COMMUNITY PARTICIPATION IN PRIMARY HEALTH CARE: THE CASE OF ASHA WORKERS IN TELANGANA STATE

A DISSERTATION SUBMITTED TO THE UNIVERSITY OF HYDERABAD IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY IN ANTHROPOLOGY

CHAR MUJUNDAR MALOTH
09SAPH07

DEPARTMENT OF ANTHROPOLOGY
UNIVERSITY OF HYDERABAD
HYDERABAD – 500046

NOVEMBER, 2017

DEPARTMENT OF ANTHROPOLOGY
SCHOOL OF SOCIAL SCIENCES
UNIVERSITY OF HYDERABAD

DECLARATION

I, **Char Mujundar Maloth**, hereby declare that this thesis entitled '**Community Participation in Primary Health Care: The Case of ASHA Workers in Telangana State**', under submission is a bonafide research work which is also free from plagiarism is supervised by **Prof. B. V. Sharma**. I also declare that it has not been submitted previously in part or in full to this University of any other University or Institution for the award of degree or diploma. I hereby agree that my thesis can be deposited in Shodhganga/ INFLIBNET.

Date: November, 2017
Place: Hyderabad.

Char Mujundar Maloth
Reg. No. 09SAPH07

CERTIFICATE

This is to certify that the thesis entitled '**COMMUNITY PARTICIPATION IN PRIMARY HEALTH CARE: THE CASE OF ASHA WORKERS IN TELANGANA STATE**' submitted by **CHAR MUJUNDAR MALOTH** bearing registration number **09SAPH07** in partial fulfilment of the requirements for award of Doctor of Philosophy in the School of Social Science is a bonafide work carried out by him under my supervisor and guidance.

The thesis is free from plagiarism and has not been submitted previously in part or in full to this or any other University or Institution for award of any degree or diploma.

Parts of the thesis has been

A. Published in the Following Publication

1. Asha Role Performances In Reproductive And Child Health (R&CH) Care And Family Planning In Warangal District Of Telangana State. Jul - Sep 2017 | Volume: 4 | Issue: 3 | Article No: 3 | ISSN: 2348 – 4349. …….. Chapter 4 in the Thesis.

2. Socio-Economic Determinants and Selection Process of Asha Workers in Telangana State. | Jul - Sep 2017 | Volume: 4 | Issue: 3 | Article No: 3 | ISSN: 2348 – 4969 ……. Chapter 3 in the Thesis.

And

B. Presented in the Following Conferences

1. ……..(National/ International)

Further, the student has passed the following courses towards fulfilment of coursework requirement for Ph.D.

Sl. No.	Name of the Course	Credits	Pass/Fail
1	Advanced Anthropological Theories	4	Pass
2	Advanced Research Methods	4	Pass
3	Medical Anthropology	4	Pass

Research Supervisor
(Prof. B.V. Sharma)

Head of the Department
(Prof. M. Romesh Singh)

Dean of the School
(Prof. P. Venkata Rao)

Acknowledgements

This thesis has made successful submission because of the many people who helped me in the course of my research journey. I am sincerely indebted to my research supervisor **Professor B.V Sharma** for his sincere supervising, constant encouragement and guidance in completing this work. I also thank to the esteem Doctoral Research Committee members' i.e. Prof. G.Sudarshanam and Dr Ramudu for their constant suggestions and encouragements. My heart full thanks to the Indian Council of Medical Research (ICMR), New Delhi for giving me the financial support through Junior Research Fellow (JRF) and Senior Research Fellow (SRF) for the period of five years. Without this ICMR fellowship I would have not finished this research at all.

I am also equally grateful to Prof. P. Venkat Rao, Dean, School of Social Sciences, and Prof. M. Romesh Singh, Head, Department of Anthropology and Professors K.K Mishra, P.Venkat Rao, Sudhakar Rao, Prof. Siva Prasad, Dr. George Tharkan, Dr. Romesh Singh, Dr. Munaf of Department of Anthropology office staff, Shekar sir, Adinarayana, Ashok Sir, Niranjan, Jangaiah, kankaiah and Anthaya.

I am grateful to my parents Mothilal Naik and Veeramma and father in-law Sakku Daramsoth and mother in-law Laxmi Daramsoth for their inspiration to reach this position and I also thankful to my beloved wife Smt. Vasantha Charu Mujundar Maltoh, my daughter Charami, and My sons Che Guevera and Hugo Chavez. I am also thankful my sister Swarupa and my brother in-law Nageshwar Naik Banoth and their daughters Chandana and Bunti. I am also thankful to my brother Subash Chandara Bose (Chinu) and his wife Lavanya and their children Mao Lenin and Castro. I also thankful, my brothers Ravi and his wife Sarada and their children Charan, Uday and Ramesh and Aruna (Kalu) and their children Irpan and Puppy (Siri Vennela).

I sincerely thank to my friends kusum Baharathi, Sureksh kuura, Veeranna Boda, Keeru, Dr. Sakru Banoth, Assistant Professor, CESS, AP and Alevelu, Dr. Bondyalu Banoth (Bharath), Sujatha Bai, Dr. Bahaggu Naik, K.Raj Kumar, R.Ravi Kiran, K.Thimma Raju, Sattesh Piyyala, Allam Ramesh, Shilaja, Sharada friend, Abbas Md, Swamy, Jawahar, Sura and my all well-wishers.

I also sincerely thanks my dear colleagues Dr. Usha and Dr. Noble and their son Akhi for constant support at the time need. Finally I would like thank ICMR HRD officers Dr. K.K Singh and Vinoy and Sandhya Diwakar madam for their help during ICMR FELLOWSHIP.

CONTENTS

LIST OF TABLES

LIST OF CHARTS

LIST OF Maps

LIST OF PLATES

ABBREVIATIONS

A.D	Anno Domini
A.H	Area Hospital
AAA	Assessment, Analysis, Action
ACT	Advocacy for Control of Tuberculosis
AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Care
ANM	Auxiliary Nurse Midwife
ARC	ASHA Resource Centre
ASHA	Accredited Social Health Activist
AWW	Anganwadi Worker
AYUSH	Ayurveda, Yoga and Naturopathy, Unani, Sidda and Homeopahty
BCG	Bacillus Calmette–Guérin
BRAC	Bangladesh Rural Advancement Committee
CA	Comilla Approach
CAD	Coronary Artery Diseases
CBR	Crude Birth Rate
CCHP	Chakaria Community Health Project
CDD	Community Driven Developemnt
CDM	Comilla Development Model
CHC	Community Health Centre

CHNCS	Community Health and Nutrition Centers
CHRP	Community Health and Rural Project
CHS	Comprehensive Household Survey
CHV	Community Health Volunteer
CHW	Community Health Worker
CVD	Cardio Vascular Diseases
D.H	District Hospital
DHM	District Health Mission
DMHO	District Medical and Health Officer
DOTS	Directly Observed Treatment, Short Course
DOTS	Directly Observed Treatment System
DPT	Diphtheria-Pertussis-Tetanus
DPU	Delayed Pressure Urticaria
FC	Farmer Club
FDHS	Fixed Day Health Services
FPAI	Family Planning Association of India
GDP	Gross Domestic Product
GOI	Government of India
GP	Gram Panchyath
GS	Gram Saba
HEED	Health, Education and Economic Development
HHN	Health, Hygiene and Nutrition
HIV	Human Immune Virus
ICDS	Integrated Child Development Services

IEC	Information Education and Communication
IFPS	The Innovations in Family Planning Services
IHS	Integrated Household Survey
IMR	Infant Mortality Rate
INP	Iringa Nutrition Project
JSA	Jan Swasthya Abhiyan
JSY	Janani Suraksha Yojana
KCR KIT	Kalvakuntla Chandrasekhar Rao Kit
KP	Kasa Project
KPCEF	Karnataka project for community action in family planning
LVGS	Local Voluntary Groups
M&E	Monitoring and Evaluation
MADA	Mandal Area Development Agency
MCH	Maternal Child Health
MCH	Maternal and Child Health
MHD	Medical and Health Department
MM	Mahila Mandal
MMR	Maternal Mortality Rate
MOH	Ministry of Health & Family Welfare
MOHFW	Ministry of Health and Family Welfare
NC	Nutritional Camps
NFHS	National Family and Health Survey
NGO	Non Governmental Organization
NGO	Non-Governmental Organisation

NHM	National Health Mission
NHP	National Health Planning
NHSRC	National Health Systems Resource Centre
NRC	Nutritional Rehabilitation Centre
NRHM	National Rural Health Mission
OBC	Other Backward Communities
OC	Other Castes
OPV	Oral Polio Vaccine
PBP	Performance-Based Payment
PC	Planning Commission
PDS	Public Distribution System
PHA	Primary Healthcare Approach
PHC	Primary Health Care
PIA	Participation Impact Assessment
PMP	Private Medical Practioner
PNC	Post Natal Care
PPP	Private Public Partership
PRI	Panchayath Raj Institution
PROMESA	Programa de Mejoramiento, Salud y Ambiente
RBSK	Rashtriya Bal Swasthya Karyakram
RCH	Reproductive Child Health
RHMS	Rural Health Mission Society
RHS	Rural Health Statistics
RMP	Rural Medical Practioner

RTI	Reproductive Tract Infection
SC	Scheduled Caste
SC	Sub-Centre
SHG	Self Help Groups
SHO	Self help Organization
SRC	State Reorganisation Act
SS	Shassthya Shebikas
SSC	School of Secondary Certificate
ST	Scheduled Tribe
STI	Sexually Transmitted Diseases
SWOT	Strength, Weakness, Opportunity and Threats
T.S	Telangana State
TB	Tuberculosis
TBDOTS	Tuberculosis directly observed Treatment Short course
TFR	Total Fertility Rate
TPI	Theoretical Practical Interaction
TSC	Total Sanitation Campaign
TSP	Tribal Sub Plan
TSRTW	Telangana State Residential Tribal Welfare
TT	Tetanus Toxoid
UIP	Universal Immunization Programme
UNESCO	United Nations Educational Social Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children Emergency Fund

UNO	United Nations Organization
VHND	Village Health and Nutrition Day
VHNSC	Village Health Nutrition and Sanitation Committee
VHP	Village Health Planning
VHSC	Village Health and Sanitation Committee
VPD	Vaccine Preventable Diseases
WC	Women's Club
WHO	World Health Organization
YC	Youth Club
ZPHS	Zilla Parishad High School

Chapter – 1

Introduction

Introduction

All developmental agencies have come to realise the need for a shift from the current trend within the context of development. Such a realisation has resulted in a paradigmatic shift from the centralised controlled model of development which is based on the top-down approach towards Community Driven Development (CDD) (which involves the bottom-up approach). The essence of the CDD is that the poor people need not be viewed as the target of poverty reduction efforts. CDD, in contrast, treats poor people and their institutions as assets and partners in the development process (Philippe Dongier,et.el, 2003). Today, CDD is becoming one of the significant forms of development assistance and is being largely incorporated in government policies for the upliftment of the people, particularly the marginalised sections of society.

According to Economic and Social Commission for Western Asia (ESCWA), Community Driven Development is a course, whereby the local community or groups exercises control over the decisions and resources in the area of local development. The main thrust of CDD is, therefore, that of participatory development, which, in broad terms, is defined as a process whereby local communities are encouraged to act as informed participants in the development process. The term community participation does not convey anything less than the CDD. The term participation implies sharing not only of information and opinion, but also of decision making power. Real participation means joint problem- solving, joint decision-making and joint responsibility (UNO-ESCWA 2004).

In this context, the participatory development model seeks to engage local populations in development and has taken a variety of forms since it emerged in the 1970s, when it was introduced as an important part of the "basic needs approach" to development. Most manifestations of participatory development seek to give to the poor a part in initiatives designed for their benefit, in the hopes that development projects will be more sustainable

and successful, if local populations are made active and responsible participants. Participatory development has now become an increasingly accepted method of development practice and is being employed by a variety of organisations. It is often presented as an alternative to mainstream “top down” development (Olanike F.Deji, 2011).

What is Community?

Understanding of what is 'community participation' perhaps could be best achieved by first comprehending the meaning of ‘community’ and 'participation'. The word “community” is commonly used to refer to a group of people who share the same religion, race, creed in a particular geographical area. In other words, we can define a community as all the people who live in a geographical area by sharing common interest values, beliefs as a group. According to Delanty (2003), communities are based on ethnicity, religion, class or politics. These may be large or small, thin or thick attachments that underline them. There may be locally based, globally organised; assenting or subversive in their relations to the established order. These may be traditional, modern and even post-modern; intransigent and progressive. In general, the sociologist community has traditionally chosen a particular form of social organisation based on small groups such as neighbourhoods, the small town, or a separately bounded locality (Delanty, 2003).

What is Participation?

The term “participation” can be interpreted in various ways, depending on the context. Shaeffer (1994) interprets and clarifies different levels and degrees of participation. These include the involvement through the consultation on a particular issue, participation in the delivery of a service, often as partners with other actors; involvement through the contribution of money, materials, and labour; participation as implementers of delegated powers; and participation in real decisions at every stage, including the identifications of problems, the stay of planning, implementation and the evaluation (Shaeffer, Sheldon ed. 1994).

According to the Oakley (1991& Warburton (1997), participation is concerned with the human development and increases peoples sense of control over issues which affect their lives, helps them to learn how to plan and implement and, on a broader front, prepares them for participation at regional or even national level. In essence, participation is a 'good thing' because it breaks peoples' isolation and lays the ground work for them to have not only a more substantial influence on development, but also a greater independence and control over their lives. The term "participation" usually implies the act of taking part in an activity, where the group of people shares the information and opinion and also takes part in the decision making process at the various level.

What is Community Participation?

The community participation is "a process by which people are enabled to become actively and genuinely involved in defining the issues of concern to them, in making decisions about factors that affect their lives, in formulating and implementing policies, in planning, developing and delivering services and in taking action to achieve change" (WHO, 2002, p. 10). However, as the term gained greater currency, different interpretations have also been made in regard to what constitutes community participation, particularly in the field of health.

Reasons for Community Participation

The community participation has been a constant theme in development dialogues for the past 60 years. In 1960s and 1970s, it became central to development projects as a means to seek sustainability and equity particularly for the poor and other disadvantaged groups.

So, in this regard, it became a central plank for health policy promoted by the World Health Organisation, in its conference in Alma Ata in 1978 (WHO/UNICEF, 1978). In accepting Primary Health Care as government policy, all members of WHO recognised the importance of involving intended beneficiaries of services and programmes, in their design and implementation. The following reasons for this acceptance were put forward.

1. **The health services argument**. The services provided are underutilized and misused, because the people, for whom these are designed, are not involved in their development.
2. **The economic argument**. In all communities, there are financial, material and human resources that could, and should, be mobilized to improve local health and environmental conditions.
3. **The health promotion argument**. The greatest improvement in people's health is a result of what they do to others and for themselves. It is not the result of medical interventions.
4. **The social justice argument**. All people, especially the poor and disadvantaged, have both the right and duty to be involved in decisions that affect their daily lives (Rifikin, 1990)

   The World Bank's reasons for community participations are:

1. Local people have a great amount of experience and insight into what works, what does not work - and why.
2. Involving local people in planning projects can increase their commitment to the project.
3. Involving local people can help them to develop technical and managerial skills and thereby increase the resources available for the programme.
4. Involving local people help to increase the resources available for the programme.
5. Involving local people is a way to bring about 'Social learning' for both the planners and the beneficiaries. 'Social learning' means the developmental partnerships between professionals and local people, in which each groups learns from the other (World Bank, 1966).

Origin of the Idea of Community Participation

Growing disappointment with the failure of the prevailing development strategies to improve the lives of the majority of people in developing countries, led to a re-thinking on the entire development process in the 1970s. This ultimately led to the emergence of the idea of community participation (Oakley &Marsden, 1984). It was pointed out that

most of the earlier strategies were planned for the people by outsiders, where people were considered as mere recipients and the transfer of technology was thought to be adequate for their development.

Emphasis was laid on the active participation of people and there was a general concern to make development strategies more people-centred, based on their own aspirations and ideas. Since then, the idea of community participation emerged as a fundamental component of any development strategy, at least in theory, including health development. Different manifestations of participatory development have been promoted as a way to improve the 'efficiency and effectiveness' of 'formal' development programmes.

Community Participation in Health

In the 20th and 21st centuries, most of the countries in the world, developing, under developed and developed, have understood that without the involvement of the community members in the health care programme, it is very difficult to remove the diseases and illness which are prevailing in the above-said countries in the world. The causes are attributed to the numerous social, cultural, economic and political issues. It is against this backdrop, an attempt is being made to study the issue of community participation in the primary health care sector. In this regard, community participation in health care is a complex entity. This has been widely and critically examined by a number of researchers, academicians, authors and the role of the community participation in the health care continues to be a great interest even today. It is brought out here that the genesis of the idea and its conceptual framework of development health are primarily attributed to the WHO.

Initiative of International Bodies for Community Participation in Health

It is one of the most distinguishing events which took place in the global public health field that gave rise to community participation a prominent place in public health. This event was the WHO and United Nations International Children's Emergency Fund (UNICEF) sponsored conference on Primary Health Care (PHC) at Alma Ata in 1978. The Alma Ata Declaration, 1978, identified that the PHC is the key to accomplish an adequate level of health throughout the world in the near predictable future as part of

social and economic development in the spirit of social justice (Declaration of Alma-Ata, 1978).

The WHO's promotion of community participation has been greatly influenced by China example of 'barefoot' doctors. This programme consisted of part-time health workers who provided basic health services in rural areas. It was very successful in China. For the transfer of this experience, it is important to notice that mobilisation for health in China was part of a much wider socio-economic and political upheaval (Welschhoff, 2006).

The Alma Ata Declaration defined PHC as "essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-care and self-determination. Following the Alma Ata Conference, other developments such as the Ottawa Charter (WHO, 1986) and Agenda 21, (1992) amongst others, have helped in placing community participation high on the political and public agendas of nations (United Nations, 1992). The emphasis on community participation ushered a paradigm shift in health planning and health care delivery that called for the involvement of the community in both the decisions and delivery of health services most appropriate to them.

The *Health for All* by the Year 2000 Movement of the WHO, having community participation at its nucleus, led to the support of this concept by several countries as the means by which significant health problems could be addressed. Community participation is acknowledged as a key accomplishment factor in improving shared approaches to health and sustainability planning (World Health Organisation, 1997). In the Alma Ata Declaration, community participation contains involvement in all phases of primary health care (United Nations, 1992).

Indian Initiatives in Health

The Government of India, since independence, has taken various steps to improve the health care of its people. The Indian government initiatives for health improvement were supposed to be based on the recommendations of the health committees appointed at different times. Hence, the recommendations of these committees are briefly stated below.

At the time of independence, India was struggling a lot to establish a vibrant democracy, despite all the social, cultural, economic and political problems like inequality, widespread illiteracy, poverty, social unrest, famine and epidemics. The Government of India, constituted numerous committees to critically assess the situation of the health status of the Indian people. In this regard, the committees have recommended certain guiding principle, which finally led to the health care reforms in India. The committees and their recommendation are discussed below.

The government of India in the year 1943 appointed a committee "the Health Survey and Development Committee", popularly known as the Bhore Committee to review the health condition of the country. The report of the committee submitted in 1946 is of special significance as it not only revealed the health condition of the country on the eve of independence, but also because of the fact that the decisions of the committee largely provided the guidelines in the field of health care administration.

Bhore Committee (1946) has made the following observations:

1. No citizen should fail to secure adequate medical care because of the inability to pay for it.
2. The health care services should provide the entire consultant laboratory and the institutional facilities necessary for proper diagnosis and treatment.
3. The health problem must lay special emphasis on the preventive aspect.
4. There is an urgent need for providing medical relief and preventive health care to the vast rural population of the country.

5. The health services should be placed as close to the people as possible, in order to ensure the maximum benefit to the community to be served.

It is essential to secure active co-operation of the people in the development of the health program.The report recommended the creation of a primary health care unit for a population of 20000, a secondary unit for a population of six lakh and above that, a district headquarters organisation. As a short term strategy, the committee recommended a three-month training programme in preventive and social medicine for persons who will guide the people for a healthier and happier life (Ranga Rao S.P pg.20).

Mudaliar Committee constituted in 1959 by the Indian Government acknowledged that not much development had taken place in health care infrastructure in the rural and urban area. The funds were not available for the improvement of the health care in rural and urban areas. It is also emphasised that the health personnel were reluctant to go to rural areas and were working in the urban areas (Ranga Rao S.P pg.23).

Chaddah Committee, constituted in 1963, recommended for the qualitative improvement of primary health care e.g. consolidation of PHCs in India, integration of health and family planning and the introduction of one male and one female multi-purpose worker per 10,000 populations to deliver the services (Duggal 2001).

Mukherji Committee was appointed by the Government of India in 1965, to review and chalk out the strategy with regard to the family planning programme. Among the several other proposals suggested by this committee was that the health worker should not be associated with the family planning and that the Malaria eradication activities should also be separated from the family planning (Ranga Rao S.P pg.23).

In 1966, this committee was called upon to work out the details of the basic health service being introduced at the block level. As far as, a PHC is concerned, the Committee proposed one basic health worker for every 10,000 population and a health inspector for every four basic workers. It was also proposed that for every 10 PHCs, there should be one health supervisor (Ranga Rao, S.P., 1993).

Mungalwala Committee was constituted in 1967, to look into the integration of health services. It made a number of recommendations. Firstly, it favoured the integration of the health services from the highest to the lowest levels. Secondly, it favoured an integrated health service with a unified approach for all the problems, instead of segmental approach for the different problems. The committee also visualised the medical care of the sick and the conventional public health programmes functioning under a single administrator and operating in a unified manner at all levels of hierarchy with due priority for each programme operating at any point of time (Ranga Rao, S.P., 1993 pg.24).

Katar Singh Committee on multipurpose workers under health and family planning was appointed by the Government of India in 1973 to suggest the structure of integrated service at the periphery and supervising levels. The committee was also asked to examine the feasibility of appointing multipurpose workers, work out their training requirements and to examine the utilisation of the mobile family planning unit for integrated medical and public health work. Among the several suggestions, the committee made the following important recommendations (Ranga Rao, S.P., 1993 pg.24-25):

1. Auxiliary-nurse-midwives should be replaced by female health workers, while the basic health workers and malaria eradication assistants and family planning health assistant should be replaced by male health workers.

2. Multipurpose workers' programmes should be introduced in areas where malaria and small pox are still a problem.

3. There should be a PHC for a population of 50,000 and each centre should be divided into sixteen sub-centers, each for a population of about 3,000.

4. Each Sub-Centre should have one male and one female health worker. For every 3 to 4 health male workers, there should be one male health supervisor, while the female health supervisor should be in charge of 4 female health workers.

5. The doctor of the PHC should have the overall charge of all supervisors and health workers in this area.

Srivastva Committee was appointed by the Government of India in 1975 to look after medical education and manpower support. This committee made a number of recommendations concerning the manpower requirements of the PHC. In the first place, the committee favoured the creation of a band of para- professional, or semi-professional, workers from the community itself to provide simple protective, preventive and curative services needed by the community. Secondly, the group visualised two cadres between the PHC and the local community, namely, health workers and health assistants. The health workers should be trained and equipped to give simple specified remedies for day-to-day illness, while the health assistants should function as intermediaries between the health workers and PHC. Thirdly, each PHC should be provided with an additional doctor with a nurse to look after the maternal and child health services. Fourthly, the possibility of utilising the services of senior doctors of the higher levels for short periods with PHC should be explored. Fifthly, the PHC should develop direct links with the community around as well as with other bigger hospitals around it (Ranga Rao, S.P., 1993 pg. 25-26).

Problems of Funding for Implementation of the Recommendations of the Committees

The health system was more influenced by the decisions of the Planning Commission. The Planning Commission (since renamed as Niti Aayog) is the most influential political body in India. All budget allocations for the Five-Year Plans are decided there. The budget distributed by this commission was not always in line with the committee's recommendations. Examining the allocation of resources for health care gives an insight into the political priorities of the Indian government. The health care system in India, before Alma Ata, was not able to adequately serve the population of the country. Family planning and management of epidemics were more important in the Five-Year Plans than the extension of primary health care in rural areas. The programmes were started as early as 1951 and 1953 respectively. From the 5th Five-Year Plan onwards, family planning received the single largest share in the health sector outlay. Reforms undertaken were not successful in improving equity in health care, or the quality of the service. The health

system, which still lacked infrastructure and resources, was not open for participation (Ranga Rao, S.P., 1993).

National Health Policy 1983

It was not until 1983 that India adopted a formal, or official, National Health Policy. For the first time in the history of free India, a very comprehensive health policy was approved by the Parliament in 1983. The policy clearly admitted the failure of the government in the health sector in the past. In the first place, the government felt that the then existing situation was largely caused by the almost wholesale adoption of health manpower development policies and the establishment of curative centers based on the western models which were in appropriate and irrelevant to the real needs of the people and the socio-economic condition prevailing in the country. Secondly, the establishment of medical services for urban people through hospitals was undertaken at the cost of providing comprehensive primary health care services to the poor in rural areas. Thirdly, the existing approach, instead of improving awareness and building up self-reliance in the community, has tended to enhance the dependence of the community and weaken its capacity to cope up with the growing health problems. Fourthly, the existing methods of education and training of medical and health personal have resulted in promoting a cultural gap between the health care personnel and the people. The government declared that India is committed to the goal of "Health for all by 2000 A.D" through the provision of compressive primary health care to all the areas in the country (Ranga Rao, S.P., 1993).

Finally, the policy stated that the existing approaches to the education and training of medical and health workers should be thoroughly overhauled. It was also felt necessary to bring out complete integration of all plans of health and human development process, more particularly with the related sectors such as food production, rural development, housing, water supply and sanitation and prevention of food adulteration, sale of drugs and conservation of the environment. It was clearly stated in the policy that it seeks to provide universal comprehensive primary health care services relevant to the actual needs and priorities of the community at a cost which people can afford while ensuring that the planning and implementation of the various health programmes is through the organised

involvement and participation of the community which also utilises the services rendered actively by private and voluntary organizations in the health sector.

National Health Policy 2002- After the national health policy, 1983, the Government of India launched the National Health Policy, 2002. This policy has set certain goals to be achieved in the stipulated time and it has also made a number of recommendations. These include:

1. **Financial resources.** To increase the health sector expenditure to 6% of the GDP.
2. **Equity**. Under this sub-head, there has been an increased allocation of 55% for public health investment for the primary health sector, 35% for secondary sector and 10% for tertiary sector.
3. **Delivery of National Health Programmes**. This envisages the gradual convergence of health programmes under a single field administration. It also suggests the scientific designing of public health projects, suited to the local situation. Therefore, the policy places reliance on the strengthening of public health outcomes on an equitable basis. It also recognises the need for user charges for secondary and tertiary public health care for those who can afford to pay.
4. It is also envisaged that the revival of the primary health care system is needed, by providing some essential drugs under central government funding through decentralised funding.
5. It is felt that a more effective supervision of the public health personal through community monitoring is needed.
6. Finally, it lays emphasis on the implementation of public health programmes through local self-government institutions.

National Health Policy (NHP) 2015

The primary aim of the NHP, 2015, is to strengthen and prioritise the role of Government of India in shaping the health systems in all dimensions (investment in health, organisation and financing of health services and prevention of diseases). This policy

envisages that promotion of good health requires cross sectoral action, access to technologies, developing human resources, encouraging medical pluralism, building the knowledge base required for better health, financial protection strategies and regulation and legislation for health. It pointed out that, to bridge the gaps in inequities in health outcomes, concern on quality health care and better performance in disease control are required (Ranga Rao, S.P., 1993).

Healthcare Reforms in India

Health is an important aspect in the human well-being not only at the individual level, but at a larger society level. Improvement of health status of the people is, therefore, on the political outline of every government. Since independence, health has been major policy issue in India. One of the determinants of the good health is the development of rural health care infrastructure. Increase in medical personnel, pulse polio, immunisation programmes and the extension of drinking water supply and sanitation have been identified as requirements for changes in the health status of people. Attending to these priorities has helped achieving the rise in life expectancy levels, decline in infant mortality and crude birth rates, as well as eradication of smallpox (Welschhoff, 2006).

Primary Healthcare Approach

Health care systems throughout the world are shaped by the historical patterns of their countries, as well as the political, economic and geographical conditions. After their independence from colonial rule, many developing countries inherited a health system which focused on curative care. Furthermore, it was built to care for a selected proportion of the population only, leaving out the rural poor. Although some achievements in health were noticed by 1950 and 1960, infectious diseases were still wide spread. By 1970, it became clear that the health systems in the respective countries were not able to achieve the health outcomes desired by the WHO. The high prevalence of infectious diseases, high infant and maternal mortality rates in the countries of Asia, Africa and Latin America made it clear, that the inherited health infrastructure was not fit to cater for the needs of the population.

It became apparent that low health status was also linked to under development, low productivity, high unemployment rates, malnutrition, and environmental degradation. Poverty was identified as one of the root causes for diseases. UNICEF and WHO called for a global conference to address these issues. In 1978, a conference was held in Alma Ata. The Primary Health Care Approach was established there and became a globally accepted policy instrument. The approach emerged out of the previous experiences of China, Tanzania, Sudan, Papua New Guinea and Venezuela. Basic health care for poor rural populations was the main concept successfully tried out there.

The experiences of those countries and the realisation that health care systems needed to change fundamentally, in order to address the immense amount of health problems in the world, led to the major 7 principles, which were laid out to promote equity in health care (see Table below): committee adaptation of the health systems to socio-cultural and political conditions, a turn towards more preventive and promotive care, focus on health education and development of other health related sectors like agriculture and housing were the main points. Community participation and self-reliance at the local level were highly emphasised.

Primary Health Care

1. This reflects the economic conditions and socio-cultural and political characteristics of the country and its communities and is based on the application of the relevant results of social, biomedical and health services research and public health experience;

2. The addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly;

3. This includes at least education concerning prevailing health problems and the methods of preventing and controlling these; promotion of food supply and proper nutrition; an adequate supply of safe water and basic sanitation; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases;

appropriate treatment of common diseases and injuries; and provision of essential drugs;

4. This involves, in addition to the health sector, all related sectors and aspects of national and community development, in particular, agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the coordinated efforts of all those sectors;

5. This requires and promotes maximum community and individual self-reliance and participation in the planning, organisation, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end, develops, through appropriate education, the ability of communities to participate;

6. This should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need;

7. This relies, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers, as applicable, as well as traditional practitioners, as needed, suitably trained socially and technically to work as a health team and to respond to the expressed health needs of the community.

Source: Alma Ata Declaration, 1978(http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf)

In totting up the Primary Health Care Approach was a paradigm change from curative, urban-based care to preventive rural-based care. This change also required a new definition of health opposed to the medical definition of health. The WHO had prepared in its constitution that health "is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity." (WHO, 1946). The Alma Ata Declaration advocated this definition of health. Even though the classification has existed for a few years, it was only after Alma Ata that its contents were transformed into policy

guidelines. All WHO member countries signed the declaration and were, therefore, requested to implement primary health care (Welschhoff. 2006).

Community Based Services for Healthcare in India

In India the idea of primary health care was under discussion long before 1978. The Bhore Committee, in 1946, already recommended promoting health and using the health system for preventive, as well as curative care. The establishment of primary health care units at the village level, in order to bring the service as close to the people as possible, cooperation of the people in the health programme, and adequate medical care for all individuals, irrespective of their ability to pay for it, was included in the Bhore Report (Ranga Rao, S.P., 1993).

The Integrated Child Development Service Scheme (ICDS)

The Integrated Child Development Service (ICDS) Scheme was launched in 1975 with the aim of providing a package of services like supplementary nutrition, immunisation, health check-up, referral services, treatment of minor illnesses, nutrition and health education for women, pre-school education of children in the age group of 3-6 years, and convergence of other supportive services like water supply and , sanitation. Target groups are children below 6 years, pregnant and lactating women, and women in the age group of 15-44 years and adolescent girls in selected blocks. (Kishore 2002: 156) The programme is community-based. A local woman is selected and trained for three months to become an Anganwadi worker. She then works in the village covering a population of 1000. In the Anganwadi centre (childcare centre), she prepares and distributes food, maintains growth charts, weighs children and gives non-formal education to the beneficiaries (Kishore 2002: 155).

Community Health Volunteer (CHV) Scheme

One of the most important health schemes in India was the Community Health Volunteer (CHV) Scheme, implemented in the year 1977. Basically, it was planned to train young men from the villages for the period of 9 months in simple curative care and hygiene for primary health service at the village level. However, the government put the programme on hold, by stating that it did not want to give less qualitative care to villagers than to

urban dwellers (Jeffrey 1988: 228). It was voluntary agencies which picked up the idea in the 1960s and 1970s, and used auxiliary personnel for the delivery of primary health care. Successes from the voluntary sector in India received international recognition and together with the China example (1960) of "barefoot" doctors, served as role models for the Indian government (Welschhoff, 2006:28).

In the policy environment, while the National Health Policy, 1983 had completely ignored the component of community health, notably after the failure of the Community Health Volunteer Scheme, the National Health Policy (2002) and the Reproductive and Child Health Programme have revived the concept of community health and, within it, the community health worker. Concurrently, the Peoples' Health Charter of the Jan Swasthya Abhiyan (JSA) (2000) reflected on new ways of addressing the issue of "Health for All" (Welschhoff, 2006).

The Universal Immunisation Programme

The Universal Immunisation Programme (UIP) was commenced in 1985 for the immunisation of infants and pregnant women. The public health campaign started was huge and involved also non-governmental organisations. Posters, slogans, radio and television messages were used to inform the villagers about the programme. By 1989, the programme covered all districts of India. Special officers at the district level were appointed for supervising the delivery of the programme through the already existing workers. The programme was successful in its outreach. In 1990, between 70 to 80 % of the target children were immunised (Chatterjee 1993: 352). The programme demonstrated that it is possible to provide health services even in remote villages. On the other hand, it also highlighted dissimilarity in implementation and outcome between states, districts or blocks, even though it is a centrally sponsored programme (Chatterjee 1993: 353).

Efforts to achieve Community Participation through Non-Governmental Organisations

Another effort to increase community participation was the attempt of the central government and state government to involve Non-Governmental Organisations (NGOs). The successes of voluntary organisations in their own health programmes led to the

question what and how these organisations could contribute in the primary health care sector. The involvement of NGOs ranges from conducting research, training of government workers to running and managing government health facilities.

However, successful of these NGO endeavours have been, for example in community participation, the government was slow to adopt these new ideas. Only a few NGOs decided to take over Primary Health Centres, with mixed success. Bureaucratic constraints, resistance of private practitioners and government staff at the centre, payment delays and lack of support from the district authorities hindered the smooth running of the Primary Health Centres (Vishnu/Sudarshan, 2003:56).

In this back ground, the Government of India launched the novel scheme i.e ASHA as one of the vital component of NRHM, to bridge gap in the primary health care in India.

Concept of NRHM and ASHA

More recently, the National Rural Health Mission (2005) has placed the Community Health Worker (CHW) – the Accredited Social Health Activist (ASHA) - at the centre of all health sector reforms. The sub-centre is the most peripheral level of contact with the community under the public health infrastructure. Currently, under the Integrated Child Development Scheme (ICDS), the Anganwadi Workers (AWWs) are engaged in organising supplementary nutrition programmes and other supportive activities. The very nature of their job responsibility (with emphasis on supplementary feeding and preschool education) does not allow them to take up the responsibility of change agents on health in the villages.

Thus, a new band of community based functionaries, named as Accredited Social Health Activist (ASHA), was proposed to fill this avoid. The ASHA worker is the first port of call for any health related demands of the deprived sections of the populations, especially women and children, who find it difficult to access health services. The ASHA worker is the health activist in the community who create awareness on health and its social determinates and mobilises the community towards local health planning and increased utilisation and accountability of the existing health services. She is the promoter of good health practices. She also provides a minimum package of curative care as appropriate

and feasible for that level and makes timely referrals. Her roles and responsibilities are outlined below.

The ASHA worker shall mobilise the community and facilitate them in accessing health and health related services available at the village / sub-Centre / primary health centers, such as immunisation, ante-natal check-up (ANC), post-natal check-up (PNC), ICDS, sanitation and other services being provided by the government. She shall inform the Anganwadi worker and Auxiliary Nurse Midwife (ANM) to participate and guide in organising the health days at the Anganwadi Centre. These workers shall coordinate with Gram Panchayats in developing the village health plan. It is envisaged that officials in the ICDS should be fully involved in the activities of the ASHA workers and should provide support for at every level.

The management support provided under RCH/NRHM at the Block, District and State levels is envisaged to be fully utilised in creating a network for support to ASHA including timely disbursement of incentives, at various levels. This support system should have full information on the number of ASHA workers, quality of their output, outcomes of the Village Health and Nutrition Day, periodic health surveys of the villages to assess their impact on the community, etc. It is also planned to conduct periodic surveys under NRHM in every village to assess the improvement brought about by the ASHA scheme and other interventions. The first survey would provide the base line for monitoring the impact of health activities in the village. The meetings of the District Health Mission seek to assess the progress of selection of ASHAs, their training and orientation, usefulness to the villages, etc., and creating a cell in the DPU (Delayed Pressure Urticaria). Department of Medical and Health at the state and central levels are looking at ASHA workers as change agents, who can bring about a revolution in the health status of the village community (NRHM, 2005).

Review of Literature

Community Participation: Lessons Learnt

An attempt has been made below to briefly review the published literature in the form of specific cases of attempts of community participation in particular curative and public

health programmes. However, as part of this review, the literature relating to the concept of community participation as it was used in the area of community development, participatory development, rural development and community health, etc., has also been reviewed extensively.

Rifkin (1986), in her book, "Health Planning and Community Participation," explained in detail the different approaches to study community participation. First, she examined the medical approach which views health services as the means by which advances in medical sciences and technology can be applied to eradicate illness in the community. For this reason, services are seen as the most critical part of any community health programme and are advocated as a priority for expansion. This approach argues that only medical science and technology through the development can improve health. The second is the health planning approach which seeks health in WHO terms of the "physical, mental and social well-being to the individual and health improvements as the result of the delivery of a health service that takes into account community needs and community mobilisation of its own resources. The third is the community development approach which views health as a human improvement in a human condition not as a service and health improvements as a response to educational process by which community members begin to take control of and responsibility for their own health care.

Sule, S. S. (2005), in his paper, "Community Participation in Health and development," discussed about community participation in health. It was noted that community participation offers various advantages in health-care development of the community, which are helping communities to develop collective problem solving skills, promoting and building them to take whole responsibility for their physical, as well as mental, health and welfare of the community. It adequately, ensures that the strategies and techniques used are socially, culturally and economically appropriate or acceptable, and hence enhances sustainability of the community.

Case Studies relating to Community Participation in Curative Programmes

Kironde (2002), in the paper, "Community Participation in Primary Healthcare Programmes: Lessons from Tuberculosis Treatment Delivery in South Africa," discussed

about the vital role of community participation in TB control. The study explored the role that community members can play in a TB programme run at the Primary Health Care level in a high-burden, but resource-limited, setting. One third of the TB patients in this study were found to receive their treatment from DOT supporters in the community. They found that community-based DOT produced outcomes were equivalent to the other treatment options for new patients and was superior to self-administration of drugs for re-treatment patients. This suggested that lay volunteers can effectively dispense anti-TB medication and community participation should be encouraged. The implication of this in high TB burden settings is that community-based TB treatment is an effective and viable option that can supplement other modes of treatment delivery. Furthermore, community-based TB treatment delivery has been found to be cost-effective, and it is a low cost technology that can easily be adapted to diverse areas of need and appropriate lay volunteers recruited according to availability in each contextual setting.

Hadley and Maher (2000) reviewed community based health care initiatives in developing countries in an effort to draw lessons for community contribution to tuberculosis control/ health care. The issues examined included: awareness raising, case detection and referral for diagnosis, providing access to treatment, addressing stigma supporting patients during treatment, record keeping and tracing those who interrupt treatment. The paper reviewed CHW programmes and discussed the lessons learnt with regard to recruitment, motivation and requirements for a successful scheme. The experience of other programmes suggests the potential for and expansion of both formal (community health workers, village workers, traditional birth attendants) and the involvement of neighbour, family members and other community members) in T.B control.

Bhuiya Abbas, Yasmin Fathima, Begam Farida, Rob Ubaidur, (1996) examined the Community Health and Rural Project (CHRP) - in Jamkhedin India. He posited that the project activities started with a curative service facility established with material support from the community, the Farmers' Club (FC) and MahilaMandals (MM) who worked together, planned and carried out health programmes. These directly benefited the members of village community as well as others in the village. It was through these FCs

and MMs the community got involved in the health programmes since the volunteers of these committees played an important role in decreasing the level of superstitions, changing attitudes and teaching healthy habits and encouraging small family norms. As a result, the people of the project villages were remarkably successful in decreasing the incidence of chronic diseases like leprosy, tuberculosis and malaria, because of the timely detection and treatment of illness and preventive measures, such as immunisation of children which effectively improved the health status of villages and also reduced the Infant Mortality Rate and Maternal Mortality Rate.

Barreto, Claro, Kawa, Cavalini, and Rosa (2006), in their paper, "Community Participation Dengue Control in Brazil," reported how the increased knowledge of dengue symptoms, transmission, vector characteristics and its breeding sites was attempted to be achieved by involving public school students and community associations. The study brought out that the information strategies have not determined effective behavioral changes in the community regarding the elimination of household mosquito breeding sites, and advocated a deeper understanding of the influence of attitude and beliefs on person's knowledge about control. Similarly, it revealed the lack of inter-sectorial coordination between local and biomedical agencies dealing with health/disease and household sanitation services. It finally emphasised the importance of the knowledge about the daily problems faced by the communities in the search for partnership with the community in discussions and elaboration of proposals for dengue control.

Bhuiya Abbas, Yasmin Fathima, Begam Farida, Rob Ubaidur, (1996) in their study, observed that the Karnataka project for community action in family planning (KPCFP) which was launched in 1979 with focus on family planning, maternal and child health, and educational and social and development activities in its first phase. In the second phase, the project aimed at increasing community participation in family planning and MCH. The project was implemented by FPAI Belgaum. In this project, Local Voluntary Groups (LVGS) constituted the backbone of the project and they provided the structure for enabling the community to take action to deal with their various development needs including family planning practices, they formed Youth Clubs (YuakMandals) and

Women Club (MahilaMandals) followed by elders' clubs, cultural clubs and farmer's clubs. The, community leaders motivated the couples to accept the small family norms and to use contraceptives methods and they established a working relationships with state adult educational council. The Rotary clubs, Lion's club and Indian Medical Association (IMA) etc. have worked together for above said family planning and as a result significant achievements were recorded. More than one third of the villages became self-reliant in planning, implementing and financing community activities.

Nathan and Lloyd (2004) in their paper "Community Participation in Environmental Management for Dengue Vector Control" reported that the most significant change resulting from the project was the way national vector control teams approached and worked together with communities and other key agencies to resolve problems for mutual concern. There was a shift away from an exclusively 'top-down' approach to one of dialogue, negation and partnership to resolve environmental sanitation and vector control problems. One consequence of this change was that some national dengue programs broadened their responsibility beyond Ae. Aegypti control, and adopted a more flexible, problem-based approach to programme management.

Case Studies relating to Community Participation in Preventive Programmes

Anthony Klouda (1993), in his paper "prevention is still more costly than cure," points out through his case study of Malawi that aimed to generate enthusiasm amongst workers as well as community to take active part in health programs. The core group failed in its attempt to convince the national structure to adapt a new approach and policy towards PHC (Primary Health Centre), he suggested that this was foremost due to lack of cooperation. Also, the little progress that was achieved had been limited to the PHC level only and no attempts were made towards a greater participation of people. The main lesson from Malawi was that, perhaps contrary to expectations, changes in government system for the benefit of those who are marginalized is possible, but may not be sustainable. Sustainability has nothing to do with finance, as was shown in Malawi; rather, it has to do with the political commitment.

Sharma B. V (2002) reported that The Kasa Project (KP) in India was a programme organised to improve nutritional level and health of woman and children in rural communities. The project operates a private health centre and provides health, nutrition, immunisation, family planning and nutrition-education services at the door steps of all children less than six years of age and married women. Community involvement was achieved through part time social workers who worked to maintain community registers, check weights and distribute supplementary nutrition etc.

Rojas, Botero and Garcia (2001), in their study on community participation in malaria control programmes in Pacific coast of Colombia, focused on "*Knowledge of Education, Community Participation and Decentralization".* The researchers found that before the beginnings of evaluation of the programme, the participants already had a high knowledge about Malaria and the reason for having high knowledge about the Malaria was that the community members got the information from the community organisation called PROMESA, which disseminated information about how Malaria spreads and what precaution should be taken and how the community members could play their role. The microscopic technicians too played a key role by exercising a sustained leadership in their respective communities. This organisation enabled the programme to ripe in other organisations and groups and Malaria committees. The government Mayor Office and local government institutions took a more active role in the municipal workshops in which decision-making was conducted jointly with the community members of the village. Finally, it was observed that in any endemic malaria region, it is possible to adequately control the disease with the participation of community members.

Shoba and Kowli (1990), in their paper, "Community participation boosts immunization Coverage," discussed the importance of community participation in the immunisation programme. The study showed that, with participation of the student community, local community and voluntary organisations, follow-up of Diphtheria-Pertussis-Tetanus (DPT) vaccination and polio primary vaccination by door-to-door immunisation services improved and that costs were reduced with the help of school children or local voluntary agencies and as a result there was considerable improvement in children's health.

Bhuiy Abbas, Yasmin Fathima, Begam Farida, Rob Ubaidur, (1996), in another study in Tanzania, reported that the community-based project was launched with the objective of understanding and addressing the problem of malnutrition in Tanzania. For this, they followed the triple 'A' (Assessment, Analysis, Action) approach. The major intervention components included: food production and its conservation, feeding practices of young children, day care centres, water supply and sanitation and support to households and village institutions. These activities were initiated and coordinated by the village health committees and the community. Almost all important aspects of the INP were characterised by a high degree of participation and application of the Triple A' strategy was identified as the key to the good progress of the INP. This approach was fundamentally participatory and empowering for households and communities. This resulted in a greater mobilisation of local resources. For example, the establishment of centers to care for young children, financed by the communities and growth monitoring played a role in social mobilisation and enhanced participation. This gradually created the demand by the communities at higher administrative levels of society.

Preston (2010), in a paper, stressed the value of genuine community-health sector partnerships to develop health services for rural communities. He argued that a developmental approach will enable communities to work in partnership with health systems to employ resources to the health issue that are of most concern to communities. However, governments, practitioners, and health systems must recognise and accept that community health development requires a long-term and consistent investment, with health system reform processes and restructures managed so that these do not impact negatively on the processes. If this can be achieved, improved community health can be expected.

Rifkin SB, Hewitt and Draper (2007), in their paper "Community Participation in Nutrition Programs for Child Survival and Anaemia," presented case studies that demonstrate that community participation can enhance the uptake and response to the scalability and sustainability of health interventions. However, they raised the point that the manner in which these programmes are implemented is crucial. According to them, the process of community-based programmes are needed to understand more fully how

the particular programmes lead to specific outcomes and to understand the processes of community participation and empowerment within programmes as these expand into new environments.

Sharma V. P. (1993), in his book "*Community Participation in Malaria Control,"* reviewed the malaria control and opined that using the residual insecticides of chemical larvicides has become difficult, non-sustainable and problematic - technically and operationally. It was noted that an alternative strategy of malaria control based mainly on the active support of the communities in the application of biological and environmental management methods was launched in the mid-1980s in some malaria endemic areas of the country. Community participation in malaria vector control was elicited from the very beginning and continued throughout the intervention period. Health education is an integral part of the strategy and communities are fully informed of the serious nature of malaria and its cause-and-effect relationship, and how the communities can help control mosquito breeding and malaria.

Bhuiy Abbas, Yasmin Fathima, Begam Farida, Rob Ubaidur, (1996), noticed that the Indonesian Department of Health took the initiative to design a participatory monitoring tool with the aim of alleviating health problems effectively through community participation. For this purpose, a local NGO was entrusted the job. One of the main goals was to ensure community involvement in implementing community health programmes. The overall community health welfare aspects include a healthy environment, a healthy way of life and healthy socio-economic conditions. From the beginning, the community was directly involved since the 'MawasDiri' survey form was designed by the community members in cooperation with a village health worker, or community health worker. The MawasDiri approach proved that community participation is not only possible in all stages of a development programme, but also increases the quality of activities.

Bhuiy Abbas, Yasmin Fathima, Begam Farida, Rob Ubaidur, (1996) says that, in Bangladesh, the Comilla Development Model (CDM) popularly, known as ComillaApproach (CA), has been taken up to know about community participation in health, family planning and development activities. One of the major goals of the project

was to empower the villages taking initiatives for improving their condition through individual and cooperative action. The implementation of the CA began with conducting meetings with the villagers at strategic geographical points to ensure maximum attendance to motivate the villagers to undertake changes, and to learn how to implement new ideas. For this purpose, village cooperative societies were designed to achieve the development of economics and functional efficiency and the model was based on primary cooperatives at village level working with a Thana Training and Development Centre with a well-built institutionalised infrastructure.

Bhuiy Abbas, Yasmin Fathima, Begam Farida, Rob Ubaidur, (1996), has reported that, in Bangladesh, the Chakaria Community Health Project (CCHP) has been adopted with the objective of discovering a strategy to initiate the peoples' participation in community health. It aims at activating the existing indigenous village-based organisations like self-help groups in order to take initiatives for improving the health of the villagers. The project relied on participatory research method to carry out its activities. Accordingly, the representatives of SHO participated in the health orientation programmes organised jointly by the project Staff and the self-help groups. The information about the health practices was communicated between and among students and school teachers. The students have learnt about the good health practices brought the message to their homes and conveyed the same to their immediate neighbours. The SHO implemented the action plan in collaboration with government health functionaries or authorities to control malaria by mosquito bed nets and the SHO established six village health posts with community resources. Village health care providers were nominated by the SHOs and trained by the government.

Sharma, B.V. (2002), in his study on 'Community Contribution to TB Care in Asian Perspective,' stated that the organisation, called BRAC (Bangladesh Rural Advancement Committee), has initiated the community-based tuberculosis control project with the association of the Anti TB Association of Bangladesh and Government TB control project. The BRAC organised the tuberculosis services with the help of community health workers, i.e., ShassthyaShebikas (SSs). TheSSs were administering injections like streptomycin during first two months and on every alternative day, they were giving other

drugs and these activities of the community health workers were closely monitoring by the BRAC and the concerned health centre, which were providing the clinical and technical help to the CHW. As a result, the prevalence of the TB cases slowly reduced which, in turn, led to the reduction of mortality and morbidity in the project area. The BRAC project successfully implemented the community-based TB programme.

Similarly, Sharma, B.V (2002) reported that a community based organisation, HEED (Health, Education and Economic Development), and was successful in the control of T.B in Bangladesh. HEED played a crucial role in mobilising the community members for the formation of women groups. These tried hard to reduce the tuberculosis cases by giving TBDOTS.

It was also reported by Sharma, B.V (2002) that ACT (Advocacy for Control of Tuberculosis) which was a project of a registered society named REACH (Resource Group for Education and Advocacy for Community Health) is a community initiative to control TB in India.

The case studies of different community based projects outlined above thus highlight the importance of community participation in health programmes. The studies throw light on different models of community involvement and also on the different contexts in which the different models worked. The importance of community participation at the time of policy formulation, as well as during implementation, of the programme is stressed.

Statement of the Problem

In tune with Alma Ata declaration, in the year 2000, Indian Government have been laying emphasis on more effective community participation in services and structures for achievement of both short term and long term goals of health policy and health planning. However, even before this, the policy of Village Health Guides, and Community Health Volunteers aimed at ensuring community participation in health programmes. Similarly, attempts were made for involving NGOs through various approaches including the strategies of Mother NGOs, Service NGOs, and Field NGOs.

Studies made to analyse the success of different development projects in India indicated that the projects have not achieved the results and that the single most important factor for such failures is the lack of people's participation. The lack of participation is attributed either to the failure of the PIAs in eliciting such participation, or to the community's resistance to cooperate, in spite of such effort. The participation of people has been taken by default and so it was felt in many instances that a conscious effort is not required for such participation. Similarly, participation is taken for granted in any and every situation and so it was attempted without appropriate analysis of the social context of project implementation. However, the philosophy of community participation continued to receive greater appreciation in India than perhaps in many other parts of the world in different areas of development.

The proposed research locates itself in medical anthropology with particular reference to 'community participation' and 'health' in Warangal district of Telangana State. The Government of India launched the Accredited Social Health Activist (ASHA) scheme as a referral between the village community and the primary health Centre (PHC) under the National Rural Health Mission (2006) to address the health issues of the rural community particularly the vulnerable sections of society. The proposed research will attempt to compare the role played by ASHA in the tribal and non-tribal areas with the following specific objectives:

Objectives of the Study

1. To understand the changes in the health behaviour of the community members due to the impact of the ASHA scheme.
2. To identify the extent of participation of ASHA workers in curative health programmes.
3. To examine how the ASHA workers are mobilising the community towards local planning and health services.
4. To understand assigned roles, role performances and role conflicts of the ASHA workers in different social and cultural contexts.
5. To study the familial and community support for ASHA workers.

