# CHAPTER -7

# BENEFICIARIES DEALT AND APPROACHES ADOPTED

# Chapter 7

# Beneficiaries dealt and approaches adopted

**Beneficiaries dealt by ASHA workers**

Poor families residing in the rural areas especially women and children of below poverty line who find it difficult to access health services are the beneficiaries of NRHM. ASHA workers render their services to them and mobilize their community to avail existing health care services. Household or beneficiaries is the most important component for all demographic profile and socio economic surveys. To study socio-economic profile of beneficiaries, socio-economic status scale developed by Pareekh and Trivedi 1964 is used with slight modification. Scores have been assigned against the responses. The analysis is based on a sample study of 2800 households to whom selected ASHA workers of this study provided health care services in three districts of Assam. 560 beneficiaries are from Sonitpur district, 1,240 from Nagaon district and 800 beneficiaries from Sivsagar district. Therefore total numbers of households are 2800. Socio economic profile of respondents are studied with the following variables- educational level, family occupation, family type, family size, social category, organizational membership, land holding, type of house, and material procession. Personal characteristics of the respondents are studied with the following variables i.e. age, marital status and family income.

**7.1 Profile of the Respondents:**

**7.1.1 Age:** The findings presented in the table 7.1 indicated that majority of respondents (73%) belongs to 15-25 years followed by 22% in age group of 26-35. The remaining 5% of the respondents belongs to 36- 45 years age group category.

**7.1.2 Marital status:** A large percentage of respondents (95.7%) are married whereas 3% are widow and negligible percentage (1.3%) belongs to separated / divorced category.

**Table 7.1, Distribution of respondents according to their age and marital status**

| Sl.no. | characteristic | category | Frequency (f) | Percentage (%) |
|---|---|---|---|---|
| 1. | Age | 16-25 | 2044 | 73 |
| | | 26-35 | 616 | 22 |
| | | 36-45 | 140 | 5 |
| 2. | Marital status | Married | 26780 | 95.7 |
| | | Widow | 84 | 3 |
| | | Divorce/ separated | 36 | 1.3 |

**7.1.3 Family income:** The highest percentages (47%) of the respondents are from middle income group followed by 35 percent and only 12 percent respondents from low and high income group respectively.

**Table 7.2, Distribution of respondents according to their family income N=2800**

| Sl. No. | category | frequency | percent |
|---|---|---|---|
| 1. | Below Rs.15,0000 | 980 | 35 |
| 2. | Rs. 15001- 45000 | 1316 | 47 |
| 3. | Above Rs. 45000 | 336 | 12 |

**7.1.4 Educational qualification:** A very less percentage (3%) of respondents is identified as illiterate while (37%) and (28%) of respondents have formal education from primary to middle school level and (16%) from high school and (6%) up to graduate level respectively (fig 7.1) it is observed from the data that majority of beneficiaries (87%) are having formal education and they are capable of acquiring technical information easily.

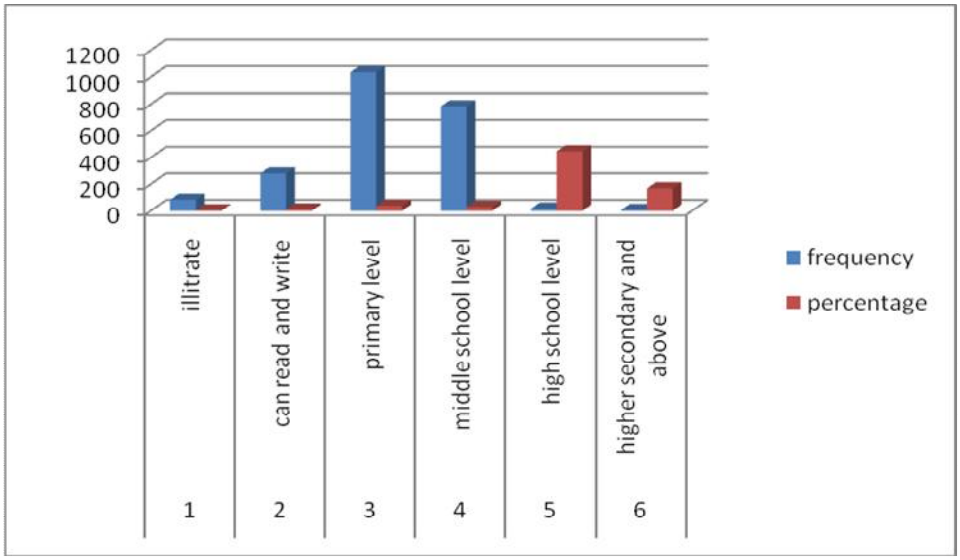


**Fig 7.1, Distribution of respondent according to their educational qualification**

**7.1.5 Family type:** The findings of the table7.3 shows that majority (87%) of the respondents belongs to nuclear family where as only 13% are from joint family. It indicates that people in the rural areas also preferred nuclear family over joint family.

