

Guidelines for **COMMUNITY PROCESSES**



ASHA



VILLAGE COMMITTEE



SUPPORT STRUCTURE



National Rural Health Mission

Guidelines for COMMUNITY PROCESSES



National Rural Health Mission

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MESSAGE



In 2005 with the launch of the National Rural Health Mission, we committed ourselves to a vision of universal access to health, with a strong focus on community engagement to ensure people's participation in health and to enable action on the social determinants of health. The key instruments were the ASHA and the Village Health, Sanitation and Nutrition Committees. In the last seven years, the ASHA has proven to be a key pillar of this process. This process has not been easy, and was rendered complex by the fact that in 2005

there was little experience with implementing large scale community health worker programmes, much less with creating community institutions such as Village Health, Sanitation and Nutrition Committees.

Despite this, most states have overcome steep learning curves to lay the foundations for a viable ASHA programme. The outcome for VHSNC is less satisfactory. The key tasks for the next phase of the NRHM are to equip the ASHA with additional skills to enable an active role for her in not just Reproductive and Child Health but also to undertake action for prevention and community level care for Non Communicable Diseases. This can be achieved through high quality training and field support and mentoring, through strengthening the VHSNC as an institution for community action and enable both, the ASHA and VHSNC to function in a coordinated manner to ensure achievement of positive health outcomes at the community level.

We must not underestimate the significant challenges to achieving this. As we have in the past, the centre and states must work in collaboration to undertake this journey forward.

One means of enabling effective implementation is this revised set of guidelines for NRHM's Community Processes. These guidelines encapsulate the learning of the last few years. They are intended to provide not a rigid framework but a guidance document as we jointly embark on the second phase of the programme. In this second phase efforts under the National Rural Health Mission will also be directed towards the identification, diagnosis and long-term management of Non Communicable Diseases. This will require new learnings, especially in those public health workers whose energies have so far been focussed only on Communicable Diseases or on issues of Maternal and Child Health. India's path to achieving Universal Health Coverage is long and paved with challenges. Investing in a programme for disease prevention and health promotion through the ASHA and VHSNC holds substantial promise in realizing this vision. I hope that states will find these guidelines useful and will work closely with the MOHFW in adapting the guidelines to specific contexts, but retaining the heart and spirit of the community processes interventions.

26 June 2013

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FOREWORD



From the time of the launch of the National Rural Health Mission in 2005, community processes have been at the heart of the outcomes of the Mission. The ASHA programme as it stands today is a powerful reflection of this. Undoubtedly, 8.89 lakh ASHAs are the most visible face, and singular achievement, of the Mission. The Village Health, Sanitation and Nutrition Committees (VHSNCs) have grown in number to exceed 5.5 lakh but more importantly, they have demonstrated unique ability to drive local health agenda.

Since the policy and programme guidelines were issued early on, in the first phase of the NRHM, the programme has expanded and been shaped by the varying contexts in which it is being implemented. We have been able to understand, in no small measure what the barriers and facilitating factors are, what support requirements are necessary at various levels to yield outcomes, what is the key set of processes to make an ASHA functional and effective and how to do so. The knowledge is by no means adequate or sufficient. However, based on the cumulative experience and understanding of those who are working at the national, state, district, and sub district levels the guidelines issued by the Ministry in 2006 have been updated and expanded. The aim is not limited to reflecting the learning of our experience but to ensure that the ASHA and VHSNC are trained, equipped and supported to provide mutual sustenance to each other to strengthen community action for health.

This set includes revised guidelines for the ASHA and also a more comprehensive set of principles for establishing and strengthening the Village Health Sanitation and Nutrition Committee and the support structures for community processes in general. The guidelines, developed in consultation with the states, distil the experiences shared by state programme managers over the years, builds on shared problems and common solutions. The document is designed to reflect the fact that guidelines for implementation must take into account the essence of problematics encountered in the field, the complexity of the intervention, and the day to day challenges that programme managers encounter and the strategies they devise to overcome these.

We must now continue to strengthen the community processes interventions, motivated by confidence and optimism, and girded by a caution that successful outcomes are possible only by careful attention to detail. Now that the parameters for the programme have been set, by and large, it is the attention to field implementation that will result in the outcome we envision: which is that it is ultimately people who should become full fledged and active stakeholders in achieving health outcomes.

It is our hope that states use these guidelines wisely, temper them with the day to day realities their sub district and district managers encounter everyday and use them to guide their programmes to achieve the vision of the programme.

26 June 2013

Anuradha Gupta

ACKNOWLEDGEMENTS

“The Guidelines for Community Processes” build on the original ASHA and Village Health Sanitation and Nutrition Committee guidelines and various orders that were issued during the period 2006-2012. Critical inputs were provided by programme managers at the national and state levels, State Nodal Officers for ASHA and Community Processes and members of the National ASHA Mentoring Group.

The Guidelines for the Village Health Sanitation and Nutrition Committee are based on the contributions from the states (Chhattisgarh, Orissa, Gujarat, Rajasthan and Kerala) which have shown effective engagement with VHSNCs and inputs from the Advisory Group on Community Action. We also acknowledge inclusion of technical content and illustrations from the various state level guidelines.

ABOUT THE GUIDELINES

These Guidelines for Community Processes encompass the guidelines for ASHA, Village Health Sanitation and Nutrition Committees and Support Structures. They supersede the earlier individual guidelines and are issued as a part of one set, so as to reinforce and enable the operationalization of NRHM's vision that the ASHA and VHSNC are part of a continuum to strengthen community engagement for health and social determinants. Part A has the ASHA guidelines and Part B includes guidelines for strengthening VHSNC effectiveness. Part C includes guidance for states on Setting up Support Structures for technical assistance and programme management of ASHA, VHSNC and other community processes.



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ASHA GUIDELINES

2013

PART - A



ASHA GUIDELINES



Background

The National Rural Health Mission (NRHM) launched in the year 2005, has completed seven years of implementation and is now commencing its second phase. The ASHA programme was introduced as a key component of the community processes intervention. Over the seven year period, the ASHA programme has emerged as the largest community health worker programme in the world, and is considered a critical contributor to enabling people's participation in health.

Guidelines for implementation of the ASHA programme were issued by the Ministry of Health and Family Welfare (MoHFW) in 2006. The original guidelines were supplemented by several orders issued by the MOHFW to communicate policy modifications to the states. The programme has evolved substantially in the past seven years. In the journey so far, there is a better understanding of the programme through learning from the experiences of the implementers and various stakeholders, assessments and evaluations. This necessitates that existing guidelines for the programme be revised. The revised guidelines build on the original guidelines and various orders issued in the period 2006–2012.

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Section - I: Roles and Responsibilities of an ASHA

The roles and responsibilities of an ASHA include the functions of a healthcare facilitator, a service provider and a health activist. Broadly her functions involve providing preventive, promotive and basic curative care in a role complementary to other health functionaries; educating and mobilizing communities particularly those belonging to marginalized communities, for adopting behaviours related to better health and create awareness on social determinants, enhancing better utilization of health services; participation in health campaigns and enabling people to claim health entitlements.

Her roles and responsibilities would be as follows:

- ▶ ASHA will take steps to **create awareness** and provide information to the community on determinants of health such as nutrition, basic sanitation and hygienic practices, healthy living and working conditions, information on existing health services and the need for timely use of health services.
- ▶ She will **counsel** women and families on birth preparedness, importance of safe delivery, breastfeeding and complementary feeding, immunization, contraception and prevention of common infections including Reproductive Tract Infection/Sexually Transmitted Infection (RTIs/STIs) and care of the young child.

- ▶ ASHA will **mobilize the community and facilitate people's access to** health and health related services available at the village/sub-centre/primary health centres, such as Immunization, Ante Natal Check-up (ANC), Post Natal Check-up (PNC), ICDS, sanitation and other services being provided by the government.
- ▶ She will **work with the Village Health, Sanitation and Nutrition Committee** to develop a comprehensive village health plan, and promote convergent action by the committee on social determinants of health. In support with VHSNC, ASHAs will assist and mobilize the community for action against gender based violence.
- ▶ She will arrange **escort/accompany** pregnant women & children requiring treatment/admission to the nearest pre- identified health facility i.e. Primary Health Centre/Community Health Centre/First Referral Unit (PHC/CHC/FRU).
- ▶ ASHA will **provide community level curative care** for minor ailments such as diarrhoea, fevers, care for the normal and sick newborn, childhood illnesses and first aid. She will be a provider of Directly Observed Treatment Short-course (DOTS) under Revised National Tuberculosis Control Programme. She will also act as a depot holder for essential health products appropriate to local community needs. A Drug Kit will be provided to each ASHA. Contents of the kit will be based on the recommendations of the expert/technical advisory group set up by the Government of India. These will be updated from time to time, States can add to the list as appropriate.
- ▶ The ASHA's role as a care provider can be enhanced based on state needs. States can explore the possibility of graded training to the ASHA to provide palliative care, screening for non-communicable diseases, childhood disability, mental health, geriatric care and others.
- ▶ The ASHA will provide **information on** about the births and deaths in her village and any unusual health problems/disease outbreaks in the community to the Sub-Centres/Primary Health Centre. She will promote construction of household toilets under Total Sanitation Campaign.

The ASHA will fulfill her role through five activities:

1. **Home Visits:** For up to two hours every day, for at least four or five days a week, the ASHA should visit the families living in her allotted area, with first priority being accorded to marginalized families. Home visits are intended for health promotion and preventive care. They are important not only for the services that ASHA provides for reproductive, maternal, newborn and child health interventions, but also for non- communicable diseases, disability, and mental health. The ASHA should prioritize homes where there is a pregnant woman, newborn, child below two years of age, or a malnourished child. Home visits to these households should take place at least once in a month. Where there is a new born in the house, a series of six visits or more becomes essential.
2. **Attending the Village Health and Nutrition Day (VHND):** The ASHA should promote attendance at the monthly Village Health and Nutrition Day by those who need Aganwadi or Auxiliary Nurse Midwife (ANM) services and help with counselling, health education and access to services.
3. **Visits to the health facility:** This usually involves accompanying a pregnant woman, sick child, or some member of the community needing facility based care. The ASHA is expected to attend the monthly review meeting held at the PHC.
4. **Holding village level meeting:** As a member or member secretary of the Village Health, Sanitation and Nutrition Committee (VHSNC), the ASHA is expected to help convene the monthly meeting of the VHSNC and provide leadership and guidance to its functioning.

These meetings are supplemented with additional habitation level meetings if necessary, for providing health education to the community.

5. **Maintain records:** Maintaining records which help her in organizing her work and help her to plan better for the health of the people.

The first three activities relate to facilitation or provision of healthcare, the fourth is mobilizational and fifth is supportive of other roles.

Section - 2: Selection of ASHAs

Selection of ASHAs is near completion in all states according to the norms laid during the first phase of NRHM. For the sustainability of programme, there is a need to plan for atleast 5% turnover and fresh selection every year. States need to engage more ASHAs to meet the deficit due to rise in rural population (as per 2011 Census).

The general norm will continue to be 'One ASHA per 1000 population'. When the population exceeds one thousand, another ASHA can be engaged.

Where there is more than one ASHA in a village, each ASHA needs to be allocated a set of households so that no households, particularly those in the periphery and outlying hamlets are missed.

In tribal, hilly and desert areas, the norm can be relaxed to one ASHA per habitation, depending on the workload, geographic dispersion, and difficult terrain.

In urban habitations with a population of 50,000 or less, ASHAs will be selected as in rural areas. The urban health mission is expected to extend the ASHA program to all urban areas.

CRITERIA FOR SELECTION

- ▶ ASHA must be a woman resident of the village – preferably 'Married/Widow/Divorced/Separated' and preferably in the age group of 25 to 45 years.
- ▶ ASHA should have effective communication skills, leadership qualities and be able to reach out to the community.
- ▶ She should be a literate woman with formal education upto Eighth Class.
- ▶ She should have family and social support to enable her to find the time to carry out her tasks.
- ▶ The educational and age criteria can be relaxed if no suitable woman with this qualification is available in the area.
- ▶ Adequate representation from disadvantaged population groups should be ensured to serve such groups better.

SELECTION PROCESS

The District Health Society is expected to oversee the process. The Society should designate a District Nodal Officer who belongs to the regular cadre to oversee the process of selection in the entire district. She/He will be supported by the District Community Mobilizer (DCM).

At the block level, the Society should designate a Block Nodal Officers, who belongs to the regular cadre, such as the Block Medical Officer or Block Extension Educator (BEE). The Block nodal officer will be supported by the Block Community Mobilizers (BCM) and ASHA facilitator in the selection process. The BCM and ASHA facilitators will work closely with the community in selecting the ASHA.

The ASHA Facilitators should be oriented to the selection process as part of their training in the Handbook for ASHA Facilitator. Training the BCM and facilitator is the responsibility of the state ASHA and Community Processes Resource Centre (CPRC).

The facilitators are required to raise awareness in the community about the roles and responsibilities of the ASHA and the criteria on which she is to be selected. This is done through community interaction in the form of meetings, Focus Group Discussions (FGDs) and mobilizational events such as Kala Jathas. These processes enthuse women to apply to become ASHA.

The trained facilitator will organize meeting of the households for which an ASHA is to be selected. In order to organize the meetings, the facilitators should engage actively with representatives of the Panchayat Raj Institutions (PRI), women's Self-Help groups, other Community based groups, and local Civil Society Institutions. In the meeting the facilitator will explain the roles and responsibilities of the ASHA and ask the community to select their ASHA from amongst the women interested in taking up this role. This interaction should result in short listing of at least three names from each village.

Ideally, a meeting of the Gram Sabha should be convened to select one of the three shortlisted names. The minutes of the approval process in Gram Sabha shall be recorded. The name will be forwarded by the Gram Panchayat to the Block and Nodal Officer for the record.

State Governments may modify the guidelines and the details of the selection process, based on their context except that no change may be made in the basic criteria of ASHA being a woman volunteer, with minimum education up to VIII class, (only to be relaxed in selected areas where no such candidate is available) and that she would be a resident of the village. In case any of the selection guidelines or process is modified, these should be widely disseminated in local languages.

ASHA DATABASE

An ASHA database/register will be maintained at Block, District and State levels. The function of the register is to maintain updated information on the ASHA, population coverage, households allocated, training inputs received, and performance, data on drop-outs and new appointments. Formats for the register at each level are at Annexure - I. This should be updated as specified.

Database registers will be maintained at block and district levels by the nodal officers, updated as and when required. On an annual basis the data will be consolidated and sent to the state as an aggregate number as specified in the Annexure I This would help in maintaining a comprehensive record of all the ASHAs working in the district as well as drop outs from the programme. The register will also record the number of areas without an ASHA.

CRITERIA FOR DECLARING AN ASHA AS A "DROP OUT"

ASHA is to be considered as drop out if:

- ▶ She has submitted a letter of resignation to the VHSNC and her facilitator **OR**
- ▶ She has not attended the three consecutive VHNDs **AND** not given reasons for the same **OR**

- ▶ She has not been active in most of the activities **AND** Block Community Mobilizer/Coordinator visited the village of the ASHA and ascertained through discussions with all VHSNC members that she is indeed not active.

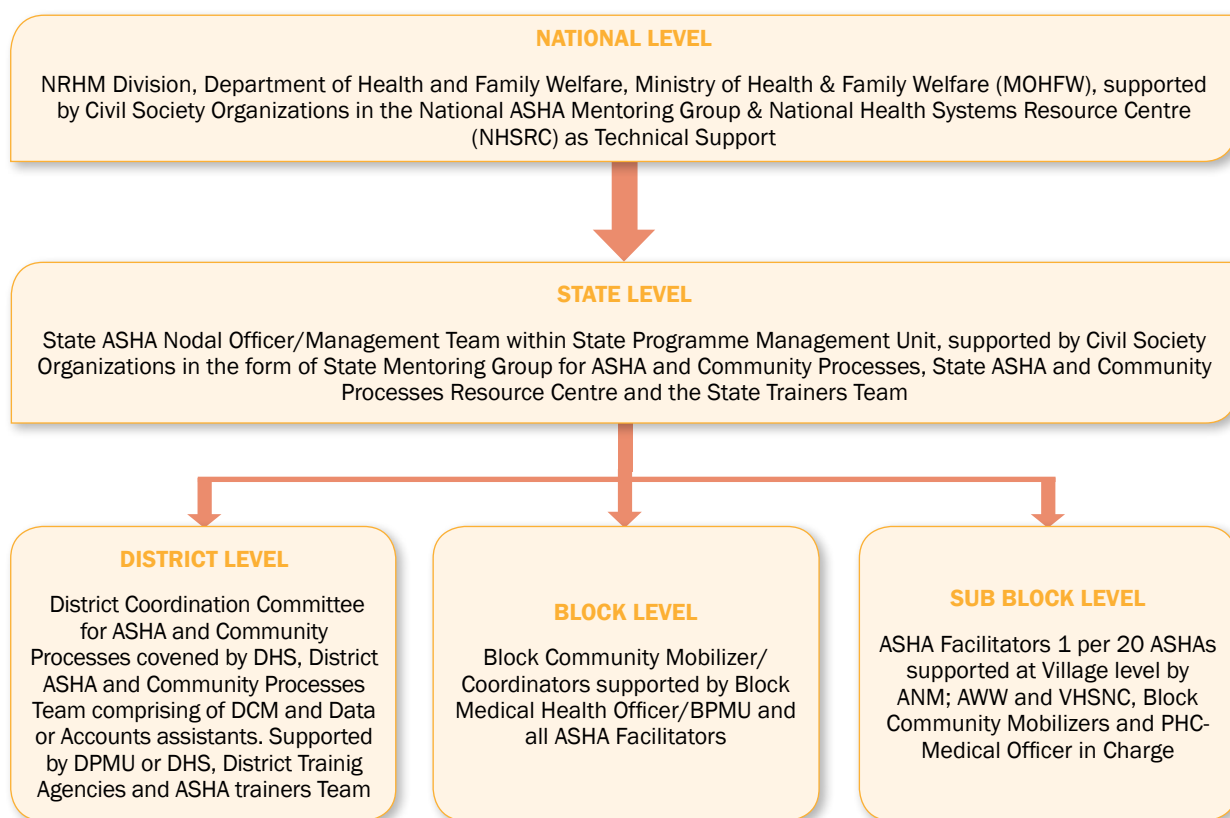
If there is a genuine problem, she should be supported until it is overcome through the VHSNC or village SHG. If the problem persists and the community also agrees that ASHA should not continue, a signed letter stating this should be obtained from her and approved by Block Community Mobilizer after due validation from Gram Sabha/Panchayat. In case of her contesting her removal, it should be referred to the district community mobilizer or other person appointed by the secretary of the district health society who would listen to her views, record them and then take a final view. It is desirable in case of all 'dropouts' whatever the reason, to conduct and document an exit interview.

Vacancies howsoever they arise, should be filled in by the same selection process as laid down by state government, based on these guidelines.

Section - 3: Programme Management and Supportive Mechanisms for ASHA Programme

The ASHA programme should have a strong network of supportive structures woven around it, to facilitate her work and make her more effective as a community health worker (Chart 1). Details of the support structure have been included in Part-C of this book - as 'Guidelines for setting up Community Processes Support Structure'.

CHART-1. SUPPORT STRUCTURE FOR ASHA



Section - 4: Capacity Building of ASHAs

Capacity building of ASHA is a continuous process. Building ASHAs knowledge base and skills is critical in enhancing her effectiveness to achieve the desired healthcare outcomes. ASHA needs more skills for her to be effective – as a facilitator, as a community level health care provider, and as a health activist. Training of the ASHA is a continuous process, and the duration and skills specified below are the absolute minimum, which must be achieved for every ASHA. States can set their own upper limit on the number of days of training.

TRAINING STRATEGY

The training strategy includes:

1. Induction Training

All newly selected ASHAs will undergo an eight day induction training to orient her to her role and responsibilities, provide the skills of community rapport building and leadership, and an understanding of the health system and a rights based approach to health.

