HANDBOOK FOR
ASHA FACILITATORS

NATIONAL RURAL HEALTH MISSION
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन

Contents

Introduction

The ASHA programme is a critical component of the National Rural Health Mission (NRHM) and is one of several processes which aim to actively engage communities in improving health status.

Programmes under NRHM that increase community participation and ownership are:

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

The ASHA is a woman selected by the community, resident in the community, who is trained and supported to function in her village to improve the health status of the community through securing people's access to health care services, through improved health care practices and behaviours; and through health care provision as is essential and feasible at the community level. There are about 846,309 ASHAs in the country and approximately one ASHA per 1000 population in the rural areas.

The ASHA facilitator is expected to be a mentor, guide, and counselor to the ASHA. She/He is also expected to provide support, supervise, build capacity of the ASHA and monitor the progress of the individual ASHA in their given area. The general norm is to appoint one facilitator for every 20 ASHA. Thus one ASHA facilitator would work with about 20 ASHAs in a population of about 20,000. To make efficient use of this human resource, they could also be deployed for supporting the VHSNC and similar community health processes.

The purpose of this handbook is to provide the facilitator with the understanding of the ASHA programme, support structures, key tasks and measurable outcomes expected of the ASHA. The facilitator is intended to enable the ASHA to achieve these outcomes. This handbook therefore

deals with the major tasks of the facilitator in supporting the ASHA and details the skills required to undertake these tasks. The facilitator is expected to be trained in the requisite skills detailed in the handbook in a two day workshop.

The handbook does not include the core competencies and skills that the ASHA is expected to acquire. The facilitators will be trained separately on ASHA modules 5, 6 and 7 and other further modules, which cover these skills.

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Section 1

The ASHA:
Activities, Skills, Outcomes

In order to provide support to the ASHA, the facilitator will need to understand the activities of an ASHA, the measurable outcomes of the ASHA programme, the specific tasks she is required to undertake, and the skills needed.

A. Activities of an ASHA

The ASHA's work consists mainly of five activities:

1. **Home Visits:** ASHA is supposed to visit households in her allocated area for two to three hours every day, for at least four or five days a week. Each house hold should be visited at least once in a month, if not more. Home visits are mainly for health promotion and preventive care. While she initially has to visit the families, over time, they will come to her when there is a problem and she would not have to go so often to their houses. Meeting them anywhere in the community/village is enough. However, where there is a child below two years of age or any malnourished child, a sick child or a pregnant woman or a woman who delivered less than 6 weeks back, she should visit such families at home for counseling and for providing first level curative care. Also, if there is a newborn in the house, a series of six visits in case of institution delivery and seven visits in case of home delivery are essential.
2. **Attending the Village Health and Nutrition Day (VHND):** The VHND is held on a fixed day of every month when the Auxiliary Nurse Midwife (ANM) visits the village to provide immunization and other services. It is generally held at the Anganwadi center. The ASHA promotes attendance of those who need the Anganwadi and/or ANM services and also helps with service delivery.
3. **Visits to the health facility:** This usually means accompanying a pregnant woman, a sick child or newborn, whose family requests her services as an escort. The visit could also be to attend a training programme or review meeting. In some months, there would be only one visit. In others, there would be more.
4. **Holding village level meeting** of women's groups, and the Village Health Sanitation and Nutrition Committee (VHSNC), for increasing health awareness and to plan health work.
5. **Maintain records** which would make her more organized, make her work easier, and help her to plan better for the health of the people. (Refer to Annexure 5-10)

The first three activities relate to facilitation or provision of healthcare and the last two are mobilizing and supportive activities respectively.

B. Measurable Outcomes of the ASHA Programme

In the course of conducting these five activities, the ASHA should ensure the following:

Maternal Health

1. That every pregnant woman and her family receive health information for promotion of appropriate healthcare practices – diet, rest and for increased use of services which would focus on care in pregnancy, delivery, postnatal care and family planning services.
2. That every pregnant woman avails antenatal care and postnatal care at the monthly health worker clinic/VHND.
3. That every family with a pregnant woman has made a plan and is prepared for the event of childbirth.
4. That every couple that needs contraceptive services or safe abortion services or care for RTI is counseled on where to avail of the service.
5. That every woman has a MCP card; is fully aware of benefits of JSY-Janani Suraksha Yojana and JSSK-Janani Sishu Suraksha Karyakram and has the contact number of the referral/transport services.

Newborn and Child Health

1. That every newborn is visited as per the schedule, more often if there are problems and receives essential home-based care as well as appropriate referral for the sick newborn.
2. That every family receives the information and support it needs to access immunization.
3. That all families with children below the age of two years are counseled and supported for the prevention and management of malnutrition and anaemia and for prevention of illness such as malaria, recurrent diarrhoea and respiratory infection.
4. That every child below five years with Diarrhoea, Fever, Acute Respiratory Infection (ARI) and worms, brought to her attention is counseled on whether referral is immediately required or whether, first contact curative care should be provided at home with home remedies and drugs in her kit.
5. That every family with a child below the years of age is aware of appropriate breast feeding and complimentary feeding practices.

Disease Control

1. That those individuals noticed during home visits as having chronic cough or blindness or a skin patch in a high leprosy block are referred to the appropriate centre for further check-up.
2. That those prescribed a long course of drugs for tuberculosis or leprosy or surgery for cataract are followed up and encouraged to take the drugs or go for surgery.
3. That those with fever which could be malaria (or kala-azar) have their blood tested to detect the disease and provide appropriate care/ referral.
4. That the village and health authorities are alerted to any outbreak of disease she notes during her visits.

Note: *Each outcome is not a separate activity. They are part of the protocol followed during one of the two activities- the home visit and attendance at the VHND.*

C. Essential Skills for an ASHA

The essential skills that an ASHA requires can be classified into six sets. These are simple skills requiring only a few hours to learn, but they can save thousands of lives. These six sets of skills are given below:

1. Maternal Care

a. Counseling of pregnant women for health care in pregnancy.

b. Ensuring complete antenatal care through enabling access to services at the VHND.

c. Making the birth plan and providing support for safe delivery.

d. Undertaking post-partum visits, and counseling for family planning.

2. Newborn Care when visiting the newborn at home

a. Counseling and problem solving on breastfeeding.

b. Keeping the baby warm.

c. Identification and basic management of LBW (Low Birth Weight) and pre-term baby.

d. Examinations needed for identification and first contract care for sepsis.

3. Child Care

a. Providing appropriate community based care for diarrhoea, Acute Respiratory Infections (ARI), fever which includes counseling, home remedies, giving drugs from the drug kit and enabling referral, as appropriate.

b. Counseling for continued feeding during illness.

c. Temperature management.

d. De-worming and treatment of iron deficiency anaemia, with referral where required.

e. Counseling to prevent recurrent illness especially diarrhoea.

4. Nutrition

a. Counseling and support for exclusive breastfeeding.

b. Counseling mothers on complementary feeding.

c. Counseling and referral for malnourished children.

5. Infections

a. Identifying persons whose symptoms are suggestive of malaria, leprosy or tuberculosis during home visits counselling on community level care and referral.

b. Encouraging those who are on treatment to take their drugs regularly.

c. Encouraging the village community to take collective action to prevent spread of these infections and individuals to protect themselves from getting infected.

6. Social Mobilisation

a. Conducting women's group meetings and VHSNC meetings.

b. Assisting in preparation of village health plans.

c. Enabling marginalized and vulnerable communities to be able to access health services.

D. How can an ASHA be effective

For an ASHA to be effective in improving people's access to health services and their health status, she should:

- Have the knowledge and skills to educate the community on health promotion and disease prevention, provide community level care for common illnesses, and facilitate access to referral services where required.
- Be friendly and polite with people and known among community, establish rapport with the family during household visits, and possess the art of listening.
- Be a special friend and facilitator to the needy, the marginalized, and the less powerful. Understand that health is a right for all people and assist and enable the most marginalized to realize their right to heath.
- Have the skill of coordination and negotiation with Panchayati Raj Institution (PRI), AWW and ANM, and other community leaders whose support is needed in undertaking her tasks.
- Be competent in conducting meetings in the community and in enthusing and motivating people to secure their health rights and entitlements.
- Be motivated and feel rewarded to help community/serve people.
- Have a positive attitude and be keen to learn new skills.

E. Support Structures for the ASHA

1. The ASHA programme has a set of supportive structures, to facilitate her work and make her more effective as a community health worker. These include:

- National ASHA Mentoring Group
- State level ASHA Mentoring Group
- State ASHA Resource Center (or a team within existing state level bodies-such as the State Institute of Health and Family Welfare, and the State Health Systems Resource Center).

