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भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
निर्माण भवन, नई दिल्ली - 110108
Government of India
Ministry of Health & Family Welfare
Nirman Bhavan, New Delhi - 110108

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Dated the 30th December, 2009

Dear

After several efforts in the past, the nation has been able to put in place an energetic and promising community health worker programme. The challenge before us is to make this programme more effective and sustainable. For this we require urgent action on four critical aspects of the programme:

a) *Clarity on role definition and measurable outputs.* This would help us measure the effectiveness of the programme in a block/district/state and also help us to support and finance the programme better. It would also help the programme manager in the field to know whether an individual ASHA is functional or needs to be replaced. To give the programme a positive direction we suggest seven core indicators which every state may adhere to. (given in annexure 1) As you would see, these indicators capture the balance between her role as facilitator and community mobiliser, and her role as service provider. States could modify or change these indicators based upon their priorities, but they may do this in consultation with us, so that we are aware of the outputs that your state has set for this programme. What is not acceptable is to have a situation where we do now know what the programme outputs are and we have no way of defining whether an ASHA is functional or not.

b) *Supervision and support structures:* This is the single biggest weakness of the programme, and the reason why in many states the programme lags being in training and in outputs. Conversely the states which are doing best in this programme have put in place an adequate support structure.

i. At the block level support and on the job training requires at least one facilitator cum trainer for 20 ASHAs (could be reduced to one per ten in much dispersed areas) and one or two block coordinators. This task of training and support could be packaged and outsourced to a suitable NGO if available. If no suitable NGO is available a dynamic and reliable health worker/supervisor or medical officer should be made nodal officer and the funds provided to him/her in instalments so as to perform this task. Monthly meetings of ASHAs are mandatory and could be even more frequent if possible.

ii. At the district level a small group of one to three community processes coordinators are to be provided for. They would regularly review and support the block teams and take care of the logistics and organisation of the programme. A district training team should also be identified and notified including and in addition to these facilitators and coordinators. In view of the department's own limited training capacity and the need to prioritise existing training capacity for training regular service providers, wherever possible an NGO could also be asked to play this role as the district training agency and if needed the coordination role as well.

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iii. At the state level a three to five person team should be in place to provide leadership to the ASHA and VHSC programmes. It would be useful to draw this team from persons with experience in social mobilisation, in training, in management and in community health- and not go by their formal qualifications alone.

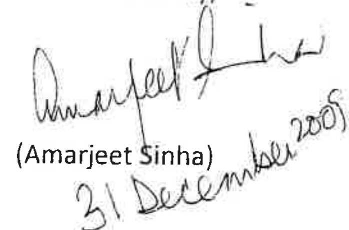
The financing for this support structure is built into the Rs 10,000 per ASHA sanctioned as the normative annual budget for the ASHA programme.

c) *Payments:* This is the third major area that needs urgent improvement. One important consideration is to ensure that the "routine' work allotted to ASHA could be done within about two hours of work per day for about six days per week. The principle is that such work should be possible to do without loss of her main livelihood earnings. Whenever she is required to give a full day's work whether it is to attend a review meeting, or participate in a training camp, or attend an immunisation session, or even to meet with visitors she must be given a full days wage compensation Rs 75 or Rs 100 per day. In addition to this we must streamline payment of the performance based incentive payments so that no payments are due for more than a month and such that the ASHA would not have to spend more time than the one trip she makes for her monthly review meeting to collect these incentives. Failing which the payment should be reached to her through her facilitators. To most ASHAs the JSY incentives and the immunisation day incentive are the main sources of payments, the rest of the package not adding any substantial amount. It is important to incentivise the rest of the activities indicated earlier with one amount (of about Rs 500) that is also a performance based incentive but paid monthly, against the record of the work in her diary and certified by and paid through the VHSC/sub-center fund/panchayat - whichever is most functional.