2. Skill based Training for key competencies in women and children's health and nutrition

This is a twenty day training to be completed in four rounds within the first eighteen months of joining. All ASHAs are required to be certified in a set of competencies related to basic reproductive, maternal, newborn, and child health and nutrition, and infectious diseases such as malaria and tuberculosis. The existing Modules 6 and 7 will be used for this training. The list of training competencies is provided at Annexure II.

3. Supplementary and Refresher Trainings

Subsequently at least fifteen days of training annually should be planned in which new topics and skills can be added. These can also serve to reinforce existing skills in areas where the ASHAs need further inputs. The new skills would be specific to local needs. Skills in certain areas such as disability screening, mental health counselling, or other skills that the state would like to prioritize can be taught to selected ASHAs rather than all ASHAs in a particular area. She could then provide such services to larger set of villages. The PHC review meetings can be used as a forum for such training. States will develop modules with central assistance as needed for state specific issues as appropriate.

KEY FEATURES OF TRAINING

ASHA training is designed in multiple levels. There are three levels of training and each level is expected to have a committed; full time cadre of trainers and corresponding training sites.

- ▶ A national team of trainers trained and accredited at the national training sites. The national trainers are a mix of the faculty of the national training site, trainers deputed from other Public Health Organizations, or freelance trainers who can be called upon when required.
- ▶ A team of state trainers trained and accredited at national training sites.
- ▶ A team of ASHA trainers for each district drawn from the sub district level, trained and accredited at the state level training sites.
- ▶ ASHA trainers would conduct the training sessions for ASHAs and ASHA facilitators in the sub district sites.

The state shall designate one state level training centre for every six districts which will have a faculty of at least four to six state trainers. The state will also designate five or more sub district training sites at which ASHAs will be trained. A batch of thirty ASHA needs a team of three ASHA trainers. Details of the training strategy are provided at Annexure III.

The core of the training syllabus is contained in the reading material provided to the ASHA. This would be supplemented by communication and equipment kit. The lists of contents of ASHA Equipment Kit are given in Annexure IV. The trainers will also be provided with trainer notes. States could add further training modules after ensuring completion of the core syllabus.

The training methodology could include some short lecture- presentations. However, most sessions would have practice of skills and/or small group discussions and small assignments. There would be field visits during the training programme. The training programme would also include examination of newborns and children as part of the practice skills and this will be done during the field work that would be undertaken by ASHA and the ASHA facilitators between the training rounds. Clinical and field situations with problem solving exercises would also be demonstrated using films and situation cards.

QUALITY ASSURANCE FOR TRAINING

Quality of training is a serious concern. Quality assurance will require the following minimum standards to be followed:

- a. All trainers and master trainers should be duly tested and accredited and only those who have so qualified should be used for training.
- b. Training sites should also be duly inspected and accredited.
- c. Training should always be accompanied by well-crafted training material that would capture the content. No training conducted without such training material with help of trainers and trainees can assure quality of training.
- d. All trainees should be evaluated at the end of each training round/camp and training evaluation results documented.
- e. Formal certification of ASHA- will take place in a phased manner. Separate set of guidelines for ASHA certification will be issued. Evaluation of ASHAs will form an important component of the certification process.
- f. Those ASHAs who do not pass the evaluation should be provided on the job training and supervision and should be recalled for refresher training.

There should be sufficient opportunity for participants to get hands on practice and a conducive training environment for participants to freely raise questions and voice opinions.

MANAGEMENT OF TRAINING AND POST TRAINING SUPPORTIVE SUPERVISION

At the National level:

- a. NHSRC will work closely with the Training/NRHM Division (MOHFW) and the National ASHA Mentoring Group. They will be responsible for developing processes for a) selection of NGOs and other organizations to serve as national and state training sites¹, b) developing guidelines

1 A site here refers to an organization or agency with the competency and infrastructure to conduct training for community level workers.

for selection of state level and ASHA trainers, c) develop prototype training modules for state adaptation and use, d) accreditation for national and state sites and trainers, e) Facilitate state coordination with the national training sites, f) facilitate accreditation of state and district training sites, and g) review and support the training at the national sites.

At the **State level**, the State ASHA and Community Processes Resource centre will be responsible for implementing the ASHA training. This includes selection of state trainers, ASHA trainers from the districts, Identification and strengthening of the state and sub district training sites, coordinating the logistics of nominating of state trainers and ASHA trainers, to the training at the national sites and state sites respectively, facilitating accreditation of the district training sites, ASHA trainers and ensure certification of the ASHA in accordance with procedures, ensure timely distribution of the ASHA reading material, modules, training material and other training aids to the sub district sites, maintaining a data base of ASHA training to enable monitoring of training schedules, drop outs among trainees and trainers between rounds, and training quality.

At the **District Level** the district community mobilizers will coordinate with the State ASHA and Community Processes Resources Centre, District Training sites, and district health society to support and supervise training of the ASHA at district level. They will support the district training agencies in developing a block wise training calendar for ASHAs, ASHA Facilitators, maintaining a data base of the ASHA training, enabling ASHA certification at accredited training sites, ensuring availability of adequate training material–equipment and books for every round, and monitoring training quality, in the sub district training sites and ensuring that every ASHA is evaluated for knowledge and skills after every round of training. This process of evaluation will be conducted through the Block community mobilizers and facilitators.

PARTNERSHIPS WITH NGO FOR TRAINING SUPPORT AND SUPERVISION OF THE ASHA PROGRAMME

States are encouraged to enter into partnerships with individual NGOs or with a consortium, provided that between them they share the competencies needed. This would be done by DHS with ASHA and Community Processes Centre support for block sites.

Annexure III includes details on- various requirements and definitions related to training and selection criteria of Trainers and District/Block Training Sites.

ASHA DRUG KIT

A drug kit has been provided to all ASHAs to provide curative first contact care for symptomatic relief, pending referral, and manage cases as per the protocols she has been trained in. Major challenges have been reported in terms of refill of drug kits. The state must put in place a clear instruction detailing:

- a. How will the drugs be sourced?
- b. How will it reach the ASHAs?
- c. What documents and records need to be maintained and by whom to ensure timely and proper refills?

The contents of the drug kit are listed in Annexure V.

The ASHA should have a stock card in which monthly refills should be recorded. ASHA facilitators should be in charge of refills. It is her responsibility to ensure that drugs have not expired and there are no stock outs. While refilling, she should put the drugs in the appropriate containers with familiar labels so that if there is any change in size, color or dose of the drug, ASHA does not get confused.

ASHA Facilitators would take the refills from the ANM or the PHC stores depending on the state norms. The quantity of drugs collected and distributed by the facilitator should be available in their own records and also kept in the store.

It also needs to be emphasized that without a robust system of procurement and an adequate logistic and supply system from where the drugs are sourced, such distribution/refill would not work. States can make appropriate addition to the list of drugs where additional tasks are allocated to ASHAs.

Section - 5: Role Coordination Between the ASHA, ANM and AWW

It is important to establish synergy and role clarity related to the functioning of these field level functionaries. The table summarizes the specific roles of these workers related to certain key activities at community level.

TABLE - 1:

Activity	Role of ASHA	Auxiliary Nurse Midwife	Anganwadi Worker
Home visits	Primary focus is on health education, care in illness, prioritising visits to households with a pregnant woman, a newborn (and post natal mother), children under two, a malnourished child and marginalised households	Prioritizing those families with whom the ASHA is having difficulty in motivating for changing health seeking behaviours, those who do not attend VHND; providing home based services for post-partum mothers; sick new born and children who need referral but are unable to go; Ensuring that there is an ASHA assigned to every household and they are aware of it. Supportive supervision through joint visits with ASHAs	Primary role on nutrition counselling, and supportive role on childhood illness Providing take home rations to those who are unable to come to AWC
VHND	Primary Focus on social mobilization for women and children to attend the VHND , through motivation and counselling. Special emphasis on marginalized groups, and enable access to health care and entitlements.	Service provider who delivers immunisation, antenatal care, identification of complications, and family planning services	Anganwadi Centre (AWC) is the venue and Anganwadi Worker (AWW) enables the support in making this possible. She weighs all children below 5 years of age, maintains growth chart and provides Take Home Rations to pregnant and lactating mothers and for children under three. On non VHND days identifies and provides care for registered children in AWC.

Activity	Role of ASHA	Auxiliary Nurse Midwife	Anganwadi Worker
VHSNC	Convener of the meetings; preparation of Village health Plans Providing leadership and guidance for convergent action of all public services	Support ASHA In convening the meetings and village health planning	Support ASHA In convening the meetings and village health planning
Escort Services	Voluntary function To be done by ASHA on the basis of requirement and feasibility however to be compensated for travel and day wages		
Record Maintenance	Maintains a drug kit stock card, a diary to record her work, a register assist her in organizing and prioritizing her work and for those who need her services.	Primary Responsibility Maintain a tracking register and record of service delivery for the services she delivers.	Primary responsibility Maintains a tracking register to record service delivery for pregnant and lactating mothers and children, weighs and maintains growth charts for children under 5 years of age.

Section - 6: Working Arrangements

An ASHA should have a flexible work schedule and her workload should be limited to putting in only about three to four hours per day on about four or five days per week, except during some mobilization events and training programmes. This would mean that in most contexts she could do this work without adversely affecting her primary livelihood. During mobilization events, such as pulse polio, or while escorting a patient, she may be required to spend a full day on the programme, in which case she must be compensated accordingly. Further, such full day work cannot be made mandatory except for training programmes. Her work accountability lies primarily within the purview of Village Health Sanitation and Nutrition Committee. Her immediate field level support will be provided by both ASHA Facilitator and the ANM. The ANM's focus will be in her skills for community level care and identification of illnesses and the facilitator's role will be on supporting her in her activist role, in mobilization and in reaching the marginalized.

Section - 7: Compensation to the ASHA

She is primarily an “honorary volunteer” but is compensated for her time in specific situations (such as training attendance, monthly reviews and other meetings). In addition she is eligible for incentives offered under various national health programmes. She would also have income from social marketing of certain healthcare products like condoms, contraceptive pills, sanitary napkins etc. The voluntary nature of the ASHA programme needs to be preserved in the second phase of NRHM. Her work should be so designed that it is done without impinging on her main livelihood and adequate monetary compensation for the time she spends on these tasks- through performance based payments should be provided.²

She is compensated for her time in the following situations:

- a. For the duration of her training both in terms of TA and DA. (So that her loss of livelihood for those days is partly compensated)
- b. For participating in the monthly/bi- monthly meetings, other than for travel and refreshments at the meeting site. (For situations (a) and (b), payment should be made at the venue of the training when ASHAs come for regular training sessions and/or meetings)
- c. For undertaking specific measurable tasks related to health or other social sector programmes (see Annexure VI).

OTHER INCENTIVES

Social recognition also takes place at a group level. The state must invest in TV and Radio programmes, in hoardings and public displays, which project the ASHA as a person holding immense responsibility and an important community resource to overcoming barriers to accessing health care services. This in itself would be an incentive.

States may consider including other incentives such as:

- ▶ Group recognition/awards
- ▶ Non-monetary incentive e.g. exposure visits, annual conventions etc.
- ▶ Cycles, ID cards etc.
- ▶ Social Security

An indicative compensation package for ASHA for training and various services provided by her is enclosed at Annexure VI. The states can add to the existing incentives but will need to revise the compensation package as further new incentives are added in the programme.

Note: *Emoluments should be regular and preferably through bank transfers. States should negotiate with all banks not to charge penalty fees for small deposits and allow the opening of zero balance accounts, since these two factors deter ASHAs from opening bank accounts.*

ASHA HELP DESK AND REST ROOMS FOR ASHA

ASHAs constitute an important link between the community and the health facility. They are regularly referring pregnant or sick mothers, children, and people with complications to the

² Recommendation of the Working Group on NRHM for the Twelfth Plan.

health facilities. An ASHA Help Desk should be established to ensure facilitation of proper service availability, to navigate the patients and help them during referrals at the health institutions.

ASHAs often need to stay overnight at the facilities and for this we need to provide a rest room for the ASHAs. Both of this is needed in all District and Sub Divisional Hospitals of the State.

SETTING UP A GRIEVANCE REDRESSAL COMMITTEE - DISTRICT STRUCTURE

- i. A five member committee will be notified by the District Health Society (DHS) (under the leadership of the Chief Medical Officer (CMO) and District Collector). The composition of the Committee is given below. At least three members should be women:

- ▶ Two of the five members will be representatives from Non- Governmental agencies, or academic institution or individual women in leadership positions.
- ▶ Two would be government representatives from a non- health sector (WCD, ICDS, Education, Rural Development, PRI), and
- ▶ One would be a nominee of the CMO.

At least three of the selected members would be women in leadership positions or from within academic institutions.

- ii. The DHS will allocate to the ASHA Grievance Redressal Committee an office with a full time secretary and a functioning landline number and P.O. Box number both of which are to be widely publicized and displayed at PHC, CHC and District hospitals.
- iii. The ASHAs should be made aware of the existence of the Grievance Redressal Committee and the processes by which their grievances can be communicated.
- iv. The complaint may be initiated telephonically but should be submitted in writing and a signed receipt of the complaint should be provided to the ASHA.
- v. The working hours of the office would be concomitant with those of the DHS. The secretary will maintain a register of grievances in a format which will include the name, date of receipt of grievance, and the specific complaint.
- vi. The secretary will write to the concerned officer who is required to take action on the grievance. A reply has to be sent within 21 days to the complainant. A written documentation of the Action taken report will also be maintained and certified by the members of the committee. If the officer denies the substance of the complaint, that too has to be recorded.
- vii. The committee will meet once a month to review the grievances and action taken. The committee will decide on the appropriate action for commonly recurring grievances.
- viii. Where the complainant is not satisfied, she could appeal to the Chairperson of the District Health Society or the Mission Director, State Health Society.

Section - 8: Fund Flow Mechanism for the ASHA Programme

Funds for ASHA Programme flow from NRHM to State Health Society and from State Health Society to District Health Society. As part of NRHM-RCH- Flexipool, the fund allocation for ASHA programme is specifically earmarked. Incentives to ASHA related to programmes like JSY, immunization, disease control programs are a part of those programs and are not taken from the ASHA budgetary head.

From the State Health Society, the funds for block and district level expenses flow to District Health Society. The District Health Society will release funds to specific institutes or individual empowered to incur expenditure. Mostly the training funds would be released to a training institution or an officer made in charge of the training program. Funds for payment to ASHA facilitators/block ASHA coordinators and district teams should be made directly from the district preferably by bank transfer.

The incentives paid to ASHAs are released to Block Medical Officers who would release it to VHSNC, Gram Panchayat or sector PHC as decided by the states. The ASHAs should be paid on a fixed day in a month from these sites:

- a. ASHA would be entitled for TA/DA for attending training programmes. She would be given the amount at the venue itself.
- b. For the compensation money under the various national programmes/Schemes, the programmes have in-built provisions for the payment of compensation. These compensations will be made in accordance with the programme guidelines.
- c. The compensation to ASHA based on measurable outputs would be given under the overall supervision and control by Panchayat. For this purpose a revolving fund would be kept at Panchayat. The guidelines for such compensation would be provided by the District Health Mission, led by the Zila Panchayat. This mechanism of fund flow for payments should be adopted by states only after the VHSNCs and Panchayats have been strengthened through appropriate capacity building in undertaking local health functions and financial management. Till then the prevalent mechanisms of payments through District Health Societies for specific outcomes should be continued.
- d. The states should ensure that as far as possible the incentive payment to ASHA is made through e-transfer wherever available, and otherwise through cheque payment.

Section - 9: Budget & Financial Mechanism for ASHA Programme

The budget package for a normative block – 180,000 population; 180 ASHAs is given in Annexure VIII. It covers cost heads related to training, Supervision and Support mechanism for ASHAs at block and sub-block levels. The cost towards the provision of kits and other job aids has also been included here. This is only an illustrative budget.

Section - 10: Monitoring and Evaluation

A. Monitoring for functionality. A Monitoring system has been developed to monitor the functionality as well as the outcomes of the ASHA programme at block, district and state level. The following steps should be followed at each level:

Step 1- ASHA. ASHAs are not required to keep any additional records, or submit filled formats but use their register and diary, which are their planning and recording tools. They are expected to provide information on set of ten indicators (BOX-1), verbally to their facilitators. This information is to be gathered by the facilitators from the ASHA at the monthly cluster meetings. Facilitators use this data collection process as a tool for supportive supervision. This also helps to ensure that reporting is reliable.

BOX -1

1	Newborn visits on first day of birth in case of home deliveries
2	Set of home visits for new born care as specified in the HBNC guidelines (six visits in case of Institutional delivery and seven in case of a home delivery)
3	Attending VHNDs/Promoting immunization
4	Supporting institutional delivery
5	Management of childhood illness – especially diarrhoea and pneumonia
6	Household visits with nutrition counselling
7	Fever cases seen/malaria slides made in malaria endemic area
8	ASHAs acting as DOTS provider
9	Holding or attending village/VHSNC meeting
10	Successful referral of IUD, female sterilization or male sterilization cases and/or providing OCPs/Condoms

Step 2- Sub block or Facilitator level. The main source of data for performance monitoring is the ASHA facilitator who records the ASHA's own report of her work as presented in the ASHA's cluster meeting or review meeting. The periodicity of this meeting should be at least once a month, though once in two weeks is desirable. ASHA Facilitator will also provide the data on number of ASHAs functional on more than 50% of the tasks ie in six out of ten tasks. This data is submitted by the facilitators to the block on a monthly basis. (Format 1 in Annexure VII)

Step 3-Block. The data from all the facilitators will then be compiled by the Block Community Mobilizer/Coordinator on a monthly basis. At the end of each quarter the Block Community Mobilizer/Coordinator will submit the consolidated report to the District Coordinator/Nodal person.

Step 4- District. At the district level, the district coordinator consolidates and reports the functionality grade of each block to the state on a quarterly basis. Grading of blocks is to be done on each of the indicator as well as on the percentage of ASHAs who are functional on more than 50% of the total tasks ie in six out of ten tasks. The criteria for grading of blocks are defined as:

- Grade A – Blocks where of the total ASHAs >75% ASHAs are functional
- Grade B- Blocks where of the total ASHAs 51-75% ASHAs are functional
- Grade C- Blocks where of the total ASHAs 25-50% ASHAs are functional
- Grade D- Blocks where of the total ASHAs < 25% ASHAs are functional

(Functional ASHA is one who is active on at least 6 out of 10 tasks)

District will also maintain a record of blocks with ASHAs functionality for each of the 10 tasks separately.

Step 5 – State. At state level block wise data for all districts will be collected and consolidated on a quarterly basis. Districts will be graded based as per the following criteria:

- Grade A – Districts where >75% blocks are graded A + B (on each of the indicators)
- Grade B- Districts where 50-75% blocks are graded A + B (on each of the indicators)
- Grade C- Districts where <50% blocks are graded A + B (on each of the indicators)

B. Correlating ASHA Functionality with Health Outcomes

Block wise data on key program outputs and health outcomes are available from HMIS data. Though ASHA functionality is only one of the many complex mechanisms that contribute to achieving each of these outputs, it is worth co-relating with functionality of ASHAs on each of her 10 tasks – so as to improve the quality and coverage of her functionality in a focussed way. We indicate below 17 indicators that are positively influenced by a functional ASHA and should be used for better program management.

