Fostering Health awareness through Communication
An analytical case study of Accredited Social health Activist (ASHA)

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Abstract
Realizing the complexity of health behavior which, in the case of Indian Society, is largely guided by informal but deep-rooted socio-cultural values, the country has adopted such measures which the people voluntarily accept to keep them healthy.Thus; the process of motivation of the people is attempted through by media and interpersonal communication. In the matter of health communication, the Ministry of Health and family Welfare at the central and state level is primarily responsible for policy planning and implementation. In rural area the central government initiated National Rural Health Mission for the development of better health of the people. One of the key components of the NRHM is to provide every village in the country with a trained female health activist. It works as an interface between the community and the public health system.

Area of Research
This case study attempts to analyze ASHA activities in the area of the health development, including its work in disseminating the information on training courses and capacity building activities in the rural areas.

Introduction
Communication and Development
Communication role in the development process cannot be underestimated. Obviously in developing communities which are characterized by isolation from ideas, information and services, its contribution is of high significance. It is also a fact that it cannot be effective alone, without practical changes in social, political and organizational changes. Hence, the development projects have direct relationship with communication for their success or failure (M.P.Jahagirdar). Communication and development are the major domains of human endeavor which are intimately linked with each other. Therefore, when we are revising our ideas about development, it is also necessary to think about the appropriate kind of communication (Victor S.D'Souza). Development communication is the process of intervening in a systematic or strategic manner with either media (print, radio, telephony, video and the internet), or education (training, literacy, schooling) for the purpose of positive social change. The change could be economic, personal, as in spiritual, social, cultural, or political.

Methodology
Qualitative methodology has been used for this study. Analytical Case study method has been conducted for critically analyzing the role of ASHA's in propagating health communications and the various types of health activities for the development of the rural areas. Mostly secondary data from government sites has been taken for the study.

Tools of Data Collection
By Content Analysis the data has been analyzing and taken. This method has provided an update on ASHA activities in the area of the health development, including its work and information on training courses and capacity building activities in the rural areas.

Research questions
Besides some, research questions have been answered in the study findings. These are -
1) What is the support mechanism for ASHA?
2) What is the funding support mechanism of ASHA?
3) What is the role of minutes of ASHA monitoring group?
4) How they act like counselors in facilitating immunization, ante natal check up(ANC), post natal check up, supplementary nutrition, sanitation etc?
5) How they will provide health information and in what basis?

The Importance of Communication in Healthcare
Communication refers to the transmission or exchange of information and implies the sharing of meaning among those who are communicating. Communication serves the purposes of (U.S. Office of Disease Prevention and Health Promotion, 2004):
1) Initiating actions
2) Making known needs and requirements
3) Exchanging information,ideas,attitudes and beliefs
4) Engendering understanding and/or
5) Establishing and maintain relations
Communication, thus, plays an integral role in the delivery of healthcare and the promotion of health. According to Healthy People 2010 guidelines, health communication encompasses the study and use of communication strategies to inform and influence individual and community decisions that enhance health. It links the domains of communication and health. Health communication encompasses the study and use of communication strategies to inform and influence individual and community knowledge, attitudes and practices (KAP) with regard to health and healthcare. The field represents the interface between communication and health and is increasingly recognized as a necessary element for improving both personal and public health. Health communication can contribute to all aspects of disease prevention and health promotion. The most obvious application

of health communication has been in these areas of health promotion and disease prevention. Research has uncovered improvement of interpersonal and group interactions in clinical situations (for example, between provider and patient, provider and among members of a healthcare team) through the training of health professionals and patients in effective communication skills.

Health communication has become an accepted tool for promoting public health. Health communication principles are often used today for various disease prevention and control strategies including advocacy for health issues, marketing health plans and products, educating patients about medical care or treatment choices and educating consumers about healthcare quality issues. At the same time, the availability of new technologies and computer-based media is expanding access to health information and raising questions about equality of access, accuracy of information, and effective use of these new tools.

