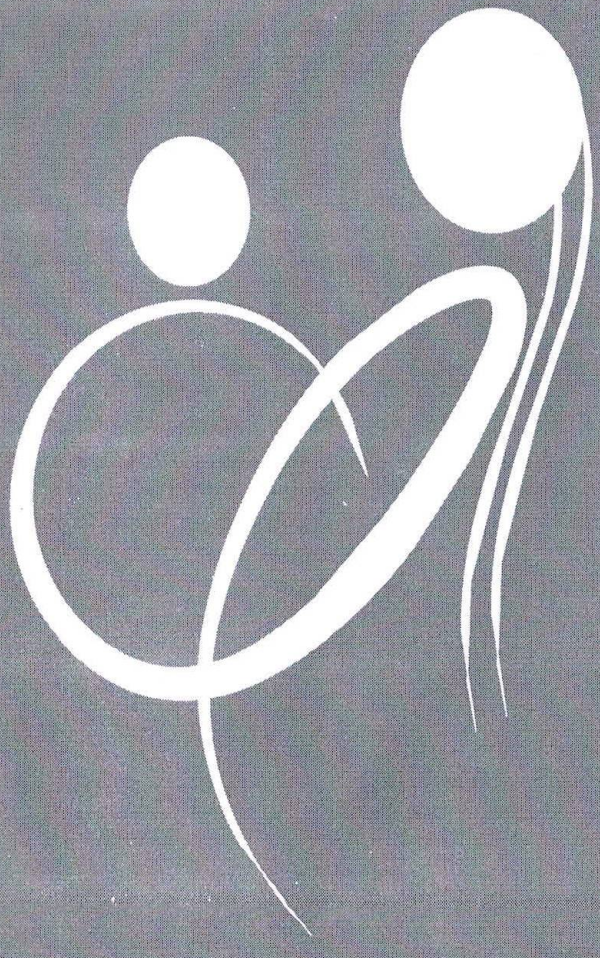
Assessment of ASHA and Janani Suraksha Yojana in Rajasthan



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April, 2007.

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PREFACE

JSY, Janani Suraksha Yojana, is an integral component of the National Rural Health Mission, launched in April 2005. JSY aims to reduce maternal and neo-natal mortality by promoting institutional deliveries, focusing on women living below the poverty line (BPL). Another core strategy of the NRHM is to have a female Accredited Social Health Activist (ASHA) for every village with a 1,000 population to act as an interface between the community and the public health system. As a volunteer she receives performance-based compensation for promoting a variety of primary health care services such as referral and escort services for institutional deliveries, universal immunization, DOTS treatment for tuberculosis or construction of sanitary toilets.

In response to a request by the Ministry of Health and Family Welfare (MoHFW) to assess JSY in Rajasthan, the United Nations Population Fund (UNFPA) commissioned the Centre for Operations Research and Training (CORT) to conduct the study. The aim was to assess the current status of the ASHA intervention and JSY in three districts of Rajasthan, namely Bhilwara, Jailsalmer, and Udaipur. The present report documents the process of implementation of the ASHA intervention and JSY, involvement of ASHA's, and services and payments received by the JSY beneficiaries, and highlights program implications that need to be addressed in order to further improve JSY. This document aims to provide useful information for policy makers and programme managers at the national and state levels for further strengthening the scheme as well as to develop training and IEC strategies and campaigns. It may also be pointed out here that the study was conducted in the initial stages of the programme being implemented in the state which has been undergoing modifications and the situation remains dynamic. As far as possible we have tried to incorporate all the themes, but in case of any lapses we are responsible for the same.

We are also very grateful to Mr. K. D. Maiti, Director, Ministry of Health and Family Welfare for his valuable inputs in framing the questionnaire and analyzing data. We would also like to acknowledge Dr. Dinesh Baswal, ASHA Training Coordinator at national level and Dr. Subhra Singh, Director NRHM, Rajasthan, DHO of the selected districts and Managers of DPMU for all the support extended by them.

At the outset, we take this opportunity to thank the UNFPA for having entrusted the work of conducting the assessment to CORT. Our sincere thanks are due to Mr. Venkatesh Srinivasan, Assistant Representative, Dr. Dinesh Agarwal, Team Manager, Technical Support Unit and Dr. K. M. Sathyanarayana, Technical Advisor (Management), for the cooperation extended to us during the various stages of the study. We appreciate their inputs in helping us develop the research tools, in administering the study in the field and commenting on the draft report. We are especially thankful to them for their meticulous work, quick replies and patience. We also appreciate and thank Mr. Hemant Dwivedi, and Mr. Sunil Thomas from the UNFPA office in Jaipur for all the support extended.

We thank our respondents - officers at the state, district and block levels, PRI members, ASHAs, ANMs, community members and of course the JSY beneficiaries without whose cooperation it would not have been possible to complete the study successfully.

I wish to put on record my deep appreciation for Dr. Bella Patel Uttekar, the Principal Investigator of this project, and all the team members for contributing their might in the success of this project and thereby ensuring quality.

Prof. M. M. Gandotra, Director

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Executive Summary

Towards achieving the objectives of the National Rural Health Mission (NRHM), Janani Suraksha Yojana was launched in April 2005 to promote institutional deliveries among the poor population, through provision of referral, transport, and escort services. JSY integrates cash assistance with delivery and post delivery care for women to have healthy outcomes of pregnancy and childbirth. The NRHM aims to have a village-based female Accredited Social Health Activist (ASHA) to act as the interface between the community and the public health system and negotiate health care for poor women and children. The Ministry of Health and Family Welfare (MoHFW) decided to undertake an assessment of JSY. The Centre for Operations Research and Training, CORT, based at Vadodara conducted this assessment of JSY for UNFPA and the MoHFW to understand the process of implementation of the programme, involvement of ASHAs and experiences of JSY beneficiaries. This report is based on the qualitative and quantitative assessment of JSY in Rajasthan covering three districts of Bhilwara, Jaisalmer and Udaipur.

Using semi-structured study tools, 173 ASHAs and 248 JSY beneficiaries were interviewed through a quantitative survey. In-depth interview were conducted with key stakeholders at state, district and block level related to JSY.

Implementation of JSY

A major modification in the national guidelines was the state's decision to bring in intersectoral convergence with the Department of Women and Child Development to involve 32,000 Sahyogini, an additional human resource working in the Anganwadi center to help the AWW, as ASHA Sahyogini and to recruit the balanced around 11,000 ASHAs to ensure complete coverage of the state by March 2007. Two state officials - ASHA nodal officer and JSY nodal officer implement the programme at the state level. ASHA Mentoring Group and a State Resource Unit play a major role along with District Project Management Unit (DPMU) to implement and monitor the progress on regular basis. JSY helpline was established in selected blocks to promote prompt emergency referral and ensure safe delivery of women with obstetric emergencies at the health facilities.

As per the national guidelines, all the pregnant women delivering in government institution or accredited private institutions are eligible for getting JSY benefits. For BPL pregnant women, cash assistance of Rs. 500 is given for delivery at home.

PRIs were involved in implementing the scheme and managing the untied fund of Rs. 10,000 at the Village Panchayat level along with the ANMs. The Gram Sabha and sarpanch selected and introduced ASHA to the village, supported their work, and helped in developing village health plan and organizing village health day. At the village level, ASHAs worked under the guidance of sarpanch, ANM, AWW, and SHG and in collaborations provided ANC and PNC services.

ASHAs are supposed to be daughter-in-law from the village, who is at least eighth standard pass and aged between 25 and 45 years. Rajasthan faced problems in identifying eligible ASHAs with eighth standard pass, particularly in remote and tribal areas.

The State Institute of Health and Family Welfare (SIHFW) organized training of state trainers for four days. First round of training of around 30,000 ASHAs of 7 days residential training, mostly organized at the district and block level, was completed in the state by December 2006. State, district, and block level officers of Medical and Health Department and DWCD monitored the implementation of training of ASHAs. ASHAs were given reading materials presenting their roles and responsibilities during training.

In Rajasthan, Swasthya Chetna Yatra (health awareness rally) was organized in December 2006 to propagate and publicize the JSY. The rally covered all the villages of Rajasthan. Largely because of this rally, the community was now aware of JSY and involvement of ASHA.

Private institutions have yet to be accredited, but each of the ASHAs were briefed during training about the nearest functional health facility for referral services. Monitoring and supervision was happening at all the levels, yet there is a need to develop a simple and sustainable monitoring system. One of the suggestions is that ASHAs need to attend all the monthly meetings at PHC.

Involvement of ASHA in the National Programme & JSY

Most of the ASHAs are young, educated and married staying in the same village where they were functioning. Of the 173 ASHAs interviewed, 16 percent did not fulfill one or the other eligibility criteria. Before JSY, two-thirds of the ASHAs themselves delivered their child at home.

On average, the respondents worked as ASHA for 7.1 months. Earlier, several of them were working as ASHA Sahyogini. It was revealing that 55 percent of ASHAs had not received any payment until the date of survey, though most of them worked as ASHA since four months or more. On average, ASHA who were paid, received rupees 339.1 monthly from working as ASHA.

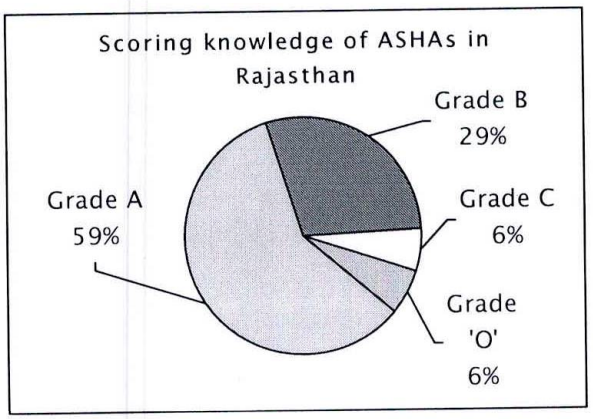
Over half of the respondents first came to know about the ASHA from ANM and nearly a quarter from the anganwadi supervisor/worker. Government doctor, health personnel, gram panchayat or hoardings kept at public health centre also informed them about ASHA.

Netaji, politician, sarpanch or Gram Sabha selected fifty-three percent ASHAs. ANMs, doctor, village elders, husbands, father-in-law, CDPO and block facilitators played a role in selection of ASHAs. In most cases (97 percent) Gram Sabha approved their name. The main motivation to be ASHA was to serve/help the community (73 percent), earn money (30 percent) and learn new things (10 percent).

In Rajasthan, training of ASHAs was done, on average, 6.4 months ago for six days. Except for some logistic arrangements at the place of training, ASHAs appreciated the training including trainers and training methods as good and useful. The study brings out need to reorient ASHAs on topics such as disposal of wastewater, nutrition, NRHM, reproductive and sexual health, and management of diarrhea and pneumonia.

Of the 165 ASHAs who attended training, 83 percent received their allowance during training. Only 9 percent of the ASHAs received the total amount, which was due to them. On average, they received rupees 605. Informal discussions with the trainers and finance personnel revealed that the ASHAs were given Rs. 100 per day for attending training and transport depending on the distance she travelled (instead of Rs. 100 irrespective of the distance travelled as per the guidelines.

Nearly 86 percent of the ASHAs had reading materials for the implementation and promotion of JSY and two-thirds of them were largely able to follow the reading materials. Majority of the ASHAs scored Grade A or O for answering 8 to 10 out of 10 questions correctly.



ASHAs knew about the complications during pregnancy, but less than 7 percent talked about abdomen or body pain, weak movement or abnormal position of foetus. In such situation, ASHAs said that they would immediately refer the pregnant woman to the nearest functional FRU, while surprisingly 45 percent said that they would ask the pregnant woman to consult the ANM the next day. Only 8 percent ASHAs would ideally accompany women with complication to the hospital and only one ASHA said she would provide money for transportation to the women. ASHAs need to put into practice their knowledge about ANC care while providing services and/or advise.

The main responsibilities of ASHAs are to accompany delivery cases (83 percent), create awareness on health/HIV, counsel, village health planning, and mobilize community to utilize health services. Only a few ASHAs mentioned about family planning, registration of birth and death, and timely referrals. ASHAs visit house to house, besides attending immunization session and accompanying ANM and women for delivery.

Only one-fourth of the ASHAs received the drug kit, and majority had used the medicines available in the kit within the last fortnight

ASHAs do provide constellation of services and play a potential role in providing primary medical care as their last client came seeking services related to immunization, advice about place of delivery, receiving IFA tablets, medicines for primary care. They also came for registration of vital events, collect information about family planning, and to collect cash assistance as JSY beneficiaries.

Eighty-six percent of the ASHAs had accompanied an average of 1.2 JSY cases for institutional delivery, mainly to CHC or PHC. Forty percent of the total ASHAs stayed with JSY beneficiaries at the place of delivery.

According to ASHAs, when women go to their natal place for delivery, they would get benefits at their natal place, and ASHAs at women's natal place would take care. Only 5 percent ASHAs mentioned that they would give JSY card from the village and referral slips so that women could receive the cash assistance at the place of delivery.

ASHAs network with the various stakeholders in the village to implement JSY. Ninety percent of the ASHAs met AWW almost daily, with ANM the meeting was once a week (42 percent), fortnightly (18 percent), or once a month (36 percent).

Only 42 percent of the ASHAs did receive some cash incentive money as ASHAs for immunization of children and half of them for attending JSY beneficiaries. The mean monthly amount received for attending JSY beneficiary in three months varied between Rs. 294-421 (ranging between 100-800) and for immunization of children between Rs. 150-187 (ranging between 100-550). Some of the ASHAs expressed that they were unsatisfied or indifferent with the cash assistance as it was *'too much of work and too little money'* (21 percent), or money was not available timely (15 percent).

ASHAs also spent 4 hours every week in preparing various registers and ASHA's work was mostly monitored by the ANMs and AWWs. Supervisory support from other officials was lacking.

Beneficiaries of JSY in Rajasthan

The JSY beneficiaries interviewed were young and mostly those who had no formal education (68 percent) or had schooling up to middle level (22 percent). One-third of the JSY beneficiaries belonged to SC/ST and one-half to the other backward classes. It can be said that JSY was reaching to the socio-economically lower strata of women covering poor segment of the society.

The beneficiaries learnt about JSY during various stages of pregnancy, or even after the delivery, from ANM, ASHA, doctor or AWW and got themselves registered under JSY. One-third of the JSY beneficiaries got registered in the first trimester, and on average, women had 4 antenatal check-ups during their index (JSY) pregnancy. Since ANC card showing that the women had taken full ANC was required for claiming payment of cash assistance, women ensured that they go for 3 or more ANC check-ups at CHC or PHC. Husbands, mother/sister-in-law, and ASHAs accompanied the beneficiary for ANC visit(s). One-tenth of the women received antenatal care at home.

Only 40 percent of the beneficiaries were informed about 4 or more aspects (out of 5) of micro-birth planning. Nine percent JSY had no discussions on any aspect of the micro-birth planning.

Talking about the actual place of delivery, 30 percent had delivery at home as against 41 percent who intended to deliver at home. A statistically significant shift can be noticed among 15 percent of the beneficiaries who intended to deliver at home but shifted to institution. It is challenging to change the mindset of the women (and their families) who intended to deliver at home and did so. Majority of the deliveries took place in CHC/PHC.

Intention vs. actual place of delivery			
	Place where last delivery of JSY beneficiary took place		
	Institutional	At home	Total
Intended place for last delivery			
Institutional	54.8	4.5	59.3(147)
At home	14.9	25.8	40.7 (101)
Total	69.7 (173)	30.3 (75)	100.0 (248)

Cash assistance, better access to institutional delivery, support provided by ASHA and other health personnel and safety of both mother and child were the main motivations for opting for institutional delivery. These were the main reasons for 62 women who had their previous birth at home to shift to institution for the index delivery.

In Rajasthan, JSY beneficiaries had to travel, on average, 11.6 kms to reach the ultimate place of delivery. Women spent approximately one hour to arrange transport and reach the ultimate place of delivery and another 25 minutes after reaching the institution on registration and administrative process and as waiting time until someone attend them.

ASHAs accompanied 18 percent of the women to the health institution for delivery despite it being one of their main responsibilities under JSY, while another 20 percent women were accompanied by dai, ANM and anganwadi worker. Out of the 31 JSY beneficiaries accompanied by ASHA, most (90 percent) said that the presence of ASHA facilitated in obtaining services at the place of delivery. They helped in expediting registration and other administrative activities, spoke to the medical personnel, and helped in getting JSY cash incentive, besides psychological and moral support.

On average, women were discharged in around 15.2 hours after normal delivery, for assisted delivery in around 2 days and for caesarean after 6 days.

Nearly 85 percent of the beneficiaries received payment and they all received it in one go (but much later) from the ANM or PHC/CHC doctor. The JSY beneficiaries spent an average of Rs. 1409 during ANC period, Rs. 280.2 for transportation to the place of delivery and Rs. 1277.6 for delivery, against which they received an average of Rs. 780.3 from the government as cash assistance.

The process of paying cash assistance to the JSY beneficiary was not so simple. The accountant at the place of delivery checked for ANM's and ASHA's signature, discharge slip signed by the MO-IC, ANC card to ensure that the women received full ANC care and ration card. Requirement of the ANC card showing full ANC services could be one of the reasons for high levels of ANC check-ups.

Most of the women were satisfied with JSY and would recommend relatives or friends/neighbours to be a beneficiary under the JSY, mainly because they did receive cash on filling up form to meet expenses incurred at hospital. Besides, they had safe delivery in the hospital.

All the JSY beneficiaries interviewed were asked about reasons why women prefer to deliver at home despite cash assistance paid under the JSY. Major reasons for not preferring institutional delivery were fears - fear of hospital, injection, needles, equipments, doctor, nurse, dai, stitches, caesarean or bad omen; lack of cleanliness maintained at hospital, no importance of institutional delivery, and opposition from family members.

Shift in the place of delivery before and after JSY (Percentage)

Particulars	Place of delivery for last (JSY) child		
	Institutional	Home	Total
Place of delivery for last but one child			
Institutional	27.7 (46)	4.8 (8)	32.5 (54)
Home	37.4 (62)	30.1 (50)	67.5 (112)
Total	65.1 (108)	34.9 (58)	100.0 (166)

Out of the 166 JSY beneficiaries who had two or more children, 67 percent of the previous delivery was reported delivery at home. Of the total 166 women, 28 percent continued with institutional delivery and 30 percent with delivery at home. Interestingly and encouragingly, a major shift from home to institutional delivery was noticed between two pregnancies among 37 percent of the total JSY beneficiaries.

The study also shows that the women with no formal education or those who had studied up to primary level and those belonging to SC/ST go for home deliveries. Even among literate and high caste Hindus, one in every 5-6 women deliver at home. Study revealed that grassroots level health functionaries were reaching this group to motivate them for ANC and institutional delivery, but it is a challenge to motivate them for institutional delivery.

CHAPTER 1

INTRODUCTION

The Background

The Government of India launched the National Rural Health Mission (NRHM) in 2005. The aim was to provide accessible, accountable, affordable, effective and reliable primary health care, especially to the poor and vulnerable sections of the population. The Mission envisages equitable, and quality health care services to rural women and children in the country with greater emphasis on 18 highly focused states. It adopts a synergistic approach by encompassing non-health determinants that have a bearing on health such as nutrition, sanitation, and safe drinking water. The mission aims to achieve greater convergence amongst related social development sectors.

One of the core strategies proposed, to accomplish the goals, was to have a female Accredited Social Health Activist (ASHA) for every village with a 1,000 population. It was suggested that ASHA would be chosen by and would be accountable to the Panchayat. She would act as an interface between the community and the public health system. As an honorary volunteer, ASHA would receive performance-based compensation for promoting variety of primary health care services in general and reproductive and child health services in particular such as universal immunization, referral and escort services for institutional deliveries, construction of household toilets, and other healthcare interventions.

In order to enable the states for proper implementation, ASHA guidelines were formulated by the Ministry of Health and Family Welfare (MOHFW), Government of India (GOI) wherein institutional arrangements, roles and responsibilities, integration with ANM and Anganwadi, working arrangements, training, compensation, fund-flow etc were discussed. The training modules and facilitators guide were prepared and shared with the states for rolling out the trainings. The guidelines accorded flexibility to the states in designing the operationalization of the intervention. Many states modified the guidelines depending on the local context to suit their requirements, in the true spirit of the NRHM guidelines of decentralized programme management.

On the other hand, as an integral component of NRHM, the Honorable Prime Minister of the Country launched safe motherhood intervention in the form of Janani Suraksha Yojana (JSY) for reducing maternal and neo-natal mortality on April 12, 2005. The scheme aims to promote institutional deliveries among poor pregnant women in all the states and Union Territories (UTs) of the country with special focus on low performing states (LPS). It is a central government sponsored scheme and links cash assistance with delivery and post-delivery care. In availing institutional delivery services, the client needs to be escort, need transport to reach the institution and in case of complications, referral services are required. The scheme considered all these elements and made provision for transport including referral and escort (by ASHAs)

and at the same time invested in improving public health institutions and services through the Reproductive and Child Health (RCH) Programme interventions. Moreover, states have flexibility to evolve public-private partnership (PPP) mechanism and accredit private health institutions for providing institutional delivery services. As stated earlier, special dispensation was made for LPS in both rural and urban areas and was linked to the ASHA intervention.

The LPS are states that have low institutional delivery rates and include Assam, Bihar, Chhattisgarh, Jammu and Kashmir, Jharkhand, Madhya Pradesh, Orissa, Rajasthan, Uttaranchal and Uttar Pradesh. In the remaining states and UTs categorized as High Performing States (HPS) similar provisions were made wherein Anganwadi worker, traditional birth attendant or ASHA like activist could be engaged and be associated with JSY. To facilitate the states in implementing JSY, a set of guidelines articulating the criteria of eligibility of beneficiaries and provisions were worked out in detail. The guidelines have undergone revisions and certain clauses have been modified for both LPS and HPS states.

Both ASHA intervention and JSY are in operation for over a year and the LPS are in different stages of implementation. To understand the status and the processes of implementation in the states of Rajasthan, Madhya Pradesh and Orissa, MOHFW sought assistance of UNFPA. UNFPA prepared the Terms of Reference for the study and commissioned it through a professional research agency Centre for Operations Research and Training (CORT) based in Vadodara, Gujarat.

Objectives of the Study

The common objectives for both ASHA and JSY were as under:

1. review adaptation of the national guidelines by states and operation of the same
2. study programme management processes (planning, MIS and supervisions, etc.) and institutional arrangements established for implementation of the schemes.
3. analyze funds flow mechanisms from state to district and to lower levels of service delivery system and reimbursement.
4. ascertain the level of understanding about these two schemes amongst the programme managers, service providers and other stakeholders
5. map community perceptions about the two schemes

For ASHA intervention study attempted to:

1. assess adherence with guidelines for community involvement / NGOs / CBOs in the selection of ASHA
2. review the training strategy including design, plans, material developed, training of trainers, quality of training and post-training follow-ups
3. analyze support of health system to ASHA
4. study engagement of PRI, NGO, SHGs and other CBOs engagement in extending support to ASHA
5. gauge satisfaction of ASHAs with the delivery of scheme including that related to compensation / reimbursement.

For JSY, specific objectives were as under:

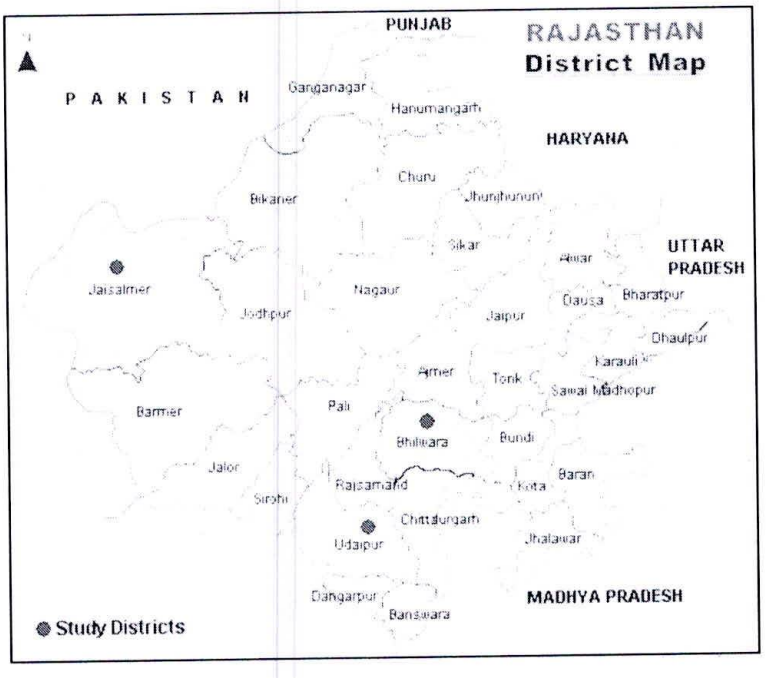
1. assess adequacy and simplicity of the processes set out by the state for claiming benefits under JSY
2. examine the utilization of the scheme and analyze factors influencing impeding utilization
3. review engagement of private sector including accreditation and compensation
4. analyze nature and scope of IEC interventions for raising awareness of JSY.