Indicator	ASHA's Contribution
1. Percentage of newborns weighed	Weighs newborns from home delivery. Reminds and encourages weighing if newborn delivery is in institution
2. Percentage of babies breast fed in first hour of birth	Counsels and supports for promotion of timely initiation and exclusive breastfeeding
3. Percentage of Low birth weight babies	Positive identification of low birth weight and preterm babies and emphasis on care for LBW, Pre-term babies
4. Percentage of children who have received full immunization	Assists in completion of immunisation schedule in the community by mobilizing children especially in under served and marginalized groups
5. Percentage of children who have received measles immunization	Same as Above
6. Percentage of immunization session where ASHA was present	ASHA is expected to be present to support ANM as also to use the occasion for health education
7. Percentage of women who received 3 ANC's	Ensures antenatal care and identification of high risk mothers
8. Percentage of Institutional deliveries	Promotes institutional delivery by empowering and enabling women to access safe delivery in health facilities
9. Percentage of JSY payments for Institutional deliveries	Same as above
10. Percentage of ASHAs who have got incentive under JSY	Same as above
11. VHSNC fund utilization	Ensures that VHSNC is convened Leadership and guidance to VHSNC by social mobilization
12. No. of children admitted for respiratory infection	An active ASHA would have identified and referred acute cases. However the local facility has to be equipped for this purpose
13. No. of children treated for diarrhoea/ dehydration	Same as above
14. Reported still birth	ASHA should inform the village level person entrusted with collecting information for birth & death registration about a still birth. In some states this is the ANM. In other it is Panchayat Clerk, yet other it is Kotwar. It is particularly important if the birth happen at home.
15. Reported still birth rate	Same as above
16. Reported perinatal mortality	Same as above. Applicable for birth at home
17. Reported neonatal mortality	Same as above. Applicable for birth & death at home

ANNEXURES

Annexure - I

ASHA DATABASE REGISTER

Frequency – Annual

1. **At Block Level.** At block level, block community mobilizer/coordinators would maintain an ASHA database register for every ASHA in the block.

ASHA Base Register format for Block Community Mobilizer Date of Filling the Register-																	
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
ASHA Name	Village Name	Mobile Number	Name of ANM In charge	Age	Education level	Caste – SC/ST/OBC/other	Marital status (M- Married) (S- Married but currently single) (U – Unmarried)	Other sources of income	Date of selection of ASHA	Date of filling the register	Letter from panchayat Y/N	ID card issued Y/N	Certificate for any skill, if issued. Date of issue of certificate. (Fill as N if None)	AADHAR/ UID number	Bank account number No... (Fill as N if no bank account)	Date of cessation from ASHA work	Reasons for dropout
1																	
2																	

Block Community Mobilizer/coordinators will also provide data on:

- Number of villages without an ASHA in the block.
- Number of ASHA who cover a population greater than 1500 in the block.

2. **At District Level.** At the District level, (refer Page 6 & 7) the district coordinator will maintain the register in the following format 2. This will be maintained on a yearly basis but in case of any drop out the state officials should be notified of the change of status.

District ASHA data base register					Date of filling the register-		
Block Name	Village name	Population of village	ANM in charge	ASHA Name	Date of selection of ASHA	Date of cessation from ASHA work	Reasons for dropout

District Coordinators consolidates data from all blocks on:

- Number of villages without an ASHA in the district
- Number of ASHA who cover a population greater than 1500 in the district

3. **At State level**– Based on the data collected above in format 1 & 2 at block and district levels the following information will be compiled by State consultant for all districts of state:

- Total number of ASHAs in the state
- Number of drop outs in the state in last year
- Number of ASHA joined in the past fiscal year
- Number of villages without an ASHA in the state
- Number of ASHA who cover a population greater than 1500 in the state

TRAINING COMPETENCIES

Competencies	Knowledge required	Skill required
General Competencies	<ul style="list-style-type: none"> ▶ Knowledge about qualities that need to be inculcated to successfully work as ASHA. ▶ Knowledge about village and its dynamics. ▶ Clear understanding of role and responsibilities. ▶ Understanding of who are the marginalized and the specific role in ensuring that they are included in health services. 	<ul style="list-style-type: none"> ▶ Conducting a village level meeting. ▶ Communication skills – especially interpersonal communication and communication to small groups. ▶ Skill of maintaining diary, register and drug kit stock card. ▶ Tracking beneficiaries and updating MCH/Immunization card.
Maternal Care	<ul style="list-style-type: none"> ▶ Key components of antenatal care and identification of high risk mothers. ▶ Complications in pregnancy that require referral. ▶ Detection and management of anaemia. ▶ Facility within reach, provider availability, arrangement for transport, escort and payment. ▶ Understanding labour processes (helps to understand and plan for safe delivery). ▶ In malaria endemic areas, identify malaria in ANC and refer appropriately. ▶ Understanding obstetric emergencies and readiness for emergencies including referral. 	<ul style="list-style-type: none"> ▶ Diagnosing pregnancy using Nischay kit. ▶ Determining the Last Menstrual Period (LMP) and calculating Expected Date of Delivery (EDD). ▶ Tracking pregnant women and ensuring updated Maternal and Child Health Cards for all eligible women. ▶ Developing birth preparedness plans for the pregnant woman. ▶ Screening of pregnant woman for problems and danger signs and referral. ▶ Imparting a package of health education with key messages for pregnant women. ▶ Attend and observe delivery and record various events. ▶ Recording pregnancy outcomes as abortion, live births, still birth or newborn death). ▶ Recording the time of birth in Hrs, Min and Seconds, using digital wrist watch.
Home Based Newborn Care	<ul style="list-style-type: none"> ▶ Components of Essential Newborn Care. ▶ Importance of early and exclusive breastfeeding. 	<ul style="list-style-type: none"> ▶ Provide normal care at birth (dry and wrap the baby, keep baby warm and initiate breastfeeding). ▶ Observation of baby at 30 seconds and 5 minutes for movement of limbs, breathing and crying.

Competencies	Knowledge required	Skill required
	<ul style="list-style-type: none"> ▶ Common problem of initiating and maintaining breastfeeding which can be managed at home. ▶ Signs of ill health or a risk in a newborn. 	<ul style="list-style-type: none"> ▶ Conduct examination of new born for abnormality. ▶ Provide care of eyes and umbilicus. ▶ Measure newborn temperature. ▶ Weigh newborn and assess if baby is normal or low birth weight. ▶ Counsel for exclusive breastfeeding. ▶ Ability to identify hypothermia and hyperthermia in newborns. ▶ Keep newborns warm.
Sick New Born Care	<ul style="list-style-type: none"> ▶ Knowledge of risks of preterm and low birth weight. ▶ Knowledge of referral of sick newborns – when and where? 	<ul style="list-style-type: none"> ▶ Identify low birth weight and preterm babies. ▶ Care for LBW, Pre-term babies. ▶ Identify birth asphyxia (for home deliveries) and manage with mucus extractor. ▶ Manage breastfeeding problems and support breastfeeding of LBW/ Preterm babies. ▶ Identification of signs of sepsis and symptomatic management. ▶ Diagnose newborn sepsis and manage it with Cotrimoxazole.
Child Care	<ul style="list-style-type: none"> ▶ Immunisation schedule. ▶ Child's entitlements in ICDS services. ▶ Weaning and adequacy in complementary feeding. ▶ Feeding during an illness. ▶ Causes of diarrhoea and prevention of diarrhoea. ▶ Knowledge of signs of Acute Respiratory Infections (ARI) – fever, chest in drawing, breath counting; and ability to manage mild Vs moderate ARI with Cotrimoxazole) (CTM), and refer the severe ones. 	<ul style="list-style-type: none"> ▶ Planning the home visits- which child to visit and at what frequency. ▶ Child immunisation tracking skills to ensure complete immunisation in the community. ▶ Weighing of children below five years of age- assessing grades of malnutrition. ▶ Analysis of causes of malnutrition in a specific child- the role of feeding practices, role of illnesses, of familial and economic factors and of access to services. ▶ Diagnosis of dehydration and ability to ascertain if referral is required. ▶ Skill to make adaption of the message of six essential feeding advice to each household. ▶ Skill in preparing and demonstrating ORS use to the mother/caregiver.

Competencies	Knowledge required	Skill required
		<ul style="list-style-type: none"> ▶ Signs of Acute Respiratory infections (ARI) – fever, chest in drawing, breath counting; and ability to manage mild Vs moderate ARI with CTM, and refer the severe ones. ▶ Skill in counselling the mother for feeding during diarrhoeal episode ▶ Testing for anaemia and ensuring appropriate treatment.
Women's Health and Gender Concerns	<ul style="list-style-type: none"> ▶ Understanding the life-cycle approach to women's health ▶ Understanding the various determinants like nutrition, discrimination, violence affecting women's health at each stage of life. ▶ Understanding overt and covert domestic violence and abuse against women and steps to counter/address them. ▶ Knowledge of key laws related to women. 	<ul style="list-style-type: none"> ▶ Communication skills in discussing gender issues in the VHSNCs or women's group meetings. ▶ Identifying women at risk for violence and taking appropriate action on a one on one basis or collective action as required. ▶ Counselling and referral support for women and families with domestic violence. ▶ Be able to disseminate provisions of acts on domestic violence, sexual harassment etc. ▶ Support women in breaking silence about violence. ▶ Organising women around issues of violence and gender.
Abortion, Family Planning, RTI/STI and HIV/AIDS	<ul style="list-style-type: none"> ▶ Understanding contraceptive needs of women/couples in various categories. <p>Knowledge of:</p> <ul style="list-style-type: none"> ▶ Contraceptives in public sector programmes. ▶ Availability of safe abortion services. ▶ Post abortion complications and referral. ▶ Types and causes of RTI/STI, including HIV/AIDS. ▶ Referral facilities for women/men suspected of RTI/STI. 	<ul style="list-style-type: none"> ▶ Counsel for delay in age of marriage, delay in age of first child bearing and in spacing the second child. ▶ Helping vulnerable and marginalized women access contraception. ▶ Supporting women in need of such services to access safe abortion services. ▶ Counsel for post abortion contraceptive use. ▶ Counsel on safe sexual behaviours. ▶ Counsel for partner treatment in case of STI.
For High Malaria Areas or High Prevalence of TB	<ul style="list-style-type: none"> ▶ Knowledge about Malaria and its prevention. ▶ Protecting pregnant women and the young child from malaria. ▶ How to prevent tuberculosis. ▶ Suspecting tuberculosis and knowledge of further referral. 	<ul style="list-style-type: none"> ▶ Managing fever in the young child-when to suspect malaria, how and when to test, when to refer, when and how to treat. ▶ Being a provider of Directly Observed Therapy- Short Course (DOTS) for TB.

Competencies	Knowledge required	Skill required
Village Health Planning	<ul style="list-style-type: none"> ▶ Knowledge of key components of village plans. ▶ Understanding of steps in preparing village health plans. ▶ Understanding of methods of data collection and PRA. 	<ul style="list-style-type: none"> ▶ Interpret and use basic data. ▶ Identify priorities for the village based on data. ▶ Conduct Participatory Rural Appraisal. ▶ Include specific actions to ensure coverage of marginalized and vulnerable women and children with services.

REQUIREMENTS AND DEFINITIONS RELATED TO TRAINING

Level	Category to be Trained	Trainer	Profile of Trainers	Venue of Training
Level 1	ASHA and ASHA Facilitators*	ASHA Trainers (Three Trainer per block)	Selected from within the district, preferably at the block level. Every block should have a team of three ASHA trainers. The team of three trainers from every block (twenty in total) constitute the District Training Team. Criteria of selection appended below.	Multiple sites, minimum five per district; each site serving two blocks, with adequate training and infrastructural facilities, close access to a community and linkages to a health facility with an adequate caseload of newborns and children with illnesses. Criteria of selection appended below. The sub district site will be accredited and serve as the site for ASHA certification.
Level 2	ASHA Trainers	State Trainers (About 9 full time trainers per state)	Four–six year experience of training in community health and preferably with a clinical background. At least nine full time state trainers are required for a state. Roughly 50% of the state trainers should be drawn from organizations which serve as the training sites. Criteria of selection appended below.	A minimum of three per state having adequate training facilities, boarding and lodging arrangements, an active community health programme, and linkages to a health facility. The State level sites should have the staff which is experienced in training of senior trainers. The state training sites will also be accredited for serving as an accreditation site for ASHA trainers.
Level 3	State Trainers	National Trainers	An individual with substantial training and subject matter expertise. Drawn from various national mentoring organisations of the ASHA programme and other training and community based organizations. Some (about 40%) of these national trainers will become available full time whereas most remain part time. They also support the state trainers in training ASHA trainers at the state level and accrediting the ASHA trainers.	NHSRC will work with MOHFW and National Institute of Open School (NIOS) to select and accredit National level training sites to serve as sites of training for national trainers.

Level	Category to be Trained	Trainer	Profile of Trainers	Venue of Training
Level 4	National Trainers	Faculty at national training site	All national training sites will have core faculty who would be responsible for training the national pool of trainers. In addition resource persons with substantive training and implementation experience would also be involved in training and accrediting the national trainers. National level faculty could also include resource persons from national ASHA mentoring group and other public health experience. They are responsible for accrediting the national and state trainers.	

*ASHA Facilitators are to be trained earlier in the cycle as they are expected to support ASHA Trainers during the actual ASHA Training. They are trained in same topics as ASHAs and for an additional two days for their capacity building in providing supportive supervision and performance monitoring.

CRITERIA FOR SELECTION OF DISTRICT (ASHA) TRAINERS

The responsibility of selection of the ASHA Trainers is that of the District Community Mobilizer with the support of local NGOs and representation from the state ASHA and Community Processes Resource Centre and the State Mentoring Group for ASHA and Community Processes.

Criteria for Selection of District (ASHA) trainers:

The team of three trainers from each block should include individuals having an appropriate mix of skills and who could include with:

- ▶ Diploma in nursing (ANM), AYUSH with at least two to three years of experience as a trainer, retired staff nurse, nurse/ANM tutors. (Preferred), OR
- ▶ Post Graduate/Graduate in public health diploma/Social Work/Social Science with more than three years of experience as a trainer in health programs or social mobilizational trainings.
- ▶ Overtime the states can create a cascade of trainers by building capacities of DCMs, BCMs and ASHA Facilitators.
- ▶ Willing to work as a full time trainer in this program for at least 18 months.
- ▶ If such an individual is selected from within the public sector, s/he should be deputed to the training programme and relieved from other work as a priority.
- ▶ Ready to travel to block and sector level.
- ▶ Understanding and empathy for rural poor and women.
- ▶ Must belong to same district.

- ▶ Women candidates, staff of the training site and Block community mobilizers will be given preference.
- ▶ For the period of the training, all ASHA trainers in districts should be affiliated to one of the five district training sites, to ensure continuity and coordination.

CRITERIA FOR SELECTION OF STATE LEVEL TRAINERS

- ▶ Should have substantial experience in training and with a nursing/clinical background. Medical degree, Diploma in Nursing, with at least even to ten years of experience as a trainer. Retired staff nurses, Nurse/ANM tutors could also be considered.
- ▶ Alternatively states can create state level trainers from amongst persons experienced in ASHA/Public health training.
- ▶ Willingness to work as a trainer in this program full time for at least 18 months.
- ▶ Ready to travel to sub district areas.
- ▶ Understanding and empathy for rural poor and women.

INSTRUCTIONS TO THE STATE

- ▶ Candidates for state trainers should be interviewed face to face and assessed for suitability.
- ▶ If possible, for the period of training, all state trainers should be affiliated to one of the three state training sites, to ensure continuity and coordination.
- ▶ Half of the trainers should be women, and preferably located and employed within an NGO or the agency which will serve as the state level training site.

CRITERIA FOR SELECTION OF DISTRICT LEVEL TRAINING SITE

Training of ASHA will take place in multiple sites within the district. In all, the sites are expected to train 1800 ASHA for four rounds of training during the course of one year. Thus at least five sites are required in a district.

The sites could be either NGO sites or the state's own Health and Family Welfare training facilities. However the following criteria will need to be met:

- ▶ Site should have experience in training and in managing community outreach programmes, with a focus on the marginalized, with referral links to service facilities, preferably in the public sector, although linkages with the private or non for profit sector could also be considered provided they conform to the principles of quality and equity. Experience in research and advocacy will be an added advantage.
- ▶ Sites should have close linkages with a community so as to enable the ASHA to conduct some practical sessions.
- ▶ They should also have the ability to run two to three batches of 30 trainees at a time, with adequate residential facilities and training infrastructure.
- ▶ The site should either have its own health facility with an adequate load of sick children, deliveries and newborns for exposure or be linked to a nearby facility.
- ▶ If an organization that has an active community presence and linkages and does have the requisite infrastructural facilities, it should be able to rent such facilities on a long term basis. The caveat is that such training facilities (accommodation and training) should be close to the field operation site, and within easy access of the health facility, which could be a block PHC or CHC depending on the case load.

- ▶ States could also choose to create/support consortia of two agencies, for example an NGO with a strong outreach programme with either a government health facility or with another NGO that has a health care facility which meets the norms described above.

CRITERIA FOR SELECTION OF STATE LEVEL TRAINING SITES

The state will select sites which will serve to train the district training teams. The choice of sites is important since they need to be developed as future Best Practice sites for training of community health workers and should serve as demonstration sites for the state.

The sites could be either NGO sites or the state's own Health and Family Welfare training sites. However the following criteria will need to be met:

- ▶ Sites should have full -fledged community health programmes with a strong and active ongoing community health worker intervention.
- ▶ Staff and Faculty of the organization are experienced in training of master trainers.
- ▶ They should also have the ability to run two to three batches of 25 -30 trainees at a time, with adequate residential facilities and training infrastructure.
- ▶ The site should either have its own health facility with an adequate load of sick children, deliveries and newborns for exposure and hands on practice, or be linked to a nearby facility.
- ▶ States could also choose to create/support consortia of two agencies, for example an NGO with a strong outreach programme with either a government health facility or with another NGO that has a health care facility which meets the norms described above.

SELECTION OF DISTRICT/BLOCK TRAINING SITES

Step 1: Expression of interest issued in major newspapers. Vernacular and state Website

Step 2: Desk review and scoring of proposals based on criteria in Table 1

Table 1: List of criteria and scoring instructions for desk review of proposals

Criteria	Score
Registration of agency more than 3 years.	<3-0 >3-1
The turnover of the agency should have been Rs. 5 lakhs at least once in the last 3 years.	<5-0 >5-1
The agency should have an established presence in the state.	No-0 Yes-1
The agency should have demonstrated partnerships with NGOs in the districts.	No-0 Yes-1
The agency should have experience of field level work/community level health or social sector development work including training/capacity building.	No-0 Social/Dev-1 Health/Trg - 2
The agency should have access to community health programmes with a strong and active ongoing community health worker intervention.	No-0 Yes-1
The agency should either have a venue for training or be able to demonstrate access to a training venue which has the capacity to run two batches of 25-30 ASHA s at a time, with adequate residential facilities and training infrastructure (LCD facilities, training rooms).	No-0 Yes-1

Criteria	Score
The agency should either have its own health care facility with an adequate case load of sick children, deliveries and newborns for exposure and hands on practice, for trainees or be linked to a nearby facility.	No-0 Yes-1
Agency should have mid level supervisory staff and demonstrate effective support to field level programmes.	No-0 Yes-1

Step 3: Shortlist proposals that received a score of ten and above.

Step 4: Write to two referees of all short listed agencies requesting letters of reference.

Step 5: Inform short listed agencies of decisions and dates for field appraisal.

Step 6: Constitute expert team for field appraisal: Member State ASHA Mentoring Group, Head of ARC/RRC (as applicable), DHS nominee, state/district public health experts, head of credible state level NGOs, State Health Systems Resource centre, state trainers.

Step 7: Conduct field appraisal of short listed agencies: meet head of agency, other key representatives, trainers, visit the training venue, and review the organization based on the following criteria:

1. Robust structure of governance (ask for board structure, review member list, meetings held, minutes) and organizational credibility.
2. Training venue and infrastructure of adequate capacity to train and house trainers for multiple training batches to run concurrently.
3. Strong management capacity to run training programmes.
4. Tradition and experience of community health programmes or strong and effective linkages with such work (to serve as demonstration and practice sites during training).
5. Effective organizational leadership that is able to inspire and provide direction to the training, and be able to liaise with state and district officials, and network with other training agencies.
6. Ability to bring in additional funds to the programme if required.

Step 8: Expert team provides brief report and recommendation for each of the agencies visited.

Step 9: Map the geographic locations of short listed agencies and match them in relation to the districts.

Step 10: District Health Society & State government informed of decision.

Step 11: Inform agencies of decision.

Step 12: Signing of Tripartite Memorandum of Understanding (between DHS, the agency & the state ARC or State Training Agency).