d) *Training Achievements*: All ASHAs must attain at least 24 days of training every calendar year. The training structure should be adequate to achieve this. The training content must be *at least* adequate to impart the skills needed to deliver the seven work areas identified at increasing levels of effectiveness. Currently ASHA training achievement is far short of this, and the most important reason for this is the lack of institutional arrangements for supporting this training. A 40 person national training team of experienced trainers drawn from NGOs and national ASHA mentoring group will help you design and plan this training, if you so need support

The ASHA programme is now well into its third year and there should be no further delay in making these basic course corrections. Before the end of the financial year, the systems that are needed to achieve the above should be put in place and every state should be in a position to state reliably how many ASHAs are functional by these criteria before the next years funds for this programme are sanctioned.

Yours Sincerely,



(Amarjeet Sinha)

31 December 2008

To

Mission Director
All States

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Annexure 1:

Indicators for the ASHA Programme:

There are nine indicators suggested on which the progress of the ASHA programme could be reported. The reports to the centre should come in the form of number of blocks in each district where ASHAs are over 70% functional or 50 to 70% functional in each of these indicators. *Reporting on the first six indicators could start immediately.*

Level 1 is what can be achieved today- everywhere, even with current levels of training. Level 1 can be achieved even if all support systems at the local level fail.

Level 2 needs a fair degree of skills, some equipment and good support at the ANM/AWW level.

Level 3 needs a higher level of skills and a functional referral support system including facility level care. Level 3 lends itself to showing an outcome impact even on a fair sized community survey.

Level setting is done by the state as appropriate to its level of programme development- but it is done in a district specific manner- so that better performing districts are given higher levels of outcomes. For each indicator, ASHA is to be reported as functional if the level of care appropriate to her context is achieved.

Self reporting by the ASHA at the monthly review meeting at sector level is adequate to gather this data. Such a monthly review meeting and data gathering exercise needs to be institutionalised. This data gathering from ASHAs could be done as part of enquiring about the health problems in her area and providing support and on the job training to her.

Verification needs a field visit and a functional ASHA diary.

Sl No.	Indicator	Levels	Description of Achievement Level	Means of Verification
1	Data collected: Did ASHA visit families of newborns as per schedule? Indicator reported: % of ASHAs who visit newborns as per schedule.	Level 1	Visited- reports that breastfeeding started within first hour/first day, feeding of mother and keeping baby warm also emphasised	Recorded in her diary. External observer can visit families of last three newborns born and cross check written/oral statements
		Level 2	Baby weighed, weight is known and recorded and LBWs are referred.	As above plus weight record is seen in MIS, ANM and AWW records
		Level 3	All Visits are as per schedule. Sick newborns successfully referred and/or provided first contact care	As above plus in appropriate referral center there is an increase
2.	Data collected: Did ASHA provide microplanning /support for pregnant	Level 1	Has discussed with family and helped it to plan- how to take mother to	Recorded in her diary. External observer can ask ASHA to name

	women- did ASHA enable full care package Indicator reported: % of ASHAs who are able to provide planned level of care for pregnant women,		institution when time comes, and if that is not possible or chosen how to get SBA at home or else next best option.	women with EDD in next month and visit to see whether plans are in place. We expect a fair part of it
		Level 2	Antenatal care is fully provided and post natal visits are complete	Recorded in her diary. ANM visits must have been regular. Reflected in ANM/AWW records. Special plans made for complications in pregnancy.
		Level 3	Complications in antenatal care and post natal care and abortions received help in referral transport and medical attention	Recorded in her diary. Appropriate referral centers show a number of cases from her area have been seen. Especially severe anemia, hypertension and
3.	Data collected: Did ASHA provide first contact care to the sick child for fever, ARI and diarrhoea. Data reported: % of ASHAs who are providing first contact care for sick children and reported over 10/20 child visits in the previous month and provide planned level of care.	Level 1	Is able to recommend between home solutions including paracetomol and appropriate referral	Records in her diary. External observer could cross check last few entries with a field visit. Caution: not all ASHAs would be rigorous about diary entries- but even oral statements should suffice for cross checking
		Level 2	Is able to give ORS, test and treat malaria, or give presumptive Chloroquine, or cotrimoxazole for ARI and sick newborn in appropriate settings.	Needs drug kits with these elements in place. Record of drug consumption and kit refills is adequate.
		Level 3	Is able to ensure sick children requiring institution are identified and referred on time or give adequate antibiotics at community level.	Institutional records of sick children referred in and ASHA records of sick children treated checked with consumption of antibiotics is the key.
4	Data collected: Did ASHA attend Immunisation day. Data reported: % of ASHAs who attended the immunisation day/VHND	Level 1	ASHA has a record of which children are immunised and who are **not. In particular which** hamlets have poor access	Record in her diary and interviews