Study Design

The assessment of ASHA and JSY adopted a blended methodology and included application of quantitative and qualitative techniques. The study covered three districts of Rajasthan, selected on the basis of performance and represented good, average and not so good performing districts. Secondary data on ASHA training and JSY beneficiaries was collected, analyzed and categorized. After discussion with state officials, the study districts were finalized. Likewise, procedure of district-level consultation was undertaken in each of the selected district to select the two blocks. Thus, in all six blocks from three districts were covered in Rajasthan.

Study Area

The report is based on the assessment study conducted in Rajasthan covering Bhilwara, Jaisalmer and Udaipur districts.



The Sample

The sample covered in the state included ASHAs and beneficiaries of JSY. Several people associated with the scheme such as state and district programme managers, block-level providers, trainers of ASHA, Auxiliary Nurse Midwife (ANMs), members of Panchayati Raj Institutions (PRIs), AWW, Community Based Organizations (CBOs), and community members were interviewed and included in the study.

Interviews of ASHAs: From each of the six study blocks, 30 ASHAs fulfilling the selection criteria were interviewed. To cover 30 ASHAs, 30 villages were visited in each of the study block, which included one CHC village, 2 PHC villages; 9 sub-centre villages (3 SCs within each selected PHC/CHC), and 18 remote villages (2 remote villages from each of the selected sub centre). In all, 173 ASHAs who had undergone first round of training and had been active in the six months prior to the survey were interviewed, while the remaining seven were not available or had opted out.

Interviews of beneficiaries of JSY: A sample of 240 beneficiaries at the rate of 40 beneficiaries per block who had availed benefits of JSY in the six months prior to the survey were included in the study. From each of the study block, 40 JSY beneficiaries were interviewed. Altogether, 248 JSY beneficiaries who availed services under the scheme could be contacted and interviewed.

Other stakeholders: In addition to quantitative survey of JSY beneficiaries and ASHAs, other people including state and district programme managers, block-level providers, trainers of ASHA, ANMs, PRIs, CBOs, AWWs and community members were also interviewed (Table 1.1).

Table 1.1: Sample covered for qualitative and quantitative component in Rajasthan, 2007

Type of stakeholders	Number of stakeholders interviewed
Qualitative study	
State officials	5
District level officers	15
Block level provider	17
Trainers of ASHA	8
PRI/NGO/SHGs/AWW	24
ANMs	49
Community based organizations	13
Community members	26
Quantitative survey	
ASHA functionaries	173
JSY Beneficiaries	248

The State Secretary-Family Welfare and MD-NRHM, Director, Family Welfare; and ASHA and JSY nodal officials were interviewed. Specific questions related to the implementation of the scheme, processes involved and challenges faced were addressed to them. The state mentoring group for ASHAs was also approached and discussions regarding adaptation of national guidelines, selection and training of ASHA, suggestions and challenges were held. District officials and three block development officers were interviewed regarding the utilization of the scheme, profile of the beneficiaries, and steps required for future improvement of the programme. In each block, ASHA trainers and facilitators were approached to understand the implementation of the training programme, participation of the ASHAs as trainees, training pedagogy and logistics. Again, at block level, members of Panchayati Raj Institutions, NGOs, and Self-Help groups, CBOs, ANMs and AWWs were interviewed to assess the networking of ASHA, its benefits and challenges.

Awareness and understanding of the scheme at the community level is important for effective utilization of the scheme. Key informants from the community including both male and female in each district were asked about their awareness of the programmes, attitude, and utilization.

Study Tools

In collaboration with the professionals from UNFPA, Ministry of Health and Family Welfare, and GTZ, CORT developed the study tools. Several questions were open-ended. For qualitative in-depth interviews, guidelines were used for collecting the requisite information from the stakeholders. These guidelines facilitated in the comparison and analysis of data across respondents within the state. The type of queries differed depending on the type of stakeholder including adaptation of the national guidelines, programme management processes, funds flow mechanisms, community perceptions about ASHA and JSY.

Field Operations

Experienced Field Manager and Field Coordinators from social sciences coordinated the entire fieldwork. Fifteen field investigators, males and females were trained at Baroda for 5 days to conduct the fieldwork. CORT and UNFPA professionals briefed them at Udaipur before launching the fieldwork in January 2007.

At the grassroots level, female field investigators interviewed JSY beneficiaries. Supervisors checked the selection of the eligible sample and ensured that the questionnaires were filled accurately and completely. UNFPA professionals actively participated during the fieldwork, facilitated the fieldwork and helped in ensuring the quality of data. Back-checks were conducted to ensure consistency in the data at site thereby ensuring quality, validity and reliability.

Ethical Considerations

MOHFW and UNFPA informed the authorities of the selected states, districts and blocks about the study and the need to share the information about ASHAs and JSY beneficiaries with the research team of CORT. The field coordinators ascertained that consent procedures were pursued and that privacy and confidentiality was ensured during interviews to minimize the potential for distress, if any. The research staff did not share individual information obtained during the study with the staff of any other organization.

Data Management and Analysis

CORT's in house specialist, who has been involved in the complete analysis of large-scale surveys like NFHS and RCH, handled the data management and analysis. The CORT programmer prepared data entry screens for the study using CS Pro. A data entry package developed by CORT for the study checked range and consistency during data entry. To ensure quality of data entry, data was entered twice and analyzed using SPSS package. The analysis plan was jointly developed by CORT, UNFPA and GTZ. Preliminary results were shared with the UNFPA and their suggestions and feedback were incorporated in the final report.

Presentation of the Report

The report has five chapters. The present chapter gives a brief introduction of ASHA component and JSY and the study design for assessment. Chapter 2 elucidates programme inputs and processes adopted in implementation of the scheme in Rajasthan. ASHA's profile, selection, training, knowledge about different aspects of reproductive and child health and other related issues are discussed in Chapter 3 while utilization of JSY by the beneficiaries, their views about the scheme and suggestions are discussed in Chapter 4. Chapter 5 is on recommendations and programmatic interventions for enhancing ASHA intervention and JSY.

CHAPTER 2

OPERATIONALIZATION OF ASHA INTERVENTION AND JSY

Adaptation of ASHA Intervention

The national ASHA guideline covers various elements and includes roles and responsibilities of ASHA, institutional mechanisms, selection and training of ASHAs, work arrangements and linkages with Anganwadi workers and ANMs, compensation to ASHA, fund-flow mechanism and monitoring and evaluation.

Adaptation of guidelines by the state went through a process and evolved gradually. The number of ASHAs to be recruited was worked out according to the national norm of one ASHA for every 1000 population. The State Institute of Health and Family Welfare (SIHFW - an autonomous body in the department of Health and Family Welfare, Government of Rajasthan an apex training/research/consulting institution) was responsible for training ASHAs.

The National Institute of Health and Family Welfare (NIHFW), (an apex national institution) organized Training of Trainer's (ToT) workshop and the staff members of Rajasthan SIHFW were trained as trainers. SIHFW prepared a training agenda, and following a cascade approach, trained 100 district level staff members for four days within three months. These trainers were to train the district and block teams.

While this training was underway, the state thought of institutionalization of ASHA intervention through a convergence model. This was deliberated and there was consensus among the senior officers of both the Secretariat and the Directorate. Incidentally, the then Secretary of Family Welfare was the State NRHM Director as well. This facilitated the process.

At the Secretariat level, the health department held discussions with their counterparts from Department of Women and Child Development (DWCD). As NRHM promotes inter-sectoral convergence, the idea was to involve this important development department with an impressive Integrated Child Development Scheme (ICDS) network. After several rounds of discussions with the DWCD and meetings at higher levels and concurrence from political level, the state decided on an integrated approach. In Rajasthan, apart from Anganwadi worker (AWW) and helper, an additional human resource named as 'Sahyogini' is working at each Anganwadi centre (AWC) for community mobilization under the DWCD programme. Considering the similarity of roles of ASHA under NRHM and Sahyogini under DWCD, it was decided that only one worker named as ASHA Sahyogini would work for community mobilization for health and Women and Child Department. Each ASHA Sahyogini would cover geographical area catminus with Anganwadi centre. ASHA Sahyogini would receive honorarium from DWCD for the work assigned as Sahyogini whereas she will be entitled to receive performance based incentives under NRHM program.

In Rajasthan, according to state officials, around 43,000 ASHAs are required for complete coverage of the state as per national norms. DWCD has 32,000 Sahyogini workers in the 32 districts. Therefore, it was decided that the balance of around 11,000 would be selected as ASHAs and upon establishment of more Anganwadi Centres; they would be converted as Sahyogini by DWCD. Just as all Sahyogini's became ASHAs, it was possible for ASHAs to become Sahyoginis in future. The decision of the state to introduce such a scheme, was indeed innovative.

Subsequent to these decisions, institutional arrangements and management processes were initiated. Given the scale and magnitude of ASHA trainings, it was necessary to have an apex advisory body. A think-tank group in the form of State ASHA Mentoring Group was set up and the State Resource Centre (SRC), (state-level resource agency working on the National Literacy Mission) was chosen as a secretariat for mentoring group. Thus, ASHA Resource Centre (ARC) was established within SRC. ARC became the fulcrum of activities for ASHA intervention. Terms of reference of the mentoring group and resource centre were worked out and finalized (Refer Annexure 2).

The Mission Director-NRHM is Chairperson of state ASHA mentoring group, whereas Director-SRC and ARC is convener. This group has representation of state officials, development partners and NGO representatives. In all, there are about 20 persons in the state ASHA mentoring group. The group is to oversee the implementation and facilitate in developing policy guidelines and be a support mechanism for intervention. The mentoring group is expected to meet at least once in a quarter.

The ARC has three persons on board now and includes-a Project Officer, a Research Data Analyst and a Computer Programmer who work full time. ARC is responsible for adapting the national training modules and materials, translating modules into local language, organizing training and workshops for state and district trainers, ensuring training of ASHAs, involving NGOs, monitoring and supervision including developing of reporting formats and registers, and documentation of the processes. ARC was made responsible for orienting Panchayat officials and other key stakeholders, and the Director, ARC functions as member secretary of ASHA mentoring group.

The ARC is technically required to report to the Mission Director NRHM. It works in convonance with, both the State Programme Management Unit (SPMU), and District Programme Management Unit (DPMU). The ARC has to rely on DPMU for below district level activities. The participation of block level workers and block facilitators is vital for ARC. Considering the enormity of tasks and scope of ARC activities, the block level participation needs to be more specified. Even the national guidelines emphasized the block level facilitators' role in implementing ASHA intervention.

As an important initial task, the state nominated the state ASHA nodal officer responsible for implementation of ASHA intervention. The adolescent reproductive and sexual health (ARSH) consultant at SPMU has been entrusted with additional responsibility as ASHA nodal officer. One of the responsibilities of nodal officer is to closely interact with ARC and plan the intervention jointly. The state nodal officer is supported by SPMU, and by DPMU at the district level; monitoring and supervisory support comes from the Chief Medical and Health Officer (CMHO) and facilitated by

the DPMU with the CMHO being the district nodal officer. As there is no presence of ARC structure at the block level, the DPMU through the block medical officers and other supervisory staff, and NGOs working in the area, provides support and report on routine basis to the SPMU and ARC.

The ASHA selection process was initiated in places where Sahyogini was not available. The selection criteria as per the national guidelines were that the ASHA worker should be resident of the village, between 25 and 45 years, and should have completed eight standards of education. The state found it difficult to find women in adherence with such requirements in tribal districts.

The guidelines specified the role of DPMU Manager, an NGO, and a Nodal Officer, preferably senior officers in-charge of the block, and the block medical officer in the selection of ASHAs. Their involvement in the selection process was seen at places where Sahyoginis were not present. The selection of ASHA Sahyogini was facilitated by ANM and AWW. Local NGOs, community based groups, Mahila Samakhyas, Anganwadis and community were involved in the selection process as well. The final approval of the name of selected ASHA Sahyogini was made by gram panchayat through gram sabha.

The compensation package for ASHA was finalized by the state and the ASHAs were expected to get the following amount for different services:

- Compensation under JSY-Rs. 600/- in 2 installments in rural areas of Rs 350 for transport and Rs. 250 for accompanying to institution for delivery whereas Rs. 200 for urban area.
- Motivation for Sterilization: Rs. 50 for male and Rs. 25 for female
- Motivation for night delivery: Rs. 100 in selected institutions
- Complete ANC and PNC for home deliveries-Rs 50
- Referral for cataract to government or private hospitals-Rs. 175
- DOTS treatment-Rs 250
- Toilet promotion-APL families Rs. 30 and BPL families Rs. 20 and Rs. 10 per month if continued for six months
- Attending training or monthly meetings at PHC - Rs. 100 per day

Concurrently, review of the national training guidelines was undertaken. The national guidelines recommended 23 days of training staggered over five rounds with the first training lasting a week followed by four training of four days each. The state, instead of a week's training, decided on a six-day package for the first round and adapted and translated the modules 1 and 2 received until then. The ARC, with the involvement of NGOs, trained block level facilitators for six days for organizing ASHA trainings in their respective areas.

Subsequently, the training of ASHAs was initiated. In each batch, 40 ASHAs were trained. Table 2.1 reveals that the state need to recruit about 43,000 ASHAs during the year. By October 2006, around 70 percent of ASHAs were selected and an equal percentage of the selected ASHAs were trained.

Table 2.1: Number of ASHAs selected and trained in Rajasthan up to October, 2006					
	Selection target (06 - 07)		Selected up to October, 2006	Trained in first round up to October, 2006	Percent trained (against the selection)
	Urban	Rural			
Total number of ASHA-Sahyogini	4279	42592	32000	23443	73.3
Udaipur	136	2410	1286	1206	93.8
Bhilwara	110	1556	1046	743	71.0
Jaisalmer	0	486	327	128	39.1

In the districts under study, Udaipur recruited half of its proposed numbers but was saturated by training most of those recruited. Similarly, Bhilwara selected about two-thirds of its requirement and trained about seventy percent ASHAs, while Jaisalmer reached about two-thirds of its requirement but trained less than 40 percent of those selected. The pace of selection was slow in the districts and varied in terms of completion of training. The GOI has sent finalized training modules for the subsequent rounds as well. While Udaipur performed better than the state average in terms of the proportion trained out of the selected, Bhilwara was around the state average and Jaisalmer fell short. At the time of fieldwork for the study, Swasthya Chetna Yatra (Health Awareness Campaign) was underway and it was used for propagating and promoting JSY. This has been briefly discussed later in this chapter. It was hoped that the state would be able to meet their requirement of recruiting and training 43,000 ASHAs by mid 2007.

As the state had taken a lead in demonstrating inter-sectoral convergence, we were curious to know how it was translated at the field level. The block-level functionaries commented that convergence and appropriate mechanisms were in place. However, one of them stated:

> *"Sahyogini being an employee on the pay-rolls of DWCD is more loyal and committed to her department and its officials. Instructions from her parent department are honoured first and the others follow later, however, important it may be. The informal instruction in the field is that forenoon should be devoted for Anganwadi work and the afternoon for motivational work as ASHA. In the process, Sahyogini is putting very little time in the afternoon, as she in inundated with registers and reports supplied by her department. Instructions by health department on meeting with clients and motivating them for services gets neglected and more importantly, accompanying pregnant women for institutional delivery on working days is restricted. This has resulted in some undercurrents between the two departments".*

> *"The undercurrents mentioned will be apparent when the monthly meeting that has been proposed is going to start. The roaster for block level meetings has been prepared and will be starting soon. ASHAs are expected to attend the meetings and the DWCD officials are going to be there. So, let's wait and see how it is going to shape. It is likely that we may be able to resolve most of the issues."*

We wanted to know whether the higher ups at the district and state were aware of such issues. We were informed that this reached the state officers informally. Regarding the actions initiated and whether they had any exchanges with their counterparts from DWCD or in the SMG, it was mentioned that there was no systematic review of the intervention undertaken till then. In fact, the SMG had not met even once in the quarter. The last time SMG met was in November 2006 when the new JSY national guidelines were discussed, revisions were expected to suit the state context and a circular was issued.

Given these circumstances and our observations, it may be inferred that the state made concrete efforts to operationalize the ASHA intervention. In the process of doing so and in addressing the core inter-sectoral convergence strategy of NRHM, the state definitely took the lead. SMG and ARC were constituted and the terms of reference of both were specified. However, the structure of ARC and the nature and scope of work below district level is a matter of concern. Also, interface between ARC and DPMU needs clarity. Given the roles and responsibilities of various tasks and with monthly meetings to be initiated at block-level, block seems to be the nucleus of activities and the structure does not depict involvement of any block functionary. Hence, there is a need for reviewing the structure and make necessary changes for effective and decentralized management of the intervention. Perhaps ASHA mentoring group can provide guidance to state in terms of how to engage block level health structure, bring on board block facilitators and set up clear reporting mechanisms.

Another important area that needs mention is the revision of Sahyogini curricula of DWCD. Since the state has already decided and has issued Government Orders of Sahyogini working as ASHA, the ASHA training component could be included as part of the future induction training programme of Sahyogini by DWCD. This needs to be deliberated in detail as it has implications on the overall job profile of ASHA Sahyogini.

Adoption of JSY Guidelines

In accordance with the national guidelines, there is a JSY nodal officer nominated from the state medical directorate to oversee JSY activities. The nodal officer works full-time and the SPMU, set-up for effective implementation of Reproductive and Child Health Programme, provides support for JSY. At the district level, the Reproductive and Child Health Officer (RCHO) or an officer of a similar rank is made responsible for JSY intervention. The Programme Manager of DPMU supports JSY district officer. JSY is linked with the block medical officer-in charge responsible for both performance and financial monitoring. At the peripheral or community level, ANM is held responsible and is supported by her supervisor. ANMs closely work with ASHAs and Anganwadi workers and interact with PRI members for promoting the scheme.

Through circulars and discussions in the monthly meetings, the state informed the health care providers of JSY and districts/blocks were asked to follow a similar procedure. The orientation of the scheme to Anganwadi workers took place during block-level monthly meetings and ANMs during their routine interactions. However, orientation of the other important stakeholder, that is the PRIs, took place on ad hoc

basis during their interactions with block functionaries. ANMs were instructed to talk to PRIs and other community stakeholders during their field visits.

In addition, inter-personal and group communication was given priority to publicize JSY activities and was reinforced through mass media activities such as hoardings at strategic locations, posters, wall paintings at health facilities and public places. Survey teams mentioned having seen paintings on JSY specifically, on payment of cash assistance to the beneficiary. This apart, NGO's and ASHAs were also given IEC materials and were asked to publicize the scheme in their area of work. Even though efforts were made by the state to generate demand for services, there has not been any formal orientation of the scheme to PRI Representatives, who are the source of information at the community level. This is a matter of concern. JSY guideline proposed that the money should be placed in the joint account of Sarpanch and ANM. Hence, it becomes imperative to equip them with the minute details of the scheme, revisions, how the funds would be drawn from the account etc. and above all for seeking their support in promotion of institutional deliveries.

During discussions with state officers, it emerged that the MOHFW has revised JSY guidelines four times. Two of which had direct bearing on the state for being classified in the LPS category. The first one came along with the launching of the intervention while the other was issued much later sometime in September 06 wherein the eligibility criteria, cash assistance and their disbursement were revised.

Table 2.2: Cash Assistance Package for JSY Beneficiaries in Rajasthan

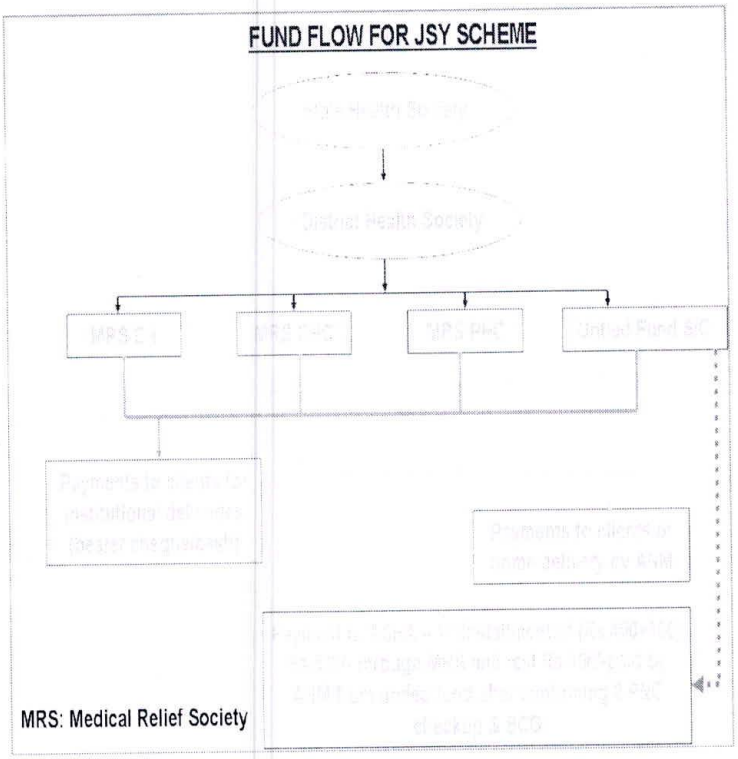
Particulars	Rural areas			Urban areas		
	Mother's package	ASHA's package	Total	Mother's package	ASHA's package	Total
Institutional delivery	1400	600	2000	1000	200	1200
Home delivery (only for BPL pregnant women)	500			500		

As per the present national guidelines for LPS, age restriction that was 19 years or less, more than two births, women from BPL families have all been removed (Table 2.2). For home deliveries, assistance of Rs. 500 has been sanctioned only for BPL women in both rural and urban areas. In the context of revised guidelines, a state officer said:

> *"Improving the guidelines is good for the programme but practically changing now and then creates confusion not only at the field level but even at programme level. Dissemination of previous guidelines by the state followed a process. Districts were communicated through circulars and responsible authorities were asked to share the information with staff members during monthly meetings or similar interactions. Trainers of ASHAs were informed too and were asked to include in the training curricula. With the revision, we have repeated this process and have explained about the changes. However, during field visits, we often hear about different amounts being quoted. It will take some time for new guidelines to sink in."*

With reference to new guidelines, the issues related to time-frame of payment to the beneficiaries came up. A block-level accounts person in Udaipur district opined that time of payment to the beneficiary has to be increased from one week to two weeks after delivery. This was a deviation from national guidelines (even the earlier) wherein

it is maintained that single total payment should be made at the time of delivery. The state officials had discussions with GOI after the new guidelines came into effect in November 2006 and the payment within a week of delivery was agreed upon. During discussions, it came to our notice that transport payment to beneficiaries in case where ASHA had not accompanied for institutional delivery, was not made to the beneficiary. With the revision of guidelines, the amount of Rs. 300/- was to be paid to the beneficiary even in case ASHA do not accompany pregnant women for institutional delivery. Since, the cut-off of selection of beneficiaries was six months prior to the survey, this element of transport reimbursement in accordance with the new guidelines could not be effected.



With reference to the fund-flow, the state worked out its mechanism along the guideline of the national government. However, at the field level, there have been some modifications in terms of payment of advance recoupable money to the ANMs. The national guidelines provided that advancing recoupable money in the range of Rs. 5,000 to 10,000 to ANMs, should be deposited in the joint account of ANM and Sarpanch. The state felt otherwise and instead suggested that the untied money given as part of NRHM could be used and upon submission of expenses, the ANMs could be reimbursed immediately (Refer Fund Flow Chart). When this issue was discussed with the block level officer, he suggested:

> *"ANMs are handling accounts and substantial money for the first time. They have not been oriented of how to handle and what transactions are involved and how to maintain the expenditure statement and cash book. Moreover, ANMs find it difficult to withdraw money due to fixed ceiling amount. Beyond that ceiling amount, ANM has to seek signature of the joint signatory who in this case is the Sarpanch. Experience has been that Sarpanch are reluctant to sign and have lot of queries. It would be good if ANMs and Sarpanch are jointly imparted training on how to manage the funds and maintain the expenditure"*

Concerning the monitoring of JSY, the CMO of Jaisalmer district said:

> *"In our district, we have tied up JSY monitoring with routine monthly field visits of my officers and DPMU. Whenever my staff and I visit the field, we look into their cashbook register, tally it with delivery register and talk with the beneficiaries if they are available at the facility on the day of visit. In addition, we also undertake random check of JSY beneficiary in the field and find out details about cash assistance, amount received, when received and so on, whether ASHA accompanied or not and any problems faced in the facility and so on."*

The CMO also said that there was lot of cash flow and disbursement involved in the scheme and therefore it was necessary to monitor it at different levels. On the quality care of deliveries happening in institutions, the state has done very little. With the uptake of institutional delivery services expected to increase under JSY and human resources being constant, it becomes important to monitor the quality of services rendered by the public health facility. Hence, it is necessary to set-up an appropriate system for monitoring quality of services within JSY. Regarding the quality, CMO of Jaisalmer district stated:

> *"As long we don't get to hear of major complications or eventuality, the services can be presumed to be reasonably good. Up gradation and strengthening of facilities and capacity building of human resources are underway and we are certain, that would be able to ensure good quality of care".*

Other districts reiterated this view as well.