**Table 7.3, Distribution of respondent according to their family structure**

| Sl.no. | characteristic | category | Frequency (f) | Percentage (%) |
|---|---|---|---|---|
| 1 | Family type | Nuclear<br>Joint | 2436<br>364 | 87<br>13 |
| 2. | Family size | Small (upto 4 member)<br>Medium (5-8 member)<br>Large (more than 8 member) | 13344<br>1092<br>364 | 47<br>39<br>14 |

**7.1.6 Family size:** As shown in the table 7.3 majority of the rural beneficiaries 47% belonged to small family followed by 39% and 14% from medium and large family respectively. It is perceived that the beneficiaries are aware about importance of small family and go for family planning.

**7.1.7 Type of house:** It has been observed from the table 7.4 that highest percentages of respondents 57.5% have mixed type of house followed by 23.3% having kuttcha house and 19.2% of respondents have pucca type of house respectively.

**Table 7.4, Distribution of respondent according to their type of house**

| Sl. No. | type of house | frequency (f) | Percentage (%) |
|---|---|---|---|
| 1. | Kutcha | 652 | 23.3 |
| 2. | Semi pucca | 1610 | 57.5 |
| **3.** | Pucca | 538 | 19.2 |

**7.1.8 Social category:** Findings of the fig 7.2 shows that majority of the respondents (46.8%) are from OBC/ MOBC category followed by 32.2% and 12.5% in SC/ ST/ Tea Tribes and general category respectively.

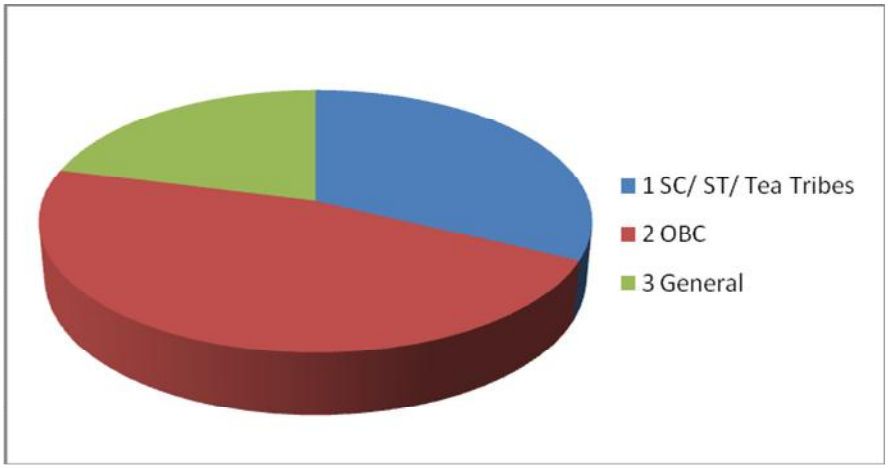


**Fig 7.2, Distribution of respondents according to their social category**

**7.1.9 Land holding:** The distribution of respondents according to the size of landholding is presented in table 7.5. It has been found that, majority of the respondents (42.7%) have small size land holding followed by 32.2% of respondents who have no land holding or less than 1 bighas of land. 10.1% have marginal land holding and only 15% have more than 10 bighas of land.

**Table 7.5 distribution of respondents according to their land holding**

| Characteristics | Category | Frequency (f) | Percentage (%) |
|---|---|---|---|
| Landholding | Landless ( <1 bigha) | 902 | 32.2 |
| | Marginal (2-4 bigha) | 283 | 10.1 |
| | Small (5-7 bigha) | 1195 | 42.7 |
| | large (> 10 bigha) | 420 | 15 |

### 7.1.10 Organizational membership

The majority of the respondents (47%) have their membership in one organization. 17% have membership in more than one organization. 35% have no membership in any organization. Only 1% respondents are in the position of office bearer in organization like mother NGO.