The many roles that health communication can play have been highlighted by the centers For Disease Control and Prevention. These roles include:-

- Increase knowledge and awareness of health issue, problem or solution
- Influence perceptions, beliefs, attitudes and social norms
- Prompt action
- Demonstrate or illustrate skills
- Show the benefit of behavior change
- Increase demand for health services
- Reinforce knowledge, attitudes and behavior
- Refute myths and misconceptions
- Help coalesce organizational relationships
- Advocate for a health issue or a population group

Health Communicator and the Process of Communication:-

Communications systems are the formal or informal structures organizations use to support their communication needs. A communication system involves people, the messages they wish to convey, the technologies that mediate conversations, and the organizational structures that define and constrain the conversations that are allowed to occur. Elements of communication systems include (Dr E Coiera):

Communication channel: The channel is the 'pipe' along which a message is conveyed, and there are a wide variety of different communication channels available, from basic face-to-face conversation, through to telecommunication channels like the telephone or e-mail, and computational channels like the medical record. Channels have attributes like capacity and noise, which determine their suitability for different tasks. When two parties exchange messages across a channel at the same time, this is known as synchronous communication. Telephones are one of the commonest two-way synchronous channels. It is the nature of synchronous communication that it is interruptive, and these interruptions may have a negative impact on individuals who have high cognitive loads. For example, a busy clinician may forget to carry out a clinical task because they have been interrupted while they are busy. In contrast, when individuals can be separated in time, they may use an asynchronous channel to support their interaction. Since there can be no simultaneous discussion, conversations occur through a series of message exchanges. This can range from Post-it notes left on a colleague's desk, to sophisticated electronic messaging systems. One of the benefits of asynchronous communication is that it is not inherently interruptive, and if a communication is not urgent, asynchronous channels may be a preferred way of communicating with otherwise busy individuals.

Types of message: Messages are structured to achieve a specific task using available resources to suit the needs of the receiver. Informal messages, which have variable structures, include voice and e-mail messages. Structured or formal messages include hospital discharge summaries, computer-generated alerts and laboratory results. When these messages are computer generated, they typically will be in a format that complies with a standard, and the HL7 standard is now arguably the international de facto messaging standard within healthcare.

Communication policies: A communication system can be bounded by formal procedure rather than technology, e.g. clinical handover. A hospital may have many different policies that shape their communication system performance, independent of the specific technologies used. For example, it might be a policy to prohibit general practitioners to obtain a medical record directly from the records department without the permission of a hospital clinician.

Agents: A communication system can be specifically constructed around the agents involved in the different information transactions. For example, in a busy clinical unit, one could devise a system where a ward clerk can be tasked to field all incoming telephone calls. The clerk's specific communication role is thus an organizational structure created in support of a policy to minimize interruption to clinical staff, who might otherwise have to answer the phone. Agents have attributes like their understanding of specific tasks and language.

Communication services: Just as computer systems can run a number of different software applications, we can think of a communication system providing a number of different communication services. Thus voice communication is only one of the many services available across a telephone line. Fax transmission of documents is an entirely different kind of service that uses the same underlying channel. For example, a mobile phone may provide voice-mail, text messaging.

Communication device: Communication services can run on different communication devices. Examples of devices in-

clude the telephone, fax machine, and personal digital assistant (PDA). Different devices are suited to handle different situations and tasks. Communication devices are a source of continuing innovation, and will continue to evolve. One area of recent interest has been the area of wearable computing, where devices are small enough to become personal accessories like wristwatches or earrings.

Interaction mode: The way an interaction is designed determines much of the utility of different information systems, and this is just as true for communication systems. Some modes of interaction for example, demand that the message receiver pays attention immediately, such as the ringing tone of a phone, while others can be designed to not interrupt. An asynchronous service that is inherently not interruptive, like e-mail, may still be designed with an interruptive interaction mode, such as the ringing of a computer tone when a message arrives, altering the impact of the service on the message receiver.

Security protocol: In health care, patient privacy concerns make it important that unauthorized individuals do not access clinical records. To protect privacy, messages can be scrambled or 'encoded' as a means to prevent unauthorized individuals intercepting and interpreting them. For example, mobile phone conversations can be scrambled to protect unauthorized eavesdropping, and reports of medical investigations sent by e-mail can similarly have their contents encrypted. Only those with access to systems that understand the encoding, for example, through the possession of a 'key', should be able to read them. A widely available public method for encoding messages is through use of the Public Key Infrastructure. As is now widely known, there are always individuals with the time and capacity to try and 'hack' security protocols and read privileged information. Fortunately, most important communications typically have extremely strong security protocols that are exceedingly hard to be cracked. For example, internet banking systems are only possible because customers have faith that system security is for practical purposes impenetrable. The use of similar encryption methods in healthcare will typically afford the same degree of protection, and confidence in the system. The choice of security protocol used will reflect the degree of risk associated with unauthorized access to message content.