Regarding quarterly progress and financial reports, the statistical assistants and account persons at district and blocks levels were of the view that each time data on beneficiaries was collated, reconciliation between performance and disbursement had to be made. An integrated format that could cover both performance and disbursement was recommended by Udaipur district. The DPMU of the district felt that this would reduce the time in reconciliation and running around and both information could be maintained and shared. The integrated format has been recommended to the State Government and the idea has been well received.

Rajasthan has tried out an innovation in JSY implementation. The state has launched JSY Helpline on experimental basis in one block of each district with the help of NGO. JSY helpline aims at promoting emergency referral and ensuring safe delivery of women with obstetric emergencies at the identified block health facilities. The NGOs ensure networking with transporters and health care providers. This intervention is in operation for several months and the state officials seem to be happy with the progress. The intervention is regularly monitored but it would be worthwhile to undertake an independent assessment of how this intervention has fulfilled its objectives. It is to be noted that JSY help-line blocks were not a part of the study sample.

Swasthya Chetna Yatra

State government organized *Swastya Chetna Yatra* (health awareness rally) in December 2006 covering all the districts and all the villages of the state. The rally was jointly organized by the Health and Family Welfare department, ICDS, Ayurved, Panchayati Raj, Education and Rajaswa department.

The main objective was

- to impart knowledge about different health scheme's availability
- to create awareness about nutrition, increase community involvement in celebration of health days and
- to create awareness and promote voluntary blood donation

Rally also propagated free health check-ups at health centre through street play and role plays. Besides through rally, the health staff attempted to identify ASHAs and propagate and publicize JSY. It can be said that, because of this rally, men & women, and old & young in the community learnt about details of JSY and involvement of ASHA

Another option provided in the national JSY guidelines is related accreditation of private institutions for delivery services. The guideline for accreditation could not be accessed, but it was mentioned by a state official that it should be a 24x7 days service having services of a gynaecologist, an anaesthetist, and a surgeon who could perform caesarean section. Further, the facility should have blood transfusion facility; proper OT and labour room with power back up. In Rajasthan, the process of accreditation of private institution has just begun with the listing exercise and this aspect has been highlighted in the revised JSY guidelines circulated in November 2006. The guideline suggests listing of private facilities not only at district headquarter but also at sub-district and block levels. According to the state official:

> *'Efforts are underway but we are finding difficulty to even identify one such institution per district in Rajasthan that comply with the accreditation norms.'*

Private sector engagement in JSY has to be given impetus and the state could review and modify the guidelines of accreditation depending on feasibility. If the present norms of accreditation, as stated by the state official are applied to public health institutions, there could be very few institutions eligible under JSY. So, the state could consider modifying the norms for accreditation of private sector institutions.

Rajasthan has made efforts to operationalize and implement JSY. They have adhered to and adopted the national guidelines and subsequent revisions to the state context. In addition, the state has tried out convergence between health and ICDS department and an innovation in the form of JSY help-line by involving NGOs. In terms of disbursement of cash advances to ANM and payments to beneficiaries, they are extremely cautious and have built a cut-off of a week for payment to beneficiaries. These could be some areas where further clarification could be sought and appropriately intervened.

CHAPTER 3

ENGAGEMENT OF ASHA IN THE NATIONAL PROGRAMMES

One of the core strategies of the NRHM is to develop a sizeable force of village-based women activists, as ASHAs, who would be able to create demand for effectively and timely utilization of health care services. At the same time, it was felt that ASHA would act as an interface between vulnerable communities, especially women and children, and with the health care providers.

In order to enable the ASHAs to perform their roles; an induction training of 23 days spread over 12 months was proposed and was staggered into five rounds beginning with one week training followed by four rounds of training of four days each. Such schedule of trainings would help ASHAs to practice whatever they learned in earlier training and to come back for next training keeping in mind their own work environ in villages. It was expected that by training the ASHAs, they would be able to facilitate implementation of the Village Health Plan along with Anganwadi worker (AWW), ANM, functionaries of other Departments, and Self Help Group (SHG) members under the leadership of the Village Health Committee of the Panchayat. In addition, ASHA guidelines proposed provision of a Drug Kit containing generic AYUSH and allopathic drugs for common ailments, oral pills and condoms so that they could provide general health care for minor ailments and act as depot holders for oral pills and condoms.

This chapter describes the socio-demographic profile of ASHAs, their motivation to become ASHAs, selection process, training, and gauges the knowledge retention regarding antenatal and childcare. Their roles and responsibilities, the way they motivate clients and ensure services are discussed. ASHAs last clientele (to understand the nature and range of interactions); networking with key stakeholders, cash assistance received by ASHAs, their supervision and monitoring are also presented.

Background Characteristics of ASHA

In all, 173 ASHAs could be interviewed from the three districts of Rajasthan. The ASHAs interviewed were around 26 years and had nine years of schooling. Given the educational attainment of women in the state, this was highly encouraging.

Most of the ASHAs interviewed were married (95 percent), while five percent were divorced, widowed or separated. Thirty-two percent belonged to scheduled caste/tribe, which was slightly more than the proportion of SC/ST population in the state. About the place of residence of ASHAs, most resided in the village/town where they worked, while about six percent came from nearby village/town. The eligibility criteria for ASHAs listed that an ASHA should be eighth class pass, aged between 25 and 45 years and preferably married resident of the village (Table 3.1).

Table 3.1: Profile of ASHA functionaries in Rajasthan, 2007 (Percentage)	
Profile	Total
Total number of ASHAs interviewed	173
Age of ASHA (in completed years)	
18 - 19 years	2.3
20 - 24 years	35.3
25 - 29 years	41.0
30 - 34 years	13.9
35 years or more	7.5
Mean (years)	26.1
Years of schooling completed	
Below 8th std	2.9
8th std	49.7
Secondary (9-10 std)	31.2
Higher secondary (11-12 std)	9.2
Undergraduate and above	6.9
Mean (year of schooling)	9.2
Caste/tribe of ASHA	
Scheduled caste	17.9
Scheduled tribe	13.9
Other backward classes	37.6
Others	30.7

Going by the criteria, it is felt that there was relaxation of the eligibility norms. Another important statistic not presented in the table reveals that 16 percent of ASHAs did not fulfill one or the other requirement for becoming an ASHA because they were either more than 45 years, had not studied up to 8th standard or were not residents of the village. It appears that these criteria were relaxed for some tribal districts where it was difficult to identify ASHAs. This may be due to the fact that minimum age criterion for Sahyogini selection is 21 years.

Majority of ASHAs were in reproductive ages and over four-fifths of them had a child. On average, ASHAs had 2.2 living children. One of the questions posed to ASHAs who had a child was the place where they delivered the last child. This question was not related to programmatic aspects but was important from the perspective of behavioural change because, it was imperative to understand ASHA's behaviour and practice. Interestingly, two out of 3 ASHAs had delivered at home, which was in line with the trends observed in the state and mirrors community behaviour and experiences. On the whole, it can be inferred that the selection criteria that were proposed in the national guidelines were adhered to by the state and relaxed in tribal districts.

Another question posed to the ASHAs was their work-status prior to becoming an ASHA. Almost half of the ASHAs were economically active before they were selected as ASHA. They worked as a *'Sahyogini'* assisting anganwadi worker at the Anganwadi Centre located in the village. These Sayoginis are selected by the State Department of Women and Child Welfare and get Rs 500 per month as honorarium.

Regarding duration of work as ASHAs, it was found that on average, they had worked for nearly six months and two-fifths had more than six months of work experience. The table further depicts that more than half of ASHAs had not earned money since the time they started working as ASHAs. This was evident even among those who had worked for more than six months though the proportion was marginally smaller in comparison to ASHAs who had worked for less than six months. ASHAs who reported having earned money through their work stated their monthly earning to be around Rs. 340/ while ASHAs who worked for six months or longer reported their monthly average earning to be over Rs. 360/. These findings point to marginal difference in earning between the two groups of ASHAs (Table 3.2).

One of the findings is that majority of ASHAs did not earn anything till the time of survey. If this trend continues, it would be difficult to sustain their interest and they may even opt out. There should be well-designed strategy to introduce ASHAs to community. Engagement of PRIs and health functionaries would be vital in doing so.

Table 3.2: Duration of work and earning of ASHA in Rajasthan, 2007 (Percentage)

Particulars	Duration since working as an ASHA worker (in months)		
	Less than or equal to 6 months	More than 6 months	Total
Approximate monthly income from ASHA work (in rupees)			
Rupees 250 or less	23.7	19.7	22.0 (38)
251-500 rupees	12.4	18.4	15.0 (26)
501 - 750	4.6	6.6	5.2 (9)
No amount earned	56.7	52.6	54.9 (95)
Do not know/can't say	3.1	2.7	2.9 (5)
Total	100.0 (97)	100.0 (76)	100.0 (173)
Mean rupees earned per month	321.3 (39)	359.6 (34)	339.1 (73)

About ASHA: Their Selection and Motivation to Work

It is important to understand the selection processes followed and motivating factors for village women to be ASHAs. Half of the respondents first came to know about the ASHA from ANM and nearly a quarter from the anganwadi worker/ supervisor. In most cases, they were motivated to attended training by family members.

Table 3.3: Motivation for being an ASHA in Rajasthan, 2007 (Percentage)

Particulars	Total
Total number of ASHAs interviewed	173
Ways got selected as ASHA*	
On account of netaji/politician/surpanch gram sabha	52.6
Was working as anganwadi Sahyogini	31.8
ANM helped me in getting selected	15.0
I think because of my good nature/ I am literate	7.5
Others/husband/father-in-law/CDPO/block facilitator	4.6
Percent mentioned that Gram Sabha approved their name	97.1
Reasons for wanting to be an ASHA*	
Want to serve/help the poor community	73.4
Source of income	29.5
Save children / For the benefit of children	17.9
Learn new things / to remove misconception	10.4
Others / reducing population growth rate	3.5
* Multiple responses	

The respondents were asked how they were selected as ASHAs. Majority (53 percent) of the ASHAs stated that elected representatives; sarpanch or Gram Sabha selected them followed by the government's decision to select Sayoginis working in anganwadi centers. Barring these two responses that accounted for 85 percent of selection, ANMs help was stated in 15 percent of cases (Table 3.3). In almost all the selections, ASHAs mentioned that the Gram Sabha approved their names. As regards the motivation factors for wanting to be an ASHA, altruism was most important factor stated, followed by source of income and supporting family and children.

Training of ASHAs

As per national guidelines, each ASHA should have attended seven days of induction training. This was modified by the state and instead of seven days the state decided to do six days training. No specific rationale was given for reducing the duration by one day. Table 3.4 shows that 95 percent of ASHAs interviewed attended the induction-training programme in the past one-year.

Table 3.4: Topics covered in the training of ASHA in Rajasthan, 2007 (Percentage)

Particulars	Total
Total number of ASHAs interviewed	173
Percent ASHAs attended ASHA training	95.4 (165)
Topics covered during training for ASHA*	
Women and health (FP, ANC, breast feeding)	83.0
Infant and child care (immunization)	75.8
HIV and AIDS	58.2
ASHA (my eight tasks)	45.5
National Rural Health Mission (NRHM)	36.4
Disposal of waste water/clean drainage	30.3
Nutrition	20.0
Anganwadi centers	19.4
Water supply at home /safe drinking water	13.3
Organizing a group meeting	10.3
Curative care	9.1
Reproductive and sexual health problem	6.1
Others /Adolescent education /Mgt. of diarrhea/pneumonia	5.4
Percent mentioning that the logistic arrangements at the place of training were adequate	
Sitting arrangement	93.3
Size of the room was adequate	95.2
Accommodation facilities	90.3
Arrangement for food	94.5
* Multiple responses	

ASHAs who attended the induction training were asked about the topics covered. The spontaneous responses included women and health, infant and childcare, HIV and AIDS and the eight tasks of ASHA. Other responses related to determinants of health such as water and sanitation, and nutrition was citied infrequently. During monthly meetings an attempt should be made to orient them in these areas and the importance of mobilizing community action in addressing common problems. It can be inferred that retention of knowledge of the topics covered during the training that was imparted about six months ago, was good.

The ASHAs were further asked about the logistical arrangements during training. Most of the ASHAs appreciated arrangements at the training site and nine out of 10 reported that sitting arrangement, accommodation, food, and size of the room were good and had no suggestions to offer. Only a few (3 percent or less each) suggested for proper arrangements of beds/bed sheets, access to latrine/bathroom, more space in the training room, need to tackle the water problem, and for proper food arrangements. A few ASHAs mentioned TV, electricity, and fan during training. Good logistic arrangements during training contributed to enhancing learning.

The NGOs in the state were engaged in organizing trainings for ASHAs at block level. Their enthusiasm to be associated with a national programme may have been reflected in the form of better arrangements.

Quality of Training

The Government of Rajasthan adopted training manuals given by Government of India. To understand the quality of training, training pedagogy and their views about the trainers, ASHAs were asked a series of questions. Majority of ASHAs found the training to be participatory and said that the trainers encouraged them to ask questions and answered their queries properly. The trainers used charts/ models to explain the topics (98 percent). ASHAs recollected the use of other materials such as posters (88 percent), lectures (67 percent) followed by flip charts, pamphlets, and role-plays (Table 3.5). Some (less than 14 percent) ASHA mentioned the use of TV/video, folksongs, and books/module. Nine out of 10 ASHAs found the training materials to be either very good or good and useful.

Table 3.5: Teaching Aid used for training of ASHAs in Rajasthan, 2007 (Percentage)

Particulars	Total
Number attended training program in last one year	165
Training aids used in the training*	
Posters	87.6
Lectures	67.1
Flip charts	51.6
Pamphlets	46.6
Role plays	40.4
TV/video/CD	13.7
Folk songs	10.6
Book/module/guideline	4.3
Others	3.7
* Multiple responses	

Payments during training: Table 3.6 depicts that of the 165 ASHAs who attended training; more than four-fifths of them received payment at the end of the induction training, while the remaining reported that they did not receive the payment. As per training guidelines prepared by the state, each ASHA should have received Rs. 100 X number of days attended training + Rs. 100 towards transportation cost. That is, in all it should have been Rs. 700/-. Majority (74 percent) of ASHAs mentioned having received Rs 600 - 630 for attending 6 days of training, while one ASHA was given more than the sanctioned amount.

Discussions with the trainers and finance personnel revealed that the ASHAs were paid at the rate of Rs. 100 per day for attending the training and transport reimbursement was done on actual basis. Concerning non-payment to about 17 percent of ASHAs, it was found that one batch of ASHAs (n= 28) who underwent training in Jaisalmer district six months prior to the survey, was not paid at all. Discussions with district officials revealed that advance money was not released in time and hence payment could not be made. ASHAs were therefore informed that they would be paid when the second round of training was conducted. This indicates necessity of monitoring training arrangements and programmes by DPMUs.

Table 3.6: Payments received during training by ASHA in Rajasthan, 2007 (Percentage)

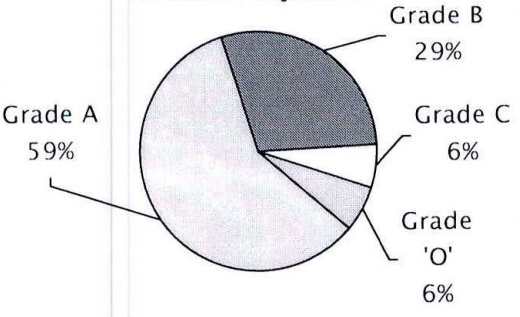
Particulars	Total
Number of ASHAs attended training	165
Average amount received during training	
No amount received	17.0
Received amount due (Rs. 100 x number of days attended training as DA + Rs. 100 transportation)	8.5
Received amount less than due*	73.9
Received amount more than due	0.6
Mean (in Rupees)	605.4

Use of reading materials: ASHAs were given reading materials/guidelines immediately after their training. In this context, a question was posed to ASHAs whether they had received it and if so, whether they could show the same to the survey team. Eighty-six percent of the ASHAs confirmed having received the reading materials. It was encouraging to find that two-thirds of them were able to refer to the reading material and the remaining could follow the same to some extent. Time constraints, small child or difficulties in comprehension were few reasons for not referring to the reading material. On the question regarding physical verification of reading materials, 60 percent of ASHAs who had received the reading materials could show the same to the field investigators.

Knowledge of ASHAs

Antenatal and Child Care Services: Knowledge of ASHAs was assessed by series of 10 questions related to their roles in ANC and Child Care. Each correct response was given a score of one mark and equal weight age was given. Later, the scores were categorized into Grade O -All correct responses, Grade A- 8-9 correct responses, Grade B 6-7 correct responses and Grade C- 5 or less correct responses. Majority (59 percent) of the ASHAs scored Grade A, 29 percent were in Grade B while the remaining 12 percent were equally distributed between Grades C and O. In other words, more than 6 out of 10 ASHAs had reasonably good knowledge of antenatal and childcare services. These findings indicated reinforcement of knowledge gained in the first round of training.

Figure 3.1: Scoring knowledge of ASHAs in Rajasthan



Pregnancy, Delivery Complications and action/s: ASHAs need to know about the complications that women may experience during pregnancy. Questions related to complications and their management were posed. A large proportion of the ASHAs commonly cited swelling of hands and feet, excessive bleeding, followed by paleness, convulsions, and visual disturbance, feeling uneasy and vomiting as pregnancy related complications.

ASHAs were asked what they would do if they recognized such complications. Majority of the ASHAs said that they would immediately refer the pregnant woman to the nearest public/private facility or accompany the pregnant woman to facility. Forty-five percent of the ASHAs said that they would ask the pregnant woman to consult the ANM the next day (Table 3.7). Considering the fact that any delay in seeking care would jeopardize the health of women, this finding was alarming and need to be addressed in subsequent monthly meetings. Simple job aids can also be developed for reminding ASHAs about course of action in the event of pregnant women with specific complications.

Table 3.7: Knowledge of ASHAs about Pregnancy Complications and their Management in Rajasthan, 2007 (Percentage)	
Particulars	Total
Total number of ASHAs interviewed	173
Complications women can experience during pregnancy*	
Swelling of hands and feet	81.5
Excessive bleeding	62.4
Paleness/Anaemic	42.8
Convulsion	36.4
Visual disturbance	27.7
Feel uneasy	19.7
Vomiting	19.7
Abdomen pain	6.9
Weak or no movement of foetus	5.8
Others (body, back pain, abnormal position of foetus, fever)	19.1
Actions supposed to be taken, if ASHA recognize complications signs in a pregnant woman*	
Immediately refer to the nearest functional FRU (Upgraded CHC, Sub divisional/district hosp.)	59.0
Ask to consult the ANM the next day	45.1
Refer to government accredited hospital	9.2
Take her to the nearest functional FRU	8.1
Refer to private accredited hospital	1.7
Others (send to ISMP/Quack/Hakim/Vaid/Provide transport money)	5.2
* Multiple responses	

Regarding the knowledge about complications at the time of delivery, ASHAs said that common complications during delivery were excessive bleeding (67 percent), convulsions (29 percent), anaemia among mothers or abnormal position of the foetus as mentioned by every fifth ASHAs (Table 3.8). Other reasons for fatal outcome could be swelling on hands and feet, weakness of the mother, abdominal pain, tetanus, fever, lack of foetal movement or death of foetus in mother's womb, and blood pressure problem. Prolonged labour as a complication was not mentioned by ASHAs and this could be life threatening if not managed in time. There was therefore, a need to cover this important aspect in the subsequent rounds of training.

Table 3.8: ASHA's Knowledge about common complications during delivery that could result into maternal mortality, Rajasthan, 2007 (Percentage)	
Particulars	Total
Total number of ASHAs interviewed	173
Complications during delivery *	
Excessive bleeding	67.1
Convulsions/fit	28.9
Anaemia / weakness of the mother	30.1
Abnormal position of the foetus	20.2
Tetanus	6.9
Lack of foetal movement or foetus dies in womb	6.9
Others/ abdominal pain, fever, headache, BP problem	26.6
Do not know	2.9
* Multiple responses	

Knowledge about Newborn Care: Regarding newborn care, majority of ASHAs rightly said that newborns are most likely to die soon after birth (67 percent), followed by a quarter of ASHAs reporting deaths in first week of life. As far as ASHAs knowledge about vaccines was concerned, ASHAs knew about BCG and DPT, however their knowledge about OPV and Measles was 71 and 62 percent respectively (Table 3.9).

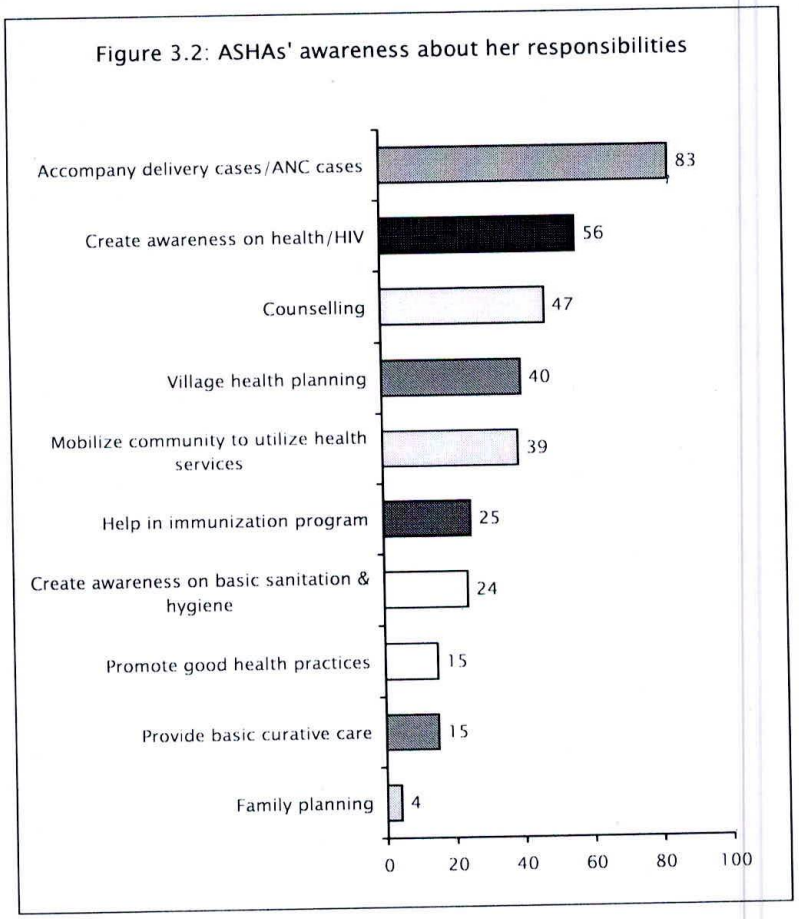
Table 3.9: Knowledge about likelihood of neonates dying after birth in Rajasthan, 2007 (Percentage)	
Particulars	Total
Total number of ASHAs interviewed	173
Period (in life) when newborns are most likely to die	
Soon after birth / first day of birth	67.1
Within one week of birth	24.3
Between one to two weeks of birth	4.6
Between 3 - 4 weeks of birth	12.7
Others	2.3
Do not know/can't say	5.8

The knowledge of ASHAs on child immunization and schedule needs to be strengthened in the next round of training specifically, about schedule and adverse events following immunization.

Knowledge about tasks to be performed by ASHAs

The study explored ASHAs familiarity with their tasks. ASHAs responded by mentioning accompanying delivery cases, creating awareness about health/HIV and counseling while a lesser number believed assisting ANM in village health planning, mobilizing community to utilize health and immunization services and creating awareness on basic sanitation and personal hygiene as other responsibilities. Very few ASHAs mentioned motivation of clients for family planning or provision of oral pills and condoms and post-natal care as their responsibilities.

Figure 3.2: ASHAs' awareness about her responsibilities



These could be areas on which the next round of training could focus. It appears that thrust on implementing JSY by programme managers resulted in "top on recall" response for accompanying delivery cases.

