Strengthening ASHA programme:

Based on the CRM reports, ASHA mentoring group inputs and a consultation held on the ASHA programme , four areas were identified for strengthening:

a. Role clarity.
b. Payment mechanisms
c. Training Strategies and focus.
d. Supervision and Support Arrangements.
e. Financing Package.

These guidelines are issued to strengthen each of these areas. The ASHA programme needs to be planned with adequate investment in its processes, adequate design for sustainability and most important a clear set of measurable health outcomes on priority goals that would merit the investment, and that would help differentiate between well performing programmes and poor performance. These guidelines would help in this process.

ROLE CLARITY:

1. The governments thrust would be to develop the ASHA as a health care facilitator and provision of a limited range of services. In parallel supported by civil society and mentoring institutions she would also have a health rights dimension, and this would partly help to hold the health services accountable. However the main form of the rights dimension is community mobilisation to improve health status and participate in health programmes.
2. The main measurable services that the ASHA would deliver are:
    I. Maternal Health and RCH
        a. Mobilisation and tracking of beneficiaries to attend the health worker clinic/village health and nutrition day that is held monthly in the village and to access all these services that are to be delivered by the health sub-center. Immunisation services, care in pregnancy and contraceptive services are the main ones that would require regular facilitation.
        b. Microplanning support for families with pregnant women- to ensure that they make the appropriate choice for assistance at delivery, and that suitable arrangements for escort to the institution, transport and finances are made. (under the first and second objectives, both ANC and PNC are addressed).
        c. Both of these tasks requires the maintenance of a village health register- which tracks pregnancies, eligible couples and children for immunisation.
    II. New Born and Child Health
        a. Home Based Newborn care: including appropriate referral where indicated. That would mean at least five visits in the first month of life. These visits would include post – natal care, it would also include identification of sick new borns special care for low birth weight babies and a limited range of home care for sepsis where indicated
        b. Home visits to families with pregnant women children below 2 – for illness management and also support to prevention and management of malnutrition and anemia in children of this age group

c. First contact care of the sick child – especially the children below 5 with appropriate referral where indicated. The drug kit is essential in this role. Diarrhoea, fever and ARIs would be the main symptoms addressed- but also worms and anemia.

III. Communicable disease:

a. Serving as DOTS provider where needed. Promoting chest symptomatic and children with failure to gain weight to get tested for tuberculosis.

b. Where required managing the drug depot for malaria treatment, and offering to take blood smears or use RDKs. To assist in early diagnosis and prompt treatment of malaria. Special focus on preventive measures for pregnant women and children.

IV. The Village health Committee:

Acting as convenor or secretary of the VHSC or at least as mobiliser and support to the VHSC. Additionally to work with SHGs or womens health committees where needed to ensure that there is community participation and health education. Main focus – village sanitation, 100% safe drinking water use, 100% access to ICDS/health department services for those who require it most- including supplementary transport arrangement where needed.

PAYMENTS AND PAYMENT MECHANISMS

a. Support to VHND /the health workers clinic is Rs 150 per month. Where there is more than one per 1000 population they would get lower amounts of Rs 50 to Rs 100 per month.(full day – 8 hours- Rs 150 per month- from immunisation budget)

b. Newborn care; should be incentivised by paying Rs 150 for each newborn for whom the five visits are made, and for whom weight is taken and reported and essential newborn care is provided. They also encourage/facilitate birth registration.(appox 2 normal newborns per month or 24 per year of which five are sick or require more follow up- 10 hours plus 20 hours- from child health budget)

c. For managing the drug kit and providing first contact care to children below 5 years and for visiting and counselling at least once every month every family with a child below 2 years. Rs 500 per month paid through the VHSC or the sub-center bank account.(appox 40 to 50 children in this age group in a population of 1000- about 20 hours per month- from VHSC and sub-center fund budget – could be added on to current amounts)

d. For every pregnant woman motivated for institutional delivery under JSY- Rs 200.(appox two women per month- about 10 hours- from JSY budget)

e. In addition for every DOTS patient who completes treatment she gets Rs 175. At best one or two patient per year. . Also in such a list are blindness control, leprosy control etc. Not taken into calculation. Funds from respective disease control programme

f. Making slides/RDK test for fever cases at Rs 5 per slide- about 20 slides per month at least. (about 5 hours over a month – about Rs 100 per month)

g. In addition whenever she is called away for a full days work such that she cannot attend to her livelihood compensation of Rs 100 per day should be paid. Eg pulse polio, training programmes, meeting a visitor in nearby block office etc. (should get on an average two days of training and two days of review meeting or other activity per month- Rs 400 per month)

Totally this would add up to about Rs 1500 per month. And about 70 hours per month or about 12 hours per week -- other than the days for which she is called out for the full day.