	during the last month.		and gaps	
		Level 2	ASHA went to the immunisation day or VHND in the place most accessible to her, and encouraged , brought along the children needing immunisaiton, antenatal care from the village.	Reflected in her diary and in AWW and ANM register. External observor could ask/see which children are due for immunisation next month.
		Level 3	100% immunisation and access to full antenatal care achieved.	Reflected in HMIS reports and in respective diaries.
5.	Data collected: Did ASHAs visit the families at risk for nutrition counselling- (malnourished children and all children in 6 – 18 months) Data reported: % of ASHAs active in home visits for nutrition counselling.	Level 1	Has knowledge of which children are malnourished and makes efforts to get them weighed at AWC	Reflected in her diary and response to questions
		Level 2	Has visited and counselled each family at risk at least thrice	Reflected in the diary. Could be cross-checked by visiting last three homes visited.
		Level 3	Has regular home visits and made efforts at social mobilisation and referral support to actually try and reduce malnutrition levels.	AWW registers should show improvement over time. Also number of severe malnutrition picked up and referred.
6.	Data collected: ASHAs held a village health and sanitation committee meeting and discussed key health issues in last three months Data reported: % of ASHAs who were active in holding a village level health meeting	Level 1	Convenes or participates in a women's group activity or village group activity that discusses health issues seriously. Could be also SHGs.	Diary record
		Level 2	The VHSC is formed, she is the convenor or member, and it holds village level meetings.	
		Level 3	Same as above plus village health plan is made and there is collective action on many issues- eg sanitation, referral transport, etc etc	
7.	Data collected: Has ASHA facilitated any contraceptive provision.	Level 1	Knows unmet needs of some families and helps them to access care	Recorded in her diary.

	Data reported % of ASHAs who were active in contraceptive provision.			
		Level 2	Acts as provider for condoms and pills, has actively escorted or helped unmet needs for sterilisation and IUDs to be met and in touch with health system for this purpose	Consumption of contraceptives given to her, sterilisation incentives due to her.
		Level 3	Unmet need in village drops to negligible amounts- no cases pending for sterilisation	eligible couple register cross-checked by Community survey.
8	Data collected: Number of ASHAs who are playing role as DOTS provider Data reported: % of DOTS providers who are ASHA (same indicators can be used for blindness control, leprosy control with modifications)		Awareness about TB and it symptoms, and those who get to play DOTS provider role.	RNTCP registers and ASHA diary.(in some districts ASHAs would be ignored in provider selection, in others they would dominate- difficult to hold ASHA accountable for her not being the DOTS provider)
9	Data collected: Is ASHA active in malaria/kala-azar control? Data reported: % of ASHAs who are active at malaria/kala-azar control.	Level 1	Is aware of malaria- refers children and pregnant women and others appropriately.	Record of fever cases attended to.
		Level 2	Has RDK kits and blood slides and chloroquine Provides special attention to pregnant women and children for prevention.	100% of pregnant women who use bednets- ITN preferably Most fever cases, especially in children – BSE or RDK done, or Chloroquine given in first day
		Level 3	Has above plus ACT, Has a village health plan which is effective for local malaria control	Key VC elements- ITN, spraying, prompt diagnosis and treatment all happening.