Study Area

In order to carry the research, the researcher has selected Warangal district in Telangana State, since this district has a high concentration of tribals who are vulnerable to high morbidity and mortality. The researcher selected three villages to carry the research. Of the three villages, one is a tribal village (Gopa Thanda) in Kuravi Mandal and one is a non-tribal village (Golla Charla) and one other, Damarvancha in Gudur Mandal, is a mixed village, where tribals and non-tribals are residing together.

Research Methodology

In order to achieve the research objectives, the researcher has employed both qualitative and quantitative research techniques. For obtaining the qualitative data, the researcher actively participated as participant observer and conducted in-depth interviews and focused group discussion. The researcher also employed the quantitative research technique like survey in order to get socio-demographic profile of the villages. The parameters included: sex ratio, marital, educational, occupational, income status of the inhabitants of the study village. The researcher consulted ASHA co-coordinators, supervisors and PHC Doctors and collected data from the ASHA workers in the PHCs of Balapala, Dornakal and Gudur on their roles and responsibilities in the respective villages.

Secondary sources: The researcher obtained the secondary data from books, articles from different journals, unpublished thesis and also popular articles. The secondary data was used for comparison of the results of the current study and also to supplement the discussions based on primary data.

Structure of ASHA Scheme at National Level

It is very pertinent to know about the structural and functional aspects of the ASHA scheme. The health functionaries at the national, state and district levels are assigned the work of implementation and supervision. In the following paragraphs, a brief explanation of the functionaries responsible for the implementation of the ASHA scheme is given.

National Level

At this level, the Ministry of Health and family Welfare, as the nodal ministry, plays an important role in the implementation of the ASHA scheme. The Ministry of Health and Family Welfare guides all the state governments regarding the implementation of the scheme in an effective manner.

State Level

At this level, the Department of Health and Family Welfare, AYUSH, Women and Child Development, Panchayat Raj institution is responsible for preparation of the integrated state action plan. Each State government is authorized to develop its own strategy for National Rural Health Mission (NRHM) under the overarching guidelines of the Government of India.

District Level

The preparation of integrated district action plan, as per the NRHM is the mandate of district health mission, led by the ZillaParishad. The ZillaParishad is required to lead the activities at the district level and has specific responsibility to monitor the ASHA schemes.

Ethical Consideration

The researcher has informed the community members of the selected village, the ASHA workers, PHC staff, Doctors, ANM workers, informed that the data collected from the field study would be used only for the study purpose and assured them that confidentiality of personal identity, and privacy would be maintained.

Chapterisation

The study has been undertaken as per the following plan described below

Chapter -1 Introduction

This covered issues like introduction of the research topic, review of literature, problem of the study, research hypothesis, research questions, and statement of the problem,

research objectives, research methodology and limitations of the study. Areas explored in some depth included: the concept of community participation (which included the one in the field of health), the initiative of International bodies for community participation in health, Indian initiatives in health, the various committees set up by the central government to make suggestions in the field of health, the National Health Policies (1983, 2002 and 2015), health care reforms in India, approach to primary health care, the Integrated Child Development Service Scheme, Universal Immunisation Programme, and the concepts of National Rural Health Mission and the ASHA

Chapter-2 Profiles of the Study Villages

This chapter presented the profile of the study villages. The areas covered here included: the sex ratio, community composition, occupational status, and educational status and income levels in the study villages. There was also a discussion on the health profile (including that of the earlier 10 districts, which have now been expanded into 31 districts) of the state of Telangana. A comparison was also made of the availability of PHCs in the state vis-à-vis other states of the country. A comprehensive account of the various life cycle rituals of the two main tribal groups, Banjaras and Koyas, residing in the study area was also presented. This was considered necessary since many health related issues like diet, clothing, care of pregnant women and new born children can be impacted by the culture, tradition and beliefs of the residents of any area.

Chapter -3 Socio-Demographic Profile of ASHA; Process of Selection and Training

This chapter discussed the process of the recruitment of the ASHA workers, the motivational factors and reasons for becoming ASHA workers. It also focused on the training aspects, which included the induction training, refresher training and the support mechanisms to the ASHA workers. It also outlined the ASHA Resource Centre (ARC) and socio-demographic profile of the ASHA workers, distribution of these workers by the community, education, income, age, and experience. Finally, it also attempted to examine the familial and community support to the ASHA workers in the study area.

Chapter-4 Roles Assigned Role Performance and Role Conflicts Faced by the ASHA Workers in Different Social and Cultural Contexts

This chapter focused on the roles assigned to the ASHA workers, role performance and role conflicts at the village and family levels. The ASHA workers have been assigned many roles and responsibilities. These include: registration of births and deaths, pregnancy confirmation, counseling women on birth preparedness, explaining the importance of safe delivery to the pregnant women and also the need for ANC and PNC check-ups. The ASHA workers also play an important role in creating awareness about breast-feeding, complementary feeding, immunisation, contraception, prevention of common infection, including Reproductive tract infections and sexually transmitted infections (RTIs/STIs), communicable and non-communicable diseases and care of the young children.

Chapter-5 Impact of ASHA: Changes in the Health Behaviors of the Community Members: Comparison of Tribal and Non-Tribal Villages

This chapter specifically focused on the changes of the health behaviour of the community members under the influence of the ASHA workers. This chapter also contained the comparative analysis of the health behavioral change in the tribal and non-tribal areas**.** This chapter focused on the outcome of the ASHA programme under NRHM. It also discussed about the success and failure of the ASHA programme in the tribal and non-tribal areas. A very positive sign was the very high level of awareness of the residents in the study area about the presence of ASHA workers there. Also, such persons were approaching these workers for help and advice on health-related issues. Equally encouraging was the fact that an overwhelming number of respondents mentioned that the ASHA workers were attending to their assigned duties regularly.

Chapter -6 Conclusion: Analysis of Success and Failure

This chapter focused on the outcome of the ASHA programme under NRHM. This also discussed the success and failure of the ASHA programme in the tribal and non-tribal areas.

Summary

The chapter primarily focused on the concept of community participation and its role in different developmental programmes. The international bodies such WHO, UNICEF is taking a lot of initiatives in the field of the community participation in the primary health care. It also discussed the Government of India initiatives in health sector, such the important committees appointed from time to time and national health policies. It also critically looked into the review of literature and case studies related to community participation in the primary health care sector. Apart from these, the statements of the research problem, research hypothesis, objectives of the studies, research methodology and research area were discussed.

Limitations of the Study

The study aims to investigate the community participation in Primary Health Care and the role of the ASHA Workers in health improvement of the community members. In fact, the study has limited to micro level due to time and cost constraints. Some of the respondents in the study area did not provide proper information because of the various reasons. Due to the above mentioned reasons I could not provide sufficient information at some parts of the thesis. However, whatever information that I have provided to suffice the argument presented in the thesis is collected putting my best efforts within given time and financial constraints.

Chapter – 2

Profile of the Study Area

Telangana State Profile

The state of Telangana, formed on the 2nd June 2014, due to the bifurcation of the erstwhile state of Andhra Pradesh, is the 29th state in India. The Telangana region was earlier part of the Hyderabad state from 17th September 1948 to Nov 1st 1956. The state has an area of 1; 14,840 sq.km and the Census 2011 had put the state population at 3, 52, 86,757. It is the 12th largest State in India and the 12th most populated State in India. Telangana is bordered by the states of Maharashtra, Chhattisgarh to the north, Karnataka to the west and Andhra Pradesh to the south and it shares a small border with Orissa too. Till recently, the Telangana State comprised of 10 districts, namely, Adilabad, Karimnagar, Medak, Warangal, Khammam, Ranga Reddy, Nizamabad, Mahbubnagar, Hyderabad and Nalgonda (Telangana State Portal, Undated). For administrative convenience, the state has been divided into 21 districts recently.

Telangana State, which acquired its identity as the Telugu-speaking region of the princely state of Hyderabad ruled by Nizam of Hyderabad (1724-1948), joined the Indian Union in the year 1948. In 1956, the Hyderabad state was dissolved as part of the linguistic re-organisation of states and Telangana was merged with the former Andhra State to form Andhra Pradesh. Following a popular movement for separation, it was accorded separate statehood on June 2nd 2014 (Telangana State Portal, Undated).

Etymology

The name Telangana is believed to have been derived from the word Trilinga, as in Trilinga Desa, which translates into “The Country of three Lingas.” According to the Hindu legend, Lord Shiva descended in the *lingam* form on three mountains, Kaleshwaram, Srisailam and Draksharama, which marked the boundaries of the Trilinga Desa. Later, it was called Telinga, Telunga or Telugu. The word “Telinga” changed over

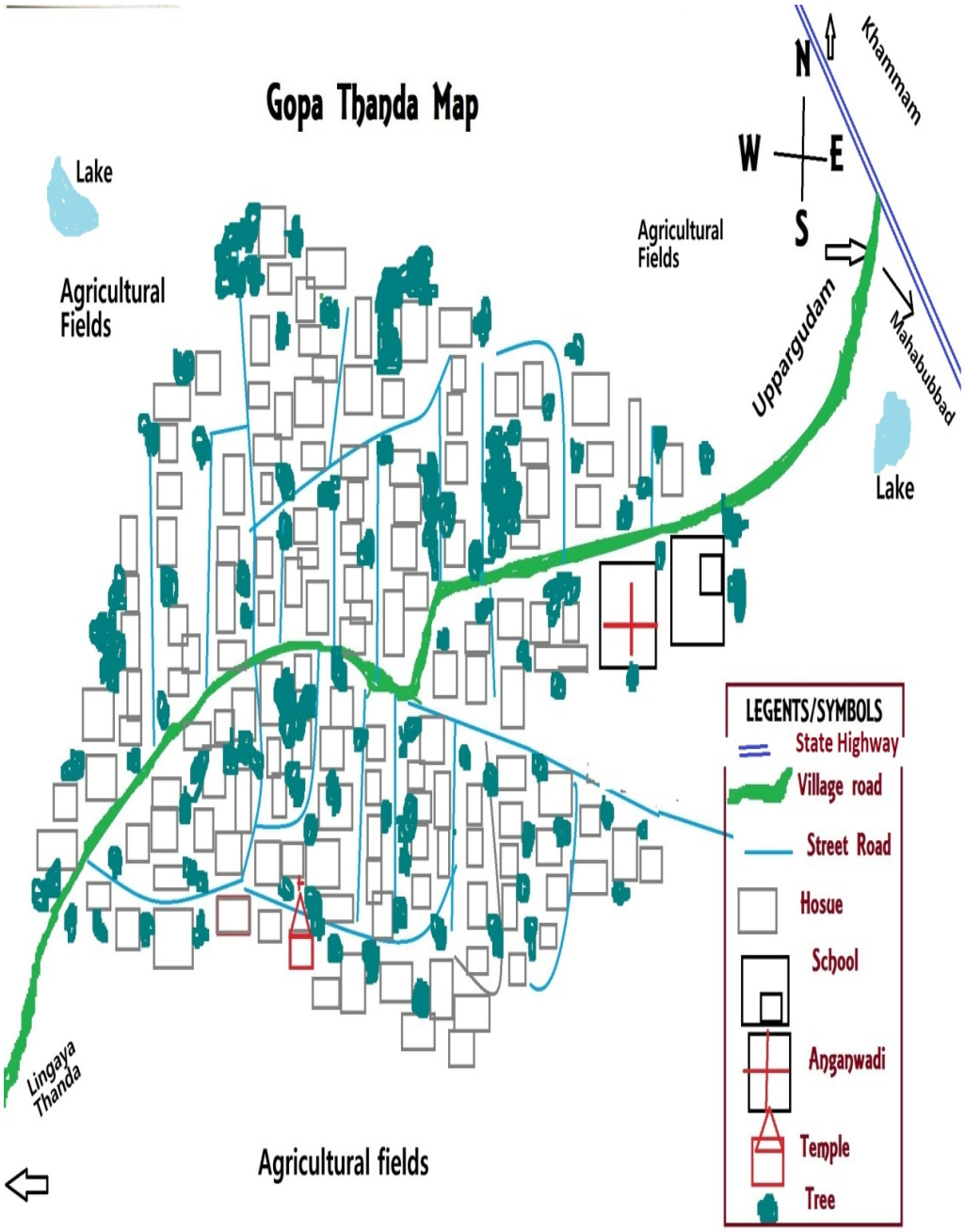
time to Telangana and the name Telangana was designated to distinguish the predominantly Telugu speaking region. (Telangana State Portal, Undated)

MAP 2.1: Political Map of India

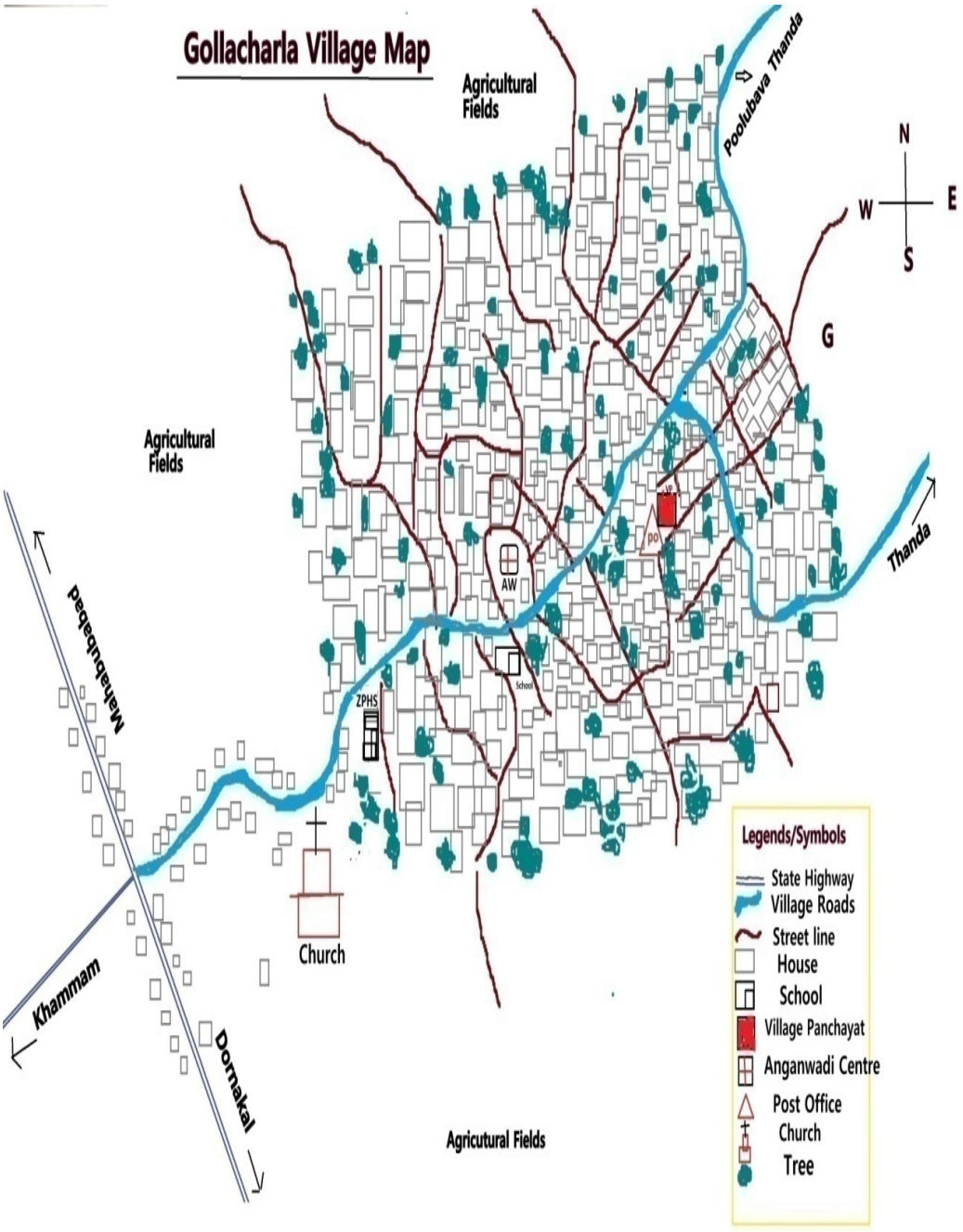
MAP 2.2: Political Map of Telangana State

MAP 2.3: Political Map of Warangal District

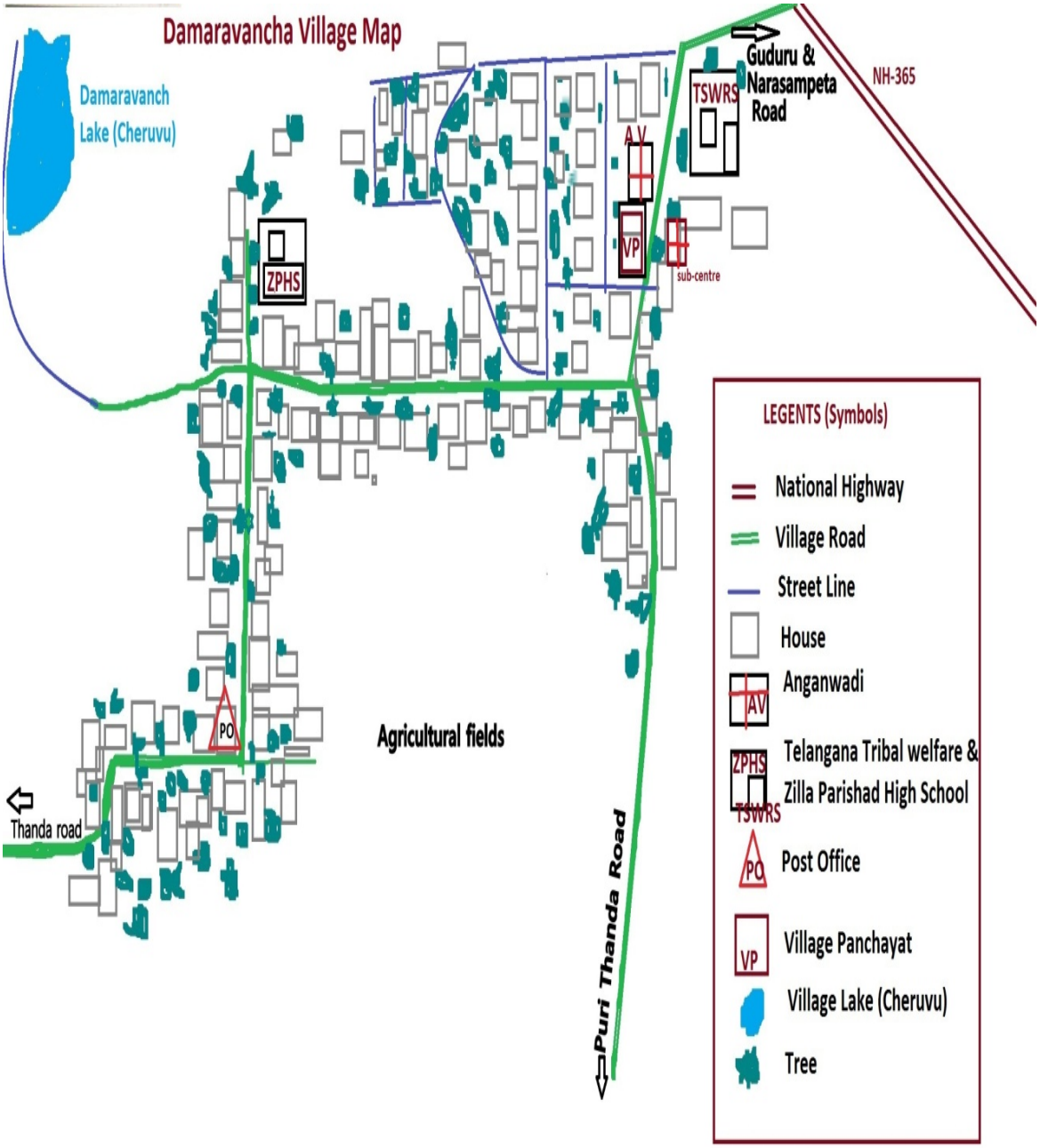
MAP 2. 4: Village Map of Gopa Thanda



MAP 2.5: Village Map of Golla Charla



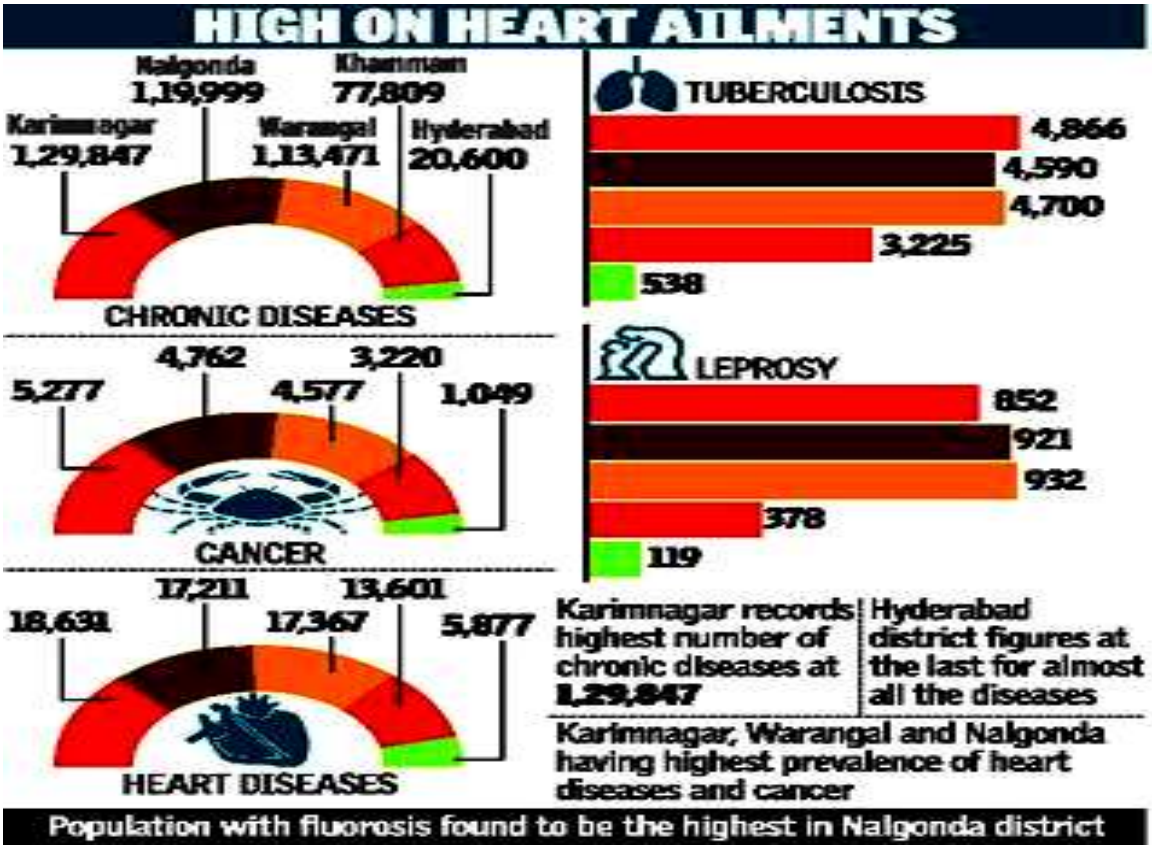
MAP 2.6: Village Map of Damaravancha



Telangana State Health Profile and Healthcare Infrastructure

Prevalence of Morbidity in Telangana State

An idea of the health profile of any region can be had by examining the prevalence of diseases there. A low prevalence of diseases can suggest that the people are generally enjoying a good state of health and can carry out their daily activities reasonably well. In the process, the economy of that region would be on a more sound footing. On the other hand, when diseases are endemic, it could lead to loss of income of the affected daily wage earners and entail expenditure on both preventive and curative treatment. The Chart below depicts the position about the major ailments in the state.



Source: http://www.thehindu.com/news/national/telangana/heart-ailments-highestamongchronic-diseases-in

It can be seen from the above chart that heart ailments figure prominently among the chronic diseases in the state. The Comprehensive Household (Samagra Kutumba) Survey (CHS) which surveyed a population of 10,193,027 puts the total population having chronic diseases at 7, 58,985 of which, 1, 17,888 were found to suffer from heart ailments.

The major heart-related ailments were found to be: Coronary Artery Diseases (CAD), myocardial infarction (commonly known as heart attack), other Cardio Vascular Diseases (CVDs), rheumatics' heart disease, hyper sensitive heart disease, cardio myopathy heart arrhymia and congenital heart disease. Asthma, tuberculosis, cancer and leprosy were also found to be widely prevalent in the state. According to information collected as part of the Integrated Household Survey (IHS) across the Telangana State during August, 2014, the relative proportion of different chronic diseases was: heart diseases (16 per cent), followed by the asthma (10 per cent), paralysis and fluorosis (9 per cent each), epilepsy and filaria, (5 percent each) and cancer and tuberculosis (4 per cent each).

District-wise Break-up

The district wise break-up of diseases shows that Karimnagar district recorded the highest number of chronic diseases at 1, 29,847, closely followed by Nalgonda (1, 19,999) and Warangal (1, 13,471) districts. The Hyderabad district 'performed' better for almost all the diseases. The survey data reported that the total number of diseases people have suffered from was 1,049 for cancer, 5,877 for heart ailments, 538 for tuberculosis, and 1,572 for paralysis, apart from 163 AIDS cases. Ranga Reddy district, neighbouring the capital city, was found to be having almost three times the chronic disease burden when compared to Hyderabad. Same was the case with another neighbouring district of Medak.

It must be mentioned here that the survey, which was carried out on a single day, could not cover the entire state population, as was originally planned. Still, it showed that the districts of Karimnagar, Warangal and Nalgonda were having highest prevalence of heart diseases and cancer. The population with fluorosis was found to be highest in Nalgonda with the incidence found to be nearly double than the second highest, Warangal District (*The Hindu*, 10th February, 2015).

As already mentioned, the health profile of the Telangana State provides the summary of the health status of the people of the state. The Table 2.1 below outlines the status regarding MMR, IMR, CBR, TFR, and immunisation status. (http://nrhm.gov.in/nrhm-instate/state-wise-information/telangana.html#state_profile) These issues will be discussed in detail in the subsequent paragraphs.

Table 2.1: Health Profile of Telangana State

District	MMR 2013*	IMR 2013*	TFR 2013*	CBR*	Full Immunisation**
Mahbubnagar	98	53	2	17.7	55.9
Ranga Reddy	78	33	2	18	35.5
Hyderabad	71	20	2	19.5	55.2
Medak	90	49	1.9	17	42.9
Nizamabad	79	48	1.6	19.4	49.4
Adilabad	152	48	1.7	19.2	38.7
Karimnagar	74	37	1.9	18	38.5
Warangal	78	39	1.8	16.3	72.3
Khammam	99	45	1.8	17.5	44.7
Nalgonda	90	47	1.6	17.4	50
State	**92**	**39**	**1.8**	**17.5**	**48.31**

(Source: RHS (Rural Health Statistics) Bulletin, March 2012, M/O Health & F.W., GOI)

It can be seen that Adilabad district was having the highest MMR (152 per 100000 maternal mothers), whereas, Hyderabad recorded the lowest (71 per 100000 maternal mothers). As regards IMR, Mahbubnagar district recorded the highest IMR (53 per 1000 live births) and Hyderabad, the lowest (20 per 1000 live births). When one views the total fertility rate (TFR), one would find that Mahbubnagar, Ranga Reddy and Hyderabad districts recorded on an average two children per one woman. Districts with the lowest TFR were Nizamabad and Nalgonda.

The Crude Birth Rate (CBR)–was the highest (19.4%) in Hyderabad, and the lowest in Warangal (16.3%). When it comes to infant and child immunisation, Warangal recorded the highest (72.3%) figures and Ranga Reddy, the lowest (35.5 %).

Availability of Public Health Facilities in Telangana State

After discussing the overall health profile in the state of Telangana, it would only be appropriate to have an overview of the public health facilities available in the districts of the state. This would give one an idea about the various 'ports of call' which the citizens could approach whenever they are facing health issues. The Table 2.2 below depicts the various health facilities available in the state.

Table 2.2: Availability of public health facilities in Telangana State

District	Population	PHCs	Ave. Pop covered by one PHC	SCs	CHNCs	CHCs	Area Hospitals	District Hospitals
Mahbubnagar	40,53,028	84	48250	680	19	14	4	1
Ranga Reddy	52,96,741	52	101860	399	11	9	4	1
Hyderabad	39,43,323	85	46392	53	14	10	3	1
Medak	30,33,288	67	45272	489	10	8	3	1
Nizamabad	25,51,335	40	63783	412	14	14	3	1
Adilabad	27,41,239	72	38072	470	17	13	6	0
Karimnagar	37,76,269	71	53186	580	20	16	3	1
Warangal	35,12,576	75	46384	605	16	14	4	1
Khammam	26,07,066	57	45738	549	14	11	5	1
Nalgonda	34,88,809	72	48455	626	15	5	7	1
Total	**3,50,03,674**	**675**	**51857**	**4863**	**150**	**114**	**42**	**9**

Note: SCs – Sub Centres; PHCs – Primary Health Centers; CHNCs – Community Health and Nutrition Centers; CHCs - Community Health Centers. **Source**: RHS Bulletin, March 2012, M/O Health & F.W., GOI.

It is evident that there are a number of health centres in all the districts of the state. Of these, Area and District hospitals are located in major cities and towns which may be located far away from some remote villages and not easily accessible for all. Hence, the

focus now will be largely on PHCs (Primary Health Centres), which are within easy reach of people residing even in remote areas.

It is evident from the above Table 2.2 that the three predominantly tribal districts of Adilabad, Warangal and Khammam have a reasonable good coverage of PHCs in terms of the population of the district. Still, the numbers are nowhere near the stipulation of one PHC for a population of 20,000 in predominantly tribal areas, as mentioned in the RHS Bulletin, March 2012, M/O Health and Family Welfare of the Government of India. The situation is even more dismal in the case of Ranga Reddy, Nizamabad and Mahbubnagar districts, where each PHC is serving a very large population.

Analysis of the Nation-wide Availability of PHCs

In the following table, data on nation-wide availability of PHCs is presented so as to understand how the state of Telangana is faring in the matter of availability of PHCs vis-à-vis other states in the country.

Table 2.3: Nation-wide Availability of PHCs

S. No	State	Population of the state	Number of PHCs	Average number of population served by the PHCs
1	U.P	199,812,341	3497	57138
2	Maharashtra	112,374,333	1811	62050
3	Bihar	104,099,452	1883	55283
4	W.B	91,276,115	909	100413
5	M.P	72,626,809	1171	62021
6	Tamil Nadu	72,147,030	1372	52934
7	Rajasthan	68,548,437	2083	32908
8	Karnataka	61,095,297	2353	25964
9	Gujarat	60,439,692	1247	48468
10	A.P	4,95,77,103	1069	46377
11	Odisha	41,974,218	1305	32164
12	Telangana	3,50,03,674	675	51857
13	Kerala	33,406,061	827	40394
14	Jharkhand	32,988,134	327	100881
15	Assam	31,205,576	1014	30774
16	Punjab	27,743,338	427	64972
17	Chhattisgarh	25,545,198	792	32254
18	Haryana	25,351,462	461	54992

19	J&K	12,541,302	637	19688
20	Uttarakhand	10,086,292	257	39246
21	Himachal Pradesh	6,864,602	500	13729
22	Tripura	3,673,917	91	40372
23	Meghalaya	2,966,889	110	26971
24	Manipur	2,855,794	85	33597
25	Nagaland	1,978,502	128	15457
26	Goa	1,458,545	792	1841
27	Arunachal Pradesh	1,383,727	117	11826
28	Mizoram	1,097,206	57	19249
29	Sikkim	610,577	24	25440
	All India	1,210,854,977	26021	46533

The 'better performing' states having the number of PHCs very close to the norm set by the Union Ministry of Health and Family Welfare (of having one PHC for every 20,000 populations in tribal areas and for every 30,000 residents in other rural areas) are: Karnataka, Odisha, Assam, Himachal Pradesh, Nagaland, Goa and Mizoram. The 'laggards' in this regard have been Jharkhand, West Bengal, Maharashtra, Uttar Pradesh, and Madhya Pradesh. The two Telugu states, Telangana and Andhra Pradesh, were found to be figuring in between the categories of states, with figures of 51,857 and 46,377 respectively.

Medical and Healthcare Infrastructure in the Warangal District

The District Medical and Health Officer (DMHO) is the administrator and overall in charge and looking after various medical and health programmes including National Health Mission (NHM) and NRHM and other various national health programmes. The DMHO is assisted by five programme officers from the medical community and three other programme officers. The Medical and Health Department in the District has the following composition:

Table 2.4: Medical & Health Care Infrastructure in the Warangal District

S.No	Health Functionaries	Numbers
1	Community Health and Nutrition Clusters	3
2	Community Health Centres	3
3	24X7 Round the Clock PHCs	6
4	Total No. of Primary Health Centres	17
5	Total No. of P.P.P Units	2
6	Total No. of AYUSH Dispensaries	21
7	Ayurvedic	11
8	Unani	2
9	Homeo	7
10	Naturopathy	1
11	Number of Sub-Centres	145
12	No. of ANMs	284
14	No. of ASHA Workers	794
15	No. of Anganwadi Workers	858
16	No. of RBSK (Rashtriya Bal Swasthya Karyakram) units	6
17	108 Ambulances	9
18	No. of 104 Services (FDHS (Fixed Day Health Services) PHC Mobile Units	3
19	Adult Sex Ratio per 1000 Males	994
20	IMR for 1000 Live Births	38
21	MMR per 1 Lakh Live Births	79
22	Total Fertility Rate	1.7
23	The C.H.Cs and PHCs are having Bed Strength of 30 and 6 respectively. There are at present 29 Medical Officers, 30 Staff Nurses, 16 Pharmacist and 13 Lab Technicians working in the PHCs	

It is evident from the above table that the Warangal District has both public and private functionaries. The above Table outlines about the existing of the public health functionaries in Warangal district which has 17 PHCs covering a population

of 35, 12,576. It in this regard, in this district 1 PHCs is serving a population 20, 6,622 populations.

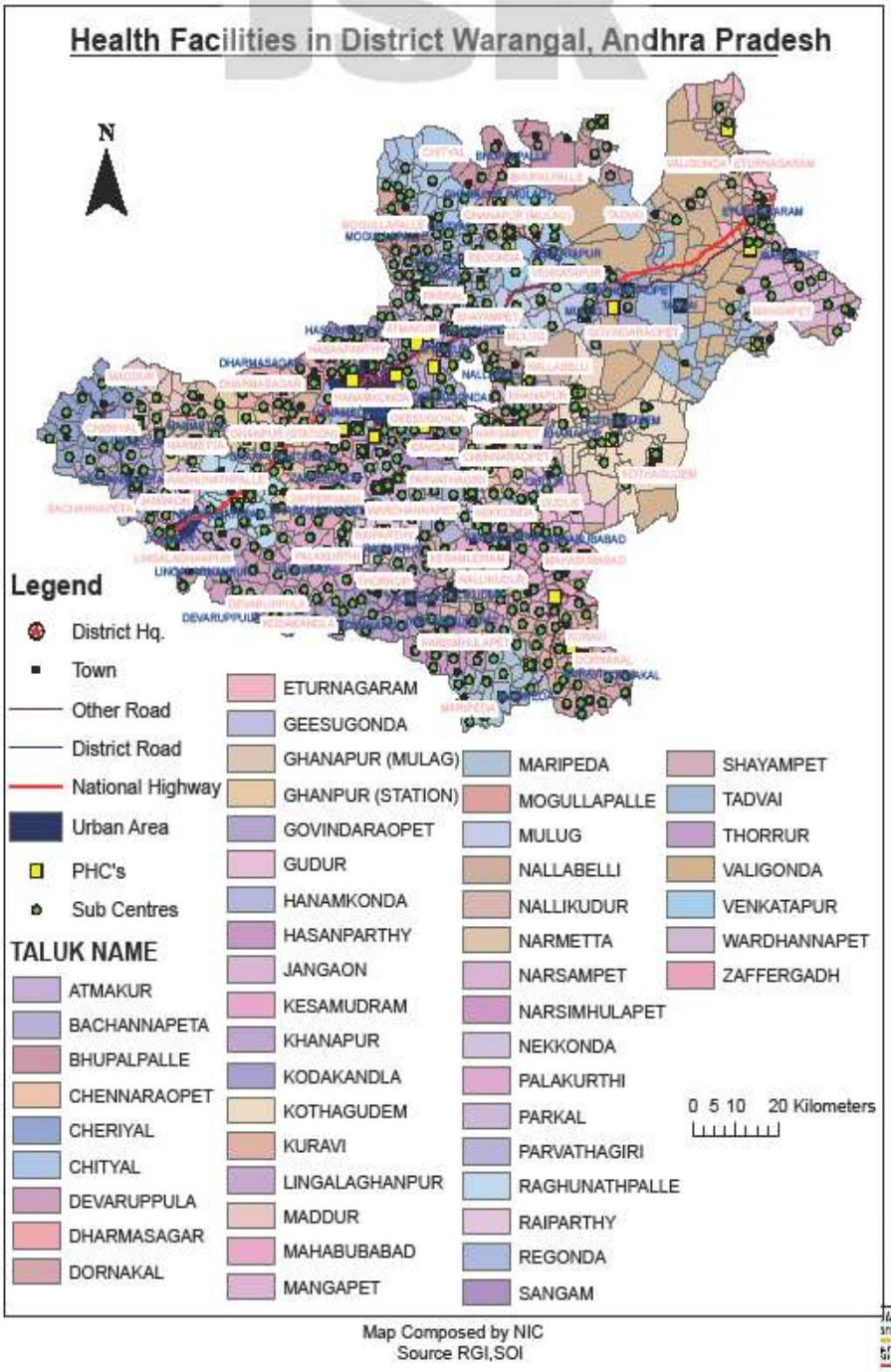
However, still, the numbers are nowhere near the stipulation of one PHC for a population of 20,000 in predominantly tribal areas, as mentioned in the RHS Bulletin, March 2012, M/O Health & Family Welfare of the Government of India. Therefore, it the has brought certain about the paucity of health care infrastructures, so in this context the concern Medical and Health Department in the District has made some proposals to the Government of Telangana State. These include:

It is proposed are being submitted to the higher authorities to

- Set up 9 more 24X7 PHCs so that every Mandal in the District has at least one 24X7 PHC.
- Enhance the bed strength of Parkal CHC to 100 Beds.
- Construct permanent government buildings for the 117 sub-centres where are now located in rented buildings.
- Provide manpower, infrastructure facilities to conduct deliveries in all the PHCs[1].

[1] Sources:http://www.warangalrural.telangana.gov.in/districtdepartments/medicalhealth/

In the case of Andhra Pradesh, the Distance sheets (Excel sheets) may not coincide exactly with the Sub-Divisions below the map.



The above graphic outlines the presence of PHCs and Sub-Centres in Warangal District.

Warangal District Profile

Socio-Demographic Profile of the District

As per the 2011 census the Warangal district of Telangana State has total population of 3,512,576 (1,759,281 males and 1,753,295 females). The average sex ratio of Warangal district is 997. In this district, 71.7 percentage of the population resides in rural areas. The average literacy rate in urban areas is 81 percentages, while that in the rural areas is 58.8 percentages. The sex ratio of urban areas in Warangal district is 990 while that of rural areas is 999. The total literacy rate of the Warangal district is 65.11 percentages (male literacy rate, 67.06 percentages and the female literacy rate, 50.49 percentages).

Warangal district is situated in the northern part of the Telangana State. The administrative headquarters is at Warangal, which is approximately 80 km. from the state capital, Hyderabad. The District has an area of 12,846 km². The district is bounded by Karimnagar District to the north, Khammam District to the east and south east, Nalgonda District to the south west, and Medak District to the west.

Warangal is one of the major districts of Telangana State in India. It extends over 12, 84,000 hectares in area. Only one-fourth of the geographical area of the district is under forest cover (http://www.telangana.gov.in/about/districts/warangal). The Warangal is well known for its granite quarries (notably the black and brown varieties) and as a market for rice, chilli pepper, cotton, and tobacco.

Etymology and History

During the reign of the Kakatiya dynasty, it was also referred as 'Orugallu'. It was also known as Vorakalli, Akshalingaram, and Tolini Koranakaula, Aravabinakosam. A literally work of Ragunatha Bhaskar mentioned Warangal as Ekasilanagaram.

Warangal was the capital of the Kakatiya kingdom from 1195 A.D, when the ruling family was defeated by the Delhi Sultanate in 1323. Then, the city was renamed as Sultanpur. The Kakatiyas left many monuments, impressive fortresses, four massive

stone gateways and temples. The Swambhu temple is dedicated to Lord Shiva and the Ramappa Temple is situated near the Ramappa Lake. The Thousand Pillar Temple, Padmakshi Hill and the Govinda Rajula Gutta are two famous hills with the temples. Bhadarakali and Weddepally are the two major lakes which add scenic beauty and are also the major sources of drinking water for the town.

The cultural and administrative distinction of the Kakatiyas was mentioned by the Italian traveller, Marco Polo. After the defeat of King Pratapa Rudra II, Masunuri Nayak united the 72 Nayak chieftains and captured Warangal from the Delhi Sultanate. The Nayaks ruled for the period of 50 years. After the decline of the Nayaks, Warangal became a part of the Bahmani Sultanate and then the Sultanate of the Golconda.

The Mughal emperor Aurangzeb conquered Golconda in 1687, and Warangal remained part of the Mughal Empire until the southern provinces of the empire broke way and became a part of the state of Hyderabad in 1724. The state included the Telangana region and some parts of the present day Maharashtra and Karnataka. Hyderabad was annexed to India in 1948. In the year 1956, Hyderabad was merged with Andhra Pradesh under the State Reorganisation Act (SRC), 1956. Finally, the Telugu-speaking region of Hyderabad state, which included Warangal, became a part of the Andhra Pradesh.

Geography and Climate

Warangal is located at 18.0 degrees' north latitude and 79.58 degrees' east longitude. It has an average elevation of 302 metres (990 feet). It is situated in the eastern part of the Deccan plateau. It is made up of granite rocks and hill formations. The left region of the Warangal is barren and the agriculture here is largely dependent on the seasonal rainfalls. There are no rivers flowing nearby Warangal, which makes it to rely for its drinking water requirements on the Kakatiya Canal, which originates from the Sriramsagar Project. The Warangal is located in the semi-arid region of Telangana, which has a predominantly hot and dry climate. The summer season starts in March and peaks in the month of May with the average high temperature of 42 degrees centigrade. The monsoon arrives in June and lasts until September with about 550 mm of precipitation. The dry and mild winters start in the month of October and last until at the end of the February, when

there is little humidity and the average temperature is around 22-23 degrees centigrade. Many lakes and hill rocks are located in and around Warangal.

Flora and fauna

The flora of the District can be broadly classified into: timber, softwood, fuel, bamboo shrubs and various kinds of grasses. The important floral species found in the Warangal district are mentioned below.

Flora

The district is endowed with the floral species like Thiruman, Maddi, Madhuca, Terminalia, petrocarpus. Teak (Tectonagrandis), Ippa (MadhukaIndika), Magno (MangiferaIndica), Palmyra Palm (Borassus flabelliform) and jack fruit (Artocarpushetero phyllus). The hardwood species found in the study area include: Vepa (Azadirecta Indica), Nallamaddi (Terminiliaalata), Tuniki (Diospyros), Jetregi (Dalbergialafifolia) and Amla (Phyllanthusemblica).

Plate 2.1: Forest in Warangal District

Plate 2.2: Animals are taking a graze on the side of a water body in Warangal District

Fauna

The fauna found in the area are: tigers, bears, jackals, and sambars, wild goats, spotted deer, wild jungle sheep, black buck, wild pig and different types of Monkeys. The bird species found in the district are: cranes, pelicans, egrets and gulls.

Eturnagaram Wildlife Sanctuary

Telangana State has been endowed with splendid wildlife reserves. The Eturnagaram Wildlife Sanctuary, located in Eturnagaram village of the district, is one such reserve. It is 100 km away from the district headquarters and 250 km (160 miles) from Hyderabad. It is one of the oldest sanctuaries of Telangana. On 30th January 1952, the erstwhile Hyderabad Government declared it as a sanctuary, because of its rich bio-diversity. The land is undulating from the steep slopes to gentle slopes from west to east. Three-quarters of the area consist of a plain while the rest of the area is hilly with many streams and springs. The Godavari River is passing through the sanctuary. The vegetation here is the tropical dry deciduous type, with teak and other trees of good quality standing 60 ft. (18 m) and above. The biennial festival of Sammakka Saralamma Jatara held in the sanctuary.

The flora presents in this sanctuary include: thriuman, bamboo, teak, madhuca, terminalia, and pterocarpus. The perennial water source, called “Dayyam Vagu,” divided

the sanctuary is into two halves. It is home to many wild animals like: tiger, leopard, wolf, dholes, gold jackals, sloth bear, chousingha, blackbuck, nilagi, sambar, spotted deer, chinkara, Indian giant squirrels and many kinds of birds. Reptiles like mugger crocodiles, pythons, cobra, kraite and Star can also be found in the sanctuary.

Agriculture

In 2011 a study on Warangal reported that 4, 71,000 ha of land are cultivated every year and of these 1, 38,000 are cultivated more than once. While 68.8% of the cultivated land enjoys irrigation facilities, the remaining crop land is rain-fed. The largest crop is rice, which accounts for 198,000 ha (32.5 % of the gross cropped area). The next largest crop is cotton; planted on 158,000 ha (26% of the gross cropped area). Altogether, farmers grow grains (mostly rice and maize with some sorghum) on 287,000 ha (47.1% of the gross cropped area), pulses and legumes (groundnut, green gram, red gram, bajra and Bengal gram) on 104,000 ha (17.1% of the gross cropped area), and horticultural crops (mostly chillies, some turmeric) on 33,400 ha (5.5% of the gross cropped area). Only 39.7% of cotton is irrigated and the remainder is rain-fed (http:/www.sourcewatch.org/index.php/Agriculture_Warangal_India).

Railways

The Kazipet Junction and Warangal railway station are two major stations which provide rail connectivity to the city. These are under the jurisdiction of the South Central Railway; whose headquarters are at Secunderabad. The stations lie on the important route of New Delhi-Chennai and New Delhi-Hyderabad main line of the Indian Railways. The Kazipet Junction is housing both Electric and Diesel Loco sheds capable of holding 175 and 142 locomotives. Kazipet town, Vanchanagiri, Hasanparthy Road are the other railway stations within Warangal city limits.

Culture and Religion

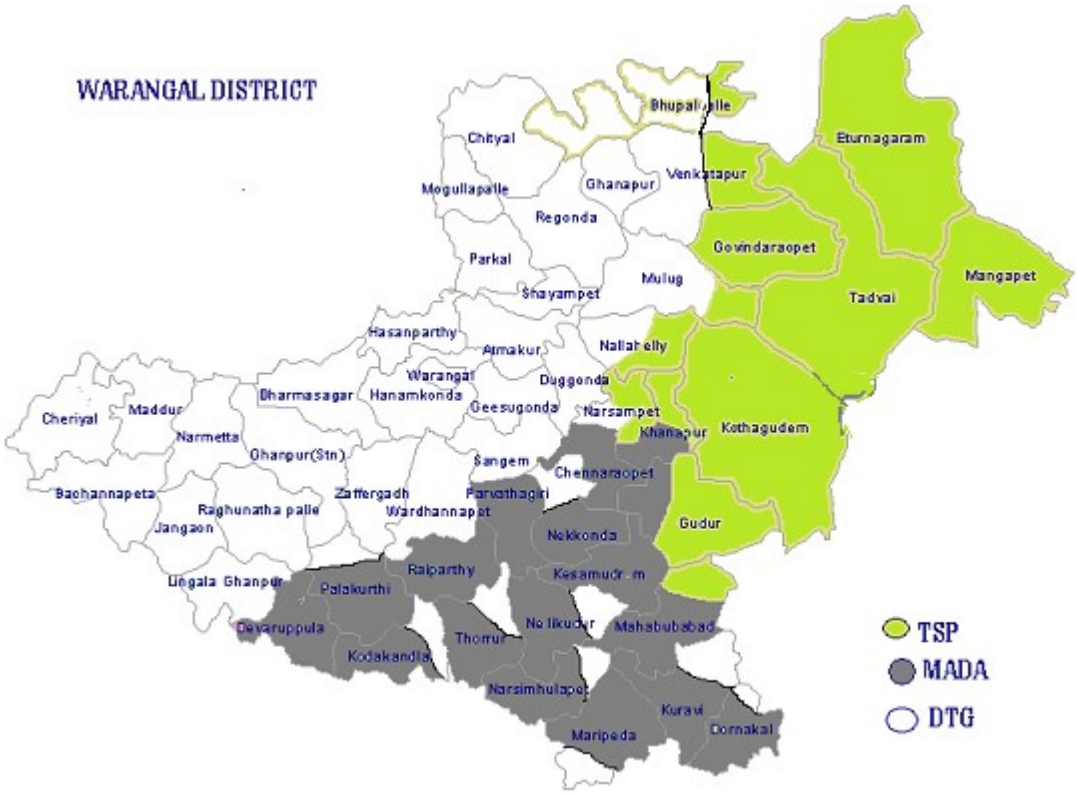
Along with "*Bathukamma" and "Bonalu*""*Sammakka Saralamma Jatara*" (a popular religious congregation in honour of Goddess at Medaram of Warangal district) amply depict the culture and tradition of the district. In the district, 83.41% of the residents are

Hindus; 14.39%, Muslims and 2.2%, Christians and Others, who include Sikhs and Jains, account for 0.55% of the population.

Tourism

The Glorious Kakatiya Temples and Gateways have been added to the tentative list of World Heritage sites by UNESCO. The main tourist attractions in the district include the Warangal Fort, Thousand Pillars Temple, Padmakshi Temple, Bhadrakali Temple, Kazipet Dargah, Ramappa Temple, Pakal Lake and Laknavaram Lake.

Koyas and Nayakpods constitute the aboriginal tribes of Warangal district. The Lambadas and Erukalas were declared as Scheduled Tribes in 1977. The tribal population of the district, according to 2011 census, is 5.305 lakh. The STs constitute 15.1% of the total population of the district.



In Warangal district, Eturnagaram, Mangapet, Tadvi, Govindaraopet, Mulugu, Kothaguda, Gudur and Mahabubabad mandals are mostly inhabited by tribals and come

under TSP area. Bhupalpally, Venkatapur, Nallabelly, Narsampet and Khanpur are the other Tribal Sub Plan (TSP) Mandals with some ST population.

Profile of the Selected Mandals

The following is the profile of Kuravi Mandal, Dornakal Mandal and Gudur Mandal.

Healthcare Infrastructure Profile

The availability of the health care infrastructure is the parameter for health care improvement and development of the people in the mandals. The Table 2.5 below outlines health care infrastructure in the selected mandals.

Table: 2.5 Health Care Infrastructure Profiles of the Selected Mandals

S.No	Mandal	SCs	PHCs	ANMs	No. of ASHA	Public/Private Doctors
1	Kuravi	23	01	45	75	5
2	Dornakal	21	01	42	74	7
3	Gudur	18	01	35	81	5
4	Total	32	03	46	230	17

From the above Table 2.5, it is evident that in all the three mandals have one PHC each. Even though, the average population in all the three mandals is more than 40,000, the number of PHCs is now here near the stipulation of one PHC for a population of 20,000 in predominantly tribal areas, as mentioned in the RHS Bulletin, March 2012, M/O Health & Family Welfare of the Government of India. The same is the case with the number of Sub-Centres. It can be seen that one doctor is serving a population of ten thousand in the Mandals under study mandals.

Kuravi Mandal: Socio-Demographic Profile

Kuravi, one of the selected Mandals for the study, has its headquarters at Kuravi town. This Mandal is surrounded by Mahabubabad Mandal towards the north; Yellandu towards the south; Bayyaram, Garla, and Dornakal Mandals towards the east; and Maripeda and Narishimulapeta towards the west. The Khammam, Yellandu, Palvancha

are the bigger towns nearby to Kuravi. The people speak Telugu and Urdu. The total population of Kuravi Mandal is 64,331(males, 32,319 and females 32,012), living in 14,335 Houses, Spread across total 106 villages and 23 Panchayats

There are 20 villages in the Mandal. Among these, Kuravi is the most populous village with a population of 7976 and Thirumalapur is the least populous village with a population of 765. The Nerada is the biggest village in the Mandal with an area of 23 km^2 and Kancherlagudem is the smallest with an area of 3 km^2.

