning measures Utilized in Dhenkanal according to DLHS-3



The study response indicates that awareness of contraceptive methods among women is also high. 51% respondent willing to go for permanent methods and 49 % will prefer temporary measures.

i. Permanent methods:

Male sterilization	0.2%
Female Sterilization	34.4%

Table No 9: permanent measures Utilized for family planning in Dhenkanal according to DLHS-3

Study shows that Female sterilization (96%) is the most widely known method, known by virtually all married women and men over male sterilization (4%).

ASHA and ANM counsel the beneficiaries during VHND about the benefits of Male sterilization but people still orthodox

ii. Preferred temporary measures:

Condoms	10%
IUD	63%
OCP	30%
Emergency Pills	2%

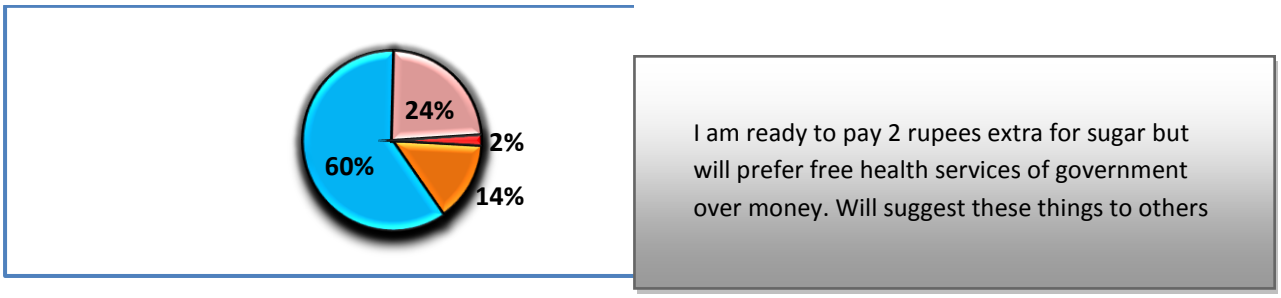
Table No 10: Temporary methods Utilized for family planning measures in Dhenkanal according to DLHS-3

The government family planning program promotes three temporary methods: the Oral pill, the IUCD and condoms. Out of all these contraceptive methods, earlier women know about the pills and are aware about condoms and the least known method was IUD.

Knowledge of sterilization has been high since the ASHA has appointed in village and knowledge of temporary contraceptive methods has increased substantially. Now the beneficiaries preferring IUD over the pills and condoms because it is one time procedure and free from the risk of skipping pills or bursting /forgetting condoms during intercourse.

All this knowledge regarding the benefits of spacing and methods of spacing is provided by ASHA especially after the delivery. Many got knowledge through the advertisements/ television advertisement especially about emergency pills.

g) *Knowledge of spacing between two children's*



Ideally the gap between the birth of two children should be 3 years for the better geo The study finding shows there is huge increase of knowledge among the beneficiaries regarding the gaps between two children's. 60 percent have an ideal knowledge regarding the gaps between two children. 24 percent are willing to have more than 3 year for next child

h) *JSY Scheme (JANANI SURAKSHA YOJANA)*

JSY is a safe motherhood intervention under the National Rural Health Mission (NRHM) being implemented with the objective of reducing maternal and neo-natal mortality by promoting institutional delivery among the

poor pregnant women.

Availing Services	Yes	No	
ANC	59	2	
PNC	49	1	
Total	**108**	**3**	**111**

Table No 11: Beneficiaries heard/know about JSY scheme

JSY scheme is one of the main intervention of NRHM which attracted the village people towards institutional delivery and government facilites. The study findings indicate a high level (97%) of awareness about JSY among beneficiaries. People know that the scheme is mainly focused on the poor pregnant and the scheme which having integrates cash assistance with delivery and post delivery services. As far as source of the awareness of the scheme is concerned, most of the mothers knew about the scheme from ASHAs. They also reported having heard about the scheme from their relatives and friends. Major sources of knowledge among community were health workers, posters and hoardings.