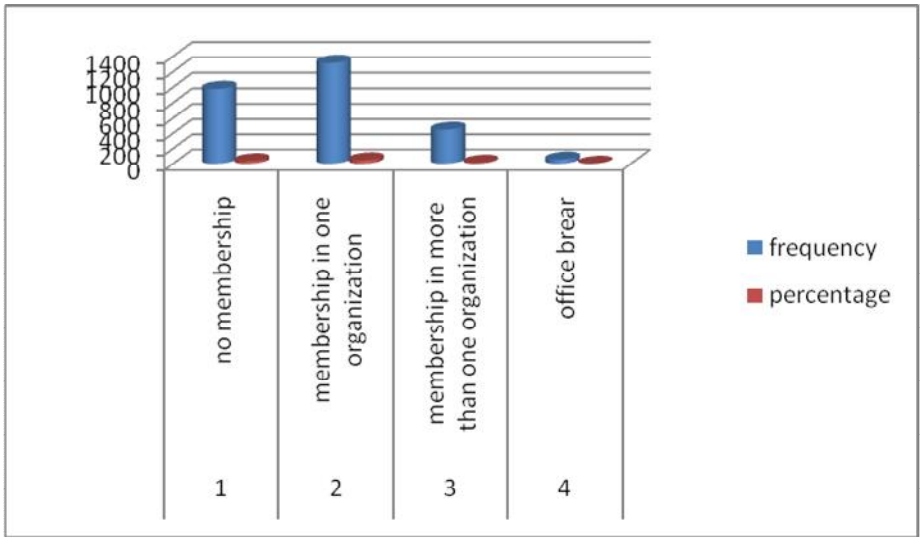


**Fig 7.3, Distribution of respondents according to their organizational membership**

**7.1.11 Occupation:** Majority of the respondents 34.6% are engaged in farming followed by 32% respondents are daily waged labor, 21.2 % are engaged in business, and small percentage of respondents i.e. 7% and 5.2% are from artisan and service respectively.

**Table 7.6, Distribution of respondents according to their main occupation of the family.**

| Characteristics | category | frequency | percentage |
|---|---|---|---|
| Occupation | laborer | 896 | 32 |
| | Artisan | 196 | 7 |
| | Business | 594 | 21.2 |
| | Agriculture | 968.8 | 34.6 |
| | Service | 145 | 5.2 |

**7.1.12 Material possession:** Majority of the respondents (63.5%) possess all the assets listed below in the table 7.7

**Table 7.7, Distribution of respondent according to their material possession N= 2800**

| Sl. no. | variables | yes | | No | |
|---|---|---|---|---|---|
| | | frequency | percentage | frequency | percentage |
| 1. | Television | 1610 | 57.5 | 1190 | 42.5 |
| 2. | Gas stove | 1772.4 | 63.3 | 1055.6 | 37.7 |
| 3. | Mobile phone | 2016 | 72 | 784 | 28 |
| 4. | bicycle | 708.8 | 88.6 | 599.2 | 21.4 |
| 5. | Motor cycle/ Scooter | 1629.6 | 58.2 | 1170.4 | 41.8 |
| 6. | Sanitary latrine | 1489.6 | 53.2 | 374.4 | 46.8 |
| 7. | electricity | 2044 | 73 | 756 | 27 |
| 8. | Modern household furniture | 1190 | 42.5 | 1610 | 57.5 |

**7.1.13 Socio economic status (SES):** The average SES score of beneficiaries is 15.24, which indicated that beneficiaries belong to lower middle class group. Findings of percentage

distribution reveal that majority of the respondents (42%) belongs to lower middle class, 27% belongs to lower class where as 22.4% are from middle class and remaining 18.6% belongs to upper middle class.