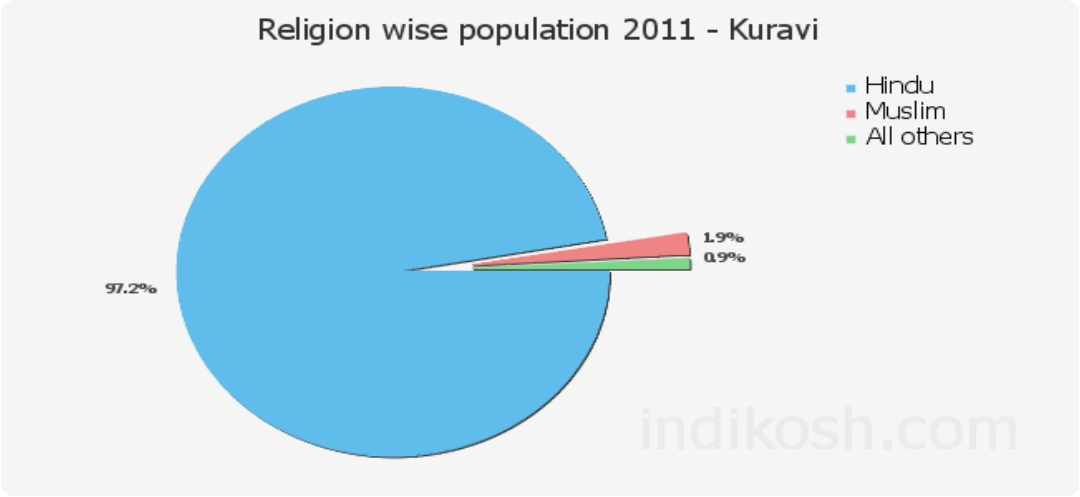
Demographics

Kuravi Mandal is home to about 67179 residents (49% males and 51%, females). Of the total population, 43% are from general caste (OC); 11%, from Scheduled Castes (SCs) and 47%, from Schedule Tribes (STs). There are about 17000 households in the sub district and an average of 4 persons live in every family.

Religion -wise Distribution of Population

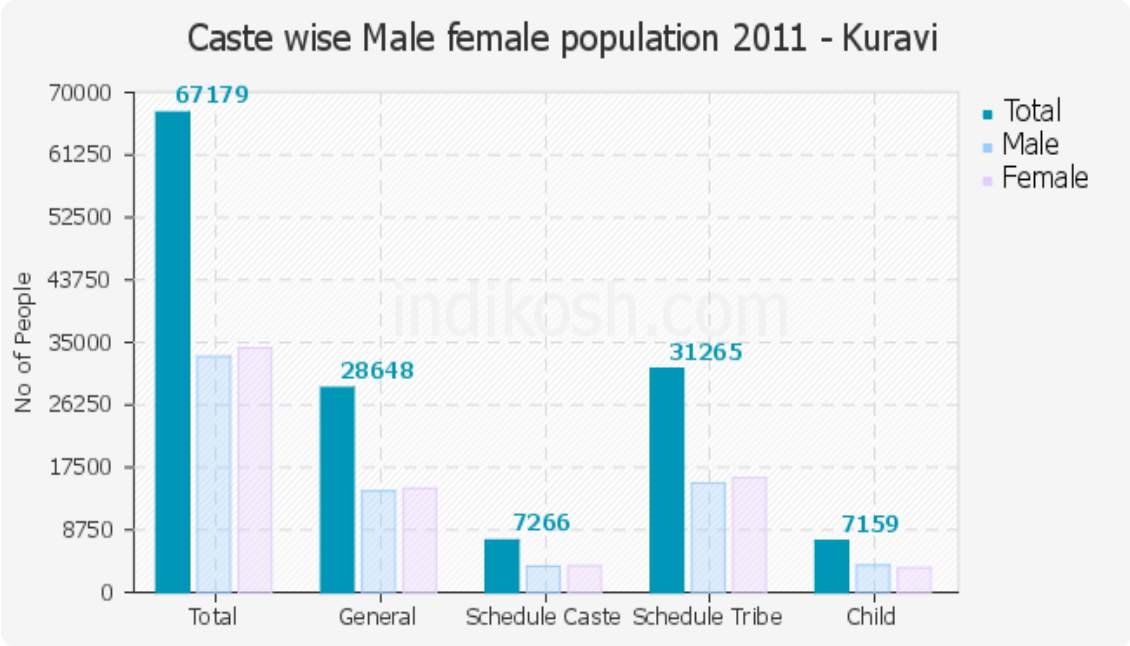
The Hindus constitute 97% of the total population, followed by Muslims (2% of the total population). The sex ratio per 1000 males for Hindus is 1037 and 1022 for Muslims.

Chart 2.1: Religion-wise Population



Source: http://indikosh.com/subd/614395/kuravi

Chart 2.2: Caste-wise Male and Female Population 2011-Kuravi



Source: http://indikosh.com/subd/614395/kuravi

Dornakal Mandal: Socio-Demographics

The Dornakal Mandal, with headquarters at Dornakal Town, is located 99 km towards the east from the district headquarters, Warangal. The Mandal is bounded by the Garla Mandal towards the north Kamepally Mandal towards the east; Bayyaram Mandal towards the north and Singareni Mandal towards the east. The Khammam, Palvancha and Kothagudam are the nearby towns. The people are speaking Telugu language and some of the also speak Urdu language. The total population of Dornakal Mandal is 55,194 (males, 27,775 and females, 27,419), living in 12,387 houses and spread across total of 89 villages and 15 panchayats[2].

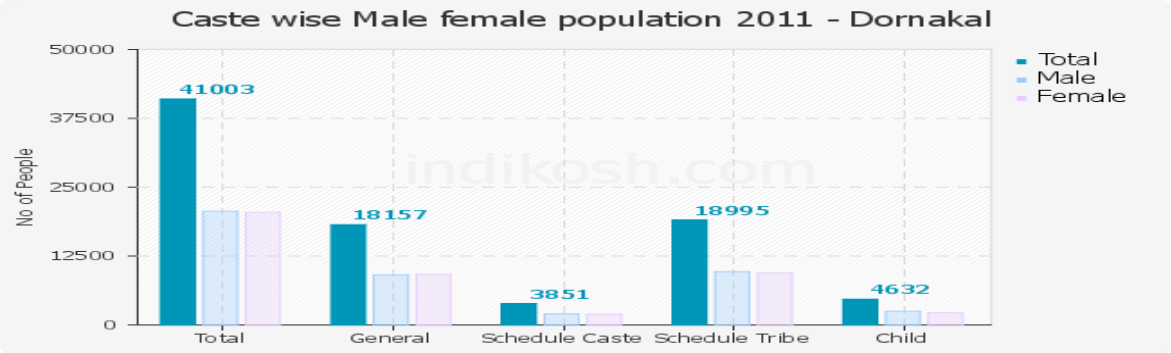
There are 12 villages in the villages, among them Mannegudem is the most populous village with a rural population of 6712 and Gurrala kunta is the least populous village with a rural population of 374. The Mannegudem is the biggest village in the mandal with an area of 20 km^2 and Burgupahad is the smallest with an area of 3 km^2.

[2] Sources: http://www.onefivenine.com/india/villag/Warangal/Dornakal

Demographics

This mandal is home to about 41000 people (53% males). Of the total population, 44% are from general caste (OC); 9% from Scheduled Caste (SCs) and 46%, from Schedule Tribes (STs). There are about 11000 households in the mandal and on an average, 4 persons live in every family.

Chart 2.3: Caste-wise Male and Female Population 2011-Dornakal

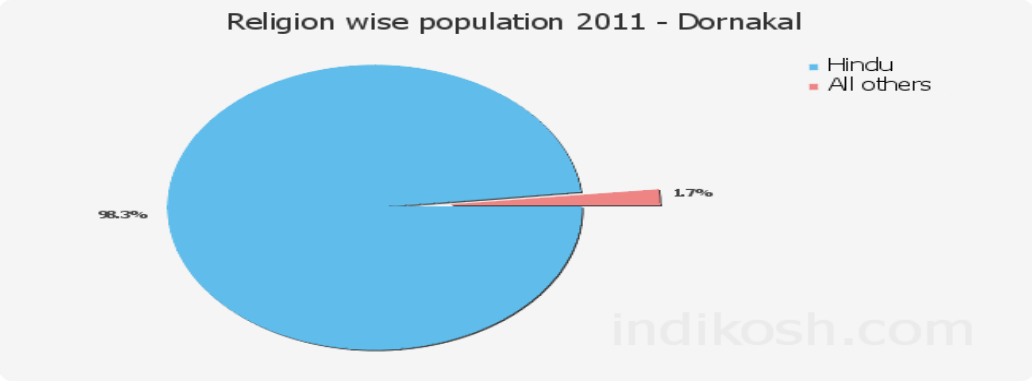


Source: http://indikosh.com/subd/614419/dornakal-22

Religion-wise Distribution of the Population

Hindus constitutes 98% of the total population, followed by Muslims (1% of the total population). The female sex ratio per 1000 male for Hindus is 988 and 1074 for Muslims.

Chart 2.4: Religion-wise Population 2011-Dornakal



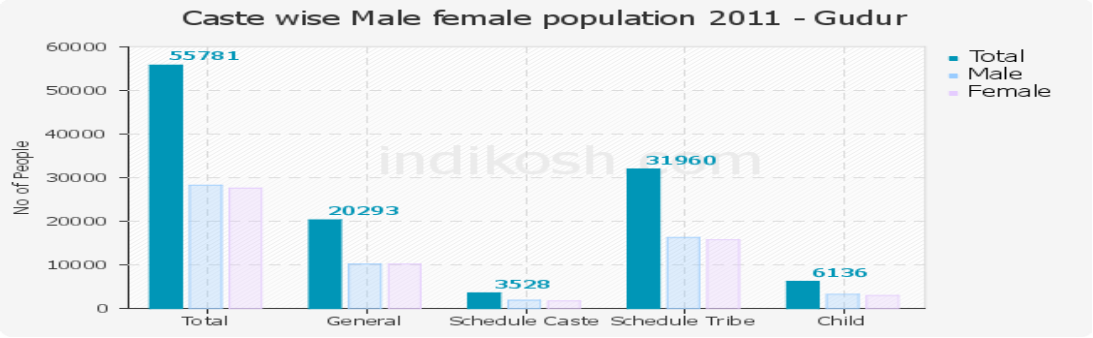
Gudur Mandal: Socio-Demographics

Gudur town, the headquarters of Gudur Mandal, is located 54 km towards the east from the district headquarters, Warangal. The Gudur Mandal is bounded by Khanpur Mandal towards the north Cheenaraopet Mandal towards the west Kothagudam Mandal towards the north and Kesamudram Mandal towards the south. The Yellandu, Warangal, Khammam and Palvancha are the near-by towns. The Gudur consist of 147 villages and 21 panchayats. The Thimmarpur is the smallest village and Gudur, the biggest, in this Mandal (http://www.onefivenine.com/india/villag/Warangal/Gudur). The people speak Telugu language. Total population of Gudur is 10690 (males, 5705 and females, 4,985), living in 2258 Houses. Total area of Gudur is 2864 hectares. There are 27 villages in the Mandal. Among these, Gudur is the most populous village with a population of about 11000 and Thimmapur is the least populous village with a population of 80. The Macherla is the biggest village in the sub district with an area of 35 km^2 and Kongara gidda is the smallest with an area of 1 km^2.

Demographics

The Mandal is home to about 56000 people, of whom 51% are males. 36% of the total population OCs constitute 36%, 6% are from Scheduled Castes and 57% belong to Scheduled Tribes. There are about 14000 households in the sub district and on an average, 4 persons live in every family.

Chart 2.5: Caste-wise Male and Female Population 2011-Gudur



Religion -wise Distribution of the Population

Hindus constitutes 97% of the total population. Muslims make up the rest of the population. The female sex ratio per 1000 males for Hindus is 973 and 1098 in the case of Muslims.

Chart 2.6: Religion-wise Population 2011-Gudur

Sources: http://indikosh.com/subd/614173/gudur

Profile of the Study Villages

Gopa Thanda: One of the study villages, Gopa Thanda, is located in the Kuravi Mandal of Warangal district. It is 85 km away from the district headquarters, Warangal. Lingya Thanda village is towards the north and Upper Gudam village towards the south. This Thanda comes under the jurisdiction of Upper Gudam Gram Panchayat. The main village can be reached only through a mud road. During the rainy season, it is very difficult to travel on this road.

Golla Charla: The other village selected for the present study is located in the Dornakal

Mandal of the Warangal district. The district headquarters, Warangal, is 95 km away and the Mandal headquarters, Dornakal, is 10 km away from the village.

Damarvancha: The third village selected for the study, is located in the Narasampet division of the district. The village is 150 km away from the district headquarters, Warangal. The village is bordered by Tribal Thandas on the Northern, eastern and western sides. Narasampet division is about 15 km away and another division is Mahabubabad, 50 km away. The distance between Warangal town and Damarvancha village is 150 km. The main characteristic of the village is the presence of both tribal and non-tribal communities. This village falls under the Agency area. Hence, the local tribals are entitled to special privileges.

Ethnographic Profile of the Two Major Tribal Communities in the District

As already brought out, tribals constitute a significant proportion of the residents of this district. The Kuravi Mandal has the total population of 67179 of which 31365 persons (47% of the total population) belong to tribal communities. The Dornakal Mandal has a total population of 41003 of which 18995 persons (46% of the total population) belong to tribal communities. The Gudur Mandal has a total population of 55781 of which 31960 persons (57% of the total population of the Mandal) belong to tribal communities. The Banjaras and Koyas are the major tribal groups found in the district. Hence, the succeeding paragraphs will briefly discuss the ethnographic profile of members of these communities in the district. This description should serve as the socio-cultural context for the health-seeking behaviour of these communities that are of special focus in this study.

Banjaras

The Banjara is a largest ethnic tribal group in India. The term Banjara/Lambadi is derived from the Sanskrit Word Banjara/Vanijya (Trading), because of their age-old tradition of trade of food items and transporting food grains from one place to another. Banjaras are also known by different names like Labans/ Lamanis/ Lamans. These people are basically

transporters of Lavan (salt). Because of this activity, they came to be known as Lamans/Labans. In the vernacular language of South India, they are called as Labanas/ Lambada/ Lambadi, etc.

The Banjaras were a nomadic tribe, with a noticeable presence in the states of Telangana, Andhra Pradesh, Madhya Pradesh, Himachal Pradesh, Bihar, Maharashtra, Karnataka Gujarat, Tamil Nadu, West Bengal and Odisha.

History of Banjaras

The period between 5th and 11th century A.D is called the "Rajputra Yugam". Unilaterally they ruled Northern India for a period of 600 years. Dynasties like the Gharjans, Palamuras, Solankis, Bundellas and Kalchorulu, belonging to Banjara community, ruled in northern India. The names of the males and females of the Banjara community reveal that they are decedents of the above-mentioned dynasties. These names include: Gajari (Gharjaras), Somla (Shiolanakas), Bhunna, Hoona, Davlai, Chokla, Gunya, Somli, Sali, Pemani and Lampali (Cheeniya Naik. B., 1998).

In northern India, the Banjara people are identified by terms like: Banjara, Vanjara, Banjaari, Banjari, Briyanyari and Brizvasi. In Karnataka, they are known by terms like Lamana, Lamni, Lambadini, and Lambada. On the other hand, in Andhra Pradesh and Telangana, they are called as Lambadas, Lambadis, Labans or Labanas, Labans, Labanis, Labhanas or Lambhanas, Baladis, Ladanias and Sugalis. In Kerala, the terms used for them are: Gathers or Gaudies. In Rajasthan and Punjab, they are referred to as Gauvariya or Gamaaliya. The other Lambada clans include: Goers, Mathura or Mathura Lambadas, Dadi Rahebs (who tell the story of Banjara Gotra), Sonars (gold smiths), Navis (barbers), Daliyas (smelters), Singadary, Marus, Bamaniyas (Brahmins), Bagoras, Digorsa or Gigoras, Charanas, Badis, Osarias, Jogis or Bharavas, Rohidases and Dhankots (Cheeniya Naik. B.,1998).

Many Banjaras have surnames like Rathod, Chauhan, Powar and Jadav. This brings out their affinity with a particular clan. From the 15th century onwards, members of the Banjara community started migrating to south India. Today, Banjaras can be found in almost all the south Indian states. As already mentioned, the Banjaras claim their descent

to clans like Rathod, Chauhan, Pawar and Jadav. The Table 2.6 below brings out the linkage of the various Lambada groups to the original clans.

Table 2.6: Banjara Descent Groups

	1.Rathod Descent Group		2.Chauhan Descent Group			4.Jadav Descent Group	
	Satispada Bhukya(27)		Panchpada Bhukya(5)		BargothPawar		BavanpadaVadithya (52)
1	Karathot	1	Karothot	1	Mood	1	Goram
2	Kanavath	2	Ramavath	2	Palthya	2	Dharavath
3	Pilthavath	3	Nenavath	3	Sabavat	3	Lokavath
4	Kethavath	4	Dungavath	4	Korra	4	Gugaloth
5	Megavath	5	Depavath	5	Dumaavath	5	Halavath
6	Nenavath		Banoth	6	Keloth	6	Kunsoth
7	Dungavath		Descent		**3.Pawar Descent Group**	7	Boda
8	Kodavath	1	Halan			8	Tejavath
9	Ramavath	2	Balan	1	Vislavath	9	Barmavath
10	Rajavath	3	Mohanmuchlo	2	Vankodth	10	Maloth
11	Degavath	4	JathyaJangad	3	Jharupla	11	Jet
12	Kumavath	5	Damsigore	4	Aamgoth	12	Bharath
13	Bhilavath	5	Dadabhika	5	Nunanvath	13	Jaloth
14	Banavath	7	RahuTarod	6	Injravath	14	Jajgiri Vadithya
15	Khilavath		Banoth Clan	7	Inlothpamar	15	Bhargavan Das
16	Meravath			8	Bhanni	16	Badavath
17	Khatroth	1	Kunthavath Rathod	9	Tharabhanni	17	Undavath
18	Aaloth	2	Jathroth Rathod	10	Pamaadiya	18	Lonavath
19	Merajoth	3	Rupavath	11	Ivath Pamar	19	Sejavath
20	Depavath	4	Ghagarivalo	12	Chaivathpamar	20	Thupar
21	Rathla(Pulia)	5	Sabdavath			21	Dungavath
22	Sotaki	6	Aadoth			22	Meravath
23	Jundavath	7	Padmavath			23	Lulavath
24	Devasoth	8	Katroth			24	Tepavath
25	Pathaloth	9	Panchapla			25	Pusnamal

26	Ransoth					26	MohanDas
27	Sangoth					27	Teravath
						28	Ajmeera

Source: Cheeniya Naik. B. (1998), Banjara Charitra (Samskruti-Pragathi), Anantapur, A.P Hathiram Bavaji Publications.

Social Organisation

Life Cycle Rituals of Banjaras

A mention has already been made of how the culture and tradition of the members of a community can impact their health-seeking behaviour. The life cycle rituals are integral parts of the culture and tradition of any community. In a number of ways, these have a bearing on the health culture of the community. Against this backdrop, the major rituals being observed by the Banjaras in the study area will now be discussed in some detail.

Rituals Connected with Child Birth

a. **Srimantham**. This is an important ceremony performed when a woman is six months pregnant. The parents, brothers and sisters of the women participate in this ceremony. Depending up on their financial condition, the relatives bring along various food items for the ceremony. The Banjara women sing the songs of '*Srimantha*m'.
b. **Delivery of the Child**. At the time of the delivery, the Banjara midwives apply pressure on the back of the pregnant woman, so that the baby will come out very easily. After the birth of the baby, they cut the umbilical cord of the baby. The Dai or the Mid-wife bathes the baby and its mother with hot water. The mother is offered food items prepared with 'Ghee' and '*Jaggery*'. '*Kado*' is one food item, which is prepared with Jaggery and some masalas (*spices)*. It is believed that 'Kado'can help the lactating mother and improve the health of the baby as well.
c. ***Vekelparo* (*Performing Pooja (prayer) to the God*).** After the birth of the baby, the family members of the women offer prayers to the Gods. During this ceremony, specially cooked food is offered to the God. A coconut is also broken and 'Deepaaradna' (prayer with a lighted lamp) is performed to the God. The Banjara women sit *together* and sing the songs, related to the birth of the baby. Thereafter,

food prepared with Ghee and Jaggery is distributed to all the people who attended this ceremony.

d. ***Dalvadhokeyore***. This festival is conducted after the 7th day of the birth of the child. Songs related to the child and the mother is sung on this occasion. In this festival, the mother of the child is given three tumblers of water. The first tumbler is filled with the coal mixed water, the second one is filled with turmeric mixed water and the third one is tied to the hair of the child. Finally, a one-rupee coin is placed in the small pond dug in front of the house. The water from the three tumblers is poured into the pond. Finally, the pond is filled with soil. The ceremony concludes with all the guests being served food prepared with *jaggery*, *rice* a*nd ghee*.

e. **Dagdero**. During this ceremony, a small needle heated in an oil lamp is attached to the body of the new born child. It is believed that this ritual will protect the child from the evil eye.

f. **Joliro Nokta**. In this ceremony, the tiny tot is put in the cradle. The women present sing songs appropriate to the occasion. Later, food is provided to the women present on the occasion. They are also given Thambulam (pan leaves with betal nuts).

g. **Phagalya phadero Nokta.** This ritual is observed when the child first starts walking. On this occasion, sweets prepared with jaggery and sugar is given to those present. The child is also given new clothes.

h. **Kali Pera Nokta**. This ceremony is performed when the girl attains puberty. From then onwards, the girl starts wear blouses, earrings, bangles and anklets (Cheeniya Naik. B., 1998).

Marriage

Sagaeer Nokta (Engagement). The process starts with the parents of the bridegroom, and their other relatives, the family friends and village elders going to the bride's house. Clothes and fruits are exchanged between the two parties. During this ceremony, the pujari (priest) of the village decides the date of the marriage. The ritual starts with women members of the bridegroom's family inviting members of all households in the village to attend the programme known as '*Sadithanero nokta.*' All the family members wear new

clothes and the bridegroom is adorned with special clothes. The bark of a tree is erected in front of the house.

Next, two goats/sheep are slaughtered; the meat is cooked without salt. A rice dish, known as '*pongali,*' is cooked for the occasion. Next, the bridegroom and along with another boy (who may be his brother or another relative) sit together. Seven pieces of the cooked meat, a coconut and '*pongali*' rice are placed in front of them. All the family members offer prayer to the God. After the prayer, the priest takes the needle, which is heated in the oil, and touches the right hand of the bridegroom with these three times. After that, the following song is sung:

Koliava! -Koli java!
Dholo Ghodo! -Hansaloo!
Kovali! -Katar cha!
Thalli Atara! - Dhal Cha!
Munge Aathara! Verecha!
*Go saee Bava! –Sada Sad*a!

The theme of the song is: You are gentlemen, don't worries about food, your desires are like white horses, and we are knotted with the thread. We put drag in your hand, just imagine war is like seeds of pulse and knife is minumalu (Green Gram) seeds. They all are more sharpening than the needle which we had put on your right hand shoulder.

Chudero Nokta: Earlier, the practice of the bridegroom tying the mangala sutra around the bride's neck was not a part of the Banjara marriage rituals. However, this system is being increasingly adopted by the Banjaras. The bridegroom visits each household and invites the members to participate in the *'Chuderonokta'* ceremony. This ceremony takes place around 3- 4 p.m. Next, the parents of the bridegroom distribute jaggery and dry coconuts to all the relatives and community members present on the occasion.

At the bride's house, the women of the community sing the '*Chudero nokta'* related songs. They all prepare to decorate the bride with new dress which is prepared for the '*Chuderonokta'*. After the comb of the bride hair which is decorated with the *'Ghagari'*

(Chotla) with tie with '*Topli*'. The bride's ear is also decorated with *'Mulo' (Jada*). She is also made to wear the 'Chudero Balya' (Bangles) on her wrists. When this process is going on, the bride cries a lot, because she is now leaving her parents and relatives, and going to a new village. Finally, all the women of the village bring the bride and bridegroom together. The bride's parents distribute the jiggery and dry coconuts to all the households of the Banjara Thanda.

Gote: This ceremony is performed before sending the bride to the bridegroom's house. In this day, bride's parents prepare the food and they invite all members of the Banjara Thanda to attend the ceremony. At this ceremony, whatever the expenditure for this ceremony is borne by the bridegroom. Finally, the bride and bridegroom leave for his house. With this, the marriage ceremony is completed.

Death Ceremony

Whenever a member of the Banjara community members dies, his or her family members inform their family members and the village community members. All the family members mourn near the dead body. After the other relatives arrive, the dead body is made ready for bathing. Thereafter, the body is taken for the cremation. After cremation, the tribal elders come to the house of the deceased and inform the family members that the elder son or sister in the family has to now look after the family. In this regard, all the community members support that family financially; on Sunday all the community make the arrangement for the 'Dado' which means 'Dinalu.' On this day the women and the community members prepares 'Rotis' with rice flour. This roti is mixed with the jaggery and distributed to all the members, who have attended the ceremony. With this, all the activities related to the death ceremony are completed (Cheeniya Naik. B, 1998).

Ethnographic Account of the Koya Tribe

The foregoing discussion was on the Banjaras and some of their important customs and traditions, all of which, directly impact their health-seeking behaviour. Since the Koya tribe is the other major community found in the study area, the succeeding paragraphs will present an ethnographic account about them.

Koya is a Scheduled Tribe (ST), whose members are predominantly found in South India. The Koyas are also called as Koyalu, Koyallu, Koi, Koya Doralu, or Dorala Sattam. This tribe can be further divided into: Koya, Doli koya, Gutta Koya or Gotti Koya, Kamara Koya, Musura Koya, Oddi Koya, Pattidi Koya, Rasha Koya (ordinary), Kottu Koya, Bhine Koya, and Raja Koya. The Koya population is mostly found in Telangana, Andhra Pradesh, Chhattisgarh, Madhya Pradesh, Karnataka and Odisha.

In Telangana, one can find Koyas in large numbers in Khammam, Warangal, Adilabad and Karimnagar districts. In Andhra Pradesh, a large number of Koyas can be seen in West Godavari and East Godavari districts. Koyas are the second largest tribe in Telangana State and Andhra Pradesh, in terms of numbers in the total Scheduled Tribe population. The Koyas are mainly settled cultivators and artisans, with expertise in making bamboo furniture which include mats for fencing, dust pans and baskets. They grow Jowar, Ragi, Bajra and other millets. The Koya are one of the few multi-lingual and multi-racial tribal communities living in India. The story of the Koyas goes back to pre-historic times. They seem to have had a highly evolved civilization in the past when they were a ruling tribe.

The Koya tribal society has different agricultural practices and hunting patterns to get resources for their survival and continuing their life style. The Koya community has also adopted the practices related to collection of minor forest timber products (MFTPs) and food materials such as vegetables, fruits and edible roots.

Social Organisation

Basically, Koya are divided into five sub-groups, viz., Racha Koya, Bhine Koya, Lingadhara Koya, Koya Rajulu or Doralu, and Gutti Koya (Thurston, 1891).

Descent

The Koyas are a patrilineal and patrilocal society. A child acquires the membership of his or her father's group. Besides this, an individual may also automatically become the member of that particular group by adoption or by marriage with a member of the Koya

tribe. Primogeniture is the rule and it is passed through male line only, i.e., from the father to the son. Koya Dora follows clan exogamy and tribe endogamy.

Family

Family is the basic unit of the Koya Dora social organisation. In majority of the cases, the family is nuclear and usually consists of the husband, wife and their unmarried children who live together in a single hut. Besides this, a few joint and extended type families were also found in the study villages. Nuclear families are predominant in the study villages, followed by joint and extended families, respectively.

It is relevant to state that neo-local residence pattern is widely prevalent among the Koya Doras of the study area. In case a Koya Dora marries more than one wife, or vice-versa, the respective couples and their children share the same hut and hearth commonly.

Marriage

As mentioned earlier, the Koya Doras observe clan-exogamy and tribe endogamy. Some clans are affine, from whom mates can be selected; while some others are treated as consanguine and marriage with them is prohibited. Thus, all consanguineously related clans are excluded from the circle of potential mates. The preferred mates are cross-cousins.

Rites-de-Passage

The Koya Doras observe many cycles of life, which are deeply embedded in their social organisation. It is obligatory for every individual to observe these rites with utmost care. Violation of this rule is considered as taboo and it is believed that the spirits and ancestors may get annoyed if they do not perform these rites.

Purudu (Childbirth)

Generally, no ceremony is observed at the time of childbirth. However, delivery is treated as an impure act and avoidance is observed for five days. On the fifth day, the mother and the child are given a ceremonial bath and food is offered to close relatives.

Annaprasana (First Feed)

Like tonsure, weaning is also performed on an auspicious day. The child is given first solid food when he or she attains the age of one year. However, it does not mean that a mother stops her child from suckling. Breast-feeding is continued even after feeding of solid food begins.

Peru Pettadam (Naming Ceremony)

Koya Doras are not particular about the fixing of the date for the naming ceremony of the new born child. Generally, it is observed after seven days of the childbirth. But it is not conventional. In some cases, it is observed after one month, or six months or one year. It is performed at the family level only. A small ceremony is performed on that day, for which close relatives and their family members are invited. On the seventh day, all the relatives gather at the concerned house. It is obligatory for the maternal uncle to offer pig and rice for the proposed feast. He then selects the name for the new born child from the list provided by the relatives. Generally, Koya Doras prefers their parents' names during this ceremony. Now-a-days, they prefer modern names, as they are influenced by the neighbouring caste people.

Samartha (Puberty)

The childhood imperceptibly merges into adolescence when the boy gains expertise in the occupations of an adult man. But for girls, biological signs of maturity (puberty) mark their initiation into adulthood. On this occasion, the Koya Doras observe a moderate ceremony. When the girl menstruates for the first time, a small portion of the house is cleaned and allotted to her during the pollution period. On the seventh or tenth day when

the menstrual flow ceases, she is given a ceremonial bath and brought to the front room (veranda). Then, her maternal uncle (mother's brother) offers new clothes to her. Now days, due to the influence of neighbouring non-tribal's, they observe the event on a bigger scale.

Manuvu (Marriage)

When a boy or girl reaches the age of fifteen to twenty, the parents start thinking about his or her marriage. In spite of outsider's influence, the process of marriage is held in traditional manner.

Ways of Acquiring Mates

There are different ways through which Koya Dora acquires their mates. These include: negotiation, elopement, seduction, and probation. Of these, marriage by negotiation is the most common type, while the others are less commonly observed in the study villages.

Marriage by Negotiation

During ceremonial occasions in the village, the parents of the prospective couple discuss the marriage proposal. In case the other party evinces interest, marriage negotiations can be initiated with the assistance of Patel, Pujari and their clan or lineage elders. After obtaining the acceptance from the bride's family, the groom's parents make arrangements for the marriage.

Marriage by Elopement:

A young man, who wishes to marry a girl, makes himself familiar with her during the marriage ceremonies of his friends. He discloses his intention to his parents. In case the parents do not give their approval, the youth can choose to go in for this kind of marriage. Everything is kept secret, till the couple elopes to a neighbouring village and lives together like wife and husband.

Marriage by Probation

This kind of mate selection was found to be less frequent in the study area. Those grooms who are unable to pay "bride price and bear the expenses of the wedding feast may decide on such a kind of mate selection. The potential groom goes to the bride's house and serves her family. This goes on till the bride's parents are satisfied with the services of the potential groom. At the end, all the expenses for the wedding feast are incurred by the bride's party.

Dinalu (Funeral Rites)

Till now, the discussion had centered on events like child birth, puberty, engagement and marriage in the community. Even in the matter of death, the Koyas believe in observing elaborate rituals. As soon as a person dies, the women of the household start wailing and the whole village is informed about the death. The term death is locally referred to as 'dolladam'. Soon after the death, other women folk of the village and relatives help the bereaved family in the domestic chores, while the men set out to inform all relatives in neighbouring areas for the impending funeral. At the time of the burial, all the personal belongings (bow, arrow, spear, utensils, his or her cot, and so on) of the deceased are buried along with the corpse. They believe that these articles will be of use to him or her in the other world.

Before burying the dead, all relatives offer a piece of white cloth to the dead. The bereaved family keeps some of these clothes and rest is buried with the dead body. Generally, Koya Dora disposes off the dead by burying. However, if the death is due to some black magic and serious illness like T.B. and syphilis, they burn the corpse along with his or her personal belongings. They believe that their spirits may enter the village and cause natural calamities. For this reason, Koya Dora keeps their burial places far away from their settlements. The burial spot is filled with earth and big stones are kept for their identification.

After the disposal of the dead body, on the fifth day, the ‘chinnadinam’ ritual is performed at the house of the bereaved family. Here, food is offered to the departed soul

by the relatives. Thereafter, food is served to those present on the occasion. After one year, Koya Dora performs elaborate death rituals popularly known as '*dinalu*.'

On the day of annual '*dinalu*', all the villagers proceed to the graveyard to offer Metuku to the dead. The relatives of the dead carry two small mud pots (Mattipidatalu) in a state of possessiveness on their heads. It is believed that one earthen pot represents their ancestors and the other, the deceased person. The relatives of the deceased carry rice mixed with turmeric and vermilion to offer to the dead. The Pujari and 'Vyapari place a handful of that mixed rice at three corners around the grave and the balance rice is poured on the grave. Later, two bottles of liquor are poured on the grave. Then they come back to the house of the bereaved and take a ceremonial bath. Later, they are served liquor. It is believed that if they do so, they can avoid the wrath of the dead person's soul.

Magico-Religious Practices

Such practices have a bearing on the health-seeking behaviour of the community. The religion of Koya Dora in the study area exhibits the characteristics of animistic form of worship. Now, they are being increasingly influenced by the neighbouring Hindu community, as well as the Christian missionaries. However, they continue to practice the traditional rituals that are designed to propitiate the supernatural powers on which their livelihood depends.

Ancestor Worship

The practice of worshipping the ancestors is widely prevalent among the Koya Doras, especially during Podu cultivation, agricultural season and life-cycle rituals as a mark of respect to them. Before eating the first crop, a portion of it is kept aside at Gondu for their ancestors.

Spirits

The Koya Doras believe that generally the soul of the dead person may move to the outside world to take rebirth. In case the death is due to black magic and the person dies without fulfilment of desires, he or she may turn into a spirit, 'Dayyam' (ghost). The Koya

Doras believe that these are extremely dangerous to human beings, as well as to their livestock, and need to be turned away since these could be malevolent and powerful enough to cause unknown sickness in the family.

Ritual Specialists

Among the Koya Doras, there are some experts like the ‘Pujari' (village priest) and 'Vejju' (witch doctor) who generally deal with magico-religious activities are apart from them, some traditional healers can be found both among Koya Doras and the as well as among non-tribal groups.

Folklore

The Koya Doras in the study area were found to be conscious of their own traditional art and craft. Folk songs and folk tales are still being passed on through oral tradition to their succeeding generations. Playing of traditional music during the various rituals, accompanied by dance, is considered essential. Musical instruments such as Dolu koyyalu (drums) and traditional head gear, studded with wild horns, are commonly used on such occasions.

Health Culture

After a discussion on the ethnographic profile of the residents in the study area, it would only be logical to examine their health culture since factors like gender-distribution, level of education, occupational status and income levels can impact the health culture of the people there.

It has been found from the study that the people of Gopa Thanda are following both ethno-medical practices and resorting to allopathic medicines. Earlier, people of these villages almost invariably used ethno-medicine to treat various illnesses. The percentages of the people who are depending on ethno medicine are gradually decreasing. Today, an increasing number of members of both, tribal and non-tribal communities have started using allopathic medicines for the various illness and diseases. These village community people have started using allopathic medicines, both for major and minor illnesses, because of the government campaign and the television advertisements. It is also evident

from the study that some of the community members still prefer to use ethno-medicines, along with the allopathic medicines.

In, Golla Charla, most of the respondents are using allopathic medicines. The PHCs, ASHA workers, RMPs and private medical practitioners are prescribing allopathic medicines to the community members. Since it is a non-tribal village, the percentage of users of ethno-medicine is negligible.

On the other hand, Damarvancha village has a sizeable tribal presence – mostly of Koyas. The life style of the Koya community is revolving around the forest, and the interaction between the Koya community and forest is quite intact without any external interference. These community members have been adopting the ethno-medical practices for many generations. However, in recent times, even the small non-tribal presence in the village is leading to the Koyas slowly shifting towards allopathic medicines. It was also seen that some members of the Koya tribal community members are adopting ethno-medicines, along with allopathic medicines.

Socio-Demographic Profile of the Study Population

A brief account of socio-demographic profile of the study population, in terms of sex ratio, occupational status, educational levels and economic status is presented below.

Distribution of Population by Sex

Sex composition plays an important role in the survival of the human society. Human society always must make an appropriate balance between the male and female population. Some of the states in India are having an adverse sex ratio. This is mainly because of the preference for the male child. Due to the dowry and perceived marriage expenditure for the girl child, some of the parents in India are going in for female infanticides and 'foeticides' (killing the foetus in the mother's womb itself). This is one of the biggest social problems in India. The gender distribution in the study area is depicted in table below 2.7.

Table 2.7: Gender Distribution of the Respondents

Sex composition				Total
Village		Male	Female	
Gopa Thanda	Count	224	201	425
	% within Village	52.7%	47.3%	100.0%
Golla Charla	Count	217	233	450
	% within Village	48.2%	51.8%	100.0%
Damarvancha	Count	233	210	443
	% within Village	52.6%	47.4%	100.0%
Total	Count	674	644	1318
	% within Village	51.1%	48.9%	100.0%

Source: Field Data collected in 2012-14

From the above the Table 2.7, it can be seen that the male and female population is more or less evenly distributed in the three villages. The Gopa Thanda, which is primarily a Banjara village, has less number of females than males. The reason for this could be the preference for male children. In their daily life, the members of the community do not show any kind discrimination towards their women folk. Still, there is the widespread longing for sons, who could carry the lineage further. It is found that many couples of this tribal community go in for sex determination of the unborn child with the help of unscrupulous doctors. If the sex is determined as female, many members of this village go for medical termination of the pregnancy and this causes adverse sex composition in this community.

However, the Golla Charla is basically a non-tribal village, it is found that the gap in the sex ratio of the male and female is very less when compared with Gopa Thanda and Damarvancha. The village Damarvancha, which is inhabited by the Koya tribals and non-tribals, has more males than females. It seems that the Koya tribal communities are egalitarian in nature and do not practice any gender discrimination towards women folk. But, still, the number of females is less than their male counterparts.

Distribution of population by Caste and Tribe

Indian society is hierarchically arranged, based on the caste and the work they perform in their daily life. Every village in India has its own caste composition. The Table 2.8 below outlines the distribution of the population by the caste and tribe in the study area.

Table 2.8: Distribution of the Community

Village	Community						Total
		SC	ST	OBC	OC	Minority	
Gopa Thanda	Count	0	425	0	0	0	425
	% within Village	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%
Golla Charla	Count	42	7	245	113	43	450
	% within Village	9.3%	1.6%	54.4%	25.1%	9.6%	100.0%
Damarvancha	Count	19	353	33	30	8	443
	% within Village	4.3%	79.7%	7.4%	6.8%	1.8%	100.0%
Total	Count	61	785	278	143	51	1318
	% within Village	4.6%	59.6%	21.1%	10.8%	3.9%	100.0%

Source: Field Data collected in 2012-14

The Gopa Thanda village does not have members of the non-tribal communities. In Golla Charla village, Scheduled Tribes (ST) was found to have a relatively insignificant presence (only 1.6% of the total population). The situation regarding Scheduled castes (SCs) was slightly better (9.3%). Other Backward Communities (OBCs) (54.4%), which includes Kummari (Pot makers), Mangali (Barbers), Gouds (Taddy Trappers), Mutrasha (Fishing community), Vadarangi (Carpenters) and Chakali (Washermen), are present. The Other Castes (OCs) constitutes (25.1%) which includes Reddys and Kammas and Minorities (9.6%). The Muslims and Christians were the other communities found in the village.

The third village, Damarvancha, is also inhabited by both tribals and non-tribal. Here, Scheduled Tribes (79.7%) were found to be the most dominant community in terms of numbers. The non-tribals included: Scheduled Castes (SCs) like Madigas and Malas (4.3%), Other Backward Communities (OBCs) constitutes (7.4%) which includes Kummari (Pot makers), Mangali (Barbers), Gouds (Toddy Trappers), Mutrasha (Fishing community), Vadarangi (Carpenters) and Chakali (Washermen). The Other Castes (OCs) constitutes (6.8%) which includes Reddys and Kammas and Minorities constitute 1.8% of the population. Since the village is located in a forest area, it is natural to expect that it

would be largely inhabited by members of the Koya tribal community. During the course of time, the interaction of the tribal and non-tribal communities took place. As a result, non-tribals started settling in the village. Trade interaction was one of the important factors for non-tribal's settling in the village. These non-tribal communities have today become the dominant communities in the village. Socio-economically, these communities are very strong since they own large tracts of land in the village. Among the non-tribals, Reddys have a very marked presence in the village, since they are economically very strong. The other non-tribal communities include: SCs (only Madigas), OBCs (Kammaris) and Muslims.

Marital and Family System

The marriage and the family are two aspects of the same social reality, viz., the bio-psychical –cum social drives (needs) of man are coeval with each other and with culture because without family there is no preservation of the species and culture and without marriage there could be no family (D.N Majumdar and T.N Madan, 2005). In this regard, it is pertinent to know about the marital status of the community members in the study area. It emerged that in all three villages; overall 45.1 percentages of the community members are married.

Family System

The family system plays an important role in every society. There are two ways of looking at the family. It can be regarded as one of the universal and permanent institutions of mankind, that is, as functional unit (D.N Majumdar and T.N Madan, 2005). The Table 2.9 below depicts the family system in the study villages.

Table 2.9: Family System

Family System				
Village		Nuclear	Extended	Total
Gopa Thanda	Count	71	29	100
	% within Village	71.0%	29.0%	100.0%
	% of Total	23.7%	9.7%	33.3%
Golla Charla	Count	77	23	100

	% within Village	77.0%	23.0%	100.0%
	% of Total	25.7%	7.7%	33.3%
Damar Vancha	Count	70	30	100
	% within Village	70.0%	30.0%	100.0%
	% of Total	23.3%	10.0%	33.3%
Total	Count	218	82	300
	% within Village	72.7%	27.3%	100.0%
	% of Total	72.7%	27.3%	100.0%

It could be seen that in all the three study villages, overall 72.7 percent of the respondents were having nuclear families. The nuclear family constitutes father, mother and their children.

Occupational Status of the Village

Certain occupations are perceived to bring about greater socio-economic benefits than the other occupations. An attempt has been made to know the occupational structure of the residents of the study villages. The Table 2.10 below depicts the situation there.

Table 2.10: Occupation Status of the Residents of the Study Area

Village	Occupation										Total
	Agriculture	Agl. Labourer	Wage Labour	Govt. Sector	Private Sector	Kirana	Others	Student	House wife	Below 5 years	
Gopa Thanda	256	9	0	7	4	2	8	101	4	34	425
	60.2%	2.1%	0.0%	1.6%	0.9%	0.5%	1.9%	23.8%	0.9%	8.0%	100.0%
Golla charla	265	17	2	11	2	1	8	114	3	27	450
	58.9%	3.8%	0.4%	2.4%	0.4%	0.2%	1.8%	25.3%	0.7%	6.0%	100.0%
Damarvancha	249	9	2	2	4	2	2	105	1	29	405
	61.5%	2.2%	0.5%	0.5%	1.0%	0.5%	0.5%	25.9%	0.2%	7.2%	100.0%
Total	770	35	4	20	10	5	18	320	8	90	1280
	60.2%	2.7%	0.3%	1.6%	0.8%	0.4%	1.4%	25.0%	0.6%	7.0%	100.0%

Source: Field Data Collected in 2012-14

It can be seen from the above Table that agriculture is the predominant occupation in all the three villages (60.2% overall). A very encouraging fact found in the three villages that

students (overall 25.0%) were having a very significant presence. The Agricultural labour was also found to be a noticeable occupation in the study area. The other occupations were not very common in any of the three villages.

It is a well-established fact that the tribal economy revolves around the forests and agriculture. The main crops grown are rice, cotton, Jowar, chillies and Bajra. The tribal community is settled in the plain areas and the members collect forest wood for using as fuel. The forest products collected by them include: Tendu leaves, fuel wood, gum and honey. Some of the tribal community members are working as wage labourers. Many tribes, who do not own any land, choose to work as wage labourers in the fields owned by others.

The reason for moving from the subsistence economy to surplus economy in the study area is because of the influence of non-tribals, who cultivate cash crops and food crops on their lands. Even though agriculture is the prime occupation of the tribal communities, some of them are also engaged in various other economic activities, besides working as agricultural labourers, because of the widespread landlessness.

Educational Status of the Village

Education is one of the parameters that can impact the awareness and development level of a region. The Table 2.11 below depicts the educational status of study population.

Table 2.11: Educational Status of the Residents of the Study Area

Village	Education								Total
	Primary School	High School	SSC	10+2 (Inter)	Degree	PG and Above	Illiterate	Age below 5 Years	
Gopa Thanda	132	26	24	27	7	9	166	34	425
	31.1%	6.1%	5.6%	6.4%	1.6%	2.1%	39.1%	8.0%	100.0%
Golla Charla	168	56	46	32	26	12	83	27	450
	37.3%	12.4%	10.2%	7.1%	5.8%	2.7%	18.4%	6.0%	100.0%
Damarvancha	141	46	29	18	13	4	163	29	443
	31.8%	10.4%	6.5%	4.1%	2.9%	0.9%	36.8%	6.5%	100.0%
Total	441	128	99	77	46	25	412	90	1318
	33.5%	9.7%	7.5%	5.8%	3.5%	1.9%	31.3%	6.8%	100.0%

Source: Field Data Collected in 2012-14

It is not an encouraging sign that as high as 39.1% of the residents of Gopa Thanda and 36.8% in Damarvancha were found to be illiterate. The situation was slightly better in Golla Charla, since the figure of illiterates there was only 18.4%. When the proportion of residents with some degree of education is considered, it emerged that the largest proportions of them seem to be content with primary school education (overall, 33.5%). One can also find that, as one proceeds to the next higher educational level, there is a general fall in numbers.

It must be mentioned here that the Banjara/Lambadi communities are now sending their children to schools. A few decades back, the Banjara tribal community village did not have much access to schools. At that time, most of the community members were illiterate. Now the situation has changed, due to the establishment of schools in this village. As a result, some of the members have got education and are pursuing higher studies. Therefore, some of the community members are now able to secure government, as well as private, jobs.

There was a time when most of the tribal communities were far away from the mainstream educational system. Since Damarvancha has been recognised by the Telangana government as part of an agency area and located in a dense forest area, the state government is now focusing on the overall development of the village. After the arrival of non-tribals in this village, with the intention of permanently settling here, leaders of the non-tribal communities projected their grievances to the government officials. As a result, some of the developmental work had been undertaken in the village by constructing schools, building the roads and government established the ANM sub-centre, AWW centre and TSRSW School in this village.

Income Level of the Village

Income is one of the important component through which one can understand the socio-economic status and health-seeking behaviour of the families in the study area. The Table 2.12 below should help one to form an opinion about the income of the residents in the study area.

Table 2.12: Income Level

Annual Income								
		1000-20000	20001-40000	40001-60000	60001-80000	80001-100000	100000 and Above	Total
Gopa Thanda	Count	6	36	32	13	7	6	100
	% within Village	6.0%	36.0%	32.0%	13.0%	7.0%	6.0%	100.0%
	% of Total	2.0%	12.0%	10.7%	4.3%	2.3%	2.0%	33.3%
Golla Charla	Count	3	20	18	29	22	8	100
	% within Village	3.0%	20.0%	18.0%	29.0%	22.0%	8.0%	100.0%
	% of Total	1.0%	6.7%	6.0%	9.7%	7.3%	2.7%	33.3%
Damar Vancha	Count	8	42	29	12	6	3	100
	% within Village	8.0%	42.0%	29.0%	12.0%	6.0%	3.0%	100.0%
	% of Total	2.7%	14.0%	9.7%	4.0%	2.0%	1.0%	33.3%
Total	Count	17	98	79	54	35	17	300
	% within Village	5.7%	32.7%	26.3%	18.0%	11.7%	5.7%	100.0%
	% of Total	5.7%	32.7%	26.3%	18.0%	11.7%	5.7%	100.0%

Source: Field Data Collected in 2012-13

As already mentioned, the main source of income of residents of the study area is agriculture, since the tribal economy revolves around agriculture and forest products. One of the important features of the tribal economy and Indian economy has been the subsistence economy. It is quite natural that the income of most of the tribal communities would be lower than the national per capita income. In all the three villages, the largest proportion of the residents (32.7.0% overall) were having annual incomes in the Rs. 20,001-40,000 range. An interesting fact that emerged in Golla Charla village was that 8.0% of the residents were having annual incomes of Rs 1, 00,000 and above. Even in

Gopa Thanda (with 6.0%) and Damarvancha (with 3.0%), there were respondents having annual incomes in this range. Otherwise, the largest proportion of respondents in all the three villages was earning less than Rs. 40,000 annually.

Some of the tribal community members who were owning 3 to 5 acres of land have been cultivating crops like cotton, rice and maize. Some non-tribal community members had annual income above Rs. 30000 because they owned large area of land and were able to sell the cash crops in the markets in the nearby towns. A positive sign was that slowly the Koya tribal communities' members are also adopting the farming methods being used by the non-tribals in the village.

Government Institutions

In Gopa Thanda only two government institutions government school and Mini Anganwadi centre, are functioning. The primary school is providing education from classes 1 to 5 and the total number of student is 53. Other institutions like PDS, PHC sub center and post office are not present in this village.

In Damarvancha the important government institutions are the government primary and secondary schools, where the village children are studying. The schools are imparting education from the first class to the tenth class. To provide education to the tribal communities, the state government established the Telangana State Residential Tribal Welfare School (TSRTWS) in the year 2000. Another institution is Gram Sabha were adequately addressing issues like drinking water, road connectivity, electricity problems and any other issues related to the village.

In order to provide health care facility to the tribal and non-tribal community members, the state government established a Sub-Centre, which has one ANM, who with the cooperation of all the ASHA workers in the villages, ensures that all the community members get the primary aid and any other medicines for minor diseases. This ANM of the sub-centre also provides immunisation to the children of the concerned village twice a week and TT injunctions to the pregnant women in the village. This Sub-Centre also provides the DOTS to the TB infected persons in the village.

The Anganwadi Centre is one of the government institutions, which is working under the Integrated Child Development Scheme (ICDS), which is wholly administered by the Central government. The ICDS provides nutritious food to the children below the age of 6 years. The centre also provides eggs, Rice, Dal and oil to the pregnant women in the villages. Apart from this, a Post office is functional in the village.

In Golla Charla, the researcher found that government institutions like Gram Sabha were adequately addressing issues like drinking water, road connectivity, electricity problems and any other issues related to the village. This village also has one Sub-Centre to provide health care to the residents. The government has appointed one ANM worker, who with the cooperation of the ASHA, AWW, and SHGs and VHNSC, takes care of the health needs of the members of the village. In this Sub centre, the community members get primary aid and any other medicines for minor diseases. This village is also having one government primary school, where the students of this village and the nearby villages are enrolled. One more government institution is the Anganwadi Centre, where the children below the age of 5 years are being given nutritious food and pregnant and lactating women and children are being provided dietary supplements.

Conclusion

This chapter provided certain insights about the state of Telangana, Warangal District, Mandal and the study villages. The profile of Telangana state dealt with the history and etymology of the State, general health profile of the state and the presence of health institutions in the state. The village profile, mainly discussed the socio-demographic profile like sex ratio, distribution of the community, educational, occupational and income level of the community members. Other issues covered were: the government institutions, religious and the health culture in the study villages.

Chapter – 3

Socio-Demographic Profile of ASHA and the Process of Selection and Training

As has been stated earlier, the Government of India launched the ASHA programme with the main objective of bridging the gap between the community and the health service providers. The ASHA workers are expected to act as catalysts between the community and health centers at different levels. The responsibility of selection and recruitment of the ASHA workers has been given to the respective States and Union Territories. The state of Telangana has further delegated this responsibility to the respective Gram Sabhas. At present, a total of 26,000 ASHA workers are functioning in tribal, rural and urban areas of the Telangana State (NRHM, 2005).

In this chapter, the socio-demographic profile of the ASHA workers in the study area will be discussed. There will also be a discussion on the reasons and motivations for their choosing this line of work, the recruitment, and training processes, and the experiences of the individual ASHA workers.

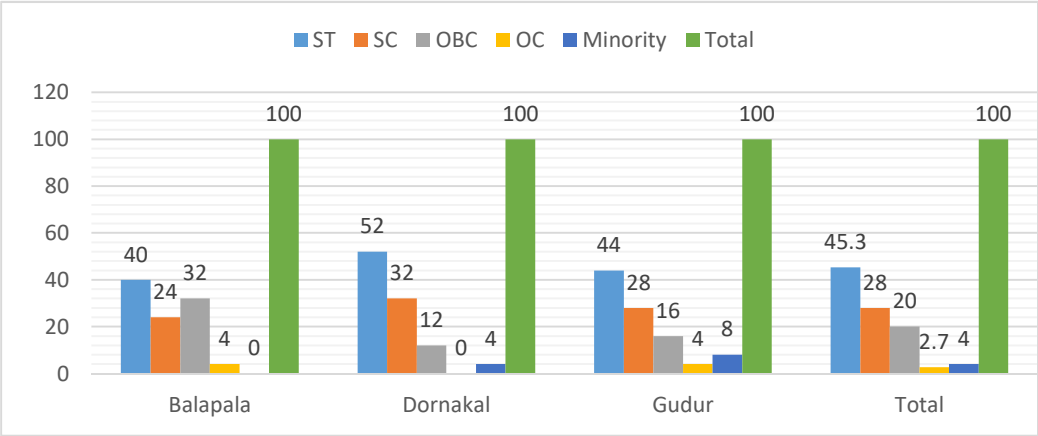
Socio-Demographic Profile of ASHA Workers

It is a known fact that Indian society is hierarchically arranged where the community members are segregated on grounds of caste or community. Keeping in view this heterogeneity in terms of caste, an attempt will be made here to see whether different castes are represented in the selection of ASHA workers. Since ASHA workers do not come under the category of Government employers, the reservation policy adopted for the recruitment of government employees cannot be applied when inducting ASHA workers.