Services under JSY scheme		Beneficiaries			
		ANC		PNC	
		Yes	No	Yes	No
1)	Cash benefits	60	1	49	1
2)	Free ambulance services	51	10	46	4
3)	Free medicine/lab test	29	32	27	23
4)	Free food	1	60	8	42
5)	Free of cost delivery	41	20	35	15
6)	Free Blood units	1	61	0	50

Table No 12: Knowledge of beneficiaries about the services provided under JSY scheme

A high proportion of the eligible beneficiaries reported having knowledge of money as incentive, free institutional delivery and the ambulance services under the JSY scheme. Almost 90-99% of the beneficiaries having no knowledge regarding the food services and free blood unit facilities available under JSY scheme. ASHAs only counsel them for the cash benefits, free ambulance services and free delivery. More than three-fourths of mothers reported that ASHA had accompanied them to the institution for delivery. A high proportion of ASHA mentioned that they arrange for transport facility for the pregnant.

S.No	BENEFICARIES	Yes	No
1)	ANC- 1st time registered/pregnant	29 (26%)	1
2)	ANC	30 (27%)	1
3)	PNC	48 (43%)	2

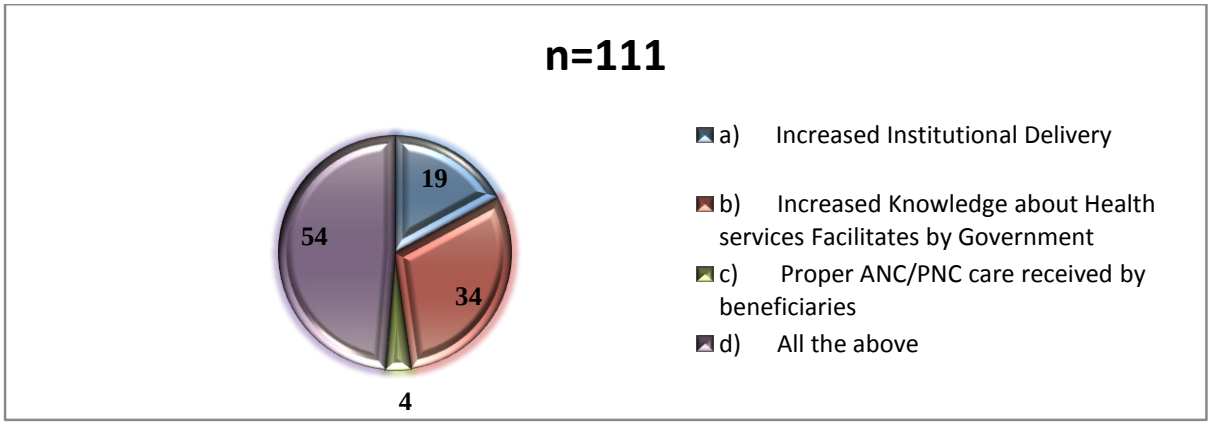
Table No 13: Response if incentive scheme withdrawn from JSY scheme

Majority of the mothers prefer free services over money.26% newly registered beneficiaries response that the free services which are currently available should be continued and make them

better day by day.43% beneficiaries respondent that they are satisfied from the current services and if some changes occur then it's good for future or else maintain the services properly.

All who are willing for institutional deliveries are under motivation of ASHA workers had significantly positive impact over the community. This reveals that likelihood is high to have an institutional delivery if woman is motivated by ASHA. Therefore, the JSY encourage mothers to avail the monetary benefit to have an institutional delivery but to reach this message ASHA works as a changing agent within the community. To make the scheme more successful ASHA have a significant role to play.

I) Changes Observed in community after Introduction of ASHAs.



…ASHA take pregnant women to medical centre,call for MAMTA divas…accompany during delivery… assist ANM „didi" for immunization…help in health meeting, mothers" meeting and home visits

Rashmitha Sathpathy ,23 yr, ANC beneficiaries
Sri Rampur ,Khamakhyanagar,Dhenkanl

Availing Services	Hospital Delivery increased	Increased knowledge about services	Proper ANC/PNC care received by beneficiaries	all the above
ANC	12	19	4	26
PNC	7	15	0	28
Total	19	34	4	54

Table No 14: Changes observed by community after introduction of ASHA

In the villages where survey and FGDs was done it revealed that before the intervention of ASHA, the situation was grim and no one was able to even think of accessing public health care facilities. Especially the children remained neglected and it was due to lack of information and proper counseling. The only information they received was from the ANM which was completely inadequate.

However, after ASHA coming to the village people do more know about the benefits government facilitated for public. The specific schemes functioning for mother and child

health. ASHA use to counsel them regularly about schemes and services which they can avail at free of cost. Earlier community people not ready to accept the ASHAs intervention. They use to get negative responses from the family heads but now all the village people consult them first regarding any health related query.