Annexure - IV

LIST OF ITEMS IN ASHA EQUIPMENT KIT

1. Digital Wrist Watch
2. Thermometer
3. Weighing Scale (for newborn)
4. Baby Blanket
5. Baby Feeding spoon
6. Kit Bag
7. Communication Kit
8. Mucous Extractor

Annexure - V

CONTENTS OF DRUG KIT

1. DDK for Clean deliveries at home
2. Tab. Paracetamol
3. Paracetamol syrup
4. Tab. Iron Folic Acid (L)
5. Tab. Punarvadu Mandur (ISM Preparation of Iron)
6. Tab. Dicyclomine
7. Tetracycline ointment
8. Zinc Tablets
9. Povidine Ointment Tube
10. G.V. Paint
11. Cotrimoxazole syrup
12. Paediatric Cotrimoxazole tablets
13. ORS Packets
14. Condoms
15. Oral pills (In cycles)
16. Spirit
17. Soap
18. Sterilized Cotton
19. Bandages, 4cm X 4 meters
20. Nischay Kit
21. Rapid Diagnostic Kit
22. Slides for Malaria & Lancets
23. Emergency Contraceptive Pill
24. Sanitary napkins (to promote Menstrual Hygiene amongst adolescent girls)

STATE SPECIFIC DRUGS

1. Paediatric Iron Syrup
2. Tab. Chloroquine

Annexure - VI

ASHA INCENTIVES UNDER VARIOUS NATIONAL PROGRAMMES

Sl. No.	Heads of Compensation	Amount in Rs./case	Source of Fund and Fund Linkages	Documented in
I	Maternal Health			
1	JSY financial package (NEW uniform package)			MOHFW Order No. Z 14018/1/2012/-JSY
	a. For ensuring antenatal care for the woman	300 for Rural areas 200 for Urban areas	Maternal Health- RCH Flexi pool	JSY -section Ministry of Health and Family Welfare -6th. Feb. 2013
	b. For facilitating institutional delivery	300 for Rural areas 200 for Urban areas		
2	Reporting Death of women (15-49 years age group) by ASHA to Block PHC Medical Officer . (New Revised incentive)	200 for reporting within 24 hours of occurrence of death by phone	Health Sub-Centre Un-tied Fund	MOHFW-OM -120151/148/2011/MCH; Maternal Health Division; 14th Feb. 2013
II	Child Health			
	Undertaking six (in case of institutional deliveries) and seven (for home deliveries) home- visits for the care of the new born and post-partum mother	250	Child Health- RCH Flexi pool	HBNC Guidelines -August 2011
III	Immunization			
1	Social mobilisation of children for immunization during VHND	150/session	Routine Immunization Pool	Order on Revised Financial Norms under UIP-T.13011i01/2077-CC-May 2012
2	Complete immunization for a child under one year	100.00		
3	Full immunization per child upto two years age (all vaccination received between 1st and second year age after completing full immunization after one year	Rs. 50	Routine Immunization Pool	Order on Revised Financial Norms under UIP-T.13011i01/2077-CC-May 2012
4	Mobilizing children for OPV immunization under Pulse polio Programme	75/day	IPPI funds	
IV	Family Planning			
1	Ensuring spacing of 2 years after marriage	500	Family planning Compensation Funds	Minutes Mission Steering Group meeting- April 2012
2	Ensuring spacing of 3 years after birth of 1st child	500		
3	Ensuring a couple to opt for permanent limiting method after 2 children	1000		
4	Counselling, motivating and follow up of the cases for Tubectomy	150	Family Planning Sterilization compensation funds	Revised Compensation package for Family Planning- September 2007-No-N
5	Counselling, motivating and follow up of the cases for Vasectomy/NSV	200		11019/2/2006-TO-Ply

Sl. No.	Heads of Compensation	Amount in Rs./case	Source of Fund and Fund Linkages	Documented in
6	Social marketing of contraceptives- as home delivery through ASHAs	1 for a pack of three condoms 1 for a cycle of OCP 2 for a pack of ECPs	Family planning Fund	Detailed Guidelines on home delivery of contraceptives by ASHAs-Aug. 2011-N 11012/3/2012-FP
V	Adolescent Health			
	Distributing sanitary napkins to adolescent girls	Re 1/pack of 6 sanitary napkins	Menstrual hygiene- ARSH	Operational guidelines on Scheme for Promotion of Menstrual Hygiene Aug. 2010
1	Organizing monthly meeting with adolescent girls pertaining to Menstrual Hygiene	50/meeting	VHSNC Funds	
2				
VI	Nirmal Gram Panchayat Programme			
	Motivating households to construct and use a toilet	75/Toilet constructed	Funds for IEC activities under District Project Outlay under TSC	Minutes MSG- Meeting April 2012; DO No. W-11042/7/2007/- CSR-Part
VII	Village Health Sanitation and Nutrition Committee			
	Facilitating monthly meetings of VHSNC followed by meeting with women and adolescent girls	150/meeting	VHSNC Untied Fund	MOHFW Order Z-18015/12/2012-NRHM-II
VIII	Revised National Tuberculosis Control Programme			
	Being DOTS Provider(only after completion of treatment or cure)	250	RNTCP Funds	Revised Norms and Basis of Costing under RNTCP
IX	National Leprosy Eradication Programme			
1	Referral and ensuring compliance for complete treatment in pauci-bacillary cases of Leprosy	300	NLEP Funds	Guidelines for involving ASHAs under NLEP
2	Referral and ensuring compliance for complete treatment in multi-bacillary cases of Leprosy	500		
X	National Vector Borne Disease Control Programme			
1	Preparing blood slides	5/slide	NVDCP Funds for Malaria control	NVDCP Guidelines for involvement of ASHAs in Vector Borne Diseases-2009
2	Providing complete treatment for RDT positive Pf cases	20		
3	Providing complete radical treatment to positive Pf and Pv case detected by blood slide, as per drug regimen	50		

Annexure - VII

FORMAT FOR ASHA FACILITATORS TO RECORD FUNCTIONALITY OF ASHAS

Format 1 for ASHA facilitators – To record functionality of ASHAs under each facilitator. Date –							
Sl. No.	ASHAs (1-20)	1	2	3	4	5	Total no. of ASHAs functional on each task
	Name of the ASHA						
1	Newborn visits on first day of birth in case of home deliveries						
2	Set of home visits for new born care as specified in the HBNC guidelines (six visits in case of Institutional delivery and seven in case of a home delivery)						
3	Attending VHNDs/Promoting immunization						
4	Supporting institutional delivery						
5	Management of childhood illness – especially diarrhoea and pneumonia						
6	Household visits with nutrition counselling						
7	Fever cases seen/malaria slides made in malaria endemic area						
8	ASHAs acting as DOTS provider						
9	Holding or attending village/VHSNC meeting						
10	Successful referral of IUD, female sterilization or male sterilization cases and/or providing OCPs/Condoms						
11	Total of no. of tasks on which ASHA reported being functional.						
12	Total No. of ASHAs who are functional on atleast 6/10 tasks³						
	Remark						

ASHA Facilitator just records as functional or non-functional in each of the cell above. How she measures whether she is functional is part of the ASHA Facilitators manual. States could alter these guidelines to reflect their priority – but we do not recommend trying to collect data in terms of numbers of newborn seen etc. – as this is not required for the possible management responses.

³ The total number of tasks out of which ASHAs are scored will also depend on the availability of potential cases or beneficiaries in her area for the said period. Eg - If there were no TB or Malaria cases recorded in the last month then Facilitator should write NA in the respective cells and mention this in the remarks. This would reduce the total no. of tasks from 10 to 9 or 8 and affect the scoring of ASHAs also. Eg- In case of total 9 tasks she should be functional on 5/9 tasks and in case of 8 tasks it should be 5/8. These scores can then be considered equivalent to the scores of other ASHAs who are scored out of 10.

ILLUSTRATIVE ASHA TRAINING AND POST TRAINING SUPPORT AND SUPERVISORY COSTS FOR ONE BLOCK (STATE LED)

The budget package for a normative block for financing training and supervision would include fund for 180 ASHA, nine facilitators, and three trainers.

A 15 day training programme every year (considering that over the last few years the majority of the ASHAs would have received training up to Module 7. Since this is complete, they will undergo about 12- 15 days of training every year (new and refresher). All new ASHAs will undergo an eight day induction training, and subsequently 20 days in module 6 and 7. This will be completed within the first two years of her entering the programme. Thus each ASHA (new or old) will get 12-15 days of training per year. This budget is based on the 15 day costing and also includes:

1. A visit by the ASHA facilitator once a month to every ASHA for post training, support, mentoring, and supervision. Cost of cluster meeting in the facilitators areas is also part of this.
2. One meeting of ASHA and facilitators at PHC every month.
3. One review meeting of all nine facilitators with the Block coordinator.

ILLUSTRATIVE ASHA TRAINING AND POST TRAINING SUPPORT AND SUPERVISORY COSTS FOR ONE BLOCK (STATE LED)

No	Item of Expenditure	Unit Rate in Rs	Quantity	Days	Total Amount
I	Training for 15 days				
1	ASHA- wage compensation for training day	150	180	15	4,05,000
2	ASHA- food, accommodation, venue	200	192	15	5,76,000
3	ASHA and facilitator travel (6 trips)-TA to training site three times (three rounds of training)	100	189	6	1,13,400
4	Trainers fees (3 trainers*6 batches*3 rounds)	600	18	15	1,62,000
5	ASHA Refresher Training in preparation for certification (includes food, accommodation, and venue: Rs.200, wage compensation for ASHA (Rs. 150), training to be led by ASHA facilitators	350	189	4	2,64,600
6	3 Trainers travel (6 trips):	200	3	6	3,600
	Sub-total				15,24,600
II	Supervision/Support Costs for training				
1	Supervision costs by ASHA facilitators(12 months) (@Rs.200/day honorarium and Rs. 50/day travel), including for PHC review meeting	250	9	240	5,40,000
2	PHC Review meeting day plus social mobilization- cost of travel of ASHA	150	180	12	3,24,000
3	Monthly Review meeting of facilitators with BCM at block level-cost of travel and meeting expenses	125	10	12	15,000
	Sub-total				8,79,000
III	Cost of Job aids; Tools and Kits for ASHA				
	Cost per ASHA for module, (Rs. 125), Drug kit (Rs.1000), Equipment kit (Rs. 150)- since most ASHA will requires refurbishing of some parts of the kit, and only new ASHA will need entire kit), communication material (Rs. 75/head); ASHA Diary and register etc.Rs. 150)	1500	180	1	2,70,000
IV	Other Non-Monetary Incentives for ASHA				
	a)Cost of - sammelans; either Block or District level Rs450/ASHA); b)Uniforms for ASHA-renewal or fresh provision(-450 per ASHA c) CUG membership; SIM Provision-(150/ASHA)	1050	180	1	1,89,000
	Total cost per year				28,62,600
	Cost/ASHA				15903
	1-Should the block level implementation be entrusted to an NGO, an additional amount of 10% of total budget should be provided for institutional overheads= 17493				
	2-In addition, States should also make provisions for cost of ASHA Awards as- Rs 5000 per block and Rs 10,000 per district.				
	3-Provision of exposure visits for ASHAs could also be made by states @ Rs10,000 per ASHA for a team of 10 ASHAs of each district from the state				

Guidelines for **VILLAGE HEALTH SANITATION & NUTRITION COMMITTEE**

PART - B



GUIDELINES FOR VILLAGE HEALTH SANITATION AND NUTRITION COMMITTEE



Background

One of the key elements of the National Rural Health Mission is the Village Health, Sanitation and Nutrition Committee (VHSNC). As the name suggests this committee is expected to take collective action on issues related to health and its social determinants at the village level. They were particularly envisaged as being central to 'local level community action' under NRHM, which would gradually develop to support the process of Decentralized Health Planning. Thus VHSNCs are expected to act as leadership platforms for improving awareness and access of community for health services, support the ASHA, develop village health plans, specific to the local needs, and serve as a mechanism to promote community action for health, particularly for social determinants of health.

In the past few years VHSNCs have been set up at village level across states. The composition, capacity, activities and effectiveness of VHSNCs varies across the states, but comparing experiences and effectiveness across different contexts provides valuable learning. In this second phase of the NRHM, it is important to incorporate such learning to streamline the functioning of the VHSNC and support capacity building so that these institutions can emerge as vibrant village level organizations to improve the health status of their communities.

These guidelines are intended to assist states in supporting the constitution, capacity building and functioning of VHSNC so as to achieve positive outcomes. These new guidelines were developed in consultation with state programme officers and representatives of civil society and NGOs who have been working on building and guiding VHSNCs. States should utilize the guidelines to improve functioning of existing VHSNCs and build the confidence and ownership of the community particularly the marginalized over these institutions. The guidelines are flexible and can be adapted to state context.

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Section - I: Objectives of the VHSNC

1. To provide an institutional mechanism for the community to be informed of health programmes and government initiatives and to participate in the planning and implementation of these programmes, leading to better outcomes.
2. To provide a platform for convergent action on social determinants and all public services directly or indirectly related to health.
3. To provide an institutional mechanism for the community to voice health needs, experiences and issues with access to health services, such that the institutions of local government and public health service providers can take note and respond appropriately.
4. To empower panchayats with the understanding and mechanisms required for them to play their role in governance of health and other public services and to enable communities through their leadership to take collective action for the attainment of better health status in the village.
5. To provide support and facilitation to the community health workers – ASHA and other frontline health care providers who have to interface with the community and provide services.

Section - 2: VHSNC and its Relationship to Gram Panchayat

The VHSNC is to be formed at the level of revenue village. The VHSNC will function under the ambit of the Panchayati Raj Institutions (PRI). In states where there are several revenue villages and thus a number of VHSNCs within a Gram Panchayat, a coordination mechanism through either the Standing Committee on Health of the Gram Panchayat, or a Coordination Committee of the Gram Panchayat, that includes the chairpersons of the VHSNCs and members of the Standing Committee, would be desirable. The VHSNCs may act as a sub-Committee or a Standing Committee of the Gram Panchayat and would act under the latter's oversight.

Where the population of a revenue village is over 4000, the VHSNC can be at the level of a Ward Panchayat (as in Kerala).

Section - 3: Composition of the Committee

Village Health Sanitation and Nutrition Committee should have a minimum of about 15 members. No upper limit is defined. A minimum critical size of the committee is essential for building effective processes of consultation and representation, but a very large committee can also impede smooth management and effective functioning. States have the flexibility to decide an optimum limit to the maximum number of members.



Principles of composition of the VHSNC

- a. Elected members of the panchayat resident in the village should be enabled to lead.
- b. All those working for health or health related services should be able to participate.
- c. The voices of service users of health services- especially of mothers should find place.
- d. There should be representation from all community sub-groups, especially from poorer and more vulnerable sections . About 50% should be women members and SC/ST sections should be well represented.
- e. All habitations/hamlets should have representation.

There is considerable over-lap between these categories- thus a woman with a small child given membership on the committee could be also representative of a distant hamlet and belonging to a marginalised community etc.

Based on these principles of composition, members of the committee will be drawn from the following categories:

1. Elected Gram Panchayat Members: Those resident in the village are to be preferred. In areas where there are no elected panchayats, members of tribal councils, could be considered. Though more than one elected member of a panchayat can be included in the VHSNC, their numbers should be limited to one third of the total number of members, and preference should be given to women panchayat members. Members of the permanent standing committees of the gram panchayat who are usually elected members should also be preferably included.
2. ASHAs: All ASHAs of the village should be on the committee. In small villages there would be only one ASHA per VHSNC.
3. Frontline staff of government health related services: The ANM of the health department, the Anganwadi worker of the ICDS, and the school teacher should be included as regular

members only if they are resident in that particular village. Otherwise they qualify to be special invitees. Volunteers or village level workers of other government departments- eg. The hand pump mechanic of Public Health and Engineering Department (PHED) or the field coordinators of the MNREGA programme, should also be considered if they are resident in the village.

4. **Community Based Organizations:** Representatives of existing community based organisations like Self Help Groups, Forest Management Committees, Youth Committees, etc. These members are also useful to ensure that every habitation and community is represented.
5. **Pre-Existing Committees:** If there are separate committees on School Education, Water and Sanitation or Nutrition, the first effort should be to integrate these committees with VHSNC. If that is not possible or till the time it has not been done, key functionaries of each of these bodies should be included as a member in the VHSNC and chairperson of the VHSNC should also become a member of these committees.
6. **Service- Users:** Pregnant women, lactating mothers, mothers with children of up to 3 years of age, and patients with chronic diseases who are using the public services should also find place.

Other than members, a more general category of special invitees can be included. They are welcome to attend and indeed their presence and interaction with the committee is essential. They are generally not residents of the village. This includes Medical Officer of the local PHC, Facilitator of the ASHA Programme, Supervisors in health and ICDS departments, Panchayat secretary and Block Development Officer, Zilla and block panchayat member.

Ideally the medical officer and block development officer should participate in every VHSNC meeting at least once or twice a year. ASHA Facilitators who are also facilitators for other community processes including the VHSNC itself should attend the VHSNC meetings more regularly.

All the selections are done by the community using these above categories and principles as guidelines. The ANM, AWW and ASHA along with the Panchayat leadership are expected to ensure that every section is represented. In particular women must be 50% of total members of VHSNC and SC, ST & Minorities should be represented as per their population in village.

CHAIRPERSON

The Chairperson of the VHSNC should be a woman elected member of the gram panchayat (panch) preferably from among the SC/ST communities, who is a resident of that village. If there is no woman panch from that village, then preference should be given to any panch from the SC/ST. But this is a decision arrived at between the gram panchayat and VHSNC with the ANM & ASHA playing a facilitating role.

MEMBER-SECRETARY AND CONVENOR

The ASHA will be the Member-Secretary and Convenor of VHSNC. If there is more than one ASHA in the VHSNC village, then one of them is to be selected by consensus as Member-Secretary and convener. This could also be by rotation amongst the ASHAs after a two or three year period- since it would be time- consuming to change bank signatories- but that is a local decision. The reasons for positioning ASHA as the convenor is based on state learnings that show VHSNCs tend to do much better where she is in the lead, because there is a more organised support

mechanism and more sustained building of capacity of the VHSNC using her as the vehicle. She also has better community ownership and acceptance, given her role, the tasks she undertakes, and the fact that she has been involved in health related issues over the past few years. Finally the ASHA for successful achievement of her objectives especially as related to health promotion, prevention and community mobilisation requires an active VHSNC.

States that have appointed AWW as the member secretary should initiate the process of replacing them with ASHA.

Section - 4: VHSNC Bank Account

Every VHSNC should have a bank account opened in the nearest bank, to which the untied fund of the VHSNC shall be credited. The district may recommend specific banks if additional services are promised, - but the VHSNC should have the final say. The Chairperson of the VHSNC and the Member Secretary ASHA should be the joint signatories of the VHSNC account. For those states which have nominated a functionary other than the ASHA as member secretary (AWW or ANM), it is recommended that they should be replaced with ASHA.

All withdrawals from VHSNC account must be done by a joint signature of both the signatories (if the account is operated by two signatories) or by two of the three signatories (if the account is operated by three signatories). The Member Secretary may be authorized expenditure of up to Rs 1000 for emergencies or undertaking any urgent activities.

Section - 5: Process of Formation and Renewal

The formation of the VHSNC (for new VHSNCs or for replacing non functional VHSNCs) is a participatory process in which community mobilization to inform community about the composition and role of the committee is essential. The Gram Panchayat members, ASHA, ASHA facilitator (or Block Mobilizer) and ANMs will be responsible for selecting members through a consultative process with the community at village level. This list will be ratified with inclusion of further suggestions, at the next Gram Sabha meeting.



Block Medical Officer would ensure that this process is completed at the earliest but not later than the 30th September 2013.

The VHSNC should be re-constituted after a new panchayat is elected. Thus the term of a committee shall be co-terminus with that of the Gram Panchayat where it is located. There should be no bar on reselecting those who have proved active and effective as VHSNC members, or dropping those who have not been active, provided the basic principles of the composition of VHSNCs are maintained. VHSNC can select new members to replace non active members or add a new member within the norms, by two thirds majority.

Section - 6: Activities and Outcomes of the VHSNC

The activities of the VHSNC are clustered into five broad categories.