Distribution of ASHA Workers by Their Community

It is pertinent to know about the distribution of the ASHA workers by their community. This will help one to know whether all the communities are represented in this scheme. The Table 3.1 below should help one to form an opinion in this regard.

Chart 3.1: Distribution of ASHA Workers by Their Community



Sources: Field work data collected in 2012-14

In all the three PHCs, the largest proportion of respondents (overall, 45.3%) was found to be of STs. A possible reason for this could be that the study area has a large percent of a tribal population. Each revenue village, in the three PHC areas, has 2 or 3 tribal hamlets and its population is more when compared with that of the non-tribal population. As per the norm of NRHM, each tribal hamlet, whose population is more than 500, is entitled to have one ASHA worker. Since the tribal hamlets are more, the proportion of ASHA workers belonging to ST categories is also more in the study area.

The second largest proportion of ASHA workers was found to be that of SCs in the PHCs covered by Dornakal and Gudur PHCs. However, in Balapala PHC, there were more OBC ASHA workers than those belonging to the SC category. The reason for this is the very high proportion of OBCs in the revenue villages under the Balapala PHC. A sizable number of families in this PHC area were found to belong to the Yadava (shepherd) community, which comes under the OBC category.

A very significant finding is the relatively low 'representation' of OCs (overall, 2.7%) and Minorities (overall, 4.0%) in the three PHCs. Further, women belonging to the upper castes like Kammas, Reddys and Velamas may be facing some social pressure in taking up such employment in these villages. Apart from this, such families are relatively financially secure and do not feel the need for their women to undertake 'low' paid

assignments. The purdah system among the Muslims may be responsible for the presence of very few women belonging to the minority communities, besides the relatively small size of their population in the study area.

A definite conclusion that can be drawn is that the poor and the marginalised sections like SCs, STs and OBCs are showing greater interest to join as ASHA workers. Engagement as ASHA workers is giving them a degree of respectability. The poor socio-economic status of many OBCs is a major motivating factor for their willingness to perform the duties of ASHA workers. It also emerged during the field study that a few ASHA workers had quit the job due to some familial problems. One ASHA worker hailing from the Balapala PHC informed that she had quit the job since the incentive was too less and she had an offer of better wage in a private firm.

Marital Status and Family System

Matrimony can have a definite impact on whether a woman can go out for work. In poor families, women may be forced to supplement the family income. Relatively financially sound families, particularly in rural areas, may not be very keen on their women folk going out for work. The Table 3.2 below illustrates about the marital status of the ASHA workers.

Table 3.1: The ASHA Workers' Family System

		Family System		
PHC		Nuclear	Extended	Total
Balapala	Count	20	5	25
	% within PHC	80.0%	20.0%	100.0%
	% of Total	26.7%	6.7%	33.3%
Dornakal	Count	17	8	25
	% within PHC	68.0%	32.0%	100.0%
	% of Total	22.7%	10.7%	33.3%
Gudur	Count	19	6	25
	% within PHC	76.0%	24.0%	100.0%
	% of Total	25.3%	8.0%	33.3%
Total	Count	56	19	75
	% within PHC	74.7%	25.3%	100.0%
	% of Total	74.7%	25.3%	100.0%

Sources: Field work data collected in 2012-14

It can be seen that in all the three PHCs overall (74.7%) of the ASHA workers belong to nuclear. It shows that there is gradual reduction in the extended or jointly family system.

More and more community members are adopting the nuclear family system. The reasons for such a change are people migrating from one place to another in search of livelihood options and the growing desire to have economic independence

Age Profile of the ASHA Workers

The work of an ASHA is considered to be quite responsible and hectic. Her working hours are considered to be 24 X 7, since emergency cases may arise at any time. Due to the nature of the job, the eligible women in the relatively older age bracket may not be very keen to join as ASHA workers. In some cases, it is true that many women above 40 years of age in the study area are either illiterate, or just drop outs of the primary school and hence ineligible for this assignment. This could be the possible reason for selecting young women to work as ASHA workers in the study area. The Table 3.3 below depicts the age profile of ASHA workers in the study area.

Table: 3.2: Age of the ASHA Worker at the Time Joining

PHC		20-25	25-30	30-35	35-40	40-45	45-50	50-55	Total
Balapala	Count	6	12	4	2	0	1	0	25
	% within PHC	24.0%	48.0%	16.0%	8.0%	.0%	4.0%	0.0%	100.0%
	% of Total	8.0%	16.0%	5.3%	2.7%	.0%	1.3%	0.0%	33.3%
Dornakal	Count	10	8	3	1	2	0	1	25
	% within PHC	40.0%	32.0%	12.0%	4.0%	8.0%	.0%	4.0%	100.0%
	% of Total	13.3%	10.7%	4.0%	1.3%	2.7%	.0%	1.3%	33.3%
Gudur	Count	8	9	8	0	0	0	0	25
	% within PHC	32.0%	36.0%	32.0%	0.0%	0.0%	0.0%	0.0%	100.0%
	% of Total	10.7%	12.0%	10.7%	0.0%	0.0%	0.0%	0.0%	33.3%
Total	Count	24	29	15	3	2	1	1	75
	% within PHC	32.0%	38.7%	20.0%	4.0%	2.7%	1.3%	1.3%	100.0%
	% of Total	32.0%	38.7%	20.0%	4.0%	2.7%	1.3%	1.3%	100.0%

Sources: Field work data collected in 2012-14

Not surprisingly, at the time of joining in the year 2005, the majority of the ASHA workers in all the three PHCs (overall, 38.7%) were found to be in the 25-30 years' age bracket. Next was the 20-25 years' age group (overall, 32.0%). It is evident that majority of the ASHA workers (as high as 70.7% overall) were less than 30 years of age

at the time of joining. Considering the fact that the ASHA scheme was launched in the year 2005, the majority of them were around 20 to 25 years at the time of their first appointment. Many educated (yet needy) young women in these study villages seized the opportunity to become ASHA workers in the villages.

Education Levels of the ASHA Workers

The NRHM guidelines clearly stipulate that the ASHA worker must have passed the SSC examination. In the tribal areas, there has been some relaxation and 8th standard has been fixed as minimum educational level. The tasks of the ASHA worker entail a degree of literacy since she has to disseminate health related information to the members of the community, besides maintaining records. The Table 3.4 below depicts the situation in the study area.

Table 3.3: Education Levels of the ASHA Workers

Name of the PHC		Primary	Higher	SSC	Inter	Degree and Above	Total
Balapala	Count	2	4	11	7	1	25
	% within PHC	8.0%	16.0%	44.0%	28.0%	4.0%	100.0%
	% of Total	2.7%	5.3%	14.7%	9.3%	1.3%	33.3%
Dornakal	Count	0	6	14	3	2	25
	% within PHC	0.0%	24.0%	56.0%	12.0%	8.0%	100.0%
	% of Total	0.0%	8.0%	18.7%	4.0%	2.7%	33.3%
Gudur	Count	0	4	16	4	1	25
	% within PHC	0.0%	16.0%	64.0%	16.0%	4.0%	100.0%
	% of Total	0.0%	5.3%	21.3%	5.3%	1.3%	33.3%
Total	Count	2	14	41	14	4	75
	% within PHC	2.7%	18.7%	54.7%	18.7%	5.3%	100.0%
	% of Total	2.7%	18.7%	54.7%	18.7%	5.3%	100.0%

(Sources: Fieldwork data collected in 2012-14

It can be seen that, by and large, the ASHA workers possessed the minimum qualifications set by the NRHM. However, in the case of some tribal women, educational qualifications were relaxed, owing to the shortage of qualified candidates. Such women, however, accounted for only 2.7% of the overall ASHA workers.

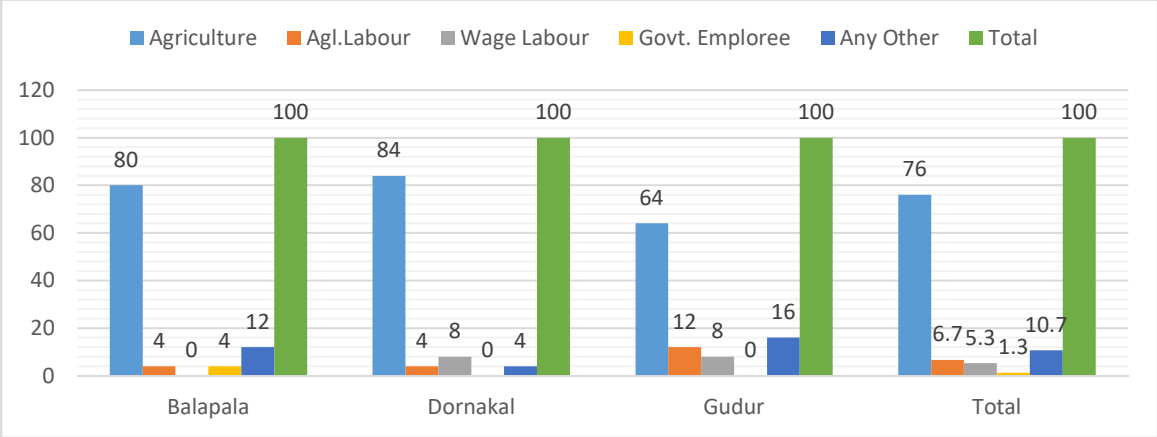
The largest proportion of ASHA workers in all the PHCs (overall, 54.7%) had SSC level education. This was followed by Intermediate level education (overall, 18.7%). Interestingly, 5.3% of the overall ASHA workers were having a degree or higher level of

education. This suggests that, at least in the study area, a higher level of education did not discourage persons from taking up such jobs – maybe financial considerations prompted them to opt for this type of work.

Primary Occupation of the Family

The occupational structure refers to the aggregate distribution of the resources in the society, which is based on the economic function. The occupational structure of the village economy is shaped by the various social, economic, cultural and political factors. In a rural setting, the primary occupation has generally been agriculture, or one based on agriculture. Table 3.5 below depicts the primary occupations of the family members of the ASHA workers.

Chart 3.2: Primary Occupation of the Families of the ASHA Workers



Source: Field Data Collected in 2012-14

Not surprisingly, the household occupations of most of the ASHA workers in all the three PHCs were found to revolve around agriculture – agriculture on own land (overall, 76.0%) and agricultural labour (overall, 6.7 %). The other occupations like wage labour and government service were hardly noticeable in number. Exclusive dependence on wage labour seems to be negligible for the families of ASHA as they constitute only 5.3% (Overall 12.00%). Owing to the meager income from agriculture, many families have looked for alternate sources of income like the ASHA scheme.

Household Income of the ASHA Workers

While social service is a noble motive for becoming an ASHA worker, the financial condition of the household is the prime motivator for opting for this line of work. It has been brought out in the discussion above Table 3.5 that the primary family occupation of 76% of the ASHA workers is agriculture. The Table 3.6 below provides summary of the annual family incomes of the ASHA workers in the study area. This should give one an idea of the financial compulsions that forced the respondents to choose to become ASHA workers.

Table 3.4: Family Monthly Income Status of the ASHA Workers (in Rs.)

PHC		1000-5000	6000-10000-	11000-15000	16000-20000	Above 20000	Total
Balapala	Count	12	5	4	1	3	25
	% within PHC	48.0%	20.0%	16.0%	4.0%	12.0%	100.0%
	% of Total	16.0%	6.7%	5.3%	1.3%	4.0%	33.3%
Dornakal	Count	0	13	11	0	1	25
	% within PHC	0.0%	52.0%	44.0%	0.0%	4.0%	100.0%
	% of Total	.0%	17.3%	14.7%	0.0%	1.3%	33.3%
Gudur	Count	4	9	10	1	1	25
	% within PHC	16.0%	36.0%	40.0%	4.0%	4.0%	100.0%
	% of Total	5.3%	12.0%	13.3%	1.3%	1.3%	33.3%
Total	Count	16	27	25	2	5	75
	% within PHC	21.3%	36.0%	33.3%	2.7%	6.7%	100.0%
	% of Total	21.3%	36.0%	33.3%	2.7%	6.7%	100.0%

Source: Field Data Collected in 2012-14

It is clear that the majority of the ASHA workers had monthly family incomes ranges of Rs 6000-10,000 (overall, 36.0%) or Rs 11,000-15,000 (overall, 33.3%). Those with monthly family incomes above Rs20, 000 were relatively fewer in number and accounted for an overall total of only 9.4%. Most of the ASHA workers have land holding of less than 1 acre, which is many times not an irrigated land. Cultivation of this land is possible only when there is good south west and north east monsoon. Due to the failure of the monsoons, their income from agriculture remains very meager.

Year of Joining of the ASHA Workers

The ASHA scheme was launched in 2005. It would be of interest to ascertain the year-wise intake of such workers. This would enable one to get an idea about the seniority and experience of these workers in the study area. The Table 3.7 below should be reasonably helpful in this regard.

Table 3.5: Year of Joining as ASHA Workers

PHC		2006	2007	2008	2009	2010	2011	Total
Balapala	Count	18	1	3	2	0	1	25
	% within PHC	72.0%	4.0%	12.0%	8.0%	.0%	4.0%	100.0%
	% of Total	24.0%	1.3%	4.0%	2.7%	.0%	1.3%	33.3%
Dornakal	Count	21	2	0	0	2	0	25
	% within PHC	84.0%	8.0%	0.0%	0.0%	8.0%	0.0%	100.0%
	% of Total	28.0%	2.7%	0.0%	0.0%	2.7%	0.0%	33.3%
Gudur	Count	22	2	0	0	1	0	25
	% within PHC	88.0%	8.0%	0.0%	0.0%	4.0%	.0%	100.0%
	% of Total	29.3%	2.7%	.0%	0.0%	1.3%	.0%	33.3%
Total	Count	61	5	3	2	3	1	75
	% within PHC	81.3%	6.7%	4.0%	2.7%	4.0%	1.3%	100.0%
	% of Total	81.3%	6.7%	4.0%	2.7%	4.0%	1.3%	100.0%

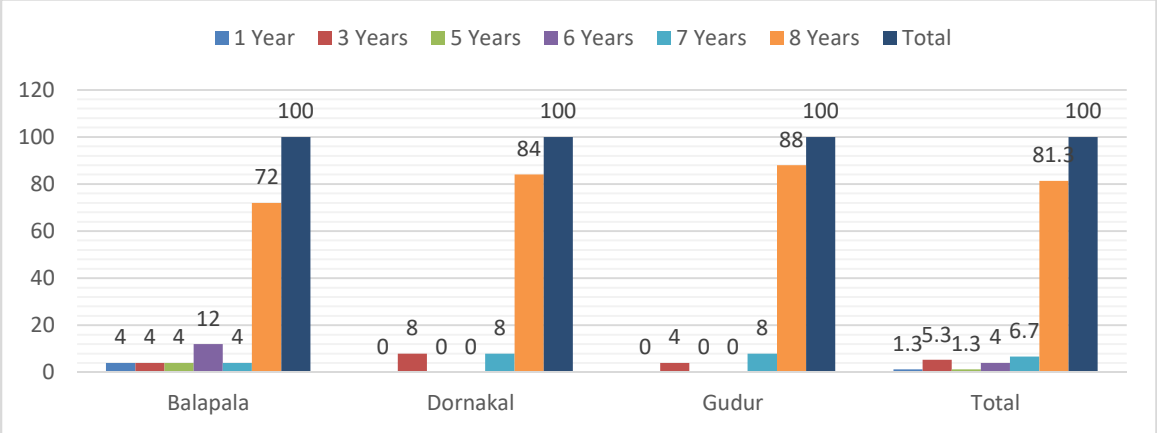
Source: Field Data Collected in 2012-14

It can be seen that the largest number of persons (overall, 81.3%) joined as ASHA workers in 2006. A possible reason for that could have been the wide publicity given to the scheme by the central and state governments. At the same time, it has been reported that, in some of the villages, the concerned authority at the time of recruitment did not find suitable candidates due to various reasons. It is also true that some of the ASHA workers left or resigned the job due to various reasons.

Experience of the ASHA Workers

The ASHA scheme has been in operation for more than 10 years now. It would now be pertinent to review the length of service of ASHA workers in the study area. A logical question may be why these persons are continuing in these assignments, even after reasonably long years of experience. Also, could they not secure better employment in say, an urban centre? A possible explanation for this could be that this task is in generally in their native places and they must have become familiar with their responsibilities. A job in a different area could entail either relocating there, or commuting to that place on a daily basis. Also, continuing as ASHA workers may help them to assist in the family occupation. In any case, the earning as an ASHA worker would in most cases be a supplement to the family income – and not the basic income. The Table 3.8 below depicts the work experience of the ASHA worker in the study area.

Chart 3.3: Work Experience of the ASHA Workers



Source: Field Data Collected in 2012-14

It has already been mentioned that the large number of persons joined as ASHA workers in 2006 and that there has generally been a fall in the number of persons inducted in the subsequent years. Hence, it is not surprising to note that the majority of the workers (overall, 81.3%) had more than eight years of experience.

The Process of Selection

Selection or recruitment processes is where the potential person or employee is selected from a number of candidates. Recruitment is concerned with reaching out, attracting and

ensuring a supply of qualified personnel and making selection of the requisite manpower in both quantitative and qualitative terms. On the other hand, it can be viewed as the development and maintenance of adequate manpower resources. This is the first stage of the process of selection and finally completed with the placement in the job. According to the Edwin B. Filippo, "It is a process of searching for prospective employees and stimulating and encouraging them to apply for positions in an organisation."(http://gobalhrm.blogspot.in/p/recruitment-selection.html).

Process of Selection in the Study Area

The selection process of ASHA workers in the study villages is expected to be according to the relevant guidelines issued by the government. As per the guidelines, the recruitment of ASHA needs to be through a consultation process involving all the stakeholders that includes the members of the PRI, ANM, and AWW. It is noted that, in the study villages, the representatives of the PRI convened a meeting with ANMs, AWWs and discussed the ASHA scheme prior to the selection of the ASHA. In this meeting, the Sarpanch of the Gram Sabha assigned the task to the Gram Sabha members, ANM and AWW to disseminate information about the ASHA scheme to the community members.

The Gopa Thanda village comes under the purview of the Upper Gudem, the concern Gram Sabha members, along with the ANM and AWW, convened the meeting. In this meeting, the village elders or peer groups and other community members were also present. This committee explained about the ASHA scheme and its importance to them. In the case of Golla Charla village, the same method was followed, i.e., by convening the meeting with the community members. But in the case of the Damarvancha along with the meeting, the committee members also visited every household and explained and created awareness about the new scheme.

It is reported that, in all the three study villages, these stakeholders actively campaign about the new scheme. Some of the interested candidates got the information directly from the Gram Sabha. They have gone through the guidelines of the NRHM, about which the researcher has already mentioned in the Chapter-1- Introduction (page No-18). It is

found that Gram Sabha, ANM and AWW and village elders played their part in the recruitment process.

Here, all three the Gram Sabha, after some publicity by involving all the concerned village functionaries like the ANM, AWW and others, received total 17 applications. Out of them, 6 were the natives of Golla Charla and 4, of Damarvancha and finally 7 from the Uppergudam Gram Panchyath. These applications were screened by the respective Gram Sabha committees by going through their educational qualifications.The committee verified the SSC marks list and other relevant documents. After due screening of the applications, the committee has called the candidates for an oral interview. The committee members assessed the candidates' motivation, as well as the knowledge, relating to the health care.

In addition, they asked for the opinion and consent of the husband (if the candidate was married) or parents (if unmarried) in order to ascertain the support of the family to her keeping in view the fact that not only the job of ASHA is hectic and requires a commitment for 24 X 7 days' work, but also needs training for a period of 23 days in the first spell and one week in the second spell in the district headquarters. The committee members clearly explained to the applicants about their roles and responsibilities, of ASHA workers. Further, the committee members summoned the husbands or parents of the candidates to explain the details of the ASHA scheme. After the responses furnished by the husbands and parents of the candidates, the committee went in for the final selection of the candidates.

Thus, the Upper Gudam Gram Sabha eliminated two candidates as their family members did not show interest. Finally, in Gopa Thanda one ASHA worker has been selected and whereas in Golla Charla two ASHA workers and in Damarvancha two members have been selected as an ASHA workers. It has been reported from the field that in Gopa Thanda that the tribal women who residing in Gopa Thanda did not show the interest to work as ASHA workers. It shows that the concerned Gram Sabha, ANM, AWW may not have properly explained to the community members about the ASHA scheme and its benefits, otherwise the women of the village could have shown interest for the ASHA post.

The next issue is a motivational factor to become an ASHA worker. The study has attempted to explore the possible person or bodies' who played a decisive role in motivating the ASHA workers. The below paragraph explain about the persons who provided the motivation for becoming an ASHA workers in the study area.

ASHA Workers: Motivation

In a rural setting, educated women rarely choose occupations other than teaching. For venturing into new areas of work, many of them need to be motivated by someone else. The Table below 3.9 provides an idea about the 'strongest influences' in this regard in the study area.

Table 3.6: Motivational Influences for Becoming ASHA Workers

Name of the PHC		Gram Sabha	ANM	AWW	Community Members	Family Members	Self-Motivation	Total
Balapala	Count	11	6	4	1	2	1	25
	% within PHC	44.0%	24.0%	16.0%	4.0%	8.0%	4.0%	100.0%
	% of Total	14.7%	8.0%	5.3%	1.3%	2.7%	1.3%	33.3%
Dornakal	Count	8	5	7	3	1	1	25
	% within PHC	32.0%	20.0%	28.0%	12.0%	4.0%	4.0%	100.0%
	% of Total	10.7%	6.7%	9.3%	4.0%	1.3%	1.3%	33.3%
Gudur	Count	9	4	3	6	3	0	25
	% within PHC	36.0%	16.0%	12.0%	24.0%	12.0%	0.0%	100.0%
	% of Total	12.0%	5.3%	4.0%	8.0%	4.0%	0.0%	33.3%
Total	Count	28	15	14	10	6	2	75
	% within PHC	37.3%	20.0%	18.7%	13.3%	8.0%	2.7%	100.0%
	% of Total	37.3%	20.0%	18.7%	13.3%	8.0%	2.7%	100.0%

Source: Field Data Collected in 2012-14

A common factor noticed in all the three PHCs under study was that the publicity made by the concerned Gram Sabha emerged as the strongest influence for becoming ASHA workers. Self-motivation emerged at the lowest end of the spectrum. Support of family members and community members too did not rank very high in the study area. The role

of ANMs and AWWs was found to be quite noticeable. Obviously, they have been acting as some sort of role models in the villages and inspiring others to become health workers.

Case Study

Ram Bai Gugulethu is working as an ASHA worker in Lingya Thanda, which comes under the jurisdiction of the Balapala PHC. She was born and brought up in the same village. Her parents are agriculturalists. She has two elder sisters, both of whom are married. She did her schooling from the ZPHS (ZilaParishad High School), Balapala and completed SSC in 1995.

Ram Bai got married in the year 2000 to the RamlalGugaloth, who also hails from the same village. They have two children; both of whom are going to the schools. Ram Bai and her husband are primarily engaged in agricultural activities. The income from agriculture is not sufficient to run their family. To get additional income, they have been running a small 'kirana shop'.

Ram Bai's husband learnt about the ASHA scheme from his brother who was then working as a pharmacist in Balapala PHC. He, in turn, passed on the information to Ram Bai. Initially, Ram Bai was reluctant to apply for the post of ASHA worker as she felt that she would not be able to manage agriculture and her business, besides looking after their children. Her husband communicated the same message to his brother. However, her brother-in-law insisted that she should apply for the post. He convinced her by mentioning that there were chances that the ASHA post would soon be regularised by the government. So, on his advice, Ram Bai and her husband met the Panchayat members and the ANM for detailed information.

The Gram Sabha members explained to Ram Bai about the eligibility criteria and the kind of incentives the ASHA workers would get from the government, for their performance in the village. Later, she shared this information with her husband who encouraged her to apply for this assignment. He convinced her that the job would give her an identity in the village. He also assured her that, in her absence, he would take care of the household work and look after the children.

Ram Bai, then collected the application form from the AWW worker, who hails from the same village. The filled in application form, along with SSC marks sheet, was handed over to the Sarpanch of the village. The Sarpanch constituted a committee with Sarpanch as Chairperson and Medical officer, ANM and AWW as other members. The committee subsequently cleared her appointment. At the time of the interview, her husband too was present. The committee took the opinion of her husband too by explaining about the nature of the job. On receiving the appointment letter, Ram Bai and her husband met the medical officer in Balapala PHC and submitted the joining letter to the Medical officer.

After Ram Bai got selected as an ASHA worker, though she was from the same locality, it was very difficult for her to know about the health conditions of the village community. In this regard, the ANM and the ASHA worker along with AWW had to assist her and they made house-to-house visits to get acquainted with the community members. Already the ANM worker had a good rapport with the village community members. Ram Bai got informed about the date of training from the Medical officer, which is going to be held at Madi Konda in Warangal district. Ram Bai, along with other selected ASHA workers, assembled at Mahabubabad area hospital, where the ASHA co-coordinator accompanied them to the training centre at Madi Konda. The first day, in the training centre the trainer grouped all the ASHA workers into 5 groups each group containing 25 members. The first class started with an introductory class, in which all the ASHA workers introduced themselves about their names and the village they came. The training took place for the period of 23 days.

The trainers took classes for 3 to 5 hours. They taught the new recruits about the roles and responsibilities, which ASHA workers would have to perform in the villages. They have covered 4 modules. The trainers mainly focused on the immunisation, women health, ANC, PNC, village health planning, health and hygiene and nutritional aspects. During training, Ram Bai raised certain questions related to immunisation, and the consequences of injections not being administered within the time. Ram Bai got a clarification from the trainer that, if any children missed the immunisation vaccines due to various reasons, they could be given that later, but they should not miss the vaccination. In this way, the Ram Bai got more information on the roles and

responsibilities of ASHA workers. The trainer gave books/modules to the ASHA workers, which has covered all the health related information. After the training, Ram Bai came back to the home and met the ANM worker, AWW and SHG members, PHC staff and the VHNSC in the village. Since then onwards, she is carrying her responsibilities in Lingya Thanda village.

Reasons for Becoming ASHA Workers

A reason for performing an act can sometimes be different from the motivation for that. Motivation needs some kind of external or intrinsic influence to opt for a particular line of work. The social, cultural, economic, political and psychological factors have played important roles in the decision to become ASHA workers. Due to social barriers and lack of education, some of the community members did not get a fair chance to become part of the government institutions. Hence, the marginalised and disadvantaged communities are looking for better avenues to become a part of the government machinery. Against this backdrop, an attempt has been made to know the reasons for becoming ASHA workers. The Table 3.10 below depicts some of the major reasons for becoming ASHA workers.

Table 3.7: Reasons for becoming ASHA Workers

PHC		Source of Income	To Serve the Community	Be a Part of Government	Social Recognition	Self Interest	Total
Balapala	Count	5	10	6	3	1	25
	% within PHC	20.0%	40.0%	24.0%	12.0%	4.0%	100.0%
	% of Total	6.7%	13.3%	8.0%	4.0%	1.3%	33.3%
Dornakal	Count	6	8	5	5	1	25
	% within PHC	24.0%	32.0%	20.0%	20.0%	4.0%	100.0%
	% of Total	8.0%	10.7%	6.7%	6.7%	1.3%	33.3%
Gudur	Count	8	10	5	2	0	25
	% within PHC	32.0%	40.0%	20.0%	8.0%	0.0%	100.0%
	% of Total	10.7%	13.3%	6.7%	2.7%	0.0%	33.3%
Total	Count	19	28	16	10	2	75
	% within PHC	25.3%	37.3%	21.3%	13.3%	2.7%	100.0%
	% of Total	25.3%	37.3%	21.3%	13.3%	2.7%	100.0%

Source: Field Data Collected in 2012-14

It can be seen that some human beings may have the desire to serve the community and it is a natural and related to the psychological motivation to serve the community. Some human beings have an inborn tendency to respond on social issues such as illiteracy, child mortality, maternal mortality, child marriages, trafficking of the girl child, suicides, poverty, and unemployment. Most of the human beings, by seeing such news in the media, naturally respond to get rid of the above said social issues. So, in this connection, the ASHA workers stated that they wanted to serve the community. These women are socially conscious of issues which are happening in and around the village community. They are contemplating to become the part of the government institutions and can strive hard to achieve objectives set by the Government so that they could bring the desired change in the society. It is also reported that before becoming ASHA workers, some of them actively took part in plantation and sanitation programmes as part of the clean and green initiatives promoted by the Government. So, 'serving the community' emerged as the most influential factor in all the three PHCs (overall, 37.3%). Some others have stated that appointment as ASHA is a fulfillment of their dream to become a part of the village community development programme. They also said that the job is giving them a lot of satisfaction since they could contribute to the wellbeing of the women and children of their community. Interestingly, 'self-interest' figured at the lowest end of the spectrum (overall, 2.7%).

The monetary consideration was also found to be a major motivator (overall, 25.3%). This is not surprising since the majority of the respondents belong to low-income families and any additional source of income would always be welcome. A number of respondents mentioned that they derived a lot of satisfaction from the fact that they were also supporting the family. The highly noticeable proportion of respondents (overall, 21.3%) who mentioned 'to be a part of the government' suggests that government jobs carry with themselves an element of prestige. At the same time, 'social recognition' did not emerge as a major influencing factor (overall only 13.3%).

Training

Training is one of the foremost prerequisites for the ASHA workers to perform their duties more effectively. 'Training is an organised activity, which is aimed at imparting information, knowledge, roles, and instructions for the better performance of the job.' According to TPI-theory, "training should not only include the development of theoretical and practical skills, but also meet interaction needs that exist among the new employees".

Induction Training

Basically, induction training is kind of introduction for the beginners or starters to enable them to perform their work in the respective villages. Induction training is imparted to the newly appointed ASHA workers to give them the kind of orientation required for the job and to acquaint them with the knowledge required for fulfilling the roles and responsibilities. The ASHA workers in the study area were sent for the induction training for a period of 23 days at Madi Konda in Warangal district. The training was designed as per the NRHM guidelines and comprised seven modules primarily to cover health subjects required to be learnt by the ASHA.

The ASHA worker from the all the three PHC that is Balapala, Dornakal and Gudur informed that training was imparted by various methods, but most predominantly by lecture method with the use of audio-visual materials. The trainers also followed the posters method and pasted the diagram about the functioning of the reproductive organ at the training centre. These ASHA workers were also given pamphlets and booklets to gain a more in-depth knowledge of the topics. The trainers imparted training in the following areas comprising 5 modules and 19 themes. Each theme contains some sub-themes. The themes covered to the ASHA worker were as follows: 1. Introduction, roles, tasks 2. Being healthy-determinates of health 3. Water –sanitation, environment 4. Nutrition and malnutrition 5. Knowing Ourselves-Human biology 6. Community, gender, PRI, Rights 7. Adolescent health 8. Communication 9. Health services, Govt. Pvt. 10. Illness causes and healing remedies 11. AYUSH/Herbal medicines 12. Contraceptive methods 13. Preventing unwanted childbirth 14. Pregnancy, birth, postnatal care 15. Genital infections

and HIV/AIDS 16. Child health 17. Common medical problems 18. National health programmes 19. Accidents and first aid.

Most of the ASHA workers also informed that they asked questions about some topics mentioned in the booklet. The trainers clarified the doubts raised by the ASHA workers.

ASHA Resource Centre (ARC)

Under the NRHM programme, the Government of India has established a strong support mechanism, i.e., the ASHA resource centre for the ASHA workers. The ARC is working as a technical and administrative body to implement the activities of NRHM in the state" and ARC is entrusted with the responsibility of improving the quality of the ASHA programme (NRHM, 2005).

Functions of the ASHA Resource Centre (ARC)

Technical backstopping in Training to the ASHA worker: ARC develops the training methodology and the training modules, based on the guidelines issue by the Union Ministry of Health and Family Welfare. These modules are then disseminated to the districts. The ARC also provides the supportive supervision to maintain quality checks and control at district and Block levels.

Developmental of IEC material: ARC is mainly responsible for developing or collecting the Information, Education and Communication (IEC) material from different institutions, to disseminate the information at the time of training. The facilitations kits like flip charts, books and posters on various issues are developed and disseminated by the ARC to the ASHA workers. The IEC material is developed from time to time, based on the felt needs of the community.

Planning of monthly meetings- ARC conducts monthly meetings of ASHA workers at the Block level, in order to discuss and resolve day-to-day problems faced by the ASHA workers and monitors the progress of the activities conducted in the villages. In these meetings, the ARC reviews the concepts and content to improve the learning process of ASHA workers. The topics covered in the training could also be examined in the monthly meetings.

Development of reporting formats and registers and Processing of Statistical Data: The RHMS has developed a reporting register and format to facilitate the work of the ASHA personnel. Such registers and forms help the ASHA workers to streamline their roles and responsibilities on a priority basis. Thereafter, the ARC centre compiles and analyses the data, it provides the feedback to NRHM.

Inter-Sectoral coordination pertaining to ASHA: Since ASHA workers can be used by other departments to promote their objectives, the ARC coordinates with other departments and facilitates empanelment of ASHA workers in various other programmes like SarvaShikshaAbhiyan (SSA) and Total Sanitation Campaign (TSC).

Involvement of NGOs to strengthen the programmes: Involvement of NGOs is playing an important role in the implementation of the ASHA scheme to work at the community level in order to develop the capacities of ASHA workers. There could be many roles of NGOs and their roles need to be identified by ARC.

Provision of Drug Kits: TheASHA workers provide the basic medical care to the community. The drug kit with basic medicines and supplies are provided to all the ASHA workers under the NRHM. The drug kit consists of allopathic, as well as AYUSH, medicines. The ASHA worker issues the medicines free of charge to the community. Initially, the drug kits are provided by the Government of India. They may need state level modification and supplementation. In such cases, ARC facilitates the procurement process and supplies the material to the ASHA workers. ARC develops the mechanism to maintain at least two months' stock of medicines with the ASHA personnel.

Refresher Training

It is possible that some ASHA workers may with the passage of time lose some of the knowledge and skills acquired during training. There are various reasons for this degradation of knowledge and skills of ASHA workers. Most often, this may be because such knowledge and skills are not being used on a regular basis. Refresher training capsules for such persons can help in reinforcing and consolidating the knowledge and skills acquired during the initial training.

The respondent ASHA workers of the study area stated that five refresher training capsules, of five days' duration each, were conducted for them. After a brief review of subjects that were covered in the induction training, the refresher training focused more on the practical problems faced by the ASHA workers in the villages. The refresher training aimed at providing certain strategies to mobilise the support of the community members and mobilisation strategies to the ASHA workers. This training also gave an opportunity to the ASHA workers to stay updated about the recent health schemes introduced by the Government.

Training and its Benefits to the ASHA Workers

It was reported by the respondents that, after the induction training and the refresher training, they got benefited immensely as they gained knowledge and skills relating to health care. After the training, their perceptions and perspectives have changed and they felt more confident to work effectively in the villages. The refresher training also immensely benefited the ASHA workers. They got new information about health topics and they have been updated with the new knowledge. They shared their field problems with the concerned authorities and got the redressal from them.

Family and Community Support to the ASHA

The emotional and psychological support provided by the members of the family can greatly help an individual to perform his or her role in the society effectively. An attempt will now be made to understand the extent to which the ASHA workers look for family support and the means of achieving that support.

Family Support Extended to the ASHA Workers

The field survey has brought out that a majority (76.7 %) of the ASHA workers are receiving support from their family members. Such a support may be because of factors like supplementary income and the enhanced social status within the community. Many ASHA workers even said that their family members, including their husbands, were willingly sharing the domestic chores.

Yaddamma (aged 35 years), an ASHA worker from Balapala PHC, said “when I go out for work, my sister in law looks after all household chores. Not only that, she also looks after my two-year-old daughter in my absence". She further stated, “sometimes, even my husband takes care of cleaning the house and cooking food, when I am away on work".

Another ASHA worker from Dornakal PHC, Swarupa, 25-year-old said, “My husband is often accompanying me in the village for conducting any surveys or in the distribution of medicines to the patients. He takes care of distribution of condoms to male members".

However, a few women complained that they do not get the support to the expected level. For instance, Rajamma, 30-year-old ASHA worker from Gudur, stated "When I needed to attend any delivery cases at night, my husband used to shout at me and sometimes he did not allow me to step out from the house. Even my mother-in-law and other family members also supported him and discouraged me from attending to deliveries during the night time".

Similarly, another ASHA from Balapala PHC, Chinamma, aged 28 years, informed that, initially, her husband did not allow her to go on official work during night time. He often asked her to quit the job as the earning from her was also not much. But later, when I insisted that he could accompany me when I had to go out at night; he understood and began to give full cooperation to me.

Support System from the Community

While performing their duties, a number of ASHA workers may come across largely illiterate community which may be having its own rigid ideas and notions. It is also possible that many members of the community may belong to a higher caste than that of the ASHA workers. Such persons may not like to be told on what to do and what not to do by a person hailing from a lower caste. It is, therefore, essential that the ASHA workers are accepted and supported by the community, irrespective of class, caste, creed and religion.

The interviews with ASHA workers across the three PHC revealed that, by and large, ASHA workers are well accepted in the community and considered as a friend by majority of the households, particularly by the pregnant and lactating mothers. The majority of the ASHA workers informed that people of all castes and religions call them for services and have been generally following their advice and accessing the healthcare suggested by them. In this regard, Chandra kala one of the ASHA worker who hailed from the Dornakal PHC, said that when "I organised the health awareness camp at the time of beginning, most of the community members did not pay heed to my call. But now, the community members are paying more attention, participating and listen my advice during the health camps conducting in the village. They shares their opinions with regard to the health related matters and follows my advice strictly. Further, she also said that some of the community did not pay heed to my advice, but I still trying my best to bring positive behavioural changes in them".

Another ASHA worker hailed from the Balapala PHC said that when she goes for the immunisation drives, all the community members of the village pay attention and take the immunisation in time. She also said that if any case any child missed the vaccination, the concerned family members immediately contacting her about the next vaccination drive. She opined that the community members are now-a-days are paying greater attention to the immunisation. In this way, the ASHA workers are getting the support of the community members. Swathi aged 29 one of the ASHA workers hailing from Gudur PHC said, "When I called pregnant women for ANC check-up in the PHC, these women came along with their husbands for ANC check-up, where all the health check-ups were done by a qualified doctor. She also said that the pregnant women and their family members are showing greater interest for ANC check-ups. This is how she is getting support from the village community.

All this discussion leads to the conclusion most of the community members are supporting the ASHA workers to perform their roles and responsibilities in the villages. The ASHA workers have brought about significant behavioural changes among the community members to take the health services from public health functionaries. It also came to notice that very few traditional families continue to cling to the tradition of home

deliveries. But because of the effort of the ASHA workers, these notions and perceptions are changing in many communities. However, it needs to be mentioned here that perceptions are influenced only when the health facility is available to the village/community.

Conclusion

This chapter discussed about the process of the recruitment of the ASHA workers, the motivational factors to become an ASHA workers. It also focused on the training aspects, which included the induction training, refresher training and the support mechanisms to the ASHA workers. It also outlined about the ASHA Resource Centre (ARC) and socio-demographic profile of the ASHA workers, distribution of the ASHA workers by community, education, income, age, and experience. As regards the community distribution of the ASHA workers, the largest proportions of these workers in the study area were found to be from the ST community. A possible reason for this could be the high concentration of tribals in this area. When one considers the age profile of the ASHA workers, the largest two concentrations were noticed in the 25-30 and 20-25 age brackets. Now coming to educational levels of these workers, the largest proportion of the ASHA workers were found to be having SSC level of education. It was also noticed that the primary occupation of the families of most ASHA workers was agriculture. It emerged that family members and self-motivation were the least common influences to become an ASHA workers. The most common reason mentioned by the respondents in the study area was 'To serve the community', followed by 'source of income'. This chapter also briefly touched upon training, including refresher training, being imparted to the ASHA workers. There was also a discussion about the roles and functions of the ASHA Resource Centre. A very important part of this chapter was devoted to the extent of support extended by the family members and the local community to the ASHA workers. While some family members were found to be supportive (by even taking up domestic chores in the absence of the respondents), there were some who objected to, say, the ASHA workers going out for work at late hours. The support from the community was found to be generally good. However, some families were found to be clinging to their age-old beliefs and refusing to pay heed to the advice given by the ASHA workers.

Chapter – 3

Socio-Demographic Profile of ASHA and the Process of Selection and Training

As has been stated earlier, the Government of India launched the ASHA programme with the main objective of bridging the gap between the community and the health service providers. The ASHA workers are expected to act as catalysts between the community and health centers at different levels. The responsibility of selection and recruitment of the ASHA workers has been given to the respective States and Union Territories. The state of Telangana has further delegated this responsibility to the respective Gram Sabhas. At present, a total of 26,000 ASHA workers are functioning in tribal, rural and urban areas of the Telangana State (NRHM, 2005).

In this chapter, the socio-demographic profile of the ASHA workers in the study area will be discussed. There will also be a discussion on the reasons and motivations for their choosing this line of work, the recruitment, and training processes, and the experiences of the individual ASHA workers.

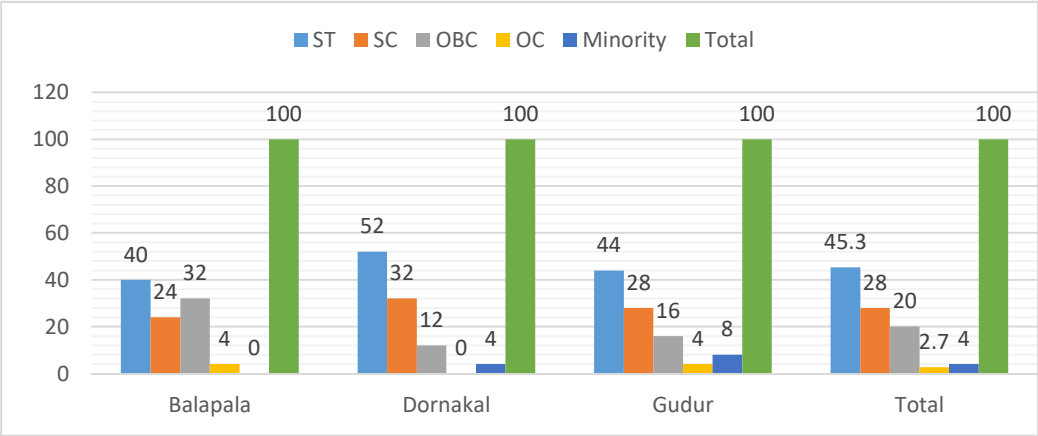
Socio-Demographic Profile of ASHA Workers

It is a known fact that Indian society is hierarchically arranged where the community members are segregated on grounds of caste or community. Keeping in view this heterogeneity in terms of caste, an attempt will be made here to see whether different castes are represented in the selection of ASHA workers. Since ASHA workers do not come under the category of Government employers, the reservation policy adopted for the recruitment of government employees cannot be applied when inducting ASHA workers.

Distribution of ASHA Workers by Their Community

It is pertinent to know about the distribution of the ASHA workers by their community. This will help one to know whether all the communities are represented in this scheme. The Table 3.1 below should help one to form an opinion in this regard.

Chart 3.1: Distribution of ASHA Workers by Their Community



Sources: Field work data collected in 2012-14

In all the three PHCs, the largest proportion of respondents (overall, 45.3%) was found to be of STs. A possible reason for this could be that the study area has a large percent of a tribal population. Each revenue village, in the three PHC areas, has 2 or 3 tribal hamlets and its population is more when compared with that of the non-tribal population. As per the norm of NRHM, each tribal hamlet, whose population is more than 500, is entitled to have one ASHA worker. Since the tribal hamlets are more, the proportion of ASHA workers belonging to ST categories is also more in the study area.

The second largest proportion of ASHA workers was found to be that of SCs in the PHCs covered by Dornakal and Gudur PHCs. However, in Balapala PHC, there were more OBC ASHA workers than those belonging to the SC category. The reason for this is the very high proportion of OBCs in the revenue villages under the Balapala PHC. A sizable number of families in this PHC area were found to belong to the Yadava (shepherd) community, which comes under the OBC category.

A very significant finding is the relatively low 'representation' of OCs (overall, 2.7%) and Minorities (overall, 4.0%) in the three PHCs. Further, women belonging to the upper castes like Kammas, Reddys and Velamas may be facing some social pressure in taking up such employment in these villages. Apart from this, such families are relatively financially secure and do not feel the need for their women to undertake 'low' paid

assignments. The purdah system among the Muslims may be responsible for the presence of very few women belonging to the minority communities, besides the relatively small size of their population in the study area.

A definite conclusion that can be drawn is that the poor and the marginalised sections like SCs, STs and OBCs are showing greater interest to join as ASHA workers. Engagement as ASHA workers is giving them a degree of respectability. The poor socio-economic status of many OBCs is a major motivating factor for their willingness to perform the duties of ASHA workers. It also emerged during the field study that a few ASHA workers had quit the job due to some familial problems. One ASHA worker hailing from the Balapala PHC informed that she had quit the job since the incentive was too less and she had an offer of better wage in a private firm.

Marital Status and Family System

Matrimony can have a definite impact on whether a woman can go out for work. In poor families, women may be forced to supplement the family income. Relatively financially sound families, particularly in rural areas, may not be very keen on their women folk going out for work. The Table 3.2 below illustrates about the marital status of the ASHA workers.

Table 3.1: The ASHA Workers' Family System

		Family System		
PHC		Nuclear	Extended	Total
Balapala	Count	20	5	25
	% within PHC	80.0%	20.0%	100.0%
	% of Total	26.7%	6.7%	33.3%
Dornakal	Count	17	8	25
	% within PHC	68.0%	32.0%	100.0%
	% of Total	22.7%	10.7%	33.3%
Gudur	Count	19	6	25
	% within PHC	76.0%	24.0%	100.0%
	% of Total	25.3%	8.0%	33.3%
Total	Count	56	19	75
	% within PHC	74.7%	25.3%	100.0%
	% of Total	74.7%	25.3%	100.0%

Sources: Field work data collected in 2012-14

It can be seen that in all the three PHCs overall (74.7%) of the ASHA workers belong to nuclear. It shows that there is gradual reduction in the extended or jointly family system.

More and more community members are adopting the nuclear family system. The reasons for such a change are people migrating from one place to another in search of livelihood options and the growing desire to have economic independence

Age Profile of the ASHA Workers

The work of an ASHA is considered to be quite responsible and hectic. Her working hours are considered to be 24 X 7, since emergency cases may arise at any time. Due to the nature of the job, the eligible women in the relatively older age bracket may not be very keen to join as ASHA workers. In some cases, it is true that many women above 40 years of age in the study area are either illiterate, or just drop outs of the primary school and hence ineligible for this assignment. This could be the possible reason for selecting young women to work as ASHA workers in the study area. The Table 3.3 below depicts the age profile of ASHA workers in the study area.

Table: 3.2: Age of the ASHA Worker at the Time Joining

PHC		20-25	25-30	30-35	35-40	40-45	45-50	50-55	Total
Balapala	Count	6	12	4	2	0	1	0	25
	% within PHC	24.0%	48.0%	16.0%	8.0%	.0%	4.0%	0.0%	100.0%
	% of Total	8.0%	16.0%	5.3%	2.7%	.0%	1.3%	0.0%	33.3%
Dornakal	Count	10	8	3	1	2	0	1	25
	% within PHC	40.0%	32.0%	12.0%	4.0%	8.0%	.0%	4.0%	100.0%
	% of Total	13.3%	10.7%	4.0%	1.3%	2.7%	.0%	1.3%	33.3%
Gudur	Count	8	9	8	0	0	0	0	25
	% within PHC	32.0%	36.0%	32.0%	0.0%	0.0%	0.0%	0.0%	100.0%
	% of Total	10.7%	12.0%	10.7%	0.0%	0.0%	0.0%	0.0%	33.3%
Total	Count	24	29	15	3	2	1	1	75
	% within PHC	32.0%	38.7%	20.0%	4.0%	2.7%	1.3%	1.3%	100.0%
	% of Total	32.0%	38.7%	20.0%	4.0%	2.7%	1.3%	1.3%	100.0%

Sources: Field work data collected in 2012-14

Not surprisingly, at the time of joining in the year 2005, the majority of the ASHA workers in all the three PHCs (overall, 38.7%) were found to be in the 25-30 years' age bracket. Next was the 20-25 years' age group (overall, 32.0%). It is evident that majority of the ASHA workers (as high as 70.7% overall) were less than 30 years of age

at the time of joining. Considering the fact that the ASHA scheme was launched in the year 2005, the majority of them were around 20 to 25 years at the time of their first appointment. Many educated (yet needy) young women in these study villages seized the opportunity to become ASHA workers in the villages.

Education Levels of the ASHA Workers

The NRHM guidelines clearly stipulate that the ASHA worker must have passed the SSC examination. In the tribal areas, there has been some relaxation and 8th standard has been fixed as minimum educational level. The tasks of the ASHA worker entail a degree of literacy since she has to disseminate health related information to the members of the community, besides maintaining records. The Table 3.4 below depicts the situation in the study area.

Table 3.3: Education Levels of the ASHA Workers

Name of the PHC		Primary	Higher	SSC	Inter	Degree and Above	Total
Balapala	Count	2	4	11	7	1	25
	% within PHC	8.0%	16.0%	44.0%	28.0%	4.0%	100.0%
	% of Total	2.7%	5.3%	14.7%	9.3%	1.3%	33.3%
Dornakal	Count	0	6	14	3	2	25
	% within PHC	0.0%	24.0%	56.0%	12.0%	8.0%	100.0%
	% of Total	0.0%	8.0%	18.7%	4.0%	2.7%	33.3%
Gudur	Count	0	4	16	4	1	25
	% within PHC	0.0%	16.0%	64.0%	16.0%	4.0%	100.0%
	% of Total	0.0%	5.3%	21.3%	5.3%	1.3%	33.3%
Total	Count	2	14	41	14	4	75
	% within PHC	2.7%	18.7%	54.7%	18.7%	5.3%	100.0%
	% of Total	2.7%	18.7%	54.7%	18.7%	5.3%	100.0%

(Sources: Fieldwork data collected in 2012-14

It can be seen that, by and large, the ASHA workers possessed the minimum qualifications set by the NRHM. However, in the case of some tribal women, educational qualifications were relaxed, owing to the shortage of qualified candidates. Such women, however, accounted for only 2.7% of the overall ASHA workers.

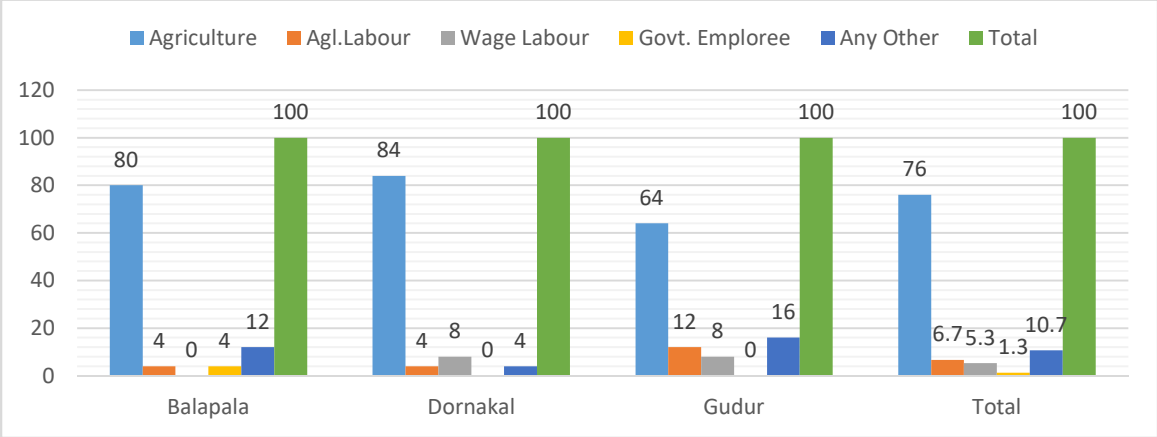
The largest proportion of ASHA workers in all the PHCs (overall, 54.7%) had SSC level education. This was followed by Intermediate level education (overall, 18.7%). Interestingly, 5.3% of the overall ASHA workers were having a degree or higher level of

education. This suggests that, at least in the study area, a higher level of education did not discourage persons from taking up such jobs – maybe financial considerations prompted them to opt for this type of work.

Primary Occupation of the Family

The occupational structure refers to the aggregate distribution of the resources in the society, which is based on the economic function. The occupational structure of the village economy is shaped by the various social, economic, cultural and political factors. In a rural setting, the primary occupation has generally been agriculture, or one based on agriculture. Table 3.5 below depicts the primary occupations of the family members of the ASHA workers.

Chart 3.2: Primary Occupation of the Families of the ASHA Workers



Source: Field Data Collected in 2012-14

Not surprisingly, the household occupations of most of the ASHA workers in all the three PHCs were found to revolve around agriculture – agriculture on own land (overall, 76.0%) and agricultural labour (overall, 6.7 %). The other occupations like wage labour and government service were hardly noticeable in number. Exclusive dependence on wage labour seems to be negligible for the families of ASHA as they constitute only 5.3% (Overall 12.00%). Owing to the meager income from agriculture, many families have looked for alternate sources of income like the ASHA scheme.