54% of the respondents had confirmed that they had received advice during pre delivery and post delivery period of their child and the nature of advice included ANC checkups ,consumption of IFA tablets, institutional delivery benefits, JSY scheme, newborn care practices, breast feeding, immunization, routine checkup and spacing methods to be adopted to delay the next child.34% said that their knowledge regarding the health has been increased after ASHAs intervention/ It was mostly the ASHA who imparted the advice.

2.9. Results & Discussion:

The role of the ASHAs in institutional deliveries was appreciable. More than three-fourth of the beneficiaries were found satisfied with the ASHAs.

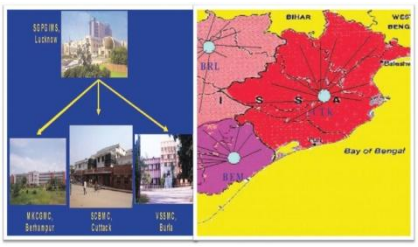
- ✓ *ANC women :*
  - i. Women are motivated to get proper & quality ANC services on "MAMTA DIVAS".
  - ii. Regular counseling regarding measures to be taken during pregnancy.
- ✓ *Mothers :*
  - i. Enhanced knowledge about infant & newborn care.
  - ii. Counseled regarding immunization and Family planning.
- ✓ *Institutional Delivery:*
  - i. Health services provision is given more priority than incentives.
  - ii. The ASHAs' support in ANC services and immunization was significantly high in comparison to other services.
- ✓ *Sterilization methods:*
  - i. Male sterilization not practiced.
  - ii. People still living in misconception regarding NSV
- ✓ *Community feeling:*
  - i. ASHA act as first contact point for the health services.
  - ii. Available 24* 7.
  - iii. Always counsel and motivate regarding healthy behaviors.
- ✓ *ASHAs View:*
  - i. People more willing for better facilities rather than money.
  - ii. Non-availability of drugs for the drug kits on time.
  - iii. Required specific facilities for ASHAs of hard to reach area.

2.10. Learning during summer internship:

i. *At CHC SRIRAMCHANDRAPUR, GONDIA,* attended the review meeting on routine immunization and the BPO told them regarding the marketing of Sanitary Pads distributed under ARSH scheme by NRHM

ii. *Visited AIRA (ARUN INSTITUTE OF RURAL AFFAIRS):* To attend the inaugural function of ASHAs module 6 & 7 along with BPO. The selection for training of ASHAs are done by Sectors of the Block. 30 ASHAs were getting training at a time for 5 days. The organization received the tender of providing training to the ASHAs along with the ASHA trainer who is appointed by NRHM.

iii. *Visit to SRIMULA PHC(NEW):* One of NRHM initiatives PP based model for providing better health to the community. PHC is managed my NGO called SOVA. 95% of funding is done by NRHM and remaining 5% by NGO. The PHC follow all the government norms and having functional Operation Theatre with neonatal ICU and PHC having their own Ambulance service.



iv. *Tele-Medicine Center at DH:* It is connected to Medical colleges and specialty hospitals. DH act as **Remote Telemedicine Centers**(RTCs) and medical colleges as **Telemedicine Referral Centers** (TRCs).funding and monitoring is done by Mission Directorate .helps in

reducing the healthcare cost and cover range of specialty including general Medicine, Radiology, Cardiology etc. reports and Case history is transferred to the concern department and conversation between doctor and consultant is maintained

v. *MCTS :* Mother & Child Tracking System is one of the new initiatives of NRHM to keep eagle eye on registration of Data regarding ANC and PNC beneficiaries .All data regarding the beneficiaries including what services they received, due services, and the date when she has to received is kept. To increased the registration on delivery and child Dhenkanal took the initiative, they keep paper in OT which has to be filled by staff after delivery to reduce the chance of skipping the IMR, MMR.

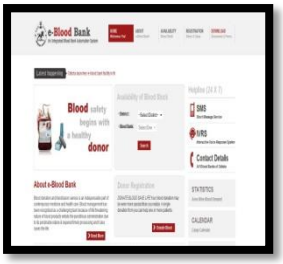
vi. *Know your Doctors:* The software developed at NRHM odhisa, it helps the community to trace the nearest hospital and facilities they can avail at that hospital. The software is developed in such a way that person can see the direction, image of the hospitals from his position.

vii. *OEMAS:* On 5th March 2013 the NRHM started Odhisa Emergency Medical Ambulance Service based on PP model with Ziqitza Healthcare ,Mumbai to provided Ambulance fully equipped with life saving equipments named as (108). Launched in 15 district with fully running 280 ambulances. Special software's developed to trace the vehicle position. Vehicle has to dispatch within 90seconds after receiving the call. Response times are categorized: 20 minute for Urban, 30 minute to Semi Urban and 35 minute in Rural areas.