Review of Literature

1.A literature review was conducted to review work done on measuring health related stigma. References were obtained through a Pub med (Medline) and Science Direct Search and through examining relevant bibliographies by WimH. VanBrakel.

The studies reviewed indicate that stigma related to chronic health conditions such as HIV/AIDS, leprosy, tuberculosis, mental health and epilepsy is a global phenomenon, occurring in both endemic areas. Stigma has a severe impact on individuals and their families, as well as on the effectiveness of public health programmes. Despite enormous cultural diversity across the world, the areas of life affected are remarkably similar. They include marriage, interpersonal relationships, employment, education, mobility, leisure activities and attendance at social and religious functions. This suggests that development of generic instruments to access health related stigma may be possible. Data obtained with such instruments would be useful in situational analysis, advocacy, monitoring and evaluation of interventions against stigma and research to better understand stigma and its determinants.

The conclusions from this review that:

The consequences of stigma affect the quality of life of individual as well as the effectiveness of public health programmes.

1. The similarity in the consequences of stigma in many different cultural settings and public health fields suggests that it would be possible to develop a generic set of stigma assessment instruments.

2. Enhancing women empowerment through information and communication technology by VAPS to department of women and child development.

Information needs of women in the new globalized environment are as diverse as the socio economic scenario. Treating women, as a monolithic group will over simplify their information needs. Within women's group itself, globalization has created the haves and the have not's i.e. those who are in an advantageous position due to globalization and those relegated further into disadvantaged position under the new economic policy.

The conclusion from this review is that:

The urban educated woman need information mainly pertaining to:-

a. Legal rights and provisions against social injustice, domestic violence, dowry system etc.

b. Health services including sexual reproductive health.

3. Empowerment of Panchayati Raj Institutions on health issues through electronic media: A pilot project in Karnataka by T.V.SEKHER.

The objective of this study is:

a.To educate and sensitize members of the Panchayati Raj institutions on issues such as population, health, and social development through the electronic media in Karnataka.

b.To utilize the electronic media to reach the larger audience of opinion makers of rural communities such as Panchayati Raj members, health workers, Anganwadi workers, Non-Govt. Organizations in Karnataka.

The conclusion from this review is that:

The active involvement of NGO's in the project areas helped ensure the participation of Gram Panchayat mem-

bers. This study also illustrated that television could be used as a powerful and effective medium for training Panchayat members in our country. The state government might take up this methodology, after making necessary adaptations while planning their future training programmes.

Broad Health Communication Structures in India:

Realizing the complexity of health behavior which, in the case of Indian Society, is largely guided by informal but deep-rooted socio-cultural values, the country has adopted such measures which the people voluntarily accept to keep them healthy. Thus; the process of motivation of the people is attempted through by media and interpersonal communication. The health communication structure in the country that exists at the national and state level varies marginally (see chart). However, the communication infrastructure is controlled by both, government and private sector. The former has the absolute control over mass media, particularly electronic media; while the latter controls newspapers, film industry and advertising. The boundary of powers and roles of central and state governments in the matters of communication policy and planning are defined under the constitution of the country. In the matter of health communication, the Ministry of Health and Family Welfare at the central and state level is primarily responsible for policy planning and implementation, of course , through the ministry of Information and Broadcasting at the national level; and through Directorate of Information and publicity at the state level.

There are a variety of ways in which mass media can promote ill health these are:

(i) Through advertising products which affect health

(ii) Through publishing information which demonstrate health risks attached to certain products

(iii) Through decrying warnings of danger, and

(iv) Through encouraging inadvertently the use of products by actively supporting similar but less dangerous substances.