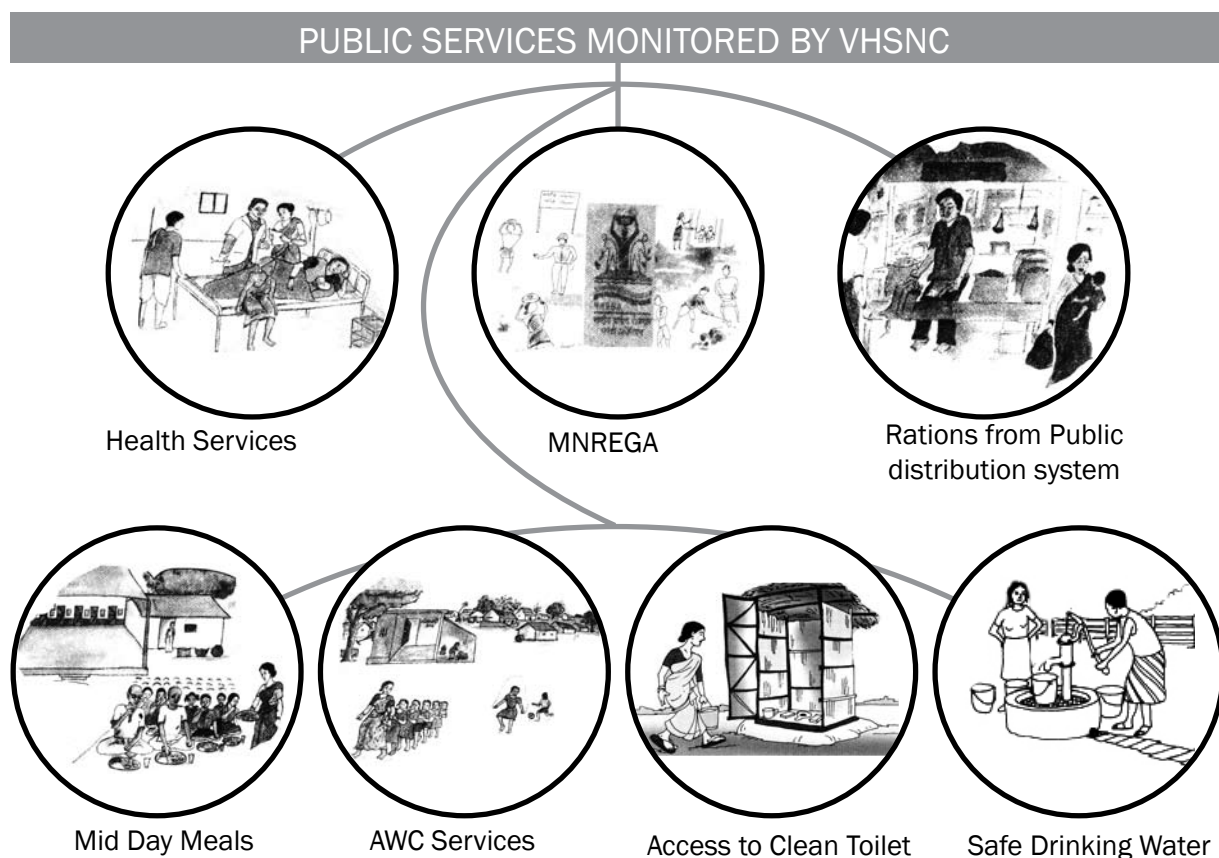
1. Monitoring and Facilitating Access to Essential Public Services- and Correlating Such Access with Health Outcomes

There are many ways for a VHSNCs to do this. One best practice is for every VHSNC to use a public services monitoring tool related to whether key services were available in the previous month, (Explained in Annexure-1). For those services that were unavailable, the VHSNC maintains a Public Services Register (Annexure 1a) in which members list the following:

- Gap in service
- Date of Meeting when the gap was noted;
- Action to be taken and
- Person (s) responsible for the action.

This is reviewed in the next meeting, and follow up conducted until the gap is resolved. This could take upto a few months or longer. This is a basic activity. From this activity other activities such as local corrective action, facilitation of service access, and seeking redressal can flow. In many states gaps are identified and acted upon even without the use of such a public service monitoring tool. But the use of such a tool enables a systematic and comprehensive approach. It is also easier to train members in the use of specific tool. Understanding how to make and use this register is one of the key elements of capacity building that is needed.

One important aspect to note is that other than health services the VHSNC also records access to related public services, including the access to work under MNREGA, rations from public distribution system, mid day meals, anganwadi services, safe drinking water, access to toilets, etc- making it the pre-eminent platform for local convergent action.



One further important dimension is for the VHSNC to clearly identify that if a service is not reaching 100% of beneficiaries, they need to assess which set of beneficiaries it reaches preferentially and who are actually excluded. Once this is identified the corrective action provides for greater focus or different approaches to ensuring utilisation by this excluded group. In this way the VHSNC becomes one of the most important ways of addressing social determinants.

The ASHA's role is not only of capacity building, she also acts as an agent of change. The ASHA uses the VHSNC to generate public awareness of health and other social sector programmes and convey that these are entitlements that everyone has a right to, thereby making special efforts to ensure that it reaches the marginalised.

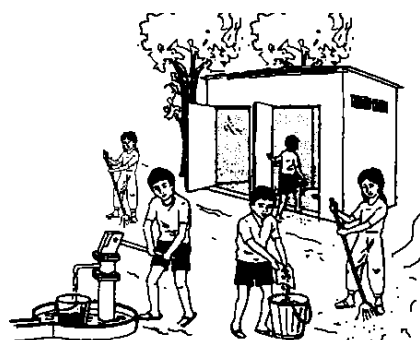
One important form of action is to inform the panchayats who would either appraise higher authorities of the gaps or organise local action with available funds. In this way – the *capacity* of the *panchayats* to govern the health care delivery and public services is improved upon.

2. Organising Local Collective Action for Health Promotion.

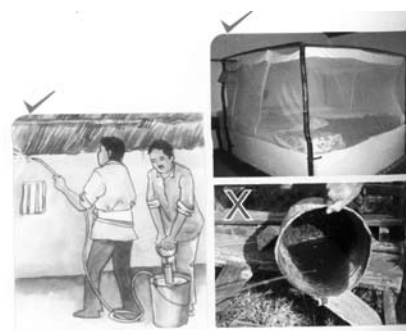
Health is a product of processes that take place at the level of the family and community. Much can be done at the community level for health promotion. We list some of the activities in which VHSNCs are involved:



- a. **Organising an event where volunteers gather and clean the village-** especially decaying solid waste (a major breeding site for the kala-azar vector, the sand fly and for the common house-fly) and pools of stagnant water –where mosquitoes breed. The VHSNC could motivate voluntarism by mobilisation and serve as an inspiring village organization, or they could pay local village youth for the task, or contract labour for this purpose. One advantage with the voluntary approach is that there is community sensitisation against poor environmental hygiene practices.



- b. **Organising teams for source reduction work-** identify areas of mosquito larva breeding and taking appropriate anti-larval measures- i) pouring oil (usually waste machine oil) on stagnant pools, closing up hollows and depressions where water accumulates, ii) de-grassing the edges of ponds and tanks with a vertical cut iii) ensuring that septic tanks are closed with no cracks and are fitted with a netting on the gas vent and iv) ensuring overhead tanks are well closed and not breeding mosquitoes. Insecticide spraying and introduction of larvivorous fish could also be done on the same day or soon after but such synergised efforts, need inputs from the health department.



3. Facilitating Service Delivery and Service Providers in the Village

The VHSNC serves as an important platform to facilitate access to services and services providers at the village:

- a. Organization of the Village Health and Nutrition Day and support to the organisation of immunization sessions is key part of facilitating service access in the village. The VHND is both a platform for the community to access all the services provided by ANM and AWW at

a site very near their homes, and the point for health education and counselling. VHSNC members should facilitate mobilization of pregnant women and children, particularly from marginalized families, facilitate the organization of and support the ANM, AWW and ASHA in conducting the VHND. A detailed checklist to assess key services provided during VHND is given in Annexure 2.



- b. VHSNCs need to allow outreach workers and community service providers to articulate their problems in these meetings. The meeting should identify those individuals whom the ANM, Anganwadi worker, the school teacher and the ASHA are unable to reach and should help these providers in reaching these sections. In cases where providers are facing personal taunts or even harassment, support from the VHSNC members may make a difference.
- c. Sometimes there are important amenities missing in the Anganwadi centre or Sub- centre or School. The VHSNC can help provide these amenities, so as to make it more comfortable and healthy for both user and provider.
- d. The meeting serves as an important platform for service providers to learn about the gaps from the community feedback and for the community to learn about the gaps from provider feedback. For example if toilet construction is not being undertaken, the frontline worker of the government may have her/his understanding of why people do not opt for it; but people may have another set of reasons. In this case the VHSNC becomes a platform for dialogue and action.
- e. Another major role that has emerged is that the committee can organise local tie-ups with vehicle owners to transport a patient to the hospital in time of need.
- f. One specific type of service for VHSNCs to focus on is the registration of births and deaths. The focus should be that every newborn is registered, and a birth certificate issued by the appropriate authority reaches the family within the given time standard. All deaths too should be followed by the issuance of a death certificate, including for still births. The VHSNC should focus on cause of death and good quality reporting of such causes, as this is likely to form the basis for village planning. This is dealt more in detail in the next section.

VHSNCs should maintain record of births and deaths in their village according to the formats mentioned in Annexure 3 and 4 respectively, which will be discussed subsequently.

4. Village Health Planning

Village health planning is understood differently across the districts. We give below some of the ways in which plans were made and used:

- i. One method of making a village health plan is to identify the problems in access to public services and close the gaps. This type of planning enables understanding on why some pockets or habitations have lower access and can suggest actions to close the gaps. This is described in the section on “Monitoring and Facilitating access to essential public services”. The VHSNC must maintain a village register (Annexure 3) which records the data on total population, households, BPL families (with information on their religion, caste, language). list of current beneficiaries of services related to health, water and sanitation and nutrition to ensure access of all sections, particularly the marginalised groups including the disabled. This would enable action on identified gaps in services if any.

Another means of taking action on information collected above is to assess gaps and organise local collective action to close these gaps. This plan is about what people can do by themselves.

A second mechanism to develop a village plan is to identify health care priorities and to take appropriate action at various levels: health education action at the level of the family, collective action at the level of the community and asking for government action or services at the level of health systems. To do this requires higher capacity. However some villages have made an interesting start. Broadly we could divide this process into two:

- a. Identifying health care priorities and
- b. Planning Action

To understand health care priorities the VHSNC could :

- i. Maintain a register where deaths over a period (quarterly) and their causes as perceived are recorded. Where the death is of a pregnant woman (regardless of cause and the stage of pregnancy) or that of a child below one year, this must be reported, and followed up by an enquiry with family members. This sort of enquiry must be facilitated by a public health resource person such as a Medical Officer. The enquiry should discuss which of the deaths in the list was preventable and how it could have been averted. In fact every death below the age of 60, certainly deaths below the age of 40 should be discussed.
- ii. Deaths are also indicative of disease loads. For every one maternal death, 30 women suffer from really troubling complications that could have been avoided. For every one malarial death, there are 50 to 100 persons who lost a week's work and spent a huge sum of money due to malaria. So deaths even though tragic only represent a small part of the problem and conceal significant morbidity among the living.
- iii. All VHSNCs must be encouraged to maintain this record of deaths and over time be able to identify report and be facilitated to conduct such verbal autopsies. In addition to this record of death, a discussion in the VHSNC may bring out other common problems that did not cause death but were causes of suffering and economic loss, and identify which of these were preventable.
- iv. Records of disability that comes from a survey for disability.
- v. Focus Group Discussions can enable the identification of frequent causes of care seeking of outpatient clinic visits or hospitalisation. This also gives us a picture of disease loads. Based on this, the village could just list the ten most common causes of premature death, of hospitalisation and of going to a doctor and based on this, develop a plan.

A plan could be developed around the following actions (suggested):

- i. Actions that people could take themselves at the family level. For example – many deaths due to heart disease or due to cancers relate to tobacco, betel chewing etc, and indicate that changes in life styles and behaviours and local health care practices are needed for prevention.
- ii. Health education through inter-personal communication at the family level, supported by mass communication at community level. The content of this activity changes with the local health priority and should include social issues such as early marriage and sex selection.
- iii. Actions that can be undertaken at the community level with or without assistance of the community level care provider. eg organising health melas, screening camps, health education during village events or festivals, making the water sources safe for drinking, improving quality of mid day meal etc.



- iv. Actions that need to be undertaken at the health systems level- here the plan should enable informing the authorities especially at the block and the PHC levels - so that they could take appropriate action – preventive or curative.

Village planning by identifying health care priorities requires substantial degrees of knowledge as well as health systems capacity at the referral levels, with good linkages between the two. However caution is needed for this approach. Though such a village health plan is one of the possible activities of the VHSNC we should not over-project the possibilities of such planning- since the institutional capacity to support and respond to such plans is quite a major challenge. Most VHSNCs are better advised to start with the other activity groups first, and attempt this only if there is a good public health team which can support them.

5. Community Monitoring of Health Care Facilities

In many districts VHSNCs have been oriented towards community monitoring of health care services in primary and secondary health care facilities in their area.

Annexure 6 contains a checklist to assess quality of services at Public Health Facilities.

VHSNCs visit PHCs or dialogue with service users- and use this information to fill a score card with a number of parameters. These parameters relate to both the services available in the PHC and the quality of care.

PHCs which do well should be felicitated- and those which are faring poorly in the scoring are singled out for appropriate action. The VHSNC could also offer to help, in cases where their assistance could make a difference.

The VHSNC also plays the role as a forum for grievance redressal on the community level issues related to health, sanitation and nutrition. It should dialogue with the service providers in case of any complaints regarding the services and also proactively monitor the access of services and schemes to the marginalised sections of the village and look into any malpractices. It must also communicate grievances not resolved at the village level to the district grievance redressal committee, where this is appropriate.

As programmes such as Rashtriya Swasthya Bima Yojana and private sector partnerships increase it is important to monitor these schemes also and include these in the forum for grievances related to these. Even where not accredited, the government has a role in regulation of the private sector to protect patient interests- and therefore complaints and problems faced in private sector services could also be taken up in the VHSNC.

Some VHSNCs have had a very positive outcome with organising Jan Samvads- which is a dialogue between the community and the authorities.

In most situations where VHSNCs have been effective in community monitoring of public health facilities, it has been actively facilitated by NGO support for the programme. The difference between this community monitoring and the earlier described facilitation of service providers is that community monitoring relates to health care services in public hospitals and private health care facilities outside the village.

The list discussed above is not exclusive, but represents the five most successful approaches to VHSNC functioning in the country. It would be useful for all states to compile best practices as related to the VHSNC into a source book for new ideas for VHSNCs to act upon.

6. Monthly Meetings

- a. Meetings of VHSNC should be held at least once every month. It is suggested that there be one regular date- like the 5th of every month, or the first Saturday of every month- when the meeting is held to ensure that members can plan on ensuring attendance. A regular venue fixed at a convenient place preferably in a public facility like AWC, Panchayat Bhawan or School, which is easy to reach and accessible for all members also helps. Despite this the Member Secretary ASHA would in most circumstances need to remind the members of the meeting, and mobilise them to attend it.
- b. A minutes register and a meeting attendance register would also facilitate proper functioning. The two registers should be maintained in format illustrated in Annexure 7 and 8 respectively.
- c. In a 15 member committee of well-chosen active members, 7 persons represent a minimum quorum. But with large committees, whose composition is intended for social inclusion and mobilization, the meeting quorum could be even 33%.
- d. The monthly meeting reviews work done, plans future activities and decides on how the untied funds are to be spent.

7. Management of Untied Village Health Fund

Every VHSNC is entitled to an annual untied grant of Rs. 10,000 from the National Rural Health Mission (NRHM). The untied grant is a resource for community action at the local level. Nutrition, Education & Sanitation, Environmental Protection, Public Health Measures are key areas where these funds could be utilized. The fund shall only be used for community activities that involve benefit to more than one household. Exceptions to this are in case of a destitute women or very poor household, where the untied grants could be used for health care needs of the poor household especially for enabling access to care.

Decisions on expenditure should be taken in the VHSNC. In special circumstances the district could give a direction or a suggestion to all VHSNCs to spend on a particular activity- but even then it should be approved first by the VHSNC. VHSNCs will not be directed to contract with specific service providers for specific activities, regardless of the nature of the activity. All payments from the untied grant must be done through the VHSNCs. VHSNC fund should preferably be not used for works or activities for which an allocation of funds is available through PRI or other departments.

The member secretary should be allowed to spend small amounts on necessary and urgent activities, of total up to Rs. 1000, for which details of activity and bills and vouchers should be submitted in the next VHSNC meeting and approval of the committee taken.

Every village is encouraged to contribute additional funds to the Village Health, Sanitation and Nutrition Committee.

Decisions taken on expenditure should be documented in the minutes. It is preferably adopted as a written resolution that is read out and then incorporated into the minutes in a meeting where there was adequate quorum.

The last seven years experience with VHSNCs informs us that most often VHSNCs spend their funds on the following heads:

- i. Village sanitation and cleanliness campaigns.
- ii. Source reduction- to reduce breeding of mosquitoes.

- iii. Conducting health melas or camps.
- iv. Improving facilities in anganwadi centres and sub- centres.
- v. Incidental expenses (tea, biscuits in monthly VHSNC meetings).
- vi. Emergency transport for poor patients- where regular arrangements fail.
- vii. School health activities.
- viii. Incentives to ASHAs for some locally decided tasks- which are very specific to the particular village.

Initially there was a problem due to lack of capacity and understanding at the village level, but this has changed considerably in most states and VHSNCs are now able to spend their money well. Further studies show that in many instances, delays in spending the money are largely due to delays in releasing funds, or different forms of trying to control or direct expenditure centrally- i.e. from the district or state level.

8. Accounting for the Untied Village Fund

- a. VHSNC has to present an account of its activities and expenditures in the bi- annual meetings of Gram Sabha and the quarterly meeting of Gram Panchayat, in which the plan and budget of the gram panchayat is discussed.
- b. The annual Statement of Expenditure, prepared by VHSNC, will be forwarded by the Gram Panchayat to the appropriate block level functionaries of NRHM, with their comments.
- c. All vouchers related to expenditures will be maintained for upto three years, by the VHSNC and should be made available to Gram Sabha, or audit or inspection team appointed by district authorities. After that the Statement of Expenditure (SOE) should be maintained for 10 years.
- d. At the state level disbursements done by the block or district NRHM will be treated as advances, and these advances will be treated as expenditures after the SOE for these advances has been received.
- e. District will conduct financial audit of VHSNC account on a test sample basis annually as a part of auditing district accounts.
- f. Utilisation Certificate (UC) should be based on the format given in Annexures 9 and 10.
- g. In case of delayed fund receipts VHSNCs need to be given a six month period to spend funds beyond financial year end. When final accounts are presented, unspent funds are to be regarded as unsettled advances. District should top-up VHSNC funds on the unsettled advances.

9. Records (Suggested Formats are at Annexure)

- a. Record of Meetings – with attendance signatures.
- b. Record of approvals. given by members for expenditure/withdrawal
- c. Cash book
- d. Public Services Monitoring Register
- e. Birth Register
- f. Death Register

Section - 7: Responsibilities of key VHSNC Members

1. Chairperson of the Committee

The Chairperson will:

- Lead the monthly meetings of the committee and ensure smooth coordination amongst members for effective decision making. She/He is accountable for ensuring that meetings are held monthly.
- Represent the VHSNC in the Standing Committee of the Panchayat on health and share details of work undertaken by VHSNC at the village level.
- Develop the annual or the bi-annual work plan for the committee, in consultation with member secretary ASHA and other members and follows up on necessary actions.
- Ensure that the village health plan prepared by the committee is reflected in the overall plan of the Gram Panchayat.
- Ensure that the records are adequately maintained.