To stream line payments the following are mandatory.

a. An ASHA diary which tracks her work and is a record of the same
b. An accounts person at the block level who is got to make the payments and keep the accounts- assists the block nodal officer or block coordinator for this function. Where blocks are large payment may be through a sector level health employee- but the accountability to the district and above is of the block accounts person.
c. An advance amount equal to three months requirements to be always available at the block office level.

TRAINING:

1 The minimum level of competencies that an ASHA in a high focus state would have is specified. (see annexure 1). (Changes can be made- but in consultation with the concerned MOHFW division, but such a list of competencies must always be in place). Individual ASHAs and ASHA trainers must be certified by a local district level process to have the required competencies.

2 Training teams have to be fixed and notified at state, district and block levels. The best way of fixing this is to identify a training institution and for them to recruit their trainers. But the training institutions must be able to recruit or have trainers who are full time and able to give a fixed number of days per month, in addition to some part time trainers.

3 Given the fact that most training capacity is used up in training regular full time service providers, it is best to use NGO training capacity wherever possible.Where there is no suitable NGO the state nodal officer , of the district or block nodal officer constitutes the training team. Every trainer must be tested and accredited by a state level agency. The same trainers must be available for training batch after batch over the years.

4 The state level ASHA resource center could be NGO run or Government run. It should have three to five full time persons plus at least one full time training resource person per district. This training resource person of the ARC placed in the district looks at training evaluation and also support the district training and management team It could be part of the SHSRC or separate from it- but should have a full time contractual or deputed team leader. (*suggest all state level ARCs are jointly constituted by state and center like the RRCs of the MNGO scheme*)

5 In every district there is a community mobiliser at place. He should be supported by a three person trainer team- at least one of whom is a nurse tutor or nurse or LHV with clinical experience and training experience. A doctor is also welcome in this role, if available.

6 At every block, there should be a full time block trainer/coordinator team, of one person for every five facilitators, and one ASHA facilitator for every twenty ASHAs.(or per sector PHC). In addition three trainers per block would be part time. These facilitators should all be women. Thus if there are 100 ASHAs in a block there would be 5 facilitators and one block coordinator. If on the other hand there are 250 ASHAs in that block, there would be about 12 ASHA facilitators and 2 block trainers/coordinators.

7 It is useful to have some health department experience and paramedical or nursing knowledge for the trainers – which is not essential for facilitators.

8 The unit of contracting out training to NGOs or other training agencies would be a block. An agency can get upto three blocks in a districts, and upto five such districts. Thus – no agency would get more than about Rs one crore per year. The process of selecting NGOs should be transparent, involve a defined selection process. Where an NGO defaults or no NGO is found the block medical officer or a block nodal officer assigned by the district health society would act as the unit of management.

9 All state level training institutions and training NGOs would gain accreditation within a year from the national mentoring group or other body assigned this role and all district and sub-district NGOs/training institutions would similarly be accredited by a notified state level body. The first year requires no accreditation. The standards would be set such that they would have a minimum standard in the first year and reach desirable levels in three years.

SUPERVISION/SUPPORT:

1. Every ASHA must be visited on the job at least twice if not thrice a month. At least one of these visits should be in the hamlet where she provides her services. The other one or two could be in a local- GP level/sector level/block level- meeting- which in many places is being held as the ASHA divas. The ASHA facilitator is responsible for making the visit.
2. The ASHA facilitator is also to be held accountable for ensuring refill of the drug kits- provided drugs are made available to her at the block level.
3. There should be at least one ASHA facilitator for every twenty ASHAs- could be more number of ASHAs where the village is large.
4. The facilitators would also supervise the VHSCs and the community monitoring processes and if it is useful the RKS of the PHCs.
5. These facilitators could be synonymous with trainers- but quite often enough skilled trainers are not available- and it would be better to get trainers on a part time basis and for the full time supervision hire facilitators.
6. These facilitators and trainers are also paid per diem – and we are assuming a maximum of twenty days of work per month with Rs 150 to Rs 200 per day.(Rs 3000 to Rs 4000 per month)
7. These facilitators should be resident in the cluster of villages of the ASHAs that she supervises/supports.
8. These facilitators would have received the same training as ASHAs, but in addition also received a package on the job training and supervision.
9. These facilitators work would be reviewed once or twice a month by the block coordinator. This review meeting which may last two days if needed- and will include gathering and consolidating information on ASHA functionality, troubleshooting problems, building solidarity and leadership skills and reinforcing the training content. A suitable NGO representative attending these meetings- even where the government is organising the programme would make a large positive difference to the outcomes.

