ASHA: A MEDICO –SOCIAL INITIATIVE

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Abstract

The rural development programmes occupy significant position in India’s economic planning, as nearly three-fourth of its population lives in villages. In fact villages represent real India. Hence without uplifting rural masses, we cannot think over accelerate the pivot of overall economic development. In order to ensure that there should be balanced economic development of the country and the fruits of the development should percolate to the grass-root levels, rural development gets the top most priority in our planned efforts. Health management are part of the core strategy of the mission. Government of India launched the National Rural Health Mission (NRHM) on 12th April 2005 throughout the India with special focus on 18 states which have weak public health indicators and/or weak infrastructure. The NRHM was launched with a view to bring about dramatic improvement in the health system and health status of the people, especially those living in rural areas by the end of 2012. The NRHM has a clear objective of providing quality health care in the remotest rural areas by making it accessible, affordable and accountable. Under NRHM, financial assistance has been provided to the states, UTs for the health systems strengthening which include augmentation of infrastructure human resources and programme management, emergency responses services, Mobile Medical units, community participation.

Keywords: ASHA workers, Training Strategy, Compensation, PHC.

I. INTRODUCTION

India was one of the pioneers in health service planning with a focus on primary health care. In 1946, the Health Survey and Development Committee, headed by Sir Joseph Bhose recommended establishment of a well-structured and comprehensive health service with a sound primary care infrastructure. In 1952 as a consequence of the Bhose Committees recommendation, Primary Health Care Centre were established to promote, prevent, curate and rehabilitate the services to entire rural population, as an integral component of wider Community Development Programme. The convulsive political changes that took place in the 1970s impelled the Central Government to implement the vision Sokhey Committee of having one Community Health Worker for every 1000 people to entrust ‘people health on people’s hand’.

Health is influenced by a number of factors such as adequate food, housing, sanitation, healthy lifestyle, protection against environmental hazards and communicable diseases. The various issues related to tribal health are:

1. Health and culture-including the traditional belief in the super nature.
2. Health, food habits and environment-covering the sanitation, water supply, settlement pattern, the total physical environment affecting health and food during socio-religious occasions.
3. Medicine, health and community-the traditional health practitioners, their position in the society, concept and treatment of diseases, nature and use of medicine-traditional and modern.
4. Fertility and mortality variations and reasons, use of traditional and modern practices of birth control.
5. Interaction of traditional and modern systems of medicine at various levels, reasons for non-adoption of modern practices.

Woman made provisions for the basic necessities like food, fuel, medicine, housing material etc. from
the forest produce. Food was obtained from shifting
cultivation and from minor forest produces (MFP)
like flowers and fruits collected from the forest.
Extraction from herbs, roots and animals were used
for medicine. All these efforts incurred an excessive
workload on women. Because of extensive cutting of
trees by vested interest, the distances between the
villages and the forest area had increased, forcing the
tribal women to walk longer distance in search of
minor forest produce and firewood. In this rapidly
changing milieu, tribal women were confronted with
an extraordinary workload.

One of the key components of the National Rural
Health Mission is to provide every village in the
country with a trained female community health
activist ASHA or Accredited Social Health Activist.
Selected from the village itself and accountable to it,
the ASHA will be trained to work as an interface
between the community and the public health system.

ASHA will be chosen through a rigorous process
of selection involving various community groups,
self-help groups, Anganwadi Institutions, the Block
Nodal officer, District Nodal office, the village
Health Committee and the Gram Sabha.

Selection and Training of ASHA
- The general norm will be ‘One ASHA per
1000 population’.
  - In tribal, hilly, desert areas the norm could
be relaxed to one ASHA per habitation, dependant on
workload etc.
  - The States will also need to work out the
district and block-wise coverage/phasing for selection
of ASHAs.
  - It is envisaged that the selection and training
process of ASHA will be given due attention by the
concerned State to ensure that at least 40 percent of
the envisaged 3ASHAs in the State are selected and
given induction training in the first year as per the
norms given in the guidelines. Rest of the ASHAs can
subsequently be selected and trained during second
and third year.