- District Community Mobilizers/Coordinators
- Block Community Mobilizers/Coordinators
- ASHA Facilitators
- At the village level, the Village Health Sanitation and Nutrition Committee (VHSNC), the Anganwadi worker and the Auxiliary Nurse Midwife (ANM).

The National ASHA Mentoring Group provides input to the National Health Systems Resource Center (NHSRC) and the Ministry of Health and Family Welfare (MOHFW) on key policy matters related to the ASHA programme. The NHSRC serves as the secretariat for the National ASHA Mentoring Group, providing technical support to the states for the ASHA and other community processes programme. It also supports the Training Division at the MOHFW on policy and operational issues.

At the state level the programme is led by the Mission Director, supported by an ASHA Resource Centre. The ASHA resource centre could be outsourced to an NGO or be a division/department in existing institution. Essentially it is a team of full time personnel who provide leadership and technical support that includes training and monitoring to the ASHA programme and other community processes. Policy guidance, programmatic oversight and technical support are also expected to be provided by a specially constituted State ASHA Mentoring Group, consisting of NGO representatives, academicians, training institutions and research organizations.

At the district level, a unit of full time District Community Mobilizer/Coordinator supported by an Accounts/Data assistant is expected to manage day to day functioning at the district level and liaise with the State ASHA Resource Centre and the District Health Society (DHS). At the Block level, a Block Community Mobilizer with the aid of ASHA facilitators (appointed at a ratio of 1:20 ASHA) is expected to provide the on site support supervision and review of the programme at the ASHA level. At the village level, the Village Health Sanitation and Nutrition Committee (VHSNC), (discussed later in this chapter) the AWW and ANM are the ASHA's support mechanisms on a day to day basis. This level of management support is considered to be critical to the processes of selection, training, support and monitoring of the ASHA and other community processes.

2. Other Support Mechanisms Include

(i) Drug Kit

(ii) Performance Based Incentives

(iii) Non-monetary incentives

(i) Drug kit

The ASHA is provided with a drug kit containing a set of drugs/products to enable her to provide appropriate first level contact care. The ASHA is expected to maintain a drug kit stock record. The drug kit should be replenished every month at the PHC review meeting. The drug kit contains; Paracetomol tablets, Albendazole tablets, Iron Folic Acid tablets, Oral Contraceptive Pills Emergency Contraceptive Pills, ORS (Oral Rehydration Salt), Chloroquine tablets, Condoms, Eye ointment, Cotrimoxazole. In addition she is provided with equipment like – Digital Thermometer, Glass slides and Lancet or RDK (Rapid Diagnostic kits), Newborn Weighing Machine, Baby wrap, digital watch, mucus extractor etc. These contents could differ from state to state.

(ii) Payment to the ASHA

National guidelines for ASHA define her as a volunteer but who needs to be compensated for her time in situations such as attending training programmes, monthly review meetings, and other meetings, which would mean loss of a day's wage. In addition she is eligible for incentives offered under various national health programmes.

She is also eligible for the incentive for promoting sterilization, but since the ANM, AWW and the beneficiaries themselves can claim the incentive, ASHAs rarely get this incentive. If ASHA have promoted the procedure, she should have the priority for the family planning incentive, this is however state specific.

ASHAs are eligible for incentive in making blood slides in fever cases in a malaria prone area or for testing with RDK. She can be compensated out of the untied funds at the VHSNC for specific outcomes. In general all states incentivize the ASHA for the Janani Suraksha Yojana, Immunization and participation in review meetings, most incentives received are for these three activities.

There are also incentives for ASHA in some states for identification of candidates for cataract surgery,

referral of eligible couples for family planning, acting as DOTS provider for Tuberculosis and in support for water and sanitation programme but the number of instances are few and in absolute amount the earnings would be limited.

Recently some additional incentives have been approved for all states. These include incentives for ensuring spacing of 2 years after marriage, ensuring spacing of 3 years after the birth of first child, adoption of permanent limiting method after two children; contraception distribution; testing of salt for presence of iodine and construction of toilets under Nirmal Gram Panchayat Programme.

In addition there are many other state specific incentives, which are updated annually and vary from year to year and from state to state.

(iii) Non-monetary incentives

States also provide the ASHA with non monetary incentives such as badges, sarees, bicycles, mobile phones, as instruments for motivating the ASHA and sustaining her interest in the programme. Rest houses in health care facilities for her use when escorting mothers or children, help desks in health facilities to reduce delays and direct prompt referral enable ASHAs to be more effective and feel more respected and this in turn improves her work output.

3. Village Health and Nutrition Day (VHND)

The VHND is a common platform for allowing the people to access the services of the ANM and the Anganwadi Centre (AWC). It is held at the AWC once every month. The ANM provides immunization to the children, antenatal care to pregnant women and counseling and contraceptive services to eligible couples. In addition, the ANM provides a basic level of curative care for minor illness with referral where needed. The AWW is also expected to take weight of children upto 6 years of age and record it for growth monitoring. She should also provide take home rations for young children, pregnant women and lactating mothers and adolescent girls and conduct counseling at the same time.

The VHND is an occasion for health communication on a number of key health issues. ASHA needs to encourage pregnant women, women with children under two, adolescent girls and general community members to attend it. The VHND is seen as a major mobilization event to reinforce health messages. The ASHA should use this occasion to provide information on key health topics.

4. Village Health Sanitation and Nutrition Committee (VHSNC)

The Village Health Sanitation and Nutrition Committee (VHSNC) is established at the level of a revenue village. It serves as a forum for participation of the community and of the representatives of the Panchayati Raj Institutions.

(i) The composition of the Village Health Sanitation and Nutrition Committee

The composition of the VHNSC should be such as to reflect the aspirations of the local community especially of the poor households and women, and it has been suggested that:

- At least 50% members on the VHSNC should be women.
- Every hamlet within a revenue village must be given due representation on the VHSNC to ensure that the needs of the weaker sections especially Scheduled Castes, Scheduled Tribes, Other Backward Classes are fully reflected in the activities of the committee.
- There must be at least 30% representation from the Non-governmental sector.
- Women's self help groups must be represented on the VHSNC.
- Government employees who are resident with the village could be members or special invitees.
- ASHA must be a member and in most states ASHA is the member secretary as well.

(ii) Functions

Every VHSNC is expected to meet regularly and has certain key functions. They are:

- Generate public awareness of health programmes, and state health related entitlements and motivate them to avail the health care services provided by the government.

- Oversee/Support work of public service functionaries and monitor health services being provided in terms of availability, quality, outreach, and reaching out to the marginalized sections. Conduct a needs assessment of the village health, sanitation and nutrition situation and make a village health plan.
- Maintain data on the following:
  - Total population of the village.
  - Number of Households.
  - Number of families falling under BPL category, information on their religion, caste, language etc.

This will enable need based interventions. (Conduct a social and resource mapping to understand which communities have difficulty in accessing essential services.)

- Assist maternal and infant death audits.
- Decide on and spend the village health fund in the most effective way possible.
- Maintain a register for untied funds where complete details of activities undertaken, expenditure incurred etc. will be maintained for public scrutiny. This should be periodically reviewed by the ANM/Sarpanch.

Note:

- The Block level Panchayat Samiti should review the functioning and progress of activities undertaken by the VHSNC.
- The District Health Society, in its meeting through district community mobilizer and nodal officers, elicit information on the functioning of the VHSNC.
- A data base may be maintained on VHSNCs by the DPMUs assisted by the District community mobilizer and nodal officer for the programme.

(iii) Orientation & training

Every VHSNC after being constituted by the State Governments needs to be oriented and trained to carry out the activities expected of them.

(iv) Village health fund

Every VHSNC is entitled to an annual untied grant of Rs. 10,000. The purpose of this untied grant is to enable local action and to ensure that Public Health activities at the village level receive priority attention. The fund can be used for any of the following activities:

a. As a revolving fund from which households can draw in times of need, to be returned in installments thereafter.

b. For any village level public health activity like cleanliness drive, sanitation drive, school health activities, ICDS, Anganwadi level activities, household surveys etc.

c. In case of destitute women or very poor households the untied grants could be used for health care needs of such households.

d. The untied grant is a resource for community action at the local level and shall only be used for community activities that involve benefit of more than one household. Nutrition, Education & Sanitation, Environmental Protection, Public Health Measures shall be key areas where these funds could be utilized.

e. Every village is free to contribute additional grant towards the Village Health Sanitation and Nutrition Committee. In villages where the community contributes financial resources to the VHSNC untied grant of Rs. 10,000/-, additional incentive and financial assistance to the village could be explored.