FINANCING PACKAGE:

The budget package for a normative block for financing training and supervision would include funds for

- a 20 day training programme every year plus
- a visit once a month to every ASHA on the job training and support and
- two ASHA meetings every month
- Plus one review meeting of facilitators
- Plus one mobilisational event every quarter.

The normative block – 100000 population; 100 ASHAs, 5 facilitators and one full time and two part time trainers.

No.	Item of Expenditure	Unit rate	Qty	Days		
	Training for 20 days					
	ASHA- compensation	Rs. 100	100	20	2,00,000	
	ASHA- food, accommodation, venue	Rs. 150	100+ 5	20	3,15,000	
	ASHA travel	Rs 60	100	4 trips	24,000	
	Trainers fees	Rs 200	4trnrs/ 3batch	20days	48,000	
	Trainers & facilitators travel	Rs 60	12	4	2880	
	Supervision/Support Costs					
	Sub-total				**5,89,880**	
	Supervision costs	Rs 100	5	20*12mnths	120,000	
	Review meeting – asha day plus social mobilisation	Rs200	100	12	240,000	
	Review meeting of supervisors at dt level	Rs 100	10	24	24,000	
	Block coordinator salary	Rs 10,000	1	12 mnths	120,000	
	Sub-total				**5,04,000**	
	Institutional overheads at 10% - payable to NGO				109388	
	Total contract amount per year				**12,03,268**	

Or approximately Rs 12,033 per ASHA

Additional Amount per ASHA- not included in the contract to NGO/Programme manager

	Training /communication material	Rs 300	100	30,000		
	Drug kit	Rs 300	100	12	3,60,000	
	Incentives from ASHA budget	Rs 500	100	12		

Approximately Rs 25 per month per ASHA on training material and Rs 300 per month per ASHA on the drug kit(currently at rs 50 per month) and Rs 500 per month for incentives paid through VHSC linked to local level programmes of sick child and newborn care, drug kit and nutrition counselling.

Expenses for the district contract :(other than what is paid per block)

Normative population of 10 blocks

No.	Item of Expenditure	Unit rate	Qty/block	days	Per block	For 10 blocks
	Training of trainers and supervisors for 25 days					
	Food, accommodation, venue	350	3+5-	25	70,000	
	Trainee travel	100	8	4 Trips	3200	
	Trainers fees	300	3 trainers / 2 batch	25	4500	45,000
	Sub-total				77,700	**777,000**
	Supervision/Support Costs					
	Review meetings of block teams	Rs 150	5	18	13500	135000
	Visits to block level meetings by dt team (mobility provision)	Rs 1000	2 persons	5 days * 12 months		120,000
	Sub-total					**255,000**
	Office and salaries					
	Community mobiliser	Rs 15000	1	12mnths		180,000
	Data assistant	Rs 8000	1	12mnths		96,000
	Full time trainers/ coordinators	Rs 8000	3	12 mnths		288,000
	Sub-total					**564000**
	Total					**15,96,000**
	Institutional overheads at 10% - payable to NGO					1,59,600
	Total contract amount per year					**17,55,600**

Or approximately Rs 1755 per ASHA for district programme management and training of trainers.

This is not much different from earlier estimates of Rs 10,000 per ASHA. The Rs 2000 more is largely on institutional overheads plus a stronger programme management structure as needed at this stage. These overheads and salaries would be less than 6% of the costs , especially if VHSCs and ASHA programme are seen together.

There would be clear protocols and outcome measures for each functionary and for each contract, so that performance could be measured before renewal.

State community processes resource center costs:

	Unit rate	Qty/Dist	days	Per Dist	For 20 Dist
Training of trainers					
Food, accommodation, venue	600	5	25	75,000	15,00,000
Trainee travel	300	5	2 trip	3000	60,000
Trainers fees	1000	4 tr * 2 batches	25 days		2,00,000
Sub Total					17,60,000
Supervision/Support Cost					
Review meeting of district team	300	5	4 times	6000	120,000
Field coordinator for monitoring	10,000	1	12 months	120000	24,00,000
Visit of field coordinator/ travel/ communication/reports	10,000	1	12 months	120,000	24,00,000
Sub Total					60,00,000
Office & Staff salary					
Program Manager	40,000	1	12		480,000
Data Assistant	10000	1	12		120,000
Resource persons- 2	20000	2	12		480,000
Office attendant	5000	1	12		60,000
Sub Total					11,40,000
Total					89,00,000
Institutional overheads at 10% - payable to NGO					8,90,000
Total contract amount per year					97,90,000

Per ASHA cost: 20,000 ASHAs: Rs 489.50- this is affordable within the Rs 12,000 per ASHA – and this is about 4% of the per ASHA cost.