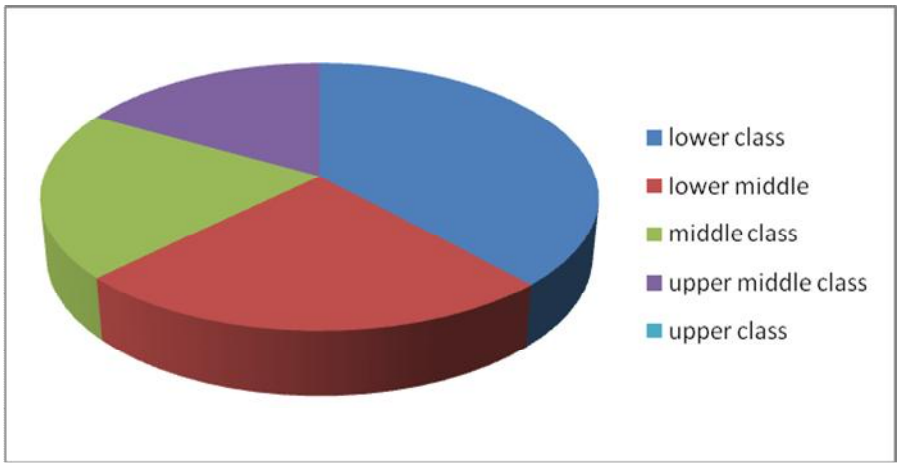


**Fig. 7.4, Socio economic status of beneficiaries**

People living in the remote villages are generally not aware about the health workers, health facilities and other related aspects. Due to their lack of awareness they mostly could not avail the required treatment even at the time of emergency. As a result, people die without treatment. The initiation of ASHA in the health care sector has unquestionably created some awareness among the community on existing health care services. Now it is the ASHA workers part to sensitize people about primary health care facilities of their community. They have to put more efforts towards playing their role effectively. Therefore ASHA should be competent and motivated individual in mobilizing community towards local health planning, and help community to adopt healthy behaviour for better health; and making them aware of health services available in the public health system like sub centers, primary health center and district hospital. Thus study of socio economic status of beneficiaries help to understand the perspectives and background of the people with whom ASHA workers deal and facilitate health care services so that ASHAs could approach according to the beneficiaries' need.

## 7.2 Methods and interventions used by ASHA workers to fulfill their objectives

The main activity of ASHAs is to transmit key health messages to the families around them, which are concerned with aspects of maternal and child health including antenatal care, tetanus toxide vaccination, birth preparedness, new born care , breastfeeding, postnatal care, child nutrition, immunization, family planning, hygiene, sanitation , clean water, malaria, HIV prevention and other health promotion activities.

### 7.2.1 Institutional approaches

To transmit these health messages to the target segment the ASHA workers are provided with instruction at the state, district, as well as block level which help ASHA workers to reach their target segment easily. These approaches are home visit, group discussion, meetings, organizing vaccinations camp, counseling, organizing village health and sanitation day, conduct demonstration education, distribution of leaflets and folders, organizing nutrition day, street play, skits and drama, which are considered as institutional method instructed to the ASHA workers

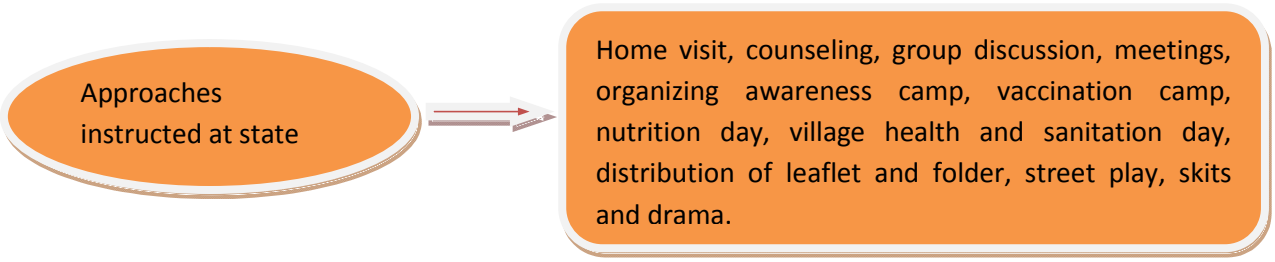


**Fig. 7.5, Institutional approaches instructed to ASHAs at the state level**

### 7.2.1 Institutional approaches adopted by ASHAs and its frequency of using by them.

**a) Home visit:** Home visit is a method through which ASHA workers directly contact their community / target segment and try to build a good relationship with them. They listen to them; guide them to the appropriate health care services. It is a very effective method used by ASHA workers as it helps them to follow up their target segment regarding their visit to health centers and monitor their self care behavior, medication, dietary intake and signs and symptoms of complication. Thus ASHA Workers link patients with appropriate primary health care. Frequency of home visit made by ASHA workers greatly vary from village to village. Analysis

of collected data reveals that in Sonitpur district 63% of ASHAs visit is regular and 37% ASHAs visit very often. In Nagaon district 57% ASHAs regularly carry out home visit and 43% do very often, whereas in Sivsagar district 63% ASHAs visit is very often and only 37% ASHAs regularly do home visit. For a more effective result ASHA workers need to strengthen their visit. Thus with reference to home visit Sivsagar district's performance is best followed by Sonitpur and Nagaon.

**b) Meeting**: Meeting is a great way to explain complex and non complex ideas and helps ASHA workers to communicate lots of information in a short amount of time. A good meeting yield many good results but a meeting with no agenda is a waste of time as well as sometimes time consuming. Mostly ASHA workers are having monthly review meeting with ASHA supervisor, community mobilizer and members of gram panchayat. These meetings usually is concerned with reviews of the accomplishments of ASHAs in the previous weeks with respect to tasks such as latrine construction, maintaining record book, organizing camps, numbers of mother encouraged by ASHAs to utilize health services and other health promotion activities. Sometimes they have meetings with their community and with their higher authority where they report about their task and constraints. In Nagaon district meetings are very irregular in nature but in Sonitpur district 80% ASHA workers and in Sivsagar district 89% ASHA workers conducted meetings very often. These kinds of review meetings played a significant role in monitoring and sustaining the commitment of ASHAs at their work. Thus with reference to meeting, performance of ASHAs of Sivsagar district is best followed by ASHAs of Sonitpur and Nagaon district.