(v) Maintenance of bank account

The Village Health Sanitation and Nutrition Committee untied fund shall be credited to a bank account, which will be operated with the joint signature of ASHA/Health Worker ANM/Anganwadi Worker along with the President of the Village Health & Sanitation Committee/Pradhan of the Gram Panchayat.

F. Roles of the ANM and AWW in Relation to the ASHA

The ASHA is expected to work in close coordination with the ANM and the Anganwadi

worker to fulfill her tasks. While all three have their own responsibilities, some are overlapping. There are five major activities at the community level where such overlap is likely, but each has her own roles as discussed below.

(i) Home visits

This is one of the ASHA's primary responsibilities. The ASHA will make home visits, prioritizing households with a pregnant woman, a newborn (and post natal mother), children under two, a malnourished or sick child and marginalized households. The role of the ANM in home visits is to support the ASHA in making joint visits to the homes of those who do not attend VHND but need ANM delivered services, to post partum mothers, sick newborn and children who need referral services but have been unable to go and to those families with whom the ASHA is having difficulty in motivating for changing health seeking behaviours. The AWW is expected to make home visits only to families where there are children under six with a focus on nutrition counseling with more visits to those who do not attend the Anganwadi center.

(ii) Village Health and Nutrition Day

All three play a role here, with the ANM providing the service and the other two playing a supportive role. The ANM gives the immunization, does the antenatal checkup and identification of complications, and provides IUD insertions and counseling. She also provides a supply of IFA tablets and oral contraceptives to the ASHA to be dispensed to pregnant and lactating mothers. The AWC (Anganwadi Center) serves as a venue for the VHND, and hence the AWW is required to enable the support in making this possible. The AWW takes weight of children upto 6 years of age for growth monitoring. She also provides Take Home Rations for pregnant women lactating mothers, adloscent girls and for children under six years of age.

The role of the ASHA is to mobilize women and children to attend the VHND, through motivation, counseling and informing when the ANM visit is due and reminding the families on that date. VHND is also an opportunity for ASHAs to convey key health messages.

(iii) Village Health Sanitation and Nutrition Committee Meeting (VHSNC)

Convening village level meetings of the VHSNC is the responsibility of the ASHA. The ANM and AWW are expected to play a supportive role in helping the ASHA conduct the meetings, including the development of village health plans. As part of this task, the ASHA is also required to identify those marginalised sections who are getting left out, and are not covered by services in any of the for a discussed above. The ASHA should take action by reaching out on her own, or enlist the support of the VHSNC to improve access to services of these sections.

(iv) Escort services to facilities

Only the ASHA is eligible for JSY incentive in all states. ASHA gets an incentive of Rs. 200 if she has promoted institutional delivery in any government facility for both urban and rural families, and ensured ANC care for the woman. In rural areas of all low performing states; North Eastern states and tribal areas of high performing states, ASHA is entitled to a package of Rs. 600. This package of Rs. 600 includes cash assistance of Rs. 250 for referral transport; cash incentive of Rs. 200 to ASHA for promotion of institutional delivery and transactional cost of Rs. 150 if ASHA escorts the pregnant woman and stays with her at the hospital. In case the transport arrangements are made directly by the beneficiary the sum of Rs. 250 goes to the beneficiary directly. The sum of Rs. 250 could also be paid directly to the transport service provider. Escort is voluntary and not mandatory for ASHA. (The family should require or desire the escort assistance and the ASHAs should be in a position to provide it.) Even if she does not escort the woman, she is entitled to Rs. 200 for promotion.

(v) Register/Record maintenance

Keeping records of services delivered and key health events is a prime function of the ANM and the AWW and is not to be passed on to the ASHA. The ASHA does have a diary to record her own activities, but this is only for the purpose of payment and documentation. She also has a register but this is only to enable her to track those in need of services and help her organize her work.

The drug stock card is for her use to record her drug supply. The ASHA does not have to submit written monthly reports and formats. The ANM and AWW should maintain a tracking register and record of service delivery for the services that they deliver. However where a regular monthly payment is made like in Rajasthan, maintaining such a register can be mandatory.

Section 2

Role of the ASHA Facilitator

ASHA facilitators are the main vehicle of monitoring, supportive supervision and on site assistance for the ASHA. One ASHA Facilitator is expected to support approximately 20 ASHAs. Thus a block would have about five ASHA facilitators (assuming 100 ASHA per block). The facilitator serves as the link between the ASHA and the support structure at the block level for the Community processes programme.

An ASHA facilitator should ensure the outcomes of the ASHA programme primarily through providing supportive supervision, and on the job training to the ASHA in their villages. The facilitator should provide supportive supervision to the ASHA through:

1. **Village visits (comprising of accompanying:** ASHA on household visits, conducting community/VHSNC meetings, attending Village Health and Nutrition Days): Depending upon the geographic dispersion, the facilitator should visit each ASHA in her village and accompany her on visits to priority households (details of village visits are given below), support her in conducting a VHSNC meeting or a women's group/community heath education meeting on the VHND. If the hamlets are far flung and the facilitator is not able to meet all ASHA within the period of one month, an alternative strategy can be used. The facilitator could form a mini cluster of three to four ASHAs and conduct all these supportive supervision related interventions in each of the hamlets by turn. This method has the advantage of peer learning and building solidarity among the smaller group.
2. **Cluster meetings:** Facilitator should conduct a monthly meeting of all ASHAs in her area at PHC village (which ever is easily accessible).
3. **Attending monthly Block PHC review meeting:** The facilitator also must attend the monthly meeting at the block level, conducted by the Block Medical Officer and Block Community Mobilizer where all other facilitators are also expected to attend.

Reaching the marginalized: An important task of the facilitator is to enable the ASHA to reach the poorest and the most marginalized. They include:

- Female headed households: Families headed by a woman - whose husband work outside the village or by a widow where she is the main earning member.
- Where the women are separated or deserted by their husbands.
- Landless families, who are working as daily wage labourers.
- Families living in distant hamlets, whose houses lie between villages or in the fields.

- Families who have migrated into the village.
- Seasonal migrants- those who migrate out in the dry season, and thus are in the village for only some part of the year.
- Households with disabled children or where some member is handicapped.
- Caste households/communities which are seen as lower in status.

Such groups are often invisible, do not access services, or are not included in general village meetings. They could be individual families or even communities. The role of the facilitator and ASHA is to understand how and why such people get excluded from services, and why they are isolated and neglected. Caste, other social and geographical issues are part of the reasons. The facilitator should work with the ASHA in undertaking social mobilization, through small cultural events. They should enlist the support of the ANM/AWW or VHSNC to enable breaking such barriers.

Four other Important tasks that the facilitator is expected to undertake are:

1. **Supporting ASHA training during training rounds at block level:**

   (i) Ensuring ASHA attendance at training rounds.

   (ii) Support the ASHA trainers in the training workshop in organizing group work, supporting field practice, and other ancillary training functions.

2. **Providing support to ASHAs to improve their functionality**

As an ASHA Facilitator, one of your most important tasks is to provide support to the ASHAs and help them improve their effectiveness. This is more important if there are some ASHAs who are poorly functional on many of their tasks or who remain absent from VHNDs/ monthly meeting/ trainings. Such ASHAs require extra mentoring support and encouragement from you. You can identify such ASHAs during village visits or cluster meetings. When you encounter such ASHA, your first task is to identify the reason for her poor performance. There could be several reasons. These include: poor performance on account of low skill or knowledge levels, delays in payments, irregular drug supply and or inappropriate behavior of the health institution staff, lack of family support, illness in the family, other social barriers, or no interest in continuing as ASHAs. The ASHA brochure on Reaching the Unreached should help you to identify other possible problems.

Once you establish the reasons for the poor performance or attendance you should try and rejuvenate her interest in the programme. If it is an issue of low confidence on account of poor capacity you need to identify areas where she needs additional knowledge and skills. This can be provided by your mentoring her during your village visits, accompanying her on household visits, and providing feedback after the visit on what she has done well and what she needs to work on more. You should also plan to meet such ASHAs in their villages more on a frequent and regular basis. Even after your repeated attempts if you find that there is no improvement in the performance then you should inform the block and district nodal officer to arrange for a refresher training of all such ASHAs. Some ASHAs may also lose interest because of their bad experiences with the health system. These may include delays in payments or irregular supply of drugs. You should facilitate this by informing your block community mobilize or block nodal officer.