Criteria for Selection
- ASHA must primarily be a women resident
of the village
  - Married/widowed/divorced, preferably in the
age group of 25 to 45 years.
  - She should be a literate woman with formal
education up to class eight. This may be relaxed only
if no suitable person with this qualification is
available.
  - She will counsel women on birth
preparation, importance of safe delivery, breast
feeding and complementary feeding, immunization,
contraception and prevention of common infections.
  - Capacity building of ASHA is being seen as
a continuous process. ASHA will have to undergo
series of training episodes to acquire the necessary
knowledge, skills and confidence for performing her
spelled out roles.
- The ASHAs will receive performance-based
incentives for promoting universal immunization,
referral and escort services for Reproductive & Child
Health (RCH) and other healthcare programmes, and
construction of household toilets.
- Empowered with knowledge and a drug-kit
to deliver first-contact healthcare, every ASHA is
expected to be a fountain head of community
participation in public health programmes in her
village.
- ASHA will be the first port of call for any
health related demands of deprived sections of the
population, especially women and children, who find
it difficult to access health services.
- ASHA will be a health activist in the
community who will create awareness on health and
its social determinants and mobilise the community
towards local health planning and increased
utilisation and accountability of the existing health
services.
• She would be a promoter of good health practices and will also provide a minimum package of curative care as appropriate and feasible for that level and make timely referrals.

• ASHA will provide information to the community on determinants of health such as nutrition, basic sanitation & hygienic practices, healthy living and working conditions, information on existing health services and the need for timely utilisation of health & family welfare services.

Selection Process

The selection of ASHAs would have to be done carefully. The District Health Society envisaged under NRHM would oversee the process. The Society would designate a District Nodal Officer, preferably a senior health person, who is able to ensure that the Health Department is fully involved.

She would also act as a link with the NGOs and with other departments. The Society would designate Block Nodal Officers, preferably Block Medical Officers, to facilitate the selection process, organizing training for Trainers and ASHA as per the guidelines of the scheme.

The Block Nodal Officer would identify 10 or more Facilitators in each Block so that one facilitator covers about 10 villages. The facilitators should preferably be women from local NGOs; Community based groups, MahilaSamakhyas, Anganwadis or Civil Society Institutions. In case none of these is available in the area, the officers of other Departments at the block or village level/local school teachers may be taken as facilitators.

These facilitators should be oriented about the scheme in a 2-day workshop which should be held at the district level under supervision of the District Nodal Officer. During this meeting, the Block Nodal Officers should also be present. The District Nodal Officer will brief the facilitators and Block Nodal Officers on the selection criteria and importance of proper selection in effective achievement of the objectives of the same and also the role of facilitators and Block Nodal Officers are required to play in ensuring the quality of the selection process.

The facilitators would be required to interact with community by conducting Focused Group Discussions (FGDs) / workshops of the local self help groups etc. This should lead to awareness of roles and responsibilities of ASHA and acceptance of ASHA as a concept in the community. This interaction should result in short listing of at least three names from each village.

Subsequently a meeting of the Gram Sabha would be convened to select one out of the three shortlisted names. The minutes of the approval process in Gram Sabha shall be recorded. The Village Health Committee would enter into an agreement with the ASHA as in the case of the Village Education Committee and Sahayogini in SarvaShikshaAbhiyan. The name will be forwarded by the Gram Panchayat to the District Nodal Officer for record.

State Governments may modify these guidelines except that no change may be done in the basic criteria of ASHA being a woman volunteer with minimum education up to VIII class and that she would be a resident of the village. In case any of the selection criteria or guidelines is modified, these should be widely disseminated in local languages. Capacity building of ASHA is critical in enhancing her effectiveness. It has been envisaged that training will help to equip her with necessary knowledge and skills resulting in achievement of scheme’s objectives. Capacity building of ASHA has been seen as a continuous process.

Training Strategy

• Induction Training: After selection, ASHA will have to undergo series of training episodes to acquire the necessary knowledge, skills and confidence for performing her
spelled out roles. Considering range of functions and tasks to be performed, induction training may be completed in 23 days spread over a period of 12 months. The first round may be of seven days, to be followed by another four rounds of training, each lasting for four days to complete induction training.

- Training materials: would be prepared according to the roles and responsibilities that the ASHA would need to perform. Her envisaged functions and tasks will be expanded into a listing of competencies and the training material would be prepared accordingly. The training materials produced at the national level would be in the form of a general prototype which states may modify and adapt as per local needs. The training material will include facilitator’s guide, training aids and resource material for ASHAs.

- Periodic Trainings: After the induction training, periodic re-training will be held for about two days, once in every alternate month at appropriate level for all ASHAs. During this training, interactive sessions will be held to help refresh and upgrade their knowledge and skills, trouble shoot problems they are facing, monitor their work and also for keeping up motivation and interest. The opportunity will also be used for replenishments of supplies and payment of performance linked incentives. ASHAs will be compensated for attending these meetings.