2. Member Secretary and Convener of the Meeting

ASHA acts as the member secretary and convener of the committee. She will:

- Fix the schedule and venue for monthly meetings of the committee and ensure that meetings are conducted regularly with participation of all members.
- Draw attention of the committee on specific constraints and achievements related to health status of the village community and enable appropriate planning.
- Facilitate collection of information for village level planning-related to total population of the village, number of maternal and infant deaths, JSY/JSSK beneficiaries, children immunized, malnourished children and those referred to Nutrition Rehabilitation Centre (NRC), number of households and details of families falling under marginalized groups such as- those below poverty line, SC/ST category, women headed households, landless families working as daily wage labourers, families living in distant hamlets, migrant labours and individuals with disability.
- Maintain records on gaps identified in health or other related sectors, This includes identifying the cause of the gap, recording the decision on collective action as needed by the village to address the gap, and designating the persons responsible for leading the collective action, the specified timeframe to undertake the action, and recording follow up action.
- Ensure utilization of the un-tied fund as per the decisions taken by the committee through regular disbursement of funds jointly with the Chairperson and other signatories, if any, and undertake regular update of the cashbook.



- f. Provide information on activity wise fund utilization to the committee every month and with bills and vouchers/documents on a quarterly basis. Also, work with Chairperson for the annual presentation of the activities and expenditures in the annual Gram Sabha, its social audit and getting the approval of the Statement of Expenditure (SOE) by the Gram Panchayat, and timely submission of the SOE at the block level.

3. AWW

Is an important member of the VHSNC. She has a critical role in enabling VHSNC to take action on addressing malnutrition. She will do this through providing information on hamlet wise malnutrition status of children (less than six years of age) and presenting before the committee any specific challenges related to the functioning of AWC or help she needs for improving her effectiveness. She helps in mapping the marginalized households needing nutrition services and extends support in forming and implementing nutrition component of the village health plan. She is also accountable for ensuring the provision of take Home ration for children of less than three age group, pregnant/lactating mothers, and supplementary food for children 3-6 years, and bringing the issues related to non-availability of supplementary nutrition before the committee. The VHSNC will ensure that the AWC provides hot cooked meals in accordance with norms.



4. ANM

She will provide information to VHSNC regarding available services, schemes, and services for maternity and child health. She will share details on marginalized groups or those unreached through health services and seek the support of the VHSNC to reach these populations. She will enable the committee prepare a village action plan to address this concern. The committee will hold the ANM accountable for smooth functioning of Sub-Centre and provision of quality services and regular conduct VHND.



5. Role of Representatives from other Departments Like Education, Water and Sanitation, and Department of Woman and Child Development

The mandate of the VHSNC encompasses Health, Sanitation and Nutrition as well as the Education, particularly in the context of the programmes like Mid Day Meal, and most importantly Department of Woman and Child Development. Accordingly the VHSNC has the role of providing oversight and monitoring of their services to ensure convergent action on wider determinants of health such as drinking water, sanitation, female literacy, nutrition and women and child health. Role of representatives from other departments in to inform VHSNC on various developments and challenges faced in implementing the respective programmes and will enable VHSNC to take action on social determinants of health and contribute towards the synthesis of a comprehensive village health plan. This allows VHSNC to ensure local level accountability in delivery of social sector programmes.



Section - 8: Capacity Building and Training Strategy

Capacity building of VHSNC is a continuous process. The knowledge base of members needs to be strengthened for a clear understanding of the objectives, functioning and roles of VHSNC. The training curriculum should aim to build their capacities for addressing the social determinants of health and finally enable them acquire complex skills of village health planning and community based planning and monitoring.

The ASHA Training structure as it exists should provide training to VHSNC members. NGOs can be used to provide additional capacities for the training process.

Though the ideal process would be a two to five day training camp for all members but there are resource constraints and limited capacity for such training. The focus in most programmes therefore has been on training ASHAs very well so that they could provide leadership and if possible, training up to five members in two or three day sessions in moderate size groups at the sector level and most importantly, supportive supervision with facilitators attending VHSNC meetings and providing guidance and thereby building capacity in the course of the meeting.

The training strategy for VHSNC members involves:

1. **Training of ASHA Trainers, ASHA Facilitators and ASHAs:** This will enable states to develop a resource pool for training VHSNC members. It is also understood that it is through them that most VHSNCs would receive supportive supervision and knowledge inputs. A three day training is adequate to start with but would require to be repeated every six months at least.
2. **Training a core team:** This involves training of five members of each VHSNC for a two or three days period. (Two days if residential or three days if non-residential). The front line workers of government departments are not part of this five. In this training, a hand book would be introduced and they would be trained in the use of the handbook. Such trainings may need to be conducted at the sub-block level. This would orient them on key objectives, functions, roles and responsibilities of VHSNC. Subsequently they should receive a one day review cum training session every quarter – or at least once every six months.
3. **Orientation Sessions for front line workers:** ANMs, AWWs, and other front line workers who are members of VHSNCs would receive a two day non- residential orientation session on VHSNCs- and what is expected of them. This could be conducted at the block level.

Section - 9: Supportive Supervision

This is key to effective functioning of the VHSNC. A significant part of the capacity building process will take place as part of supportive supervision.

Supportive supervision in this context will mean a designated and well trained person attending the VHSNC meeting and ensuring that members understand and have the skills and support to carry out all their functions. The existing ASHA support structure is best used for undertaking this function. They have the orientation and have the skills for community interaction- and most important it is more cost effective. In areas where ASHA support structures do not exist they need to be constituted to meet the supervision needs of both programmes. A support structure is required at all levels of programme management (State, District, Block and sub Block,) for monitoring, mentoring and handholding of VHSNCs- and again savings are maximal if we overlap this with the ASHA support structure. This support structure is outlined and explained in detail in Part-C of this book containing 'Guidelines for setting up Community Processes Support Structure'.

Section - 10: Monitoring

The District Community Mobilizer would assist DPMU in maintaining a detailed data base on VHSNCs. The data base should have information on:

- a. No. of revenue villages in the district
- b. No of VHSNCs formed
- c. Composition of the committees
- d. Monthly meetings held
- e. No. of VHSNCs with Joint Accounts opened
- f. Dates of release of the un-tied fund to each
- g. Total Fund spent by each VHSNC – as per UCs received.

Other than this, the district community mobilizer reviews once a month, if possible twice a month meeting of the block coordinators who similarly conduct once a month meeting of facilitators. In these meetings, the information regarding functionality is received and the facilitators are trained through assistance in solving the problems they face. All supervisory staff must make a sample visit to VHSNC meetings and facilitators must try and attend almost all VHSNC meetings, at least once in two months.

- a. % of VHSNCs having regular monthly meeting
- b. % of VHSNCs who have submitted UCs
- c. % of VHSNCs who have submitted UCs with over 90% of their funds spent
- d. % of VHNDs held as compared to VHNDs planned

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Section - 11: Awards to the Best Performing VHSNC

Performance of VHSNCs can be assessed on certain key activities (Annexure 11), based on which their efforts to improve status of health and its determinants can be reviewed. Every year states could select one best performing VHSNC in each district based on the criteria given above and provide an additional amount of Rs. 10,000 as an award.

The performance assessment will be carried out by a 6-7 member core committee constituting of Chief Medical Health Officer, District Community Mobilizer, representatives of local NGOs in the district and representatives of ICDS, Rural Development and Water and Sanitation departments at the district level. The assessment will take place every six months, and will give an opportunity to VHSNCs to review their performance and make efforts for improvement. The awards will be given on an annual basis.



ANNEXURES

Annexure - I: PUBLIC SERVICES MONITORING TOOL

Sl. No.	Indicators	Jan.	Feb.	March
Anganwadi Centre				
1	Did all Anganwadi centres open regularly during the month ?			
2	Number of children aged 3 - 6 years?			
3	Number of children aged 3 - 6 years who came regularly to Anganwadi centre ?			
4	No. of 0-3 year children in village			
5	No. of 0-3 year children who are in malnourished or severe malnourished grade			
6	Was the weight measurement of children done in all centres last month?			
7	Were pulse and vegetables served all days in cooked meal last week in all the centres?			
8	Was Ready to Eat food distributed in all centres on each Tuesday during the last month?			
Complementary Feeding				
9	Number of children aged 6-9 months whose complementary feeding has not started yet ?			
Health Services				
10	Did the ANM come last month for the Immunization/VHND ?			
11	Whether all children of all hamlets are being vaccinated in appropriate age ?			
12	Whether the BP measurement of pregnant women was done in the VHND ?			
13	Did the ANM provide medicines to the patients free of cost ?			
14	Did all the ASHAs have more than 10 chloroquine tablets with them ?			
15	Did all the ASHAs of the village had more than 10 Cotrimaxazole tablets with them ?			
16	Whether the transportation facility was available to take the serious patients, delivery cases, sick newborn cases, etc to health facilities ?			
17	Number of families not using mosquito net ?			
18	Number of deliveries that took place at home during the last month ?			
19	Number of diarrhoea cases during the last month ?			
20	Number of fever cases during the last month ?			

Sl. No.	Indicators	Jan.	Feb.	March
Food Security				
21	Whether the ration shop provided all ration items during the last month ?			
22	Did the old age pensioners get pension in time ?			
23	Was the MNREGA payment made in time ?			
Education				
24	Number of girls under the age group of 6-16 not attending the school ?			
25	Did all the schools teachers come to the schools regularly during the last month ?			
Mid-Day Meal				
26	Were pulse and vegetables served all days in cooked meal last week in all the schools (upto 8th) ?			
Water and Sanitation				
27	How many hand pumps are non-functional as on today?			
28	Number of hand pumps with stagnant water around it as on today?			
Individual Household Latrines				
29	Number of households with individual household latrines constructed and used?			
Status of Women				
30	Number of cases of violence against women during the last month ?			
31	Number of cases of early childhood marriages reported?			

The above table is based on the experience of Chhattisgarh VHSNCs. Exact details of each row can change according to the state or district. VHSNC too can add on aspects which it wants to monitor.

Based on above table- the following notes are kept- which is a monthly action plan.

Annexure Ia: Public Services Register

Sl. No.	Gap Identified in table above	Date on which identified	Action to be taken	Person responsible	What happened next

Annexure - II: Checklist for Village Health Nutrition Day

Name of block: _____

Name of PHC: _____

Name of Subcentre: _____

Name of village: _____

Sl. No.	Parameters	Assessment- Yes/No/Partial/NA- Not Applicable	Remarks
Presence of Health Workers During VHND			
1	Was ANM present during VHND?		
2	Was ASHA present during VHND?		
3	Was AWW present during VHND?		
Services Delivery During VHNDs by ANM			
1	Was ANM doing ANC check- up of pregnant women?		
2	What components of ANC were being provided?		
i	Tetanus toxoid injections		
ii	Blood pressure measurement		
iii	Weighing of pregnant women		
iv	Blood test for anaemia using Haemoglobinometer		
v	Examination of abdomen		
vi	Counselling of appropriate diet and rest		
vii	Inquiring about any danger signs like – swelling in whole body, blurring of vision and severe headache or fever with chills etc.		
viii	Counselling for institutional delivery		
3	Was ANM providing vaccination to children?		
4	Did she also provide medicine or referral in case of any sickness of any child below 2 years of age ?		
Services Provided by AWW During VHND			
1	Was AWW weighing all the children of 0-6 years of age?		
2	Was AWW weighing the children correctly?		
3	Did AWW record the weight on the growth monitoring card correctly?		
4	Did AWW give take home rations to children 6months – 6 years of age?		
5	Did AWW give take home rations to adolescent girls?		

Sl. No.	Parameters	Assessment- Yes/No/Partial/NA- Not Applicable	Remarks
6	Did AWW give take home rations to pregnant women?		
7	Did AWW give take home rations to lactating mothers?		
Quality of Services Delivered During VHND			
1	Weighing machine of ANM was in order		
2	Weighing machine of AWW was in order		
3	Thermometer was working accurately		
4	BP apparatus was working accurately		
5	Supplementary food was available		
6	Quality of supplementary food was good		
Roles Played by ASHA			
1	Did ASHA make a list of potential beneficiaries who need either ANM or AWW services?		
2	Was ASHA able to motivate most (>75%) of the beneficiaries to attend VHND?		
3	Did she inform the beneficiaries atleast a day before about the date of VHND?		
4	Did she help ANM or AWW in organizing the VHND?		
General Questions			
1	What was the venue of the VHND		
i	Anganwadi centre		
ii	Sub centre		
iii	Panchayat hall		
iv	Some other – open venue		
2	Was VHND held on a fixed date every month?		

Annexure - III: Village Health Register

The village health register should contain information on the following:

- Total Population of the village.
- Total Number of Households in the village.
- Total Number of BPL Families; with details of their religion, caste and language.
- Current beneficiaries/target lists for services related to health, water and sanitation, and nutrition to ensure access of all sections, particularly the marginalized groups.
- Details of Individuals with Disability.

Annexure - IV: Birth Register

Name of village: _____

Name of Panchayat: _____

Sl. No.	Name of Infant	Sex of Infant	Name of Mother and Father	Name of Hamlet	Date of Birth	Time of Birth	Place of Birth	Birth Weight

VHSNC can use this information:

- ▶ To facilitate birth registration for issuance of birth certificate by appropriate authority.
- ▶ In monitoring institutional delivery, birth weight.
- ▶ In improving home visits by ASHA for HBNC, monitoring of neonatal deaths.

Annexure - V: Death Register

Name of village: _____

Name of Panchayat: _____

Sl. No.	Name of Deceased individual	Age and Sex	Name of Father/ Spouse	Name of Hamlet	Date of Death	Place of Death	Cause of Death

VHSNC should use this information to facilitate death registration for issuance of death certificate by appropriate authority. All deaths should be recorded, including still births if any. This list is used for discussion in VHSNC meetings on how to prevent such deaths in future as record of causes of death is important and will form the basis for village planning.

Annexure - VI: Checklist for Assessing Quality of Services at Health Facilities

A. OBSERVATION CHECKLIST FOR HEALTH SUB-CENTRE

General information

Name of the sub-centres village: _____

Total population covered by the sub-centre: _____

Distance from the PHC: _____

Availability of Staff at the Sub-centre

- | | |
|--|--------|
| ▶ Is there an ANM available/appointed at the centre? | Yes/No |
| ▶ Is there health worker-male (MPW) available/appointed? | Yes/No |
| ▶ Is there a part-time attendant (female) available? | Yes/No |

Availability of Infrastructure at the Sub-centre

- | | |
|--|--------|
| ▶ Is there a designated government building available for the sub-centre? | Yes/No |
| ▶ Is the building in working condition? | Yes/No |
| ▶ Is there a regular water supply at this sub-centre? | Yes/No |
| ▶ Is there regular electricity supply at this sub-centre? | Yes/No |
| ▶ Is the blood pressure apparatus in working condition in this sub-centre? | Yes/No |
| ▶ Is the examination table in working condition in this sub-centre? | Yes/No |
| ▶ Is the steriliser instrument in working condition in this sub-centre? | Yes/No |
| ▶ Is the weighing machine in working condition in this sub-centre? | Yes/No |
| ▶ Are there disposable delivery kits available in this sub-centre? | Yes/No |

Availability of Services at the Sub-centre

- | | |
|--|--------|
| ▶ Does the doctor visit the sub-centre at least once a month? | Yes/No |
| ▶ Is the day and time of this visit fixed? | Yes/No |
| ▶ Is facility for delivery available in this sub-centre during a full 24-hour period? | Yes/No |
| ▶ Is treatment of diarrhoea and dehydration offered by the sub-centre? | Yes/No |
| ▶ Is treatment for minor illness like fever, cough, cold, etc. available in this sub-centre? | Yes/No |
| ▶ Is facility for taking a blood slide in the case of fever for detection of malaria available in this sub-centre? | Yes/No |
| ▶ Are contraceptive services available at this sub-centre? | Yes/No |
| ▶ Are oral contraceptive pills distributed through this sub-centre? | Yes/No |
| ▶ Are condoms distributed through the sub-centre? | Yes/No |

B. OBSERVATION CHECKLIST FOR PHC CENTRE

General Information

Name of the PHC village: _____

Total population covered by the PHC: _____

Availability of Infrastructure

- | | |
|--|--------|
| ▶ Is there a designated government building available for the PHC? | Yes/No |
| ▶ Is the building in working condition? | Yes/No |
| ▶ Is water supply readily available in this PHC? | Yes/No |
| ▶ Is electricity supply readily available in this PHC? | Yes/No |
| ▶ Is there a telephone line available and in working condition? | Yes/No |

Availability of Staff in the PHC

- | | |
|---|--------|
| ▶ Is a Medical Officer available/appointed at the centre? | Yes/No |
| ▶ Is a Staff Nurse available at the PHC? | Yes/No |
| ▶ Is a health educator available at the PHC? | Yes/No |
| ▶ Is a health worker-male(MPW) available/appointed? | Yes/No |
| ▶ Is a part time attendant (female) available? | Yes/No |

General Services

Availability of Medicines in the PHC

- | | |
|--|--------|
| ▶ Is the anti-snake venom readily available in the PHC? | Yes/No |
| ▶ Is the anti-rabies vaccine readily available in the PHC? | Yes/No |
| ▶ Are drugs for malaria readily available in the PHC? | Yes/No |
| ▶ Are drugs for tuberculosis readily available in the PHC? | Yes/No |

Availability of Curative Services

- | | |
|--|--------|
| ▶ Is cataract surgery done in this PHC? | Yes/No |
| ▶ Is primary management of wounds done at this PHC? (stitches, dressing etc. | Yes/No |
| ▶ Is primary management of fracture done at this PHC? | Yes/No |
| ▶ Are minor surgeries done at this PHC? | Yes/No |
| ▶ Is primary management of cases of poisoning done at the PHC? | Yes/No |
| ▶ Is primary management of burns done at the PHC? | Yes/No |

Reproductive and Maternal Care and Abortion Services

Availability of Reproductive and Maternal Health Services

- ▶ Are ante-natal clinics regularly organised by this PHC? Yes/No
- ▶ Is facility for normal delivery available in the PHC 24 hours a day? Yes/No
- ▶ Are facilities for tubectomy and vasectomy available at the PHC? Yes/No
- ▶ Are internal examination and treatment for gynaecological conditions and disorders like leucorrhoea and menstrual disturbance available at the PHC? Yes/No.
- ▶ Is facility for abortion- Medical Termination of Pregnancy (MTP) available at this PHC? Yes/No
- ▶ Is treatment for anaemia given to both pregnant as well as non- pregnant women? Yes/No
- ▶ How many deliveries have been conducted in the last quarter (three months)? _____

Child Care and Immunisation Services

- ▶ Are low birth-weight babies treated at this PHC? Yes/No
- ▶ Are there fixed immunisation days? Yes/No/No information
- ▶ Are BCG and measles vaccine given at this PHC? Yes/No
- ▶ Is treatment for children with pneumonia available at this PHC? Yes/No
- ▶ Is treatment of children suffering from diarrhoea with severe dehydration done at this PHC? Yes/No

Laboratory and Epidemic Management Services

- ▶ Is laboratory service available at the PHC? Is blood examination for anaemia done at this PHC?— Yes/No
- ▶ Is detection of malaria parasite by blood smear examination done at this PHC? Yes/No
- ▶ Is sputum examination to diagnose tuberculosis conducted at this PHC? Yes/No
- ▶ Is urine examination of pregnant women done at this PHC? Yes/No

Annexure - VII: VHSNC Monthly Meeting Attendance Record

Village Health and Sanitation Committee Village:, GP:

Block: Meeting Date: Meeting Time:.....

Meeting Chaired by:

Sl No.	Name*	Hamlet/Post	Signature

*Mention details of special invitee if any.

Annexure - VIII: VHSNC Monthly Meeting Minutes Record

Agenda Item	Key Discussions*	Decisions Taken	Name of individuals Assigned Responsibilities	Financial Allocations, if any with Stated Details

*Specify issues in objection or support of the Agenda item.

Sign of Member Secretary:

Sign of Chairperson:

Annexure - IX: Cash Book for VHSNC

- ▶ The cash book of the VHSNC is to be maintained for recording of income & expenditure of the VHSNC.
- ▶ This cash book is totally maintained by the VHSNC Member Secretary cum Convener (ASHA) with the help of AWW/ANM/Chairperson of VHSNC.
- ▶ One part (PART 1) of the cash book comprises income of the VHSNC (untied fund, donation, other source) and other part (PART 2) of the cash book comprises expenditure.