In your area you may also have some ASHAs who do not want to continue working as ASHAs for various reasons. You should visit these ASHAs in their villages and try to ascertain the reasons for lack of interest. In case there is some systemic problem or need for capacity building, you should try to address the problem as discussed above and motivate the ASHAs to continue working as ASHA. However if after your discussion you feel there is a genuine problem and ASHA would not be able to fulfill her responsibilities then you should inform the Block Nodal Officer to expedite the process of res-selection.

3. **Facilitating selection of new ASHA:**

   (i) In most of the villages the selection of ASHAs is near complete, thus your role

would primarily be to identify the drop outs from the ASHA Programme. Any ASHA is to be considered as drop out if – She has submitted a letter of resignation 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 that she is indeed not active. If there is a genuine problem, she should be supported until it is overcome through the ASHA Facilitators, 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.

(ii) It is also important to note that there would be some villages or hamlets in your area where ASHAs are yet to be selected.

(iii) In both these cases, you should work with the Block Community Mobiliser and the community to select a new ASHA for that village / hamlet.

(iv) Your role in selection of new ASHAs is to create awareness in the community about the roles and responsibilities of ASHAs as well as the criteria for ASHA selection. This can be done through community interaction in the form of community meetings and mobilization events like – kala jathas. Such interactions would result in short listing of at least three potential candidates. Then along with the Block Community Mobiliser you should also facilitate guidelines the organization of the Gram sabha, which would then select the ASHA for their village from the three short listed candidates. (See Annexure 13 for ASHA selection guidelines)

4. Enabling grievance redressal system for the ASHA

If grievance redressal system is in place, then the ASHA Facilitator should get the relevant government orders, understand the processes and orient ASHAs on the steps involved in the grievance redressal. In absence of any such system the ASHA Facilitator should develop a grievance redressal system in consultation with the Block Community Mobilizers, ASHA District Coordinators, District Programme Managers and District chief Medical Officer in the following manner:

ASHA Grievance Redressal Committee can be notified by the District Health Society (DHS) with five members - two representatives from Non Governmental agencies, two government representatives from a non health sector (WCD, ICDS, Education, Rural Development, PRI), and one nominee of the CMO. At least three of the member should be women.

The ASHAs should be made aware of the existence of the Grievance Redressal Committee. The functioning landline number and P.O. Box number of the ASHA Grievance Redressal Committee are to be widely publicized and displayed at PHC, CHC and District hospitals. The complaints can be initiated telephonically but should be submitted in writing against a signed receipt. The secretary of the committee should write to the concerned officer who is required to take action and a reply should be sent within 21 days to the complainant. The committee can decide on the appropriate action for some of the recurring grievances.A written documentation of the name, date of receipt of grievance, specific complaint and the action taken report has to be maintained. The committee should meet once a month to review the grievances and action taken. Where the complainant is not satisfied, she could appeal to the Chairperson of the District Health Society or the Mission Director, State Health Society.

Role of ASHA Facilitators in Grievance redressal

- During field visits ASHA will convey the grievances mostly verbally and rarely, in written form. The ASHA Facilitator should address the grievances immediately if possible.
- If higher authorities need to be consulted, make note of the grievances each day to present to higher authorities in a regular systematic manner. ASHA facilitators must find out the appropriate nodal person who can handle such issues.
- The ASHA Facilitators must meet the Block Community Mobilizer and brief

him/her about the progress of the ASHAs, their performance & their problems. It is best to present grievances in the form of written points. Note down the points that are discussed during these meetings with higher authorities so that you have record to follow up. It will also work as a reminder to the authorities. Keep these written records systematically in folders or files.

- Encourage ASHAs to give all complaints in writing.
- ASHA Facilitators should ensure that ASHAs get full payments in a timely manner.ASHA Facilitators must see that the ANMs sign the forms for payments and that they are submitted at the PHC timely.

The grievances can relate to several issues:

1. Personal issues
2. Payments
3. Supplies
4. Record Keeping
5. Referral system
6. Services in the hospitals
7. Gender issues

Key Tasks

A. Supportive Supervision

This is done through the (i) Village visits (ii) Cluster meetings (iii) Monthly Review Meeting at Block level PHC.

(i) Village visit

Preparation for a village visit is ideally done during a cluster level meeting, when the facilitator has a chance to meet all the ASHAs.

1. Ensuring a mutually convenient time and date for her visit in consultation with the ASHAs.
2. Specify if this visit will also include conducting a VHSNC meeting or falls on a VHND.
3. Work with ASHA in identifying the households to be visited. The household should be selected from families with:
   - Newborns 0 to one month of age.
   - Children between the age group of one month to two years.
   - Children suffering from moderate or severe malnutrition or sickness in the last month.
   - Women in the third trimester of pregnancy.
   - Households that the ASHA has not visited in the past one month.
4. ASHA should also try that Anganwadi worker and ANM (and where there is a practicing Dai) are included.
5. Informing in advance if there are any changes in her schedule to the ASHA.

(a) Household visits

On reaching the village, the facilitator must prioritize home visits to those households where the ASHA needs additional support in motivating such families to adopt healthy behaviours, utilize ASHAs services, or access referral.

The ASHA and facilitator should prioritize their visits as follows: For instance if there are three pregnant women in the area, then the one who is past the seventh month of pregnancy should be prioritized over one who is about five months pregnant. In the former case, the facilitator can thus review the birth plan and discuss arrangements for transport and institutional delivery.

In the case of children, this is illustrated by the following example: The ASHA facilitator should visit the first three children in the order of priority as mentioned in the box below:

	Name of the child	Age
1	Lakshmi's baby	1 day
2	Baby Semaru	14 days
3	Baby Lata	27 days
4	Baby Kareem	Three months

In the case of malnourished children, the facilitator should assess if the ASHA is aware of children who are malnourished. Assuming that there are eight children who have normal weights, four who are moderately underweight, and four that are severely underweight, the ASHA facilitator should

first visit those who are severely underweight. For those children that are moderately underweight the facilitator should prioritize home visits as follows:

1. Child whom ASHA has not been able to visit.
2. Child who has not been weighed regularly.
3. Child who is not attending the AWC regularly.

For other categories, the facilitator should rely more on women's meetings of appropriate groups, rather than visiting each home repeatedly. These may include:

- Visiting mothers of sick newborn where referral arrangements were made by ASHA.
- Number of referrals that have been made in the last month and the place of referral.
- Follow up mechanism by ASHA and ANM for referral cases.

During the home visits, the facilitator first allows the ASHA to undertake counseling and advice, including demonstration as appropriate. The facilitator uses a checklist to record the ASHA's steps. (See *Annexure 2* for the checklist). ASHA facilitator should have at lest one set of all the forms used by ASHA's (Annexures 5-10) to see if ASHA's are following all the steps and taking appropriate action as per the forms. Then the facilitator adds those points that the ASHA may have missed or corrects any errors, in a manner that does not embarrass or humiliate the ASHA. After one visit the facilitator should review the check list with the ASHA and give her the appropriate feedback. This is repeated as the ASHA and facilitator visit other households. The facilitator uses this opportunity to strengthen the ASHA's clinical knowledge and skills. The Facilitator also makes notes of the areas where the ASHA needs additional formal training. The household visits can also be used to remove misconceptions.

Where the facilitator chooses the option of having three to four ASHAs (a mini cluster visit), each ASHA should be given the opportunity by turns to take the lead in a one household, the second one in another and so on.

(b) Facilitating community meetings

Assist the ASHA to conduct a VHSNC meeting on the day of the village visit. If there is a VHND taking place the facilitator should also use the checklist (See Annexure-3) for monitoring the services delivered during VHND. The facilitator should also use the opportunity to support the ASHA in conducting the village level meeting or a women's meeting. The meeting should begin with an inspirational song, appropriate local song, or other local custom common to community gatherings. The ASHA facilitator should help the ASHA to involve all the women in the area and members of the VHSNC. The discussion would center around the points below:

- Problems and local solutions possible.
- Review general water and sanitation status.
- Ask if any disease outbreaks have taken place.
- Births and deaths and if they have been registered.
- Regularity and quality of VHND.
- Discussion on the mid-day meal programme, Anganwadi services, NREGA (National Rural employment Guarantee Act).
- Discussion on the sanitation issues that were identified during the area visit and inform the VHSNC about them.
- **Solving the problems of ASHAs convening the VHSNC meeting:** Look for level of interest and participation of the members? Who is irregular? How to motivate? See whether VHSNC notebook, cashbook, and passbook are updated or not? (If not then enable completion on the spot). Is the VHSNC meeting being organized every month? [If not then make an action plan for this], Are Untied funds being utilized or not?
- Has information been obtained on the infant and maternal deaths in that area?
- Whether the people of the area are participating in preparing the village health plan.
- Work with the VHSNC in identifying those parts of the village/communities where there is poor performance (higher home deliveries, fewer children coming for immunization, etc.).