- On-the-job Training: ASHAs needs to have on the job support after training both during the initial training phase and during the later periodic training phase it is needed to provide on the job training to ASHAs in the field, so that they can get individual attention and support that is essential to begin and continue her work. ANMs while conducting outreach sessions in the villages will contact ASHA of the village and use the opportunity for continuing education. NGOs can also be invited to take up the selection; training and post training follow up. Similarly block facilitators identified earlier for selection of ASHAs can also be engaged for regular field support.

- Training of trainers: A cascade model of training is proposed. At most peripheral level, Block trainers (who are the members of identified block training teams) would have to spend at least the same number of days in acquiring the knowledge and skills as ASHAs. These ToTs will also have to be similarly phased. These trainers should be largely women and chosen by block nodal officer. The block teams would be trained by a district trainer’s team. (Or Master trainers) who are in turn trained by the state training team. The duration of District Training Teams (DTT) and State Training Teams (STT) will be finalized by the states depending on the profile of the members to be selected as DTT and STT.

- Constitution of Training teams: It follows that each state, district and block would have a training team compromising of three-four members. Existing NGOs especially those working on community health issues at the district / block level may also be entrusted with the responsibility for identifying trainers and conducting of TOTs. The trainers would be paid compensation for the days they spend on acquiring or imparting training –both camp based training and on the job training. The similar guideline applies to the district level also where trainers would be drawn in
from Programme Managers and NGOs. The State Institutes of Health and Family Welfare along with reputed and experienced NGOs would form training teams at the state level. State level training structures to be used for trainings under various National Health and Family Welfare Programmes Training may be adhered wherever feasible.

- Continuing Education and skill up gradation: A resource agency in the district of state (preferably an NGO) will be identified by the State. The resource agency in collaboration with open schools and other appropriate community health distance education schemes will develop relevant illustrated material to be mailed to ASHAs periodically for those who would opt for an eventual certification.

- Venue of training: The principle of choice of venue shall be that the venue should be close to their habitation that the training group should not be more than 25 to 30. In most situations this could be the PHC or alternatively Panchayat Bhavan or other facilities that are available.

- National Level: At the national level the NIHFW would in coordination with the National Rural Health Mission & its technical support teams and the Training Division of the Ministry will coordinate and organize periodic evaluation of the training programmes. The findings of these concurrent evaluations should be shared with State Governments.

- State level: At the State level, the State Institute of Health and Family Welfare (SIHFW) in coordination with the State Training Cell of Directorate of Family Welfare will oversee the process of training, monitor and organize concurrent evaluation of training programme.

**Compensation to Asha**

- ASHA would be an honorary volunteer and would not receive any salary or honorarium. Her work would be so tailored that it does not interfere with her normal livelihood.

  However ASHA could be 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 training, as the case may be.

  (For situations (a) and (b), payment will be made at the venue of the training when ASHAs come for regular training sessions and meetings).

  c) Wherever compensation has been provided for under different national programmes for undertaking specific health or other social sector programmes with measurable outputs, such tasks should be assigned to ASHAs on priority (i.e. before it is offered to other village volunteers) wherever they are in position.

  (For situation (c) disbursement of compensation to ASHAs will be made as per the specific payment mechanism built into individual programmes).

  d) Other than the above specific programmes, a number of key health related activities and service outcomes are aimed within a village (For example all eligible children immunized, all newborns weighed, all pregnant women attended an antenatal clinic etc). The Untied Fund of Rs.10,000/- at the Sub-centre level (to be jointly operated by the ANM and the Sarpanch) could be used as monetary compensation to ASHA for achieving these key processes. The exact package of processes that form the package would be determined at the state level depending on the supply-side constraints and what is feasible to achieve within the specified time period.
situation (d) the payment to ASHAs will be made at Panchayats).

- Group recognition/ awards may also be considered.
- Non-monetary incentive e.g. exposure visits, annual conventions etc can be considered.
- A drug kit containing basic drugs should be given.

One of the key strategies under the National Rural Health Mission (NRHM) is having a Community Health Worker i.e. ASHA (Accredited Social Health Activist) for every village with a population of 1000. Detailed guidelines have been issued by the Government of India in matter of selection and training of ASHA. The States have been given the flexibility to relax the population norms as well as the educational qualifications on a case to case basis, depending on the local conditions as far as her recruitment is concerned.

2. The above said guidelines also clearly bring out the role of ASHA vis-vis that of Anganwadi Worker (AWW) and the Auxiliary Nurse Midwives (ANM). The non-ASHA States (including the NE) have been advised that they could provide for similar link workers at the village level in the revised Project Implementation Plan for RCH-II in the current year. States like Andhra Pradesh and Haryana are already having the link workers. The 10 states where ASHA scheme is presently in place can select ASHAs in urban areas also as link workers subject to similar provisions being made in the State PIP for RCH-II in the current financial year.