Household Income of the ASHA Workers

While social service is a noble motive for becoming an ASHA worker, the financial condition of the household is the prime motivator for opting for this line of work. It has been brought out in the discussion above Table 3.5 that the primary family occupation of 76% of the ASHA workers is agriculture. The Table 3.6 below provides summary of the annual family incomes of the ASHA workers in the study area. This should give one an idea of the financial compulsions that forced the respondents to choose to become ASHA workers.

Table 3.4: Family Monthly Income Status of the ASHA Workers (in Rs.)

PHC		1000-5000	6000-10000-	11000-15000	16000-20000	Above 20000	Total
Balapala	Count	12	5	4	1	3	25
	% within PHC	48.0%	20.0%	16.0%	4.0%	12.0%	100.0%
	% of Total	16.0%	6.7%	5.3%	1.3%	4.0%	33.3%
Dornakal	Count	0	13	11	0	1	25
	% within PHC	0.0%	52.0%	44.0%	0.0%	4.0%	100.0%
	% of Total	.0%	17.3%	14.7%	0.0%	1.3%	33.3%
Gudur	Count	4	9	10	1	1	25
	% within PHC	16.0%	36.0%	40.0%	4.0%	4.0%	100.0%
	% of Total	5.3%	12.0%	13.3%	1.3%	1.3%	33.3%
Total	Count	16	27	25	2	5	75
	% within PHC	21.3%	36.0%	33.3%	2.7%	6.7%	100.0%
	% of Total	21.3%	36.0%	33.3%	2.7%	6.7%	100.0%

Source: Field Data Collected in 2012-14

It is clear that the majority of the ASHA workers had monthly family incomes ranges of Rs 6000-10,000 (overall, 36.0%) or Rs 11,000-15,000 (overall, 33.3%). Those with monthly family incomes above Rs20, 000 were relatively fewer in number and accounted for an overall total of only 9.4%. Most of the ASHA workers have land holding of less than 1 acre, which is many times not an irrigated land. Cultivation of this land is possible only when there is good south west and north east monsoon. Due to the failure of the monsoons, their income from agriculture remains very meager.

Year of Joining of the ASHA Workers

The ASHA scheme was launched in 2005. It would be of interest to ascertain the year-wise intake of such workers. This would enable one to get an idea about the seniority and experience of these workers in the study area. The Table 3.7 below should be reasonably helpful in this regard.

Table 3.5: Year of Joining as ASHA Workers

PHC		2006	2007	2008	2009	2010	2011	Total
Balapala	Count	18	1	3	2	0	1	25
	% within PHC	72.0%	4.0%	12.0%	8.0%	.0%	4.0%	100.0%
	% of Total	24.0%	1.3%	4.0%	2.7%	.0%	1.3%	33.3%
Dornakal	Count	21	2	0	0	2	0	25
	% within PHC	84.0%	8.0%	0.0%	0.0%	8.0%	0.0%	100.0%
	% of Total	28.0%	2.7%	0.0%	0.0%	2.7%	0.0%	33.3%
Gudur	Count	22	2	0	0	1	0	25
	% within PHC	88.0%	8.0%	0.0%	0.0%	4.0%	.0%	100.0%
	% of Total	29.3%	2.7%	.0%	0.0%	1.3%	.0%	33.3%
Total	Count	61	5	3	2	3	1	75
	% within PHC	81.3%	6.7%	4.0%	2.7%	4.0%	1.3%	100.0%
	% of Total	81.3%	6.7%	4.0%	2.7%	4.0%	1.3%	100.0%

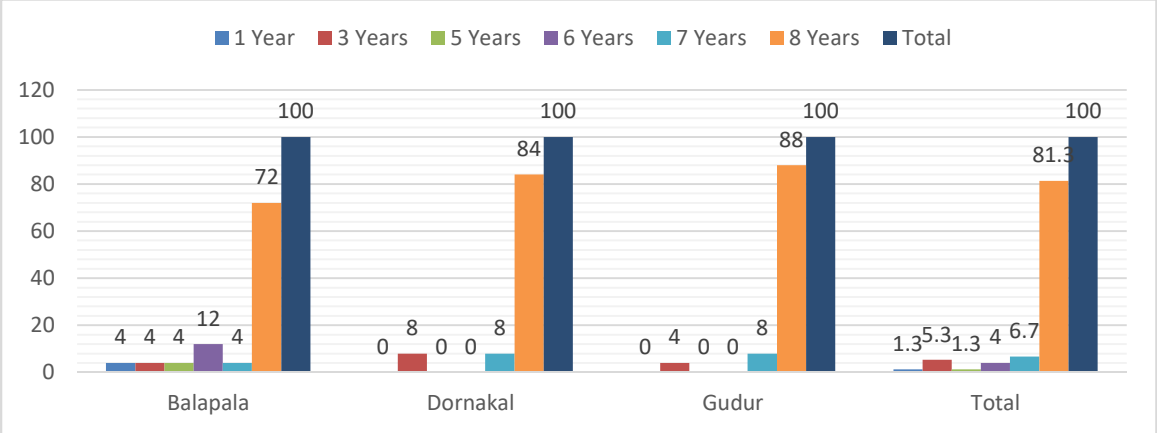
Source: Field Data Collected in 2012-14

It can be seen that the largest number of persons (overall, 81.3%) joined as ASHA workers in 2006. A possible reason for that could have been the wide publicity given to the scheme by the central and state governments. At the same time, it has been reported that, in some of the villages, the concerned authority at the time of recruitment did not find suitable candidates due to various reasons. It is also true that some of the ASHA workers left or resigned the job due to various reasons.

Experience of the ASHA Workers

The ASHA scheme has been in operation for more than 10 years now. It would now be pertinent to review the length of service of ASHA workers in the study area. A logical question may be why these persons are continuing in these assignments, even after reasonably long years of experience. Also, could they not secure better employment in say, an urban centre? A possible explanation for this could be that this task is in generally in their native places and they must have become familiar with their responsibilities. A job in a different area could entail either relocating there, or commuting to that place on a daily basis. Also, continuing as ASHA workers may help them to assist in the family occupation. In any case, the earning as an ASHA worker would in most cases be a supplement to the family income – and not the basic income. The Table 3.8 below depicts the work experience of the ASHA worker in the study area.

Chart 3.3: Work Experience of the ASHA Workers



Source: Field Data Collected in 2012-14

It has already been mentioned that the large number of persons joined as ASHA workers in 2006 and that there has generally been a fall in the number of persons inducted in the subsequent years. Hence, it is not surprising to note that the majority of the workers (overall, 81.3%) had more than eight years of experience.

The Process of Selection

Selection or recruitment processes is where the potential person or employee is selected from a number of candidates. Recruitment is concerned with reaching out, attracting and

ensuring a supply of qualified personnel and making selection of the requisite manpower in both quantitative and qualitative terms. On the other hand, it can be viewed as the development and maintenance of adequate manpower resources. This is the first stage of the process of selection and finally completed with the placement in the job. According to the Edwin B. Filippo, "It is a process of searching for prospective employees and stimulating and encouraging them to apply for positions in an organisation."(http://gobalhrm.blogspot.in/p/recruitment-selection.html).

Process of Selection in the Study Area

The selection process of ASHA workers in the study villages is expected to be according to the relevant guidelines issued by the government. As per the guidelines, the recruitment of ASHA needs to be through a consultation process involving all the stakeholders that includes the members of the PRI, ANM, and AWW. It is noted that, in the study villages, the representatives of the PRI convened a meeting with ANMs, AWWs and discussed the ASHA scheme prior to the selection of the ASHA. In this meeting, the Sarpanch of the Gram Sabha assigned the task to the Gram Sabha members, ANM and AWW to disseminate information about the ASHA scheme to the community members.

The Gopa Thanda village comes under the purview of the Upper Gudem, the concern Gram Sabha members, along with the ANM and AWW, convened the meeting. In this meeting, the village elders or peer groups and other community members were also present. This committee explained about the ASHA scheme and its importance to them. In the case of Golla Charla village, the same method was followed, i.e., by convening the meeting with the community members. But in the case of the Damarvancha along with the meeting, the committee members also visited every household and explained and created awareness about the new scheme.

It is reported that, in all the three study villages, these stakeholders actively campaign about the new scheme. Some of the interested candidates got the information directly from the Gram Sabha. They have gone through the guidelines of the NRHM, about which the researcher has already mentioned in the Chapter-1- Introduction (page No-18). It is

found that Gram Sabha, ANM and AWW and village elders played their part in the recruitment process.

Here, all three the Gram Sabha, after some publicity by involving all the concerned village functionaries like the ANM, AWW and others, received total 17 applications. Out of them, 6 were the natives of Golla Charla and 4, of Damarvancha and finally 7 from the Uppergudam Gram Panchyath. These applications were screened by the respective Gram Sabha committees by going through their educational qualifications.The committee verified the SSC marks list and other relevant documents. After due screening of the applications, the committee has called the candidates for an oral interview. The committee members assessed the candidates' motivation, as well as the knowledge, relating to the health care.

In addition, they asked for the opinion and consent of the husband (if the candidate was married) or parents (if unmarried) in order to ascertain the support of the family to her keeping in view the fact that not only the job of ASHA is hectic and requires a commitment for 24 X 7 days' work, but also needs training for a period of 23 days in the first spell and one week in the second spell in the district headquarters. The committee members clearly explained to the applicants about their roles and responsibilities, of ASHA workers. Further, the committee members summoned the husbands or parents of the candidates to explain the details of the ASHA scheme. After the responses furnished by the husbands and parents of the candidates, the committee went in for the final selection of the candidates.

Thus, the Upper Gudam Gram Sabha eliminated two candidates as their family members did not show interest. Finally, in Gopa Thanda one ASHA worker has been selected and whereas in Golla Charla two ASHA workers and in Damarvancha two members have been selected as an ASHA workers. It has been reported from the field that in Gopa Thanda that the tribal women who residing in Gopa Thanda did not show the interest to work as ASHA workers. It shows that the concerned Gram Sabha, ANM, AWW may not have properly explained to the community members about the ASHA scheme and its benefits, otherwise the women of the village could have shown interest for the ASHA post.

The next issue is a motivational factor to become an ASHA worker. The study has attempted to explore the possible person or bodies' who played a decisive role in motivating the ASHA workers. The below paragraph explain about the persons who provided the motivation for becoming an ASHA workers in the study area.

ASHA Workers: Motivation

In a rural setting, educated women rarely choose occupations other than teaching. For venturing into new areas of work, many of them need to be motivated by someone else. The Table below 3.9 provides an idea about the 'strongest influences' in this regard in the study area.

Table 3.6: Motivational Influences for Becoming ASHA Workers

Name of the PHC		Gram Sabha	ANM	AWW	Community Members	Family Members	Self-Motivation	Total
Balapala	Count	11	6	4	1	2	1	25
	% within PHC	44.0%	24.0%	16.0%	4.0%	8.0%	4.0%	100.0%
	% of Total	14.7%	8.0%	5.3%	1.3%	2.7%	1.3%	33.3%
Dornakal	Count	8	5	7	3	1	1	25
	% within PHC	32.0%	20.0%	28.0%	12.0%	4.0%	4.0%	100.0%
	% of Total	10.7%	6.7%	9.3%	4.0%	1.3%	1.3%	33.3%
Gudur	Count	9	4	3	6	3	0	25
	% within PHC	36.0%	16.0%	12.0%	24.0%	12.0%	0.0%	100.0%
	% of Total	12.0%	5.3%	4.0%	8.0%	4.0%	0.0%	33.3%
Total	Count	28	15	14	10	6	2	75
	% within PHC	37.3%	20.0%	18.7%	13.3%	8.0%	2.7%	100.0%
	% of Total	37.3%	20.0%	18.7%	13.3%	8.0%	2.7%	100.0%

Source: Field Data Collected in 2012-14

A common factor noticed in all the three PHCs under study was that the publicity made by the concerned Gram Sabha emerged as the strongest influence for becoming ASHA workers. Self-motivation emerged at the lowest end of the spectrum. Support of family members and community members too did not rank very high in the study area. The role

of ANMs and AWWs was found to be quite noticeable. Obviously, they have been acting as some sort of role models in the villages and inspiring others to become health workers.

Case Study

Ram Bai Gugulethu is working as an ASHA worker in Lingya Thanda, which comes under the jurisdiction of the Balapala PHC. She was born and brought up in the same village. Her parents are agriculturalists. She has two elder sisters, both of whom are married. She did her schooling from the ZPHS (ZilaParishad High School), Balapala and completed SSC in 1995.

Ram Bai got married in the year 2000 to the RamlalGugaloth, who also hails from the same village. They have two children; both of whom are going to the schools. Ram Bai and her husband are primarily engaged in agricultural activities. The income from agriculture is not sufficient to run their family. To get additional income, they have been running a small 'kirana shop'.

Ram Bai's husband learnt about the ASHA scheme from his brother who was then working as a pharmacist in Balapala PHC. He, in turn, passed on the information to Ram Bai. Initially, Ram Bai was reluctant to apply for the post of ASHA worker as she felt that she would not be able to manage agriculture and her business, besides looking after their children. Her husband communicated the same message to his brother. However, her brother-in-law insisted that she should apply for the post. He convinced her by mentioning that there were chances that the ASHA post would soon be regularised by the government. So, on his advice, Ram Bai and her husband met the Panchayat members and the ANM for detailed information.

The Gram Sabha members explained to Ram Bai about the eligibility criteria and the kind of incentives the ASHA workers would get from the government, for their performance in the village. Later, she shared this information with her husband who encouraged her to apply for this assignment. He convinced her that the job would give her an identity in the village. He also assured her that, in her absence, he would take care of the household work and look after the children.

Ram Bai, then collected the application form from the AWW worker, who hails from the same village. The filled in application form, along with SSC marks sheet, was handed over to the Sarpanch of the village. The Sarpanch constituted a committee with Sarpanch as Chairperson and Medical officer, ANM and AWW as other members. The committee subsequently cleared her appointment. At the time of the interview, her husband too was present. The committee took the opinion of her husband too by explaining about the nature of the job. On receiving the appointment letter, Ram Bai and her husband met the medical officer in Balapala PHC and submitted the joining letter to the Medical officer.

After Ram Bai got selected as an ASHA worker, though she was from the same locality, it was very difficult for her to know about the health conditions of the village community. In this regard, the ANM and the ASHA worker along with AWW had to assist her and they made house-to-house visits to get acquainted with the community members. Already the ANM worker had a good rapport with the village community members. Ram Bai got informed about the date of training from the Medical officer, which is going to be held at Madi Konda in Warangal district. Ram Bai, along with other selected ASHA workers, assembled at Mahabubabad area hospital, where the ASHA co-coordinator accompanied them to the training centre at Madi Konda. The first day, in the training centre the trainer grouped all the ASHA workers into 5 groups each group containing 25 members. The first class started with an introductory class, in which all the ASHA workers introduced themselves about their names and the village they came. The training took place for the period of 23 days.

The trainers took classes for 3 to 5 hours. They taught the new recruits about the roles and responsibilities, which ASHA workers would have to perform in the villages. They have covered 4 modules. The trainers mainly focused on the immunisation, women health, ANC, PNC, village health planning, health and hygiene and nutritional aspects. During training, Ram Bai raised certain questions related to immunisation, and the consequences of injections not being administered within the time. Ram Bai got a clarification from the trainer that, if any children missed the immunisation vaccines due to various reasons, they could be given that later, but they should not miss the vaccination. In this way, the Ram Bai got more information on the roles and

responsibilities of ASHA workers. The trainer gave books/modules to the ASHA workers, which has covered all the health related information. After the training, Ram Bai came back to the home and met the ANM worker, AWW and SHG members, PHC staff and the VHNSC in the village. Since then onwards, she is carrying her responsibilities in Lingya Thanda village.

Reasons for Becoming ASHA Workers

A reason for performing an act can sometimes be different from the motivation for that. Motivation needs some kind of external or intrinsic influence to opt for a particular line of work. The social, cultural, economic, political and psychological factors have played important roles in the decision to become ASHA workers. Due to social barriers and lack of education, some of the community members did not get a fair chance to become part of the government institutions. Hence, the marginalised and disadvantaged communities are looking for better avenues to become a part of the government machinery. Against this backdrop, an attempt has been made to know the reasons for becoming ASHA workers. The Table 3.10 below depicts some of the major reasons for becoming ASHA workers.

Table 3.7: Reasons for becoming ASHA Workers

PHC		Source of Income	To Serve the Community	Be a Part of Government	Social Recognition	Self Interest	Total
Balapala	Count	5	10	6	3	1	25
	% within PHC	20.0%	40.0%	24.0%	12.0%	4.0%	100.0%
	% of Total	6.7%	13.3%	8.0%	4.0%	1.3%	33.3%
Dornakal	Count	6	8	5	5	1	25
	% within PHC	24.0%	32.0%	20.0%	20.0%	4.0%	100.0%
	% of Total	8.0%	10.7%	6.7%	6.7%	1.3%	33.3%
Gudur	Count	8	10	5	2	0	25
	% within PHC	32.0%	40.0%	20.0%	8.0%	0.0%	100.0%
	% of Total	10.7%	13.3%	6.7%	2.7%	0.0%	33.3%
Total	Count	19	28	16	10	2	75
	% within PHC	25.3%	37.3%	21.3%	13.3%	2.7%	100.0%
	% of Total	25.3%	37.3%	21.3%	13.3%	2.7%	100.0%

Source: Field Data Collected in 2012-14

It can be seen that some human beings may have the desire to serve the community and it is a natural and related to the psychological motivation to serve the community. Some human beings have an inborn tendency to respond on social issues such as illiteracy, child mortality, maternal mortality, child marriages, trafficking of the girl child, suicides, poverty, and unemployment. Most of the human beings, by seeing such news in the media, naturally respond to get rid of the above said social issues. So, in this connection, the ASHA workers stated that they wanted to serve the community. These women are socially conscious of issues which are happening in and around the village community. They are contemplating to become the part of the government institutions and can strive hard to achieve objectives set by the Government so that they could bring the desired change in the society. It is also reported that before becoming ASHA workers, some of them actively took part in plantation and sanitation programmes as part of the clean and green initiatives promoted by the Government. So, 'serving the community' emerged as the most influential factor in all the three PHCs (overall, 37.3%). Some others have stated that appointment as ASHA is a fulfillment of their dream to become a part of the village community development programme. They also said that the job is giving them a lot of satisfaction since they could contribute to the wellbeing of the women and children of their community. Interestingly, 'self-interest' figured at the lowest end of the spectrum (overall, 2.7%).

The monetary consideration was also found to be a major motivator (overall, 25.3%). This is not surprising since the majority of the respondents belong to low-income families and any additional source of income would always be welcome. A number of respondents mentioned that they derived a lot of satisfaction from the fact that they were also supporting the family. The highly noticeable proportion of respondents (overall, 21.3%) who mentioned 'to be a part of the government' suggests that government jobs carry with themselves an element of prestige. At the same time, 'social recognition' did not emerge as a major influencing factor (overall only 13.3%).

Training

Training is one of the foremost prerequisites for the ASHA workers to perform their duties more effectively. 'Training is an organised activity, which is aimed at imparting information, knowledge, roles, and instructions for the better performance of the job.' According to TPI-theory, "training should not only include the development of theoretical and practical skills, but also meet interaction needs that exist among the new employees".

Induction Training

Basically, induction training is kind of introduction for the beginners or starters to enable them to perform their work in the respective villages. Induction training is imparted to the newly appointed ASHA workers to give them the kind of orientation required for the job and to acquaint them with the knowledge required for fulfilling the roles and responsibilities. The ASHA workers in the study area were sent for the induction training for a period of 23 days at Madi Konda in Warangal district. The training was designed as per the NRHM guidelines and comprised seven modules primarily to cover health subjects required to be learnt by the ASHA.

The ASHA worker from the all the three PHC that is Balapala, Dornakal and Gudur informed that training was imparted by various methods, but most predominantly by lecture method with the use of audio-visual materials. The trainers also followed the posters method and pasted the diagram about the functioning of the reproductive organ at the training centre. These ASHA workers were also given pamphlets and booklets to gain a more in-depth knowledge of the topics. The trainers imparted training in the following areas comprising 5 modules and 19 themes. Each theme contains some sub-themes. The themes covered to the ASHA worker were as follows: 1. Introduction, roles, tasks 2. Being healthy-determinates of health 3. Water –sanitation, environment 4. Nutrition and malnutrition 5. Knowing Ourselves-Human biology 6. Community, gender, PRI, Rights 7. Adolescent health 8. Communication 9. Health services, Govt. Pvt. 10. Illness causes and healing remedies 11. AYUSH/Herbal medicines 12. Contraceptive methods 13. Preventing unwanted childbirth 14. Pregnancy, birth, postnatal care 15. Genital infections

and HIV/AIDS 16. Child health 17. Common medical problems 18. National health programmes 19. Accidents and first aid.

Most of the ASHA workers also informed that they asked questions about some topics mentioned in the booklet. The trainers clarified the doubts raised by the ASHA workers.

ASHA Resource Centre (ARC)

Under the NRHM programme, the Government of India has established a strong support mechanism, i.e., the ASHA resource centre for the ASHA workers. The ARC is working as a technical and administrative body to implement the activities of NRHM in the state" and ARC is entrusted with the responsibility of improving the quality of the ASHA programme (NRHM, 2005).

Functions of the ASHA Resource Centre (ARC)

Technical backstopping in Training to the ASHA worker: ARC develops the training methodology and the training modules, based on the guidelines issue by the Union Ministry of Health and Family Welfare. These modules are then disseminated to the districts. The ARC also provides the supportive supervision to maintain quality checks and control at district and Block levels.

Developmental of IEC material: ARC is mainly responsible for developing or collecting the Information, Education and Communication (IEC) material from different institutions, to disseminate the information at the time of training. The facilitations kits like flip charts, books and posters on various issues are developed and disseminated by the ARC to the ASHA workers. The IEC material is developed from time to time, based on the felt needs of the community.

Planning of monthly meetings- ARC conducts monthly meetings of ASHA workers at the Block level, in order to discuss and resolve day-to-day problems faced by the ASHA workers and monitors the progress of the activities conducted in the villages. In these meetings, the ARC reviews the concepts and content to improve the learning process of ASHA workers. The topics covered in the training could also be examined in the monthly meetings.

Development of reporting formats and registers and Processing of Statistical Data: The RHMS has developed a reporting register and format to facilitate the work of the ASHA personnel. Such registers and forms help the ASHA workers to streamline their roles and responsibilities on a priority basis. Thereafter, the ARC centre compiles and analyses the data, it provides the feedback to NRHM.

Inter-Sectoral coordination pertaining to ASHA: Since ASHA workers can be used by other departments to promote their objectives, the ARC coordinates with other departments and facilitates empanelment of ASHA workers in various other programmes like SarvaShikshaAbhiyan (SSA) and Total Sanitation Campaign (TSC).

Involvement of NGOs to strengthen the programmes: Involvement of NGOs is playing an important role in the implementation of the ASHA scheme to work at the community level in order to develop the capacities of ASHA workers. There could be many roles of NGOs and their roles need to be identified by ARC.

Provision of Drug Kits: TheASHA workers provide the basic medical care to the community. The drug kit with basic medicines and supplies are provided to all the ASHA workers under the NRHM. The drug kit consists of allopathic, as well as AYUSH, medicines. The ASHA worker issues the medicines free of charge to the community. Initially, the drug kits are provided by the Government of India. They may need state level modification and supplementation. In such cases, ARC facilitates the procurement process and supplies the material to the ASHA workers. ARC develops the mechanism to maintain at least two months' stock of medicines with the ASHA personnel.

Refresher Training

It is possible that some ASHA workers may with the passage of time lose some of the knowledge and skills acquired during training. There are various reasons for this degradation of knowledge and skills of ASHA workers. Most often, this may be because such knowledge and skills are not being used on a regular basis. Refresher training capsules for such persons can help in reinforcing and consolidating the knowledge and skills acquired during the initial training.

The respondent ASHA workers of the study area stated that five refresher training capsules, of five days' duration each, were conducted for them. After a brief review of subjects that were covered in the induction training, the refresher training focused more on the practical problems faced by the ASHA workers in the villages. The refresher training aimed at providing certain strategies to mobilise the support of the community members and mobilisation strategies to the ASHA workers. This training also gave an opportunity to the ASHA workers to stay updated about the recent health schemes introduced by the Government.

Training and its Benefits to the ASHA Workers

It was reported by the respondents that, after the induction training and the refresher training, they got benefited immensely as they gained knowledge and skills relating to health care. After the training, their perceptions and perspectives have changed and they felt more confident to work effectively in the villages. The refresher training also immensely benefited the ASHA workers. They got new information about health topics and they have been updated with the new knowledge. They shared their field problems with the concerned authorities and got the redressal from them.

Family and Community Support to the ASHA

The emotional and psychological support provided by the members of the family can greatly help an individual to perform his or her role in the society effectively. An attempt will now be made to understand the extent to which the ASHA workers look for family support and the means of achieving that support.

Family Support Extended to the ASHA Workers

The field survey has brought out that a majority (76.7 %) of the ASHA workers are receiving support from their family members. Such a support may be because of factors like supplementary income and the enhanced social status within the community. Many ASHA workers even said that their family members, including their husbands, were willingly sharing the domestic chores.

Yaddamma (aged 35 years), an ASHA worker from Balapala PHC, said “when I go out for work, my sister in law looks after all household chores. Not only that, she also looks after my two-year-old daughter in my absence". She further stated, “sometimes, even my husband takes care of cleaning the house and cooking food, when I am away on work".

Another ASHA worker from Dornakal PHC, Swarupa, 25-year-old said, “My husband is often accompanying me in the village for conducting any surveys or in the distribution of medicines to the patients. He takes care of distribution of condoms to male members".

However, a few women complained that they do not get the support to the expected level. For instance, Rajamma, 30-year-old ASHA worker from Gudur, stated "When I needed to attend any delivery cases at night, my husband used to shout at me and sometimes he did not allow me to step out from the house. Even my mother-in-law and other family members also supported him and discouraged me from attending to deliveries during the night time".

Similarly, another ASHA from Balapala PHC, Chinamma, aged 28 years, informed that, initially, her husband did not allow her to go on official work during night time. He often asked her to quit the job as the earning from her was also not much. But later, when I insisted that he could accompany me when I had to go out at night; he understood and began to give full cooperation to me.

Support System from the Community

While performing their duties, a number of ASHA workers may come across largely illiterate community which may be having its own rigid ideas and notions. It is also possible that many members of the community may belong to a higher caste than that of the ASHA workers. Such persons may not like to be told on what to do and what not to do by a person hailing from a lower caste. It is, therefore, essential that the ASHA workers are accepted and supported by the community, irrespective of class, caste, creed and religion.

The interviews with ASHA workers across the three PHC revealed that, by and large, ASHA workers are well accepted in the community and considered as a friend by majority of the households, particularly by the pregnant and lactating mothers. The majority of the ASHA workers informed that people of all castes and religions call them for services and have been generally following their advice and accessing the healthcare suggested by them. In this regard, Chandra kala one of the ASHA worker who hailed from the Dornakal PHC, said that when "I organised the health awareness camp at the time of beginning, most of the community members did not pay heed to my call. But now, the community members are paying more attention, participating and listen my advice during the health camps conducting in the village. They shares their opinions with regard to the health related matters and follows my advice strictly. Further, she also said that some of the community did not pay heed to my advice, but I still trying my best to bring positive behavioural changes in them".

Another ASHA worker hailed from the Balapala PHC said that when she goes for the immunisation drives, all the community members of the village pay attention and take the immunisation in time. She also said that if any case any child missed the vaccination, the concerned family members immediately contacting her about the next vaccination drive. She opined that the community members are now-a-days are paying greater attention to the immunisation. In this way, the ASHA workers are getting the support of the community members. Swathi aged 29 one of the ASHA workers hailing from Gudur PHC said, "When I called pregnant women for ANC check-up in the PHC, these women came along with their husbands for ANC check-up, where all the health check-ups were done by a qualified doctor. She also said that the pregnant women and their family members are showing greater interest for ANC check-ups. This is how she is getting support from the village community.

All this discussion leads to the conclusion most of the community members are supporting the ASHA workers to perform their roles and responsibilities in the villages. The ASHA workers have brought about significant behavioural changes among the community members to take the health services from public health functionaries. It also came to notice that very few traditional families continue to cling to the tradition of home

deliveries. But because of the effort of the ASHA workers, these notions and perceptions are changing in many communities. However, it needs to be mentioned here that perceptions are influenced only when the health facility is available to the village/community.

Conclusion

This chapter discussed about the process of the recruitment of the ASHA workers, the motivational factors to become an ASHA workers. It also focused on the training aspects, which included the induction training, refresher training and the support mechanisms to the ASHA workers. It also outlined about the ASHA Resource Centre (ARC) and socio-demographic profile of the ASHA workers, distribution of the ASHA workers by community, education, income, age, and experience. As regards the community distribution of the ASHA workers, the largest proportions of these workers in the study area were found to be from the ST community. A possible reason for this could be the high concentration of tribals in this area. When one considers the age profile of the ASHA workers, the largest two concentrations were noticed in the 25-30 and 20-25 age brackets. Now coming to educational levels of these workers, the largest proportion of the ASHA workers were found to be having SSC level of education. It was also noticed that the primary occupation of the families of most ASHA workers was agriculture. It emerged that family members and self-motivation were the least common influences to become an ASHA workers. The most common reason mentioned by the respondents in the study area was 'To serve the community', followed by 'source of income'. This chapter also briefly touched upon training, including refresher training, being imparted to the ASHA workers. There was also a discussion about the roles and functions of the ASHA Resource Centre. A very important part of this chapter was devoted to the extent of support extended by the family members and the local community to the ASHA workers. While some family members were found to be supportive (by even taking up domestic chores in the absence of the respondents), there were some who objected to, say, the ASHA workers going out for work at late hours. The support from the community was found to be generally good. However, some families were found to be clinging to their age-old beliefs and refusing to pay heed to the advice given by the ASHA workers.

Chapter - 4

Assigned Roles, Performance, and Conflicts Faced by ASHA Workers in Different Social and Cultural Contexts

Introduction

The present chapter will focus on the role expectations by the community members from the ASHA workers and role performance of ASHA workers in the study area. This chapter will also critically examine the roles and responsibilities of ASHA workers towards Reproductive and Child Health Care (RCH) that includes ANC, PNC, immunisation and family planning. This chapter will also focus on the role performance of the ASHA workers in the promotion of nutrition and hygiene cultures in the communities. The contribution of these workers as members of the Village Health Nutrition and Sanitation Committee (VHNSC), in the Village Health Planning will also be examined.

Role Expectations by the Community Members from the ASHA Workers

The village community members have certain expectations in regard to the ASHA based on the health issues being faced by the community. In view of non-availability of any alternate health functionary in their villages, the foremost expectation of the community members is that ASHA workers should be available 24x7 and provide medical services for the illnesses they suffer from. They believe that ASHA workers, after their training in medical matters, will have sufficient skills and knowledge to treat many of the medical problems they experience.

Further, they are also feeling that since many of the medical problems like fever, headache, diarrhea and stomach pain they experience are minor in nature, these workers should be able to cure these problems. Some members also held the opinion that in their villages complicated medical problems do arise due to snake bites, taking of poisons, effects of improper use of pesticides, complicated delivery cases. It is strongly held that during those critical times even first aid can save some lives. The availability of ASHA

workers within their villages will be fruitful if they can effectively render first aid in such cases and help in referring the patients to places where appropriate medical facilities are available. Therefore, the presence of ASHA workers, as members of an effective referral system, can help to reduce the morbidity to a considerable extent.

The members of the community have come to realise that unhygienic practices and also their foods, drinks and other habits can lead to some diseases. These members feel that their knowledge in this regard needs to be improved for prevention of many illnesses. In this regard, their expectation of the ASHA workers is that they regularly observe the practices of the members and proactively render advice regarding prevention of diseases. According to them, an ASHA worker should be a role model and her family members should be role models for emulating the food practices as well as other hygienic practices. In this regard, the community members, in general, and the pregnant women, old aged, chronic patients, in particular, expect different services from the ASHA workers in their villages. The varied role expectations from the ASHA workers are described in detail below, based on specific data from the fieldwork.

1. The Role Expectation of the Pregnant Women from the ASHA Workers.

The fieldwork revealed that the pregnant women often face dilemmas in regard to appropriate food that will ensure growth of the fetus in view of advices given by many lay members of their community. Hence they expect the ASHA workers to resolve their doubts and correctly advice on diet, and supplement nutrition needed during pregnancy. Similarly, the pregnant women expect advice from the ASHA worker about the work and rest for normal delivery. Further, some women also expressed that they expect information about safe sexual intercourse during pregnancy. The younger women, especially the women preparing for their first delivery, expected kind of psychological guidance from the ASHA worker about safe delivery etc.

The pregnant women feel that lot of care is required from the first month onwards for safe delivery. They further realise that since many of them are illiterate, they do not have knowledge about the facilities available within the realm of modern health care. Thus, the pregnant women expect the ASHA workers to provide information and help in taking

appropriate actions for ANC. It is expected that she will undertake to arrange necessary medical check-ups in order to detect any complications much in advance so that remedial measures can be taken.

Swarupa, one of the pregnant women, who hails from Damarvancha, said "When I got pregnancy after the marriage, I expect that the ASHA worker would guide me about the care that needs to take during the pregnancy and kind food need to be taken during the pregnancy.

Another pregnant woman from Gopa Thanda stated, "This is my first pregnancy, right now I did not know anything about the pregnancy. So in this regard, I am expecting advice from the ASHA worker and care need to be taken right from the first month of my pregnancy. Apart from that, I want her to escort me to the hospital for ANC check-ups and monitor my pregnancy periodically. These are the services which I am expecting from the ASHA worker.

2. **The Role Expectations by Aged Persons from the ASHA Workers:**

The Banjara tribal community believes that normally a man's life is divided in 5 stages, namely, Na Balak (Infancy), Balak (Childhood), Kumaro (Adolescence), Motiyaro (Adulthood) and Budo (Old age). In each of the stages, the individual faces different problems. In this regard, old age is viewed as an unavoidable, undesirable and problem ridden phases of life. The problems of old age appear after 65 years. These may be physiological, psychological, social, emotional and financial etc. Therefore, it is natural for elderly people to seek health services from the ASHA workers.

In this regard, an elderly person, Kasha Banoth, from the Gopa Thanda said, "I used to get *Kado Du karo* (Back Pain) and *Godo Du karo* (Joint Pains). During such health problems, I expect certain health services from the ASHA worker. I want her to give medicine to provide relief from the back and joint pains. I also expect that during such difficult time, if possible, she would accompany me to the hospital. The ASHA worker should enquire about my health status from time to time and give necessary advice with regard to the old age health problems. These are health services which I expect from the ASHA worker.

Another elderly person, Mangamma, who hails from Golla Charla said, “I have been suffering with eye problem, so in this regard, I am expecting health services from the ASHA worker who should inform me about eye camps being arranged in the PHCs. The ASHA worker should accompany me to the PHCs, so that I feel more comfortable. The ASHA worker should inform me about the medicines which I need to take regularly. These are the health services which I am expecting from the ASHA worker in the village.

The Role Expectation of Chronic Patients: The patients suffering from diseases like TB, Leprosy, cancer, HIV/AIDS, arthritis, diabetes, Alzheimer’s diseases etc., need proper counseling and timely medication. In such cases, it is the ASHA worker who plays an important role by providing the health related services to such patients. In this regard, the ASHA worker provides medical services like medicines and psychological confidence to recover from such chronic ailments/diseases. They shall provide and create awareness in the community with regard outbreak of the certain seasonal diseases in the village.

It is in this context one of the TB patients, Damarvancha said, “I have been suffering TB from the last two years. When I met the ASHA worker to inform about my health condition, she advised me to take the TB diagnosis. During the diagnosis, the ASHA worker accompanied me. The result was positive, and then the ASHA worker told that I need to take DOTS for a period of 6 months. The ASHA worker advised me to take the drugs very regularly and not stop the taking medicines regularly under any circumstances. So I am expecting the ASHA worker to supply the medicines on time and constantly monitor my health condition. I also expect the ASHA worker to accompany me to the hospital and counsel me to get rid of TB.

Another resident of Golla Charla village said, “I have been suffering with diabetes from the last 3 years. I expect certain health services from the ASHA worker that she has to constantly check my sugar level and guide me about steps I need to take to reduce the sugar level. I also expect that the ASHA worker would inform me about the diet that

needs to be taken and accompany me to the blood camp for the health check-ups. These are the services, which I expect from the ASHA worker in the village.

Role Performance of the ASHA Worker in the Villages

According to the job chart of the ASHA workers, they have certain specific tasks, roles, and responsibilities. These roles and responsibilities include: registration of births and deaths, pregnancy confirmation, counseling women on birth preparedness, explaining the importance of safe delivery to the pregnant women and also explaining the need for ANC and PNC checkups. The ASHA workers are expected to creating awareness about breast-feeding, complementary feeding, immunization, contraception, prevention of common infection including, Reproductive tract infections and sexually transmitted infections (RTIs/STIs), communicable and non-communicable diseases and care of the young children.

The researcher administered certain questions to the ASHA workers to examine the role performances Vis-a -Vis the expectations of their roles in the respective villages. Further, the researcher desired to know about the ASHA worker's interaction and support from the ANM, AWW, SHG, VHNSC and Gram Sabha while performing their roles. Observations in regard to these issues are presented below.

Birth Registration-A major task assigned to the ASHA worker is the registration of births in the villages allotted to her. According to the United Nations Convention on the Rights of the Child, "The child shall be registered immediately after birth and shall have the right from birth to a name, the right to acquire a nationality and, as far as possible, the right to know and be cared for by his or her parents"[1]. In some of the states in India, the registration process is not taking place properly. The current registration level of birth in the country is about 58%. While some states like Kerala, Tamil Nadu and Gujarat have over 90% success rates in the matter of registration, other states lag far behind. States like Rajasthan, Uttar Pradesh, Madhya Pradesh and Andhra Pradesh have reported registration rates as low as 11%, even though these states account for approximately one-quarter of all children born every year in India (UNICEF India, undated).

[1] Article 7 of the 1989 U.N Convention on the Rights of the Child(CRC)

The child whose birth is not registered stands the risk of being denied the right to an official identity and officially recognised name and nationality. The registration of the child birth is also an important input for a nation's development and growth because the process of birth registration means the collection of data for the national planning for children development. The registration of the birth of a child in the village is assigned to the ASHA worker. The details of birth registration by ASHA workers in the study area during the previous year are depicted in the Table 4.1 below.

Table 4.1: Birth Registration by the ASHA Workers during the Last One Year

PHC		1-5	6-10	11-15	Total
Balapala	Count	8	12	5	25
	% within PHC	32.0%	48.0%	20.0%	100.0%
	% of Total	10.7%	16.0%	6.7%	33.3%
Dornakal	Count	13	9	3	25
	% within PHC	52.0%	36.0%	12.0%	100.0%
	% of Total	17.3%	12.0%	4.0%	33.3%
Gudur	Count	18	6	1	25
	% within PHC	72.0%	24.0%	4.0%	100.0%
	% of Total	24.0%	8.0%	1.3%	33.3%
Total	Count	39	27	9	75
	% within PHC	52.0%	36.0%	12.0%	100.0%
	% of Total	52.0%	36.0%	12.0%	100.0%

Source: Field Data collected in 2012-14

It is evident that the ASHA workers are giving primacy to the duties of registration of vital statistics. It was seen that majority of the ASHA workers (overall, 52.0%) in the study area had registered 1-5 births, followed by 5-10 (overall, 36.0%) and 10-15 (overall, 12.0%). Further, it is also noticed that, by and large, all the births that occurred in the study villages have been recorded by the ASHA workers.

Table 4.2: Percentages of Birth Rate of Children Recorded By ASHA Worker

% of births recorded	% of ASHA workers
Less than 50%	0%
50% to 60%	0%
61% to 70%	0%
71% to 80%	2%
81% to 90%	10%
Above 90%	88%

The high performance of ASHA workers in regard to birth registration is due to the incentive of Rs. 100/- for every birth registration. Further, it becomes the starting point for earning other incentives that are given for BCG, DPT, etc. The claim of performance of other tasks and the incentives that go with those tasks are necessarily related to the birth registration. Further, the ASHA workers informed that this task does not involve much effort. The birth is any way publicly discussed in the community and the ceremonies that are conducted with birth are publicly notified. Thus, the ASHA workers get ample support from the community members in discharging this duty.

Death Registration-Along with the registration of births, that of deaths is important for a number of reasons. For development planners, it can give an idea about the present population in a place. For the individual families, the ensuing death certificates can come in handy when dealing with issues like succession and property disputes and insurance claims to the family members. The Table 4.2 below depicts the situation regarding registration of deaths by ASHA workers in the study area.

Table 4.3: Death Registration by the ASHA Workers from the Last One Year

PHC		1-2	3-4	No Deaths	Total
Balapala	Count	12	1	12	25
	% within PHC	48.0%	4.0%	48.0%	100.0%
	% of Total	16.0%	1.3%	16.0%	33.3%
Dornakal	Count	14	3	8	25
	% within PHC	56.0%	12.0%	32.0%	100.0%
	% of Total	18.7%	4.0%	10.7%	33.3%
Gudur	Count	9	3	13	25
	% within PHC	36.0%	12.0%	52.0%	100.0%
	% of Total	12.0%	4.0%	17.3%	33.3%
Total	Count	35	7	33	75
	% within PHC	46.7%	9.3%	44.0%	100.0%
	% of Total	46.7%	9.3%	44.0%	100.0%

Source: Field Data Collected in 2012-14

Many ASHA workers claimed that there were no deaths in the areas where they were serving during the field work. Thus, the percent of 'No deaths' reported in the PHC areas constituted 48.0% in Balapala; 32.0% in, Dornakal and 52.0% in, Gudur). Though there is an incentive of Rs. 100 for every death registered, it surely does not encourage any over reporting of deaths. Possible under-reporting of deaths however cannot be ruled out.

Though death is also as public as the birth in these villages given the close kin networks, some ASHA workers expressed that the grief associated with death results in some delay in reporting the death and also causes some loss of data.

ASHA Role Performance in Reproductive and Child Health (R&CH)

ASHA workers are expected to particularly play a very vital role in the reproductive and child health aspect of the village communities. The ASHA workers' role performance in their respective villages in this area is examined below.

Pregnancy Registration by the ASHA Workers. Pregnancy is a fairly long-drawn process - spread over a period of some 9-10 months. During this period, a pregnant woman requires special care and has certain nutritional requirements. Timely detection of pregnancy cases and adequate pre-natal care can ensure good health - both for the mother and the child. Since the ASHA worker is the link between the community and the healthcare system, her services become very crucial for the success of maternal and child health (MCH) aspects under NRHM. (Roy &Sahu, 2013). The study by Shukla & Bhatnagar (2012) found that ASHA workers have optimal knowledge of the expected work and are the major source of information and support for pregnancy-related services. The Table 4.3 below depicts the position regarding registration of pregnancy cases in the study area.

Table 4.4: Pregnancy Registration by the ASHA Workers during the Last One Year

Pregnancy Registration					
Name of the PHC		1-5	6-10	11-15	Total
Balapala	Count	8	12	5	25
	% within PHC	32.0%	48.0%	20.0%	100.0%
	% of Total	10.7%	16.0%	6.7%	33.3%
Dornakal	Count	13	9	3	25
	% within PHC	52.0%	36.0%	12.0%	100.0%
	% of Total	17.3%	12.0%	4.0%	33.3%
Gudur	Count	18	6	1	25
	% within PHC	72.0%	24.0%	4.0%	100.0%
	% of Total	24.0%	8.0%	1.3%	33.3%
Total	Count	39	27	9	75
	% within PHC	52.0%	36.0%	12.0%	100.0%
	% of Total	52.0%	36.0%	12.0%	100.0%

Source: Field Data Collected in 2012-14

Registration of pregnancies is one of the important duties of the ASHA workers, through which ASHA workers come to know about providing the ANC to the pregnant women. ASHA workers share the same information with ANM and PHC immediately after they confirm the pregnancy for appropriate follow up by them. In the three PHCs, the number of the ASHA workers who registered 1-5 pregnancies in last one year constituted 52.00%. Similarly, those who registered 6-10 pregnancies and 11-15 pregnancies accounted for 36.0% and 12.0%, respectively. The percent of ASHA workers who have registered 11-15 pregnancies were very high in Balpala PHC. It is very encouraging to note that the figures in this regard are totally in agreement with those for registration of births. The ASHA worker informed that they are registering all the pregnancy cases in the villages, since their income is dependent on the antenatal care services. The community is taking the ASHA workers into confidence for confirmation of pregnancy. The ASHA workers are also eager to utilise their skills and knowledge in regard to confirmation of pregnancy for enhancing their reputation.

Ante Natal Care (ANC): It is well-established fact that ANC plays an important role in the reproductive and child health. The ASHA worker is provides ANC to the pregnant women in coordination with the health staff at the PHC and sub-centre. In this respect, the ASHA firstly provides valuable health information to the pregnant women about diet, exercise and rest. They clarify on the pregnancy related morbidity. Most importantly, as part of the ANC, the ASHA workers ensure that the pregnant woman undergoes the monthly health check-ups for preventive care and medical aid during delivery. They make it a point to inform the pregnant women of the visit of the health workers to the village in advance for health check-ups and the necessary immunisation. In case the health workers are not visiting the village, they fix up appointments at the PHC and accompany the pregnant women for the health check-ups.

The ASHA workers have been entrusted with the task of administering TT injections to all the pregnant women who are present in the villages. The Table 4.4 below would give

one an idea about the dedication of the ASHA workers in the study area regarding their work in this regard.

Table 4.5: Pregnant Women Administered TT Injections during the Last One Year

Pregnant women Administered TT Injections					
PHC		1-5	6-10	11-15	Total
Balapala	Count	8	12	5	25
	% within PHC	32.0%	48.0%	20.0%	100.0%
	% of Total	10.7%	16.0%	6.7%	33.3%
Dornakal	Count	13	9	3	25
	% within PHC	52.0%	36.0%	12.0%	100.0%
	% of Total	17.3%	12.0%	4.0%	33.3%
Gudur	Count	18	6	1	25
	% within PHC	72.0%	24.0%	4.0%	100.0%
	% of Total	24.0%	8.0%	1.3%	33.3%
Total	Count	39	27	9	75
	% within PHC	52.0%	36.0%	12.0%	100.0%
	% of Total	52.0%	36.0%	12.0%	100.0%

Source: Field Data Collected in 2012-14

It was found that, in all the three PHCs, all the pregnant women got TT injection with the assistance of the ASHA workers. These workers have successfully highlighted the need for TT injections for all the pregnant women. While being successful in their educative role, they also succeeded in organising the administration of TT in coordination with the local health staff. It should also be noted that the general awareness in regard to the need for TT during pregnancy has increased in the rural communities. The public image of the quality of the services in this regard has also increased. In fact, there is a demand for this service these days. The ASHA workers are under pressure from the public for timely discharge of these duties. The monetary incentive for ASHA workers for monitoring the TT injection periodically is also helping in the 100% performance of these workers.

Ante-Natal Care (ANC) Visits by ASHA Workers- Singh, et.al (2012) found that the ASHA workers have been the major facilitators for higher utilisation of ante-natal care

(except IFA consumption/receipt) and natal care. The Table 4.5 below presents details about the ANC visits made by the ASHA workers in the study area.

Table 4.6: ANC Visits by ASHA Workers in the Last One Year

PHC		Excellent (above 6)	Good (5-6)	Average (3 to 4)	Poor (less than 2)	Total
Balapala	Count	7	12	5	1	25
	% within PHC	28.0%	48.0%	20.0%	4.0%	100.0%
	% of Total	9.3%	16.0%	6.7%	1.3%	33.3%
Dornakal	Count	12	9	3	1	25
	% within PHC	48.0%	36.0%	12.0%	4.0%	100.0%
	% of Total	16.0%	12.0%	4.0%	1.3%	33.3%
Gudur	Count	18	6	1	0	25
	% within PHC	72.0%	24.0%	4.0%	.0%	100.0%
	% of Total	24.0%	8.0%	1.3%	.0%	33.3%
Total	Count	37	27	9	2	75
	% within PHC	49.3%	36.0%	12.0%	2.7%	100.0%
	% of Total	49.3%	36.0%	12.0%	2.7%	100.0%

Source: Field Data Collected in 2012-14

It is recommended to the ASHA worker that they have to make 4 visits for the ANC check-up. It is reported from the field study that in all the three PHCs, the frequencies of visits were: above 6 (Excellent) visits (Balapala, 28.0%; Dornakal, 48.0%; Gudur, 72.0% and overall, 49.3%) it appears that nearly half of the (overall 49.03%) of the ASHA workers are making more than their prescribed visits. This indicates that the ASHA workers are performing outstandingly in the study area. This should be regarded as a positive sign since it shows that the ASHA workers have been quite regular in this area of their duties. It is also noticed that the some of the ASHA worker, who made more than prescribed, i.e.,5-6 (Good) visits, in all the three PHCs the ASHA worker demonstrates that 5-6 (Good) visits were (Balapala, 48.0%; Dornakal, 36.0%; Gudur, 24.0% and overall, 36.0%). The other frequencies were 3-4 (Average) visits (overall, 12.0%) and less than 2 (poor) visits (overall, 2.7%). This indicated that some of the ASHA workers

are not performing this aspect of their duties properly and it shows that there is an absence of supervision.

ASHA Workers Accompanying Pregnant Women to the Hospital

A pregnant woman, who is being taken to the hospital, can be expected to be under a degree of physical, mental and emotional stress. The presence of someone she trusts, apart from the close kin, can be very reassuring and confidence-building for her. The ASHA worker has a reasonable degree of medical knowledge and some intimacy with the woman in question, due to the previous ANC visits and hence her presence at the time of delivery will be all the more important. However, since some woman may deliver suddenly, it may not always be possible for the ASHA workers to accompany all the pregnant women to the hospitals. The Table 4.6 below depicts the position in this regard in the study area.

Table 4.7: Number of Cases in which ASHA Workers Accompanied the Pregnant Women to the Hospital during the Last One Year

PHC	% of women accompanied					
	91% +	80-90%	70-80%	60-70%	Less than 60%	Total
Balpala	12	3	3	4	3	25
Dornakal	8	4	5	6	2	25
Gudur	8	6	3	3	5	25
Balpala	48%	12%	12%	16%	12%	100%
Dornakal	32%	16%	20%	24%	8%	100%
Gudur	32%	24%	12%	12%	20%	100%

Source: Field Data collected in 2012-14

One fact that came to light during the field survey was that an increasing number of women are opting for deliveries in private hospitals. The ASHA workers are generally reluctant to escort women to such hospitals since the ‘escort' incentives are admissible only for government hospitals. However, this is not the case all the time. In Balpala, 48% of ASHA workers accompanied all the pregnant women for delivery. Those who could do so for 70% to 90% of cases constituted another 24%. The ASHA whose performance is less than 60% (i.e. who accompanied less than 60% of cases) accounted for 16%.

In Dornakal, 32% of the ASHA workers have accompanied every pregnant woman to the hospital. Those ASHA workers who could do so for 60% to 70% of cases constituted 24%. The ASHA workers, whose performance is less than 60% is accounted for 8%. Whereas, in the Gudur PHC 32% of ASHA workers accompanied every pregnant woman for the delivery. Those who could do so for 80% to 90% of cases constituted 24%. The ASHA worker, whose performance is less than 60% of cases accounted for 20% in the Gudur PHC.

The Presence of ASHA Workers at the Time of Delivery. When anASHA worker escorts a pregnant woman to hospital either felt that the woman is now in 'safe hands' and her obligation is met, or is curious to remain in the hospital till the delivery is completed. Hence, the number of persons accompanying pregnant women to hospitals may not always exactly match the number present at the time of actual delivery. At the same time, an ASHA worker who could not accompany a pregnant woman to the hospital may still land up at the hospital at the time of the actual delivery. The Table 4.7 below presents the position on this issue in the study area.

Table 4.8: Presence of ASHA Workers at the Time of Deliveries

	% of Presence of ASHA at the Time of Delivery					
PHC	91% +	80-90%	70-80%	60-70%	Less than 60%	Total
Balpala	16	4	3	1	1	25
Dornakal	13	2	5	3	2	25
Gudur	8	6	7	3	1	25
Balpala	64%	16%	12%	4%	4%	100%
Dornakal	52%	8%	20%	12%	8%	100%
Gudur	32%	24%	28%	12%	4%	100%

Source: Field Data collected in 2012-14

In Balapala, the ASHA workers who were present for more than 90% of delivery of women from their PHC area constituted 64%. This is reasonably good performance keeping in view the fact that not all women preferred to have their delivery in public hospitals. However, not all ASHA have performed well in regard to the task of presence during the delivery in the hospital. The ASHA worker whose performance is poor (attended to less than 60% of cases) accounted for 4% in the same PHC.