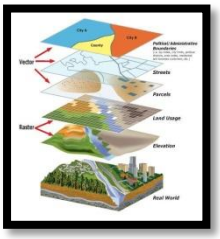
viii. *Health Milestone:* At the entry of every Village a milestones are placed on which detail regarding the JSY and contact number of JE is written.

ix. *MHU:* Mobile Health Unit is facilitated at Block and district level where Hard to reach areas are more .the Mobile unit works 26 days in a month. They visit the schools and AWCs for check-ups and creating awareness among community and act as referral unit if required. The unit does BCC and IEC in the villages. They collect blood samples and provide required medicines. The mobile unit having Medical Officer, Pharmacist, ANM, Lab technician and attendants.

x. *Urban Slum Health project:* urban slum having major problem of Sanitation, Nutrition and medical services. Based on PP model. 100% funding is by NRHM. Involved municipal co-operation or local urban body for direct monitoring over the NGOs. The NGOs appoint one Doctor, two ANM, one Staff nurse who conduct OPD in the slum and provide basic required treatment and if any complicated or serious case then they are referred to community hospitals.



xi. *e-Blood bank:* e-Blood Bank is an integrated blood bank automation system. This web based mechanism inter connects all the Blood Banks of the State into a single network. Integrated Blood Bank MIS refers the acquisition, validation, storage and circulation of various live data and information electronically regarding blood donation and transfusion service. It also provides online status of blood group wise availability of blood units in all the licensed blood banks in the state. It includes online tracking and trailing system of the blood and blood products (components of blood) by the state level administrators. The system manages all the activities from blood collection both from camps & hospitals till the issue of blood units. It includes donor screening, blood collection, mandatory testing, storage and issue of the unit (whole human blood IP, different Blood component and aphaeresis blood products).



xii. *GIS Mapping:* In the Odisha, GIS technology is being used as an important part of the toolkit to link information from different data sources and identify key areas for resource utilisation. This ability to link datasets can help public health practitioners plan more cost-effective interventions.

NRHM-Odisha is the first State in the Country to initiate and successfully complete the development of urban health GIS for all its 8 class-I towns. Development of Urban health GIS for 105 NAC/urban local bodies has been done.

2.11. Limitations of the Survey:

The following limitations of the survey were identified:

i. Sample sizes were taken on basis of the convenience and the size might not represent the entire universe of the study.
ii. There was scope for more in-depth probing of various components making the study more interesting.
iii. Short time available for completion of the report.

2.12. Recommendation:

i. Involvement of GKS members to assist ASHA & ANM during counseling regarding male sterilization.

ii. Creating BCC/IEC materials and according to the areas requirement for highlights advantages of Male sterilization (NSV).

   a. How it is painless procedure?

   b. Benefits of POST-NSV ?

iii. Counseling and Motivating the Pregnant women of vulnerable area for utilizing the service of Maternity Waiting Home (MWH)

iv. Specific facilities (torches) for the ASHAs located in difficult to reach habitations.

v. ASHA should get recognization as base line member of health system.

2.13. Conclusion:

i. The study shows that the ASHA is acting as a catalytic agent to bring positive health behavior change in the community.

ii. ASHA is playing major role to enhance institutional delivery significantly as a result decrease in MMR & IMR rapidly.

REFERENCES

1. NRHM-ASHA guideline, 17,National Rural Health Mission ‘s ASHA guidelines
2. Centre for health promotion (2005). National Rural Health Mission: identify the gaps, Rural Technology Development Centre, Himachal Pradesh .
3. Handbooks for ASHA facilitators.pdf
4. Update on ASHA programme January 2013.pdf
5. Handbook of Gaon Kalyan Samiti Guideline.
6. District Level Household and Facility Survey (DLHS-3), Fact Sheet Orrisa.pdf
7. Odhisa Health Sector Plan, April 2008- March2012(Policy & Activity Briefs).pdf
8. Centre for Operations Research and Training (CORT) (2007). *Assessment of ASHA and Janani Suraksha Yojana in Rajasthan.*Sponsored by UNFPA, New Delhi. http://
9. www.cortindia.com/RP%5CRP-2007-0302.pdf.
10. Ministry of Health and Family Welfare (2005b). *National Rural Health Mission: Framework for Implementation (2005–2012)* http://www.mohfw.nic.in/NRHM/Documents/
11. NRHM%20-%20Framework%20for%20Implementation.pdf.
12. Handbook of Operational guideline for utilization of Untied Fund Annual Maintenance Grant & RKS Grant.