They were asked about their own work. It was observed in Table 3.10 that most of them were proud of their newly acquired status and social obligation of serving the poor. Increase in knowledge and respect from the community were the stronger factors in comparison with earning money. These "motivational pegs" needs to be reinforced for sustaining their interest on long-term basis.

Table 3.10 Feeling of working as ASHA in Rajasthan, 2007 (Percentage)

Particulars	Total
Total number of ASHAs interviewed	173
Reasons for feeling good about being an ASHA*	
It is good that poor people will get benefits	48.6
Increases knowledge and understanding of ASHA	16.2
Get money	15.0
Villagers respect/support / acknowledge work	15.0
Knows about antenatal and natal care/Reduces misconception	8.1
It is necessary to create awareness among illiterate/ignorant people	8.1
People in the village recognize ASHA/ know families, doctor	8.7
Reasons for not feeling good about being an ASHA	
Lot of work and running around	10.4

* Multiple responses

Organization of Work by ASHAs

The ASHAs were asked how they organize their work. Almost all the ASHAs said that they visited house to mobilize women and children to seek health care. Six out of 10 ASHAs mentioned that they facilitate immunization sessions conducted at the anganwadi centre and more than 3 out of 10 mentioned that they accompanied women for delivery. Likewise, few of them mentioned helping in organizing of village health day. In responding, the ASHAs confused the activities they perform with the activities they may or ought to perform. However, most of them depended on inter-personal contact as the mode of organizing different health care services, though this is not there in the national guidelines. The ASHAs repeatedly visit the houses of the clients and motivate them to avail services and on the day of immunization or village health day, an advance visit is made to remind and motivate the community to avail the services.

Availability and Utilization of Drug Kits

It was planned to provide ASHAs with drug kits with few medicines for minor ailments. To promote community based contraceptive availability, oral pills and condoms were made available. States were given flexibility to procure drugs and make them available to ASHAs at the end of training itself so that they could familiarize themselves. The state provided the following drugs:

- → ORS Powder
- → Paracetomol-500 mg
- → Tab Dyclomine HCL-10mg
- → Cotton Wool Absorbent (500gms)
- → IFA (large)
- → Ordinary Bandage

The drug kit in addition to what has been listed above includes more items of Disposable Dai Kits, ISM preparation of iron, Povidine Ointment, Thermometers, Condoms and Oral pills. Addition of Dyclomine HCL in ASHA kit was not recommended by GOI, as symptomatic treatment of abdominal pain may mask some underlying signs.

The study revealed that only one-fourth of the ASHAs received drug kit, immediately after training. Another 37 percent ASHAs received drug kit much later after their training and the remaining were yet to receive it. Non-availability of drug kits, long after induction trainings was a matter of concern. Availability of drug kit helps ASHAs in not only attending some primary medical care needs, but also builds confidence of community in ASHAs as some one available in " hour of need".

Among the ASHAs who received drug kit, majority used the medicines available in the kit at some point in time. There were no problems of stock outs as Anganwadi workers, ANMs or others replenished medicines at PHCs/SCs. An Anganwadi worker said:

> *"Drug kits containing medicines and contraceptives were provided to the ASHAs in April 2006. Since ASHA is also a Sahyogini replenishment of medicines is not an issue because of our daily interaction at the centre. ASHAs usually collect medicines from ANM and me. During campaigns, she is also provided with medicines from the health institutions and Mahila Bal Vikas."*

The anganwadi worker concluded that state government's decision to select Sahyogini's as ASHAs was a pragmatic decision and resulted in effective convergence.

ASHAs Clientele

ASHAs were asked about their last client, to get an idea of profile of clients and range of services provided (Table 3.11). On average, the last client availed services from an ASHA around 20 days prior to the interview date. This was an interesting finding and ran counter to the usual argument of "overloading or inundating" ASHAs with variety of activities.

Concerning the profile of the last client who visited ASHA, it was observed that the average age of women was 25.8 years. Four out of 10 cases were SC/ST and an equal number belong to OBC group. This indicated that ASHAs reached the disadvantaged population. As far as provision of services for the last case was concerned, mobilizing children for immunization (35 percent) was most common. This was followed by advice about place of delivery (20 percent), IFA tablet distribution (16 percent) and primary medical care (17 percent). These findings indicate the potential role for ASHA in terms of provision of primary medical care for women and children in rural areas.

Regarding ASHAs role in JSY, few questions were asked. Eighty-six percent of the ASHAs had handled cases since they started functioning and 40 percent of the total ASHAs had actually stayed with the women at the place of delivery. They said that the last JSY beneficiary was accompanied 1½ months (44 days) prior to the date of interview. Half of them stayed with the women at the place of delivery and the number of days of stay ranged between one and six with the average duration of stay being 1.4 days. In a village with a population of 1000, with the birth rate of 30 per annum, the average births per quarter would be 7-8. If we take BPL population to be one-third in Rajasthan, ASHAs are nearly capturing all women eligible under JSY. However, recently all population groups have been made eligible for benefits if availed institutional delivery services under revised JSY guidelines.

Table 3.11: Brief details of ASHAs interaction with her last client, Rajasthan, 2007 (Percentage)

Particulars	Total
Total number of ASHAs interviewed	173
Average number of days ago when the last client availed services from ASHA	20.0
Caste of the client	
Schedule caste	17.4
Schedule tribe	20.1
OBC	42.3
General	20.1
Reasons for the interaction or ASHAs contact with her*	
Immunization	34.9
Delivery/to get advice about place of delivery	20.1
IFA tablet distribution	16.1
Collect medicines for fever, back pain, vomiting, pain in lower abdomen	17.4
Registration of pregnancy /antenatal care/check-up	8.0
Information regarding sterilization/getting OCP, condom	2.7
Routine contact	2.0
Others- did not get money after delivery	5.3
Duration of days ago when ASHA last accompanied a woman for delivery (in days)	44.2
Number of ASHAs who had handled a JSY case	86.1(149)
Percent ASHAs who stayed with JSY beneficiary at the place of delivery	47.0 (70)
Average number of days ASHA stayed with JSY beneficiary at place of delivery	1.4
Range (minimum - maximum days)	1 - 6

* Multiple responses

Cash Remuneration Received by ASHAs

All the ASHAs were asked about the cash incentives received by them. As can be seen from Table 3.12, only four out of 10 ASHAs received some cash remuneration while majority were yet to receive the same, despite the fact that they had assisted in promoting institutional delivery or had rendered some health services.

Table 3.12: Cash Remuneration Received by ASHA in Rajasthan, 2007 (Percentage)

Particulars	Total
Total number of ASHAs interviewed	173
Percent received any cash incentive money as ASHA till now	41.6 (72)
Services for which ASHA received cash incentive money*	
Immunization of children	75.0
Attending JSY beneficiary	50.0
Family planning cases	2.8
DOTS treatment	1.4

* Multiple responses.

Three-fourths of the ASHAs received remuneration for immunization of children and half of them for attending to JSY beneficiaries. Only a few ASHAs were paid for family planning cases or for providing DOTS treatment. The state government has fixed rates for each of the activities and accordingly payments are made.

Regarding the mode of payment, ANM (50 percent) was commonly mentioned as making payment followed by Medical Officer of CHC/PHC (24 percent) and doctor or staffs at the institutes (17 percent). Two-fifths of the ASHAs received the remuneration immediately on submitting the accounts while 36 percent received the same within a month and the remaining 25 percent after a month. The main reasons for the delay in payments were: no or less advance money at the facility (55 percent), delay in approval process, signing authority not being available or delay in payment by ANM.

The ASHAs who had received money had on average earned about Rs. 400/- (calculated on the basis of cases motivated in the three months prior to the survey) while the projected estimate of the maximum the ASHAs could earn is three times more. Majority of the ASHAs were satisfied (43 percent) or somewhat satisfied (36 percent) with the remuneration received, mainly because *'they could earn extra money'* (39 percent) or it gave them an opportunity to learn many new things and work within the village. In contrast, one-fifth of the ASHAs were not satisfied with the cash assistance as it involved *'too much of work for too little money'* (21 percent), and that the money was not given on time (15 percent). It was felt that some ASHAs were favoured even if activities did not occur. It is obvious that streamlining of fund flow is necessary so as to ensure timely disbursements. ASHAs are bound to loose interest if performance based incentives are not dispersed within stipulated time. There are incidents of nepotism and favour in some cases. High level of satisfaction (satisfied and somewhat satisfied) with remuneration owes itself to the fact that Sahyoginis received Rs 500 each month for their work at AWC in the village as well.

Interface and Monitoring System

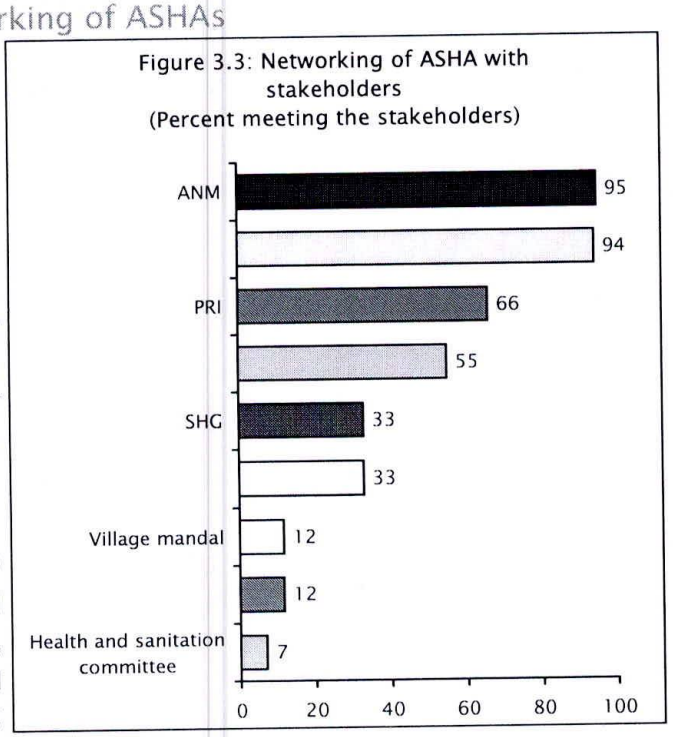
In the guidelines it is stated that ASHAs are expected to facilitate the work of ANM and Anganwadi workers by mobilizing pregnant and lactating women and children for RCH services on immunization and Village Health and Nutrition days and help in updating household/eligible couple registers.

ASHAs were asked about supervision and monitoring system. Few ASHAs maintained information related to ANC (name, address, EDD, registration, weight), immunization of children and delivery in a book/personal diary and shared with ANMs and Anganwadi workers. This was possible because a substantial proportion of ASHAs selected in Rajasthan work as Sahyogini. In Rajasthan, ASHAs responsibilities are more and they are accountable to DWCD functionaries and staff members and report routinely to their parent departments. Majority of them reported that they regularly met with Anganwadi workers and ANMs. The activities undertaken were reviewed, discussed and problem-solving exercise was undertaken. For instance, if ASHA identified a pregnant woman who had refused antenatal services, ANM along with ASHA visited the household and advised the person to avail necessary services. Supportive supervision and discussion in meetings held regularly formed the supervisory mechanism in the study area.

This apart the ASHAs were asked whether any district or block officials visited the place in the past 3 months. Majority (56 percent) of the ASHAs said that *'nobody ever visited since they started working'*, while a quarter of them mentioned visits by senior officials. Advance and prior information on their visits was communicated to the ASHAs. The ASHAs were happy that such supervisory visits would be more productive in enhancing the quality of work and would facilitate their position and work in the community.

Support Mechanisms and Networking of ASHAs

ASHAs cannot work in isolation. They need to have a congenial and collaborative environment at the local level. As community ownership, participation and inter-sectoral convergence are key components stated in NRHM, ASHAs were asked about the pattern of working and networking with various stakeholders and the role of stakeholders as understood by them (Figure 3.3 and Table 3.13).



It is evident that nine out of 10 ASHAs reported having interacted with Anganwadi workers and ANMs, followed by interactions with PRI (66 percent), PHC staff members (55 percent), SHGs and Block facilitators (33 percent each). Interaction with other stakeholders such as village mandal, NGO staff members and Health and Sanitation Committee was limited.

A sizeable number of ASHAs had met Anganwadi workers and ANMs more frequently than the other stakeholders. ASHAs met the Anganwadi workers almost daily and it was more of a weekly and monthly interaction with the ANM. Probably, meeting ANM was tied to ANMs visit to the village. In case of village mandal, only a few ASHAs interacted but, the frequency of meetings was good.

Table 3.13: Networking of ASHA with other stakeholders in Rajasthan, 2007 (Percentage)

Stakeholders	AWW	ANM	Block facilitator	PHC staff	NGO staff	SHG	PRI	Health & sanitation committee	Village mandal
Percent ASHA who met stakeholders	94.2 (163)	94.8 (164)	32.9 (57)	54.9 (95)	11.6 (20)	32.9 (57)	65.9 (114)	6.9 (12)	11.6 (20)
Frequency of meeting stakeholders									
Daily / Weekly once	90.2	42.1	8.8	16.8	0.0	17.5	0.0	8.3	30.0
At least once a month	6.7	54.2	64.9	73.7	45.0	79.0	72.1	66.7	45.0
Less frequently	3.1	3.7	26.3	9.5	55.0	3.5	7.9	25.0	25.0

* Multiple responses

National and State mention bi-monthly or monthly meetings of all ASHAs at block PHC level. Rajasthan issued these guidelines in November 2006. During the fieldwork, study teams did not learn of any monthly meetings. Perhaps, it would take some time to ensure regular organisation of monthly meetings.

It is essential for ASHAs to understand role of other stakeholders with whom they interact. ASHAs were clear about the roles of Anganwadi and ANMs and to an extent about the role of PRIs in facilitating work. Regarding the roles of other stakeholders such as NGOs, SHGs, only a few ASHAs were aware and it seems that this critical element has not been dealt with during the first round of training. As convergence and collaborations are the motto of good governance, this element has to be reiterated in the next round of training. Efforts have to be made by senior supervisory officers to orient them about the roles of other stakeholders, common areas of work and how they could perform together or complement each other.

On the whole, discussions with other stakeholders revealed that ASHAs made efforts to promote government health schemes and were recognized in the community. The views of stakeholders about the ASHAs interact are summarized below.

PRIs

According to the six PRIs interviewed from six blocks, the community held the ASHAs to be good and realized that ASHAs did useful things, motivating women for institutional delivery and informing people about JSY. Some (two of the six) of the PRIs did say that community was not happy with the ASHAs because they did not pay regular household visits and did not do their job properly. It is not mandatory for ASHAs to make home visits, yet they probably made contacts only by visiting beneficiaries personally. Perhaps, the orientation training of PRIs might not have discussed the roles and responsibilities of ASHAs in detail. PRI members suggested that ASHAs should be given fixed monthly payments and timely reimbursements and they would facilitate her work by talking to the community. They also suggested that there should be a dress code for ASHA, so that people in the community recognize them easily.

Non-Governmental Organizations

Three district NGOs were interacting with ASHA and efforts were made by NGOs to involve ASHAs in their programme activities. The NGOs said that their interactions were limited and more ad hoc, but since the inception of the programme, ASHAs have done what none of us could do. Appreciating the work, an NGO staff said:

> *"Until now no delivery from this village took place outside the village. With continuous motivational effort of ASHA and JSY, women from the village have started going to the institution for delivery. We have also noticed an increase in the immunization of children".*

In another case, an NGO representative remarked:

> *"Just 15 days ago, a BPL woman was taken to Pokharan for delivery. Her newborn was sick and had to be referred. ASHA took the baby to Jodhpur for further treatment".*

Similar such incident was mentioned by another NGO:

> *"This is an incident that happened more than one and a half months ago. All family members of the pregnant woman were working on the farm and the woman developed labour pains. Since it was an emergency and ASHA couldn't wait for the family members to arrive, she alone shifted the woman to the institution for delivery. Both the mother and child are doing well and the family is indebted to ASHA".*

ANM

In each block, ANM was contacted to get the names of the ASHAs and discuss the role of ASHAs and their interactions. ANMs confirmed that ASHAs took part in all the stated activities. In words of an ANM,

> *"It is beneficial to have ASHAs. Earlier when I was alone, I was not able to cover all the areas. Now through ASHAs we are able to cover the entire area. She goes there and motivates people to avail services. Most benefit till now has been for immunization programme and antenatal check ups".*

Another ANM said:

> *"Most important is that she is from the same village. So she enjoys good cooperation from the people in the village. For example, it has helped me a lot and I could reach out to women from the tribal (Bhil) community with the help of ASHA and explain about the national health programmes and the benefits under it. ASHA followed up with my visits and was able to motivate women for institutional delivery."*

While these were the positive experiences, there were instances where ASHAs received benefits without performing due to their proximity to local power.

Anganwadi workers

All the six Anganwadi workers interviewed knew about JSY and ASHA programme in detail. They met ASHAs almost every day or every alternate day. Every first Thursday of the month was observed as immunization day jointly by ANM, AWW and ASHA. ASHAs came to AWW regularly for getting records checked. Both, AWW and ASHA worked together during *Swasthya Chetna Yatra*. AWWs opined that such an arrangement was beneficial, mainly for ensuring better coverage of women; poor women got quality services and nutritional food, and all the benefits of JSY. A demand for services was created as was reflected by an AWW:

AWW and ASHAs work together to

- Celebrate immunization day
- Organize health camp
- Participate actively in Swasthya Chetna Yatra
- Create awareness about the programme
- Identify pregnant women
- Attend gram sabha meeting
- Organize health camps
- Take care of antenatal women
- Timely immunization of children
- Household survey of the village
- Discuss about institutional delivery
- Weighing children
- Maintains records
- Provide curative medicines
- Provide nutritional supplements
- Explain about malnutrition and balanced diet
- Door-to-door visits
- Awareness about HIV/AIDS

> *"Now people understand and have started coming to us on their own. They ask for immunization, IFA tablets, and are prepared to go for institutional delivery".*

Intersectoral linkages were evident at the grassroots level. Such linkages and networking had an advantage in creating demand by bringing about community awareness, on the one hand, and increasing utilization of the services on the other. Both implementation and monitoring of the scheme at the village level would prove beneficial to the community and could lead to community mobilization and better uptake of health services and overall development of the villages.

Strengthening of ASHA Intervention as Perceived by ASHA

All the ASHAs were asked strengthening intervention and challenges they faced. The ASHAs interviewed opined that their engagement as ASHA was useful and most of them thought that their overall knowledge and skills as ASHA worker were being utilized. Majority of the ASHAs felt that they required more practical training (Table 3.14).

Seven out of 10 ASHA had suggestions to offer. The common suggestions for improving the ASHA intervention were related to enhancing cash assistance, giving complete information during trainings, and teaching aids, role-plays, drama and practical training. One-sixth of the ASHAs suggested that the scheme should be propagated more on TV, in newspaper, camps and rallies. Others suggested monthly payment, dai training, dress code and more incentives for motivating sterilization cases.

Competition among ASHAs, breaking the social and cultural taboos practiced by the community regarding weighing or immunizing the baby, institutional deliveries were major reasons apart from opposition from the family for not willing to work as ASHA. Besides, delay in payment to JSY beneficiaries and constant reminders from them indirectly hampered the work. ASHAs complained that sterilization cases motivated by them were being registered by ANM. It also came to light that few doctors refused to handle complicated cases and then taking the beneficiary elsewhere resulted in awkward situations. It can be inferred that ASHAs work has to be complemented by rigorous and overarching behavioural changes by communication campaigns. ASHAs should be given proper recognition so that they are respected as important resources on health related issues in the community.

Table 3.14: Suggestions for further strengthening their work as ASHAs and challenges faced by ASHA in Rajasthan, 2007 (Percentage)

Particulars	Total
Total number of ASHAs interviewed	173
Percent giving suggestion for improving JSY	71.7 (124)
Suggestions made by ASHA for improving the scheme*	
Cash assistance should be more	35.5
Should give complete information	30.6
Should use posters, role play, drama for training ASHA	26.6
Should get good/practical training for ASHA	20.2
More propagation/advertise on TV/newspaper/camp/rally	16.1
Should get monthly payment	8.9
Dai should be trained	8.1
Facilities should be improved	6.5
Some officials/doctors/nurse should talk to village people to explain JSY	3.2
ASHA should have a dress code	3.2
Arrangement of transportation/van	2.4
Others**	9.6
Challenges faced by ASHA*	
Other ASHAs take away my cases	24.9
Village people are not ready for institutional delivery	19.7
Women do not listen regarding weighing baby/immunizing child	15.6
My husband / family do not like my job	11.0
I have to listen to complaints from community for delay in payment	9.2
Opposition from community/illiterate people	2.3
Others	12.7
Do not know	4.0

* Multiple responses

**People should recognize ASHA, good behaviour at the place of delivery, availability of lady doctor, dai kit for ASHA, and more incentive for sterilization, should get joining letter soon

To sum-up, the training of ASHAs progressed well. The state modified the training module of GOI and compressed the first round of training from seven to six days. Initially SIHFW was entrusted the responsibility for conduct of training, however mid way ARC was asked to organize trainings with the help of NGOs. Engagement of NGOs at the block level for organizing trainings resulted in improved logistical and training arrangements and ASHAs were happy with the training pedagogy. ASHA's knowledge on various reproductive and child health aspects was good; however, there was need for strengthening non-RCH components and other determinants of health.

ASHAs were able to generate demand and mobilize clients for reproductive and child health services. ASHAs also started accompanying few beneficiaries for institutional deliveries. In executing their role as ASHAs, they networked with various stakeholders other than Anganwadi worker or ANM and community has started recognizing them for their work. It was observed that PRIs and others lacked precise knowledge on the

functioning of ASHAs and expected them to make home visits. ASHAs mentioned areas of strengthening logistic arrangements that need to be taken up in the next round of training. Performance based cash payments to ASHAs were untimely and there were delays in payment. Only a small proportion of ASHAs were able to earn money while majority of them were yet to start earning. This emerged as a serious concern as in absence of regular cash in hand, it would be difficult to sustain interest of ASHAs. One can hope that with change in eligibility criteria for JSY and including all women, ASHAs would be in position to make more money for each woman escorted by them.

CHAPTER 4

BENEFICIARIES OF JSY IN RAJASTHAN

The JSY beneficiaries were interviewed to ascertain their awareness, and the kind of support received from ASHA, Anganwadi workers and ANM. The study examined the processes of claiming benefits, difficulties faced in availing services/benefits, and overall client satisfaction. The findings of interviews with 248 JSY beneficiaries from the three districts who had availed JSY help in the six months prior to the survey are presented. The study covered 40 JSY beneficiaries from each of the six blocks.

Background information of JSY Beneficiaries

Table 4.1 gives the characteristics of JSY beneficiaries. The mean age of the women was 24.6 years. Above three-fourths of the women were aged 20-29 years, and one-sixth were aged 30 years or more. Majority of the JSY beneficiaries were illiterate (68 percent) or had studied only up to primary and middle level (22 percent). Less than 10 percent had studied above secondary level.

Table 4.1: Background information of JSY beneficiaries, Rajasthan, 2007 (Percentage)

Particulars	Total
Total number of JSY beneficiary interviewed	248
Age of JSY beneficiary in completed years	
≤ 19 years	6.0
20 - 24 years	43.1
25 - 29 years	32.7
30 years and above	18.2
Mean (in years)	24.6
Years of schooling completed	
Illiterate	68.2
Up to primary or middle (1 - 8 std)	22.2
Secondary and above	9.6
Religion	
Hindu	83.9
Muslim	16.1
Caste	
Scheduled caste	16.9
Scheduled tribe	16.9
Other backward classes	50.0
General	13.3
Do not know	2.8
Monthly family income (in rupees)	
≤1000	16.5
1001-2000	56.9
2001+	26.6
Mean (in rupees)	2043

Eight out of 10 beneficiaries were Hindus and the remaining were Muslims. Given the caste break-up of the state against those who were randomly selected in the survey, it can be inferred that JSY has addressed its cause of covering socially dis-advantaged communities, as one-third of the beneficiaries were from SC and ST categories. This observation is in line with the caste composition of the state. According to 2001 Census, 30 percent of the state population belonged to SC and ST. The beneficiaries largely represented lower income groups. It appears that JSY was able to address the core issue of social equity.

Awareness about JSY

All JSY beneficiaries were asked how and when they came to know of JSY. Figure 4.1 reveals that 7 out of 10 beneficiaries heard about the scheme during pregnancy, about two after their delivery and only one had heard about JSY before pregnancy. The beneficiaries were asked about the sources from where they came to know of JSY (Table 4.3). It was observed that ANMs were the main source of information followed by ASHAs (24 percent). Other functionaries like doctors and anganwadi workers propagated JSY to about 12-14 percent of JSY beneficiaries while an insignificant number of beneficiaries mentioned relatives and gram Panchayat. The role of media was limited, as only three percent stated radio or television and 10 percent beneficiaries reported hoardings at health facilities.