These should be addressed both by the ASHA and also by the VHSNC. The Facilitator should also meet the Panchayat representative in the village to enhance their awareness of the health situation, enable support for the ASHA and help them view the work in a positive way.

(c) Check the drug kit and stock record

The ASHA Facilitator should check the content of the drug kit and should ensure that the requisitions for the supplies are sent when the stocks of ASHAs have decreased to around 25%. She/He can also make a quick assessment of the date of manufacture of these drugs and make certain that no expired drugs are being carried. He/She should also review the durg stock card (Annexure 5) of the ASHAs.

(d) Obtaining data on key health indicators related to ASHA's tasks

The ASHA is not expected to collect data or maintaining records to submit to the facilitator. It is the facilitator's task to obtain information from the ASHA on the key activities that she undertakes (this is dealt in more detail in Section 4). This helps in identifying resistant households and areas with poor health outcomes.

(ii) Conducting monthly cluster meetings

The facilitator will organize a monthly meeting of all ASHAs in his/her area. ASHA facilitator should a) conduct performance review and planning, b) discuss common issues and problems faced by ASHA during the month, c) highlight those actions which need to be discussed at monthly PHC review meeting, d) obtaining data from the ASHA to enable consolidation at the block level and e) keep the ASHAs updated about guidelines and other technical details about programmes related to health and her work. Last but not least, cluster meetings are a forum for building solidarity among the ASHA. Cluster meetings should begin and end with inspirational songs and the ASHA should be encouraged to share successes and challenges related to her work. The facilitator should discuss with the group the following:

a. **The number of pregnant women and those who are going to deliver next month** Ask whether ASHAs have been regular with their home visits, have helped in making a birth plan, arrangement for transport with the family has been discussed, do they have any alternate plan, have they been informed about JSY. Also obtain information about the women who delivered last month [institutional delivery, benefit from JSY etc].

b. **The number of malnourished children** Ask how many of them belong to the 2nd and 3rd degree of malnutrition, have ASHAs been able to visit them, undertook counseling of the families on prevention of malnutrition and any child with Grade 3 malnutrition was referred to a facility.

c. **The number of newborns and those visited:** Ask how many children were examined on 1, 3, 7, 14, 21, 28 and 42nd day? Also ask about the additional postnatal visits and counseling which includes advice on recognizing danger signs, breastfeeding practices, newborn care and suitable family planning methods.

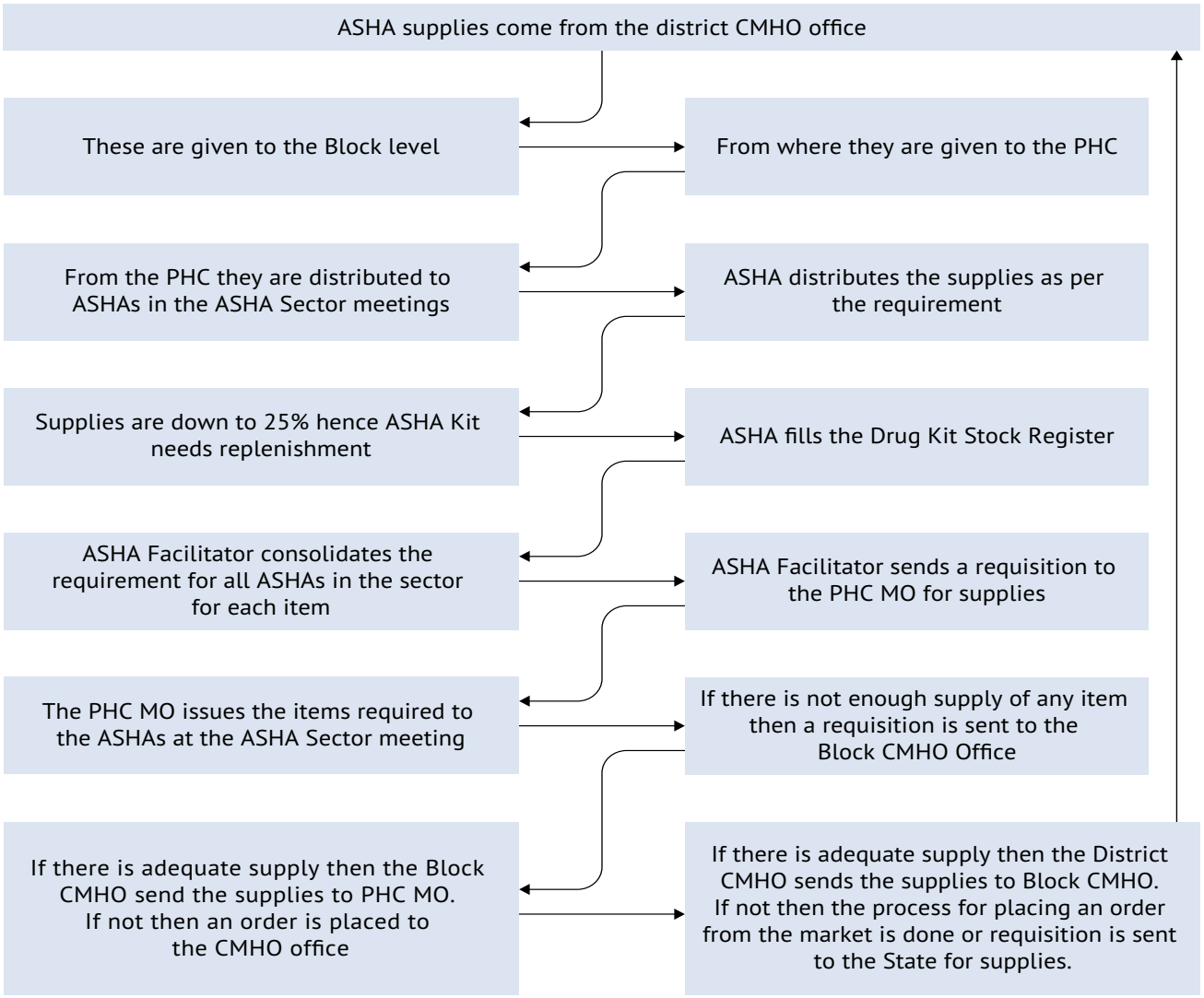
d. **Immunization and VHND:** Whether it was observed last month, how many children attended it, was incentive given to ASHA for encouraging immunization and what was the involvement of VHSNC members.

e. **The number of TB/Leprosy/Malaria cases:** Ask whether such cases have been identified, any problems encountered in doing so, was assistance provided by ASHA as DOTS provider, referral, treatment status etc.

f. **Number of newborn and infant deaths and maternal deaths:** Ask for any infant and maternal deaths in the given area. And make an action plan for ASHA to provide information about infant and maternal mortality-causes and prevention to the community. In case of any deaths ASHA facilitator should visit the family and record the details as per the forms (Annexure 11 & 12). These forms should then be submitted to the ANM of that SHC.

g. **VHSNC and village health plan:** Ask whether meetings are regular, untied funds being judiciously utilized and involvement

The Flow Chart of Supplies



of the community in the making of village health plan.

h. **Drug kit:** The process regarding the refilling of the kit should be assessed. Ask whether the drugs are available? Being used or not?

This is helpful for the facilitator to analyze which villages/areas of her cluster are not performing well, and where the outcomes are not positive. A check list is annexed (*Annexure 4*) to help the facilitator in supervision.

(iii) Monthly review Meeting/Block level PHC/ CHC review meeting

The Block Medical Officer at the Block PHC/CHC convenes this monthly meeting, to be attended by ANM ASHAs, LHVs and the Facilitator. These meetings are an opportunity for the ASHA to interact with block officials and with the ANMs/MOIC of their area in a larger platform. Monthly meetings serve as an additional forum for capacity building, trouble shooting, problem solving and motivation. The ASHA kits also could be replenished at this time.