**c) Organizing vaccination camp:** vaccination camp is organized once in a month in the nearest Public Health Centers or Anganwadi School with the help of ANM and anganwadi workers. The Village Health Sanitation Committee is responsible for arranging all the essential instruments such a BP machine, weighing machine, examination table, screen for maintenance of privacy during health check up and other support required in organizing the camp. These camps help ASHA workers to create awareness in the community about immunity and the importance of vaccine to fight against six killer diseases. It also helps them to keep record of health status of their clients. They also informed about need for proper nutrition thus creating a convincing

psychological climate for the adoption of healthy practices amongst the community. 100% ASHA workers from all the districts regularly organize vaccination day. During the survey it was observed that in all the districts majority of community members (or parents) are aware about vaccination and its importance. Majority of children are found fully immunized.

**d) Village Health and Nutrition Day (VHND)**: VHND act as a platform for providing first contact with primary health care to community people and create awareness regarding importance of food and proper diet during pregnancy and lactation. 65% ASHAs from Sonitpur district, 68% from Nagaon district and 72% ASHAs from Sivsagar district conducted Village Health and Nutrition Day very often. Thus with reference to VHND the performance of ASHAs of Sivsagar district is best followed by Nagaon and Sonitpur district.

**e) Village Health and Sanitation Day (VHSD)**: The Village Health and Sanitation Committee are formed with Gaon burra (village head) as a chair person, panchayat member, Auxiliary Nurse Midwife and ASHA workers. ASHA workers organize VHSD to create awareness about hygiene and sanitation. This help to stimulate interest of people and the VHSC to participate in maintaining quality health services and sanitation, which can prevent occurrence of epidemics in the villages. VHSD is organized rarely in Sonitpur, Nagaon as well as in Sivsagar districts. Only 30% ASHAs in Sonitpur district, 42% in Nagaon districts and 52% ASHA workers in Sivsagar districts organized sometimes VHSD. Among the ASHA workers of Sivsagar districts 52% ASHAs rarely, 30% very often, and 12% never discussed about construction of latrine, hand washing, drinking water, foot wears and drainage channel. In Sonitpur district 42% ASHAs rarely, 30% sometimes only 20% ASHAs always and 8% never discussed about sanitation and hygiene. In Nagaon district 42% ASHAs discussed rarely, 40% very often and 18% ASHAs never discussed about sanitation and hygiene, due to which rural or people living in char or remote areas are not aware about proper drainage and hygiene and not mobilized for the construction of latrines. In some villages it is observed that members of gram panchayat are not fully involved in the village health planning. They rarely attended meetings. Even some ASHAs from all the districts are not aware about VHSD. Though this is an important task of ASHAs and they are expected to play a key role in preparing village health planning.

**Table 7.8 Distribution of ASHAs according to the approaches used by them.**

| Approaches | Category | Sonitpur district | Nagaon district | Sivsagar districts |
|---|---|---|---|---|
| Home visit | Always | 63% | 57% | 39% |
| | Very often | 37% | 43% | 61% |
| | | | | |
| Meetings | Very often | 80% | - | 89% |
| | Sometimes | 15% | 32% | 21% |
| | Rarely | 5% | 68% | - |
| | | | | |
| Vaccination camp | Always | 82% | 78% | 85% |
| | Very often | 18% | 22% | 15% |
| | | | | |
| Village health and sanitation day | Sometimes<br>rarely | 65%<br>35% | 68%<br>32% | 72%<br>22% |

f) **Skits and Dramas:** Skits and drama are very effective method in educating people about health issues and use of services. It reach a large group of people at a time. It is an interactive approach as well as informative to all age groups of people in all social classes. To raise the issues ASHA workers have to design drama and skits in a very convincing manner to complement and to extend existing information and education. This method is ocassionally used in the three districts. Only 20% ASHAs from Sonitur district, 35% from Nagaon district and 32% ASHAs from Sivasagar district used this method sometime.

