Introduction to the ASHA programme

State Institute of Health and Family Welfare, Jaipur

ASHA

Accredited

Recognized by the community

Social

From the community, By the community and For the community.

Health Activist

Spreading awareness for health concerns

Promoting change in health related practices

ASHA

ASHA is the first port of call for any health related demands of deprived sections of the population, especially women & children, who find it difficult to access health services.

ASHA-Sahyogini: Convergence brought in

- Convergence of ICDS and Health Dept.
- Sahyogini as 3rd worker at AWC already existed before NRHM
- To avoid Duplication- Sahyogini taken as ASHA (in Rajasthan)
- Nomenclature devised as ASHA-Sahyogini

Key elements of community processes in NRHM

- The ASHA and her support network at block, district and state levels.
- The Village Health Sanitation and Nutrition Committee (VHSNC) and village health planning.
- Untied funds to the Sub Centre and the VHSC to leverage their functions as avenues for public participation in monitoring and decision making.
- District Health Societies, the district planning process and the Rogi Kalyan Samitis as avenue for promoting public participation in facility management.
- Community Monitoring.
- NGOs and other civil society organizations to support the implementation of these components,

ASHA-Sahyogini: Selection

- Listing of interested and eligible women by ANM and LS
- Panel of three names
- Approval through Gram Sabah- Community empowerment

ASHA-Sahyogini: selection Eligibility

- Intensive mobilization to get active ASHA-Sahyogini.
- Any woman can not be the ASHA-Sahyogini.
  - Age – 18 years to 45 years
  - Qualification - 10th Pass Minimum (relaxation for tribal and desert areas)
  - Married/divorcee/separated
  - Must be 'BAHU' of the community
  - Resident of the village
  - Active/Vocal/leadership qualities

Roles & Responsibilities

- Total information of the community
- Village Health Plan
- Create Awareness
- Coordination with AWW/ANM/MPW
- Counseling/Mobilization
- Escorts/Accompany
- Provision of Primary Medical Health Care
- Maintain Drug Kit
- Record and Registration

Understanding ASHA's role

A. ***A facilitator or link worker*** – where there is low use of health services, the ASHA enables people to access health services
B. ***A volunteer and activist-*** to enable access to health entitlements and reaching the marginalized.
C. ***A community level care provider-*** important for her credibility, to respond to local health needs, particularly in underserved areas. Closely linked to health outcomes

- *All three roles defined in the guidelines: initially a link worker in the RCH 2 design, active civil society intervention enabled the articulation to incorporate all three roles*

- **Getting the right mix is the challenge. If limited to link worker role – she is unable to reach the marginalised and results in a huge missed opportunity to save lives.**

Working Arrangements

- ***Flexible work schedule***
- Workload to be limited to 3-5 hours per day on about 4-5 days per week
- This would mean in most contexts- ***ASHA work will not adversely affect her primary livelihood.***
- During mobilization events, Eg- pulse polio, or escorting a patient, she may spend a full day, and would be compensated accordingly.
- ***Such full day work cannot be made mandatory except for training programmes.***
- ***Her accountability lies primarily within the purview of VHSNC***
- Immediate field level support will be provided by both ASHA Facilitator and the ANM.
  - ANM's focus will be on her skills for community level care and identification of illnesses
  - facilitator's role will be on supporting her in her activist role, in mobilization and in reaching the marginalized.

ASHA's tasks

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ASHA's time- her five tasks

- ***Home Visits:*** all houses initially, families at risk- subsequently and then visits to priority households
- ***MCHN Day participation:*** Platform where all outreach services are provided: Immunization, ANC, PNC- approx. one day per month.
- ***Visits to a health facility-*** the review meeting, (1 day per month) and escort function- as required
- ***Village level meeting***: convening VHSNC, SHGs
- Maintaining **her** diary and register- for her own work management

Work load: ASHA (1000 Pop.)

Beneficiary category	Expected number in an Year
Pregnant women	30-31 • Out of which 4-5 may have complications • 50% shall have anemia
New Born	27-28
Children in 0-1 Year	30 (3% of the population)
Children 1-5 years	130, (13 % of Population)
Eligible couples	16-17% (15-45 years)
Eligible for Vasectomy/ Tubectomy	5-7% of Eligible couples
Eligible for spacing Methods	11-12% of Eligible couples

Requisites for converting functionality in to effectiveness

- Continued Training and Support – 15 to 20 days per year.
- Support structures: The facilitator, the block and district coordinator, and the state ASHA resource center and state programme management.
- Drug kit, an equipment kit and a communication kit to facilitate her tasks
- Performance Based Incentives
- State- NGO partnership at all levels- through ASHA mentoring groups, involving NGOs in training, support and supervision
- Performance Monitoring System