3. The reports received from the States indicate that over 1, 20,000 ASHAs have been selected in the year 2005-06 and that they are being provided with orientation training as envisaged in the guidelines issued on ASHA. Now, a careful strategy needs to be devised for providing the necessary management support to ASHA so that she is not left alone in the village without having any linkage with the health system. The group includes experts and practitioners in the field of Community Health representing NGOs, training and research institutions, academic and medical colleges.

4. In order to provide adequate support to the ASHAs, the following has been provided:
   - At State Level:
     In the implementation framework of the NRHM a provision has been made for a State Health System Resource Centre (SHSRC) in every State. It is envisaged that once this centre is set up they would provide the leadership and support to the ASHA scheme at the State level. However, setting up of SHSRC may take a year. Since the support mechanism for ASHAs at the State level cannot wait for that long, a provision is being made for ASHA resource centre on the lines of the set up in Rajasthan. In the State having more than 20,000 ASHAs, a resource Centre would comprise a Project Manger (MBA), a Deputy Project Manager (MSW), one Statistical Assistant (Graduate in Statistics), a Data Assistant and Office Attendant.

     In the smaller States (other than North Eastern States) having less than 20,000 ASHAs, three persons are being provided at the State level i.e. one Project Manager, a Statistical Assistant, and one Office Attendant. These functionaries together would comprise an ASHA Resource Centre which would ultimately get subsumed in the State Health Resource Centre (SHRC) as and when the SHRC gets off the ground.

     In the detailed cost estimates (annexured), adequate provisioning has been done for office expenses and other contingent expenditure. This amount will be provided as a lump sum so that the States have the flexibility to use the amount as per their needs.
   - At District level:
     In the existing ASHA guidelines, at the district level a District Nodal Officer has been provided. The
District Nodal Officer is to be an officer nominated by the Civil Surgeon. Since the guidelines do not provide for additional human resources, it is expected that he/she would be doing the work with the existing human and financial resources. However, as has been mentioned above, managing the various aspects of the functioning of more than 1,000 ASHAs will not be a simple task without adequate human and financial resources. It is, therefore, now proposed that each District Nodal Officer would be supported by a Community Mobiliser who would have the qualification of MSW. A Data Assistant may also be provided to satisfactorily discharge the work.

- At Block Level:

At the block level, as per the existing ASHA guidelines, the Block Nodal Officer is to be nominated by the Block Medical Officer. The Block Nodal Officer will have the services of a number of Block Facilitators @ 1 per 10 ASHAs. Even though a need has been actually felt for the services of a Block Coordinator, looking to the large number of blocks in the States, the outgo in providing for an additional Block Coordinator at the block level would be considerable. It may not, therefore, be possible to provide for the services of a Block Coordinator without overshooting the norm of Rs. 10,000 per ASHA. However, in the earlier guidelines, a provision of one Facilitator for ten ASHAs has already been made. It is expected that this arrangement would suffice. However, a flexibility would be available to the Block Nodal Officer to utilize the services of the Facilitator posted at the block or any other Facilitator for other administrative work in his office relating to ASHAs. For this purpose a small honorarium could be permissible to the Facilitators.

- At PHC level:

There would be considerable workload at PHC level as many of the bills for payment to ASHA would be processed in that office. Since no additional manpower is provided at this level, a suitable honorarium for LHV and the Block Supervisor for ICDS is being provided in the guidelines.

**Present status of ASHA**

- The total Number of ASHAs engaged by States/UTs increased from 7.06 Lakhs in 2009 to 8.90 lakh in 2013
- To further enhance the skill of ASHAs, they are now being trained on the Home Based New Born Care and have been provided HBNC kits. This is to improve new born care practices at the community level and the early detection and referral of sick new born babies in first 42 days of life.
- For career progression of ASHAs, States have been asked to give priority to ASHAs in ANM/GNM schools, subject to their meeting the eligibility criteria. Five states have already implemented this initiative.
- A proposal for certification of ASHAs to enhance competency and professional credibility of ASHAs by knowledge and skill assessment has been approved recently. The certification will be done by National Institute of Open Schooling (NIOS).
- The cost norms for ASHAs have been enhanced from Rs.10,000 per ASHA to Rs.16,000 per ASHA
- The rates of existing performance based incentives for ASHAs have been enhanced and fresh incentives have also been introduced including those for routine activities so as to ensure that each ASHA worker can work properly.

**II. REFERENCE**