**g) Distribution of leaflets and folders:** Leaflets and folders contain gist of information or messages in pictorial and written form which is intended to catch and hold the attention of the people. They are very convenient and effective for communicating improved technology to the rural population. Leaflets and folders on health issues and diseases are given to ASHA workers in order to distribute these among the populace so that they can understand the issues and keep the handouts for future reference. Leaflet and folders may be used as reminders. ASHA workers

distribute the hand outs when they are provided with these by the state or district authority when the need arises to control the epidemics and communicable diseases etc. 45% ASHAs distribute handouts sometimes in Sonitpur district, 62% ASHAs in Sivsagar district whereas only 15% ASHAs distribute handouts sometimes in Nagaon district.

**Table 7.9, Distribution of ASHAs according to the approaches used by them.**

| **Approaches** | **Category** | **Sonitpur districts** | **Nagaon districts** | **Sivsagar districts** |
|---|---|---|---|---|
| Counseling | always | 68% | 62% | 76% |
| | Very often | 25% | 38% | 24% |
| | sometimes | 7% | - | - |
| | | | | |
| Distribution of handouts | Sometimes | 45% | 15% | 62% |
| | Rarely | 50% | 66% | 48% |
| | never | 5% | 19% | |
| | | | | |
| Skits and drama | Sometimes | 20% | 35% | 32% |
| | Rarely | 60% | 50% | 55% |
| | never | 20% | 15% | 13% |
| | | | | |
| Street play | rarely | 75% | 32% | 28% |
| | never | 25% | 68% | 72% |

### 7.2.2 Unique approaches adopted by ASHAs at the districts.

**Unique approaches using by ASHAs are observed in the district level as follows-**

**a) Group discussion**: Group discussion help to bring out ongoing problems faced by the community and try to find out solution for that problem. They discuss about the change or improvement in their communities which could include promotion and adoption of better health care practices. Group discussion method is instructed at district level to the ASHA workers of Sonitpur and Sivsagar district. ASHAs of stated districts used this method very often. This method is rarely used by ASHA workers in Nagaon district. Group discussion gives opportunity

to ASHA Workers to know satisfaction, dissatisfaction and expectation of beneficiaries. At the same time the community becomes aware about the constraints faced by the ASHA workers in conducting their job. Group discussions develop a positive and supportive attitude amongst them and help to get deeper insight to attitudinal changing influences and improve communication skills of ASHA workers. Therefore this method should be used more frequently in the entire districts by ASHA workers.

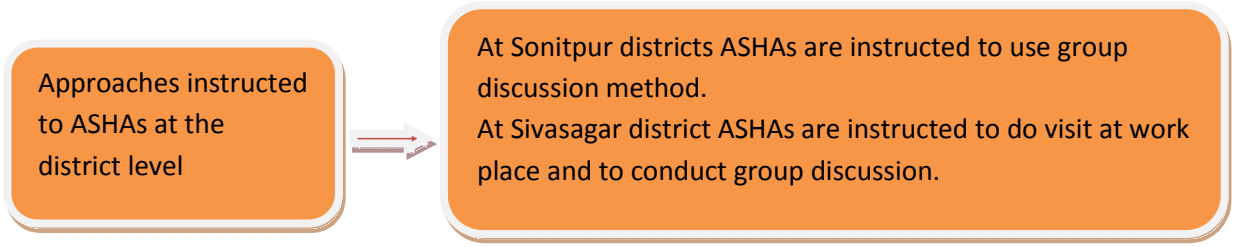


**Fig. 7.6, approaches adopted by ASHAs at the district level**

**b) Visit to the work place**: In rural areas and in tea gardens people are live below poverty line where both husband and wife (parents) goes to the field /work to earn for the family, in such case for ASHA workers to make their visit more effective, they contact their clients in the work place to monitor patients self care behavior, medication and for a better follow up. This method is introduced to ASHA workers of Nagaon and Sivsagar district by district health officials. ASHA workers also provide social support and give their care to the families. This kind of visit should be encouraged in other districts also. This method is helping ASHAs to maintain their frequency of visit to contact their clients.

### 7.2.3 Unique approach adapted by ASHAs is observed at the block level.

**a) Demonstration education**: workshops are been organized for ASHAs under Jakhlabondha Health Development Block at PHC and they are trained to conduct demonstration education and counseling with the help of health officials for mothers and care takers on critical nutrition intervention, postnatal care, infant care and family planning. It helps ASHAs to further advocate and clarify good care practices to the beneficiaries.

b) **Baby shows:** The entire tea gardens under Biswanath Charali and Pithakhua Health Development Block of Sonitpur districts conduct baby shows with the help of ASHA workers, children from 0-5 years of age are considered for the shows and they are grouped into two

categories on the basis of their age. Children were measured height and weight. The judges of the show check their vaccination cards and discussed with parents about rearing of children in a healthy environment. On the basis of children health and hygienic state they are ranked and the best are awarded prizes. This kind of programmes helps parents to understand to take best care of their children.