ASHAs are paid according to the work done, which is verified by the ANMs and payments are made on a monthly basis. Each state has its own norms for payments for each service rendered. Payment of incentive to ASHAs under various schemes can be organized on this day so that ASHAs need not visit the PHC multiple times to receive their incentives. States may ensure that payment to ASHA is made promptly through a simplified procedure. ASHA Facilitators should ensure that ASHAs get the exact amount from the payment that is due to them. If

there is a delay in payments then they should bring it to the notice of the Block Community Mobilizers and pursue the process till payments are made. Since the data from the facilitators is aggregated at the block level, the meeting provides an opportunity for review of data, assessment of performance in the various villages/clusters and feedback, as well as search for solutions.

An example of trouble shooting for problems related to logistics (Supply chain), Drug kits and replenishment

Logistics management is a cyclical process and involves several steps, namely demand estimation, indenting, receipt, storage and distribution of supplies to ASHAs in a timely fashion. Logistics management ensures regular and smooth flow of the supplies to ASHAs for the ASHA kit.

Role of ASHA Facilitators in Logistics and supplies

- It is important that an adequate supply is always available with ASHAs. Hence ensure that supplies are checked regularly especially during field visits.
- During Field visits make a record of the supplies where there is a shortfall.
- Feedback regarding the supplies with ASHA can also be taken at cluster meetings.
- Compile this information in a table ASHA wise.
- Submit this to the PHC .
- Records of all supplies should be maintained.
- ASHA Facilitator should check the supplies before signing the receipt forms.
- On issuing the supplies to ASHA, the ASHA Facilitator should get the signatures of ASHAs.

Ensuring coverage of the marginalized

Reviewing population coverage for the key indicators is an important task. If the coverage is less than what is expected, this should serve as a warning signal to the facilitator. The most common reason for low coverage is that marginalized families are being left out of services. It is also likely that the lower coverage is because the better off families in the village access higher levels of health care providers directly. This is not a cause for worry.

It is the job of the facilitator to define the reasons for low coverage. If it is the marginalized who are being left out then she/he should spend time in the village to build rapport between ASHAs and the marginalized communities. There are some categories of women who will need additional support to access services. For example, the woman in a female headed household will require ASHA to take care of her older children rather than perform the escort function at the time of delivery or support her in making suitable arrangements.

One important caution for every ASHA Facilitator is that ASHAs may self report a lower denominator for the number of households that they are expected to cover. This is particularly the case in large villages with more than one ASHA, where there are a significant number of households that are not allocated to any ASHA of that village. It is important for ASHA Facilitators to identify the number of families in the village and ensure that the sum of the families allocated to each ASHA is equal to the population of that village. This is an important technique to assess coverage. ASHA facilitators should be accountable for the coverage of the ASHAs.

Section 3

Supportive Supervision
and Skills for the ASHA Facilitator

The ASHA Facilitator is the person directly in contact to the frontline workers. Providing supportive supervision is the main role of the ASHA facilitator. Effective supportive supervision improves the performance of the health workers and thereby the quality of services. ASHA facilitators should carry out participatory Supportive Supervision rather than traditional supervision which is focused more on inspection and fault finding rather than on problem solving to improve performance. It is not an ad hoc or casual visit or questioning, it consists of a planned set of processes and uses tools such as checklists and protocols as aids to better performance assessment and provision of feedback. The facilitator must not only be skilled in the technical areas, job responsibilities, and outcomes of the ASHA but also understand the processes of supportive supervision.

Skill 1: Supportive Supervision

A. What does Supportive Supervision do?

- Enables ASHAs in achieving her outcomes.
- Provides guidance and on the job mentoring to improve capacity and performance.
- Helps ASHA reach the marginalized and secures their health rights and entitlements.
- Strengthens the ability of the ASHA to work more effectively with the VHSNC, AWW, and other local leaders and village groups.
- Builds solidarity among the ASHA.

B. Supportive Supervision should Result in Measurable Outcomes

a. If there are clear outcomes/objectives, ASHAs know better what is expected of them and can try to reach these outcomes.

b. If there are clear outcomes/objectives, the facilitator:

i. Can praise and encourage good work.

ii. If objective has not been completed properly, the facilitator can identify what the problem is and try to correct it. This may mean:

- Identifying and addressing gaps in a workers knowledge or skill, helping them on the spot, or arrange for additional training.
- Identifying a social problem (between the ASHA and the community, or ASHA, and ANM/AWW/TBA etc.) and try and resolve this through discussion, individually or in a group of those concerned or where needed bring the influence of the government to overcome the problem.
- If there is a problem with lack of supplies, try and ensure sufficient supplies.

c. If there are clear objectives/outcomes community also knows what is expected

of ASHA and would not have unreasonable expectations from her and would be able to cooperate with her, where needed. Also the work or gaps in performance of other functionaries would not be attributed to the ASHA.

d. Use of checklists and protocols to assess ASHA's skills and performance should be seen as an enabling tool, to ensure that she has covered all the key points rather than as an instrument for penalizing her.

C. Characteristics of a Supportive Supervisor/Facilitator

- Is kind and greets the ASHA warmly,
- Praises what is done well, there is always something to praise. This bolsters the worker's self-esteem and trust in the facilitator.
- Explains what can be improved clearly without making the worker feel bad about herself, asking what the worker thinks would help the situation.
- If there is a weakness, identifies the cause (e.g., insufficient training, insufficient resources lack of drugs, less understanding of the task, discouraged by lack of progress or lack of encouragement, worried by personal problems), and assists in finding a solution.
- Gives feedback and suggestions for improvement in a respectful rather than abusive way. The supervisor must provide feedback in such a way that workers respond positively and try to improve their performance.
- Uses the 'sandwich approach', praises accomplishments, gives constructive suggestion to improve work, and ends with praise and encouragement (for motivation).

D. Types of Supervision

Supervision is of two types – Autocratic and Supportive/Participatory.

E. Differences between Supportive Supervision and Monitoring

The ASHA facilitator has to carry out Supportive Supervision, and monitoring. The highlights of each of these roles are outlined below:

- Monitoring is the repeated assessment of a programme to ensure that the programme is being implemented correctly.

Autocratic	Supportive/Participatory
Like being an Inspector. Seen as "checking-up" on workers or fault finding	More like a teacher, coach, mentor – Supportive and firm when required
It is often a negative experience for the health worker, who then learns to hide things from the supervisor. Looked upon as a visit from policeman from head office	Looked upon as a positive experience and a visit from a supportive senior colleague
Making decisions on their own and enforce decisions as per their own standards	Decision making is in a participatory manner and standards are used as guidelines. Adjustments are done as per the group and the situations
Always controlling	Delegation is done
Focus is on the final product and not on the processes	Focus is mainly on the processes and team work
Fear is used to get work done	Positive reinforcement is used to get work done
Do not listen to subordinates	Listen to subordinates all the time and encourage discussions
Do not provide support on a day to day basis	Provide support all the time and encourage solutions
Little or no follow-up	Follow up regularly

- It is the process of routinely gathering information on all aspects of the programme.
- It differs from supervision as monitoring is concerned with aspects of the programme that can be counted where as supervision deals with the performance of the people working within the programme.
- However some aspects of monitoring are closely connected to supervision. Supervision will establish whether the ASHAs are using the resource material and the reasons they may not be using them. The associated part of monitoring will note how many ASHAs out of the total are using the resource material.
- Monitoring is done to improve the implementation and outcomes of the programme.
- Monitoring provides managers with information needed to:
  - Analyze current situation.
  - Identify problems and find solutions.
  - Discover trends and patterns.
  - Keep programme activities on schedule.
  - Measure progress towards objectives and formulate/revise future goals and objectives.
  - Make decisions about human, financial, and material resources.
- Monitoring is a continuous process.
- The first level of monitoring is done by programme staff.
- Supervisors are responsible for monitoring the staff and tasks under them, and the programme manager is responsible for monitoring all aspects of the programme.
- Monitoring can be carried out through field visits, review of services and records and the management information systems (MIS) (explained in section 4).

Skill 2: Provide Feedback to ASHA on Counseling and Review Technical Skills

ASHA facilitators have a very important role in building the capacities of the ASHA for informing and counseling mothers and families on improving home care behaviors:

1. ASHA Facilitators need to have a clear understanding of communication skills and counseling.
2. They should do a self analysis to see if they themselves follow the principles.
3. During field visits the ASHA Facilitators must first observe how effectively ASHA is able to communicate the messages and how correct the messages are.
4. Without being too obvious the facilitator should supplement information during the home visit.
5. Point out what she did well and what more needs to be done.
6. Make a list of which counseling skill needs to be reinforced and during review meetings organize role plays to reinforce good communication skills.
7. Observe the ASHAs again and reinforce the areas of improvement till ASHA effectively communicates.