Whereas, in the case of Dornakal PHC, the ASHA workers who were present at the time of delivery for percent of cases constituted 52%. Those who could do so for 70-80% of the cases constituted another 20%. Thus, the ASHA whose performance was poor in this regard accounted for 8% respectively. With only 32% of the ASHA workers being present for all the deliveries, the performance of the ASHA in Gudur PHC can be rated as relatively poor.

PNC Visits by the ASHA Workers.-Providing PNC care is one of the critical interventions of ASHA workers. Through such interventions, ASHA workers are trying to prevent the death of new-born babies. Before the ASHA scheme was introduced, PNC had not received adequate attention in India. The earlier National Family and Health Survey(NFHS)-III reports had brought out a very dismal position regarding the visits by the community health workers during the first month of the child. It is the duty of the ASHA worker to take care of the child after the birth for the post-natal check-ups to know the health status of the mother and the child. If the ASHA worker finds any health problems in the child, she has to intimate the same to the ANM worker, or the doctor. The Table 4.8 below depicts the situation regarding the PNC visits made by the ASHA workers to the individual households during the last three months.

Table 4.9: Performance of ASHA Workers in PNC Visits

PHC		Poor (less than 2)	Average (3 to 4)	Satisfactory (5-6)	Good (7-8)	Excellent (above 8)	Total
Balapala	Count	6	8	6	4	1	25
	% within PHC	24.0%	32.0%	24.0%	16.0%	4.0%	100.0%
	% of Total	8.0%	10.7%	8.0%	5.3%	1.3%	33.3%
Dornakal	Count	9	7	5	2	2	25
	% within PHC	36.0%	28.0%	20.0%	8.0%	8.0%	100.0%
	% of Total	12.0%	9.3%	6.7%	2.7%	2.7%	33.3%
Gudur	Count	5	12	3	1	4	25
	% within PHC	20.0%	48.0%	12.0%	4.0%	16.0%	100.0%
	% of Total	6.7%	16.0%	4.0%	1.3%	5.3%	33.3%
Total	Count	20	27	14	7	7	75
	% within PHC	26.7%	36.0%	18.7%	9.3%	9.3%	100.0%
	% of Total	26.7%	36.0%	18.7%	9.3%	9.3%	100.0%

Source: Field Data Collected in 2012-14

The ASHA worker is required to make at least 7 PNC visits in each case. Thus data is analysed for examining the performance of ASHA in regard to PNC visits. The performance is observed under 5 categories as 'Poor' (when the average number of visits were less than 2), Average (when the average number is between 3 and 4), 'Satisfactory' (when the average number varied between 5 and 6) 'Good' (when the average number varied between 7 and 8) and 'Excellent' (when the average number was more than 8). The per cent of ASHA under these categories for different PHC areas was as follows

As can be seen from the Table above, though about 20% of ASHA's performance was either 'good' or 'excellent', there is a significant per cent of ASHA whose performance is 'Poor' in regard to the PNC visits. A slightly more than one-third of the ASHA workers have performed at a level of average with an average number of PNC visits between 3 and 4. Some of the ASHA workers have visited less than the prescribed level due to non-availability of time and some others because of family responsibilities.

Further, some ASHA felt that routine visits are not necessary and that they can visit only when they are summoned by the family members.

Immunization

The Role of the ASHA Worker in Immunisation-The ASHA workers is required to play an important and proactive role in polio eradication campaign in the village. They have to inform the community members about the importance of immunisation and the consequences of not taking it within the prescribed time period. The ASHA workers visit the households and campaign about the pulse polio immunisation vaccine and the day of the immunisation. Usually, the immunisation camps are held weekly twice on Wednesdays and Saturdays in the SC and PHC.

On this day, the ASHA workers go from house to house and inform the community members about the immunisation drive. Now-a-days, the community members are also recognising the contribution or efforts made by the ASHA workers in this direction. The community members are following the advice given by the ASHA workers and taking the vaccines like DPT, BCG, OPV and TT injections for children.

In this regard, it is well understood that immunization is an ongoing process right from birth to till five years. Therefore, it is pertinent to understand that how many children had vaccinated from that last one year according to the schedule. How many of them had vaccinated due to the effort of the ASHA workers. It brought into noticed from the field study that in Gopa Thanda village 7 children vaccinated according to the schedule out of them 4 children's had vaccinated due to the effort of the ASHA workers. In the Golla Charla village total 13 children's vaccinated according to the schedule, out of that 9 children's had done the vaccinated due to the effort of the ASHA workers. Interestingly, whereas in Damarvancha village, it is noticed that total 11 members are vaccinated according to the schedule and all of them had done due to the effort of the ASHA workers.

It is brought into noticed that in all the three villages, it is the ASHA workers, who is playing a dominant role in the vaccination/immunization process. Still, the ASHA workers need to play important role to achieve the hundred percent results in the immunization process.

Plate 4.1 & 4.2: ASHA Workers in the Immunization Mission

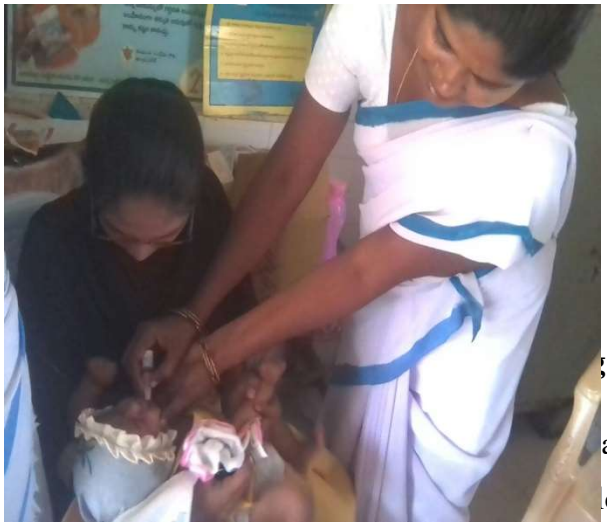


Table 4.10: Schedule for Immunisation and Dispensing Vitamin Pills

S. No	Name of the Vaccine	When to Give
1	BCG	At birth or any time up to one year
2	Polio – 0	At birth (if delivery is in institution)
3	Polio – 1+DPT	6 weeks
4	Polio – 2+DPT	10 weeks
5	Polio – 3+DPT	14 weeks
6	Measles+ Vit A (1ml)	Nine months
7	1st Booster DPT & Polio +Vit A 2ml	18 months
8	Vitamin -A 2ml	24 months
9	Vitamin- A 2ml	30 months
10	Vitamin- A 2ml	36 months
If a child is not given the right vaccines in time, get them started whenever possible and complete the primary immunization before the child reaches the first birthday.		

Sources: ASHA MODULE FOR TRAINING: NRHM Reading Material for the ASHA Book No-1

It has been reported from the study area that the ASHA workers create awareness about the immunisation to the community members. The schedule chart of the immunisation, explains about the name of the vaccine and when to or administer this to the infants and children. The Bacillus Calmette–Guérin (BCG) is a vaccine primarily administered in places where tuberculosis is common.

The BCG should be given at the time of the birth or any time within a year. Polio-0 is given at the time of birth, Polio-1+DPT is given within 6 weeks of the birth of the child and Polio-2+DPT should be administered within 10 weeks after the birth. Thereafter, Polio-3+DPT should be administered to the baby within 14 weeks after the birth and Measles+Vit A (1ml), within nine months after the birth. Thereafter, the 1st Booster DPT & Polio +Vit-A 2 ml should be given to the newly born baby within eighteen months after the birth. It is also important to give the baby Vitamin-A 2 ml after 24 months, 30 months and 36 months respectively.

Family Planning

The Role of ASHA Workers in Promoting Family Planning

The ASHA worker plays an important role in the creating awareness in the village community members about the importance of family planning. The ASHA worker plays

a vital role to motivate the community members, in general, and newly married couples, in particular, after the birth of the child to go for family planning.

The ASHA workers are required to hold monthly community meetings to discuss various health issues such as ante-natal care, post-natal care, complications during delivery, nutrition and diet and family planning and HIV/AIDS (IFPS, 2012). They are key agents for motivating the community to adhere to small family norms by adopting various family planning methods. So, in this context, the researcher enquired about how the ASHA workers in the study area are performing in matters relating to family planning. The Table 4.10 summarizes the data in this regard.

Table 4.11: Role of ASHA Workers in Promoting the Family Planning

PHC		Vasectomy	Tubectomy	Condoms	Contraceptive Pills	IUD	Total
Balapala	Count	3	14	5	2	1	25
	% within PHC	12.0%	56.0%	20.0%	8.0%	4.0%	100.0%
	% of Total	4.0%	18.7%	6.7%	2.7%	1.3%	33.3%
Dornakal	Count	5	9	3	4	4	25
	% within PHC	20.0%	36.0%	12.0%	16.0%	16.0%	100.0%
	% of Total	6.7%	12.0%	4.0%	5.3%	5.3%	33.3%
Gudur	Count	9	12	2	2	0	25
	% within PHC	36.0%	48.0%	8.0%	8.0%	.0%	100.0%
	% of Total	12.0%	16.0%	2.7%	2.7%	.0%	33.3%
Total	Count	17	35	10	8	5	75
	% within PHC	22.7%	46.7%	13.3%	10.7%	6.7%	100.0%
	% of Total	22.7%	46.7%	13.3%	10.7%	6.7%	100.0%

Source: Field Data collected in 2012-14

Since all the ASHA workers are females, it could be reasonably expected that they would feel more comfortable to discuss contraceptive methods with women than men. In view of their ease to discuss these matters with women, they appear to be encouraging Tubectomy operations almost immediately after birth of two children. The data reveals that 54 ASHA workers in all the three PHC could convince for Tubectomy in the reference period of one year. As against this only 17 men could be convinced of Vasectomy. The failure of the ASHA in regard to convincing the couples for use of

family planning methods for spacing of children is also evident from the data as only 23 ASHA reported to have succeeded in this regard during the reference period of one year. This poor performance of them is largely due to the domination of men in reproductive decisions of the couples and the ASHA workers inability to involve men in their efforts to promote family planning.

Role of ASHA Workers in Preventive Healthcare

Promoting Health, Hygiene and Nutrition

The ASHA worker plays an important role in creating awareness about health, hygiene and nutritional aspects to the community members. It is the job of the ASHA worker to motivate the community members towards good health practices that can ameliorate or prevent the diseases. By motivating the members to adopt good practices, such as maintaining the surroundings clean, ensuring the proper drainage or sewage disposal facility for the waste water and using clean drinking water, it is expected that the morbidity rates will fall in the communities. Similarly, it is also the job of the ASHA worker to explain, motivate and create awareness about the importance of nutrition and ill effect of malnutrition to the community members, especially for the members of the poor and marginalised communities. On the whole, it is evident that the ASHA workers have to play a proactive role by sensitising the community members towards health, hygiene and nutrition.

Means Adopted by ASHA Workers for Promoting Health, Hygiene and Nutrition- The ASHA workers are working with the Village Health and Sanitation Committee for improving the sanitation conditions in the villages. The Village Health and Sanitation Committee are also expected to operate a fund with the joint signatures of ASHA/Health Link Worker/Anganwadi Worker, along with the President of the Village Health and Sanitation Committee/Pradhan of the Village Panchayat. The details of various avenues used by ASHA worker to promote health, hygiene and sanitation in the various villages are presented in the Table below 4.11.

Table 4.12: Means Adopted by ASHA Workers for Promoting Health, Hygiene and Nutrition

PHC		Personal Interaction	Group Discussions	Gram Sabha Gathering	Posters	Pamphlets	All the Above	Total
Balapala	Count	9	3	11	0	1	1	25
	% within PHC	36.0%	12.0%	44.0%	.0%	4.0%	4.0%	100.0%
	% of Total	12.0%	4.0%	14.7%	.0%	1.3%	1.3%	33.3%
Dornakal	Count	5	5	11	1	1	2	25
	% within PHC	20.0%	20.0%	44.0%	4.0%	4.0%	8.0%	100.0%
	% of Total	6.7%	6.7%	14.7%	1.3%	1.3%	2.7%	33.3%
Gudur	Count	4	5	12	1	1	2	25
	% within PHC	16.0%	20.0%	48.0%	4.0%	4.0%	8.0%	100.0%
	% of Total	5.3%	6.7%	16.0%	1.3%	1.3%	2.7%	33.3%
Total	Count	18	13	34	2	3	5	75
	% within PHC	24.0%	17.3%	45.3%	2.7%	4.0%	6.7%	100.0%
	% of Total	24.0%	17.3%	45.3%	2.7%	4.0%	6.7%	100.0%

Source: Field Data collected in 2012-14

The Gram Sabha gathering emerged as the most popular forum (overall, 45.3%) for promoting health, hygiene and nutrition. Given the low level of literacy in the study area, posters and pamphlets were felt to be ineffective means for spreading such messages. The face-to-face interactions were found to be popular methods through which the ASHA workers were disseminating information to the community members (overall, 24.0%). The ASHA workers appeared to be generally satisfied with the particular communication means used by them and generally did not consider it necessary to use a combination of options.

ASHA Participation with AWW in Nutrition Camps-The ASHA workers is expected to enlist the support of the AWW in the village during the nutritional camps. It is the job of the ASHA worker to inform the AWW worker about the pregnancy cases immediately after confirmation of the pregnancy. The ASHA workers are required to actively participate in the nutrition camp organised by the AWW in the village. Details of the Participation of ASHA workers in the three PHCs are depicted in the Table 4.12 below.

Table 4.13: ASHA Participation with AWW in Nutrition Camps

PHC		Regularly	Often	When AWW informs	Total
Balapala	Count	16	8	1	25
	% within PHC	64.0%	32.0%	4.0%	100.0%
	% of Total	21.3%	10.7%	1.3%	33.3%
Dornakal	Count	18	5	2	25
	% within PHC	72.0%	20.0%	8.0%	100.0%
	% of Total	24.0%	6.7%	2.7%	33.3%
Gudur	Count	16	9	0	25
	% within PHC	64.0%	36.0%	0.0%	100.0%
	% of Total	21.3%	12.0%	0.0%	33.3%
Total	Count	50	22	3	75
	% within PHC	66.7%	29.3%	4.0%	100.0%
	% of Total	66.7%	29.3%	4.0%	100.0%

Source: Field Data collected in 2012-14

It can be seen that the largest proportion (overall, 66.7%) of ASHA workers in all the three PHCs confirmed that they 'regularly' participate in the nutritional camps. The next higher proportion was that of those who participate 'often' (overall, 29.3%). It was very encouraging to note that, in most of the cases, the ASHA workers were not waiting for the AWWs to inform them about these camps. This shows the high self-motivation levels of the ASHA workers in the study area.

ASHA Interaction with the AWW- The ASHA worker needs the support of the AWW to perform her assigned duties in the village. The cordial relationships between ASHA worker and the AWW will ensure appropriate coordination of many tasks assigned to them. Details about the frequency of interactions between the ASHA workers and AWWs are presented in Table below 4.13.

Table 4.14: Interaction of ASHA Workers with the AWW in a Week

PHC		Weekly Once	Weekly Twice	More than twice	Total
Balapala	Count	8	9	8	25
	% within PHC	32.0%	36.0%	32.0%	100.0%
	% of Total	10.7%	12.0%	10.7%	33.3%
Dornakal	Count	7	12	6	25
	% within PHC	28.0%	48.0%	24.0%	100.0%
	% of Total	9.3%	16.0%	8.0%	33.3%
Gudur	Count	5	10	10	25
	% within PHC	20.0%	40.0%	40.0%	100.0%
	% of Total	6.7%	13.3%	13.3%	33.3%
Total	Count	20	31	24	75
	% within PHC	26.7%	41.3%	32.0%	100.0%
	% of Total	26.7%	41.3%	32.0%	100.0%

The most common frequency of interaction of ASHA workers with the AWWs in all the three PHCs was found to be twice a week. The next most common frequency of interaction in Balapala and Gudur was more than a week. In Dornakal, this emerged as once a week. The conclusion that could be drawn from this is that the ASHA workers and AWWs are interacting quite regularly

Means used for Creating Awareness about Washing Habits: -Washing the hands properly after defecation can help in preventing many communicable diseases. Unfortunately, many persons in rural areas are not very conscious about this issue. The ASHA workers have a major responsibility of spreading awareness on this issue in the areas under their jurisdiction. For this, they can use various means of personal interaction, group discussions, and utilise the Gram Sabha meetings. Since the literacy levels are quite low in the study area, means like posters and pamphlets may not be very effective. Table 4.14 below depicts the most common means being employed by the ASHA workers in the study area.

Table 4.15: Means Used for Creating Awareness about Hand Wash after Going to the Toilet

PHC		By personnel	Group Discussion	By GramaSabha Gathering	All the above	Total
Balapala	Count	12	1	9	3	25
	% within PHC	48.0%	4.0%	36.0%	12.0%	100.0%
	% of Total	16.0%	1.3%	12.0%	4.0%	33.3%
Dornakal	Count	11	3	6	5	25
	% within PHC	44.0%	12.0%	24.0%	20.0%	100.0%
	% of Total	14.7%	4.0%	8.0%	6.7%	33.3%
Gudur	Count	18	1	5	1	25
	% within PHC	72.0%	4.0%	20.0%	4.0%	100.0%
	% of Total	24.0%	1.3%	6.7%	1.3%	33.3%
Total	Count	41	5	20	9	75
	% within PHC	54.7%	6.7%	26.7%	12.0%	100.0%
	% of Total	54.7%	6.7%	26.7%	12.0%	100.0%

Source: Field Data collected in 2012-14

A mention has already been made about the large-scale illiteracy prevailing in the study area. Hence, pamphlets did not emerge as very popular means for spreading a message of this type. It was, therefore, not very surprising that personal interaction (49.3%), Gram Sabha meetings (29.3%) and group discussions (12.0%) emerged as the more popular means of disseminating information of this type. The Gram Sabha is a body manned by influential persons in the village. Hence, use of such a forum for disseminating such can impart a degree of authenticity to what is being said. The personal interaction method can also be very effective, since the target audience can seek clarifications on the spot and ask the communicator to repeat the message, in case they do not understand this in the first instance.

Impact of the Meetings

Majority of the respondents stated that all these meeting have had brought the health behaviour change among the community members. One of the ASHA workers who hailed from the Balapala PHC said, "When I conducted the group meeting the community members understood the ill effects of not washing hands after going to the toilet. The results of the meeting are that the community members are now prewashing their hands after answering the call of nature. This has led to good health behaviour change among the community members."

Swathi, an ASHA worker from the Dornakal PHC said that during the group discussion with community members, she learnt that only a few members have the knowledge and had the habit of the hand wash after defection. She stated, "I, along with ANM and AWW, participated in the campaign of preventive and promotive health behaviour and were able to create awareness about washing habits. As a result of our intensive efforts through group meetings most of the community members have now adopted behaviours that prevent infectious diseases".

Population Sizes Served by the ASHA Workers

The NRHM guidelines prescribe that each ASHA worker has to serve a population of 1000. In tribal villages, the population limit has been reduced to 500. However, where

the tribal population in an area is less than 500, the concerned PHC centre and DMHO have been given the authority of allotting two or three villages to each ASHA worker so that the total population served works out to near about 500. Though the NRHM guidelines prescribe the population size to be served by each ASHA workers, the actual number can vary due to a number of factors. Table 4.15 below depicts the population size covered by the ASHA workers in the study area.

Table 4.16: Population Size Served by the ASHA Workers

PHC		100-200	200-300	300-400	400-500	500 Above	Total
Balapala	Count	0	4	7	3	11	25
	% within PHC	0.0%	16.0%	28.0%	12.0%	44.0%	100.0%
	% of Total	0.0%	5.3%	9.3%	4.0%	14.7%	33.3%
Dornakal	Count	1	1	6	7	10	25
	% within PHC	4.0%	4.0%	24.0%	28.0%	40.0%	100.0%
	% of Total	1.3%	1.3%	8.0%	9.3%	13.3%	33.3%
Gudur	Count	1	1	8	6	9	25
	% within PHC	4.0%	4.0%	32.0%	24.0%	36.0%	100.0%
	% of Total	1.3%	1.3%	10.7%	8.0%	12.0%	33.3%
Total	Count	2	6	21	16	30	75
	% within PHC	2.7%	8.0%	28.0%	21.3%	40.0%	100.0%
	% of Total	2.7%	8.0%	28.0%	21.3%	40.0%	100.0%

Source: Field Data Collected in 2012-14

It could be seen that very few ASHA workers, in all the three PHCs, were serving a population size of 300 or less (overall a total of 10.7%). The largest proportion (overall, 40.0%) was serving a population of 500 or more. The next most common population sizes were: 300-400 (overall, 28.0%) and 400-500 (overall, 21.3%). The probable reason for serving a population size of less than 500 is that many of the Thandas (tribal hamlets) are predominantly inhabited by tribal population. These Thanda have 100-120 households which have a population or less than 500.

Number of Working Hours Put in by the ASHA Workers. According to the NRHM guidelines, the ASHA worker must work three to four hours in the respective village on a daily basis. However, it is possible that, due to reasons like shortage of staff and the unforeseen nature of some medical emergencies, this person may have to work more than four hours in a day. In this way, ASHA workers are striving hard to improve the health status of the village community by spending quality time with the community members. It must be noted here that the appointment of the ASHA worker is purely on a voluntary

basis and not a permanent one. This worker receives performance-based incentives for the work she performs in the villages. On an average, an ASHA worker works for 2 to 4 hours daily. After that, she can attend to her private/domestic work. Table 4.16 below depicts the position in this regard.

Table 4.17: Number of Working Hours Put in by the ASHA Workers Per Day

PHC		2 Hours	3 Hours	4 Hours	5 Hours	Above 5 hours	Total
Balapala	Count	5	6	9	3	2	25
	% within PHC	20.0%	24.0%	36.0%	12.0%	8.0%	100.0%
	% of Total	6.7%	8.0%	12.0%	4.0%	2.7%	33.3%
Dornakal	Count	8	6	6	0	5	25
	% within PHC	32.0%	24.0%	24.0%	0.0%	20.0%	100.0%
	% of Total	10.7%	8.0%	8.0%	0.0%	6.7%	33.3%
Gudur	Count	5	8	5	0	7	25
	% within PHC	20.0%	32.0%	20.0%	0.0%	28.0%	100.0%
	% of Total	6.7%	10.7%	6.7%	0.0%	9.3%	33.3%
Total	Count	18	20	20	3	14	75
	% within PHC	24.0%	26.7%	26.7%	4.0%	18.7%	100.0%
	% of Total	24.0%	26.7%	26.7%	4.0%	18.7%	100.0%

Source: Field Data collected in 2012-14

It is informed by the ASHA coordinator that each day the ASHA workers have to work for 3-4 hours per day, totally they have to spend 25 hours/week. The researcher got a varied response from the ASHA workers that based on the workload they are working more than the prescribed hours. This is happening due to health camps, 104 health check-ups, survey works by the government, plantation work, etc. It could be seen that, with marginal variations, the most frequent working hours ranged between two to four hours. Interestingly, in Dornakal and Gudur, 20.0% and 28.0% of the ASHA workers were found to be working for more than five hours.

Remuneration of the ASHA Workers: It has already been brought out that monetary considerations were the prime motivators for persons joining as ASHA workers. Many of them perceived that they would be able to contribute to the overall family income per month. The ASHA worker gets the incentives based on her performance. Hence, we can say that it is the performance-based incentive - not the monthly salary. The Table 4.17 below depicts the 'take home' amounts of the ASHA workers in the study area.

Table 4.18: Monthly Remuneration of an ASHA Worker

PHC		500-1000	1000-1500	Total
Balapala	Count	19	6	25
	% within PHC	76.0%	24.0%	100.0%
	% of Total	25.3%	8.0%	33.3%
Dornakal	Count	13	12	25
	% within PHC	52.0%	48.0%	100.0%
	% of Total	17.3%	16.0%	33.3%
Gudur	Count	16	9	25
	% within PHC	64.0%	36.0%	100.0%
	% of Total	21.3%	12.0%	33.3%
Total	Count	48	27	75
	% within PHC	64.0%	36.0%	100.0%
	% of Total	64.0%	36.0%	100.0%

Sources: Field work data collected in 2012-14

It is clear that the largest proportion of ASHA workers in all the three PHCs are receiving incentive amounts of Rs 1,000 or less.

Job Satisfaction of ASHA Workers

Job satisfaction is a major indicator of the quality of work life of any individual. It is very encouraging to note that despite the increasing demand for regular salaries, the majority of ASHA workers (overall, 82.7%) confirmed that they were enjoying job satisfaction. One possible reason could be the hope that their services would be regularised in the near future and that they would be getting regular salaries after that. The reason for the dissatisfaction is over the money they are getting as incentives. Many of them feel that they are working hard and many times much more than the expected hours of work, and sometimes even during the night time. It is felt that initiatives like regularisation of the services of the ASHA workers and assuring them of regular monthly salaries (as against the present system of providing them incentive amounts – that too on an irregular basis) may motivate these workers to pay more interest to their work.[2]

[2]On 6th may 2017, *the Chief Minister of Telangana announced that ASHA workers, who were till now receiving amounts of Rs. 1,000 – 2000 per month would be given Rs. 6,000 per month from May 2017 onwards. He also announced that this was only the first phase of increase and, by the next Budget, the salaries of ASHA workers would be hiked to bring these on par with those of Anganwadi workers. Another highlight of the announcement was that ASHA workers, with requisite qualifications, would be given preference in the appointment as ANMs*

Plate 4.3 and 4.4: ASHA Workers Staging Agitation for Salary Hike.

Plat 4.5, Plate 4.6 and Plate 4.7: CM has Convened Meeting with ASHA Workers

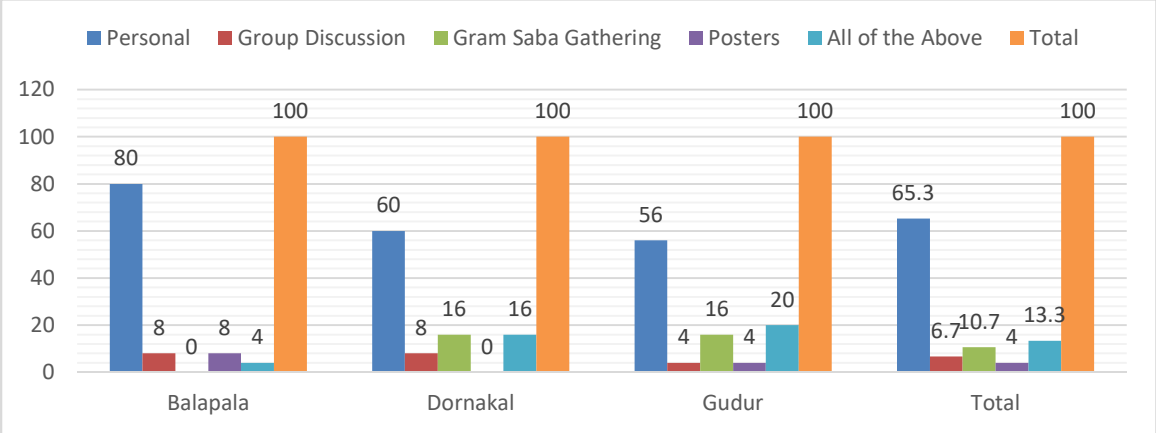
Plate 4.6 The Presence of ASHA Workers at CM Meeting

Plate 4.7 The ASHA Worker Applaud the CM for Hiking the Salary

Means Employed for Mobilizing the Community in Curative Health Programmes:

The ASHA workers are expected to mobilise the community members and ensure their active involvement in the various curative health programmes undertaken in the villages. They have to spread awareness about the existing curative health services like DOTS for eradication of TB, Polio eradication, Malaria, Dengue, Chicken Gunya, so that the people make optimum use of these. In this regard, it is noticed that ASHA workers of all the three PHC have mobilized maximum number of community members in the drive of the curative health programmes. The Table 4.18 below presents the various means being employed by the ASHA workers in the study area for ensuring the active involvement of the local community in the various health programmes.

Chart 4.1: Means Employed for Mobilising the Community in Curative Health Programmes



Source: Field Data collected in 2012-14

The importance of face-to-face interactions has once again been highlighted in this case too since 41.30% of the respondents favored this method for spreading their message. The next most popular means were Gram Sabha Meetings (37.30%) and Group Discussions (9.30%). The Posters were not found to be very effective. It was also noticed that the ASHA workers appeared to be quite content with the one method they used and generally did not try to reinforce their messages by using a combination of all the available means of communication.

The Role of ASHA Workers in Times of Medical Emergencies (108 Services)- Whenever medical emergencies arise; the ASHA worker is required to immediately contact the ANM. Thereafter, the concerned doctor of the PHC is informed. At the same time, the 108 ambulance service is also contacted. The ASHA worker is required to escort the particular person to the hospital. In this way, she acts as the link between the community and the health centre. Some of the ASHA workers revealed that they inform the RMP doctor who is available in the village so that the particular person can get the first aid and then sent to the hospital.

ASHA Accompanied to the Hospital at the time of Health Emergency

The ASHA workers are expected to help the community members in any health emergency. One important role expected of her is that she will coordinate to arrange ambulance services immediately after a medical emergency is reported to her and accompanies the patient to the hospital. The Table 4.19 below depicts about the ASHA accompanied to the hospital at the time of health emergency during the reference period.

Table: 4.19 Frequencies of Cases where ASHA Workers Accompanied the Patients to the Hospital during Health Emergencies in the Last One Year

ASHA Accompanied to the Hospital at the time of health Emergency					
PHC		1-5	6-10	10 Above	Total
Balapala	Count	12	11	2	25
	% within PHC	48.0%	44.0%	8.0%	100.0%
	% of Total	16.0%	14.7%	2.7%	33.3%
Dornakal	Count	14	10	1	25

	% within PHC	56.0%	40.0%	4.0%	100.0%
	% of Total	18.7%	13.3%	1.3%	33.3%
Gudur	Count	8	13	4	25
	% within PHC	32.0%	52.0%	16.0%	100.0%
	% of Total	10.7%	17.3%	5.3%	33.3%
Total	Count	34	34	7	75
	% within PHC	45.3%	45.3%	9.3%	100.0%
	% of Total	45.3%	45.3%	9.3%	100.0%

Source: Field Data collected in 2012-14

It is reported from the study that in all the three PHCs overall (45.3 percentage) of the ASHA worker accompanied 1 to 5 persons to the hospital. It is also noticed that relatively more number of ASHA of Dornakal PHC have attended to such medical emergencies (56.0%). The fact that those who had accompanied patients in the ambulance regarding medical emergency more than 10 times in the reference period constitute only 9.3% shows that either such medical emergencies are few in number or that members in village arrange for ambulance on their own owing to the emergency.

How Many Times ASHA Workers Helped to Call 108 from the Last One Year

Already it is discussed in the above paragraph that the ASHA worker plays and important role at the time health emergency. She acts affirmatively in such situations by calling the 108 ambulances services to reach spot immediately. The Table 4.20 below illustrates how many times the ASHA worker helped to call the 108 services in the last one year.

Table 4.20: How many Times ASHA Helped to call 108 from the Last One Year

How many times ASHA helped to call 108					
PHC		1-5	6-10	10 Above	Total
Balapala	Count	18	6	1	25
	% within PHC	72.0%	24.0%	4.0%	100.0%
	% of Total	24.0%	8.0%	1.3%	33.3%
Dornakal	Count	20	3	2	25
	% within PHC	80.0%	12.0%	8.0%	100.0%
	% of Total	26.7%	4.0%	2.7%	33.3%
Gudur	Count	15	8	2	25
	% within PHC	60.0%	32.0%	8.0%	100.0%
	% of Total	20.0%	10.7%	2.7%	33.3%
Total	Count	53	17	5	75
	% within PHC	70.7%	22.7%	6.7%	100.0%
	% of Total	70.7%	22.7%	6.7%	100.0%

Source: Field Data collected in 2012-14

From the above table it is noticed that the in all the three PHCs overall 70.7% of the ASHA workers arranged the free ambulance service by calling 108 services one to five times. However, some of the ASHA worker informed that when free ambulance service was not available they looked for other alternatives to send persons to the hospital as early as possible. It is noticed that those who called the 108 ambulance services 6 to 10 times constitute 22.7%

ASHA Worker Contributions to Institutional Deliveries

As NRHM envisaged ASHA worker is the first 'port of call' for the health improvement of the village community members. It is noticed from the field work that the ASHA worker playing an important role in the overall health improvement of the community in general and women and child in particular. In this contest, it is pertinent to illustrate about the ASHA worker contributions in institutional deliveries. The ASHA worker entrusted with the job of ANC and PNC of the women of the villages. Since, from the registration of pregnancy to the delivery and after delivery the ASHA worker had been playing a vital role. It is the ASHA worker who performs the pregnancy test to the women and confirms the pregnancy and counsels the pregnant women about care need to be taken during the pregnancy i.e. ANC.

In this regard one of the pregnant from Damarvancha village said that for the confirmation of the pregnancy I approached the ASHA worker, then the ASHA performed the urine test, finally ASHA confirmed that I became pregnant. The ASHA guided me about the care need to be taken during pregnancy; ASHA said that I have to visit the PHC for ANC check-ups periodically. In this regard, the ASHA worker accompanied to the hospital and doctor examined me and recommended for the blood check-ups. The blood reports were shown that the deficiency of hemoglobin (HB). The doctor and the ASHA worker advised me to take leafy vegetables to improve the HB. In this way, the ASHA worker helped me during my pregnancy.

The ASHA worker has been guiding, counseling the pregnant women for the institutional deliveries. The ASHA workers also motivating and counseling pregnant women family members about the importance of the institutional deliveries. The ASHA workers

explaining about the benefits of institutional deliveries and the incentives provided by the central and state governments like JSY and KCR Kit etc., to the pregnant women.

In this regard, one of the pregnant women hails from Golla Charla said that the ASHA worker motivating me and my husband for the institutional deliveries. My Aunty (Attamma' Husband Mother) insisting me about the home delivery. I and my husband decided to deliver the baby in the hospital. The ASHA worker accompanied me to the hospital, the ASHA worker called 108 ambulance services to take me to the hospital. Therefore, it is arrived from the above two interviews of the ASHA worker that the ASHA worker is instrumental for mobilizing the pregnant women for institutional deliveries in the villages. In this endeavours, not only the ASHA worker but also ANM, AWW and health personnel are assisting the ASHA worker for such kind of action. It is once again acknowledged that the ASHA worker cornerstone of the NRHM programme for the overall health improvement of the community members in the rural areas.

Reasons for More Institutional Deliveries

In earlier times, delivery at the home was almost the norm. Today, an increasing number of couples are opting for deliveries in proper medical establishments. Table 4.21 below depicts the major motivating factors for the increasing enthusiasm for institutional deliveries.

Table 4.21: Reasons for More Institutional Deliveries

PHC		Because of ASHA Scheme	PHCs are functioning well	Because of Government Campaigns	All of these	Total
Balapala	Count	13	2	6	4	25
	% within PHC	52.0%	8.0%	24.0%	16.0%	100.0%
	% of Total	17.3%	2.7%	8.0%	5.3%	33.3%
Dornakal	Count	4	7	9	5	25
	% within PHC	16.0%	28.0%	36.0%	20.0%	100.0%
	% of Total	5.3%	9.3%	12.0%	6.7%	33.3%
Gudur	Count	4	8	10	3	25
	% within PHC	16.0%	32.0%	40.0%	12.0%	100.0%
	% of Total	5.3%	10.7%	13.3%	4.0%	33.3%
Total	Count	21	17	25	12	75
	% within PHC	28.0%	22.7%	33.3%	16.0%	100.0%
	% of Total	28.0%	22.7%	33.3%	16.0%	100.0%

Source: Field Data collected in 2012-14

One cannot fail to acknowledge the contribution of ASHA workers, in all the three PHCs, for popularizing the notion of institutional deliveries. In fact, the proportion was as high as 52.0% in Balapala. When the overall figures are seen, a lot of credit should be given to government campaigns as also the confidence in the PHCs.

Village Health Planning in the Study Villages

The NRHM envisages a bottom-up health planning process, whereby village health concerns are reflected at block and district levels, and ultimately to reflect these in the health plan of the concerned states. For this purpose, the NRHM has introduced a concept called 'Village Health Plan'. The ASHA workers are expected to play an active role in the constitution of a Village Health, Nutrition and Sanitation Committee (VHNSC) committee and it is functioning so as to properly implement the Village Health Plan. The committee acts as a sub-committee of the Gram Panchayat, largely comprising elected members of the Panchayat. In order to know the performance of ASHA workers in regard to constitution of VHNSC, data on the presence and functioning of these committees in the selected villages was obtained. These issues will be examined in the Tables below.

Table 4.21: Presence of VHNSC in the Villages Covered by the ASHA Scheme

Presence of VHNSC				
PHC		**Yes**	**No**	**Total**
Balapala	Count	19	6	25
	% within PHC	76.0%	24.0%	100.0%
	% of Total	25.3%	8.0%	33.3%
Dornakal	Count	15	10	25
	% within PHC	60.0%	40.0%	100.0%
	% of Total	20.0%	13.3%	33.3%
Gudur	Count	13	12	25
	% within PHC	52.0%	48.0%	100.0%
	% of Total	17.3%	16.0%	33.3%
Total	Count	47	28	75
	% within PHC	62.7%	37.3%	100.0%
	% of Total	62.7%	37.3%	100.0%

Source: Field Data collected in 2012-14

It can be seen that in all the three PHC (overall 62.7%) of the respondents confirmed about the presence of VHNSC in their villages has not constituted the VHNSC. In this regard, it important to know how many VHNSC are actively functioning and conducting

the meeting regularly. The below paragraphs explains about the active functioning of VHNSC in the study area.

Active Functioning of the VHNSC during the Last One Year

The VHNSC plays an important role in the execution of the village health plan in the respective villages. Therefore, it is pertinent to understand the active functioning of the VHNSC and how many meetings they held from last one year. The Table 4.23 below illustrates about the active functioning.

Table: 4.23 Active Functioning of VHNSC

Active Functioning of VHNSC				
PHC		Actively functioning	Not properly functioning	Total
Balapala	Count	13	6	19
	% within PHC	68.4%	31.6%	100.0%
	% of Total	27.7%	12.8%	40.4%
Dornakal	Count	10	5	15
	% within PHC	66.7%	33.3%	100.0%
	% of Total	21.3%	10.6%	31.9%
Gudur	Count	11	2	13
	% within PHC	84.6%	15.4%	100.0%
	% of Total	23.4%	4.3%	27.7%
Total	Count	34	13	47
	% within PHC	72.3%	27.7%	100.0%
	% of Total	72.3%	27.7%	100.0%

Source: Field Data collected in 2012-14

The respondents have given varied responses, with regard to the active functioning of the VHNSC in village health planning process in the study villages. Overall in all the three PHC areas, (72.3%) of the respondents informed that the committees are actively functioning in their respective villages. The reason for not properly functions of the VHNSC appears to be non-cooperation of the members of the VHNSC and the concerned Gram Panchayat.

The study has attempted to know the mechanisms and process of preparing village health plans in the study villages and the participation of ASHA workers in village health planning in the study area.

VHNSC Meetings Held from the Last Three Months

It is pertinent to evaluate the performance of the VHNSC meeting during the last three months. It is against this backdrop that the table below has been prepared.

Table: 4.24 VHNSC Meetings held from the Last 3 Months

VHNSC MEETING						
PHC		Once	Twice	More Than Twice	Not Conducted	Total
Balapala	Count	3	8	5	3	19
	% within PHC	15.8%	42.1%	26.3%	15.8%	100.0%
	% of Total	6.4%	17.0%	10.6%	6.4%	40.4%
Dornakal	Count	2	5	7	1	15
	% within PHC	13.3%	33.3%	46.7%	6.7%	100.0%
	% of Total	4.3%	10.6%	14.9%	2.1%	31.9%
Gudur	Count	0	6	5	2	13
	% within PHC	.0%	46.2%	38.5%	15.4%	100.0%
	% of Total	.0%	12.8%	10.6%	4.3%	27.7%
Total	Count	5	19	17	6	47
	% within PHC	10.6%	40.4%	36.2%	12.8%	100.0%
	% of Total	10.6%	40.4%	36.2%	12.8%	100.0%

Source: Field Data collected in 2012-14

It could be seen that there are 47 VHNSCs in the study area. It emerged that in 19 VHNSCs (overall 40.4%) the meetings were held twice. In 17 VHNSCs (overall (36.2%), the VHNSC meetings were held more than thrice. This shows that 76.6% of total VHNSCs are functioning actively. On the negative side, in 6 VHNSCs (overall 12.8%), even one meeting was not held. This clearly shows that some VHNSCs are not actively functioning in the study area.

The Role of VHNSC in Village Health Planning in the Study Area

One of the main objectives of the VHSNC is to create awareness about nutritional issues and the significance of nutrition as an important determinant of health to the village community members. For this, the committee needs support and cooperation of the ANM, ASHA, and AWW of the study villages. In Damarvancha and Golla Charla villages, VHNSC is actively working on the village health planning. It is found that no such committee has been constituted so far in Gopa Thanda and so no village health and nutritional survey has been conducted until now. In Damarvancha and Golla Charla, the VHSNC committees are identifying and sharing knowledge with the village community

members about the locally available food stuff of high nutrient value. It is also creating the awareness and promoting the best practices of traditional knowledge in congruence with the local culture like leafy vegetables which have high nutritional value. It is also reported that the committee is also undertaking an in-depth analysis by conducting the survey in the village to ascertain the causes of malnutrition at the community and household levels by involving the ANM, ASHA, and ICDS staff. On the basis of this survey, the committee recommends to the concerned functionaries the special care needed to be given to some members of their community.

The general norm is that the VHNSC organises 'Village Health and Nutrition Day' (VHND) every month on the first Wednesday of the month at the Anganwadicentre in the village. The Anganwadicentre is identified as the core centre for providing services under the Reproductive Child Health-II Programme of the the National Rural Health Mission. It is also envisaged as a platform for intersectional convergence between the village community and the health system.

The ASHA workers, AWWs, ANMs and other paramedical forces mobilise the community members of the village, especially women and children, at the Anganwadicentre. On this day, the community members of the village interact with health personnel and get basic health services and health-related information. The community members learn about the preventive and other health care aspects. Since the VHND meeting is held in the village itself, the community does not have to spend money or time to travel to distant places.

In Golla Charla village, it has been found that the Nutrition Day programme is being conducted once in two or three months. But in the case of the Damarvancha, this day is being conducted every month at the AWW centre. However, it has also been reported that not all members of the VHNSC are taking part in the 'Nutrition Day' programme regularly.

It is mentioned in the NRHM guidelines that 'if any malnourished children are found, the VHNSC committee has to send the malnourished children to the nearest nutritional rehabilitation centre (NRC). But in study area, no such centre has been found. It came to

notice that the VHNSC committee is not taking any action or asking the concerned authority to establish the NRC. Yet another responsibility of the committee is to supervise the functioning of Anganwadicentre (AWC) in the village and ensure that it is working in improving the nutritional status of women and children. The Committee also acts as the grievances redressal forum on health and nutrition issues.

Role Conflicts Faced by the ASHA Workers

While the ASHA workers are performing their roles and duties at the village level, they are facing certain role conflicts which are affecting their performance. These can be categorized as intra and inter-role conflicts. The ASHA worker, while discharging her duties in the villages, needs the cooperation of her family members. Some of the ASHA workers revealed that they do not get such cooperation from the family members. The non-cooperation is mainly on the basis of their perception that the ASHA workers are spending more time on their job than is expected and also that their financial contribution to the family is not commensurate with the time spent on their job. Some of the ASHA workers informed they are also facing problems from the community members.

The major role conflict for the ASHA workers appears to be from the expectation of their family members in regard to their participation in the household works and farm work. In the peak agricultural season, the family members expect them to give priority to the farm work. Further, even when the families of the ASHA own any agricultural land, the family members expect them to work as farm labourers as it is more rewarding economically. Many times, the ASHA workers are also blamed for failing to fulfil the reciprocal obligations in the farm work. Due to shortage of labour and kinship ties, the members in the study area depend on the principle of reciprocity for services during the agricultural operations. When the ASHA workers are not able to provide the 'return services' at the time when their partners need, they are blamed for not fulfilling their commitments.

The inter-role conflicts are of intense nature in case of ASHA workers who are living in joint, or extended, families and who have infants and children who are below five years. These women are not able to justify their roles as mothers and/or daughters-in-law.

Similarly, when the responsibilities of taking care of the aged members in their families fall on them, they face lot of role conflicts.

Role Conflicts due to Family Responsibilities

Table: 4.25 Role Conflicts due to Family Responsibilities

Role conflicts due to family responsibilities						
PHC		Due to aged family members	Due to taking of care children	Due to sick family members	Any Other	Total
Balapala	Count	5	15	3	2	25
	% within PHC	20.0%	60.0%	12.0%	8.0%	100.0%
	% of Total	6.7%	20.0%	4.0%	2.7%	33.3%
Dornakal	Count	4	17	2	2	25
	% within PHC	16.0%	68.0%	8.0%	8.0%	100.0%
	% of Total	5.3%	22.7%	2.7%	2.7%	33.3%
Gudur	Count	6	12	4	3	25
	% within PHC	24.0%	48.0%	16.0%	12.0%	100.0%
	% of Total	8.0%	16.0%	5.3%	4.0%	33.3%
Total	Count	15	44	9	7	75
	% within PHC	20.0%	58.7%	12.0%	9.3%	100.0%
	% of Total	20.0%	58.7%	12.0%	9.3%	100.0%

It is natural that in diversified societies, conflicts arises due to different mind sets of the people. This is also applicable to family members, where a conflict arises due to various role expectations from the members of the family. It is expected that the ASHA workers face inter role conflicts due to her job expectations and the expectations of her family responsibilities. The Table 4.25 outlines the ASHA workers' role conflicts due to family responsibilities. It can be seen that majority role conflicts arise due to their responsibility of child care (overall 58.7%). Role conflicts arose due to aged family members (overall 20.0%) and sick family members too (12%).

Thus, the challenge of balancing the professional and personal life is proving to be a very difficult task for some of the ASHA workers. Besides the family, the community members, as well as from the health functionaries, can also complicate issues for the ASHA workers. It emerged that some of the ASHA workers were not getting proper

support from the community members. Those belonging to the upper castes appeared to feel it below their dignity to be advised on health issues by the ASHA workers belonging to a lower caste than theirs. Intra-role conflict can arise when such workers find to difficult to choose between their chosen line of work and their family and social responsibilities. This can bring in the issue of 'opportunity cost'. Since a person cannot generally perform multiple tasks simultaneously, attending to one responsibility will mean the inability to perform the other tasks.

It has already been mentioned that the ASHA workers need the active cooperation of ANM, Doctors, ASHA's supervisors, AWW and others officers associated with the ASHA scheme. The researcher came to know that the ASHA workers are facing certain role conflicts from the above said health personal and public health functionaries in the PHC.

One of the ASHA workers from the Balapala PHC informed that the community members are expecting her to focus more on the curative health programmes like providing medicines for the ailments they are suffering from. However, the health functionaries generally insist that the ASHA worker should concentrate more on preventive health care programmes like HIV/AIDS, TB, and Leprosy etc., Such differential role expectations from the community members, on one hand, and health functionaries, on the other, can lead to role conflicts for the ASHA workers.

An ASHA worker, Chandara kala, from the Dornakal PHC said, "From time to time, I used to get instructions from the health functionaries that I need get support of the community members to create the awareness about preventive and curative health practices. But, it is always not possible to enlist the support of the community members in preventive and curative health practices. But the community members felt that it is the responsibility of the state government to take such responsibilities.

Swarupa, an ASHA worker from Balapala PHC, said that the health functionaries are not providing the drugs in time to her. The community member asks medicines/drugs for the minor ailments, but she is not in a position to provide the drugs to the community

members. As a result, the ASHA workers are losing the credibility among the village community members.

One of the doctors from the Balapala PHC informed that the keeping the birth and death record is one of the foremost duties of the ASHA worker. Some of the ASHA workers are not maintaining proper records of births and deaths. The concerned health functionaries are taking necessary action against the ASHA workers. However, one ASHA worker informed that due to work load, she is not always able to properly maintain the records keeping.

From the above analysis, it can be concluded that the ASHA workers are encountering inter- and intra-role conflicts while performing their duties and responsibilities in the respective villages.

Plates 4.8& 4.9: ASHA/ANM Workers in a Meeting on the ASHA Day

Conclusion

This chapter specifically dealt with the assigned roles, role performance and role conflicts of the ASHA workers in different social and cultural contexts in the villages. The NRHM has assigned certain roles to the ASHA workers. These include: registration of births and deaths, pregnancy confirmation, counselling women on birth preparedness, explaining the

importance of safe delivery to the pregnant women and also explaining the need for ANC and PNC check-ups. This chapter also discussed the role performance of the ASHA workers in reproductive and child health (R&CH): which includes pregnancy registration, ANC and PNC visits made by the ASHA workers. There was also a discussion on the interaction of the ASHA workers with AWW and ANM and role conflicts being faced by the ASHA workers. This chapter also focused on the ASHA role of ASHA workers in the village health planning.

Chapter – 5

Impact of ASHA and Changes in the Health Behaviour of the Community Members: A Comparison of Tribal and Non-Tribal Villages

This chapter will specifically focus on the impact of the ASHA workers on the health behaviour of the residents of tribal and non-tribal study villages. The researcher would seek to know how the ASHA workers are playing a key role in changing the health-seeking behaviours in the study villages and responding at the time of illness in different social and cultural contexts. Generally, a typical Indian village consists of multi ethnic and religious groups coexisting together. Each of these groups has its own norms, values, beliefs, food habits and health culture, some of which may be diametrically opposite to those of the other groups. The ASHA workers, working in the field, may face challenges in accommodating the cultural and other ethos of these groups.

It would, therefore, be necessary to critically ascertain the role of the ASHA workers in enlisting the support of the community members for improving the health of the community members. Against this backdrop, an attempt will be made to study the health seeking and illness behaviour of the community members. These would include: the preventive health care practices like contact for the health information, health check-ups, and diagnosis and health service providers for the treatment of the diseases.

Perception of the Community Members Regarding the ASHA Workers

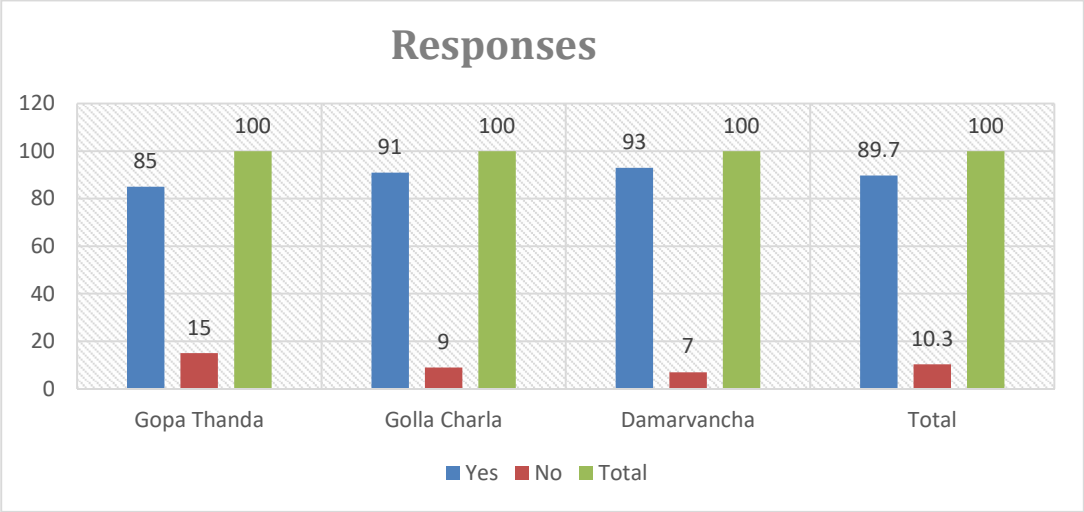
Much akin to the Chinese concept of 'barefoot doctors,' that of ASHA workers has become an almost integral part of rural India today. They can be considered as the 'first port of call' in the case of medical emergencies before more specialised treatment, if required, can be given to the patients. However, it is not always enough to have a facility in place. Of greater importance is that the intended beneficiaries should be aware about it and utilize it.

It was very encouraging to note that all the respondents in the study area were fully aware about the presence of ASHA workers in their villages. A very positive sign noticed in all the three villages was that all the respondents were approaching the ASHA workers for help and advice on health-related issues. This clearly shows a high degree of acceptability of the ASHA scheme in the study area.

Regularity of Visits by the ASHA Workers

Very often one comes across news reports about functionaries like school teachers, doctors, health workers, etc., not reporting to their work places on a regular basis, since they may be perceiving that there is no one to monitor their performance and the community members, whom they are supposed to serve, are either too ignorant or scared to report about this to the higher authorities. It is to be understood that matters like education and healthcare need to be attended to on an almost daily basis since these concern the very future of the nation. Table 5.1 below depicts the feedback of the respondents regarding the regular attendance of the ASHA workers.