PART 1- INCOME DETAILS-(TO BE MAINTAINED ON LEFT SIDE OF THE CASH BOOK)

Sl. No.	Opening Balance	VHSNC Fund Received- Donation or Untied (Amount)	Details of Funds Received by the VHSNC-Donation or Untied - (Cheque No./Draft No/ Cash)	Date of the Details Donation/ Income (To be Written in red pen)	Source of Donation/ Income	Sign of Member Secretary

PART 2- EXPENDITURE DETAILS-(TO BE MAINTAINED ON RIGHT SIDE OF THE CASH BOOK)

Sl. No.	Amount of Fund Spent by VHSNC	Details of Funds Spent by the VHSNC- (Voucher No./Bill No.)	Date of the Expenditure (To be written in red pen)	Activity on which Funds were spent	Signature of Member Secretary

Annexure - X: VHSNC Statement of Expenditure

Sl. No.	Period of Activity (Date/Month)	Name of Activity	Purpose (Including Details on Beneficiaries and Location of Activity)	Details of Expenditure (Rates of Items, Break-up of Expenses)	Total Expenditure on Activity
Total Expenditure (All Activities)					
Total Amount Received					
Total Unspent Amount					
(a) Total Amount at Hand/Cash					
(b) Total Amount in Bank					

Annexure - XI: Activities for Assessment of Best Performing VHSNC

Sl. No.	Activity	Indicator	Means of Verification	Score Given:1/0
a) Functioning of VHSNC				
1	Meeting of VHSNC	One meeting held every month and minutes recorded	VHSNC monthly meeting attendance record and meeting minutes record	
2.	Expenditure of VHSNC untied fund	80% of the total fund spent with proper record maintenance	Cash Book for VHSNC and the Statement of Expenditure	
3.	Action taken on gaps in delivery of services at the village level	Number of gaps identified and action taken	Public Services Register	
4.	Record of births	Number of births for which a birth certificate has been issued in the past one year	Registrar for issuing birth certificates	
b) Achievement of Health and related Indicators				
1	VHNDs organised as per the quality assessment checklist(annexure 2)	100% achievement following the guideline	ANM register	
2	Malnutrition of children	Percentage of children aged 3-6 years regularly coming to Anganwadi Centre	AWW register	
3	Institutional Delivery	90% achievement	ANM register	
4	Safe drinking water source	Number of non-functional Hand-Pumps in last one year(less number indicates good functionality of VHSNC)	Public Service Register and physical verification	
5	Construction and use of Individual Household Latrines(IHL)	At least 50% households having IHL constructed and used	Records maintained by VHSNC/ASHA and physical verification	
6	Use of mosquito nets	All pregnant women and infants in malaria endemic area must be using mosquito nets	Record maintained by ANM/ASHA and physical verification	

Sl. No.	Activity	Indicator	Means of Verification	Score Given:1/0
c) Other Activities				
1	Mid-Day Meal	All schools (up to class8th) should have served pulse and vegetables in cooked meal in the last one year	Public Services Register	
2	Early Marriage	No case of early childhood marriage reported	Public Services Register	
3	Any additional fund mobilization from other sources (except VHSNC untied fund)	Funds received and utilized	VHSNC cash book, Bank pass book	

The above indicators are to be achieved in all the villages and hamlets covered under the VHSNC for the period of last six months for the qualification to be declared as “Best Performing VHSNC”.

**GUIDELINES FOR SETTING UP
COMMUNITY PROCESSES SUPPORT STRUCTURES**

PART - C



Background

In order for the ASHA and Village Health and Sanitation Committees (VHSNC) to be functional and effective and fulfil NRHM's vision of active community participation, convergence and addressing social determinants, a support structure at all levels of programme implementation (State, District, Block, Sub-Block level) is required for training, supportive supervision, mentoring and handholding. This document lays out clear guidelines to establish support structures for Community Processes at all the levels mentioned above. In the first phase of the NRHM, the support structure was envisaged only for the ASHA programme, but in the second phase of the National Health Mission this support should encompass the VHSNC as well.

GUIDELINES FOR SETTING UP COMMUNITY PROCESSES SUPPORT STRUCTURES



Section - I: Composition of ASHA and Community Processes Support Structure at Various Levels

Sl. No.	Level	Name of the Structure	Composition
I	State	State Mentoring Group for ASHA and Community Processes	Experts and practitioners in the field of Community Health representing NGOs, training and research institutions, academia and medical colleges
		State Management Team (housed within SPMU)	One Nodal Officer for Community Processes will head this small team of consultants
		State ASHA and Community Processes Resource Centre. (Outsourced or placed in SHSRC)	A dedicated resource Centre for States with more than 20,000 ASHAs and VHSNCs. Consists of: <ul style="list-style-type: none"> ▶ Team Leader ▶ Programme Manager - ASHA ▶ Programme Manager - Village Health Sanitation and Nutrition Committee and other community processes, including community monitoring ▶ Consultant - Documentation & Communication ▶ Regional Training and Supportive Supervision Coordinators* ▶ Data Assistant ▶ Accounts assistant ▶ One office attendant. <p>*Large states would benefit by engaging a Regional Training and Supportive Supervision Coordinator responsible for a minimum six districts to supervise and support the training and other interventions related to ASHA and other community processes.</p>
			States with less than 20,000 ASHAs do not need Documentation & Communication Officer and Regional Coordinators
		State Training Team ¹	State Trainers- Synonymous with State Training Sites described in -ASHA Guidelines 2013 (Part: A)
II	District	District Coordination Committee for ASHA and Community Processes	<ul style="list-style-type: none"> ▶ Committee functions under the strategic guidance and leadership of District Health Society. ▶ It is convened by District Nodal Officer/CMHO and functions through a full time District Community Mobilizer. ▶ It includes, at least five to eleven members, such as members from State Mentoring Group for ASHA and Communities Processes, programme officers and representatives from district training sites, and also one or two representatives from District Planning and Monitoring Committee formed under NRHM.
		District ASHA and Community Processes Team	District Community Mobilizer District Data Assistant All Block Community Mobilizers
		District Training Team ¹	District/ASHA Trainers synonymous with the training sites at the district level
III	Block	Block ASHA and Community Processes Team	Block Medical Officer/Nodal Officer Block Community Mobilizer All ASHA Facilitators
IV	Sub Block		One ASHA Facilitator for a cluster of 20 ASHAs(10 in special situations) The Non-High Focus states and Union Territories may assign the role of ASHA Facilitators to the additional/second ANM at the Sub-Centres. States having less than 20,000 ASHAs could utilise existing support mechanisms at PHC level to support ASHAs. But dedicated ASHA Facilitators must be recruited in areas of geographic dispersion and those with marginalised and vulnerable populations.

- 1 A team of state trainers trained and accredited at national training sites. The state shall designate one state level training centre for every six districts which will have a faculty of at least four to six state trainers. The state will also designate five or more sub district training sites at which ASHAs will be trained.

Section - 2: Roles and Responsibilities of ASHA Support Structure at Various Levels

STATE LEVEL

The State ASHA and Community Processes Nodal Officer or Management team based within the State Programme Management Unit, State ASHA and Community Processes Resource Centre, the Civil Society Advisory Group called the State ASHA and Community Processes Mentoring Group, and the State Trainers Team are the essential support structures present at state level.

A. State Programme Management Team headed by Nodal Officer–ASHA and Community Processes

It will manage and supervise the overall implementation of ASHA, VHSNC and other Community Processes at state level. It enables effective operationalization of the programme through:

- a. Issuing relevant orders and guidelines to the districts.
- b. Fund release and collecting utilization certificates.
- c. Financing and establishing mechanisms for regular ASHA payments.
- d. Financing, supervision and contract management of State ASHA and Community Processes Resource Centre.
- e. Financing and supervision of state training sites.
- f. Logistics for smooth supply of materials like-ASHA kits, Training Manuals and other job aids.
- g. Periodic review of programme implementation and assess performance reports.
- h. Feedback to the Mission Director NRHM in programme administration and facilitating policy decisions related to ASHA and Community Processes.

All these functions will be undertaken in consultation and coordination with the State Community Processes Resource Centre team.

B. State ASHA or Community Processes Resource Centre

State ASHA and Community Processes Resource Centre should operate under the direction and leadership of Mission Director, NRHM. It works in close coordination with the State ASHA and Community Processes Nodal Officer or Management Team and State Mentoring Group for ASHA and Community Processes. This can be based within State Health Resource Centre or State Institute of Health and Family Welfare or be outsourced as NGO or set up as an independent agency. Key roles and responsibilities are:

a. Establishing coordination partnerships

It acts as the secretariat for State Mentoring Group for ASHA and Community Processes and coordinates with the National Health Systems Resource Centre (NHSRC) for facilitation of technical assistance to strengthen programme effectiveness and capacity building. It builds partnerships with civil society organizations, academia and NGOs to serve as resources in policy, training and capacity building of ASHA and other community processes. It also addresses issues of convergence with other departments like PRI and WCD to strengthen programme effectiveness.

b. Ensuring high quality, competency based training by:

- ❖ Adaptation or development of state specific- training strategy, curriculum, training material and methodology and ensuring standardization for a set of skills for the ASHA and VHSNC.

- ❖ Identifying and developing state and district training sites and creating a cadre of state and district trainers with appropriate skill mix.
- ❖ Coordinating with NHSRC in training its state trainers at selected national training sites (that combine a high quality competency based training programme located in a credible community based intervention with active people's participation).
- ❖ Implementing training programme based on the needs assessment and identifying state specific issues for inclusion into future rounds/refreshers for ASHA and VHSNC training.
- ❖ Monitoring the training process for logistics, quality, availability of training aids and ensuring post training evaluation of trainers and ASHAs.
- ❖ Planning for refresher trainings as required.
- ❖ Accreditation of Training curriculum; State training site, District training site; State and ASHA Trainers.
- ❖ Enabling ASHA certification through the National Open School System.

c. Supportive supervision and continuous performance monitoring through:

- ❖ Periodic supportive supervision visits to various districts.
- ❖ Developing or adapting supervisory protocols and checklists for the Community Processes mobilizers and facilitators.
- ❖ Conducting Quarterly state level review meetings with the district team and facilitate monthly review in the districts.
- ❖ Maintaining a comprehensive data base of ASHA and VHSNC as reported from support structure at sub-block, block and district level. This enables tracking status of- ASHA selection VHSNC formation, training, drug kits, dropouts and payments which enables effective planning and monitoring.
- ❖ Building capacities of the support personnel across all levels in collecting and consolidating the data on performance reports as per performance monitoring formats, to monitor functionality and outcomes of the programme at district and block levels and enable them to provide supportive supervision.

d. Development of IEC or BCC material, and Documentation:

It develops IEC/BCC and advocacy material related to community processes activities for the state. Undertakes regular documentation of successful innovations and model community processes, and also shares the details with other stakeholders for scaling up and strategic planning related to the programme.

e. Strategic Planning and Policy Support

It is the nodal agency for providing strategic guidance to the state officials and SPMU for overall programme evolution. It facilitates programme design and planning and extends technical support to the district team and District Health Societies in operationalization of the ASHA and other community processes components of NRHM. This is achieved through developing state specific policy, guidelines, protocols, budgetary guidance, monitoring tools and other specifications for SPMU, and supports active onward dissemination to the districts.

C. State Mentoring Group for ASHA and Community Processes

It serves as a technical and advisory body for all Community Processes components of NRHM, including ASHA and extends support to the State Government in overall implementation, mentoring and monitoring of the programme.

Key tasks of the State Mentoring Group for ASHA and Community Processes:

- a. Provide technical guidance and inputs for policy to the State ASHA and Community Processes Resource centre and the SPMU on overall implementation and development of the ASHA and Community Processes.
- b. Each member to identify one or a few districts and provide on-site mentoring through periodic supportive supervision visits.
- c. Meet on a bi-annual basis to share the major observations and provide assessment reports related to programme progress, challenges and innovations across different districts.
- d. Identify constraints; provide feedback and strategic recommendations to the State ASHA and Community Processes Resource centre and the SPMU and district officials for appropriate interventions.
- e. Support in undertaking programme evaluation at regular intervals, to enable evidence based understanding of programme effectiveness and propose strategies for improved outcomes.
- f. Facilitate scale up of ASHA and VHSNC trainings through- serving as training sites, supporting in identification or selection of trainers, assisting in state specific adaptation or design of training curriculum and providing inputs for or developing state specific training material and support refresher trainings.
- g. Identify the emerging priorities and support in planning future goals to enable long term sustenance of the programme.

DISTRICT LEVEL

District Coordination Committee for ASHA and Community Processes

This committee undertakes regular progress and financial review of ASHA and other Community Process components of NRHM and is responsible for overall programme implementation. It undertakes administrative decisions related to the programme. Streamline all major components of programme operationalization like- district level programme planning, budget design, fund release, and logistics for distribution of ASHA kits and training manuals and other job aids. It is an important link between the support structure of the Community Processes Programme at state and district level.

District ASHA and Community Processes Team

Note: Given the dynamic and evolving nature of the ASHA programme and bearing in mind the enormity of supporting tasks it is mandatory that recruited DCMs are strictly engaged as an exclusive support for Community Processes interventions and their services are not diverted for undertaking ancillary functions related to other programmes.

It manages, supervises and support overall implementation of ASHA and Community Processes at district level. Key roles are:

- a. **Supporting programme implementation by:**
 - ❖ Dissemination of orders and guidelines to block levels and below.
 - ❖ Enabling selection of new ASHAs through an assessment of drop outs and villages without ASHAs.

- ❖ Ensuring uninterrupted fund release (from district to blocks) and facilitating optimal utilization.
- ❖ Creating streamlined mechanisms for ASHA payments and sound logistics-for supply distribution and replenishment ASHA Kits.
- ❖ Strengthening additional support mechanisms for ASHA like- ASHA Awards, Grievance Redressal System, ASHA Help Desk and waiting/rest rooms (ASHA Gruha) at public health facilities.
- ❖ Supervising formation of VHSNCs and developing processes for community monitoring in all the villages of the districts falls within the purview of District level Support Team.

b. Enabling regular high quality trainings through:

- ❖ Developing district training sites and supporting in constitution and capacity building of the district training team.
- ❖ Developing a systematic training plan, organizing and monitoring block wise training of district trainers, ASHAs, ASHA Facilitators and VHSNC members.
- ❖ Ensuring that quality standards are adhered to in the training process through smooth logistics like- availability of adequate infrastructure and training material.
- ❖ Maintaining a comprehensive data base of trainers and trainees which serves as a monitoring tool to enable early diagnosis of lacuna in training schedules, drop outs among trainees and trainers between rounds, and training quality.
- ❖ Ensuring post training evaluation and support in accreditation of District training site and District Trainers.
- ❖ Ensuring ASHA certification.

c. Establishing coordination with:

- ❖ District Nodal Officer, State ASHA and Community Processes Resource Centre and provides supervision and mentoring to the block team.
- ❖ DPMU for compilation of block level health plans and contribute in preparation of budget for the Community Processes section of the district health action plan.
- ❖ NGOs and district level functionaries of other government departments such as; Women and Child Development, Water and Sanitation, Rural Development and Panchayat Department, to strengthen district resource pool for training and capacity building.

d. Undertaking supportive supervision and continuous monitoring through-

- ❖ Periodic review meetings with block support team and frequent field visits to review the activities related to ASHA and community processes.
- ❖ Maintaining a block wise data base for the profile of every ASHA, training status and drop outs.
- ❖ Compiling district level performance reports in accordance to the formats submitted by Block Community Mobilizers, to assess functionality of ASHAs on key tasks.
- ❖ Identifying the poor performing blocks, assessing causes of low performance and devising strategies for improvement.
- ❖ Maintaining a block wise database of VHSNCs for their training, functionality, expenditure and back logs.

Over time, the role of training and supportive supervision could be merged, keeping an adequate balance in the workload.

BLOCK LEVEL

The Block ASHA and Community Processes Team supports programme operationalization at block level. Key roles are:

- ▶ Organizing block review meetings every month on a fixed day, in coordination with Block Medical Officer In-Charge (BMOIC) and Block Programmer Manager for facilitating:
 - i. Periodic refresher trainings, capacity building, updating information and sharing new guidelines
 - ii. Review and assessment of performance of ASHAs along with trouble shooting
 - iii. Replenishment of ASHA drugs/equipment kits
 - iv. Verifying records and release of payments
 - v. Review and assess the functionality of VHSNCS in terms of regular meetings, fund utilization etc.
- ▶ Provides direct support in a wide range of activities such as- ASHA selection, release of ASHA payments, regular supply distribution and replenishment ASHA Kits and training material.
- ▶ Supports the District Community Mobilizer in the formation and improved functioning of VHSNCs and assists in developing processes for community monitoring in all the villages of the blocks.
- ▶ Sharing data on the trainings to District Community Mobilizer for report compilation, planning, and facilitating training of ASHA facilitators, ASHA and VHSNC members.
- ▶ Provides supportive supervision and continuous monitoring through - monthly meeting of the ASHA facilitators at block headquarters and field visits to assess functionality and handholding ASHA Facilitators and ASHAs.
- ▶ Reports and maintains a facilitator wise data base for the profile of every ASHA, training status and drop outs.
- ▶ Undertakes monthly block level compilation of performance reports according to the formats submitted by ASHA Facilitators, to assess functionality of ASHA on key tasks. Further, identifies the poor performing ASHAs, assess the causes of low performance and devise strategies for improvement.
- ▶ Coordinates with- district level functionaries, BPMU and Block Medical Officer/In Charge to ensure efficient implementation of community processes and also establishes smooth working relationships with block level functionaries of other government departments such as; WCD, Water and Sanitation and Rural Development to avoid/solve issues related to field level incoordination or conflicts if present.
- ▶ Works with Block Programme Manager in compilation of all the village health plans made by VHSNCs and contribute in preparing the community processes section of the block/district health action plan.
- ▶ Maintains a block wise database of VHSNCs for their training, functionality, expenditure and back logs is also a regular function.

SUB BLOCK LEVEL

ASHA Facilitator should assist Block Community Mobilizer and provide continuous handholding support to ASHAs. She supports ASHA in coordination with ANM, AWW, PRI, VHSNC, SHG etc. It is expected that she will spend 20 days in the field to provide support to ASHAs in her area of operation. ASHA facilitators form the main vehicle of community mobilization and monitoring.

Roles and Responsibilities

- ▶ Village visits (comprising of accompanying her on household visits, conducting community/VHSNC meetings/attending Village Health and Nutrition Days).
- ▶ Conducting cluster meetings of all ASHA in her area once a month.
- ▶ Attending monthly block PHC review meeting.
- ▶ An important task of the facilitator is to enable the ASHA to reach the poorest and the most marginalized.
- ▶ Supporting ASHA training during training rounds at block level.
- ▶ Facilitating selection of new ASHA and constitution of VHSNCs.
- ▶ Enabling grievance redressal system for the ASHA.
- ▶ Facilitating community meetings such as- VHSNC and the process of community monitoring.
- ▶ Check the drug kit and stock record and solve problems related to logistics (Supply chain), Drug kits and replenishment.
- ▶ Obtain data on key health indicators and consolidate the data collected during the review meeting especially for the functionality of ASHAs and do monthly reporting to Block Community Mobilizer.

The Terms of Reference and illustrative budget for the support structures has been included in Annexure S.1 and S.2 respectively.