Figure 4.1: Time when the beneficiary heard about the JSY

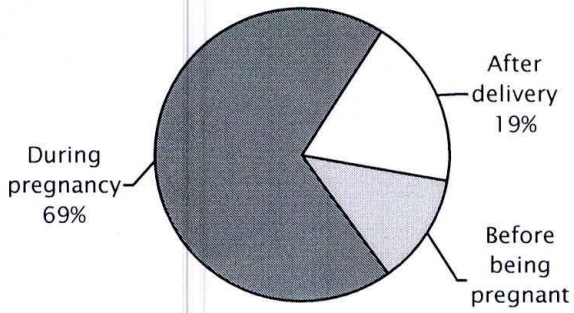


Table 4.2: Sources of information about JSY in Rajasthan, 2007 (Percentage)	
Particulars	Total
Total number of JSY beneficiary interviewed	248
Source from where heard about JSY*	
ANM	71.0
ASHAs	24.2
Doctor	13.7
Anganwadi Centre/Worker	11.7
Relatives (parents, sister-in-law)	4.4
Gram Panchayat	2.4
Radio/ TV	2.8
Others / Hoardings at SC/PHC etc.	10.1
Don't Remember	0.8
Things heard about JSY*	
Free institutional delivery services for poor women with monetary benefits	71.4
Get/receive money	33.9
Promotion of institution delivery	23.0
Benefit of mother	18.5
For poor family	16.9
Family planning / population stabilization	10.5
For intake of nutritious food	2.8
Others	1.2
* Multiple responses	

Other responses about JSY (Table 4.2) indicated that majority (71 percent) of the beneficiaries heard that JSY provided for free institutional delivery services for poor women with monetary benefits. About 34 percent heard that they would get some money and another 23 percent mentioned that the scheme was for promotion of institution delivery. Others understood JSY as one for benefit of mothers and poor families, while few linked it with family planning and population stabilization.

There is no doubt that ANMs and ASHAs have made lot of efforts to propagate the scheme at the community level. Whatever the beneficiaries understood and reported seems to be their own interpretation of the scheme. Some of the respondents believed that the scheme was for family planning, which needs to be corrected. Communication interventions should focus on disseminating unambiguous and consistent message about the scheme.

Process of Registration under JSY

Registration under JSY is pre requisite to availing the benefits, and more so for monitoring of the activities. Half of the beneficiaries had themselves approached someone in the health department for JSY registration, and health functionaries approached the remaining half. ANMs/LHV (70 percent), doctors (15 percent), and ASHA/Anganwadi workers (13 percent) were responsible for ANC registration.

Table 4.3: Process of registration under JSY of the beneficiary in Rajasthan, 2007 (Percentage)

Particulars	Total
Total number of JSY beneficiaries interviewed	248
Person who registered respondent for JSY	
Doctor	15.4
LHV/ANM/FHW	70.0
Anganwadi worker	4.9
ASHAs	8.5
Others	1.2
Stage of pregnancy when registered for availing benefits of JSY	
First trimester	33.2
Second trimester	29.2
Third trimester	14.6
After delivery	10.5
Do not know	12.6
Place where respondent was registered	
District/sub-district hospital	4.0
Community Health Centre	21.1
PHC	12.6
Sub-centre	19.8
Anganwadi centre	15.8
At home	24.3
Others	2.4
Percent who got a JSY card	27.0

One-third registered in 1st trimester, 29 percent registered in the second trimester, 15 percent in 3rd trimester, whereas 11 percent registered after delivery. Thirteen percent did not know when they registered for availing benefits of JSY (Table 4.3). Further probing on the place of registration revealed that 24 percent were registered at home; around one-fifth each at the CHC, sub-centre, and 13 to 16 percent were registered in the PHC and Anganwadi centres respectively. Presuming that early registration (first trimester) would have motivated them to seek full schedule of ANC, which would have better results in terms of outcomes of pregnancy.

The study revealed that only 27 percent of JSY beneficiaries had JSY cards, and the field team could verify only 18 percent of them at the time of the survey. In half of the cases (48 percent), JSY cards were facilitated by ASHA. None, except one beneficiary faced difficulty in procuring JSY card because ASHA and ANM did not support, as BPL card was not available with the woman.

Utilization of ANC Services by JSY Beneficiaries

The beneficiaries were asked about the antenatal services utilized by them. Six out of 10 women, the beneficiary themselves contacted someone from the health department while the remaining were visited by health personnel. On average, the first contact was made at 3.3 months of pregnancy with a median value of 3 months.

Regarding motivation to avail antenatal services, the study indicated that women were influenced by the ANM/FHW, husbands, and by ASHAs. Self-motivation was another prominent response.

Table 4.4: Number of antenatal check-ups during index pregnancy, Rajasthan, 2007 (Percentage)	
Particulars	Total
Total number of JSY beneficiaries interviewed	248
Number of times antenatal check-ups done	
None	11.3
1 time	3.2
2 times	18.1
3 times	20.6
4 or more	44.8
I don't remember	2.0
Mean (number of times)	4.0

As can be seen from Table 4.4, 9 out of 10 JSY beneficiaries had antenatal check-ups and that too three times or more. Among those who availed antenatal services, majority visited the district hospital/ CHC (51 percent), PHC/sub-centre (45 percent), and Anganwadi centres (9 percent). One-tenth of the women received antenatal care at private hospitals or at home. Husbands, mother-in-law/sister-in-law, and ASHAs accompanied the beneficiary for ANC visit(s). Other family members accompanied the women for ANC visits as well. Two-fifths of women incurred some expenses during antenatal visits including doctors' fees, laboratory tests, transport costs etc. The average amount spent during ANC period including doctors' fees, laboratory test was Rs. 1408.9 approximately.

These findings seem to be exaggerated. In comparison, the Government of India's District Level Household Survey (DLHS), 2002-04 indicated that the antenatal coverage in Bhilwara, Jaisalmer and Udaipur was between 36 percent and 87 percent and 'three or more times' coverage ranged between 18 and 47 percent. Since the disbursement of cash to ASHA was linked with antenatal, prenatal and BCG vaccination, there could have been over reporting but on the other hand, the mean number of times visited was around four times. Given these differences in results between the two surveys, and considering the pre-conditions of linking payment to ANC services, the finding were indicative of increasing ANC coverage in the study area.

In all, 11 percent (n=28) of them did not avail of any antenatal care services during index pregnancy. These are difficult cases. ASHAs were able to identify these women and efforts would have to be made to cater to this specific segment of the population. ASHAs could enlist support of PRI members to persuade, cajole or motivate these women for seeking ANC. In fact, cross-tabulation analysis depicted that, ASHAs made more contacts with resistant communities and those from SC/ST and low-income groups (Refer Appendix tables)

Table 4.5: Role of ASHA in micro birth planning for JSY beneficiary, Rajasthan, 2007 (Percentage)	
Particulars	Total
Total number of JSY beneficiaries interviewed	248
Percent discussed about micro birth planning during the antenatal period*	
Date of next check-up	85.9
Place of next check-up	63.3
Place of delivery	61.3
Expected date of delivery	54.8
Place of referral, if complications arise	11.3
* Multiple responses	

Role of ASHA in Micro-Birth Planning

Micro-birth planning includes discussion and deciding the date of next check-up, place of next check-up, place of delivery, expected date of delivery, and place of referral, in case of complications. Majority of the ASHAs during their interactions with the beneficiaries discussed one or all

aspects of micro-birth planning. They discussed the date (86 percent) and place (63 percent) of next antenatal check-up, and 55-61 percent discussed the expected date of delivery and place of delivery, but only 11 percent talked about the places of referral in case of complications (Table 4.5).

Forty percent of beneficiaries were informed by ASHAs about four or more aspects of micro-birth planning, 20 percent were given half of the information, while the remaining 32 percent were told about only one or two aspects of micro-birth planning. Nine percent of JSY beneficiaries said that no aspect of micro birth planning was ever discussed. Birth planning being one of the key elements for avoiding one of the four delays is an area that could be taken up during the subsequent rounds of ASHA training and by ANMs and Anganwadi workers with whom the ASHAs interact frequently.

Intention and Actual Place of Delivery

The respondents were asked about the place where they intended to deliver and against it, the place where they actually delivered was cross-tabulated. It was found that of the 248 beneficiaries interviewed, 147 (59 percent) intended to deliver in institutions and the remaining (41 percent) wanted to deliver at home. It was observed that 173 (70 percent) delivered in institutions and the remaining 30 percent at home. In other words, between intention and actual practice there was a shift of 11 percent from home to institution. Majority of the deliveries took place in CHC/PHC.

Table 4.6: Intention vs Actual place of delivery, Rajasthan, 2007

	Place where Delivered		
	Institutional	At home	Total
Intended place for last delivery			
Institutional	136 (54.9)	11 (4.4)	147(59.3)
At home	37 (14.9)	64 (25.8)	101(40.7)
Total	173 (69.8)	75 (30.2)	248 (100.0)

Motivation and Decision making for Institutional Delivery

It was important to analyze the motivating factors and decision-making involved in institutional deliveries (Table 4.7). It was observed that monetary benefit offered in JSY was reported by as many as 56 percent of the JSY beneficiaries, followed by 44 percent stating better access to institutional delivery within the area as major motivators for opting for institutional

Table 4.7: Motivation for institutional delivery among JSY beneficiaries who had institutional delivery, Rajasthan, 2007 (Percentage)

Particulars	Total
Total number of JSY beneficiaries who had an institutional delivery	173
Motivation for opting for institutional delivery*	
Money available under JSY	56.1
Better access to institutional delivery services in the area	43.9
Support provided by ASHA	22.0
Support provided by health personnel	7.5
Previous child was born in an institution	8.1
Safe delivery of child/safety of both mother and child	7.5
Complicated delivery, had health problem, white discharge	4.6
Others / Previous history of still birth/miscarriage	5.2
Person who finally decided for institutional delivery*	
Self	59.0
Husband	74.6
Mother-in-law	30.1
Father-in-law	4.0
Relatives/neighbours/users of the scheme	20.8
ASHAs	3.5
ANM	5.8
Others	1.2
* Multiple responses	

delivery. This was followed by previous experience of institutional delivery, complications or still birth/ miscarriage and safe delivery of child and mother etc. All these responses of motivation cited by beneficiaries were internalized on the basis of their personal experiences. However, the interesting external motivating factor was the support provided by ASHA (22 percent) and other health personnel (8 percent). Further analysis of data on the background of beneficiaries in terms of education and caste and income did not reveal major differences though the percentage varied (Appendix Table 10). The responses of money available and access cut across all segments.

In the final decision-making, husband, self, mother-in-law and relatives/ neighbours or prior users of the scheme led to institutional delivery. The role of ASHAs and health providers was insignificant. It is clear that just motivation of the beneficiary may not suffice and other decision-makers in the family do matter. Some special efforts to address this segment ought to be looked into.

Process of Arranging Transport to Reach Health Institution

Some of the major delays in accessing health services during delivery are, time taken in recognizing the problem, arranging the transport, travelling time, and delay in getting services after reaching the ultimate place of delivery. All the beneficiaries reached the ultimate place of delivery directly from home travelling an average distance of 11.6 kms from residence to the institution.

Table 4.8: Process of arranging transport to reach health institution, Rajasthan, 2007 (Percentage)

Particulars	Total
Number of JSY beneficiaries who had institutional delivery	173
Percent who directly came from home to the place of delivery	100.0
Average distance to the place of delivery from respondent's residence (in kms)	11.6
Do not know-calculated by omitting this	12.2
Mode of transport used to reach the ultimate place of delivery*	
Car/Jeep	60.7
Walking	15.6
Auto rickshaw	6.4
Motor cycle/scooter	5.8
Tempo/tractor	5.8
Bullock/Camel cart/chakda	4.0
Bus	1.7
Persons who all facilitated in arranging the transport*	
Family members	82.9
ASHAs	8.2
ANM/Health worker	4.8
TBA	3.4
Panchayat members/SHGs	2.7
Anganwadi worker	1.4
Others	3.4
Percent mentioning that arranging transport was pre-planned and necessary arrangements were made beforehand	22.6

* Multiple responses

Majority (61 percent) used car or jeep to reach the place of delivery, 16 percent walked down (3 cases walked between 3-5 kms), while 6 percent or less used auto rickshaw, motor cycle, tempo, tractor, bullock/camel cart or chakda to cover distance up to 10 kms to the place of delivery (Table 4.8). For 11 or more kms mainly car, jeep or tempo were used to reach the ultimate place of delivery. Family members mainly arranged the transport. ASHAs, trained dais, Panchayat members, self-help group, and Anganwadi workers also played a role in arranging the transport. Despite the

programme interventions and availability of ASHA, only 23 percent of JSY beneficiaries mentioned that the arrangements were pre-planned. This could be an area of strengthening and can be linked as part of micro-birth planning orientation.

The average time taken to arrange the transport to the place of delivery was estimated to be 27.8 minutes, ranging between 1 minute (to make a call) and 6 hours. Again, it took on average more than half an hour (31.8 minutes) to reach the place of delivery from the time the transport facility reached the beneficiary. The time taken to travel to the place of delivery ranged between 5 minutes to 3 hours (Table 4.9). Around 10-12 percent respondents did not know details about the distance travelled, or time taken in arranging the transport and reaching the place of delivery.

Table 4.9: Duration of time to arrange transport and travel to place of delivery, Rajasthan, 2007

Particulars	Total
Number of JSY beneficiaries who had institutional delivery	173
Average time taken to arrange the transport since respondent decided to visit the ultimate place of delivery (in minutes)	27.8
Range (Minimum - Maximum)	1 - 360
Do not know/can't say	11.6
Average travel time taken to reach the ultimate place of delivery (From the time the transport facility reached the respondent) (in minutes)	31.8
Range (Minimum - Maximum)	5 - 180
Do not know/can't say	9.6
Average cost incurred for transportation to reach the ultimate place of delivery (in rupees)	280.2
Range (Minimum - Maximum)	10 - 2050
Do not know	19.9

On average, the beneficiaries spent Rs. 280.2 on transport to reach the place of delivery. Nine out of 10 beneficiaries paid money for the transport expenses on their own and an insignificant proportion were reimbursed later by either ASHA or ANM. Eighty percent of those who paid on their own had made prior cash arrangements for transport. It was noticed that in the previous guideline issued by the state, transport reimbursement was not done at the institutions and ANMs were expected to do so. Realizing gaps in reimbursement of transport to beneficiaries, the state sanctioned an amount of Rs. 300/- and instructions were issued in form of circulars for reimbursing at the facility in case ASHA has not accompanied the beneficiary.

Difficulties Faced in Reaching the Place of Delivery

Under JSY, it is planned that ASHAs would provide a referral slip to women for their easy access to place of delivery and help in case of complications. JSY beneficiaries were asked about their transport to the place of delivery, role of key stakeholders in arranging for transport, and difficulties faced. Study found that less than five percent of JSY beneficiaries were given referral slips by ASHA or other health personnel to help them access delivery services. About nine beneficiaries, who had institutional delivery, had some difficulty in reaching the health institution. In five cases, it was too late in the night and transport was not available immediately, whereas in one case the respondent did not have sufficient money. Issue of referral slip and payment of advance transport money to the beneficiary or keeping some advance money with ASHAs to be given to women, are few operational issues that could be considered.

Persons Accompanying JSY Beneficiaries to the Health Institution

Regarding ASHAs accompanying JSY beneficiaries to the places of delivery, it was found that 19 percent of the beneficiaries reached the place of delivery between midnight and early morning. Spouses accompanied three-fourths of the women, other family members and mother-in-law accompanied about 51-53 percent, and mothers accompanied one-fifth of them (Table 4.10). ASHAs accompanied 18 percent women to the health institution for delivery, while Dai, ANM and Anganwadi worker accompanied 10, 6, and 4 percent women respectively. Needless-to-say that the presence of ASHAs facilitated obtaining services at the place of delivery, as confirmed by most (90 percent) of the 31 JSY beneficiaries escorted by ASHA. They helped in expediting registration and other administrative activities (68 percent), spoke to the medical personnel (46 percent), and helped in getting JSY cash assistance (43 percent). A few provided psychological and moral support.

Table 4.10: Persons accompanying JSY beneficiaries to the health institution, Rajasthan, 2007 (Percentage)

Particulars	Total
Number of JSY beneficiaries delivered in institution	173
Timing of the day when JSY beneficiary reached the place of delivery	
6 AM - 12 noon	28.3
12 PM - 6 PM	26.0
6 PM - 12 AM	27.2
12 AM - 6 AM	18.5
Persons who all accompanied JSY beneficiary to the health institution*	
Husband	72.3
Other family members	53.2
Mother-in-law	50.9
Mother	20.2
ASHA functionary	17.9
TBA/dai	9.8
ANM/Health worker	6.4
Neighbour or other	4.6
Anganwadi worker	3.5
Number of JSY beneficiaries accompanied by ASHA	31
Percent of ASHA who facilitated in obtaining services for JSY beneficiary on accompanying them	90.3

* Multiple responses

Quality of Services Available at the Place of Delivery

The study tried to ascertain the quality of services at the place of delivery like, promptness in attending the delivery case, waiting time, person attending the delivery and average stay in the hospital following the delivery. Twenty-one percent of the women did not know about the time taken to complete the registration process, others said that, on average, it took 12.3 minutes to complete the administrative process. It took another 12.7 minutes of waiting until someone attended JSY beneficiary.

Most (95 percent) of the deliveries were normal, three percent were caesarean, and two percent were assisted deliveries. The doctor conducted 31 percent of the deliveries at the institution, while ANM, nurse or LHV conducted two-thirds of the institution deliveries. On average, women were discharged within 22 hours (or on same day) after delivery. Further analysis showed that a woman with normal delivery was discharged within 15.2 hours, around 2 days for assisted delivery and after 6 days for caesarean (Table 4.11). Going by the GOI norms, the minimum duration of stay recommended for normal

Table 4.11: Average hours after delivery women was discharged, Rajasthan, 2007 (Percentage)

Particulars	Total
Normal delivery (n = 164)	15.2
Assisted (forceps, centouse, vacuum) (n = 3)	49.7
Caesarean (n = 6)	188.0

delivery is 48 hours. Thus, there was a departure from the prescribed norms. Government of India should tackle this in subsequent discussions with the state.

Payments Incurred for Services at the Health Centre

It is necessary to know the expenses incurred by women to avail certain services at the health institution. Table 4.12 shows that majority of the women (64 percent) had to pay for services at the health centre, mostly for medicines/IV fluids (94 percent), delivery and operation charges (60 percent). Others (less than 12 percent) paid for food, accommodation, laboratory tests and diagnostic or sonography tests. On average, JSY beneficiary spent Rs. 1277.6 for the index delivery. One-fifth of the women did not know about the expenses incurred and hence were omitted while calculating average amount spent. This important finding could not be probed further in the field during the survey activities. There is a need to examine this aspect in detail because the scheme is meant for the poor. The poor have started accepting services, the motivating factor has been the monetary incentive, and if they incur non-reimbursable expenses as observed, it would be difficult for ASHAs and ANMs to deal at the field level.

Table 4.12: Payments incurred for services at the health centre, Rajasthan, 2007 (Percentage)

Particulars	Total
Number of JSY beneficiary delivered in institution	173
Percent who had to pay for services at the health centre	64.2
	(111)
Number of JSY beneficiary delivered in institution	173
Specific services for which were charged	
Medicines/IV fluids	93.8
Delivery/caesarean /Operation charge	59.8
Food charges	11.6
Accommodation charge	10.7
Laboratory test	9.8
Diagnostic/sonography	9.8
Paediatric care	2.7
Average total amount spent for the index delivery (in rupees)	1277.6
Do not know	20.4

Satisfaction with the Services at the Place of Delivery

Despite additional expenses, it was observed that almost all JSY beneficiaries were satisfied with the services available at the place of delivery. The reasons were good behaviour of the health staff and doctors, cleanliness maintained at the health facility, and counselling about follow-up visits, breastfeeding, immunization, family planning, newborn care, and diarrhoea management (Table 4.13). A few others (2 percent) expressed dissatisfaction with the services as the staff members were rude, facilities were not clean or adequate and quality of services was poor. On the other hand, majority of the ASHAs during their interviews reported that the cooperation received at the place of delivery was very good (33 percent) or good (55

Table 4.13: Satisfaction with the services at the place of delivery, Rajasthan, 2007 (Percentage)

Particulars	Total
Number of JSY beneficiary delivered in institution	173
Percent satisfied with the services available at the place of delivery	97.7
Reasons for satisfaction with the services at the place of delivery*	
Health staff and doctors were courteous	72.8
Counselled about follow-up visit	37.0
Health facility was clean	36.4
Counselled for breast feeding/immunization	26.0
Counselled for family planning	6.9
Counselled for newborn care, diarrhoea management	2.3

* Multiple responses

percent) while a few expressed their apprehension regarding cooperation received at the place of delivery.

Persons who Assisted Home Delivery and Views about TBA

Of the 75 deliveries conducted at home, majority were attended to by the TBAs and LHV/ANM/Nurse (Table 4.14). The beneficiaries also mentioned assistance of friends and relatives.

Table 4.14: Persons who assisted Home delivery and views about TBA, Rajasthan, 2007 (Percentage)

Particulars	Total
Persons who all assisted the delivery*	
Doctor	2.7
LHV/ANM/Nurse	33.3
ISMP doctor	1.3
TBA	73.3
Friends/relatives	33.3
Others	13.3
Number reporting delivery at home	75
Percent opined that TBA can provide all necessary midwifery services	31.5
Reasons for saying that TBA can provide necessary midwifery services*	
TBA is easily accessible	32.1
TBA charges less money	32.1
Traditionally has been conducting deliveries in the family	32.1
TBA has better knowledge of the cultural practices and follows it	28.2
Better comfort level with TBA	29.5
Others	2.6
* Multiple responses	

All the JSY beneficiaries who delivered at home were asked to give their opinion about the role of TBA in providing the necessary midwifery services. Every third beneficiaries believed that TBA/dai could provide all the necessary midwifery services. They mentioned that TBAs were easily accessible, charged less money, had been traditionally conducting deliveries for other family members, were familiar with the cultural practices, and women felt more comfortable with TBA around (than doctor or nurse).

Dynamics of Delivery at Home - Who all prefer delivering at Home?

Analysis was undertaken to understand those who delivered at home and their access to the health system. The analysis presented in Table 4.15 clearly shows that every third women who had no formal education or had studied up to primary, delivered at home. It is surprising that even among the literate, every sixth woman in Rajasthan preferred to deliver at home. Caste wise break-up shows that 42 percent of the women belonging to SC/SC delivered at home as against 26 percent belonging to other backward classes and 20 percent of the high caste Hindus. Income wise, women who had home deliveries had an average monthly family income of Rs 1,642 as against Rs 2,221 among women who had institutional deliveries.

Table 4.15: Background information of JSY beneficiary , Rajasthan, 2007 (Percentage)

	Institution	At home	Total N
Percent not attended formal education or studied up to primary	65.6	34.4	192
Middle level or more	83.9	16.1	56
Percent belonged to			
Scheduled caste / Scheduled tribe	58.3	41.7	84
Other backward classes	74.2	25.8	124
High caste Hindus/general	80.0	20.0	40
Average monthly family income (In Rs.)	2221.2	1642.0	248

No doubt, women with lesser education, from SC/ST and lower economic status preferred home deliveries but there were substantial proportion within these categories that opted for institutional deliveries. The issue of home deliveries was probed and JSY beneficiaries who delivered at home were asked their reasons.

The reasons for not preferring institutional delivery were fear of hospitals/fear of needles, injections and equipment, belief that women get better care at home, poor cleanliness at hospital and fear of doctors and other staff members. These three responses contributed to about half of the responses. There were more apprehensions among women who delivered at home in comparison with their counterparts who delivered in institutions. Family opposition and hospital expenses were other important reasons. Thus, apprehensions of visiting health institutions, fear of injections, needles, equipment and service providers, and cost incurred on services are the reasons rather than other elements listed as reasons in Table 4.16. It can be said that the apprehensions of the beneficiaries prevent them from utilizing institutional services, which should be attended to.