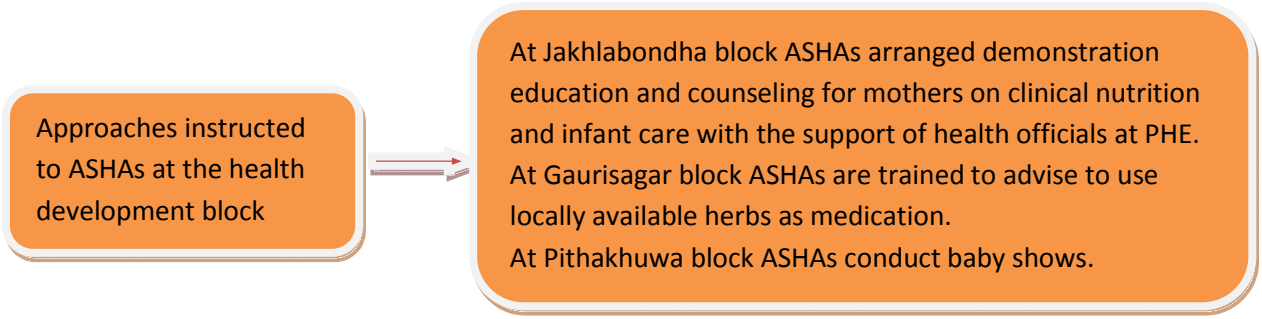


**Fig. 7.7, Approaches instructed to ASHAs at the health development block level**

**c) Advice to use locally available herbs as medication**: People of rural areas especially elderly people hesitate to use medication and injection out of fear of having side effects. In that case ASHA workers advice their target segment to use locally available herbs as medication when injection and saline are not necessary. ASHA workers of Gaurisagar health development block of Sivsagar district has provided training at their primary health centre in a block level to advice their target segment to use locally available herbs as medication. For example for cough and cold they suggest tulsi leaf juice with honey and black tea with ginger, use of neem leaves is helpful for skin diseases and itching, they advise to grow aloevera in their kitchen which is used in several ayurvedic preparation, one can use it for burn treatment as dressings, for dandruff and for the growth of hair. Aloe is also useful for liver disorder and women's illness like pain in periods. One can use triphala powder in constipation, obesity and diabetes. People easily convinced to adopt home remedies instant of taking medicines and this way ASHA workers help community to save their expenses with the help of simple remedies and raising health awareness. More of those ASHA workers make people aware to take care of their kitchen garden and to grow herbs and all kind of vegetables.

**7.2.4 Unique approaches adopted by ASHAs:** Following approaches are adopted by ASHAs other than the instructed approaches to reach their target segment-

**a) Invite community members to share their experiences on health care and sanitation**: ASHA workers of Tumuki gram panchayat under Pithakhua health development block of Sonitpur district invite community members those who are actually practicing proper sanitation and have benefited by the health care services provided to them to share their experiences which help ASHA workers to mobilize households and communities to build latrines and drainage cannel. It is an effective step to mobilize community and also help them to build a positive/good relationship with them.

**b) Creates songs and poems on health issues**: ASHA workers of Puronigudam grampanchayat under Samuguri health development block of Nagaon district come out with innovative methods to reach to the heart of the people. They created songs and poems on health issues which help them to bring awareness among illiterate people and children. It also develop ASHA's creativity and communication skills. ASHA workers used this method to express their knowledge that they had gained about health to teach or inform members of their community in an informal and entertaining manner.

**c) Organizes puppet show, games and competitions:** ASHA workers arrange games and drawing competition among children during school vacations on topics like good health, sanitation, and small family is a happy family, healthy environment etc. School also encourage them and allow them to conduct such events, and to talk about health issues and benefits of yoga, which creates awareness among children about healthy practices and motivate towards a healthy adolescence. Sometimes ASHA workers remake songs in their local language containing health messages on a tune of very popular number, it sounds more catchy and understandable to all the age groups of people.