Broad Framework of Health Communication in India:

Level	Policy planning agency	Implementing agency
Central	Ministry of Health and Family Welfare	Mass Media Unit (Directorate General of Health Services),(Central Health Education Bureau)
State	Ministry of Health	Director-ate of Health Services),(State Health Education Bureau, Family Planning Bureau)
District	District Health Office	District Health Education unit(District Mass Media and Education Officer)
	District Publicity Office	District Publicity Officer
Primary health centre/peripheral level	District Health Office	Block Extension educator Auxiliary Nurse Midwife Multipurpose Health Worker Community Health Volunteer

Health Communication: A Strategy

Health development and communication development are closely interlinked and mutually interdependent. In the country like India the communication strategy needs to be developed in a manner that can cater to the needs of diverse groups based on social and cultural background. Merely by transferring health information to the people through mass communication alone will not bring health development. The goal of achieving health behavior change should be a central point of communication strategy which needs to be operated in the spirit. Health communicator, therefore.Should have the following components of activities if it is directed to achieve behavioral change.

1. **Assess the needs of the community: different target groups**
2. **Assess the local resources available to meet these needs**
3. **Assess the areas of likes and dislikes of the people towards types of communication**
4. **Generate need of the programme**
5. **Provide scientific, specific and basic information**
6. **Build up attitudinal change and assess its extent**
7. **Create atmosphere to act for decision**
8. **Confirm the extent of action**
9. **Provide support to sustain action**

In the new situations where the role of communicator is not as a transmitter of knowledge, he has to widen the boundaries of his roles thus performing a role of Social Activist or the change. Although communication is a specialized science it can be enriched by integrating fundamental elements of social sciences which can offer communicator realm of knowledge that may make him

sensitive to social values, social needs and social dynamics of the community. The communicator for the health field has to work and for the people. Therefore, he cannot afford to ignore the forces that either integrate or disintegrate the community. (A.B.Hiramani and Neelam Sharma).

NRHM-

National Rural Health Mission launched in April 2005 by government of India. It aims to providing government's commitment to meet people's aspirations for better health and access to healthcare services. The scheme is fully funded by central government. The scheme aims to provide the valuable healthcare services in rural households. Better health is central to human happiness and well being. It also makes an important contribution to economic progress, as healthy populations live longer, are more productive and same more. This tries to make sense of these complex links. It is concerned with the impact of better health on development and poverty reduction, and conversely, with the impact of development policies on the achievement of health goals. In particular, it aims to build support across government for higher levels of investment in health, and to ensure that health is prioritized within overall economic and development plans. In the context, health and development work supports health policies that respond to the needs of the poorest groups. ASHA also works with donors to ensure that aid for health is adequate, effective and targeted at priority health problems. One of the key components of the NRHM is to provide every village in the country with a trained female community in health activist. Selected from the village itself and accountable to it, the ASHA will be trained to work as an interface between the community and the public health system. NRHM provides for engagement of ASHA for every 1000 population to serve as a link between the community and the public health system.

It specially focuses on 18 states of our country.

1) Arunachal Pradesh
2) Assam
3) Chhattisgarh
4) Himachal Pradesh
5) Jharkhand
6) Jammu & Kashmir
7) Madhya Pradesh
8) Mizoram
9) Manipur
10) Meghalaya
11) Nagaland
12) Orissa
13) Rajasthan
14) Sikkim
15) Tripura
16) Uttar Pradesh
17) Uttarakhand
18) West Bengal

Health Scenario in Rural India:-

The constitution of India envisages the establishments of a new social order of freedom, justice, equality and the individual. It aims at the elimination of poverty, ignorance and ill health and it directs all state to increase the level of nutrition and the standard of living of its people and improvement in public health among its primary duties. Since the inception of the planning process in the country, the successive five year plans have been providing the framework within which the state may develop their healthcare infrastructure, medical education and research etc. Rural India in general and tribal people in particular has their own beliefs and practices regarding health. Some tribal groups still believe that the disease is always caused by some hostile spirits or by the breach of some tattoo. So, therefore they seek remedies through magic religious practices. On the other hand, the rural people follow the rich, undocumented and traditional systems of medicines in addition to the recognized cultural systems of medicines like Ayurveda, Unani, Siddhha and naturopathy for maintain positive health and to prevent diseases.

Healthcare Infrastructure:-

Snapshot of Healthcare Market 2006 (in US $)	
Primary health centers	23,000
community health centers	2,935
District hospitals centers	4,400
State owned hospitals	1,200

ASHA (Accredited Social Health Activist): -

The Accredited Social Health Activist (ASHA) is a health activism initiative within communities. It also creates awareness on health and its social determinants and mobilizes the community towards local health planning and increased utilization and accountability of existing health services provided by the government. ASHA also provides a minimum package of curative care as appropriate and feasible for that level and makes timely referrals. Under the National Rural Health Mission, the government envisaged appointment of a female Accredited Social health Activist (ASHA) in every village to act as an interface between ANM and the village and to be countable to the panchayat.