Table 4.16: Perceived reasons for women to deliver at home despite cash assistance being paid under JSY for institutional delivery, Rajasthan, 2007 (Percentage)

Particulars	Total
Reasons for preferring home delivery*	22.7
Fear of going to hospital / needle, injection, equipments	25.3
Women believe they get better care at home/no cleanliness maintain at hospital	12.0
Fear of doctor, nurse	14.7
Illiteracy and lack of understanding of the importance of institutional delivery	13.3
Opposition from family members	10.7
There are expenses in the hospital /Home delivery is cheaper	10.7
Because of poverty	4.0
Unaware about JSY	9.3
Unavailability of transport facility on time	8.0
Because of stitches / fear of caesarean	9.3
Dai (TBA) takes better care while assisting delivery	5.3
Clinic far away/much distance	8.0
If there is any complication they go to hospital or contact us	5.3
Prefer home delivery by dai	2.7
Don't get time to go at hospital/delivered before due date	1.3
Staff is not cooperative/rude	5.3
Others**	8.0
Do not know	75
Total	

* Multiple responses

**Fear of bad omen, most go to hospital, fear of dai, dai does not allow to go to hospital, ANM prescribes home delivery, nobody at home to accompany for hospital, didn't get money for institutional delivery, shy of going to a doctor for delivery, roads are bad, ANM told us to give money at home

Mode of Payment and Difficulties Faced

The study reveals that 85 percent of the beneficiaries received JSY cash assistance for delivery. Three-quarters of the women who delivered at home as against 88 percent of those who delivered at institutions received JSY cash assistance (Table 4.17).

Table 4.17: Payment made for JSY beneficiaries, Rajasthan, 2007 (Percentage)

Particulars	Institution	At home	Total
Percent received JSY cash assistance for delivery	88.4 (153)	76.0 (57)	84.7 (210)
Number of JSY beneficiary	173	75	248
Time when received the money			
Before the delivery	4.0	5.3	4.3
Immediately after or within a week after delivery	45.0	7.0	34.8
Much later	51.0	87.7	61.0
Person who gave cash assistance to JSY beneficiary			
ANM	50.3	87.7	60.5
CHC / PHC doctor / MO	26.8	0.0	19.6
Staff at Health Centre / Accountant	14.4	3.5	11.5
Panchayat	0.0	5.3	1.4
ASHA	1.3	0.0	1.0
Others / do not know	7.2	3.5	6.2
Place where received cash assistance money			
At home	24.2	26.3	24.8
Place of delivery	33.3	0.0	24.3
Within the village	7.2	31.6	13.8
CHC/ PHC / Sub-centre	27.5	31.6	28.5
Camp	5.2	8.8	6.2
Do not know	2.6	1.8	2.4
Average amount received by JSY beneficiary (in rupees)	885.7	496.2	780.3

* Multiple responses

It is remarkable that all JSY beneficiaries received cash assistance in one go. However, the timing of receiving cash was significant. Four out of 10 beneficiaries received before the delivery or within a week of delivery and the remaining received much later. Break-up between institution and home deliveries indicated that half of the beneficiaries who delivered in institutions received cash assistance within a week of delivery while only 12 percent received for home deliveries. In majority cases, especially home deliveries, ANMs was the main source of cash disbursement, and for institutional deliveries, it was ANM followed by medical officer at the CHC/PHC and accountant.

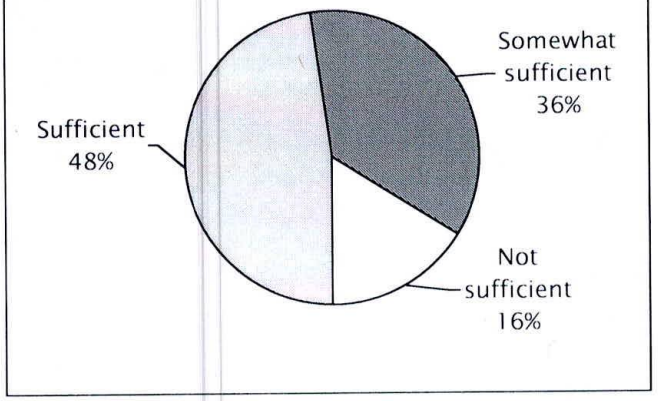
Place of disbursement of cash assistance depended on the place of delivery. The findings are in conformity with the fund flow mechanism set up by the state. Most of the home delivery beneficiaries received payment in the village of their residence while institutional delivery beneficiaries were paid at the place of delivery or at PHC/ CHC/SC or by the ANM. The beneficiaries, who delivered in institutions, were given vouchers with discharge. This voucher along with verification of ANM or ASHA was mandatory for release of payment. In few instances; ANM accompanied beneficiaries spouse or relatives and in several other cases, vouchers were collected and submitted by the ANM at the facility, cash was collected and distributed to beneficiaries at their residence. Multiple channels of disbursement were followed and the state made efforts to ensure payments.

On average, a JSY beneficiary who delivered in an institution received, Rs. 900 while home delivery beneficiaries received around Rs. 500. Since beneficiaries covered were given cash assistance at different points in time (survey included beneficiaries who

had delivered six months prior to it, conducted between January and March), it was difficult to relate to the different guidelines because some of them received Rs. 700 when the scheme began, which was increased to Rs. 1,400. There could have been spill over of few cases.

Most (96 percent) of the beneficiaries felt that the process in disbursing cash assistance was simple. Eight out of 210 (4 percent) of them who received incentive for delivery reported that they had problems in getting money. They did not get their payment when they needed it most and had to visit the facility several times.

Figure 4.2: Sufficiency of cash incentives received by JSY beneficiary



The adequacy of cash incentives has to be interpreted with caution as the amount has doubled since the inception. Given whatever was offered at that time, one-sixth of beneficiaries said that the cash assistance was not enough to meet the expenses. Others thought that it was sufficient (48 percent) or somewhat sufficient (36 percent).

Explaining the process of payment at the health institution, an Account Officer said,

> *"Our cashier makes the payment. A discharge slip is required with signature of the medical officer in-charge. Then the Babu (local term for Clerk) fills in a form, and attaches discharge slip and ANC card to ensure that full ANC care has been received by the beneficiary. Only those JSY beneficiaries who received full ANC care get the cash assistance. The form is also signed by ANM or ASHA who accompanied JSY beneficiary and the beneficiary herself. This process takes a long time".*

It appears that in order to get the incentives, full ANC care is essential and hence women ensure that they get full ANC care so that they get total cash assistance.

Use of Cash Assistance Received for Delivery

The beneficiaries were asked *'how did they use the money received under JSY?'* About two-fifths of them purchased consumables for the family and bought medicines/ tonics for self and child, while one-fourth said that they used it for self-nutrition or the husbands took it away. A few (6 percent) saved it, while only one percent used the money for medical expenses for delivery. According to the Anganwadi workers, women used cash assistance for buying medicines, household expenses, to meet expenses during delivery, and some women used it to repay loans taken for meeting delivery expenses. The cash assistance was beneficial to poor women.

Appreciation of JSY by the Beneficiaries

Most women were satisfied with JSY and they would recommend relatives or friends/ neighbours to be beneficiaries under JSY as they received cash immediately on filling forms. The cash received helped them to meet additional expenses incurred at hospital. Besides, they had safe deliveries in the hospitals and staff members and nurses were good. They received nutritious diet and the newborn was looked after. Women also appreciated that immunization of babies was initiated and were explained details. While these were views of majority of them, a few (miniscule proportion) did not appreciate the scheme because they did not receive the cash assistance. Few others said that they preferred home deliveries by Dai. They said that Dai understood social and cultural customs better than doctors did, and family members could relate better to Dai who was from the community. They added that even home deliveries were compensated so why worry about the difference in assistance. In this environment, it would be difficult for an ASHA like person to cope up and hence they should be empowered to discuss finer aspects of going for institutional deliveries and bring such cases to the notice of supervisory health officials.

Impact of JSY on Institutional Delivery

JSY beneficiaries were asked about place of delivery of the last child born prior to the index child. Of the total 173 JSY beneficiaries interviewed, 166 had history of previous birth more than one and half years ago. These 166 beneficiaries were considered and cross-tabulated by place of delivery of previous child with that of the index child. This would indicate whether there has been any shift in place of delivery since the inception of JSY. It was observed that 54 JSY beneficiaries (33 percent) had gone to institutions even for their previous delivery, while the remaining 112 (67 percent) were home deliveries. In case of index pregnancy, 108 births (65 percent) were institutional and remaining 58 births (35 percent) were home deliveries. Institutional births were around one-third for the last birth that had doubled for the index pregnancy. Sixty-two women shifted from home to institution between two deliveries mainly because of money available under JSY (n=33, 53 percent), better services at hospital (n=27, 44 percent) and support provided by ASHA (n=11, 18 percent). Consequently, there has been a substantial decline in home deliveries. The findings cannot be generalized because the sample had confined to only those who had availed JSY benefits. Yet by comparing with their past behaviour, there has been substantial change and the results could be considered as indicative.

Table 4.18: Shift in the place of delivery before and after JSY in Rajasthan, 2007 (Percentage)

Particulars	Place of delivery for last (JSY) child		
	Institution	Home	Total
Place of delivery for last but one child			
Institutional	46 (27.7)	8 (4.8)	54 (32.5)
Home	62 (37.4)	50 (30.1)	112 (67.5)
Total	108 (65.1)	58 (34.9)	166 (100.0)

To substantiate the finding, service statistics on institutional deliveries for the three selected districts and the state were analyzed for three years from 2004-05 to 2006-07, that is, one year before and one year after JSY intervention (Table 4.19). It is found that in 2004-5, about 3.83 lakh institutional deliveries took place in public sector institutions and in the subsequent year, there was a marginal drop of 0.25

percent. However, in 2006-7, one year following the launch of JSY, the performance was 5.20 lakh. In other words, the performance increased by more than one-third over the 2005-6 performance.

Table 4.19: Performance of Institutional Deliveries in Public Sector, Rajasthan, 2004-7 (percentage)

District	2004-05	2005-06	2006-07	Percent increase/ decrease between 2004-5 and 2005-6	percent increase/ decrease between 2005-6 and 2006-7
Bhilwara	10084	10811	14712	7.21	36.08
Jaisalmer	2355	2623	3741	11.38	42.62
Udaipur	22588	22628	36086	0.18	59.47
Rajasthan	383086	382128	519579	-0.25	35.97

Likewise, increase in institutional deliveries was witnessed in the study districts. Based on observations from the survey and service statistics, it can be inferred that JSY has had an impact.

Role of ASHA in JSY

ASHAs, as expected, had heard about JSY during induction training and were later briefed about it by various health functionaries, the most common being the ANM. ASHAs were clear about the different activities they were to perform in JSY. This is evident from the beneficiary assessment wherein it was found that they were supportive right from pregnancy to childbirth in at least one-fourth of deliveries.

ASHAs were aware of their roles and responsibilities in JSY regarding antenatal services, complications during pregnancy and child-birth and thereafter, micro-planning, referral care, arranging for transport, accompanying women for deliveries to institutions and ensuring child immunization services. However, their knowledge about eligibility criteria of beneficiaries and the amount to be paid to them for institutional and home deliveries was inadequate. This is understandable because JSY guidelines had undergone four revisions since inception and in LPS, there were two revisions related to payment.

Post-natal care was the most infrequently discussed topic. It was mentioned neither by beneficiaries nor by ASHAs. Interestingly, the state had provided cash incentive of Rs. 50 to ASHA for rendering post-natal care, but it did not come out clearly during the interviews. What came out during discussions on post-natal care with ASHAs, was related to breast feeding, child immunization, new-born care and follow-up advice. Analysis of cash incentive earned by ASHAs pointed to only two things and that was related to delivery services and child immunization. It is felt that post-natal care might not have been emphasized much in comparison with delivery and other elements. There is a need for reorientation on this important aspect because of its direct relevance on maternal mortality.

All in the community and health functionaries recognized the services of ASHAs. Her role in motivating beneficiaries for institutional delivery services and accompanying them to institutions has emerged significantly. Given proper support from the health system and other stakeholders and strengthening her hands with effective

behavioural change communication, the role of ASHA in promoting institutional deliveries will be more visible in near future.

It can be inferred that the state has been able to disseminate the scheme through various inter-personal and mass-media activities. Most of the beneficiaries heard about JSY during their pregnancy and their knowledge about the scheme was incomplete in respect to the content of JSY guidelines. ANMs and ASHA were the sources from whom majority beneficiaries became aware of the scheme and its benefits. Reach of other media was limited. As far as uptake of services by background characteristics of beneficiaries was concerned, one could say that JSY has been able to address its objectives of promoting institutional deliveries, among the poor and socially disadvantaged population. ASHAs have explained micro-birth planning aspects in part to the beneficiaries and accordingly worked out details of institutional deliveries. It appears that more thought needs to be given for operationalizing micro-birth planning to make this a distinct activity.

Most of JSY beneficiaries were satisfied with the services at the institution and were happy with the courteous behaviour of the staff members. The transport cost for reaching the facility in majority of cases was not reimbursed either at the facility or later and cash assistance for delivering in the institution was received within a week of delivery or much later. Nonetheless, the beneficiaries were satisfied and as satisfied users, they expressed that they would be recommending institutional deliveries within their community. The major triggering factors for availing institutional delivery facility were the cash incentive, accessibility and availability of health staff and support of ASHA, while the reasons for not availing institutional delivery services despite the cash assistance were fear of visiting hospital, behaviour of doctors and other staff. When beneficiary's place of delivering the child prior to the index birth was compared with the index birth, there was a clear shift from home to institutional delivery indicative of impact of JSY. Thus, it can be inferred that JSY has been able to address its objectives and given further impetus by streamlining payment related mechanisms, and undertaking demand generation activities, the performance could be further enhanced.

CHAPTER 5

RECOMMENDATIONS

Summary of Findings

Rajasthan has made concerted efforts to operationalize ASHA intervention and JSY. National guidelines of ASHA and JSY, were reviewed, adapted and translated to suit the local context. The State has also thought through of setting up an institutional modality for nesting ASHA intervention in an inter-sectoral convergence environment.

The state took a policy decision for selecting Sahyogini of Anganwadi Centre as ASHA-Sahyogini. This has been hailed as a major step facilitating convergence at the cutting edge level. State ASHA Mentoring Group was constituted with representation from DWCD, Health Department, NGOs and Development Partners with clear terms of reference. However, the meetings of this group do not take place on regular basis. Likewise, ARC has been set up to function as Secretariat of ASHA intervention. While SMG provides mentoring support and is a policy advisory group, ARC has been mandated to organize and deliver ASHA intervention right from selection, training to monitoring and supervision and updating the progress and informing SMG on a periodic basis. Thus, the state has sent out very clear signals in terms of focus on convergence and at the same time achieved synergies.

The state modified the book number 1 and facilitators, guide of GOI and compressed the first round of training from seven to six days. Initially, SIHFW was entrusted with the responsibility for conducting the training, however mid way through ARC was asked to organize trainings with the help of NGOs. Involvement of NGOs at block level for organizing trainings have resulted in improved logistics and training arrangements and ASHAs were happy with the training pedagogy. ASHA's knowledge on various reproductive and child health aspects is good, yet there is need for strengthening non-RCH components and other determinants of health.

ASHAs were able to generate demand and mobilize clients for reproductive and child health services. ASHAs also started accompanying few beneficiaries for institutional deliveries. In executing their role as ASHAs, they networked with various stakeholders other than Anganwadi workers or ANM and the community has started recognizing them for their work. It was observed that PRIs and others lacked knowledge on the functioning of ASHAs and expected them to make home visits on regular basis. Performance based cash payments to ASHAs were untimely and there were delays in payment. Only a small proportion of ASHAs were able to earn money while majority of them were yet to start earning. This emerged as a serious concern, because in the absence of remuneration, it would be difficult to sustain interest of ASHAs for long. One also hopes that with change in eligibility criteria for JSY, ASHAs will be able to make money for each woman in delivery escorted by them.

About JSY, the state was able to disseminate JSY through various inter-personal and mass media activities. Most of the beneficiaries had heard about JSY during their pregnancy and their knowledge about the scheme was incomplete. ANMs and ASHA were the sources from whom majority beneficiaries became aware of the scheme and its benefits. The scheme will benefit from investment in ANMs and ASHAs reorientation in the form of FAQs about the scheme for effective transmission of unambiguous messages. Reach of other media was limited. One can conclude that JSY was able to address its objectives of promoting institutional deliveries among the poor and socially disadvantaged population. ASHAs explained micro-birth planning aspects partially to the beneficiaries and accordingly worked out details of institutional deliveries. It appears that more thought needs to be given to operationalizing micro birth planning and efforts have to be made to project it as a distinct activity, distinguishable from the routine messages.

Most of JSY beneficiaries were satisfied with the services at the institution, as the staff members were courteous. The transport cost for reaching the facility in majority of the cases was paid by the beneficiaries and only a few were reimbursed. This is an area of concern where further explanation need to be sought. Concerning cash assistance to the beneficiaries delivering in institutions, majority were given within a week of delivery or much later. The beneficiaries were satisfied and as satisfied users, they expressed that they would recommend institutional deliveries within their community.

On the role of the state in respect to involvement of private sector in JSY, very little has been done. A medical professional expressed that private sector presence in most of the districts of the state was minimal and the accreditation criteria seem to be stringent to it. However, some headway is being made and listing of private facilities has been initiated. Overall, the major triggering factors for availing institutional delivery facility were the cash incentive, accessibility and availability of health staff and support of ASHA. The reasons for not availing institutional delivery services despite the cash assistance were fear of visiting hospital, behaviour of doctors and other staff.

Recommendations

These recommendations stem from analysis of the findings and discussions with stakeholders. These findings are organized in three clusters such as policy; programme related and demand side issues.

Policy

The state took a major policy decision of forging inter-sectoral convergence with DWCD with institutionalization in perspective and looked forward to implementing ASHA intervention by setting up of ARC within the state resource centre. This was indeed a remarkable decision and the study suggested for certain areas requiring attention. They are:

1. SMG last met in Nov 2006 and the meeting of the group is yet to be held this year. SMG being think tank can offer guidance on implementation issues related to health department officials complaining about Sayoginis division of work, acceleration of pace of trainings, integration of ASHA trainings with Sahyogini trainings, accountability and spending more time on ICDS activities. These issues could have been given priority and resolved. SMG should also suggest communication strategy for the interventions.

2. ARC is seen as an implementation arm for ASHA intervention. Non-availability of ARC network in the districts remains an issue. It appears that interface of ARC with DPMUs through SPMUs or directly needs clarity in terms of reporting arrangements. The present structure of ARC depicts direct monitoring of ASHAs by DPMU, while the national guideline has stressed the role of block facilitators in monitoring, supervising and providing mentoring support to ASHAs. As continuing education of ASHAs through monthly PHC level meetings has been proposed, there is a need to look into the existing structure and involve block facilitators in accordance to the national guidelines.

3. The findings from the study clearly suggest the need for effective engagement of PRIs in implementation of ASHA and JSY. District Health societies should ensure active participation of PRIs at different levels. In fact, SMG should develop a guidance note on design of activities to facilitate PRIs engagement at different levels. This will also take cognizance of critical support the PRIs are to offer for formulation of village health plans, use of untied funds etc.

4. Another important area that did not emerge in the study but is worth mentioning is the revision of Sahyogini curricula of DWCD. Since the state has already decided and has issued Government Orders of Sahyogini working as ASHA, the ASHA training component could be included as part of the future induction training programme of Sahyogini. This topic could be taken up for discussion in SMG.

5. A new addition in JSY guideline is the provision of Rs. 1,500/- to a private practitioner attending complicated deliveries in public health setting. So far, no money was spent under this provision. SMG should also provide guidance note on how this facility can be utilized by public system doctors. This will entail clear definitions of complications, setting up procedures for hiring private doctors and assigning responsibilities amongst staff members.

Programme Management

1. The state has nodal officers for ASHA and JSY who are involved in all the activities like development of annual plans, implementation, review, monitoring and supervision. District and state health action plans for NRHM should reflect on ASHA and JSY interventions including activities and financial requirements. This will facilitate results based management. It is a matter of concern that only one round of training was completed although GOI has finalized and disseminated book 2, 3 and 4 as reading material for ASHA. ARC

should be entrusted with the responsibility of developing consolidated state work plan for ASHA, while district plans should be developed by the DPMUs, based on the guidelines formulated by ARC.

2. Monthly meeting with ASHAs at the PHC level has been proposed in the state guidelines. State guidelines are elaborate and provide information about agenda items, participants and financial resources. Continuing education is an important component and has to be supplemented with appropriate reading materials/on the job tools that are easy to comprehend. Hence, it is recommended that ARC should put together appropriate reading materials to be shared with ASHAs during the monthly meetings. This will also help in reinforcing knowledge in key areas.

3. Issues related to timely payments after training and ensuring availability of kits during training also need immediate attention. Study findings indicate non-receipt of payments by ASHA at least in one district. The supply of drug kits to ASHAs was done much later after the training. This has to be streamlined so that ASHAs can be explained the contents of kit and its use. One of the observations relates to inclusion of drug Dyclomine HCL-10mg in the kit. This drug is supposed to be made available only through prescription and is not an over-the-counter (OTC) drug. It is expected that state authorities would review contents of the drug kit in light of these observations.

4. Timely payments to ASHAs and JSY beneficiaries are necessary for sustaining interests of ASHAs for mobilizing women to seek institutional delivery services. The study found that payment to ASHAs were delayed in several instances, despite clear instructions for immediate payment. Likewise, payment to JSY beneficiaries were proposed. The new guidelines suggest that payments should be made immediately at the facility itself. Our finding is that, there is scope for causing ambiguity regarding payments. State should issue a guideline for making payments and same should be widely publicized in terms of entitlements

5. The Support Mechanism to ASHA has been designed by GOI and shared with the states. After reviewing the ARC structure, it is clear that Rajasthan has not followed it and the role of block facilitators has been kept at the minimal level after the training. The national guidelines clearly state that for every 10 ASHAs there has to be a block facilitator who would be responsible for supporting her. The involvement of DWCD members and PRIs in block and district monitoring should be ensured and implementation related issues could be deliberated and resolved. The state should work out ways for strengthening the support system. By doing so, it will strengthen ASHAs and recoil effects would enable improvements in utilization of other health services and JSY uptake.

6. One of the areas where very little work has been done is involvement of private sector in providing institutional delivery services. The state could initiate accrediting private sector facilities in the districts with significant presence of

private sector. As of now amount of money for cash assistance has been increased substantially and given the prevailing charges for a normal delivery, which is around Rs. 1000/- to 1500/- in a sub-district private facility, there is definitely scope for increasing number of institutional deliveries through the private sector.

7. Innovation in the form of JSY help-line through NGOs has been experimented by the state and one block of each district is covered. However, before the state decides on replication or up scaling, a proper assessment should be undertaken.

8. State may also like to consider organizing exchange visits of ASHAs to neighbouring districts, so they learn from each other and also build a network. Block facilitators /NGOs can be identified for organizing such activities.

Demand Generation

Need for proper programme related communication has been observed at various levels: providers, stakeholders including community. The state government introduced the ASHA intervention and JSY and followed the routine track of publicity without getting into the nitty-gritty's of how the communication strategies could be made effective. Communication interventions were limited to disseminating guidelines in the form of circulars and some mass media activities in the form of wall paintings and billboards.

The way the state has gone about has resulted in incomplete dissemination of messages. Neither the key stakeholders such as PRIs, SHGs and others nor the community have complete knowledge of roles and responsibilities of ASHA or finer details of JSY. Overall, there was no Behavioural Change Communication (BCC) plan for publicizing ASHA intervention and JSY. Moreover, there was no conscious effort for disseminating messages during Village Health and Nutrition Day, Immunization Sessions or RCH Camps. Hence, it is suggested that the following be done:

1. Prepare a comprehensive BCC annual plan for ASHA intervention and JSY spelling out BCC objectives, key messages, target audience using different communication medium, when and by whom undertaken, and at what levels. In doing so, State may consider seeking professional inputs in formulating the communication strategy.

2. Study findings indicate women having apprehensions about deliveries in hospitals for whatever reasons. Communication strategy should attempt to address myths and misconceptions about hospitals/health centres. Satisfied users of hospitals could be involved in sharing their experience and motivating women to deliver in hospital.

3. To ensure consistency in messages delivered through different information sources, state should develop appropriate media briefing kits, and orientation packages for different stakeholders in the form of Frequently Asked Questions

(FAQs). The information package should also detail the role envisaged for different stakeholders in ASHA and JSY.

4. The State should conduct orientation programmes for medical and health department, DWCD, PRI members and other stakeholders for effective dissemination of both schemes. Civil society groups and networks of NGOs can be engaged to reach out to vast number of stakeholders.

5. A wallpaper for ASHAs/AWWs and PRIs on a periodic basis documenting success stories, profiling role models and also providing a platform for exchanging views and experiences can also be an effective medium .