### 7.2.4 Unique approaches adopted by ASHAs

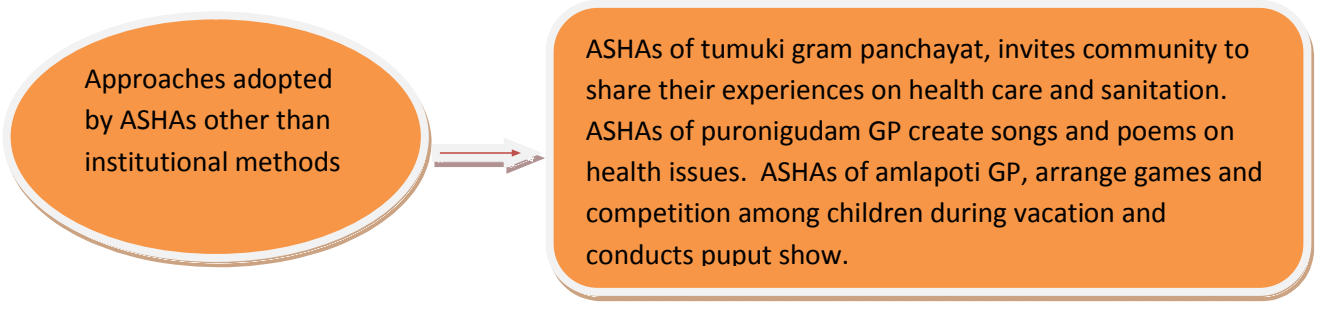


**Fig. 7.8, unique approach adopted by ASHAs other than institutional approaches**

**7.3 Success story of ASHAs observed during the survey.**

Few success stories of ASHAs have been observed during the survey which shows the impact of ASHA programme that it helping to bring desirable changes in the health status of the community at the same time providing livelihood to ASHA workers and empowering them.

a) Usha Bora, an ASHA of Puronigodum gram panchayat of Samuguri health development block of Nagaon district is always on the move and alert. This is proved by the amount received as incentives through Janani Suraksha Yojana, which is highest in the district till date. She attended the modular training of ASHAs and also received a 2-days training on malaria detection and control. Mrs. Bora has an artistic streak in her, who comes out clearly even in her work and she has composed songs on healthy habits and work on ASHAs which they call ASHA song and proudly sings whenever there is any meeting in the block or their village. She says that being an ASHA she has been getting respect in the village. It has also brought improvement in managing her family.

b) The entire South Vir area near Biswanath Ghat of Biswanathcharali Health Development Block under Sonitpur district is dominated by schedule caste and minority people. The people are socio economically backward. This area is flood affected and highly endemic to malaria. People have been found to be quite reluctant to co-operate with health depertment in various programme due to superstitious beliefs, wrong concept regarding immunization etc. There was a time in the recent past when the people refused to immunize their children, to administer polio drops. The people could not overcome these things due to lack of awareness and other reasons like poor socio economic status. But the situation at present is not same. Now people are fully co-operating with health department and participating in the entire health programme. This is due to the continuous efforts of Biswanath Charali health development block. A great portion of this change is credited to Kanika, Lajanti, Purnima and Fatima Begum, the ASHA workers of NRHM at Vir gram panchayat. The strong leadership character and motivating capacity of these ASHAs leads to creation of health awareness and rise of health seeking behaviour among the community. They helped the block PHC in organizing immunization camps regularly. They hold health day regularly, demonstrating important things on health issues in a very simple way to the people in their local language and using methods like group discussions and meetings to communicate

with target segment. These ASHAs have been successful in motivating the people to choose the right way to healthy lifestyle.

c) Bina Baruah who is a widow was engaged as ASHA of Kalung Gaon under Kalung Gaon Health Development Block under Sivsagar district, who is a widow. She has a son and a daughter. After her husband's death she was going through a financial crises and she needed a work to overcome it. She was selected as ASHA worker from her village as because she has been doing many social welfare activities like pulse polio immunization campaign, forming self helps groups etc. She got induction training as ASHA during 2007. She carries out survey, does regular home visits and tries to convince mothers as well as other family members for availing ANC services followed by institutional delivery and finally availing post delivery care and follow up support from concerned ANM. She is also involved in mobilization of community for increasing routine immunization coverage, organizing village health and nutrition day etc. The ASHA incentives, she earned so far, enabled her to buy one bigha of agricultural land. She is extremely happy about her gain and her ability to send her children to school.

ASHA workers should be encouraged and felicitated properly to increase their motivation and sense of voluntarism, which led to their active involvement at work they are responsible. This will help them to gear up their activities for better implementation of NRHM.

**Conclusion**

From the above findings, it is evident that SES of beneficiaries in the study area varied on the basis of their socio economic background. Majority of beneficiaries comprised of lower middle class. Further it is noticed that the majority of ASHA workers used home visit method to convey health messages and to follow up their client/ target segment. Few success stories of ASHAs are precisely documented, which depicts the innovative approaches adopted and sincerity of few ASHAs that helped to bring desirable changes in the health status of the community.