The ASHA's would get performance-based compensation for promotiong universal immunization, referral and escort services for RCH, construction of household toilets and other healthcare delivery programmes. Though central government makes general guideline for appointment of the ASHA's, various states are free to follow their own models based on the requirements of the state. The success of government's health programmes in rural areas depends much on the success on

the scheme.

Maternity Hospitals in India-

Leading Indian hospitals with gynecology departments and women's hospitals have facilities for the prevention and early detection of gynecology disorders.

Anganwadi Centers-

Anganwadi Centers come under the Integrated Child Development Scheme. The main objective of this programme is to cater to the needs of the development of children in the age group of 3-6 years. Pre-School education aims at ensuring holistic development of the children and to provide learning environment to children, which is conducive for promotion of social, emotional, cognitive and aesthetic development of the child.

(Source: - National Portal Content Management Team, Reviewed on: 19.09.2011)

No. of ASHA selected during(including ASHA in tribal areas in Non-High Focus States)	2005-06	130315
	2006-07	300636
	2007-08	171466
	2008-09	105150
	2009-10	102070
	2010-11	0
	Total	809637
No.of ASHAs who have received training	1st module	763560
	2nd module	632022
	3rd module	625879
	4th module	613149
	5th module	254608
No. of ASHAs in position with drug kits		553061
Total No. of MonthlyVillage Health & Nutrition Days held in the state	2006-07	3505902
	2007-08	4962883
	2008-09	5819410
	2009-10	5620331
	2010-11	844645
	Total	**20753171**

(Data as on 30th June 10 by govt of India)

Key Components of ASHA:

ASHA must primarily be a woman resident of the village - married/widowed/divorced, preferably in the age group of 25 to 45 years.

• She should be a literate woman with formal education up to class eight. This may be relaxed only if no suitable person with this qualification is available.

• ASHA will be chosen through a rigorous process of selection involving various community groups, self-help groups, Anganwadi Institutions, the Block Nodal officer, District Nodal officer, the village Health Committee and the Gram Sabha.

• building of ASHA is being seen as a continuous process. ASHA will have to undergo series of training episodes to acquire the necessary knowledge, skills and confidence for performing her spelled out roles.

• The ASHAs will receive performance-based incentives for promoting universal immunization, referral and escort services for Reproductive & Child Health (RCH) and other healthcare programmes, and construction of household toilets.

• Empowered with knowledge and a drug-kit to deliver first-contact healthcare, every ASHA is expected to be a fountainhead of community participation in public health programmes in her village.

• ASHA will be a health activist in the community who will create awareness on health and its social determinants and mobilize the community towards local health planning and increased utilization and accountability of the existing health services.

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

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

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

• ASHA will mobilize the community and facilitate them in accessing health and health related services available at the Anganwadi/sub-centre/primary health centers, such as immunization, Ante Natal Check-up (ANC), Post Natal Check-up supplementary nutrition, sanitation and other services being provided by the government.

• She will act as a depot older for essential provisions being made available to all habitations like Oral Rehydration Therapy (ORS), Iron Folic Acid Tablet (IFA), chloroquine, Disposable Delivery Kits (DDK), Oral Pills & Condoms, etc.

• At the village level it is recognized that ASHA cannot function without adequate institutional support, Wom-

en committees (like self-help groups or women health committees), village Health & Sanitation Committee of the Gram Panchayat, peripheral health workers especially ANMs and Anganwadi workers, and the trainers of ASHA and in-service periodic training would be a major source of support.