Chart 5.1: Regularity of Visits by the ASHA Workers



Source: Field Data collected in 2012-14

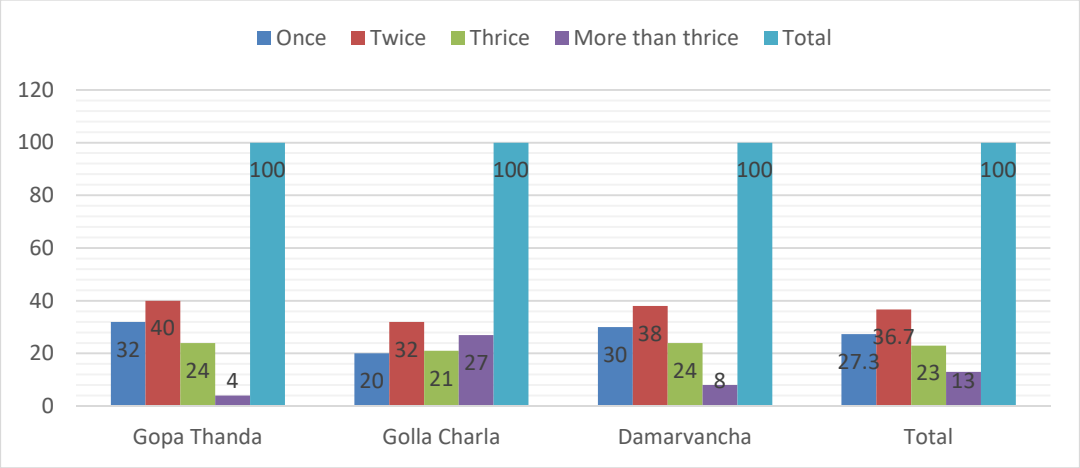
One need not be overly enthused by the fact that the majority of respondents in all the three villages (overall, 89.7%) stated that the ASHA workers were attending to their duties regularly. Of greater concern is the highly noticeable proportion (overall, 10.3%) who said that these persons were not visiting their locality regularly.

The concerned administrative authorities need to put in place a monitoring mechanism regarding the regularity of attendance of health workers.

Frequency of general visits to the households by the ASHA worker during the last 3 months

The nature of work of an ASHA worker is not a one-time activity. She is expected to make frequent visits to the households of the persons she is serving. Her job entails monitoring the health status of the community members and take follow-up action on the treatment given to her 'patients'. For instance, she may have dispensed ORS kits, Paracetamol, etc., to persons suffering from minor and major ailments like loose motions, or high fever. She is required to ascertain whether that person has recovered, or needs a different type of treatment, including hospitalisation. The Table 5.2 below can give one an idea about the frequency of visits by the ASHA workers in the areas they are required to serve.

Chart 5.2: Frequency of General Visits to the Households by the ASHA Worker from the Last 3 Months



Source: Field Data collected in 2012-14

The ASHA worker is required to make general visits to the households in the respective villages. In this general visits the ASHA workers enquire about the health status of the households and if the members of the households are suffering from any ailments/diseases. If the ASHA workers come across any such health incidents, the

ASHA worker gives the medication for minor ailments and for the major ailments, the same has to be reported to the PHCs.

The most common frequency, in all the three villages and overall (36.7 per cent) was found to be two visits. This was followed by one visit (overall, 27.3 per cent), three visits (overall 23.0 per cent) and more than three visits (overall 13.0 per cent). It is clear that more than two visits did not appear to be the norm. The lesser frequency of the visits may be reasons like high workload on the ASHA workers, their preoccupation with their household matters, apathy due to the low incentive amounts, or these workers being busy with other income-generating activities, like agriculture.

A logical question would be whether the ASHA worker needs to visit a household where no illness has been reported. It has possible that persons in such households have just recovered from illnesses. It is for the ASHA worker to ascertain that there is no relapse and that the concerned persons are taking the medicines, like energy tablets or tonics, which they are required to take for some more time. There may also be a situation where a person may initially instances like high fever as a 'passing phase', whereas he or she may be in the initial phases of, say, malaria. The ASHA workers would be in a better position to make reasonably good detection of such cases.

Medical Aid Being Provided by the ASHA Workers

Plate 5.1: Distribution of Medicines to the Village Community Members by the ASHA Workers in Golla Charla Village

The ASHA workers are not trained to take care of some minor ailments. In view of this training to them, it is expected that the villagers approach them for medical aid in case of

fever, headache, diarrhea and cough/ sneezing, etc., first rather than the untrained medical providers. During the field visits, the researcher found that majority of the respondents in all the three villages gave the topmost priority to obtaining medicine, immunisation; RCH services, etc., from the ASHA workers.

Similarly, members of these study villages have slowly given up the practice of home delivery under the supervision of untrained dais. The shift towards institutional deliveries and a demand for pre- and post-natal health care by qualified providers has been noticed. It also emerged from the study that respondents are also seeking services from the ASHA workers on issues like family planning methods and distribution of contraceptives. Since this is a rather 'intimate' subject, the proportion of respondents in Gopa Thanda availing of such services was relatively very low because the ASHA worker hailed from a different village and the residents here felt a bit hesitant discussing such matters with her.

Minor Ailments Generally Treated by the ASHA Workers

One of the primary roles of the ASHA worker is to treat the minor ailments in the villages. Normally, the members of the community often come across various diseases/ailments seasonally. Under these circumstances, the ASHA worker gives medicines to the affected person/patients. The Table 5.3 below depicts the minor ailments generally treated by the ASHA workers in the study area.

Table 5.1: Minor Ailments Generally Treated by the ASHA Workers

Minor ailments generally treated by the ASHA worker									
		Fever	Cough/ Sneezing	Diarrhoea	Head Ache	Body pain	Sunstroke	All of the Above	Total
Village	GopaThanda	27	19	14	8	9	3	20	100
		27.0%	19.0%	14.0%	8.0%	9.0%	3.0%	20.0%	100.0%
	Golla Charla	23	15	16	9	7	5	25	100
		23.0%	15.0%	16.0%	9.0%	7.0%	5.0%	25.0%	100.0%
	Damarvancha	20	10	24	8	0	9	29	100
		20.0%	10.0%	24.0%	8.0%	.0%	9.0%	29.0%	100.0%
Total		70	44	54	25	16	17	74	300
		23.3%	14.7%	18.0%	8.3%	5.3%	5.7%	24.7%	100.0%

Source: Field Data collected in 2012-14

It can be seen that 'Fever' appeared to be the most common of the ailments, listed above, and handled by the ASHA workers in the study area (overall, 23.3%). A cause for alarm is the highly noticeable proportion of diahorrea cases handled by the ASHA workers in all the three PHCs (overall, 18.0 per cent). This ailment must have been largely due to consumption of unhealthy food and unsafe drinking water. The very noticeable proportion of cough/sneezing cases present (overall, 14.7 per cent) can perhaps to attributed to not covering the body properly, especially during the rare cold spells.

Health Seeking Behaviour

Many health conditions can be addressed if the persons themselves adopt good health practices like maintaining a clean environment around them, consuming a healthy diet, having a proper work-life balance and avoiding addiction to harmful substances like tobacco, liquor and drugs. Also, many diseases, especially those related to children and women, can be fully cured by timely treatment and inoculations, etc.

Preventive and Promotive Health Behaviour

The section below will discuss the preventive health-seeking behaviour of the residents in the study area. The people generally try to be healthy, in order to have better, long and healthy life. This can be achieved only when the community members have knowledge about what are the good health practices, like a balanced diet, nutritive food, low fat, mineral and vitamin rich vegetables, fruits and daily exercise. On the other hand, avoiding the alcohol and tobacco products can also help in preventing certain diseases.

According to the (Kasl and Kobb 1966 p, 246), preventive health behaviour is "any activity undertaken by a person who believes that he/she is healthy for the purpose of preventive disease in an asymptomatic stage". In this regard, positive beliefs and attitudes can play an important role in the maintaining of the good health as part of the preventive health behaviour[1].

[1]Carolina Werle, The Determinants of Preventive Health Behavior: Literature Review and Research Perspectives, Working paper series RMT (WPS 11-15) 14 p. 2011. <hal-00638266>

Against this backdrop, an attempt has been made to find out in the study villages, how the ASHA workers are playing an important role in the preventive health care and health promotion aspects in the community.

Immunisation

Immunisation is one of the most well-known and cost-effective methods of preventing diseases. Though most of the vaccine preventable diseases (VPDs) have been largely brought under control by now, immunisation has to be sustained, not only to prevent VPDs, but also to eliminate Tetanus, reduce the poliomyelitis, Diphtheria, Pertussis (whooping cough), measles, and tuberculosis. In this regard, it is the duty of the ASHA worker to spread awareness among the community members and counsel the parents about the importance of the vaccination. The vaccines must be given at the right age, in the right dosage, at the right intervals and the full course must be completed. In the study area, the ASHA workers are playing an important role in the immunisation campaign to eradicate polio. One of the functions of the ASHA workers is to guide and mobilise the community members and explain the importance of vaccination on time and the adverse consequences if it is not administered.

In Gopa Thanda, the ASHA worker is not a resident of the village, but hails from UpparGudam village, which 1.5 km away. She visits the individual households and campaigns about the pulse polio immunisation vaccine. On the day of the immunisation, she, along with ANM and the AWW worker, help the medical authorities in the immunisation process. Now-a-days, the community members are also recognising the contribution of the ASHA workers. The village community members are listening to the advice given by the ASHA workers and ensuring that the immunisation vaccines like DPT, BCG, OPV and TT injunction are administered to the infant children. Through these rigorous campaigns, the ASHA workers are motivating the community members to avail the immunisation vaccination at the PHC and at the area hospital. The Table 5.4 below depicts the level of awareness about immunisation in the study area.

Table 5.2: Awareness about Immunisation

Response				
			Yes	**Total**
Village	GopaThanda	Count	100	100
		% within Village	100.0%	100.0%
		% of Total	33.3%	33.3%
	GollaCharla	Count	100	100
		% within Village	100.0%	100.0%
		% of Total	33.3%	33.3%
	Damarvancha	Count	100	100
		% within Village	100.0%	100.0%
		% of Total	33.3%	33.3%
Total		Count	300	300
		% within Village	100.0%	100.0%
		% of Total	100.0%	100.0%

Source: Field Data collected in 2012-14

A very encouraging sign was that respondents in all the study villages were aware about the importance of immunisation. The next issue of importance would be the person who helped in this aspect.

Person who Created Awareness about Immunisation

In a rural setting, like the study area, where the educational levels are generally low, most of the residents may not be having self-awareness about such issues. Some knowledgeable person, whom they trust, can only inform them about the need for immunisation, etc., the Table 5.5 below should be quite informative on this aspect.

Table 5.3: Person Who Created Awareness about Immunisation

Person From whom Respondents Learnt About Immunisation						
			ASHA Worker	EM/OHP*	Others	Total
Village	GopaThanda	Count	61	30	9	100
		% within Village	61.0%	30.0%	9.0%	100.0%
		% of Total	20.3%	10.0%	3.0%	33.3%
	Golla Charla	Count	49	34	17	100
		% within Village	49.0%	34.0%	17.0%	100.0%
		% of Total	16.3%	11.3%	5.7%	33.3%
	Damarvancha	Count	68	25	7	100
		% within Village	68.0%	25.0%	7.0%	100.0%
		% of Total	22.7%	8.3%	2.3%	33.3%
Total		Count	178	89	33	300
		% within Villages	59.3%	29.7	11.0%	100.0%
		% of Total	59.3%	29.7%	11.0%	100.0%

Note: EM/OHP: Ethno-medical/Other health providersSource: Field Data collected in 2012-14

A very positive sign was that the majority of the respondents in all the three villages gave credit to the ASHA workers on this issue. Still, one cannot totally discount the role of Ethno-medical/Other health providers for their contribution in this area. In all the three villages, 'Others' figured last in this category.

Contacts for Health Information

Health information and communication is more important than the pills and injections. Proper health information and advice help the community members to stay healthy. There was a time when most ailments were considered as 'acts of God' and not much effort was made to secure prior advice on health-related issues. The tendency was to tackle the problem as and when it arose. Today, more and more persons are adopting a proactive approach towards diseases and ailments and seeking advice from the different health providers. It is in this context that the ASHA worker is filling the gap by providing health information and acting as a local resource on health issue. It is also true that the availability of information triggers changes in health promoting behaviours and adoption of healthy practices. Table 5.6 below presents the situation in this regard, in the study area.

Table 5.4: Whether the Residents have been Seeking Health Information

Response					Total
			Yes	No	
Village	GopaThanda	Count	67	33	100
		% within Village	67.0%	33.0%	100.0%
		% of Total	22.3%	11.0%	33.3%
	Golla Charla	Count	81	19	100
		% within Village	81.0%	19.0%	100.0%
		% of Total	27.0%	6.3%	33.3%
	Damarvancha	Count	59	41	100
		% within Village	59.0%	41.0%	100.0%
		% of Total	19.7%	13.7%	33.3%
Total		Count	207	93	300
		% within Village	69.0%	31.0%	100.0%
		% of Total	69.0%	31.0%	100.0%

Source: Field Data collected in 2012-14

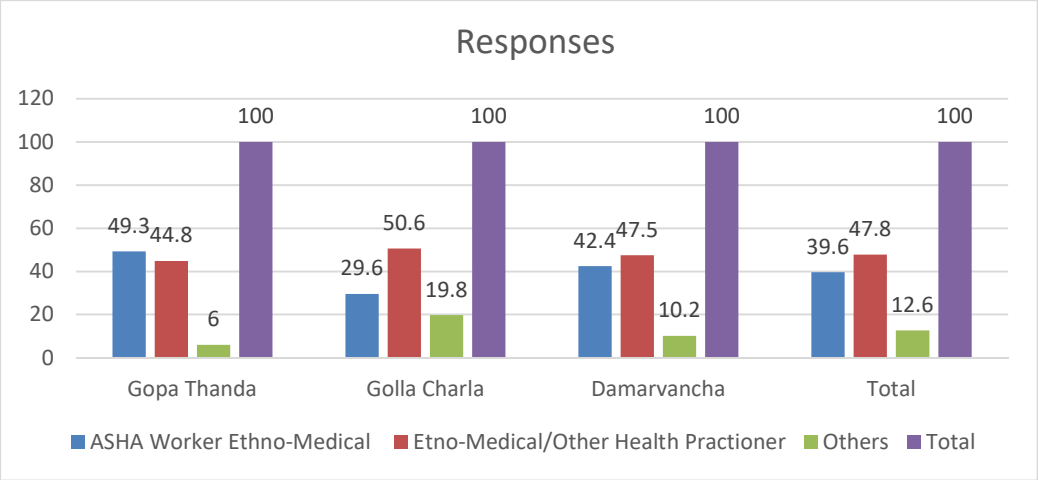
It was very encouraging to note that the majority of respondents in all the three villages are taking their health issues quite seriously and have been seeking health information from persons who are better informed than them. Still, one cannot totally the highly noticeable proportion of persons who are still not seeking information on health-related issues.

The concerned functionaries must target such persons so as to achieve 100% outcomes. The focus should be on the reasons for their not approaching the health functionaries whenever health issues arise in their households.

Persons Being Approached for Health Information

A mention has already been made about the health functionaries who have been providing information about immunisation. The Table 5.7 below will depict the persons being approached for this and other types of health information.

Chart 5.3: Persons Being Approached for Health Information



Source: Field Data collected in 2012-14

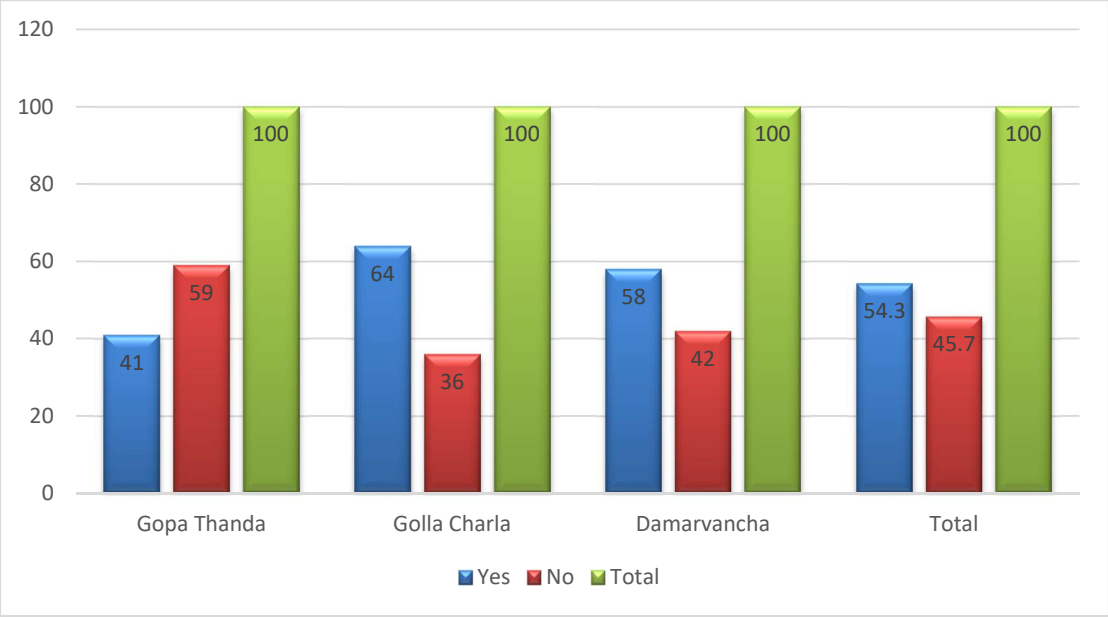
Gopa Thanda, a predominantly tribal village, was found to be slightly different from the other two villages in terms of the impact of ASHA workers on spreading awareness on such issues. In the former village, the ASHA workers were found to 'dominate' the other two categories on information providers. A possible reason for the limited role of ASHA

workers in Golla Charla and Damarvancha villages could be the greater presence of alternative health providers like RMPs there.

Whether a Health Check-ups is the Norm in the Study Area

There seems to a tendency to consult a medical practitioner only when the particular ailment becomes a bit unmanageable. There may be some diseases and ailments which can be diagnosed by a competent medical functionary in the preliminary stage itself, and save a lot of time, money and anxiety for the person/his or her family. For instance, a pregnant woman may need periodic check-ups to confirm that both she and the yet to be born child are in a good health. During such check-ups, the medical functionary can advise on matters like proper diet and the necessary precautions to be taken. Table 5.8 below depicts the extent to which the respondents in the study area are giving importance to the need for health check-ups.

Chart 5.8: Whether the Respondents are going in for Health Check-ups



Source: Field Data collected in 2012-14

One cannot fail to notice that in Gopa Thanda, a predominantly tribal village, the larger proportion (59.0%) of the respondents said that they were not going in for medical check-

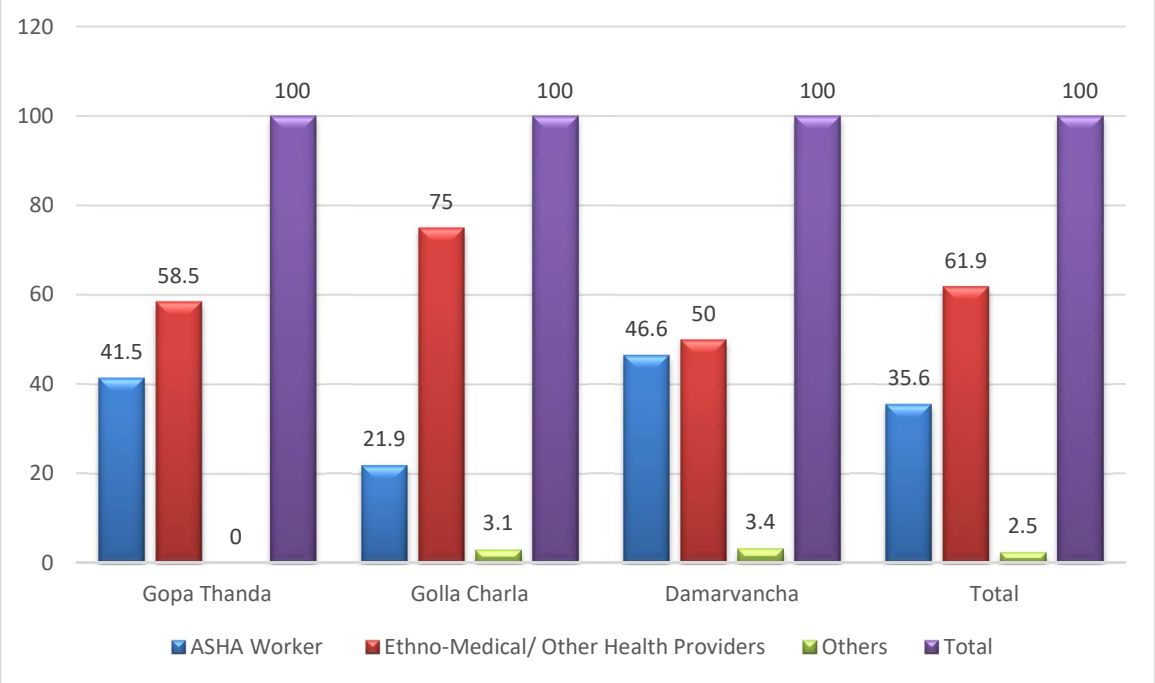
ups. It is possible that such persons were going in for self-medication. In the other two villages, the majority of the respondents mentioned that they were having medical check-ups.

The concerned medical functionaries must be more proactive and ensure that more and more residents in such areas understand the need for frequent check-ups, especially since many of such services are being provided free of cost.

Contact Persons for Medical Check-ups

Today, even in very remote areas, different types of medical practitioners are available for conducting health check-ups. The Table 5.9 below depicts the persons being approached for such services in the study area.

Chart 5.5: Contact Persons for Medical Check-ups



Source: Field Data collected in 2012-14

A common feature noticed in all the three villages was that the Ethno-medical/Other health providers were considered more acceptable that ASHA workers for conducting

health check-ups. This is not surprising since the role of ASHA workers is that of motivators and dispensers of medicines for minor ailments - and not of qualified doctors.

Promotive Health Behaviour

One of the underlining aims of health promotion is to help an individual or group to reach a state of complete physical, mental and social well-being. Health promotion makes it possible for people to increase control over the determinants of health and thereby improve their health. Health promotion and diseases prevention activities are more focused on keeping people healthy. Health promotion engages and empowers the individuals and communities to engage in healthy behaviours and make changes that reduce the risk of developing chronic diseases and other morbidities. Disease prevention focuses on the prevention strategies to reduce the risk of developing chronic diseases and other morbidities.

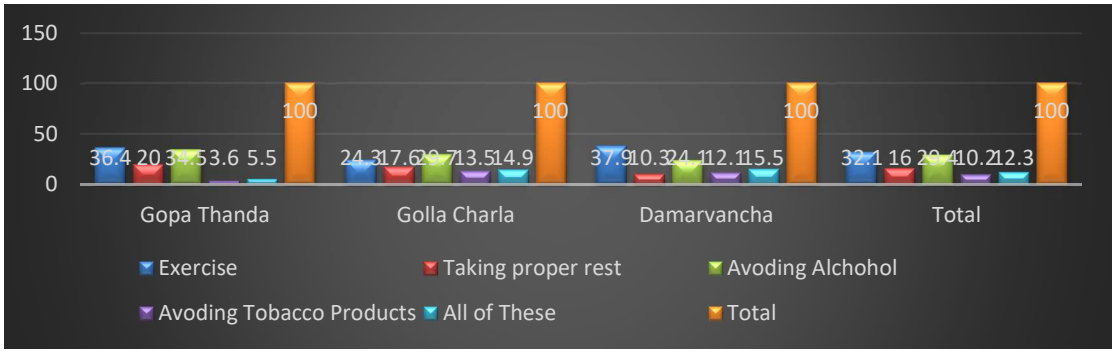
The Ottawa Charter for Health Promotion is very much relevant for our present discussion. This was the first international conference on health promotion, held in Ottawa on 21 November, 1986. This Conference was primarily a response to the growing expectations for a new public health movement around the world. Hence, the Ottawa Charter focused on health promotion and defined it as "The process of enabling people to increase control over and to improve their health; to reach a stage of complete physical, mental and social well-being; and individuals or groups must be able to identify and to realise aspirations to satisfy needs and to change or cope with the environment." Health is a positive concept emphasizing social and personal resource, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond a healthy life style to well-being. A sound health depends on factors and resources such as peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity.

Means for Promoting One's Health

The foremost player in promoting good health is the individual himself. This is because many health conditions are due to factors like: improper diet, lack of exercise, living in insanitary conditions, improper work-life balance and addiction to substances like

tobacco, liquor and drugs. Table 5.10 below depicts the means by which the respondents have been taking care of their health.

Chart 5.6: Means being adopted for promoting one's Health



Source: Field Data collected in 2012-14

It did not come as a total surprise that, in all the three villages, regular exercise was cited as the most common means for keeping oneself healthy. Considering the milieu of these villages, one can safely assumes, that such an exercise may not have been in a gym, but while engaged in one' occupation, which was largely agriculture that entailed hard work in the fields. Addiction to tobacco/tobacco products appears to be very high in the study area, since very few respondents mentioned avoidance of these products as a means of improving their health.

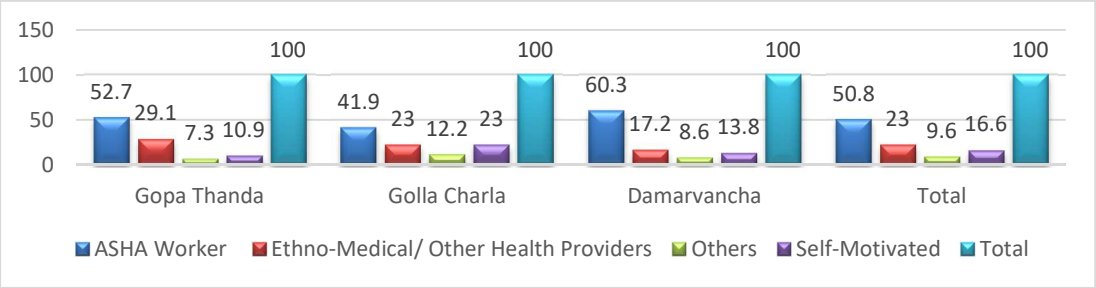
However, disappointment on this issue is offset by the fact that a very significant proportion of the respondents in the study area mentioned that they were avoiding alcohol to protect their health. Significantly, taking proper rest was not mentioned as a means of health promotion by many respondents. Equally noticeable was the fact that not many respondents cited 'a combination of all the other means' as a major promoter of health.

Persons Providing Health Promotive Information

As already mentioned, due to the high level if illiteracy in the study area, many residents may not be properly aware of how they can enjoy a better health. Also, a person may be consuming harmful items like tobacco, alcohol and drugs just because he or she has seen someone else using these. Such a person may not be properly aware of the ill effects of such substances. It is here that persons with proper awareness of health promotion

become important. The Table 5.11 below would provide a good idea about such health promoters in the study area.

Chart 5.7: Persons Providing Health Promotive Information to the Respondents



Source: Field Data collected in 2012-14

It should not be a total surprise that the options 'Self-motivated' and 'others' figured as the least common ones. Since the ASHA workers primarily function as information providers, it was normal to expect them as the most popular persons who were providing health promotive information to the respondents.

Communicative Methods Adopted by the ASHA Workers for Health Promotion

Majority of the respondents in the study area reported that the ASHA workers are playing a proactive role in health promotion and diseases prevention activities in the villages. It is well recognised that, the health status of community members is influenced by factors such as social, economic, cultural and political conditions in which people are born, grow and live. All these factors, directly and indirectly, reinforce each other to ultimately impact the health status of the community members. The ASHA workers, in order to promote good health practices among the community members, are adopting different approaches in the villages. These include: health communicative role, health educative role and spreading awareness about the health policies of the Government. Let discuss these roles, one by one.

1. **Health communicative role**. The ASHA workers are raising awareness among the community members by communicating information on health-related issues. It has

already been stated that the ASHA workers are functioning as intermediaries between the village community members and the public health functionaries. It is the responsibility of the ASHA workers to inform the people about the new health schemes or initiatives, like immunisation drives launched by the health departments, or public health functionaries. During such activities, it is the ASHA workers who are instrumental in disseminating health information to the community members with the help of ANM and AWW worker in the villages.

The community members in the study area reported that the ASHA workers are informing them about the new health initiatives undertaken by the state and central governments. It was found that of the community members from all the three study villages reported that during the health camps, the ASHA workers were mobilising the community members for the health check-ups. The ANM, AWW and doctors are also present during the health camp. If the members are having any doubts or queries on health issues, they inform the ASHA workers, who, in turn, communicate the same to the health official present in the health camp.

2. **Educative Role in Health Promotion**- the ASHA workers is playing an important role by disseminating health education to the community members. As part of their duties, they have to educate the community members about health problems and frequently occurring diseases in their area of work. The ASHA workers have been informing the community members about the importance of immunisation and the benefits of health check-ups. The ASHA workers are also explaining to the community members about the importance of adopting good dietary health practices. Already, children below the age of 6 years are being provided nutritive food, '***Balaamurutham***' from the AWW centre. Such a diet is saving the children from malnutrition and helping in their physical and mental growth.

3. **Disseminating information about the health Policies of the Governments to the community members**- The ASHA workers are also disseminating information about the health initiatives or programmes to the community members. For instance, there

are schemes like ***Janani Suraksha Yojana (JSY)***, **KCR Kit,** where the pregnant women are entitled to get Rs. 1500 for institutional deliveries under JSY, whereas in KCR KIT the pregnant are entitled to get Rs. 12000. In order to motivate the pregnant women to opt for institutional deliveries, the ASHA workers are explaining about the benefits of the institutional deliveries.

4. In this regard "*One of the pregnant women from the Golla Charla revealed, "The ASHA worker explained and motivated me and my husband to go in for institutional delivery. My first delivery took place at my native place, which was a normal delivery in the presence of the TBA. But for the second delivery, my husband and I opted for the institutional delivery. The ASHA worker even accompanied us to the hospital." It is largely due to the efforts of the ASHA workers that an increasing number of pregnant women in the rural areas prefer institutional deliveries. In this way, the ASHA workers are bringing about attitudinal changes in the community members*."

5. **Creating awareness about the ill effects of tobacco and alcohol to the community members.** It is one of the mandatory duties of the ASHA workers to create awareness among the community members about the ill effects of tobacco products like cigarettes, bidi, hookah, and amber (kind of tobacco made products) and alcohol. The ASHA workers in the study area have been successfully sensitising the community members about the ill effects of such products.

The preventive health services provided by the government of India and the respective state governments can also have a direct impact on the people. These preventive services are highly popularised by the health department through the media. The NRHM has entrusted certain responsibilities to the ASHA workers to sensitise the community about health promotion. The ASHA workers have been creating awareness on the importance of nutrition and how a balanced diet can help in improving the health of a person.

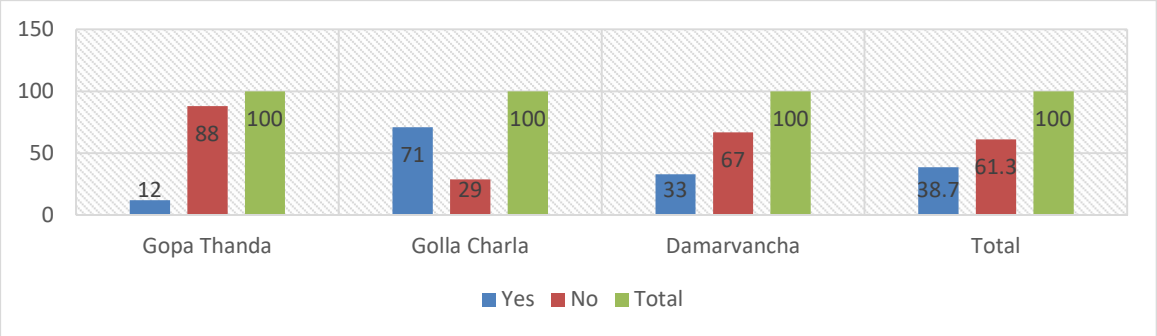
Health promotion is not just the responsibility of the health sector. The responsibility has to be shared among individuals, community groups/schools, health professionals, health service institutions and governments. They must work together to provide a health care system that promotes health.

Hygiene Behavioral Changes

Toilet Facilities in the Households

It is almost common knowledge that defecating in the open is almost the norm in our rural areas. One very specious argument against domestic toilets is, "The house is a very pure place, since food grains, utensils and idols of Gods are kept there. A toilet is a filthy place. How can we allow a filthy place in a place which has very pure things?" The Table 5.12 below can give one an idea how strong such a perception has been in the study area.

Chart 5.8: Presence of Toilet Facilities in the Households



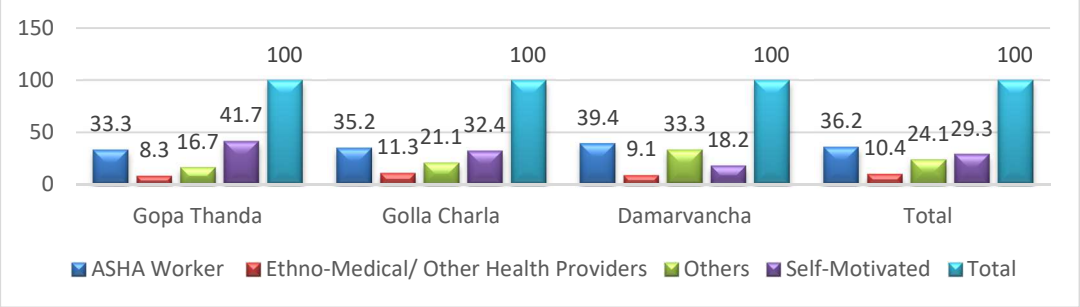
Source: Field Data collected in 2012-14

Only Golla Charla appeared to have a remarkably high degree of positive outlook, since 71.0% of the respondents gave affirmative responses on this issue. The corresponding figures for Gopa Thanda and Damarvancha were only 12.0% and 33.0% respectively. This suggests that the concerned rural development agencies have still to do a lot to popularise the idea of domestic toilets.

Person Who Created Awareness about the Need for a Domestic Toilet

Some unhealthy practices, like defecating in the open, seem to have become almost a habit, especially in the rural areas. It is also possible that many persons are not aware of the hazards of continuing with this practice. The hazards include: risk of bites by reptiles or insects, risk of contacting many communicable diseases and the dignity and privacy (especially of women) being severely compromised. In such a milieu, only an opinion leader can help in bringing about an attitudinal change on such issues. The Table 5.13 below will show the various 'change agents' in the study area.

Chart 5.9: Person who Created Awareness on the need for Domestic Toilets



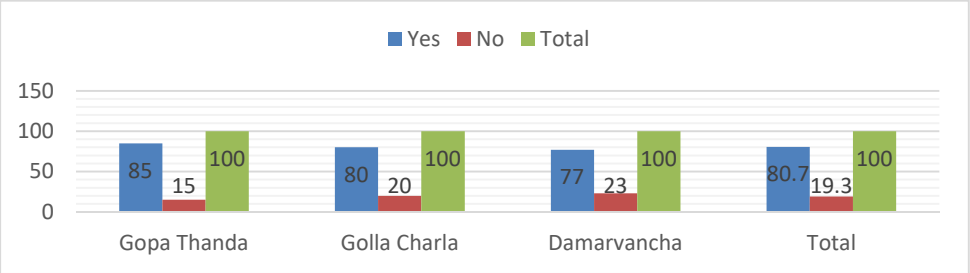
Source: Field Data collected in 2012-14

A very amazing fact noticed in Gopa Thanda, a largely tribal village, was that the high proportion of the respondents mentioned that they were self-motivated on this issue. Even in Golla Charla, the proportion of such respondents was very high. It was only in Damarvancha that the ASHA workers 'scored' the highest on this issue. As regard the other two motivators, 'Others' dominated the Ethno-medical/Other health providers.

Washing /Bathing Habits

Many health issues can be caused by improper washing/bathing habits. Table 5.14 below depicts the degree to which the respondents are paying attention to this issue.

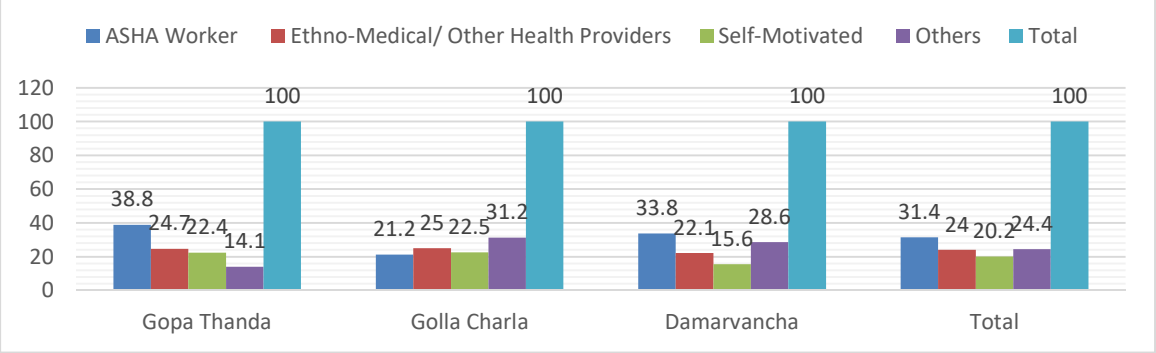
Chart 5.10: Whether Attention is being Paid to Clean Washing/Bathing Habits



Source: Field Data collected in 2012-14

A very pleasing fact found in all the three villages was that the respondents were taking their personal hygiene very seriously. A related issue would be the person who played a major role in spreading such a health culture. The Table 5.15 below would give a clear picture on this issue.

Chart 5.11: Person who Inculcated such a Health Culture



Source: Field Data collected in 2012-13

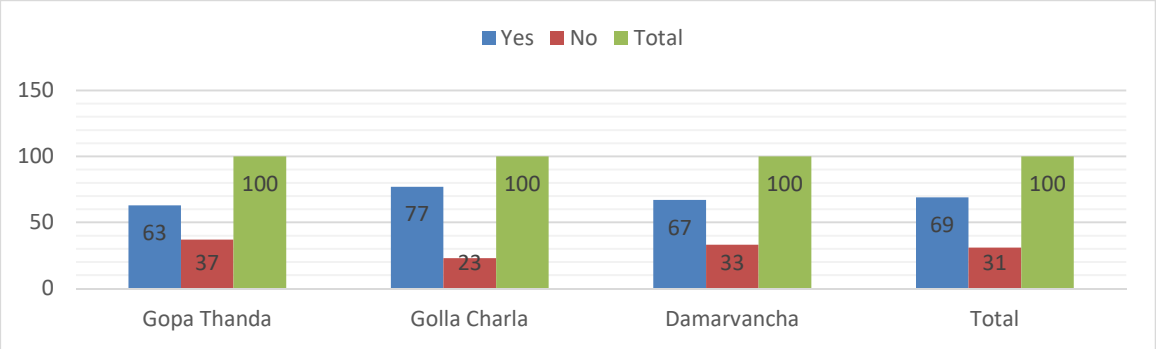
ASHA workers emerged as the most influential motivators in Gopa Thanda and Damarvancha villages. However, in Golla Charla, Ethno-medical/other health providers and 'Others' were found to be more dominating than the other motivators. Self-motivation was not found to be as effective in clean personal hygiene as it was in the case of construction of domestic toilets.

Boiling Water before Using It

Diseases like jaundice can be caused by consuming unsafe water. In rural areas like the study villages, it is unlikely that chlorinated water would be supplied through the municipal water system. Water obtained from sources like rivers, ponds and wells can

contain many harmful pollutants. No wonder, it is always advisable to boil such water before consuming it. Table 5.16 below can give us an idea of the extent to which the respondents have been taking this precaution.

Chart 5.12: Whether Water is being Boiled Before Use



Source: Field Data collected in 2012-14

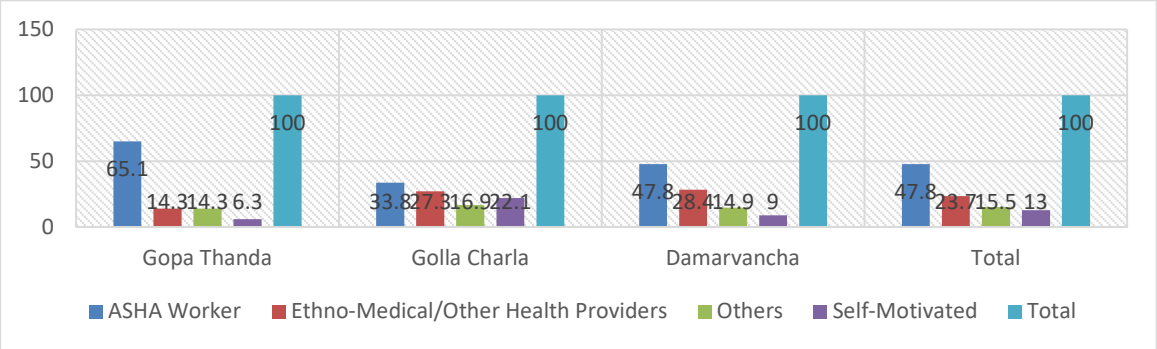
It is very heartening to note that majority of the respondents in all the three villages confirmed that they are consuming boiled water. Yet, one cannot totally ignore the highly noticeable proportion (overall, 31.0%) of the respondents who stated that they were not boiling the potable water

The concerned health promoters in such areas need to motivate the residents to pay more attention to such issues.

Person Who Created Awareness about the Importance of using Boiling Water

It has been repeatedly mentioned that a large proportion of the respondents in the study area are illiterate. Hence, there is a very strong possibility that such persons would not be aware about the need to boil water before consuming it. Therefore, a more knowledgeable person may have to urge these persons to adopt such a healthy practice. In this regard, Table below 5.17 depicts about the persons who created awareness about the importance of using boiling water.

Chart 5.13: Person Who Created Awareness about the Importance of Using Boiling Water



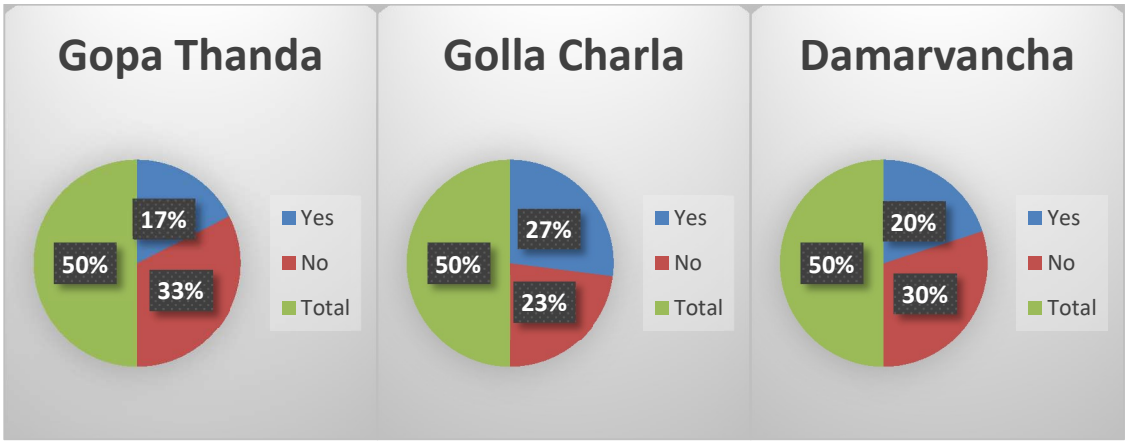
Source: Field Data collected in 2012-14

One cannot fail to notice that, in all the three villages, the ASHA workers were the most influential motivators on this issue. Self-motivation figured at the other end of the spectrum in Gopa Thanda and Damarvancha villages. Ethno-medical/Other health providers also emerged as very important motivators in the entire study area. The category of 'Others' (who included: relatives, friends, neighbours, village officials and the media) did not figure very prominently in the study area (overall, 15.5%).

Mosquito Nets

The study area, due to its location in a predominantly hot region and relatively insanitary living habits of many residents, can serve as a breeding ground for disease causing mosquitoes. Use of mosquito nets, especially when sleeping, can save persons from contacting diseases like malaria and dengue fever. The Table 5.18 below will help us to ascertain the extent to which the respondents have been taking this health precaution.

Chart 5.14: Whether Mosquito Nets are being Used



Source: Field Data collected in 2012-14

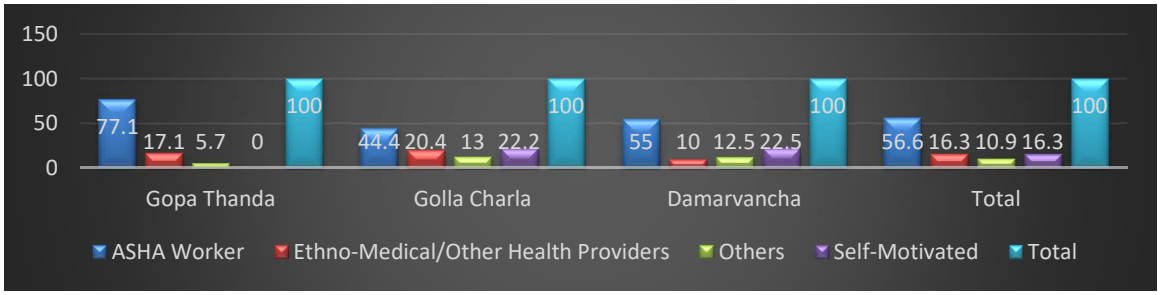
A very discouraging picture emerged in both Gopa Thanda and Damarvancha, since a greater proportion of the respondents gave negative responses on this issue. It was only in Golla Charla that 54.0% of the respondents confirmed that they have been using mosquito nets.

The concerned health motivators need to spread greater awareness among the 'non-users' about the importance of mosquito nets. Only then can the incidence of a number of diseases can be significantly brought down.

Person who Created Awareness about the Importance of Mosquito Nets

The above discussion clearly brings that use of mosquito nets has not been a very popular health precaution in the overall study area. Even those who use been using these nets must have been motivated by someone else. The Table 5.19 below would give an idea about such a motivator.

Chart 5.15: Person who Created Awareness about the Importance of Mosquito Nets



Source: Field Data collected in 2012-14

One cannot discount the dominant role of ASHA workers in all the three study villages in spreading awareness about the importance of mosquito nets (overall 56.6%). This situation was even more pronounced in Gopa Thanda, a predominantly tribal village, where the figure was as high as 77.1%. Self-motivation emerged as a highly noticeable factor in the other two villages. As regard the other two categories of motivators, Ethno-medical/other health providers generally appeared to be more influential than 'Others'.

Menstrual Behaviour

This is a health condition of particular relevance to females belonging to a particular age group. This entails certain health precautions at that particular time in the month. In order to obtain the information with regard to the on menstrual behaviour, the researcher has selected the 45 women from three study villages. The researcher got the varied response in this regard. The Table 5.20 below depicts whether the respondents were aware of menstrual hygiene during the monthly period.

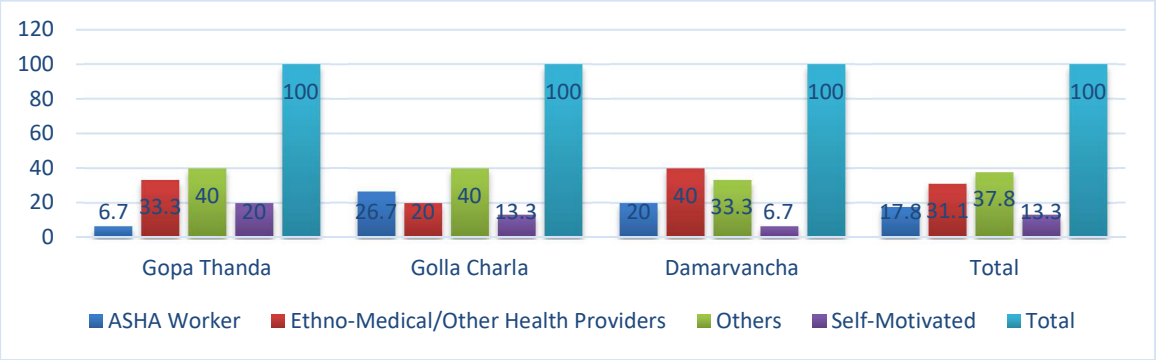
Table 5.5: Whether the Female Respondents had Awareness on Menstrual Hygiene

Does the female members are getting menstrual awareness				Total
			YES	
Name of the Village	Gopa Thanda	Count	15	15
		% within Name of the Village	100.0%	100.0%
	Golla Charla	Count	15	15
		% within Name of the Village	100.0%	100.0%
	Damarvancha	Count	15	15
		% within Name of the Village	100.0%	100.0%
Total		Count	45	45
		% within Name of the Village	100.0%	100.0%

Source: Field Data collected in 2012-14

It was not surprising that all the female respondents in the study area had awareness on this issue. Table 5.21 below depicts the source of information on this issue. A related issue is whether the persons concerned are taking adequate precautions in those 'difficult' days and utilising sanitary napkins either from the market or those being provided free by health functionaries like the ASHA workers.

Chart 5.16: Person Who Spread Awareness about Menstrual Behaviour



Source: Field Data collected in 2012-14

A very significant fact that can be seen from the above Table is the highly noticeable proportion of 'Others' (who may include the mothers, elder sisters and other female relatives) as the 'information providers' on this issue. This situation was found in all the three study villages. Since, this is a sensitive subject; only those who are close to the person concerned can speak freely on such matters. As in most other cases, ASHA workers continued to be the most dominant influence here also. Self-motivation was found to be more effective that the remaining category of motivators for the following possible reasons:

1. Many ethno-medical/other health providers could be males who would feel hesitant to speak on such issue with their female patients,
2. Many female respondents may have learnt from their initial experience of menstruation and stated taking precautions thereafter.
3. Female respondents informed that earlier they used the used cloths as napkins during the monthly menstruation, now because of the ASHA worker, who motivated and created the awareness to use sanitary napkins. During the menstruation, they are

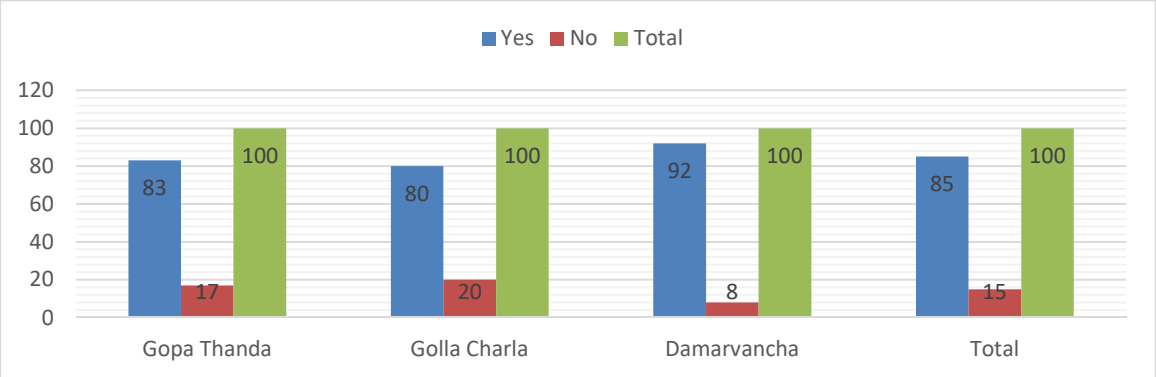
giving utmost importance to the cleanliness of their body parts and during the sexual intercourse both the partners prefer to give importance to hygiene factors.

4. It is well understood that lack of cleanliness leads to many genital diseases among the men and women, especially among the women white and yellow discharge is the common phenomena. It is in this context, the ASHA workers are playing a pivotal role by creating awareness about the ill-effects of uncleanliness.
5. It is the job of the ASHA worker to distribute the napkins to the young girls in the respective villages. But one of the glaring facts emerged from the field that the government is not providing the sanitary napkins to them.
6. In this regard, the ASHA worker has brought tremendous hygiene behavioural change among the women and girl of the respective study villages.

Nutritional Awareness

A number of health issues can arise due to ignorance about dietary issues; what diet is good for health and what can be harmful. A related issue is that of a balanced diet, since many health issues can arise due to deficiency or excess of some substances. For instance, night blindness may be due to deficiency of vitamin A, diabetes may be due to consumption of a lot of sweet items, or a heart condition may be aggravated by excessive use of oils or salt. Communication of information on nutritional issues can assume a lot of importance, especially in places where the residents are not aware about a healthy diet. The Table 5.22 below will depict the level of awareness on this issue in the study area.

Chart 5.17: Level of Nutritional Awareness

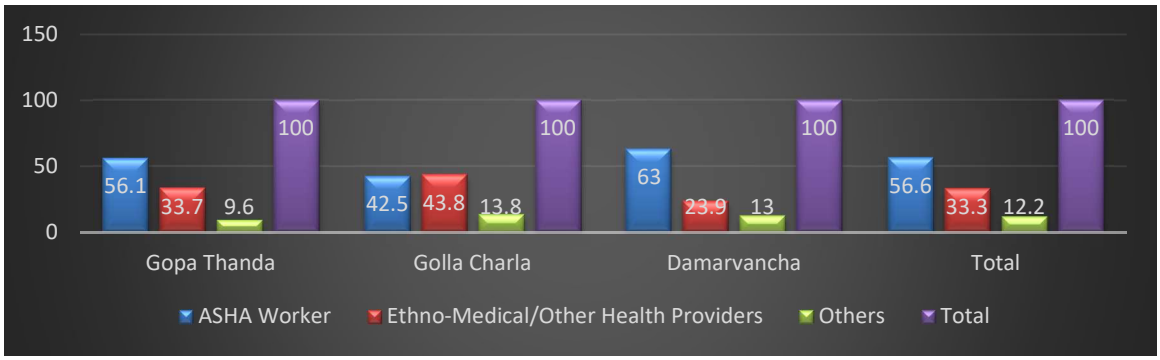


Source: Field Data collected in 2012-14

At first glance itself, one can find a high level of awareness about nutritional issues in all the three villages. However, a related issue is whether one can afford a balanced diet and the accessibility to nutritional food items (like vitamin pills, etc., being provided free of cost by health functionaries like the ASHA workers). A fact often ignored is that even some relatively cheaper items like groundnuts and snacks like idly are very nutritious.