ASHA Training

- **Induction Training – (Modules 1-5)**

  Originally consisted of 21 days of training in five module ; but now modified to **an eight days training in one Induction Module**

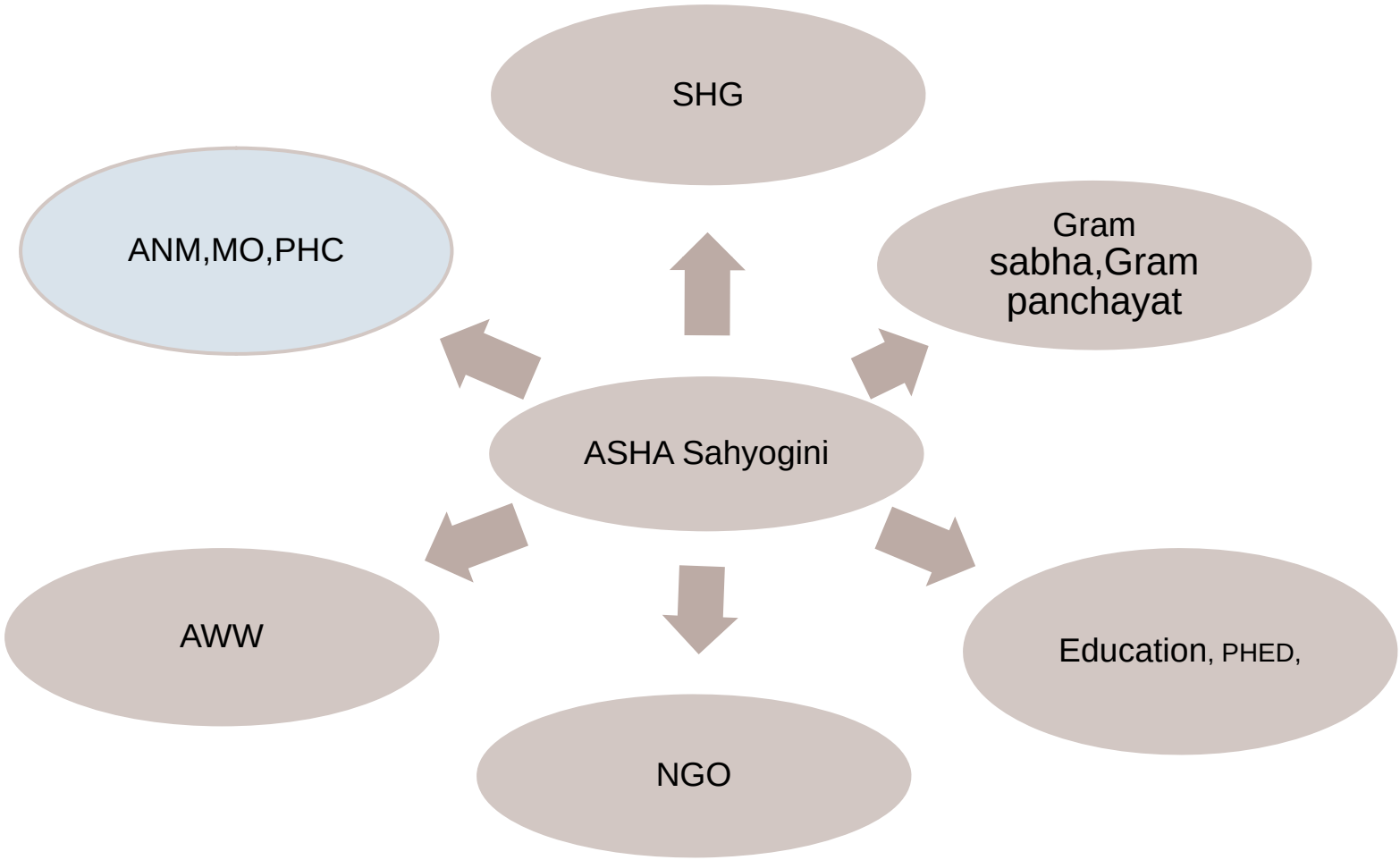
- **Module 6 & 7- 20 day training** to be completed in four rounds. Consists of key competencies in maternal, new born, children's health and nutrition

- **Supplementary or refesher Trainings**
  - At least **15 days of training annually** planned in which new topics and skills can be added.
  - Can serve to reinforce existing skills or adding New skills specific to local needs such as disability screening, mental health counselling.
  - PHC review/Sector meetings can be used as a forum for such training

Support Structures

State	• MD, NHM and PD, NHM • ASHA Resource Centre and SIHFW • State ASHA Mentoring group
District	• District ASHA Coordinator/ Mobilizer • DPMU/District Health Society
Block	• Block Community Mobilizer • Block Programme Manager • Block ASHA facilitator
Sub block	• ASHA Facilitator/PHC Supervisor • VHSNCs