Compensation Package for Accredited Social Health Activist (ASHA)

Sl. No	Head of Compensation	Suggested Compensation (in Rs.) / per case	Estimated case/ work load per ASHA per annum	Estimated Maximum out go for compensation per ASHA per annum
1	JSY-Institutional Delivery (rural) LPS	350 for ASHA & 250 for ref. transport	13	7800
	Urban	200	9	1800
2	Motivation for Tubectomy/ motivation for Vasectomy /NSV	150/200	8/4	1200 /1800
3	Immunization Session	150	12	1800
4	Pulse polio day- if it is full day work it should be rs.75	75	6	150
5	Organizing village health nutrition day	150	12	1800
6	DOTS	250	1	250
7	Household toilet promo, fee	75	12	1200
8	Detection, referral, confirmation and registration of leprosy case / after complete treatment for PB leprosy cases/ after complete treatment for MB leprosy cases	100 /200 /400	1/1/1	100 /300 /500--
	Total		17,200	

(Data as on 30th June 10 by govt of India)

Support mechanism for ASHA:-

The following set of guidelines are issued to enable the status to develop and put in place a proper support mechanism for ASHA

a) ASHA Mentoring Group :-

The Government of India has set up an ASHA Mentoring Group comprising of leading NGOs and well known experts on community health. Similar mentoring groups at the State/District/Block levels could be set up by the states to provide guidance and advise on matter relating to selection, training and support for ASHA.

b) Selection of ASHA :-

As ASHA will be in the village on a payment basis, she should be selected carefully through the process laid down in the first set of ASHA guidelines. It is possible that the selected ASHA drops out of the programme.

c) Training of ASHA :-

The guidelines already issued on ASHA envisage a total of 23 days training in five episodes. However, it is clarified that ASHA training is a continuous one and that she will develop the necessary skills & expertise through continuous on the job training.

d) Familiarizing ASHA with the village :-

Now, that ASHAs have been selected, the next step would be to familiarize her with the health status of the villagers and facilitate her adoption to the village conditions. Although , ASHA hails from the same village, she may not be having knowledge and information on the health status of the village population.

e) Maintenance of Village Health Register :-

A village health register is maintained by the AWW which is not always complete. ASHA can help AWW to complete and update this register by maintaining a daily diary. The diaries, registers, health cards, immunization cards may be provided to her from the united funds made available to the sub-centre.

f) Organization of the Village Health and Nutri-

tion Day :-

All state governments are presently organizing monthly Health and Nutrition day in every village (Anganwadi centers) with the help of AWW/ANM. ASHA along with AWW should mobilize women, children and vulnerable population for the monthly health day activities like immunization, careful assessment of nutritional status of pregnant/lactating women, new born & children, ANC/PNC and other health check-ups of women and children, taking weight of babies and pregnant women etc. and all range of other health activities.

g) Co-ordination with SHG Groups :-

ASHA would be required to interact with SHG Groups, if available in the villages, along with AWW, so that a work force of women will be available in all villages.

h) Meeting with ANM :-

ANM should have a monthly meeting the ASHAs stationed (5-6 ASHAs) in the villages of her work area at the Anganwadicentre during the monthly Health and Nutrition Day to assess the quality of their work and provide them guidance.

i) Monthly meetings at PHC level :-

The Medical Officer In-charge of the PHC will hold a monthly meeting which would be attended by ANM and ASHAs, LHVs and Block Facilitator. During this period, the health status of the villages will be carefully reviewed.

j) Monthly meetings of ASHAs :-

A meeting of ASHA could be organized on the day monthly meetings are organized at the PHC level to avoid unnecessary travel expenditure and wastage of time. In addition to monthly meetings at PHC, periodic retraining of ASHAs may be held to help then to refresh and upgrade their knowledge and skills, as provided for in the original guidelines for ASHA.

k) Block level Management :-

At the block level, the BMO will be in overall charge of ASHA related activities. However, an officer will be designated as Block level Organizer for the ASHA to be assisted by Block Facilitators (one for every 10 ASHAs).

l) Management Support for ASHA :-

Officials in the ICDS should be fully involved in ASHAs activities and their support should be provided for at every level i.e. PHCs, CHCs, District Society etc.

m) Community Monitoring :-

Periodic surveys are envisaged under NRHM in every village to assess the improvement brought about by ASHA and other interventions. The funding for the survey will be provided out of the united funds provided to the sub-centre. The first survey would provide the base line for monitoring the impact of health activities in the village.

n) Role of District Health Missions :-

The District Health Mission in its meetings will specially assess the progress of selection of ASHAs, their training and orientation, usefulness to the villages etc. this information should be accessible by the State Health Missions as well as the Mission at the national level.

o) Linkage with Health Facility :-

The success of NRHM to great extent depends on performance of ASHA and her linkage with functional health system. The health system has to give due recognition to ASHA and take prompt action on the referrals made by her; otherwise the system cannot be sustained. Every ASHA must be familiar with the identified functional health facility in the respective area where she can refer or escort the patients for specific services.