It is essential to keep the motivational levels of ASHAs high since only then they will show progress. Praising the ASHA hence becomes very important and giving of negative feedback should also be done in a constructive manner.

Skill 3: Calculations of Beneficiaries

Calculations of beneficiaries are essential to know the coverage of the ASHA. This can be used to develop strategies to address low coverage. Facilitators are expected to understand and be able to calculate the expected and the actual users of services provided by ASHAs. Please refer to *Annexure 1* for detail explanations and examples.

(i) Maternal health status

These indicators should be used by the ASHA Facilitators to see the progress for Maternal Health.

Indicators	Expected figures	Data from ASHA	Percentage covered
Pregnant women registered			
Pregnant women received 3 ANC			
Pregnant women received TT 2			
Pregnant women received 100 IFA tablets			
Institutional deliveries			
Home deliveries			
Delivery by SBA			
Cases of Maternal Complications			
Women referred for complications			
Maternal deaths			

Make a table with these indicators and enter the data on a monthly basis. Calculate the percentages for each of the indicator. The total number of Pregnant women should be calculated from the population data and the Crude Birth rate.

The service data and the data from monitoring visits should be analyzed every month to see the progress at the level of each ASHA.

(ii) Child health

The following indicators (See table below) should be used by the ASHA Facilitators to see the progress for Child Health.

Make a table with these indicators and enter the data on a monthly basis. Calculate the percentages for each of the indicator. The total number of live births should be calculated from the population data and the Crude Birth rate. Also calculate the expected: (refer to Annexure 1).

- Number of Neonatal deaths
- Number of Infant deaths
- Number of Under 5 deaths
- Number of children under 5 years of age

The data from ASHAs and the data from monitoring visits should be analyzed every month to see the progress at the level of ASHAs.

Compare the ASHA data with the expected data

Indicators	Expected figures	Data from ASHA	Percentage covered
Live Births			
Children 12-23 months fully immunized			
Newborns breastfed within one hour of birth			
Children exclusively breastfed for at least 6 months			
Children age 6-9 months receiving solid/ semi-solid food and breast milk			
Neonatal deaths			
Infant deaths			

	Indicators	Actual figures of the denominators*	Data from ASHA	Percentage covered
1	Neonates with complications, who were referred			
2	Children with diarrhoea who received ORS			
3	Children with diarrhoea who were given treatment			
4	Children with diarrhoea who were hospitalized			
5	Children developed Acute Respiratory infection or fever			
6	Children with acute respiratory infection or fever who were given treatment			
7	Children with acute respiratory infection or fever who were hospitalized			

* S. No. 1 – Total neonates with complications in coverage area of the ASHA.

* S. No. 2–4 – Total children with diarrhea in coverage area of the ASHA.

* S. No. 5–7 – Total children with ARI in coverage area of the ASHA.

If the estimated numbers do not match with the figures reported by the ASHA then ASHA facilitator should find out whether it is due to a problem of low coverage or if there is a change in population of the area v.i.z, migration and change in fertility trends etc.

Section 4

Tools

Tools for Supervision

Checklist: *The checklist is a useful tool for supervision since it systematically examines all the items which need to be looked at during a field visit by the ASHA facilitator. The Facilitator should be familiar with the Supervisory checklists and forms, ASHA registers and reporting formats.*

The advantages of using checklists during supervision are as follows:

- They provide a standardized approach to what is reviewed during supervision.
- They help the facilitator to cover all key issues and not to forget anything.
- They provide a means of documenting the findings in a simple manner that can be referred to in the future to remind the facilitator of what was found and to provide a record which enables performance changes over time to be tracked.
- They provide a basis for identifying needs for follow-up by both the facilitator and the ASHA.

Checklists are annexed for the ASHA Facilitator record (Annexure 2 for household visits, Annexure-3 for VHNDs and Annexure 4 for cluster meeting).

- The checklists have points related to: Understanding of ASHA's work.
- Understanding of skills.
- Capacity building needs – Knowledge & Skills.
- Identifying any issues related to her work and help in solving them.

Instructions for the Checklist

1. Fill up the checklist during or immediately after the Home visits.
2. Check the records.
3. Give Feedback at the end of the visit. Praise the good work and point out where more efforts are required.
4. Fill out the checklists and make a report on the visits.

5. Make a Follow up plan.
6. The observations should be recorded as Yes/ No/partially adhered to.
7. Remarks should be entered to describe in detail about any observation.
8. It is important that the checklist be filled in full.

Records are the registers and formats in which the data is collected with respect to details of pregnant women, delivered women, children 0-5 years, eligible couples and others in need of services. These registers and formats remain with ASHA in her village. These are meant for taking action at the local level.

ASHAs have the following forms to help them with there work:

- Village Health register
- ASHA diary
- Drug Kit Stock Register Card – Annexure 5
- Format for Individual Birth Preparedness Plans – Annexure 6
- Delivery Forms – Annexure 7
- Format for First examination of the Newborn – Annexure 8
- Home Visit Form – Annexure 9
- Home Visit Form for High Risk Baby – Annexure 10

Reports are made from the records and are submitted to higher levels of programme management. Both the documents are necessary for information on a regular basis and for actions to be taken.

The reports tell about:

- Pregnant women – numbers, registered, ANC, danger signs.
- Deliveries: numbers, Institutional and Home deliveries, Danger signs.
- Newborn Care: Numbers, feeding practices.
- Children: Immunization and Feeding practices.
- VHND: beneficiaries given services, participation of VHSNC members.
- Home visits: birth preparedness plan.
- Deaths: Mothers, Newborns, Infants and children.

Programme Monitoring of the ASHA Programme for Outcomes and 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. ASHA facilitators have a major role to play in the collection and consolidation of the data during the review meeting especially for the functionality of ASHAs. It is important to note that the ASHAs are not required to keep any additional records, but use their register and diary, which are their planning and recording tools, to provide this information verbally to their facilitators.

A. Functionality of ASHAs – Frequency – Monthly up to Block level and Quarterly from District to State 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 cluster meeting or review meeting. The periodicity of this meeting should be atleast once a month, though once in two weeks is desirable.

Step 1

- The facilitator records ASHAs responses in the following recording format 1 on a monthly basis and presents this at the block meeting in a reporting format 2.
- Facilitator should converse with ASHAs and ask about each of the tasks listed in the format 1 using the suggestive data definitions in the Box 1. For every task on which ASHA is functional as per the data definitions provided in Box 1, you would mark (1) in the respective cell. In case of non functionality you would mark (0) in the respective cell. If the information is not available for any ASHA then also she would be marked as non functional.

  Eg- For new born visits, the facilitator should first ask ASHAs about the total number of newborns that were born at home during last one month and out of them how many did she visit on the first day of birth. In order to mark her functional she should have visited all of these newborns. If she has visited all the newborns that were born

at home then the facilitator would mark 1 in her column.

- The format would be filled in the similar manner using the data definitions (Box 1) for all the tasks from all ASHAs.
- The last column is for facilitators to compile the number of ASHAs who were functional on each of the tasks. Here all the 1s should be added to get the figure for total number of ASHAs functional on each task.
- Based on the data collected for functionality of ASHAs, each facilitator should assess and write the no. of tasks each ASHAs reported being functional on in the 11th row of format 2. S/He would be able to_write the number of ASHAs who are functional on at least 6 out of the 10 tasks in the last column of the 12th row.

(This will also include ASHAs who are functional on 6 or 7 or 8 or 9 or 10 tasks)

It is also important for every facilitator to realize that monitoring is mainly to find out which ASHAs need more assistance and help her. It is only secondary for reporting to higher authorities. Monitoring serves no purpose if not followed by assistance.

Format 1 for ASHA facilitators – To record functionality of ASHAs under each facilitator												**Date-**
	ASHAs	1	2	3	4	5	6	7	8	9	10	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 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 or attending village/VHSNC meeting											
10	Successful[1] referral of IUD/female sterilization/male sterilization cases and/or providing OCPs/Condoms											
11	**Total of number of tasks on which ASHA reported being functional**											
12.	**Total number of ASHAs who are functional on at least 6/10 tasks[2]**											
	Remark											

[1] Successfully referred – People who were counseled by ASHA for use of family planning measures (IUD/Male or Female Sterilization) and who got the procedure done.