ANNEXURE 1

Table 1: Average family income of JSY beneficiaries by background characteristics (Percentages)

	Education status			Caste category				Income level			Total
	Illiterate	1-8	9+	SC	ST	OBC	General	≤1000	1001-2000	2001+	
Total number of JSY beneficiary interviewed	168	56	24	42	42	127	37	41	141	66	248
Mean monthly family income (rupees)	1787.9	2350.9	3125.0	2011.9	1713.1	2015.4	2545.3	800.0	1680.1	3515.5	2043.1

Table 2: Early registration during index pregnancy by background characteristics (Percentages)

	Education status			Caste category				Income level			Total
	Illiterate	1-8	9+	SC	ST	OBC	General	≤1000	1001-2000	2001+	
Total number of JSY beneficiary interviewed	168	56	24	42	42	127	37	41	141	66	248
Month of index pregnancy when realized that women could be pregnant											
≤ 2 months	66.7	71.4	83.3	81.0	59.5	66.9	75.7	73.2	63.8	78.8	69.4
3rd month	29.8	17.9	12.5	16.7	31.0	29.1	16.2	24.4	29.8	16.7	25.4
4th month or later	1.2	3.6	4.2	2.4	0.0	2.4	2.7	2.4	2.1	1.5	2.0
Do not know	2.4	7.1	0.0	0.0	9.5	1.6	5.4	0.0	4.3	3.0	3.2

Table 3: Contacts with health personnel during index pregnancy by background characteristics (Percentages)

	Education status			Caste category				Income level			Total
	Illiterate	1-8	9+	SC	ST	OBC	General	≤1000	1001-2000	2001+	
Total number of JSY beneficiary interviewed	168	56	24	42	42	127	37	41	141	66	248
Percent contacted by someone or self contacted health personnel during last pregnancy											
Somebody from health department contacted	46.4	33.9	12.5	35.7	59.5	40.2	24.3	46.3	41.8	33.3	39.8
JSY beneficiary contacted somebody	48.2	66.1	87.5	61.9	35.7	55.1	75.7	53.7	51.8	66.7	56.6
No contact made	5.4	0.0	0.0	2.4	4.8	4.7	0.0	0.0	6.4	0.0	3.7
Number of JSY beneficiary who had contact with health personnel	159	56	24	41	40	121	37	41	132	66	239
Stage of pregnancy when first contact was made											
< 2 months	27.0	28.6	58.3	24.4	25.0	27.3	54.1	34.1	27.3	34.8	30.5
3rd month	37.7	39.3	33.3	29.3	37.5	41.3	35.1	29.3	37.9	42.4	37.7
4th month	16.4	16.1	8.3	19.5	15.0	16.5	8.1	19.5	15.2	13.6	15.5
5th month or later	18.9	16.1	0.0	26.8	22.5	14.9	2.7	17.1	19.7	9.1	16.3
Mean	3.4	3.3	2.5	3.6	3.6	3.3	2.6	3.3	3.4	3.1	3.3
Person with whom had first contact with											
Doctor	19.5	32.1	54.2	29.3	5.0	24.0	51.4	14.6	21.2	42.4	25.9
LHV	0.6	3.6	0.0	2.4	2.5	0.8	0.0	0.0	2.3	0.0	1.3
ANM/FHW	64.2	64.3	37.5	56.1	77.5	63.6	43.2	65.9	66.7	48.5	61.5
Anganwadi worker	6.9	0.0	4.2	4.9	10.0	3.3	5.4	12.2	3.8	3.0	0.5
ASHA worker	8.2	0.0	4.2	4.9	5.0	8.3	0.0	7.3	6.1	4.5	5.9
Others	0.6	0.0	0.0	2.4	0.0	0.0	0.0	0.0	0.0	1.5	0.4
Percent advised by the health personnel for antenatal check-up											
Yes, advised for ANC	89.9	94.6	91.7	95.1	87.5	92.6	86.5	92.7	90.2	92.4	91.2
No, not advised	8.2	1.8	8.3	4.9	7.5	6.6	8.1	4.9	8.3	4.5	6.7
Do not know/can't say	1.9	3.6	0.0	0.0	5.0	.8	5.4	2.4	1.5	3.0	2.1

Table 4: Details of antenatal check-ups during index pregnancy by background characteristics (Percentages)

	Education status			Caste category				Income level			Total
	Illiterate	1-8	9+	SC	ST	OBC	General	≤1000	1001-2000	2001+	
Total number of JSY beneficiary interviewed	168	56	24	42	42	127	37	41	141	66	248
Percent availed of any antenatal check-up during index pregnancy	85.1 (143)	94.6 (53)	100.0 (24)	92.9 (39)	83.3 (35)	87.4 (111)	94.6 (35)	87.8 (36)	85.1 (120)	97.0 (64)	88.7 (220)
Month of pregnancy when availed antenatal care services for the first time											
≤ 2 months	27.3	20.8	54.2	20.5	17.1	29.7	45.7	38.9	24.2	31.3	28.6
3 - 4 months	51.0	62.3	45.8	46.2	60.0	55.0	48.6	41.7	53.3	59.4	53.2
5 - 6 months	15.4	13.2	0.0	25.6	14.3	10.8	5.7	16.7	15.8	6.3	13.2
7th month or later	5.6	3.8	0.0	7.7	5.7	4.5	0.0	2.8	5.8	3.1	4.5
Do not know	0.7	0.0	0.0	0.0	2.9	0.0	0.0	0.0	0.8	0.0	0.5
Mean (month)	3.5	3.4	2.5	3.9	3.6	3.3	2.8	3.3	3.5	3.1	3.4
Number of times of antenatal check-ups											
1 time	4.9	1.9	0.0	5.1	5.7	3.6	0.0	2.8	4.2	3.1	3.6
2 times	22.4	22.6	4.2	33.3	31.4	18.0	2.9	11.1	27.5	12.5	20.5
3 times	26.6	18.9	12.5	15.4	20.0	27.9	20.0	44.4	18.3	20.3	23.2
4 or more	44.1	52.8	83.3	43.6	40.0	49.5	71.4	41.6	47.4	61.0	50.4
I don't remember	2.1	3.8	0.0	2.6	2.9	0.9	5.7	0.0	2.5	3.1	2.3
Mean (number of times)	3.7	4.2	5.3	3.5	3.6	4.0	4.7	3.7	3.8	4.5	4.0
Place where received antenatal care*											
District/sub-district hospital	7.0	13.2	33.3	5.1	22.9	9.0	14.3	8.3	11.7	12.5	11.4
Community Health Centre	38.5	45.3	37.5	48.7	14.3	45.0	40.0	30.6	38.3	48.4	40.0
PHC	13.3	18.9	12.5	17.9	8.6	13.5	20.0	2.8	13.3	23.4	14.5
Subcentre	36.4	18.9	12.5	10.3	54.3	29.7	25.7	47.2	31.7	15.6	29.5
Private hospital	7.0	11.3	20.8	15.4	5.7	5.4	20.0	8.3	6.7	15.6	9.5
Anganwadi centre	12.6	9.4	0.0	10.3	14.3	9.9	8.6	19.4	10.8	4.7	10.5
At home	10.5	11.3	0.0	10.3	11.4	9.0	8.6	2.8	15.8	1.6	9.5
Others	2.1	0.0	0.0	0.0	0.0	2.7	0.0	5.6	0.8	0.0	1.4

Table 5: Persons motivating for antenatal check-ups during index pregnancy by background characteristics (Percentages)

	Education status			Caste category				Income level			Total
	Illiterate	1-8	9+	SC	ST	OBC	General	≤1000	1001-2000	2001+	
Number of JSY beneficiary who availed antenatal check up	143	53	24	39	35	111	35	36	120	64	220
Percent influenced or motivated by someone to avail antenatal check-up	95.1 (136)	96.2 (51)	95.8 (23)	97.4 (38)	85.7 (30)	97.3 (108)	97.1 (34)	100.0 (36)	92.5 (111)	98.4 (63)	95.5 (210)
Persons who influenced or motivated respondent's decision to go for antenatal check-up*											
Self motivated	29.4	27.5	52.2	39.5	23.3	22.2	58.8	19.4	29.7	41.3	31.4
No one	3.7	5.9	0.0	7.9	0.0	4.6	0.0	0.0	5.4	3.2	3.8
Husband	31.6	54.9	56.5	34.2	40.0	38.0	52.9	27.8	40.5	46.0	40.0
Mother-in-law	12.5	9.8	4.3	10.5	10.0	13.0	5.9	13.9	9.9	11.1	11.0
Doctor	2.9	0.0	8.7	2.6	.0	4.6	0.0	5.6	1.8	3.2	2.9
LHV/ANM/FHW	47.1	37.3	17.4	34.2	66.7	38.9	35.3	50.0	41.4	36.5	41.4
Anganwadi worker	10.3	5.9	.0	10.5	13.3	6.5	5.9	13.9	6.3	7.9	8.1
ASHA worker	17.6	21.6	13.0	13.2	20.0	22.2	8.8	11.1	19.8	19.0	18.1
Other family members/ relatives/friends	4.4	5.9	4.3	7.9	3.3	5.6	0.0	2.8	4.5	6.3	4.8

Table 6: Cost incurred for ANC visits by background characteristics (Percentages)

	Education status			Caste category				Income level			Total
	Illiterate	1-8	9+	SC	ST	OBC	General	≤1000	1001-2000	2001+	
Number availed of any antenatal check-up during index pregnancy	133	49	24	35	32	105	34	36	106	64	206
Percent incurred any expenses for receiving antenatal checkups	40.6	34.7	83.3	37.1	21.9	48.6	58.8	33.3	36.8	62.5	44.2
Average amount spent during ANC period including fees, laboratory test											
No expense	59.4	65.3	16.7	62.9	78.1	51.4	41.2	63.9	60.4	37.5	53.9
≤ 100 rupees	7.5	2.0	20.8	5.7	3.1	9.5	8.8	5.6	8.5	7.8	7.8
101 - 250 rupees	5.3	6.1	12.5	2.9	0.0	8.6	8.8	5.6	3.8	10.9	6.3
251 - 500 rupees	4.5	6.1	4.2	5.7	6.3	4.8	2.9	8.3	2.8	6.3	4.9
501 - 750 rupees	3.8	6.1	8.3	5.7	0.0	6.7	2.9	0.0	6.6	4.7	4.9
751 or more rupees	15.8	8.2	33.3	17.1	9.4	14.3	26.5	11.1	10.4	28.1	16.0
Do not know	3.7	6.2	4.2	0.0	3.1	4.7	8.9	5.6	7.5	4.7	6.3

Table 7: Reasons for not seeking ANC services by background characteristics (Percentages)

	Education status			Caste category				Income level			Total
	Illiterate	1-8	9+	SC	ST	OBC	General	≤1000	1001-2000	2001+	
Total number of JSY beneficiary interviewed	168	56	24	42	42	127	37	41	141	66	248
Percent not availed antenatal care services during index pregnancy	14.9 (25)	5.4 (3)	0.0 (0)	7.1 (3)	16.7 (7)	12.6 (16)	5.4 (2)	12.2 (5)	14.9 (21)	3.0 (2)	11.3 (28)
Reasons for not availing any antenatal care services*											
Not necessary	64.0	66.7	0.0	66.7	71.4	62.5	50.0	20.0	71.4	100.0	64.3
Not customary	24.0	33.3	0.0	33.3	14.3	25.0	50.0	0.0	23.8	100.0	25.0
Cost too much	16.0	66.7	0.0	0.0	14.3	31.3	0.0	20.0	23.8	0.0	21.4
Too far/no transport	8.0	33.3	0.0	0.0	14.3	12.5	0.0	0.0	14.3	0.0	10.7
No time to go	36.0	0.0	0.0	0.0	28.6	37.5	50.0	80.0	23.8	0.0	32.1
Family did not allow	16.0	0.0	0.0	33.3	0.0	18.8	0.0	20.0	14.3	0.0	14.3
Lack of knowledge	12.0	0.0	0.0	33.3	14.3	6.3	0.0	0.0	14.3	0.0	10.7
Others	20.0	33.3	0.0	33.3	0.0	25.0	50.0	20.0	23.8	0.0	21.4

Table 8: Sources of information about JSY by background characteristics (Percentages)

	Education status			Caste category				Income level			Total
	Illiterate	1-8	9+	SC	ST	OBC	General	≤1000	1001-2000	2001+	
Total number of JSY beneficiary interviewed	168	56	24	42	42	127	37	41	141	66	248
Time when heard about JSY											
Before being pregnant	8.9	12.5	33.3	7.1	9.5	10.2	27.0	14.6	9.2	16.7	12.1
During pregnancy	69.6	69.6	58.3	69.0	69.0	71.7	56.8	58.5	73.8	63.6	68.5
After delivery	20.8	16.1	8.3	23.8	21.4	16.5	16.2	26.8	16.3	18.2	18.5
Do not know/can't say	0.6	1.8	0.0	0.0	0.0	1.6	0.0	0.0	0.7	1.5	0.8
Sources of information of JSY *											
Radio	1.8	0.0	8.3	0.0	4.8	0.8	5.4	0.0	0.7	6.1	2.0
TV	0.6	0.0	4.2	0.0	0.0	0.8	2.7	0.0	0.0	3.0	0.8
Hoardings at SC/PHC	0.0	3.6	8.3	0.0	0.0	1.6	5.4	0.0	0.7	4.5	1.6
ASHA worker	22.6	28.6	25.0	19.0	28.6	26.0	18.9	22.0	22.0	30.3	24.2
Anganwadi worker	14.3	7.1	4.2	19.0	19.0	9.4	2.7	14.6	12.1	9.1	11.7
ANM	76.8	60.7	54.2	64.3	92.9	70.9	54.1	80.5	73.8	59.1	71.0
Doctor	12.5	14.3	20.8	16.7	0.0	15.0	21.6	9.8	13.5	16.7	13.7
Gram Panchayat	1.2	0.0	16.7	0.0	2.4	0.8	10.8	0.0	1.4	6.1	2.4
Parent, in-law, relatives	3.0	8.9	4.2	2.4	0.0	6.3	5.4	2.4	5.0	4.5	4.4
Others	6.0	16.1	8.3	14.3	4.8	4.7	18.9	0.0	9.2	12.1	8.5
Do not know	0.6	1.8	0.0	0.0	0.0	1.6	0.0	0.0	0.7	1.5	0.8

Table 9: Process of registration under JSY of the beneficiary by background characteristics (Percentages)

	Education status			Caste category				Income level			Total
	Illiterate	1-8	9+	SC	ST	OBC	General	<1000	1001-2000	2001+	
Total number of JSY beneficiaries interviewed	168	56	24	42	42	127	37	41	141	66	248
Person who registered respondent for JSY											
Doctor	10.8	19.6	37.5	16.7	7.1	15.9	21.6	4.9	13.6	25.8	15.4
LHV	0.6	0.0	4.2	2.4	0.0	0.0	2.7	0.0	0.7	1.5	0.8
ANM/FHW	74.3	64.3	45.8	69.0	78.6	68.3	62.2	78.0	74.3	53.0	69.2
Anganwadi worker	5.4	3.6	4.2	7.1	11.9	3.2	0.0	7.3	4.3	4.5	4.9
ASHA worker	8.4	10.7	4.2	4.8	2.4	11.1	10.8	9.8	6.4	12.1	8.5
Others	0.6	0.0	0.0	0.0	0.0	0.8	0.0	0.0	0.7	0.0	0.4
Do not know	0.0	1.8	4.2	0.0	0.0	0.8	2.7	0.0	0.0	3.0	0.8
Place where respondent was registered											
Dist./sub-district hospital	2.4	3.6	16.7	4.8	2.4	5.6	0.0	2.4	2.1	9.1	4.0
CHC	18.0	21.4	41.7	31.0	7.1	19.0	32.4	14.6	22.1	22.7	21.1
PHC	9.0	19.6	20.8	14.3	2.4	14.3	16.2	2.4	10.0	24.2	12.6
Subcentre	24.0	14.3	4.2	14.3	35.7	16.7	18.9	26.8	20.7	13.6	19.8
Anganwadi centre	16.8	17.9	4.2	9.5	23.8	16.7	10.8	22.0	14.3	15.2	15.8
At home	26.3	23.2	12.5	26.2	23.8	24.6	21.6	31.7	27.9	12.1	24.3
Others	3.6	0.0	0.0	0.0	4.8	3.2	0.0	0.0	2.8	3.0	2.4
Percent who got a JSY card	21.4	28.6	62.5	14.3	31.0	29.9	27.0	29.3	20.6	39.4	27.0
Percent showed JSY card to the interviewer											
Yes, JSY card seen	11.1	18.8	33.3	0.0	15.4	21.1	20.0	8.3	24.1	15.4	17.9
Yes have JSY card but not seen	88.9	81.3	66.7	100.0	84.6	78.9	80.0	91.7	75.9	84.6	82.1
Percent mentioning that ASHA worker helped in getting JSY card	44.4	62.5	40.0	33.3	53.8	50.0	40.0	41.7	41.4	57.7	47.8

Table 10: Motivation for institutional delivery among JSY beneficiaries by background characteristics (Percentages)

	Education status			Caste category				Income level			Total
	Illiterate	1-8	9+	SC	ST	OBC	General	≤1000	1001-2000	2001+	
Total number of JSY beneficiaries interviewed	168	56	24	42	42	127	37	41	141	66	248
Percent who delivered at institution	68.5	67.9	83.3	69.0	47.6	74.8	78.4	58.5	65.2	86.4	69.8
Motivation for opting for institutional delivery*											
Money available under JSY	53.9	60.5	60.0	51.7	75.0	56.8	44.8	58.3	62.0	45.6	56.1
Better access to institutional delivery services in the area	43.5	47.4	40.0	41.4	50.0	34.7	72.4	50.0	41.3	45.6	43.9
Support provided by ASHA	17.4	31.6	30.0	10.3	30.0	26.3	13.8	20.8	19.6	26.3	22.0
Support provided by health personnel	7.8	2.6	15.0	6.9	20.0	7.4	0.0	12.5	6.5	7.0	7.5
Previous child was born in an institution	7.8	5.3	15.0	0.0	15.0	8.4	10.3	4.2	7.6	10.5	8.1
Safe delivery of child/safety of both mother and child	5.2	2.6	5.0	10.3	10.0	3.2	0.0	0.0	6.5	3.5	4.6
Complicated delivery, had health problem, white discharge	8.7	7.9	0.0	3.4	5.0	7.4	13.8	4.2	8.7	7.0	7.5
Previous still birth/ miscarriage/ caesarian	5.2	2.6	5.0	6.9	0.0	4.2	6.9	4.2	2.2	8.8	4.6
Others	0.9	0.0	0.0	0.0	0.0	1.1	0.0	0.0	0.0	1.8	0.6
Do not know/can't say	0.9	0.0	0.0	3.4	0.0	0.0	0.0	0.0	0.0	1.8	0.6

* Multiple responses

Table 11: Difficulties faced in reaching place of delivery by background characteristics (Percentages)

	Education status			Caste category				Income level			Total
	Illiterate	1-8	9+	SC	ST	OBC	General	≤1000	1001-2000	2001+	
Number of JSY beneficiaries who had institutional delivery	115	38	20	29	20	95	29	24	92	57	173
Percent given a referral slip to help them access delivery services by ASHA or health personnel	6.1	0.0	5.0	6.9	0.0	5.3	3.4	4.2	3.3	7.0	4.6

Table 12: Process of arranging transport to reach health institution by background characteristics (Percentages)

	Education status			Caste category				Income level			Total
	Illiterate	1-8	9+	SC	ST	OBC	General	≤1000	1001-2000	2001+	
Number of JSY beneficiaries who had institutional delivery	115	38	20	29	20	95	29	24	92	57	173
Mode of transport used to reach the ultimate place of delivery*											
Auto rickshaw	3.5	15.8	5.0	6.9	0.0	7.4	6.9	0.0	5.4	10.5	6.4
Car/Jeep	61.7	50	75.0	55.2	55.0	62.1	65.5	62.5	60.9	59.6	60.7
Motor cycle/scooter	3.5	7.9	15.0	6.9	5.0	6.3	3.4	4.2	2.2	12.3	5.8
Bus	2.6	0	0.0	6.9	0.0	1.1	0.0	4.2	2.2	0.0	1.7
Bullock/Camel cart/chakda	4.3	5.3	0.0	6.9	10.0	3.2	0.0	8.3	4.3	1.8	4.0
Walking	18.3	13.2	5.0	13.8	25.0	14.7	13.8	16.7	18.5	10.5	15.6
Tempo/tractor	6.1	7.9	0.0	3.4	5.0	5.3	10.3	4.2	6.5	5.3	5.8
Persons who all facilitated in arranging the transport*											
ANM/Health worker	6.4	3.0	0.0	0.0	6.7	6.2	4.0	0.0	5.3	5.9	4.8
Anganwadi worker	2.1	0.0	0.0	0.0	0.0	2.5	0.0	5.0	1.3	0.0	1.4
ASHA worker	9.6	9.1	0.0	8.0	0.0	11.1	4.0	20.0	6.7	5.9	8.2
Family members	79.8	87.9	89.5	84.0	100.0	75.3	96.0	75.0	80.0	90.2	82.9
Panchayat members/SHGs	3.2	3.0	0.0	0.0	0.0	4.9	0.0	5.0	2.7	2.0	2.7
TBA	4.3	3.0	0.0	8.0	0.0	3.7	0.0	5.0	4.0	2.0	3.4
Others	3.2	0.0	10.5	4.0	0.0	4.9	0.0	5.0	5.3	0.0	3.4

* Multiple responses

Table 13: Persons accompanying JSY beneficiaries to the health institution by background characteristics (Percentages)

	Education status			Caste category				Income level			Total
	Illiterate	1-8	9+	SC	ST	OBC	General	≤1000	1001-2000	2001+	
Number of JSY beneficiaries delivered in institution	115	38	20	29	20	95	29	24	92	57	173
Persons who all accompanied JSY beneficiary to the health institution*											
ANM/Health worker	8.7	2.6	0.0	3.4	10.0	6.3	6.9	8.3	6.5	5.3	6.4
Anganwadi worker	5.2	0.0	0.0	3.4	10.0	2.1	3.4	4.2	5.4	0.0	3.5
ASHA worker	20.0	21.1	0.0	20.7	5.0	22.1	10.3	16.7	19.6	15.8	17.9
Husband	69.6	73.7	85.0	69.0	90.0	63.2	93.1	66.7	70.7	77.2	72.3
Mother	16.5	26.3	30.0	17.2	15.0	24.2	13.8	12.5	17.4	28.1	20.2
Mother-in-law	49.6	60.5	40.0	55.2	55.0	49.5	48.3	54.2	48.9	52.6	50.9
Neighbour or other	6.1	0.0	5.0	0.0	5.0	7.4	0.0	4.2	6.5	1.8	4.6
Other family members	54.8	42.1	65.0	48.3	40.0	56.8	55.2	37.5	56.5	54.4	53.2
TBA/dai	7.0	23.7	0.0	13.8	0.0	11.6	6.9	12.5	5.4	15.8	9.8

* Multiple responses

Table 14: Payments made for services at the health center by background characteristics (Percentages)

	Education status			Caste category				Income level			Total
	Illiterate	1-8	9+	SC	ST	OBC	General	≤1000	1001-2000	2001+	
Number of JSY beneficiary delivered in institution	115	38	20	29	20	95	29	24	92	57	173
Percent who paid for services at the health centre	65.2 (76)	55.3 (21)	75.0 (15)	48.3 (14)	65.0 (14)	61.1 (58)	89.7 (26)	54.2 (13)	63.0 (58)	70.2 (40)	64.2 (112)
Specific services for which were charged*											
Delivery/caesarean /Operation charge	56.6	81.0	46.7	64.3	57.1	55.2	69.2	69.2	53.4	65.9	59.8
Accommodation charge	13.2	9.5	0.0	14.3	0.0	12.1	11.5	30.8	3.4	14.6	10.7
Medicines/IV fluids	94.7	90.5	93.3	92.9	92.9	91.4	100.0	100.0	93.1	92.7	93.8
Food charges	14.5	4.8	6.7	14.3	7.1	13.8	7.7	30.8	6.9	12.2	11.6
Laboratory test	9.2	9.5	13.3	21.4	21.4	3.4	11.5	7.7	8.6	12.2	9.8
Paediatric care	3.9	0.0	0.0	0.0	0.0	1.7	7.7	0.0	3.4	2.4	2.7
Diagnostic/ sonography	9.2	4.8	20.0	28.6	0.0	6.9	11.5	23.1	3.4	14.6	9.8
Average total amount spent for the index delivery (in rupees)	1032.6	1158.3	2600.0	1645.5	1486.4	1095.0	1376.3	1425.0	801.3	1740.0	1277.6
Do not know	23.3	10.0	20.0	21.4	21.4	16.7	26.9	0.0	32.1	10.3	20.4

* Multiple answers

Table 15: Views about TBA among those who delivered at home and institute by background characteristics (Percentages)