Annexure:

Annexure 1: List of people interacted during my internship.

S.No	Name	Designation	
1)	Dr.Pramod Kumar Meherda, I.A.S.,	Commissioner -cum - Mission Director	Overview of NRHM functioning and achievement
2)	Mr. Adait Kumar Pradhan	State Programme Manager	Overall co-ordination for implementation of PIP Immunization Disease Control Programme
3)	Mr. Santosh Kumar Nayak,	PPP Consultant	All Public Private Partnership Activities Urban Health Advocacy of NRHM/NGO Activities
4)	Mr. Pranaya Kumar Mohapatra,	Health Plan Consultant	Rogi Kalyan Samiti Annual Maintenance Grant
5)	Mr. Deepak Kumar Biswal,	Monitoring & Evaluation Consultant	Swasthya Mela HMIS
6)	Mr. Sushanta Nayak	Coordinator, CPRC (Community Process Resource Centre)	ASHA VHSC Village Health Plan
7)	Dr. R.N. Panda	Child Health Consultant	All Child Health Activities (IMNCI/SNCU/Prustikar Diwas/Immunization)
8)	Mr. Debashis Dash Mr. Guruprasad Rath IT Consultant	IT Consultant	IT implementation in NRHM

9)	Mr. Biswajit Modak	Training Consultant	All Trainings(DPM,BPM,ASHA)
10)	Ms. Mithun Karmakar	GIS Mapping	GIS Mapping
11)	Mr. Sanjay Kumar Das	HMIS Report & Data analysis	

Annexure2: List of Timeline study

Sl No.	Task	Timeline	Duration
1)	Document study and development of study design and tools	8th April'13 to 21st April'13	2 weeks
2)	Field testing of tools ,field study and data collection	22nd April'13 to 5th May'13	2 weeks
3)	Data analysis	6th May'13 to 12th May'13	1 weeks
4)	Finalization of Data And presentations	13th May'13 to 17th May'13	5 Days
5)	Presentation	18th May '13 `	1 day
6)	Relieved from NRHM	20th May'13	

Annexure3:

Effect of ASHA to bring change in Health Behavior at Community Level

Interview Schedule

(For Beneficiaries – Pregnant women/Mother of child age < 6 months)

Informed consent: All responses will be kept confidential.Your interview responses will only be shared with research team members and will ensure that any information we include in our report does not identify you as the respondent. Remember, you don't have to talk about anything you don't want to and you may end the interview at any time.

Sub center	
Village	
Date of Interview	☐☐ ☐☐ ☐☐☐☐
Duration of interview (in minutes)	☐☐☐

Section 1 – Background Characteristics				
Q. NO.	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**		**SKIP TO**
Q1	How old are you? (Age in completed years)			
Q 2	How old is your husband?			
Q 3	Education (self)	Illiterate	1	
		Literate, no formal education	2	
		Literate, formal education	3	
		Don't know/ can't say	98	
Q4	Education (husband)	Illiterate	1	
		Literate, no formal education	2	
		Literate, formal education	3	
		Don't know/ can't say	98	
Q5	How old were you at the time of your marriage?			
Q6	No of children	☐		

Section 2 -			
Q. NO.	**QUESTIONS AND FILTERS**	**CODING CATEGORIES**	**SKIP TO**
1.	. Do you know about ASHA?	Yes No	If ans "2"then end the questionnaire
2.	If yes , please tell the name of the ASHA.		
3.	How many times did ASHA visit your home during pregnancy period?	I. Once a month II. Twice a month III. More than twice IV. Other (please specify)_____	
4.	. What kind of problem did you face during pregnancy/delivery earlier before receiving the services from ASHA? (Birth planning, ANC checkup, transportation, PNC)?		
5.	Did you receive the services ASHA facilitates? (During and After Pregnancy)	Yes No	If "NO" then refer to question no 7
6.	a) JSY Registration (Cash Benefits)	Yes No	
	b) Proper help during ANC Check up (immunization, IFA tablets)	Yes No	
	c) Counseling for Institutional Delivery	Yes No	
	d) Counseled for Birth Planning (Money, Contact number ,sterile Clothes, address of hospitals)	Yes No	
	e) Calling to attend Village health and nutrition day	Yes No	
	f) Counseling for Post Natal Care (colostrums feeding ,child immunization)	Yes No	
	g) Explaining the benefits of Family Planning	Yes No	
	h) Other any specific:		