Support Mechanism for ASHA

Support	Site	Activity
State Mentoring Group at state level SPMV	STATE	Periodic Surveys by District Health Society to access improvement brought by ASHA. District Mission Meeting to access progress of ASHA Scheme
Block Medical Officer Block Organiser Block Facilitator ICDS Officials	BLOCK PHC	Monthly meeting feedback from block facility
Medical Officer ASHA Facilities	PHC	Payments of Incentives to ASHA under various schemes. Periodic Training Monthly Meeting Replishment of ASHA kit.
ANM	SUBCENTER	Meeting Monthly

SHG AWW AIIM Gram Panchayat	VILLAGE	As members of village Health & Sanitation Committee. Develop village Health Plan. Help ANm to maintain village Health Register Organise Village Health Day with ANM & AWW

(Data as on 30th June 10 by govt of India)

Findings:-

The reports received from the States indicate that over 1,20,000 ASHAs have been selected in the year 2005-06 and that they are being provided with orientation training as envisaged in the guidelines issued on ASHA. Now, a careful strategy needs to be devised for providing the necessary management. Support to ASHA so that she is not left alone in the village without having any linkage with the health system. Mr. Nongyai, NHSRC presented the current status of the ASHA programme on key parameters; selection and training of ASHA, support structure and drug kit distribution. He stated that while quantitative data was useful, presentation of qualitative data would illustrate the strengths and challenges of the programme. Dr. RajaniVed informed the group that NHSRC was planning a bi-annual ASHA update report. The first of this series was published in October 2009, and the next one is due in April 2010. The ASHA update report would include numerical parameters as well as brief reports on the ASHA/CP programme in each state and highlight strengths and challenges. MOHFW has 235 poor performing districts (based on RCH indicators) for which priority action was needed to review and strengthen the status of ASHA programme. Of the 235 backward districts, 125 districts have been identified as those requiring greater focus. The members were requested to write directly to the Ministry on this issue.

Preliminary findings from the ASHA evaluation:-

Dr. RajaniVed made a presentation on framework and design of ASHA evaluation, and the preliminary findings from ASHA evaluation phase-I in 8 states; Assam, Andhra Pradesh, Bihar, Jharkhand, Orissa, Rajasthan, Kerala and West Bengal. The evaluation has three phases. Phase I aims to understand the programme narratives as understood by systematic functionaries based on the variations of contexts, mechanisms and outcomes, the underlying rationale of the realist mode of evaluation. Phase II aims to generate quantitative data on the programme through the interviews with the ASHAs, AWW, ANM, PRI members and beneficiaries (mother with children less than 6 months, and mothers with children 6 months to 2 years of age). Findings from phase I and II would be consolidated, and in phase III, this information would be shared with different stakeholders at the state level. Several AMG members had formed part of the evaluation and were able to clarify some of the evaluation findings. The evaluation approach and progress were discussed in detail and enclosed. The report would be ready by May end and would be discussed in the next AMG.

Conclusion:-

The constitution of India envisages the establishments of a new social order of freedom, justice, equality and the dignity of the individual. It aims at the elimination of poverty, ignorance and ill health and it directs all state to increase the level of nutrition and the standard of living of its people and improvement in public health among its primary duties. The govt of India have established various healthcare centers in both rural and urban area. In the urban agglomerations, the municipal and local authorities like district hospitals are working not only for primary but also for all types. And in this context the ASHA plays an important role especially in rural area. Over the last one year, the states have selected more than 200,000 ASHAs. The number of ASHAs is likely to be increase very rapidly over the next two years. As a matter of fact, a district alone is expected to have more than 1,000 ASHAs. Obviously, a very strong support mechanism is required at block, district and state level to ensure that the scheme of community health worker meets the objectives, which the Mission has envisaged for it. The support functions which would have to carried out at these levels include inter-alia, preparation of training calendar for the trainers as well as for ASHAs, monitoring the implementation of the training programmes, adapting the training modules (provided to the states by the GoI) to suit the local conditions, translation in local language, printing and distribution of these manuals, developing ASHA monitoring forms and monitoring her performance, developing IEC materials, addressing grievances of ASHAs if any etc. Thus the ASHA (Accredited Social Health Activist) has a significant role in the developmental process in rural area.

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