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Dy. No.231/JS(AG)/2012  
 Dated: 3<sup>rd</sup> April, 2012

Dear Sh. Wahlang,

I am writing to you in connection with establishing a system for performance monitoring of the ASHA programme. Although many states have developed means of monitoring the ASHA programme at various levels, there is little uniformity or evidence of action based on the monitoring. It also appears from various evaluations and field visit reports that although some form of ASHA data base exists at block level, there is no consolidation at district or state levels, making it difficult for programme managers to review the status of drop outs and plan for selection and training of new ASHA. I request that the state now put into place the following:

1. **Developing an ASHA database:** An ASHA database/ register will be maintained at block, district and state levels. The function of the register is to track the ASHA, their entry, educational levels, training inputs and performance and drop-outs. This should be updated as specified. (Formats for the register at each level are at annexure 1).
2. **A system for outcome monitoring:** A system to monitor the ASHA functionality and effectiveness needs to be put in place at Block, District, and State levels. The following indicators need to be monitored:
  1. Newborn visits within the first day at home or in the institution (if the ASHA is not present at the institution then as soon as the mother and baby return home)
  2. Set of six visits as specified in the Home Based New Born Care Guidelines
  3. Attending VHNDs / Promoting immunization
  4. Supporting institutional delivery / escorting women to the institution
  5. Management of childhood illness – especially diarrhea and pneumonia
  6. Household visits with nutrition counseling
  7. Fever cases seen/ malaria slides made in malaria endemic area
  8. ASHAs acting as DOTS provider
  9. Holding village/ VHSC meeting
  10. Successful<sup>24</sup> referral of IUD/ female sterilization/ male sterilization cases

Contd...

<sup>24</sup> Successfully referred – People who were counseled by ASHA for use of family planning measures and who got the procedure

The following steps are to be followed at each level:

- (i) **ASHA:** Please note that this information is to be gathered by the facilitators from the ASHA at the monthly meeting. The ASHA are not required to keep any additional records, but use their register and diary, which are their planning and recording tools, to provide this verbally to their facilitator.
- (ii) **Sub block or Facilitator level:** This data is submitted by the facilitators to the block on a monthly basis. The facilitator at the sub block level, reports on (i) total number of the ASHAs are functional on each task, and (ii) the total number of ASHA who are functional on at least five of the nine tasks.
- (iii) **Block:** The block mobilizer/coordinator consolidates this report from all the facilitators and reports to the district.
- (iv) **District:** At the district level, the district coordinator consolidates and reports on the functionality of ASHA from each block. No numbers regarding functionality are to be reported by the district to the state. For functionality of the ASHA on each of nine tasks, the district grades the blocks thus:
  - Type A: Blocks where of the total ASHAs >75% ASHAs are functional on each of the tasks 1-10
  - Type B: Blocks where of the total ASHAs 50-75% ASHAs are functional on each of the tasks 1-10
  - Type C: Blocks where of the total ASHAs 25-50% ASHAs are functional on each of the tasks 1-10
  - Type D: Blocks where of the total ASHAs <25% ASHAs are functional on each of the tasks 1-10
- (v) The report to the state and national level needs only to specify the total number of blocks and the actual number of blocks in each type as defined above.

3. **Instituting a Grievance Redressal Mechanism for the ASHA:** Setting up a grievance redressal mechanism for ASHA needs to be attended to. The ASHA need a forum to be able to air their issues related to delayed payments and work situations. Such a forum should be set up at the district level. (Please see Annexure 2 for guidelines)

I look forward to hearing from you regarding immediate implementation of the points in the letter and a response from you in this regard would be greatly appreciated.

With Warm regards,

Yours sincerely,

Encls: As above.

  
(Anuradha Gupta)

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Annexure 1: ASHA Data base register  
Frequency - Annual.

1. At block level, block community mobilizer/ coordinators would maintain an ASHA database register (format 7) for every ASHA in the block.

ASHA Base register format for Block Community Mobilizer															
Date of filling the register-		3	4	5	6	7	8	9	10	11	12	13	14	15	16
1	2	Village Name	Name of ANM in charge	Age	Basic Education level	Marital status M- Married S- Married but currently single U- Unmarried	Other sources of income	Date of appointment of ASHA	Date of filling the register	Letter from panchayat	ID card issued	Certificate for any skill, if issued. Date of issue of certificate. (Fill as N if None)	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 the District level, the district coordinator will maintain the register in the following format 8. This will be maintained on a yearly basis but in case of any dropout the state officials should be notified of the change of status.

District ASHA data base register				Date of filling the register-		Date of appointment of ASHA		Reasons for dropout	
Block Name	Village names	Population of village	ANM in charge	ASHA Name	ASHA Name	Date of cessation from ASHA work	Date of cessation from ASHA work	Reasons for dropout	Reasons for dropout
1.									
2.									

Any ASHA is to be considered as dropout if -

- She has submitted a letter of resignation
- OR
- She has not attended the three consecutive VHNDs AND not given reasons for the same
- AND She has not been active in most of the activities

d) AND Block Community Mobilizer / Coordinator visited the village of the ASHA and ascertained that she is indeed not active. If there is a genuine problem, she should be supported until it is overcome through the VHSC or village SHG. If she cannot continue, a written and signed declaration should be obtained from her and approved by Block Community Mobilizer. District has the authority to remove her name from the data base register. Arrangements should then be made to fill in the vacancy

District Coordinators consolidates data from all blocks on --

- i. Number of villages without an ASHA in the district
- ii. 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 8 & 9 at block and district levels the following information will be compiled by State consultant for all districts of state -

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

## Annexure 2: 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 would be as follows:

- Two of the five members will be representatives from Non Governmental agencies, of which one could be from an academic institution
- 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.

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