The Table 5.23 below will bring out the source that provided awareness on nutritional issues in the study area.

Chart 5.18: Person Who Created Nutritional Awareness



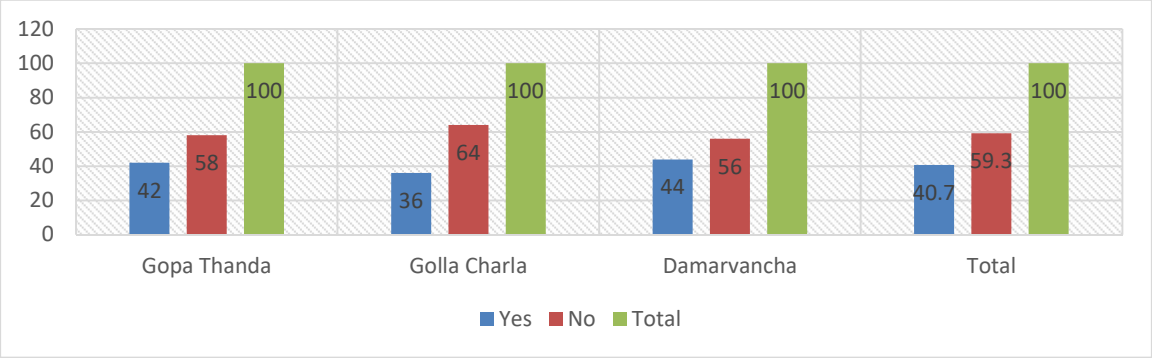
Source: Field Data collected in 2012-14

As in most other cases, the ASHA workers were generally found to be the most dominant influence (overall, 56.6%) in the study area. The ethno-medical/other health providers too emerged as important sources of information (overall, 33.3%). 'Others' did not figure as important sources of information on this issue.

Illness Behaviour

Due to factors like geographical location, general ignorance of many residents, their improper dietary habits and insanitary living conditions, many areas can become vulnerable to a host of seasonal and other diseases. Table 5.24 below will depict the prevalence of morbidity in the study area.

Chart 5.19: Prevalence of Morbidity in the Study Area from August, 2012 to November, 2013.

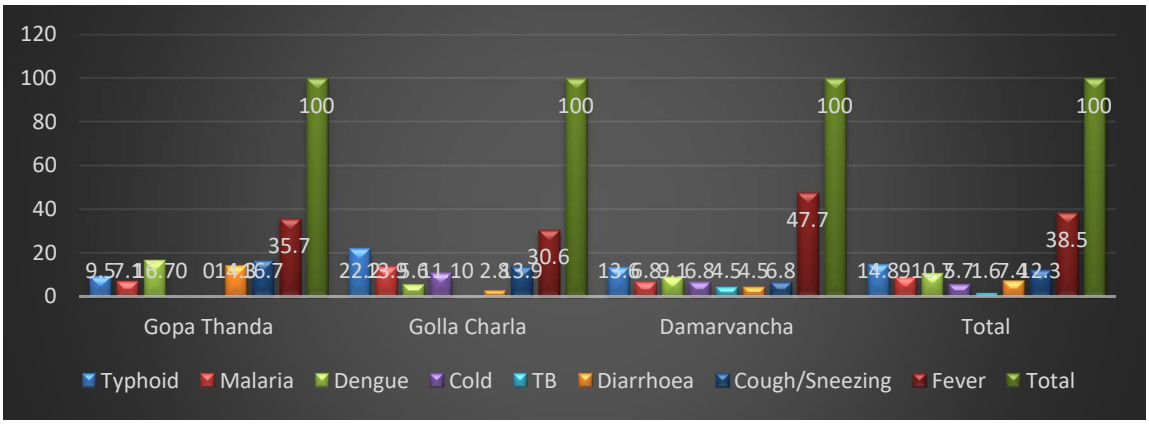


One cannot ignore the fact that the majority of the respondents in the study area (overall, 59.3%) said there was no morbidity in their particular village. It is very possible that such persons made this statement out of ignorance.

Nature of the More Prevalent Ailments/Diseases in the Study Area from August, 2012 to November, 2013

The discussion in the immediately preceding paragraphs was largely centred on the health service functionaries being approached by the residents of the study area. A topical issue, in this context, would be the more prevalent ailments/diseases there. Table 5.28 below should help one to form an opinion on this issue.

Chart 5.20: Ailments/Diseases More Prevalent in the Study Area



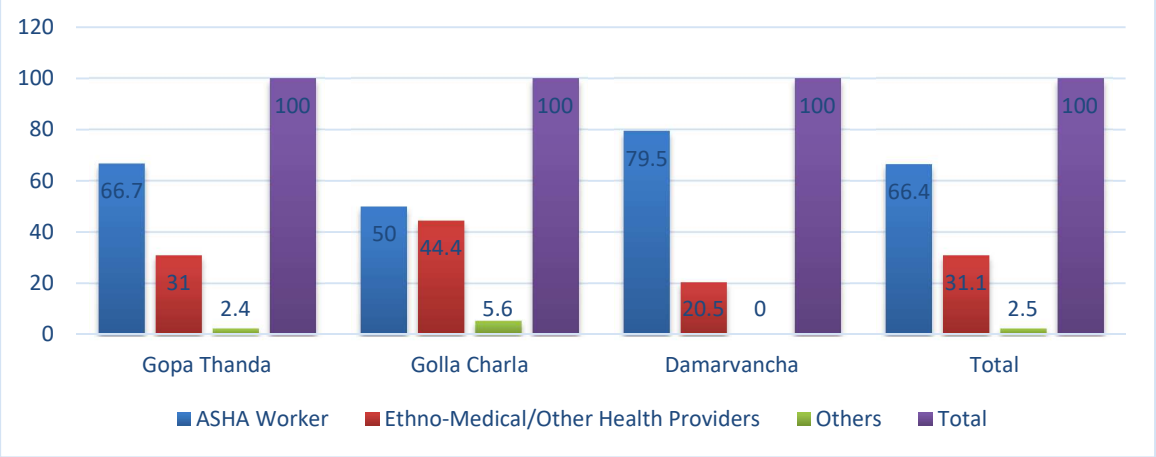
Source: Field Data collected in 2012-14

A significant finding is that TB is not a major ailment in any of the three villages. On the other hand, normal fever figured very prominently in the entire study area (overall, 38.5%). Yet another conclusion that could be drawn was that a disease like typhoid, which was very noticeable in Golla Charla, was not so in the other two villages. A similar situation was noticed in the case of dengue, which figured quite prominently in Gopa Thanda, but no so in the other two villages.

Health Service Providers Contacted

Be that as it may, despite the availability of the best preventative medical facilities, the residents of any area cannot always escape the wrath of some seasonal and congenital diseases. It emerged from the study that initially, they are contacting private and public health functionaries. It is also emerged from the study that the delay was on the part of community members in contacting the health service providers. On their part, the ASHA workers have been stressing on the community members that such kind of delay may lead severe health problems. The Table 5.25 below depicts the health service providers who are first contact whenever a health condition arises.

Chart 5.21: Health Service Providers Contacted Whenever a Health Condition Arises



Source: Field Data collected in 2012-14

One cannot ignore the fact that, in all the three villages, the ASHA workers emerged as the first 'port of call'. Even though such workers are not fully qualified medical practitioners, the following factors would have been influencing such a choice

1) **Ready Availability, almost on 24x7 Basis**: Since most ASHA workers reside in the same village, they must have gained a degree of acceptability there. Also, such workers are reasonably equipped to advice the patients regarding the best available medical facility for further treatment. Also, in most cases, they are accompanying the patients to the hospitals and staying there to render all possible help.
2) **Ethno-medical/Other Health Providers not always being available all the time**- Many such practitioners must be observing fixed consultation hours in their clinics. At that time, there could be a rush of other patients, due to which it may not be possible to pay much individual attention, even in emergency cases. Also, medical emergencies can occur at any time – even when the clinics are not open.
3) **Others,' like relatives, neighbours and friends may not be competent to handle medical emergencies**. At best, they may only be able to provide emotional support, or render advice.

Contact with Professional Health Service Providers

The discussion in the above paragraph mainly centred on the health service providers who were initially approached whenever a serious health condition arose. A related issue is the contact with such persons on a more regular basis. It has been repeatedly brought out that ASHA workers are not fully trained medical practitioners. Their role is generally advisory and motivational in nature and in giving primary medication for minor ailments like fever, cough/ sneezing, head ache, body pain, sun stroke and diarrhoea, and contacting the general health providers, if the ailment or disease is still not cured or is persisting. It is in this context that the ASHA worker motivates and accompanies the patients for more professional health services. It is, therefore, not surprising that, in all the three villages, ethno-medical/other health providers scored heavily regarding for professional treatment.

Diagnosis of the Ailment

The community members are approaching different health providers for diagnosis of ailment/diseases. It is emerged from the study that the community members are going for public and private health functionaries to diagnosis of their diseases. However, some

chronic ailments can be diagnosed only by qualified persons. It is in this context, the ASHA workers inform the community members about the further diagnosis of certain chronic diseases like TB, cancer, etc., the conclusion arrived at in the section on medical functionary being regularly contacted could be seen in this case too; even though the figures may not be exactly the same. One can therefore safely surmise that, even in a tribal village like Gopa Thanda, the residents have greater faith in the 'qualified' medical practitioners than in ASHA workers when they want a medical condition to be properly diagnosed.

Adherence to the Treatment of the Ailment/Diseases Suffered in Study Area from August, 2012 to November, 2013

Diagnosis of a disease is one side of the coin. Equally important is whether the patient is continuing with the treatment, which includes taking the prescribed medicines and frequently reporting to the medical practitioners for confirmation on whether there is an improvement in his or her medical condition. In case the treatment is discontinued, there is always the risk of a relapse.

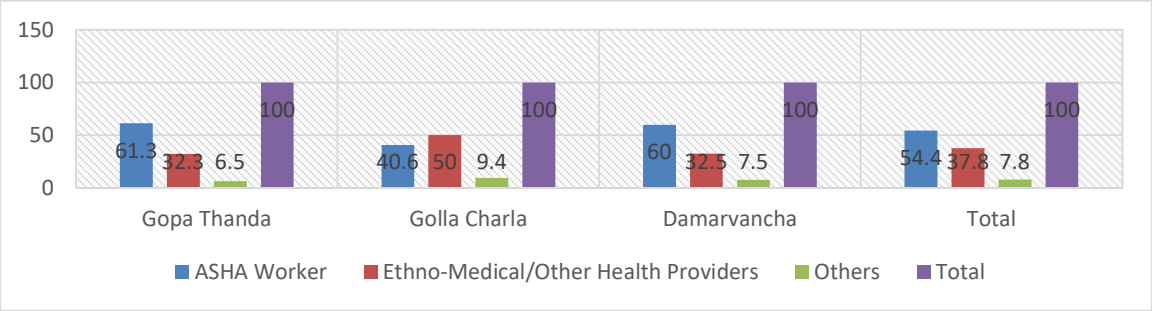
Whether the Treatment is being continued from the Period August, 2012 to November, 2013

One can draw a lot of comfort from the fact that an overwhelming majority of the respondents in the three villages (overall 84.4%) are continuing with the treatment and not leaving this midway. This suggests that most of the respondents are indeed serious that there should be an improvement in their health condition.

Persons who Motivated for Adherence to the Treatment

The discussion in the preceding paragraph is centred on adherence to the treatment. The Table below 5.30 depicts about the person who motivated the residents to adhere to the treatment in the study area.

Chart 5.22: Persons Who Motivated for Adherence to the Treatment



Source: Field Data collected in 2012-14

From the above table, it becomes clear that the largest proportion of respondents (overall 54.4 percent) mentioned that the ASHA workers convinced them to adhere to the treatment. However, overall 37.8 percent) of the respondents informed they were motivated by the Ethno/ other health functionaries.

Conclusion

This chapter specifically focused on the impact of the ASHA workers on the health seeking behaviour of the residents of tribal and non-tribal study villages. The researcher discussed about how the ASHA workers are playing a key role in terms of health-seeking behaviour and responding at the time of illness in different social and cultural contexts. In this regard, an attempt was made to study the health seeking and illness behaviour of the community members.

Chapter - 6

Summary and Conclusion

Summary

The thesis examined the community participation in primary health care, in general, and the service of Accredited Social Health Activist (ASHA) workers, in particular. This research was undertaken with the aim of examining the widely held perception that many welfare programmes initiated by the government are not attaining the intended results. The researcher made an attempt to examine the on-ground situation and ascertain how far such a perception is correct.

The intention has been to conduct a SWOT (Strengths, Weaknesses, Opportunities and Threats) of one such initiative, the ASHA scheme, so that the strengths could be shored up weaknesses, minimised; opportunities, tapped to the fullest and threats, removed to the extent possible. Since a large number of welfare schemes have been launched by the government ever since our independence in 1947, it would have been a very difficult task to examine all of these. It was, therefore, decided to select one representative initiative, The ASHA scheme, for a more focused study.

The ASHA scheme is a major initiative in providing primary healthcare in rural India. In recent times, development planners have been paying more focused attention to rural areas. This has largely been because of the growing realisation that the country can no longer afford to have lop-sided development and that a more holistic growth can be achieved only when people in the rural area (who constitute nearly 70% of the country's total population) are made responsible and willing partners of the developmental process.

Healthcare should be a major focus area of any welfare state, since widespread ill-health of its citizens can be a major drain on its economy. Ill-health carries with itself disadvantages like: avoidable heavy expenditure on treatment, loss of income and destitution of the family when the wage earner either dies or becomes disabled. The high prevalence Infant Mortality Rate (IMR), Maternal Mortality Rate (MMR) and

communicable and non-communicable diseases is one of the main reasons for Government of India to initiate various health programs since Independence.

Against this backdrop, the government of India launched the National Rural Health Mission (NRHM) in 2005 to improve rural healthcare service and to secure the health of women and children. The ASHA scheme is a vital component of the NRHM. Most of the workers hail from the particular area where they serve and hence are expected to have a degree of community acceptability. Since the scheme has been in operation for over 12 years and has been continued by the successive governments, the present research has endeavoured to take stock of its working. The researcher chose three representative villages in Warangal district of Telangana state for a more detailed study. It needs to be clarified that it may not be feasible to generalise all the findings for the entire country, because each state and region may be having its unique socio-economic features. However, some of the conclusions can have nation-wide relevance.

For this purpose, the researcher has undertaken the research with the following objectives:

- To understand the changes in the health behaviour of the community members under the influence of ASHA.
- To identify the extent of ASHA participation in curative health programmes.
- To examine how ASHA workers are mobilising the community towards local planning and health services.
- To understand the assigned roles, role performances and role conflicts for the ASHA workers in different social and cultural contexts.
- To study the familial and community support for ASHA workers.

Choice of the Study Area

As already mentioned, three villages (Gopa Thanda, Damarvancha and Golla Charla) from Warangal district of Telangana state were selected for a detailed examination. The choice was a very deliberate one. One of these, Gopa Thanda, is almost fully inhabited by tribals. Damarvancha has a mixed composition of tribals and non-tribals and the third,

Golla Charla is a non- tribal village. The underlying intent was to ascertain whether the class/caste composition of a place could have a bearing on the health-seeking behaviour of the residents and their attitude towards the ASHA workers operating there. After all, such workers can succeed only when the residents allow them to perform their tasks and pay heed to the advice given.

The study was covered in six chapters: These will be briefly outlined in the succeeding paragraphs.

Chapter -1 Introduction. This covered issues like introduction of the research topic, review of literature, problem of the study, research hypothesis, and research questions, statement of the problem, research objectives, research methodology and limitations of the study. Areas explored in some depth included: the concept of community participation (which included the one in the field of health), the initiative of International bodies for community participation in health, Indian initiatives in health, the various committees set up by the central government to make suggestions in the field of health, the National Health Policies (1983, 2002 and 2015), healthcare reforms in India, approach to primary healthcare, the Integrated Child Development Service Scheme, Universal Immunisation Programme, and the concepts of National Rural Health Mission and the Accredited Social Health Activist have been attempted.

Chapter 2 - Profiles of the Study Villages. This chapter presented the profile of the study villages. The areas covered here included: the sex ratio, community composition, occupational status, and educational status and income levels in the study villages. There was also a discussion on the health profile (including that of the earlier 10 districts, which have now been expanded into 31 districts) of the state of Telangana. A comparison was also made of the availability of PHCs in the state vis-à-vis other states of the country. A comprehensive account of the various life cycle rituals of the two main tribal groups, Banjaras and Koyas, residing in the study area was also presented.

This was considered necessary since many health related issues like diet, clothing, care of pregnant women and new born children can be impacted by the culture, tradition and beliefs of the residents of any area. A noticeable feature relating to the gender distribution was that, in none of the three study villages, it was not heavily skewed in favours of

males – a feature quite pronounced in a number of relatively developed regions of the country. As in most rural area, agriculture/that related to agriculture was the most predominant occupation in the study area. Illiteracy emerged as a major area of concern in Gopa Thanda and Damarvancha. Majority of the residents of the study area appeared to be quite content with primary school level of education.

Income levels too did not present a very encouraging picture, since the majority of the respondents in the three study villages were found to have annual incomes below Rs. 30,000.

Chapter 3 - Socio-Demographic Profiles of ASHA Workers and the Process of Selection and Training. This chapter discussed about the process of the recruitment of the ASHA workers, the motivational factors to become an ASHA worker. It also focused on the training aspects, which included the induction training, refresher training and the support mechanisms to the ASHA workers. It also outlines about the ASHA Resource Centre (ARC) and socio-demographic profile of the ASHA, distribution of the ASHA by the community, education, income, age, and experience.

As regards the community distribution of the ASHA workers, even though the reservation policy of the government cannot be strictly applied in this case (since this is not a regular government employment), the largest proportion of these workers in the study area were found to be from the ST community. A possible reason for this could be the high concentration of tribals in this area. Also, many upper caste women may not find this assignment commensurate with their social status. When one considers the age profile of the ASHA workers, the largest two concentrations were noticed in the 25-30 and 20-25 age brackets. Now coming to educational levels of these workers, the largest proportion of the ASHA workers were found to be having SSC level of education.

It has already been mentioned that agriculture is the primary occupation of majority of the residents in the study area. This fact was also substantiated by the primary occupation of the families of the ASHA workers in this area. A related issue was the household income of the families of these workers. It emerged that the two most common

monthly income brackets were Rs. 6,000-10,000 and Rs. 11,000-15,000. Income from the ASHA scheme appeared as a welcome supplement to the family income of these workers.

Most of the ASHA workers were found to be engaged in this line of work for about eight years. A possible reason for their not seeking alternative jobs elsewhere must be the fear of relocating to other places, or commuting daily from their native places. Also, the earnings from this line of work must be supplements to the family income – and not the basic income for the families.

The selection process is required to be in accordance with the guidelines issued by the NRHM. It was found that the Gram Sabha, ANMs and AWWs were important decision makers in this regard. A pertinent issue raised by the 'authorities' was whether the particular candidate would get the support of her family members to take up this job. This is not surprising since the ASHA workers may have to attend to emergency cases even at unusual hours. This leads us to the issue of the persons who had motivated the ASHA workers to adopt this line of work. It emerged that family members and self-motivation were the least common influences. The publicity by the Gram Sabha, ANM and AWW was cited as the strongest factors.

Let us now come to the reasons for becoming ASHA workers. The most common reason mentioned by the respondents in the study area was 'To serve the community', followed by 'source of income'. One also needs to take notice of the response, 'To be a part of the Government'. These points out to the recognition of the need for job security, a steady income, etc. Incidentally, many ASHA workers, across the country, have been agitating that their services should be regularised and they should be paid higher amounts.
It is perhaps in response to such demands that the Government of Telangana recently announced a substantial hike in the amounts being paid to these workers and assured that they would be given priority when filling up the posts of ANM's, etc.

This chapter also briefly touched upon training, including refresher training, being imparted to the ASHA workers. The former one is intended to equip them with the basic

skills required for their tasks. The latter seeks to consolidate and reinforce the skill-sets and knowledge of these workers. There was also a discussion about the roles and functions of the ASHA Resource Centre. A very important part of this chapter was devoted to the extent of support extended by the family members and the local community to the ASHA workers. While some family members were found to be supportive (by even taking up domestic chores in the absence of the respondents), there were some who objected to, say, the ASHA workers going out for work at late hours. The support from the community was found to be generally good. However, some families were found to be clinging to their age-old beliefs and refusing to pay heed to the advice given by the ASHA workers.

Chapter 4 - Roles Assigned Role Performance and Role Conflicts faced by the ASHA Workers in Different Social and Cultural Context: This chapter focused on the roles assigned to the ASHA workers, role performance and role conflicts at the village level. The assigned roles to the ASHA workers are like birth and death registration, ANC, PNC, immunisation, the curative and preventive care, TB eradication, etc. Role conflicts of ASHA from the perspective of the expectation of community, health functionaries, and community members in regard to roles and responsibilities of ASHA were also discussed.

The ASHA workers have been assigned many roles and responsibilities. These include registration of births and deaths, pregnancy confirmation, counseling women on birth preparedness, explaining the importance of safe delivery to the pregnant women and also explaining the need for ANC and PNC checkups. The ASHA workers also play an important role in creating awareness about breast-feeding, complementary feeding, immunization, contraception, prevention of common infection including, Reproductive tract infections and sexually transmitted infections (RTIs/STIs), communicable and non-communicable diseases and care of the young children.

The researcher sought to know whether the ASHA workers are providing information to the community on health determinants such as nutrition, basic sanitation and hygienic practices, safe drinking water, healthy living and working conditions. Researcher also

tried to ascertain level of interaction of the ASHA workers and support they were getting from the ANM, AWW, SHG, VHNSC and Gram Sabha while performing their roles in immunisation, ANC and PNC care, Women health and sanitation, health and hygiene, curative and preventive care, etc. It emerged from the study that the ASHA workers were registering all birth and death cases to a reasonable degree in their areas of work.

ASHA Worker roles in RCH and Curative Health Programmes

It was also a positive sign that these workers were keeping a tab on the pregnant women and ensuring that they were being given the best possible pre- and post-natal care. The ASHA workers playing a vital role in the immunization drive, creating the awareness about the family planning methods like IUD and use of Condoms for spacing between the children. One needs to take cognisance of the role of ASHA workers in promoting family planning in the study area. A very significant finding has been that an increasing number of women are opting for Tubectomy, almost immediately after the delivery. A significantly large number of ASHA workers were accompanying the pregnant women to the hospitals at the time of deliveries. However, with the increasing 'allure' of private hospitals (where the incentive amount for accompanying pregnant women to hospital is not admissible), there has been a fall in such numbers.

It is also pertinent to bring out that these workers have been creating awareness about health, hygiene and nutrition in their community. The most popular forums were found to be Gram Sabha meetings and personal interactions. Posters and pamphlets did not emerge as effective media maybe due to the high level of illiteracy in the study area. The ASHA workers in the study area were also found to be giving a lot of importance to nutritional camps. Equally significant was the fact that most of them were not waiting for the AWWs to inform them about these camps. Another very positive factor in the study area was the relatively high frequency of interaction of these workers with the AWWs.

It should be abundantly clear by now that the ASHA workers are rendering valuable health-related services in the places where they have been deployed. During the field visit, it emerged that the majority of them were being paid less than Rs. 1,000 per month, since the payment is based on factors like number of TT injections administered,

immunisation of infants, and assistance during institutional deliveries and rendering advice on family planning matters. Despite the low level of monetary compensation being paid to them, majority of these workers confirmed that they were enjoying their work. As brought out in Chapter 3, a possible reason for their job satisfaction could be the hope that their services would be regularised in the near future and the incentive amounts would be significantly hiked. A mention has already been made that the Government of Telangana has very recently announced a substantial hike in the payments to these workers and assured that they would be given priority when filling up posts of ANMs, etc.

Chapter 5 -Impact of ASHA: Changes in the Health Behaviors of the Community Members: Comparison of Tribal and Non-Tribal Villages. This chapter specifically focused on the changes of the health behaviour of the community members under the influence of the ASHA workers. This chapter also contained the comparative analysis of the health behavioral change in the tribal and non-tribal areas**.** This chapter focused on the outcome of the ASHA programme under NRHM. It also discussed about the success and failure of the ASHA programme in the tribal and non-tribal areas. A very positive sign was the very high level of awareness of the residents in the study area about the presence of ASHA workers there. Also, such persons were approaching these workers for help and advice on health-related issues. Equally encouraging was the fact that an overwhelming number of respondents mentioned that the ASHA workers were attending to their assigned duties regularly.

However, the health department of the state government should still monitor the instances where the ASHA workers are lax in performing their duties. One of the normal duties of the ASHA workers is to dispense medicines for various types of seasonal and other ailments. It did not come as a big surprise that diahorrea was a common complaint in all the three villages studied. A possible reason for the prevalence of this complaint could be the consumption of unhealthy food and unsafe drinking water. The researcher also sought to explore the health-seeking behaviour of the residents of the study area. Particular stress was laid on the impact of ASHA workers in inculcating healthy habits in their areas of work. A very significant component of good healthcare is the preventative

aspect, of which immunisation is of utmost importance. The ASHA workers in all the three study areas deserve to be commended since they have been able to mobilise the local community to utilise the various immunisation facilities from the nearest medical centre.

Whether the Residents have been seeking Health Information

Many diseases can be prevented by adopting measures like immunisation, consuming a healthy diet, maintaining a clean environment and avoiding addictions to substances like tobacco, liquor and drugs. Some others can be fully cured, if detected early and proper treatment is given. However, in areas where poverty and illiteracy are rampant, it is possible that deteriorations in health are either ignored, or regarded as 'Acts of God'. Due to ignorance about the free medical facilities now available, many persons may not be availing of these.

The next issue examined by the researcher was regarding the health information being sought by the residents of the study area. It made for rather unhappy reading that as high as 31.0% of the respondents said that they were not seeking such information. An even more alarming situation was found with regard to going in for regular health check-ups, where as high as 45.7% of the overall respondents replied in the negative. *The concerned health functionaries in such areas should put in sustained efforts to ensure that all the residents seeking health-related information of consequence to them.*

Promotive Heath Behaviour

The concerned individual can be the primary player in promoting good health. Activities like proper exercise and taking proper rest and avoidance of addictive substances can significantly improve one's health. Majority of the respondents in the study area mentioned 'exercise' as the primary means for this. However, considering the milieu in the study area, one can only surmise that this must be due to the hard work that the respondents have to put in daily to earn their livelihood. A very positive sign was that a very significant proportion of the respondents mentioned that they were avoiding alcohol to protect their health.

Role of ASHA workers in Promotive Healthy Habits in the Community

It emerged during the field study that the ASHA workers in the study area were performing both communicative and educative roles on this issue. They were also spreading awareness on aspects like the ill effects of substances like tobacco and alcohol. Other issues on which they were trying to mobilise the community have been: the need to have domestic toilets, paying attention to clean washing/bathing habits, boiling water before use, the importance of using mosquito nets, consumption of nutritional diet, etc. It was also brought out during the study that, in most instances, it was the ASHA workers who were being initially approached for help and guidance whenever a medical condition arose in the community. Possible reasons for such a choice are:

(a) Their ready availability almost round the clock, since, in most cases, they reside in the same village

(b) The ethno-medical and other health practitioners in the vicinity must be having fixed consultation hours and may not be available when the medical emergency arises,

(c) Relatives, neighbours, friends, etc., may not be in a position to handle medical emergencies.

Major Findings

- The ASHA workers have gained a high degree of acceptability in the study area. An increasing number of residents are seeking their help and guidance regarding their health problems,
- These workers have been rendering valuable service as motivators and facilitators for adoption of good sanitary practices and in the various immunisation drives and health camps,
- The ASHA worker playing a vital role in the aspects of Reproductive and Child Health care (RCH) and ASHA workers role in the Preventive and Curative health care programs such as Immunisation, Malaria, TB and Leprosy Eradication.
- The incentive amounts being paid to these workers have been serving as good supplements to the overall family incomes of these workers. Even though some workers did express dissatisfaction over the low amounts being paid to them, they did mention that they were continuing in this line of work since they felt proud to serve

the community. It is hoped that the recent hike in incentive amounts for these workers (announced by the government of Telangana) would significantly minimise the grievances of the ASHA workers on this issue,

- Majority of the respondents confirmed that their family members were supportive towards them.
- Some of the upper caste households in the study area appear to be reluctant to pay heed to the health related advice given by the 'lower caste' ASHA workers. The reason for not heeding advice given by the ASHA worker could be due to the high level of educational status and may have the family doctors, who could give the medical advice, when they approach to him/her. Another reason could be that it is emerged from the study that since the ASHA worker belong to the lower caste community like SC, ST, OBC communities. It may be due to caste superiority the upper caste may feel that getting advice from the ASHA worker is degrading their status. Hence, in this concerted efforts need to be made by the concerned social welfare department functionaries to dispel such unfounded prejudices.

Suggestions

- The concern state governments must permanent all the ASHA workers immediately and ensure them to provide monthly salary of 10,000 Rupees.
- The NRHM guidelines did not mention how the Village Health Planning should be carried out in the villages. The Ministry of Health and Family Welfare must focus on this issue, should be come up with proper guidelines.
- The ASHA worker service should restrict to the concern village health development only. The ASHA worker service shall not be diverted for other governmental work like census survey, election duty, plantation programs etc.
- The health department authorities should substantially empower the ASHA workers so that their contributions towards improving the health of the village community receive greater recognition and support, the family members of the ASHA workers should be urged to be even more supportive towards them.

- The village level functionaries should take greater initiative in measures like construction of domestic toilets and not leave the task almost entirely to the ASHA workers.

Suggestions for Further Research

Due limitations like that of time, financial resources and the restrictive scope of the study, the researcher could examine only a few issues during his research study. The following areas could be taken up for detailed examination for future researchers

- A comparative analysis of the functioning of the ASHA scheme in a couple of districts of the state.
- Comparison of the outcomes of this scheme in Telangana with those of the neighbouring states and states like Maharashtra, Tamil Nadu, Bihar, Uttar Pradesh, Madhya Pradesh, Jharkhand and Chhattisgarh.
- A comparative analysis of the concept of barefoot doctors in countries like China and India's ASHA scheme.

References

Alma –Ata. (1978). *Primary health care, report of the international conference on primary health care Alma-Ata, USSR, 6-12 September 1978.* Retrieved from http://www.who.int/publications/almaata_declaration_en.pdf

Anthony, Klouda. (1993). Prevention is still more costly than cure." in Rhode et al, r*eaching health for all*. New Delhi: Oxford University Press.

Barreto, Lenita, Lorena Claro, Helia Kawa, Luciana Tricai Cavalini, and Maria Luzia Garcica Rosa. (2006). Community participation dengue control in Brazil. *Dengue Bulletin,* 30, 214-222.

Bhuiy Abbas Yasmin Fathima, Begam Farida, Rob Ubaidur.(1996). *Community participation in health, family planning and development activities a review of international experiences.* Retrieved from http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.507.7035&rep=rep1&type=pdf

Chatterjee, M. (1993). Health for Too Many: India's Experiments with Truth. *In Rhode, J.Chatterjee, M./ Morley, D. (Ed.), Reaching health for all* (PP.342-377). Delhi: Oxford Publications.

Community Participation. (n.d). *Community participation in relation to the success of health and well-being programme*. Retrieved from http://www.hsmdghs-bd.org/community_participation.htm

Das, S. (2012). ASHA-the lady health activists and health status of rural women –A case study of Karimganj district. *Journal of Humanities & Social Science*, 1(1), 57-67.

Declaration of Alma-Ata. (1978). *Alma Ma-Ata, USSE: International conference on primary health c*are. Retrieved from http://www.who.int/publications/almaata_declaration_en.pdf

Delanty, G. (2003). *Community*. London: Rutledge Publication.

Duggal, R. (2000). *The private health sector in India. nature, trends and a critique*. New Delhi: Health Association of India.

Hadly. M and Maher. D. (2000). Community involvement in tuberculosis control: Lessons from other healthcare programmes. *International Journal of Tuberculosis and Lung Disease,* 4(5), 401-408.

The Hindu (2017, June 15). Health ailments highest among chronic diseases in Telangana (Blog post). Retrieved from http://www.thehindu.com/news/national/telangana/heart-ailments-highest-among-chronic-diseases-in-telangana/article6876813.ece

IFPS Technical Project. (2012). *Community-based workers improving health outcomes in Uttarakhand*, India", IFPS Technical Assistance Project, USAID. http://pdf.usaid.gov/pdf_docs/pnadz558.pdf

Joshi, S. R. and George, M. (2012). Health care through community participation. *Economic & Political Weekly*, 47 (10), 70-76.

Kasl, S. V., & Cobb, S. (1966). Health behavior, illness behavior and sick role behavior. *Archives of Environmental Health*, 12(2), 246-266.

Kironde. (2002). Community participation in primary health care (PHC) programmes: lessons from tuberculosis treatment delivery in South Africa. *African Health Science,* 2(1), 16-23. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/12789110

Kishore, J. (2002). *National health programmes of India* (4th Edition). New Delhi: National Policies and Legislation Related to Health.

Kranthi S. Vore, Dileep V.Mavalankar, Ramani K.V, Mudita Upadhyaya, Bharati Sharma, Sharad Iyengar, Vikram Gupata, and Kirti Iyengar. (2009). Maternal health situation in India: A case study. *Journal of Health Population Nutrition,* 27(2), 184-201.

Kumar, R. (2008). *Challenges of health care in India economics and administration*. New Delhi: Deep and Deep Publication.

Majundar, D. N. & Madan, T.N. (2012). *An introduction to social anthropology.* Delhi: Mayur Publications.

Mane, A B, & Khandekar, S. V. (2014). Strengthening primary health care through ASHA workers: A novel approach in India. *Primary Health Care: Open Access*, 4 (1), 1-3.

Murthy, A.S.N. (1991). *Religion and society a study of koyas*. New Delhi: New Delhi Discovery Publishing.

Naik, Cheeniya, B. (1998). *Banjara Charitra (Samskruti-Pragathi)*. Anatpur, Andhra Pradesh: Hathiram Bavaji Publications.

Nathan and Lloyd. (2004). Community participation in environmental management for dengue vector control: Experience from the english speaking caribbean. *Dengue Bulletin*, l 28, 13-16.

National Health Mission. (2017). *Categories: ministry of health and family welfare.* Retrieved from http://nhm.gov.in/nrhm-instate/state-wise-information.html

Oakley and Marsden. (1984). *Approaches to Participation in rural development*. Published Geneva: International Labour Office.

Olanike F Deji .(2011). *Gender and rural development*. Berlin: Alexander Von Humboldt Foundation.

One-five-nice, Dornakal Mandal. (n.d). Retrieved from http://www.onefivenine.com/india/villag/Warangal/Dornakal

One-five-nine, Gudur Mandal. (n.d). Retrieved from http://www.onefivenine.com/india/villag/Warangal/Gudur

One-five-nine, Kuravi Mandal. (n.d). Retrieved from http://www.onefivenine.com/india/villages/Warangal/Kuravi/Kuravi

Philippe, Dongier, Julie Van Domelen, Elinor Ostrom, Andrea Rizvi, Wendy Wakeman, Anthony Bebbington, Sabina Alkire, Talib Esmail, and Margaret Polski (2003). *Community driven development: Core techniques and cross-cutting issues*. Retrieved from http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.532.8799&rep=rep1&type=pdf

Prasad D.V. (2007). *Natural resource management: A study of livelihood system among the koyas of andhra pradesh*. Hyderabad: University of Hyderabad (Unpublished Thesis).

Preston Roby, Hilary Wagh, Sarah Larkins and Judy Tylor.(2010). Community participation in rural primary health care: Intervention or approach. *Australian Journal of Primary health,* 16 (1), 4-16.

Ramaiah, P. (1981). *Tribal economy of India a case study of koyas of andhra pradesh*. New Delhi: New Delhi Light and Life Publisher.

Rambabu, Mallavarapu. (2000). *Ethonomedicinal practices of the koyas of bhadrachalam a case of bodduguidam village*. Hyderabad: University of Hyderabad (Unpublished).

Ranga Rao, S.P. (1993). *Administration of primary health centers in india: A Study from the three southern states*. New Delhi: Mittal Publications.

Rifkin SB, Hewitt G & Draper A.K. (2007). *Community participation in nutrition programs for child survival and anemia.* Retrieved from https://www.spring-nutrition.org/sites/default/files/a2z_materials/community_participation_review_october_1_09.pdf

Rojas, Botero, Garcia. (2001). An integrated malaria control program with community participation on the pacific coast of colombia. *Cadernos De Saude Publica,* 17 (103), 81.

Roy, Shree & Biswamita Sahu. (2013). Can ASHA be the ray of hope for providing MCH services in Odisha, India? Exploring through a qualitative study. *Journal of Global Health Care Systems*, 3(2), 1-14.

Shaeffer, Sheldon. (Ed.). (1994). *Partnerships and participation in basic education: A series of training modules and case study abstracts for educational planners and managers*. Paris UNSCEO: International Institute for Educational Planning.

Sharma, B.V. (2002). *Community contribution to tuberculosis care: An asian perspective.* Retrieved from http://apps.who.int/iris/bitstream/10665/67594/1/WHO_CDS_TB_2002.302.pdf

Sharma V.P. (1993). *Community participation in malaria control*. New Delhi, Indian Council of Medical Research.

Shoba S. Kowli, Vijaya R. Bhalerao, Asha S. Jagtap &Rajesh Shrivastav. (1990). Community participation boosts immunization coverage. *World Health Forum*, 11, 169-172.

Shukla, Amit & Bhatnagar Tarun .(2012). Accredited social health activists and pregnancy related services in uttarakhand, India. *BMC proceedings,* 6 (suppl 1), 1-2.

Singh, MK, Singh JV, Kumari R, Ahmad, N and Khanna, A. (2012). Utilization of ASHA services under NRHM in relation to maternal health in rural Lucknow, India. *South East Asia Journal of Public Health*, 2 (1), 24-27.

Sule S.S. (2005). Community participation in health and development. *Nigerian Journal of Medicine,* 14 (4), 460.

Telangana State Portal. (n.d). Retrieved from http://www.telangana.gov.in/about/state-profile

Susan B. Rifkin. (1986). *Health planning and community participation: Case studies in south east asia*. London: Croom Helm.

UNICEF India. (n.d). Why birth rate is important? Retrieved from http://unicef.in/Story/365/Why-is-birth-registration-important

United Nations. (1992). *Rio: United nations conference on environment & development.* Retrieved from https://sustainabledevelopment.un.org/content/documents/Agenda21.pdf

United Nations. (1993). *Sustainable development: United nations conference on environment & development Rio de Janerio*, *Brazil*. Retrieved from https://sustainabledevelopment.un.org/content/documents/Agenda21.pdf

United Nations. (2004). *Economic and social council: Economic and social commission for western asia (ESCW).* Retrieved from shttps://www.unescwa.org/sites/www.unescwa.org/files/publications/files/sdd-06-tp-3-e.pdf

Vishnu/ Sudarshan, H. (2003). Public sector- voluntary organization partnership for primary healthcare services. *Health for the Millions*, 30(4 & 5), 52-57.

Welschhoff Anja. (2006). *Community participation and primary health care in India*. Retrieved from https://pdfs.semanticscholar.org/931f/510e0b534e8fbe1bc94f8a6b1a247f2bfe17.pdf

World Health Organization. (1986). *Europe*: O*ttawa charter for health promotion.* Retrieved from http://www.euro.who.int/__data/assets/pdf_file/0004/129532/Ottawa_Charter.pdf

World Health Organization. (1997). The world health report 1997 conquering, suffering, enriching the humanity. Retrieved from http://www.who.int/whr/1997/en/

ANNEXURE - I

Household Census Schedule on

Community Participation in a Primary Health Care: The Case of ASHA Workers in Telangana State

DEPARTMENT OF ANTHROPOLOGY
UNIVERSITY OF HYDERABAD

1. Name of the Head of the Household: _____
2. Name of the village: _____
3. Household No: _____
4. Mandal: _____
5. District: _____

6. (A) Family Particulars:

S.No	Relation with Head of House Hold	Age	Sex	Marital Status	Profession Occupation	Education	Approximate Annual Income

B) **Perception of the Community Members Regarding the ASHA Workers in the Study Area**

7. Does the ASHA worker present in your village: 1: Yes ☐ 2: No ☐

8. If yes, can you please give her name: ----------

9. Household visits by the ASHA workers from the last three months

   1) Once ☐ 2) Twice ☐ 3) Thrice ☐ 4) More than Thrice ☐

10. Medical aid provided by the ASHA workers ----------
    ----

11. Minor diseases generally treated by ASHA workers

    1) Fever ☐ 2) Cough/Sneezing ☐ 3) Diarrhoea ☐ 4) Head Ache ☐ 5) Body Pain ☐ 6) All of the above ☐

C) **Health Seeking Behaviour**

12. Do you have the awareness about the immunization? 1: Yes ☐ 2: No ☐

13. Person who created the awareness about the immunization?

    1) ASHA worker ☐ 2) Ethno-medical/Other Health Providers ☐

    3) Others ☐

14. Are you contacting for health information? 1: Yes ☐ 2: No ☐

15. Whom you are contacting for health information?

    1) ASHA worker 2) ethno-medical/other health providers 3) others

16. Are you visiting for health check-up regularly? 1: Yes ☐ 2: No ☐

17. The person being approached for medical check-up regularly?

    1) ASHA worker ☐ 2) Ethno-medical/Other Health Providers ☐

    3) Others ☐

18. Are you promoting your health status? 1: Yes ☐ 2: No ☐

19. If yes, means being adopted for promoting one's health?

    1) Exercise ☐ 2) Taking proper rest ☐ 3) Avoiding alcohol ☐

4) All the above ☐

20. The person who provided health promotive information?

1) ASHA worker ☐ 2) Ethno-Medical/Other Health Providers ☐ 3) Others ☐ 4) Self-Motivated ☐

Hygiene Behavioural Changes

21. Do you have the toilet facilities in your house? 1: Yes ☐ 2: No ☐

22. The person who created awareness about the domestic toilet?

1) ASHA worker ☐ 2) Ethno-Medical/Other Health Providers ☐ 3) Others ☐ 4) Self-Motivated ☐

23. Do you have the washing / bathing habits regularly? 1: Yes ☐ 2: No ☐

24. The person who inculcated such a health culture?

1) ASHA worker ☐ 2) Ethno-Medical/Other Health Providers ☐ 3) Others ☐ 4) Self-Motivated ☐

25. Are you boiling the drinking water? 1: Yes ☐ 2: No ☐

26. The person who created the awareness about the importance of using boiling water?

1) ASHA worker ☐ 2) Ethno-Medical/Other Health Providers ☐ 3) Others ☐ 4) Self-Motivated ☐

27. Are you using the mosquito nets? 1: Yes ☐ 2: No ☐

28. The person who created the awareness about the importance of using the mosquito nets?

1) ASHA worker ☐ 2) Ethno-Medical/Other Health Providers ☐ 3) Others ☐ 4) Self-Motivated ☐

Menstrual Behaviour

29. The female respondents had awareness on menstrual hygiene 1: Yes ☐ 2: No ☐

30. The person who spread awareness about menstrual behaviour?

1) ASHA worker ☐ 2) Ethno-Medical/Other Health Providers ☐ 3) Others ☐ 4) Self-Motivated ☐

Nutritional Communication

31. Do you have the importance of nutrition? 1: Yes ☐ 2: No ☐

32. The person who provided the nutritional awareness?

1) ASHA worker ☐ 2) Ethno-Medical/Other Health Providers ☐ 3) others ☐

Illness Behaviour

B) Morbidity and Mortality: if any**,** please give details of illness suffered by the members of the family during the last three months (if the same member had fallen ill more than once, the details may be provided for each time of illness)

Morbidity

33. Did members of your household suffer from any illness during the last three months:

1: Yes 2: No

34. If yes, please give details of members who suffer an illness

S.No	Relation with Head of House hold	Age	Sex	Duration suffered	Nature of Disease	Source of treatment	
						First contact	Subsequent contact(s)

(b) Mortality

35. Has anyone died in the family during the last one year? 1: Yes☐ 2: No☐

36.If yes, give details:

S.No	Relation with House Hold	Age	Sex	Cause attributed to death

Health Service Provider Contacted

37. Whom you're contacting at the time of illness?

1) ASHA worker☐ 2) ethno-medical/other health providers☐ 3) others☐

38.Are you adhered to the treatment? 1: Yes☐ 2: No☐

39.The person who motivated for adherence to the treatment?

1) ASHA worker ☐ 2) Ethno-Medical/Other Health Providers☐ 3) Others☐

Role performance of the ASHA worker

40.Do you register the birth registration? 1: Yes☐ 2: No☐

41. No of birth registration by the ASHA worker from the last one year

1) 1-5☐ 2) 6-10☐ 3) 11-15☐ 4) more than 15 ☐

42.Do you register the death registration? 1: Yes 2: No

43. No of death registration by the ASHA worker from the last one year

1) 1-2☐ 2) 3-4☐ 3) 5-6 ☐ 4) more than 6☐ 5) no deaths ☐

ASHA role in reproductive and child health

44.Do you register the pregnancy registration? 1: Yes ☐ 2: No☐

45.Pregnancy registration from the last one year.

1) 1-5☐ 2) 6-10☐ 3) 11-15 ☐ 4) More than 15 ☐

46.Do you administer the TT injection from the last one year?

47.The no of pregnant women administered TT injection?

1) 1-5☐ 2) 6-10☐ 3) 11-15 ☐ 4) More than 15 ☐

48. The no of ANC visits by ASHA worker from the last one year?

1) 1-5☐ 2) 6-10☐ 3) 11-15 ☐ 4) 16-20 ☐ 5) More than 20 ☐

49. Do you accompany the pregnant woman to the hospital from the last one year?1: Yes ☐ 2: No☐

50. The no of cases in which ASHA worker accompanied to the hospital

1) 1-2☐ 2) 3-4☐ 3) 5-6 ☐ 4) 7-8 ☐ 5) 9-10 ☐ 6) All Attended☐

51. Do you present at the time of delivery of the pregnant woman from the last one year? 1: Yes☐ 2: No☐

52. The presence of ASHA worker at the time of delivery?

1-2 ☐ 2) 3-4 ☐ 3) 5-6 ☐ 4) 7-8 ☐ 5) 9-10 ☐ 6) All Attended☐

53. The no of PNC visits by the ASHA workers

1) 1-5☐ 2) 6-10☐ 3) 11-15☐ 4) 16-20 ☐ 5) More than 20☐

54. Are you promoting the family planning? 1: Yes ☐ 2: No☐

55. The methods advised by the ASHA worker for family planning?

1) Vasectomy☐ 2) Teubectomy☐ 3) Condoms☐ 4) Contraceptive Pills ☐ 5) IUD☐

56. Do you promote the health, hygiene and nutritional awareness 1: Yes☐ 2: No ☐

57. The means adopted by the ASHA worker for promoting the health, hygiene and nutritional awareness.

1) Personal Interaction ☐ 2) Group Discussion☐ 3) Gram Sabha Gathering ☐ 4) Posters ☐ 5) Pamphlets ☐ 6) All of the above☐

58. Do you participate in AWW in nutrition camps?1: Yes ☐ 2: No☐

59. ASHA worker participation in nutrition camp?

1) Regularly ☐ 2) Often ☐ 3) When AWW informs ☐

60.The no of interaction with the AWW?

1) Weekly once ☐ 2) Weekly twice ☐ 3) More than twice ☐

61.Do you create the awareness about the hand wash after going toilet?

1: Yes ☐ 2: No ☐

62. The means used for creating awareness about hand wash after going toilet?

1) Personal interaction ☐ 2) Group discussion ☐ 3) Gram Sabha gathering ☐ 4) All of the above ☐

63.Population size served by the ASHA worker?

1) 100-200 ☐ 2) 201-300 ☐ 3) 301-400 ☐ 4) 401-500 ☐ 5) 500 above ☐

64. The no of working hours put by the ASHA worker per a day?

1) 1hrs ☐ 2) 2 hrs ☐ 3) 3 hrs ☐ 4) 4 hrs ☐ 5) 5 hrs ☐ 6) More than 5 hrs ☐

65.Remuneration of the ASHA worker per month?

1) 100-500 ☐ 2) 501-1000 ☐ 3) 1001-1500 ☐ 4) More than 1500 ☐

66.Do you mobilise the community member for curative health programmes?

1: Yes ☐ 2: No ☐

67.The means employed by the ASHA worker for curative health programmes?

1) Personal interaction ☐ 2) Group discussion ☐ 3) Gram Sabha gathering ☐ 4) Posters ☐ 5) All of the above ☐

68.The reason for more institutional deliveries because of?

1) Due to ASHA worker ☐ 2) PHCs are functioning well ☐

3) Government campaigns ☐ 4) All of these ☐

69.Do you participate in village health planning?

1: Yes ☐ 2: No ☐

1) What mode of communication they are following:

2) Personnel ☐ 2.Posters ☐ 3. Pamphlets ☐ 4. Public Address 5. Others ☐

3) Which type of medicine you prefer to have while you suffer any illness?

1. Local medicine ☐ 2. Allopathic medicine ☐

Additional information by ASHA worker

Illness	**Nature of information provided**
Polio	
Measles	
Malaria	
Dengue	
Filaria	
Diarrhoea	
Tuberculosis (TB)	
Leprosy	
Typhoid	
STI	
HIV	
AIDS	
Gannerhia	
Syphilis	
Cough/sneezing	
Any other	

ANNEXURE – II

SCHEDULE

Socio- Demographic Profile of the ASHA workers: No: _____

1. Name: _____
2. Age: _____Sex:_____
3. PHC you are working with:_____
4. Name of the village your are currently posted as ASHA worker:_____
5. Caste\Tribe?
    a. ST
    b. SC
    c. OBC
    d. OC
    e. Minority
6. Educational Qualification?
    a. Primary
    b. Higher
    c. SSC
    d. Intermediate
    e. Degree
    f. PG
7. Date and Year of Joining as ASHA worker:?
    a. 2006
    b. 2007
    c. 2008
    d. 2009
    e. 2010
    f. 2011
    g. 2012
    h. 2013
    i. 2014

8. Experience as ASHA worker?
    a. One year
    b. Two year
    c. Three year
    d. Fourth year
    e. Fifth year
    f. Sixth year
    g. Seventh year
    h. Eighth year

9. Earlier work experience?
    a. Yes
    b. No
    c. If Yes

    _____
    _____

10. Place of Residence?
    a. Same village
    b. Neighbouring village

    If not in the same village, reasons for staying in the other village: _____

11. Details of Family Members:

Sl. No.	Name of the members of the house hold	Age	Educational Qualification	Occupation	Annual Income	Marital Status

12. Process of Selection and Training:_____
    _____
    _____
    _____
    _____

13. Response or support from the family members to continue as an ASHA worker:

_____
_____
_____

14. What are the problems you face from the Government side:_____

_____
_____
_____

15. What problems you face from the PHC where you work:-

_____
_____
_____

16. What are the challenges involved in your job in the family level (children's education, Husband or wife working in other place, elders to take care of, family members are not happy that you are working, relatives or neighbors' response because of you are an ASHA worker)

_____
_____
_____
_____

17. What is the response of community which you work while discharging your duties:_____

_____
_____
_____

18. Are you treating everybody in the community as equals (especially in the Non- Tribal area) :

_____
_____
_____
_____

19. What are your needs and demands from the Government side to perform your duties better as a ASHA worker:

_____
_____
_____

_____
_____

20. Why you decided to join as an ASHA worker:
_____
_____
_____

21. Are you satisfied with the job : YES / NO

22. If Yes
Why?_____
_____
_____

23. If No
Why?_____
_____
_____

24. Are you Planning to quit the job if you get another opportunity to work somewhere else in other field: YES/ NO

25. IF yes? Why:
_____
_____
_____

26. What is your suggestion in making this ASHA Program more effective and useful for the people:
_____
_____
_____
_____

27. Do you consider staying without any work is better than being an ASHA worker:_____
_____
_____

28. How much money you are getting as an ASHA worker (if you feel like informant is not okay with your question avoid this

question):_____
_____

29. What challenges do you face from the community members-
:_____
_____
_____

Community Participation in Primary Healthcare: A Study of ASHA Workers in Warangal District, Telangana State

ORIGINALITY REPORT

15%	14%	4%	5%
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

PRIMARY SOURCES

1	edoc.ub.uni-muenchen.de Internet Source	3%
2	en.wikipedia.org Internet Source	1%
3	indikosh.com Internet Source	<1%
4	www.mohfw.nic.in Internet Source	<1%
5	www.warangalrural.telangana.gov.in Internet Source	<1%
6	shodhganga.inflibnet.ac.in Internet Source	<1%
7	www.managementparadise.com Internet Source	<1%
8	www.ncbi.nlm.nih.gov Internet Source	<1%
9	mohfw.nic.in	