Q. NO.	QUESTIONS AND FILTERS	**CODING CATEGORIES/DESCRIPTION**	SKIP TO
7.	What are the initiatives you have taken when your Pregnancy got confirmed?		
8.	Do you attend Village Health and Nutrition Day?	Yes No	If "2" skip to q 10
9.	Why do you attend the Village Health and Nutrition Day?	Yes No	
10	Did you prepare for birth planning?	Yes No	If "2"skip to Q 12
11	What kind of birth planning have you done during pregnancy?		
12	What is your preferred place for delivery?	I. Govt. Hospital II. Private Nursing Home/Hospital III. At home	
13	Do you know about the JSY scheme?	Yes No	If "NO" skip to q 17
14	What are the benefits provided under JSY scheme?		
15	If the incentive scheme of JSY is stopped, then will you prefer to have institutional delivery?	Yes No	If "2" skip to q.17
16	If yes, then explain why?		
17	Did you feed colostrums to your new born child?	Yes No	If '2' skip to Q 19
18	What are the benefits you know regarding the colostrums feeding?		
19	Till which month do you prefer exclusive breast feeding?	i. 1 months ii. 3 months iii. 6 months iv. Don't know	
20	What are the complementary foods that should be given along with your breast feeding to the child?		
21	Are you suggesting all this to any of your pregnant relatives or neighbors?	Yes No	
22	Do you use family planning measures?	Yes No	If "2" skip to ques 28
23	Which type of family planning measures you prefer?	i. Permanent **ii.** Temporary	If "ii"then skip to ques no

			25
24	If permanent, then which measure have you used?	i. Male sterilization ii. Female sterilization	
25	If temporary, then which measure you will prefer?	i. IUD ii. OCP iii. Condoms iv. Emergency pills v. others	
26	From where do you get the required family planning devices?	**i. Government** **ii. Medical shop** **iii. ASHAs**	
27	What should be the gap between two children (approximately)? What is the importance of maintaining gap between two children?		
28	After the introduction of ASHA what are the changes you observed in health seeking behaviors of community ?		

THANK YOU

Annexure 4:

Date:___/___/____

IN- DEPTH INTERVIEW SCHEDULE

(For ASHA only)

S.No : ☐

Village:	**Sub- centre**	**Block :**
Starting Time:	**End Time:**	
Name of ASHA		
Educational Level		
Year of Experience		
Signature of ASHA		

1. What is your role and services for the community?
2. Which women do you think you should serve/reach/ provide ANC services especially in community? (geography, class, caste, religion)
3. What kind of support you get from the ANM and AWW and others in providing better services?
4. What are the various remuneration that you are entitled to receive?
5. Are you satisfied with the remuneration you receive?
6. Do you really think that people are changing their health seeking behaviors?
7. Do you think colostrums feeding is important / beneficial? How?
8. Why people did not prefer institutional deliveries earlier?
9. What are the problems you faced during initial stages to convince the people?
10. How you make sure that the pregnant lady attends regular ANC checkups?
11. Do you think today families have started Birth planning as compared to earlier? How?
12. Do you think family planning measures have been on a rise compared to earlier? How?
13. Do you think if JSY scheme is withdrawn, people would still continue with institutional deliveries?
14. Do you have the Drugs-kits? What are the drugs included in it?
15. Any suggestion or feedback?

Thanks a lot

Annexure 5 :

Date:___/___/____

IN- DEPTH INTERVIEW SCHEDULE

(For GP/Local Community Leader only)

S.No : ☐

Village:	**Sub- centre**	**Block :**
Starting Time:	**End Time:**	
Name of GP/LCL		
Educational Level		
Year of Experience		
Signature		

1. Have you heard about the ASHA workers in your village?
2. Do you know any of them personally?
3. What according to you is the role that ASHA worker should play in the village?
4. Do you think they are fulfilling their roles?
5. Is there an increase in institutional deliveries and immunization of children?
6. Who according to you is responsible for bringing about this change?
7. Do people prepare for the birth of a child? How can you say so? Who is responsible?
8. What is your view on feeding the baby with the mother's first milk?
9. Do you think there is an increase in birth control measures in your village?(ASHA's roles)
10. What are the help you provide her if she approaches to you?

Thanks a lot