ANNEXURE

Annexure S-I

TERMS OF REFERENCE FOR KEY POSITIONS

1. Team Leader - State ASHA and Community Processes Resource Centre

Eligibility and Qualifications

- ▶ Postgraduate qualification in any discipline of Social Sciences/Social Work/Rural Development/Public Administration/Public Health/Community Medicine/Preventive & Social Medicine/Management, Preferably with a doctorate in relevant area of work.
- ▶ Minimum 8 years of experience in community mobilization or related field with at least of 5 years experience in health sector.
- ▶ Familiarity with/work experience in community health worker programmes or gender empowerment programmes.
- ▶ Sensitivity to and knowledge and experience of working on issues related to community health.
- ▶ Experience of having organized or worked at the field level as Manager or Trainer and as organizer of training programmes and consultative workshops is essential.
- ▶ Experience in developing monitoring of district and state level programmes.
- ▶ Action Research or project publications on community participation and community health worker programmes.
- ▶ Computer proficiency with high level of familiarity with data base management programme and commonly used packages like MS Word, Excel, power point etc.
- ▶ Excellent communication and presentation skills, analytical and interpersonal abilities, excellent oral and written communication skills in English and Hindi.
- ▶ Desirable- Experience of working for health rights or in a health rights framework.

Roles and Responsibilities

- ▶ Providing leadership in developing capacities and strategies for implementation of ASHA program and other community processes like the VHNSC, Rogi Kalyan Samitis, Community Based Planning and Monitoring and NGO engagement in such programmes.
- ▶ Involving NGOs or other Community Based Organization (CBOs), academic and other research agencies in support of the ASHA and community processes interventions.
- ▶ Enabling the development of appropriate training material for ASHA and other Community Processes.
- ▶ Developing state specific mechanisms for community monitoring for health.
- ▶ Developing policies and strategies that enhance people's participation in public health planning and management, including for social determinants of health.

- ▶ Ensuring development and implementation of Community Processes strategies for addressing the needs of marginalized and vulnerable populations including tribals, dalits, minorities and other such vulnerable community groups.
- ▶ Developing study design and evaluation methodologies for periodic review of the programme and use evidence for developing strategies for programme improvement.
- ▶ Developing policies and strategies that promote and enable decentralization and empower community.
- ▶ Providing overall administrative and technical support to the state ASHA and Community Processes Resource Centre.

Reporting: Reports directly to the Mission Director – NRHM or Team Leader State Health Resource Centre or the State Nodal Officer ASHA and Community Processes, as the state deems appropriate.

Age limit: Below 50 Years of age.

2. Programme Manager - ASHA

Responsible for Training, Review and Supportive Supervision

Eligibility and Qualifications

- ▶ Postgraduate qualification in any discipline of Social Sciences/Social Work/Rural Development/Public Administration/Public Health/Community Medicine/Preventive & Social Medicine/Management.
- ▶ At least 5 years experience in management of community health programmes or community mobilization or related field activities with a minimum of 3 years experience in health sector.
- ▶ Familiarity with/having worked in community health worker programmes, or on empowerment of health volunteers or health projects involving Government and/or NGOs.
- ▶ Sensitivity to, knowledge and experience of working on issues related to prevention and promotion of health care services.
- ▶ Experience of having worked as trainer and as organizer of training programmes is essential.
- ▶ Publication on community participation in health programmes or in coordination of government-NGO supported community health projects.
- ▶ Computer proficiency with high level of familiarity with data base management programme and commonly used packages like MS Word, Excel, power point etc.
- ▶ Excellent communication and presentation skills, analytical and interpersonal abilities, excellent oral and written communication skills in English and Hindi.

Roles and Responsibilities

- ▶ Develop strategic plan and budget for State and District level: besides a monitoring plan and training calendar.
- ▶ Support development of appropriate training modules, and MIS for successful monitoring of Community processes.
- ▶ Ensure functional coordination with SPMU, NGO Cell, DPMU and other Health officials in the state.

- ▶ Coordinate with State Mentoring Group for ASHA and Community Processes and convene the meeting of Mentoring Group to develop policy and other appropriate support mechanism towards better functioning/performance of ASHA program and other community processes.
- ▶ Facilitate documentation of best practices, case studies relating to community processes besides developing IEC/BCC materials.
- ▶ Analysis and provide feedback on training conducted on the community processes by District and NGOs.
- ▶ Undertake periodic visits to district and selected NGOs to do the supportive supervision of activity implementation.
- ▶ Provide support to NRHM for effective functioning of community processes through advocacy & networking.
- ▶ Support in programme related research and evaluation.
- ▶ Undertake reviews & assessments & pilot innovative initiative as required.

Reporting Will report to Team Leader State ASHA and Community Processes Resource centre, who will be responsible for Monitoring and Evaluation of his/her performance.

Age limit: Below 45 Years of Age.

3. Programme Manager - Village Health Sanitation and Nutrition Committee and other Community Processes

Eligibility and essential qualifications

- ▶ Postgraduate qualification in any discipline of Social Sciences/Social Work/Rural Development/Public Administration/Public Health/Community Medicine/Preventive & Social Medicine.
- ▶ Minimum 3 to 5 years of progressively responsible relevant post qualification work experience in the area of community participation/community health or local self governance or strengthening community institutions, is essential.
- ▶ Those with a mix of work experience in grass-root level programme as well as experience at district or state level programme management in large development programmes will be given preference.
- ▶ Competencies in participatory training and capacity building support as well as grass-root level participatory practices are essential.
- ▶ Policy advocacy and networking of civil society in large development programmes are desirable.
- ▶ An understanding and experience of working on issues of building local level community action on health and social determinants of health as well as village health planning and capacity of undertaking participatory processes at the community level and building them in to large scale programme interventions is highly desirable.
- ▶ An understanding of issues of reaching the unreached communities and capacity to plan and implement such interventions is desirable.
- ▶ Exposure to working of civil society groups in the area of healthcare/public health/rural development and decentralized governance is desirable.

- ▶ Computer proficiency with high level of familiarity with data base management programmes and commonly used packages like MS Word, Excel, and Power Point etc.
- ▶ Excellent communication and presentation skills, analytical and interpersonal abilities, excellent oral and written communication skills in English and Hindi.

Roles and Responsibilities

- ▶ Assist the state in developing strategies and operational approaches for strengthening VHSNCs and other interventions of community processes such as Community Based Planning and Monitoring, Rogi Kalyan Samitis and NGO engagement to improve mechanisms of community action on health and its social determinants and enable Village Health Planning.
- ▶ Design, implement strategies and ensure release of relevant guidelines for establishing institutional structures for the VHSNC and other community processes interventions
- ▶ Develop strategies for and coordinate capacity building and extend hand-holding support for health personnel regarding the VHSNC and other community processes interventions.
- ▶ Assist in periodic monitoring and data base management for regular assessment of VHSNC and other community processes interventions under NRHM.
- ▶ Design and implement the strategies and operational approaches for convergence of programme interventions of cross cutting government departments (PRI, Water and Sanitation and Dept. of Woman and Child Development) and other programmes to ensure improvement in service delivery goals and community health outcomes.
- ▶ Design and implement processes for collaborations and engagement/recruitment and development of TORs for NGOs and other civil society groups and resource agencies/elected representatives, for VHSNC and other community processes interventions.
- ▶ Undertake any such assignments, which may be assigned by the Team Leader, State ASHA Resource Centre as may be required from time to time.

Reporting: Will report to Team Leader State ASHA and Community Processes Resource centre, who will be responsible for Monitoring and Evaluation of his/her performance.

Age: up to 45 years of age.

4. Regional Coordinator for Training and Supportive Supervision (One Coordinator Responsible for six Districts)

Eligibility and Qualifications

- ▶ Postgraduate qualification in any discipline of Social Sciences/Social Work/Rural Development/Public Administration/Public Health/Community Medicine/Preventive & Social Medicine.
- ▶ At least 3 years experience in management and coordination of community health programmes or community mobilization or related field activities with a minimum of 2 years experience in health sector.
- ▶ Familiarity with/having worked in community health worker programmes, or on empowerment of health volunteers or NGO health projects.
- ▶ Sensitivity to and knowledge and experience of working on issues related to prevention and promotion of health care services involving Government & NGO cooperation.

- ▶ Experience of having worked as trainer and as organizer/coordinator of training programmes at the district/regional level is essential.
- ▶ Computer proficiency with high level of familiarity with data base management programme and commonly used packages like MS Word, Excel, power point etc.
- ▶ Excellent communication and presentation skills, analytical and interpersonal abilities, excellent oral and written communication skills in English and Hindi.
- ▶ Desirable- Experience of working for health rights or in a health rights framework or in addressing issues of Women's Health projects.

Roles and Responsibilities

- ▶ Develop support system, budget and work plan, for the ASHA program and other community processes in their specified districts.
- ▶ Analyze and provide feedback on training conducted on the community processes by District trainers and NGOs.
- ▶ Disseminate the government orders and guidelines division wise and ensure their availability at district level.
- ▶ Ensure periodic training of district level officials.
- ▶ Ensure smooth working relationship with DPMU and CMHO to district level to strengthen implementation of Community processes.
- ▶ Supervise District Community Mobilisers and Block Community Mobilisers.
- ▶ Undertake periodic visits to district and selected NGOs to conduct supportive supervision.
- ▶ Provide support to NRHM for effective functioning of community processes through advocacy & networking.
- ▶ Establish linkages with NGOs at Division level.
- ▶ Undertake any such assignments, which may be assigned by the State ASHA Programme Manager, ASHA Resource centre.

Reporting: Will report to Team Leader-State ASHA and Community Processes Resource centre, who will be responsible for Monitoring and Evaluation of his/her performance.

Age limit: Below 40 Years of Age.

5. Consultant for Communication and Documentation

Eligibility and Qualifications

- ▶ Postgraduate qualification in any discipline of Social Sciences/Social Work/Rural Development/Public Administration/Public Health/Community Medicine/Preventive & Social Medicine.
- ▶ At least 5 years experience in IEC/BCC Strategic interventions assisting management of community health programmes or community mobilization efforts or related field activities with a minimum of 3 years experience in health sector.
- ▶ Familiarity with/having worked in community health worker programmes, or on empowerment of health volunteers or health projects involving gender empowerment programme.

- ▶ Experience of having worked as IEC/BCC trainer and as organizer of training programmes in health field is essential.
- ▶ Facilitate documentation of best practices, and case studies relating to community processes.
- ▶ Contributions in the publication on IEC/BCC or related community participation in health programmes/health projects.
- ▶ Computer proficiency with high level of familiarity with data base management programme and commonly used packages like MS Word, Excel, power point etc.
- ▶ Excellent communication and presentation skills, analytical and interpersonal abilities, excellent oral and written communication skills in English and Hindi.

Roles and Responsibilities

- ▶ Develop and initiate strategies for appraisal/assessment and documentation of ASHA initiatives and related community processes like VHSNC, Rogi Kalyan Samities, Hospital Development Societies and the community monitoring programmes etc.
- ▶ Develop IEC/BCC strategies and training materials for ASHA and related community processes and training of civil society – PRIs and local bodies & council members.
- ▶ Develop communication support materials and communication strategies for use in community processes targeting effective implementation of ASHA Scheme.
- ▶ Assist in monitoring and mentoring of community processes.
- ▶ Office support and organization of documentation of ASHA Resource centre functioning.
- ▶ Undertake any such assignments, which may be assigned by the Team Leader, ASHA Resource Centre.

Reporting: Will report to Team Leader, ASHA and Community Processes Resource centre, who will be responsible for Monitoring and Evaluation of his/her performance.

Age limit: Below 40 Years of Age.

6. State ASHA and Community Processes Resource Centre - Data Assistant

Eligibility and Qualifications

- ▶ Bachelors degree in Computer Applications/Arts/Science/Commerce with having PG Diploma in Commuter Science/Applications.
- ▶ At least 3 years of work experience in handling data base support to effective functioning of health or social sector projects or organizational management involving data analysis, data management and maintenance of data resource.
- ▶ Computer proficiency with high level of familiarity with data base management programme and commonly used packages like MS Word, Excel, power point and spreadsheets for programmatic analysis and projections.
- ▶ Excellent communication and presentation skills, analytical and interpersonal abilities, excellent oral and written communication skills in English and Hindi.

Roles and Responsibilities

- ▶ Maintain district specific database on the community processes.
- ▶ Ensure collection and collation of reports from the district level and compile the same for presentation to the Community Processes Resource Centre Team.
- ▶ Consolidate the data on the reporting format and submit the collated report.
- ▶ Responsible for the documentation of the activities.
- ▶ Undertake any such assignments, which may be assigned by the Team Leader Community Processes Resource Centre.

Reporting: Will report to Team Leader ASHA and Community Processes Resource centre, who will be responsible for Monitoring and Evaluation of his/her performance.

Age limit: Below 30 Years of Age.

6. Accounts Assistant

Eligibility and Qualifications

- ▶ Bachelors degree in Commerce.
- ▶ At least 3 years of work experience in handling financial data base support to effective functioning of health or social sector projects or organizational management involving accounts/financial analysis, financial management and assistance in maintenance of accounts.
- ▶ Computer proficiency with high level of familiarity with data base management programme and commonly used packages like MS Word, Excel, power point and spreadsheets for financial analysis and projections.
- ▶ Excellent communication and presentation skills, analytical and interpersonal abilities, excellent oral and written communication skills in English and Hindi.

Roles and Responsibilities:

- ▶ Maintain day-to-day accounts record of Community Processes Resource Centre.
- ▶ Responsible for day-to-day functioning of the Community Processes Resource Centre.
- ▶ Ensure placement of funds and receipt of the utilization certificate from the districts and other expenditures. Undertake any such assignments, which may be assigned by the State ASHA Manager, ASHA Resource Centre.

Reporting: Will report to Team Leader-ASHA and Community Processes Resource centre, who will be responsible for Monitoring and Evaluation of his/her performance.

Age limit: Below 30 Years of Age.

TERMS OF REFERENCE FOR SUPPORT STRUCTURES AT THE DISTRICT AND SUB-DISTRICT LEVELS

1. District ASHA Coordinator/District Community Mobilizer

Eligibility and Qualifications

- ▶ Master's degree in social work or any of the social sciences.
- ▶ At least 2-3years experience in management/coordination of community health programmes or community mobilization or related field activities with a minimum of 1 years experience in health sector.

- ▶ Familiarity with/having worked in community health worker programmes, or on empowerment of health volunteers or NGO health projects or on involvement of PRIs in Health projects.
- ▶ Sensitivity to and knowledge and experience of working on issues related to monitoring of health projects and coordination of Government & NGO cooperation in health programmes at the grassroots set-up.
- ▶ Experience of having assisted/contributed/coordinated or worked as trainer and as organization support to training programmes at the district level is essential.
- ▶ Computer proficiency with high level of familiarity with data base management programme and commonly used packages like MS Word, Excel, power point etc.
- ▶ Excellent communication and presentation skills, analytical and interpersonal abilities, excellent oral and written communication skills in English and Hindi.

Roles and Responsibilities

Same as District ASHA and Community Processes Team – Refer Page 70 and 71

Reporting: Will report to Team Leader State ASHA and Community Processes Resource centre, with support from Regional ASHA and Community Processes Coordinator responsible for that district, who will be responsible for Monitoring and Evaluation of his/her performance.

Age limit: Below 30 Years of Age.

2. District Data Assistant

Eligibility

- ▶ PG Diploma in Computer Science/Applications.
- ▶ One Year of work experience in handling database support of health or Social sector projects.
- ▶ Computer proficiency with high level of familiarity in packages like MS Word, Excel, Spreadsheet etc.

Roles and Responsibilities: Same as the Data Assistant at State ARC/CPRC.

3. Block Community Mobilizer– Responsible for Support at the Block Level

Eligibility and Qualifications

- ▶ Bachelor's degree in social work or any of the social sciences.
- ▶ Familiarity with/having worked in community health worker programmes, or on empowerment of health volunteers or NGO health projects or on involvement of PRIs in Health projects.
- ▶ Sensitivity to and knowledge and experience of working on issues related to monitoring of health projects and coordination of Government & NGO cooperation in health programmes at the grassroots set-up.
- ▶ Computer proficiency and familiarity with data base management programme and commonly used packages like MS Word, Excel, power point etc. desirable.
- ▶ Excellent communication and presentation skills, analytical and interpersonal abilities, excellent oral and written communication skills in English and local language.

Roles and Responsibilities

Same as: Block Level Support: Refer Page 72

Reporting: *Will report to District ASHA Coordinator/Mobilizer who will be responsible for Monitoring and Evaluation of his/her performance with the support of the Regional ASHA and Community Processes Coordinator Responsible for that District from the State ASHA Resource centre.*

Age limit: Below 30 Years of Age.

4. Facilitators for ASHA

The ideal candidate for an ASHA facilitator is a woman who is a resident of the local area (living in the cluster of villages where she supports the ASHA), with training and experience in health. Experience shows that an ideal candidate is an ASHA with academic qualification of Class XII pass, is dynamic and has demonstrated success in her role as ASHA. She could continue to be the ASHA for her area, provided there is agreement that she can manage both tasks. OR a new ASHA can be selected.

Roles and Responsibilities: Refer Page 73

The ASHA facilitators will report to the Block Community mobilizers who with the support of the District Community Mobilizers will be responsible for their operational effectiveness and capacity building on a regular basis.

Annexure- S-2

ILLUSTRATIVE BUDGET FOR ASHA SUPPORT SYSTEM AT STATE, DISTRICT AND BLOCK LEVEL

Sl. No.	Particulars	Rate (in Rs.)	Quantity	Cost
AT THE STATE LEVEL				
1	State ASHA Nodal Officer; Full time State Government Official			
2	Two State ASHA Programme Consultant based within SPMU; Personnel (Salary will come from HR Budget for SPMU)			
i	ASHA RESOURCE CENTRE (under SHRC)			
	Personnel (Hired through an Agency on contract basis) salary			
A	Team leader State ASHA Resource Centre salary	55,000	12	6,60,000
B	ASHA Programme Manager	45,000	12	5,40,000
C	VHSNC and other community processes- Programme Manager	45,000	12	5,40,000
D*	Documentation & Communication Consultant	35000	12	4,20,000
E*	01 Regional Coordinator/6 districts salary (Taking an average of three Regional Coordinators/state(@ Rs.35,000)	1,05,000	12	12,60,000
F	Accounts Assistant salary	15,000	12	1,80,000
G	Statistical/Data Assistant salary	15,000	12	1,80,000
H	Office Attendant salary	8,000	12	96,000
Sub Total				38,76,000
	Overhead Charges @ 5%			19,38,00
Sub total				40,69,800
ii	Admin Expenses			
A	Office Expenses on telephone, photocopy, Stationery	30000	12	3,60,000
B	Monitoring and supervision/ documentation, Workshops, seminars and review meetings (including ASHA Mentoring Group meetings)	6,00,000 per annum		6,00,000
Sub Total				9,60,000
	Overhead Charges @ 5%			48,000
Sub total				10,08,000
Total at state level				50,77,800

Sl. No.	Particulars	Rate (in Rs.)	Quantity	Cost
AT THE DISTRICT LEVEL				
	District Health Society (Programme Management Unit)			
1	Personnel			
A	District Community Mobilizer salary	30000	12	3,60,000
B	District Data Assistant salary	15000	12	1,80,000
C	Office contingencies	3000 per month	12	36,000
D	TA/DA for monitoring visits and collection of information. (Telephone, fax, computer, stationeries etc to be used from District PMU.)	at Rs. 500 per visit for minimum ten visits in a month = 5000 per month	5000*12	60,000
Total Budget for One District				6,36,000
AT THE BLOCK LEVEL				
1	Personnel			
A	Block Community Mobilizer salary	15,000	12	1,80,000
B	TA/DA for monitoring visits and collection of information. (Telephone, fax, computer, etc. to be used from District PMU)	at Rs. 300 per visit for minimum 12 visits in a month = 3600 per month	12	43,200
C	Contingency for stationery & Meeting expenses, etc.	300/- per month	12	3,600
Total Budget for One Block				2,26,800

* For states with less than 20,000 ASHAs at the state level, Documentation & Communication Officer and Regional coordinators are not required to be put in place. DCMs and ASHA facilitators are a must across the board. At the block level - states having less than 20,000 ASHAs could utilise existing support mechanisms at PHC level to support ASHAs. But dedicated ASHA Facilitators must be recruited in areas of geographic dispersion and those with marginalised and vulnerable populations.

Note

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Note

[illegible]



National Rural Health Mission
NATIONAL RURAL HEALTH MISSION
Ministry of Health and Family Welfare
Government of India
New Delhi