	Education status			Caste category				Income level			Total
	Illiterate	1-8	9+	SC	ST	OBC	General	≤1000	1001-2000	2001+	
Total number of JSY beneficiaries interviewed	168	56	24	42	42	127	37	41	141	66	248
Percent opined that TBA can provide all necessary midwifery services	36.3 (61)	26.8 (15)	8.3 (2)	38.1 (16)	28.6 (12)	32.3 (41)	24.3 (9)	34.1 (14)	35.5 (50)	21.2 (14)	31.5 (78)
Reasons for preferring TBA *											
TBA is easily accessible	29.5	40.0	50.0	37.5	41.7	26.8	33.3	7.1	38.0	35.7	32.1
TBA charges less money	31.1	26.7	100.0	25.0	41.7	29.3	44.4	57.1	28.0	21.4	32.1
Traditionally has been conducting deliveries in the family	31.1	40.0	0.0	37.5	8.3	39.0	22.2	50.0	30.0	21.4	32.1
TBAs are better aware of the cultural practices and follows it	29.5	26.7	0.0	25.0	25.0	29.3	33.3	35.7	30.0	14.3	28.2
Better comfort level with TBA	32.8	20.0	0.0	31.3	16.7	34.1	22.2	28.6	28.0	35.7	29.5
Others	1.6	6.7	0.0	6.3	0.0	2.4	0.0	0.0	2.0	7.1	2.6

* Multiple responses

Table 16: Payment made to JSY beneficiaries by background characteristics (Percentages)

	Education status			Caste category				Income level			Total
	Illiterate	1-9	9+	SC	ST	OBC	General	≤1000	1001-2000	2001+	
Number of JSY beneficiary	168	56	24	42	42	127	37	41	141	66	248
Percent received JSY cash incentive for delivery	84.5	83.9	87.5	85.7	92.9	79.5	91.9	90.2	83.0	84.8	84.7
Time when received the money											
Much before the delivery	3.5	6.4	0.0	0.0	0.0	6.9	2.9	8.1	1.7	5.4	3.8
Within a week before the EDD	0.7	0.0	0.0	0.0	0.0	0.0	2.9	0.0	0.9	0.0	0.5
Immediately after the delivery	11.0	2.1	23.8	11.1	10.3	11.9	5.9	13.5	9.4	10.7	10.5
Within a week after the delivery	21.0	27.7	38.1	27.8	17.9	22.8	32.4	24.3	20.5	32.1	24.3
Much later	62.0	63.8	38.1	58.3	71.8	58.4	52.9	54.1	66.7	50.0	60.0
Others	1.4	0.0	0.0	2.8	0.0	0.0	2.9	0.0	0.9	1.8	1.0
Person who gave the cash incentive to JSY beneficiary											
ANM	66.0	53.2	38.1	63.9	71.8	52.5	67.6	81.1	61.5	44.6	60.5
CHC/PHC doctor/MO	19.2	21.2	9.5	27.8	7.7	24.8	2.9	0.0	0.0	3.6	1.0
ASHA	0.7	0.0	4.8	0.0	0.0	1.0	8.8	10.8	22.4	19.6	19.6
At Health Centre	3.5	17.0	23.8	2.8	7.7	9.9	11.8	2.7	6.8	16.1	8.6
Panchayat	1.4	2.1	0.0	0.0	7.7	0.0	0.0	0.0	1.7	1.8	1.4
Accountant	2.1	2.1	9.5	0.0	0.0	4.0	5.9	0.0	1.7	7.1	2.9
Others	2.8	4.3	14.3	2.8	2.6	5.9	2.9	5.4	4.3	3.6	4.3
Do not know	2.8	0.0	0.0	2.8	2.6	2.0	0.0	0.0	1.7	3.6	1.9
Place where received cash incentive money											
Place of delivery	18.0	27.7	57.1	30.6	15.4	27.7	17.6	21.6	20.5	33.9	24.3
At the PHC	9.9	10.6	4.8	11.1	2.6	13.9	2.9	8.1	10.3	8.9	9.5
Within the village	18.0	6.4	4.8	5.6	33.3	10.9	8.8	16.2	16.2	7.1	13.8
At home	28.0	23.4	9.5	30.6	17.9	21.8	35.3	45.9	18.8	23.2	24.8
CHC	11.0	14.9	14.3	13.9	2.6	13.9	14.7	0.0	15.4	12.5	11.9
Sub-centre	6.3	10.6	4.8	2.8	15.4	3.0	14.7	8.1	7.7	5.4	7.1
Camp	7.0	4.3	4.8	2.8	12.8	5.9	2.9	0.0	7.7	7.1	6.2
Do not know	2.8	2.1	0.0	2.8	0.0	3.0	2.9	0.0	3.5	1.8	2.4
Average amount received by JSY beneficiary	784.4	789.4	733.3	832.4	621.1	809.9	818.5	818.5	801.4	773.2	780.3

Table 17: Difficulties faced by JSY beneficiaries in getting cash incentive for delivery by background characteristics (Percentages)

	Education status			Caste category				Income level			Total
	Illiterate	1-9	9+	SC	ST	OBC	General	≤1000	1001-2000	2001+	
Number received JSY cash incentive for delivery	142	47	21	36	39	101	34	37	117	56	210
Responses on the sufficiency of cash incentive											
Sufficient	57.4	33.3	36.1	43.6	49.5	58.8	42.7	40.5	47.9	51.8	47.6
Somewhat sufficient	27.7	47.6	38.9	46.2	34.7	26.5	38.5	40.5	39.3	26.8	36.2
Not sufficient	14.9	14.3	19.4	7.7	14.9	11.8	14.6	13.5	11.1	19.6	13.8
Do not know / can't say	0.0	4.8	5.6	2.6	1.0	2.9	4.1	5.4	1.8	1.8	2.4
Ways money received under JSY was utilized*											
Purchased consumables for the family	39.4	40.4	33.3	33.3	43.6	36.6	47.1	35.1	39.3	41.1	39.0
Bought medicines/tonics for self and child	31.7	46.8	71.4	30.6	30.8	46.5	35.3	37.8	34.2	50.0	39.0
Used for medical expenses for delivery	1.4	2.1	0.0	0.0	0.0	2.0	2.9	2.7	0.9	1.8	1.4
Husband took it away	29.6	19.1	9.5	36.1	28.2	22.8	17.6	24.3	29.9	16.1	25.2
Did not spend money	6.3	6.4	4.8	2.8	7.7	4.0	14.7	2.7	7.7	5.4	6.2
Use of self nutrition/fruit	28.9	19.1	28.6	22.2	30.8	25.7	29.4	37.8	24.8	23.2	26.7
Others	0.7	4.3	0.0	0.0	5.1	1.0	0.0	0.0	0.9	3.6	1.4
Do not know / can't say	1.4	0.0	4.8	2.8	2.6	1.0	0.0	2.7	1.8	0.0	1.5

* Multiple responses.

ANNEXURE 2

Government of Rajasthan
Directorate of Medical, Health and Family Welfare
Swasthya Bhawan, Tilak Marg, Jaipur

Office Orders

National Rural Health Mission (NRHM) has been launched to address the health needs of rural population especially the vulnerable sections of societies. One of the major components of NRHM is deployment of large taskforce of volunteers at grass root level named as ASHA- Sahyogini (Accredited Social Health Activist). She will be the link between the community and health institutions.

ASHA Sahyogini is a voluntary health activist selected by and responsible to the Gram Sabha. She is envisaged at village levels, on a population of 1000; analogous to the Anganwadi jurisdiction. Since she is expected to receive performance-based emoluments from different Departments of the Government, it is important that all these Departments are involved in finalizing the policy/mentoring framework of ASHA Scheme.

The Mentoring Group is constituted at state level for strengthening ASHA- Sahyogini Programme. This group will oversee the implementation of the scheme and facilitate in developing the policy guidelines. It will act as a think - tank for the programme, also provide technical inputs, and support mechanism.

The members of ASHA Mentoring Group shall comprise of the following:

1. Mission Director - NRHM Chairperson
2. Director - DWCD
3. Director - PRI
4. Director - Rural Development
5. Director - PHED
6. Director- PH
7. Director -RCH,
8. Director - AIDS
9. Director - SIHFW
10. Additional Director, NRHM
11. Representative of RVHA, URMUL, ARTH, Seva Mandir, EKAT, Prayas
12. Representatives of UNFPA, UNICEF and EC
13. Director - State Resource Center - ASHA Resource Center - Convener

The Mentoring Group will meet at least once in three months to review and provide inputs for the ASHA- Sahyogini Intervention.

Additional Director - NRHM

No. Dated-

Copy to -

1. P.S. to Principal Health Secretary
2. Secretary, FW and Mission Director - NRHM
3. All concerned member as above
4. Director- SRC- ASHA Resource Center- with the request to act as a facilitator for Mentoring Group

Additional Director - NRHM

1 Mission Director - NRHM Chairperson
Directorate of Medical & Health Services Rajasthan
Swasthya Bhawan, Jaipur.
Contact No. 0141-2227722

2 Director - DWCD
Directorate of Women & Child Development Department
Behind Govt. Sr. Sec. Girls School, Gandhi Nagar.
Rajasthan Jaipur.
Contact Person - Anurag Bhadwaj
Contact no. 0141-2705561, 2702243, 94140-71933

3 Director - PRI
Directorate of Panchati Raj
Rajasthan Jaipur.
Contact No.

4 Director - Rural Development
Directorate of Rural Development Department
Contact No. - 0141-2227915

5 Chief Engineer
Public Health Engineering Department (PHED)
Jal Bhawan , Near Railway Hospital, NBC Road Jaipur.
Contact Person & No. - 0141-2222053

6 Dr. O.P. Gupta
Director- PH
Directorate of Medical & Health Services Rajasthan
Swasthya Bhawan , Jaipur.
Contact No. - 0141-2229858, 9829333936

7 Dr. S.P. Yadav
Director -RCH,
Directorate of Medical & Health Services Rajasthan
Swasthya Bhawan , Jaipur.
Contact No. - 0141-2228707, 9414-016297

8 Dr. Satish Sharma
Director - AIDS,
Directorate of Medical & Health Services Rajasthan
Swasthya Bhawan , Jaipur.
Contact No. - 0141- 2223326, 9414-220624

9 Dr. Shive Chand Mathur
Director - SIHFW , Jhalana Institutional Area
Near Doordarshan Kendra Jhalana
Rajasthan Jaipur.
Contact No. 0141- 2701938, 2706534

10 Dr. S.P. Sharma
Additional Director- NRHM,
Directorate of Medical & Health Services Rajasthan
Swasthya Bhawan , Jaipur.
Contact No. 9414-371357

11 Representative
Rajasthan Voluntary Health Association (RVHA)
A-12 Mahaveer Udhyan Path, Bajaj Nagar,
Rajasthan Jaipur
Contact Person & No. Satyen Chaturvedi 0141- 2708006, 2706601

12 Representatives
United Nations Population Fund (UNFPA)
Shri Ram Pura Colony Opp. CM Residence
Rajasthan Jaipur
Contact No. 0141-2200028

13 Representatives
UNICEF
B-9 Bhavani Singh lane, Bhawani Singh Road,
Rajasthan Jaipur.
Contact No.0141-

14 Representatives
ARTH Society
39, Fatehpura, Udaipur.
Contact Person & No. Dr. Sharad Ayyangar 0294-2451066

15 Representatives
EKAT Bodh Gram
70/169, Patel Marg Maansarover Jaipur
Contact Person & No. Dr. Satyen Chaturvdei , 0141-2784443, 9414-076449

16 Representatives
PRAYAS
B-8 , Bapu Nagar, Saithi Chittorgarh
Contact Person & No. Pallavi Gupta , 01472-243788, 250044

17. Representative
URMUL Trust
Urmul Dairy Campus near New Bus Stand, Bikaner
Contact No.- Arvind Ojha 0151-2523093, 2545097, 9414-137093

18 Representative
Seva Mandir Trust, Purana Fatepura
Udaipur.
Contact Person & No. - Neelima Khatan , 0294-2450960,

19 Director,
State Resource Center
7 - A , Jhalana Institutional area
Near Doordarshan Kendra Jaipur
Contact Person & No. - Shri Anil Roongta, 0141-2707602, 9829064615

20 Dr. Kumkum Shrivastava (EC-SIP)
IInd Floor, Swathya Bhawan,
Directorate of Medical & Health Services Rajasthan
Swasthya Bhawan , Jaipur.
Contact No.-

ASHA Resource Center for providing support to ASHA Programme at State level

Introduction -The Government of India and Government of Rajasthan has launched the National Rural Health Mission (NRHM) to address the Health needs of rural population especially the vulnerable sections of societies. 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 5000, but is effectively serving much larger population.

Currently Anganwadi workers under Integrated Child Development Scheme (ICDS) are engaged in organizing supplementary nutrition programmes and other supportive activities. The very nature of her job responsibility does not allow her to take up the responsibility as change agent on health in a village. Thus, a new band of community based functionaries, named as ASHA (Accredited Social Health Activist) is proposed to fill this void.

ASHA will be the first port of call for any health related demands of deprived sections of the population, especially women and children, who find it difficult to access health services. She will be the link in between the community and health institutions.

ASHA is a voluntary health worker selected by the community through Gram Sabha on the population of 1000; however, the selection criterion in tribal and desert area is 500. ASHA will not get any monthly honorarium but will get the performance-based incentives. The detailed compensation package is worked out at state level

Status of ASHA intervention in the State - As per the guidelines, initially around 43,000 ASHAs will be selected in the rural areas of the State. In the State, more than 31,000 ASHAs have been selected through Gram Sabhas. Initially the training of 23 days in 5 rounds in a year (7 + 4+ 4+ 4+ 4 Days) will be given to ASHA. Second year onwards refresher training will be given to the ASHAs. The training module for first round of training is developed and State level, District level and Block level trainings of trainer completed with the technical support of SIHFW.

Need for ASHA Resource Center - ASHA is at the base of NRHM pyramid and National Rural Health Mission is looking at ASHA as a change agent in Health Sector Reform. She will play a vital role in improving the health indicators of the State especially IMR and MMR. She will also facilitate the improvement in service off take of the healthcare institutions.

The State of Rajasthan is spread over a large geographic area with religious, social, cultural, economic variations, so implementation of ASHA component in the state is a challenging task. In this context, it is very important to provide technical inputs and

strong supportive mechanism to the programme so that expected results can be achieved.

State Project Management Unit is established at state level under Mission Director NRHM. SPMU is working as a technical and administrative body to implement the activities of NRHM in the State. ASHA Resource Center (ARC) is conceptualized to improve the quality of the programme. This Center will be established at state level and will work under direction of Mission Director of NRHM

Functions of the ASHA Resource Center -

1. Technical backstopping in Training - The training of ASHAs is planned for 23 days in a year with refresher trainings every year. ARC will develop user-friendly training methodology and the training modules, print the modules in prescribed time, and disseminate the modules in the District. The modules are being developed by MOHFW; GOI .These will be modified in the state context based on functions of ASHA. ARC will also work on the training modalities and will provide the supportive supervision to maintain quality checks and control at District and Block level.

2. Development of IEC material - ARC will be responsible for developing or collecting the IEC material from different agencies for dissemination during the training. The facilitation kit including flipbooks, chart, posters etc on different related issues will be developed and disseminated. Need based IEC material will be developed from time to time.

3. Planning of bi -monthly Meetings - It is planned to conduct bi - monthly meeting of ASHAs at block level to resolve day -to -day functional problems faced by ASHA and to ensure the progress of the activities conducted by ASHA. It is very important to revise the concepts and contents to improve the learning process. The topics covered during the training will be revised in the bi - monthly meeting. ARC will develop tentative monthly agenda for the monthly meetings; provide required resource material and IEC material. It will develop the monitoring mechanism for the meetings.

4. Development of Reporting formats and registers - ASHA is envisaged as a voluntary worker and to facilitate her work some very easy and basic reporting formats and registers will be developed. The registers and the formats will be used by ASHA only to streamline her priorities. ARC will develop the formats and will orient ASHA for its utility and use.

5. Processing of Statistical Data and records - Based on reports and registers of ASHA and other sources of data's. ARC will compile the statistical data, analyze the data and provide the feedback of the programme to the Mission.

6. Intersectoral Coordination pertaining to ASHA - ASHA is conceptualized as a volunteer responsible for the Health needs of the particular village, Dhani or Mohalla. The credibility of ASHA in the community could be used by other

Development Departments to promote their objectives. ARC will coordinate with different departments and facilitate empanelment of ASHAs in various other programmes like Sarva Shiksha Abhiyan, Total Sanitation Programme etc.

7. Involving NGOs to strengthen the programme – Involvement of NGOs is an important task in the implementation of ASHA programme. NGOs could support the ASHA to work at community level or to develop capacities of ASHA etc. There could be many roles of NGOs and the ARC would identify these roles. In consultation of NRHM, the NGOs should be involved in the programme.

8. Provision of Drug Kits – ASHA will provide the basic medical care to the community. The drug kit with basic medicines and supplies will be provided to all the ASHAs under NRHM. The drug Kit will consist of allopathic as well as Ayush medicines. ASHA will charge the user fees from the community. Initially the drug Kits are being provided by GOI. It may need state level modification / supplementation. In such case, ARC will facilitate the procurement process and supply it to ASHA. This is not one time activity and regular stocks should be available with ASHA. ARC will develop the mechanism to maintain at least two months stock of medicines with ASHA.

9. Formation of VHC and VHT – NRHM is promoting the down – up approach for implementation of different health programmes. It is proposed to form Village Health Societies and Village Health Teams to address the health needs of the Village. ASHA will be one of the important members of VHC and VHT. ARC will be responsible for capacity building of ASHA so that ASHA could help in planning and implementation of Health Programmes in the Village.

10. Organize Monthly meeting of Mentoring Group – A Mentoring Group will be constituted to provide overall guidance to the programme and act as a think – tank for the programme. The mentoring group will provide technical inputs and support mechanism. ASHA Resource Center will conduct the monthly meetings of the mentoring group and incorporate the valuable inputs provided by the group in the programme.

11. Provision of services of Helpline – ASHA in near future will work in entire state. There will be more than 50,000 ASHAs in the rural and urban areas of the State. Time to time trainings or monthly meetings may not suffice the need of the ASHA. So the ARC will form the helpline for the ASHA and associated functionaries. ARC will respond to the queries or clarifications needed in the field. ARC will ensure that the prompt help is provided to ASHA.

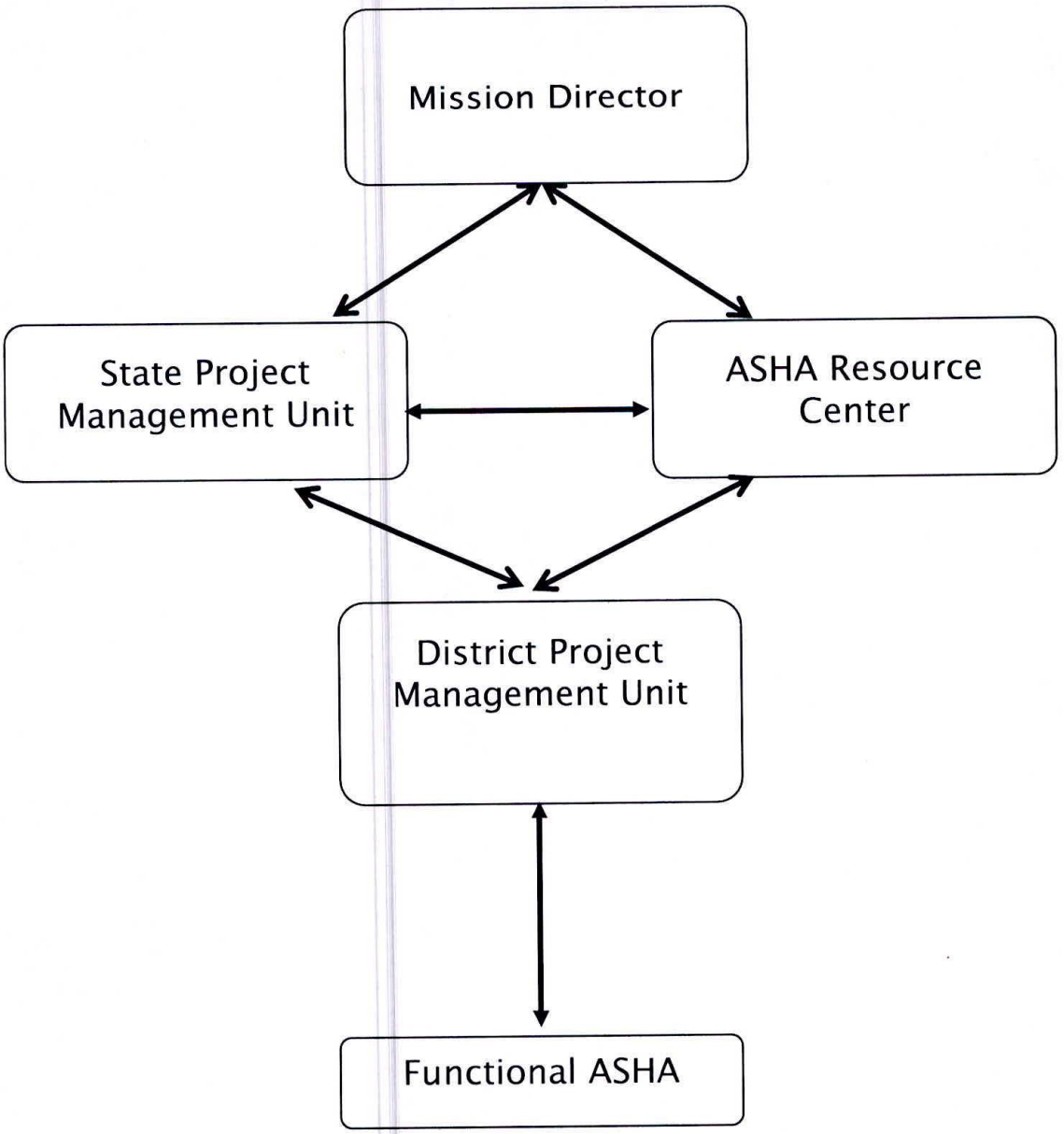
12. Organizing ASHA Sammelan, Exposure visits – There will be Sammelans at State level, Zonal level and District level to share the experiences of ASHA and for cross learning's. ARC will organize such events with the help of State Society and district Society. ARC will also organize the exposure visits with in the state and outside the state.

13. Facilitation of Focused Group Discussion in Villages - Focus group discussion is a tool, which will be used for the assessment of the needs of the community and ASHA. ARC will make a planning for Focused group discussion, organize it with the NGO and prepare the requirement of the ASHA as well as Community.

14. Other issues related to the functioning of ASHA - Some of the functions of ARC is mentioned above. The role of ARC is multifaceted and visualized in broader sense. The functions of ARC could be revised as per the need and requirement of the programme. Some new roles could also be incorporated.

Linkages of ASHA Resource Center - ASHA resource Center is a Hub for ASHA Component under NRHM, which will work in close association with Mission Director-NRHM. The administrative control on the ARC will be of the outsourced agency, but the Mission Director will be involved in major decisions like recruitment of professionals, budget etc however day to day functioning will be the responsibility of outsourced agency. ARC will provide support to the districts through NRHM and all the administrative guidelines will be issued through NRHM.

Flow Chart for linkages of ASHA Resource Center



Approved Budget Provisions for ASHA Resource Center

No.	Activity	Tentative Budget
1.	Personnel component • Project Officer - !8,000/- X 12 = 2,16,000 • Data Assistant -11,000/- X 12 = 1,32,000 • Office attendant - 2000/- X 12 = 24,000/- (all should be hired through an Agency)	Rs 3,72,000/- + agency charges 5 percent 18,600/- Total Cost-3,90,600/-
2.	Office Expenses Telephone, Photostats, stationary	Rs. 1,00,000/-
3.	Development of training modules, IEC material, reporting formats, monitoring formats, Resource material for bimonthly meeting • Development of training modules- 5 Sets of 2 books - Rs.30,000/- per book i.e 3,00,000/- • Development of IEC material Rs. 2,20,000/- • Development of Reports and formats, monitoring formats, Rs.1,00,000/- Development of resource material forbid - monthly meeting @ 15,000/- - Rs- 90,000/-	Rs.7, 10,000/-
4.	Monitoring and Supervision and NGO support Approx. 10,000 per district	Rs. 3,20,000/-
5.	Operational Research and Documentation	Rs. 1,00,000/-
6.	ASHA Sammelan and Exposure Visit	Rs. 2,00,000/-
7.	Contingency	Rs. 1,00,000/-
8.	Workshops and seminars	Rs. 3,00,000/-
9.	Total	Rs. 22,20,600/-