Linkages of ASHA Sahyogini



ASHA Drug kit

- Iron Folic Acid tablets
- ORS IP 20.5 gm (WHO formula)
- Paracetamol Tablets IP 500 mg and syrup
- Dicyclomine Tablets IP 10 mg
- Providine Iodine Ointment (USP 5% w/w) 15 mg
- Absorbent Cotton IP 500 gm
- Gentian violet topical solution USP 50 ml
- Paracetamol syrup IP 125 mg/5ml (60 ml)
- Cotrimoxazole tablet and syrup
- Zinc tablet
- Malaria slide and prick needle
- Sanitary napkins
- Oral pills/ e-pills/ nirodh and Nischay kit

Factors critical to success of ASHA

- Selection of ASHA by prescribed process as per the ASHA guidelines.
- Linkage with nearest functional health facility for referral services.
- Identified transport for referral of cases from village to facility.

Factors critical to success of ASHA

- Successful organization of monthly Health and Nutrition Day (in every village with the ANM / AWW)
- Monthly meeting of ASHA at PHC.
- Timely payment of incentives to ASHA.
- Timely replenishment of ASHA kit
- Priority and recognition of cases referred by ASHA to MO / ANM

Role of ASHA

- Counsel all the eligible couples for contraceptive choices
- Client screened by the MO/ANM before selling OCPs
- Prepare a list of eligible couples of her village
- Mention the preferred type of contraceptive

- Regular collect stock of contraceptives
- Deliver contraceptives at door step of the beneficiaries
- Charge the beneficiary at the approved rates as an incentive for her efforts

Role of MO I/C/ANM

- Certify the list of eligible couples
- Ensure all ASHAs collect supply
- Verify ASHAs' performance on a monthly basis
- Screen the couple for eligibility for OCPs

Responsibilities of MOIC

- Facilitation of ASHA selection & training
- Ensuring timely payment
- Providing conducive environment
- Information exchange during sector meeting
- Timely replenishment of ASHA drug kit
- Supportive supervision to ASHA or providing supportive supervision to ASHA
- Motivation and re-orientation of ASHAs
- Grievance Redressal and guidance to ASHA
- Keep a sensitive attitude towards ASHA

Role of State

- Designate a person for manage and monitor the scheme
- Orient the ASHA & ANMs of the districts where the scheme is being launched
- IEC material displayed at all PHC and sub-centers

Role of PHC Health Supervisors

- Prepare list of ASHAs
- Collect, Compile and prepare report
- Regularize the payment or incentives
- Facilitate with BCMO,BPM,BHS
- Monitoring
- Meeting & Training

Role of DACs/BHSs

- Create database of ASHA.
- Liaise with district level stakeholders for mobilizing support
- Supervision and monitoring of the ASHAs, NGOs and Block ASHA facilitators and PHC ASHA Supervisors.
- Attend ASHA meetings at block and PHC.
- Prepare annual training plan of ASHA for different rounds.

Role of DACs/BHSs

- Compilation of monthly report with the help of Data Assistant of DPMU.
- Dissemination of guidelines related to ASHA to all functionaries at different levels.
- Follow up with Block ASHA facilitators/ BPMs on the progress of assigned job.
- Monitor timely payments of ASHAs
- Monitor physical and financial progress of the component.
- Field visits

Role of DPM/BPM

- Develop annual plan for selection and training for ASHA
- Drafting of annual targets for ASHA, CHC-PHC (sterilization, ID & immunization)

Role of DPM/BPM

- Support District ASHA Coordinator in developing localised implementation plans.
- Monitor physical and financial progress of the component.
- Ensure adoption and implementation of plan and fund flow at local level.

Collective Role of DAC/DPM/BHS/BPM

- **Reporting** – timely and properly
- **Hand holding** support to ASHAs
- **Timely payments to ASHA-Sahyogini**
- **Regular** monthly meetings at PHC/CHC
- **Identification** of non-performing ASHAs

The grievances can relate to several issues

- Personal issues
- Payments
- Supplies
- Record Keeping
- Referral system
- Services in the hospitals
- Gender issues

Issues

- Selection of ASHAs.
- Timely training of ASHA 6th and 7th module.
- Drug Kit to new ASHAs and timely replenishment.
- ASHA payments.
- ASHAs performance w.r.t different components.
- Regular reporting at state level latest by 10th of every month.
- Regular reporting in the formats given for Home delivery of contraceptives scheme.
- Timely readressal of problems in ASHA payment.

Challenges

- 1.Non availability of Drug Kits
- 2.Non availability of Tool Kit
- 3.Tender process in Districts
- 4. ASHA Selections and dropouts

Thank you