[2] 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 during the period of last one month.. Eg - If there were no TB and Malaria cases in ASHA's area 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 8 and affect the scoring of ASHAs also. In case of total 8 tasks she should be functional on at least 5/8 tasks and in case of 7 tasks it should be at least 4/7. These scores can then be considered equivalent to the scores of other ASHAs who are scored out of 10.

Box 1 - Data Definitions for functionality		
1	Newborn visits within first day of birth in case of home deliveries	Ask the ASHA about in number of deliveries that happened at home in her area in last one month and ask how many of these newborns she visited on the first day of birth. In order to mark her as functional she should have visited all of the newborns who were delivered at home Eg – Of the three newborns delivered at home, if she has visited all three newborns, then you would write (1) in the respective cell and if no newborn or only one or two were visited then you should write (0) in that cell.
2	Set of home visits for newborn care as specified in the HBNC guidelines	As per HBNC guidelines ASHAs are mandated to visit every newborn in her area as per the following schedule – seven visits in case of home deliveries (1st, 3rd, 7th, 14th, 21st, 28th, 42nd day after birth) and six visits in case of institutional deliveries (3rd, 7th, 14th, 21st, 28th, 42nd day after birth). She is entitled for an incentive of Rs. 250 per newborn if she has made all the visits as per the schedule. In order to mark her as functional (1) you should ask whether she has visited **at least half or more** of the total newborns in her area and has **followed the schedule of visits for each of these visited newborns.**
3	Attending VHNDs/ Promoting immunization	Ask whether the last month's VHND was attended by ASHA. Write 1 in the column if she has attended the last VHND and 0 if has not attended the VHND held in last month.
4	Supporting institutional delivery	Ask about the total number of pregnant women in her area who have their EDD – expected date of delivery in the coming month. ASHA would be marked as functional only if she has made **birth plan for all of these women** – (who are going to deliver in the coming month). She would be marked as non functional if she missed making birth plan in even a single case. Eg- There are four pregnant women who have their expected dates of delivery in the coming month and ASHA has made birth plans with three of them. In this case ASHA would be considered as non functional because she has not made the birth plan for all such women and you should mark (0) in the respective cell.
5	Management of childhood illness – especially diarrhea and pneumonia	Ask the ASHA about the status of drugs in her kit. You should ask about the number of sick children up to the age of 5 years in her area during last month. ASHA would be marked as functional if **at least 50% or more** of these families sought ASHA's advice for the care or treatment of their children. In case less than 50% families sought her advice then you would mark (0) in the respective cell.
6	Household visits with nutrition counseling	For household visits and nutrition counseling ASHA should make regular household visits to the following families – a) Vulnerable sections (families with poor economic or social status. Eg- households headed by women, poor families or families facing discrimination because of their caste or religion etc.) b) Households which have children up to 2 years of age c) Households where there are children (up to 5 years of age) with moderate or severe of mal-nutrition.

		Ask whether ASHA is aware of how many such families are present in her area. Then you would ask whether she has **visited all of them at least once** during last one month and has provided counseling on nutrition. If she is able to provide you the number of such households and reports that she has made at least one visit to all such families and provided nutrition counseling in last one month, then you should mark her as functional (write 1 in the column). If she was unable to visit all such households then mark (0) in the cell.
7	Fever cases seen/ malaria slides made in malaria endemic area	If your area is a malaria endemic area, then ask about the last three cases of fever in ASHA's area in last one month. She should have made malaria slides/or RDK/and/or given anti malarial drugs in **50% or more** of these fever cases to be considered as functional. If the performance is less than 50% on this task then mark (0) in the cell.
8	ASHAs acting as DOTS provider	If ASHA is currently acting as DOTS provider for the most recently detected TB patient in her area then put (1) in the respective cell, else mark (0) in the cell.
9	Holding or attending village/VHSNC meeting	If ASHA has held or attended at least one village/VHSNC meeting in last one month then she should be considered as active on this task and you can mark (1) in the respective cell.
10	Successful referral of the IUD, female sterilization or male sterilization cases and/or providing OCPs/Condoms	Ask ASHA about the no. of eligible couples for family planning in her area. ASHA would be considered functional if she has successfully referred 1 or more IUD/female sterilization/male sterilization cases in last one month **and/or** ASHA has provided Oral contraceptive pills (OCP) and Condoms (CC) to couples in last one month. Referral would be considered as successful if people who were counseled by ASHA for use of family planning measures actually got the procedure done. Mark (1) in case of a successful referral and/or if she has provided OCP and CCs.
11	**Total of number of tasks on which ASHA reported being functional**	Total of all the rows from 1-10 for every ASHA (column)
12	**Total number of ASHAs who are functional on at least 6/10 tasks**	Total number of ASHAs who get a total of 6 or above in the 11th row. **It is very important to note that if some of the ASHAs do not have any potential beneficiary requiring her services for any task during last month then she should not be marked as non functional for those tasks. In such cases you have to reduce the total number of tasks against which her functionality is being judged for that month.** Eg- If an ASHA does not have any TB patient and also does not live in a malaria endemic area then total number of tasks she is expected to perform reduces from 10 to 8 for that month. If she is functional on five out of eight (5/8) tasks then she would considered equivalent to ASHAs who are functional on 6 or 7 or 8 or 9 or 10 tasks out of the original list of ten tasks. You should then add her along with other AHSAs functional on at least 6/10 tasks in the last cell of the 12th row.

Step 2

Reporting Format 2 and forwarding it to the Block Community Mobilizer/Coordinator.

Format 2 Reporting format for ASHA Facilitators - Consolidation of the functionality numbers			**Date -**	
A	**Total no.of ASHAs under the facilitator**			
		Total no. of ASHAs functional	Total no. of ASHAs who did not report/not known	Remarks
1	Newborn visits within first day of birth in case of home deliveries			
2	Set of home visits for newborn 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 diarrhea and pneumonia			
6	Household visits with nutrition counseling			
7	Fever cases seen/malaria slides made in malaria endemic area			
8	Acting as DOTS provider			
9	Holding or attending village/VHSNC meeting			
10	Successful referral of the IUD, female sterilization or male sterilization cases and/ or providing OCPs/Condoms			
11	**Total number of ASHAs who are functional on at least 6/10 tasks**			

Example for filling the functionality format –

There are 3 ASHAs under facilitator (A) and the data was collected during the review meeting held on 15th of March, 2012.

Example Format 1 for ASHA facilitators – To record functionality of ASHAs under each facilitator	**Date –15/03/2012**

	ASHAs	1	2	3	Total no. of ASHAs functional on each task
1	Newborn visits within first day of birth in case of home deliveries	1	0	1	2
2	Set of home visits for newborn care as specified in the HBNC guidelines (six visits in case of Institutional delivery and seven in case of a home delivery)	1	0	1	2
3	Attending VHNDs/Promoting immunization	1	1	1	3
4	Supporting institutional delivery institution	0	1	1	2
5	Management of childhood illness – especially diarrhea and pneumonia	1	0	1	2

	ASHAs	1	2	3	Total no. of ASHAs functional on each task
6	Household visits with nutrition counseling	0	0	1	1
7	Fever cases seen/malaria slides made in malaria endemic area	0	1	NA	1
8	ASHAs acting as DOTS provider	0	1	NA	1
9	Holding or attending village/VHSNC meeting	1	0	1	2
10	Successful referral of IUD/female sterilization/male sterilization cases and/or providing OCPs/Condoms	1	0	1	2
11	**Total of number of tasks on which ASHA reported being functional.**	**6**	**4**	**8**	
	Total Number of ASHAs who are functional on at least 6/10 tasks				**2**
	Remarks			No TB and Malaria cases in her area – Total No. of tasks – 8 (not 10) for this period	

1. Visits within first day of birth in case of home deliveries

i. **ASHA 1:** There were 3 newborns in last one month who were delivered at home and ASHA 1 visited all three of them on the first day of birth.

ii. **ASHA 2:** Only 1 out of 3 newborns who were delivered at home was visited on the first day of birth while the other two were visited for the first time on third day of birth.

iii. **ASHA 3:** ASHA 3 had reported two home deliveries in her area in last one month and had was visited both these newborns on the first day of birth.

2. Set of home visits for new born care as specified in the HBNC guidelines

i. **ASHA 1:** All five newborns were visited as per schedule.

ii. **ASHA 2:** ASHA visited two of the three newborns but did not follow the schedule of visits as per the HBNC guidelines in one case.

iii. **ASHA 3:** One out of two newborns was visited as per schedule.

3. Attending VHNDs/Promoting immunization:

All 3 ASHAs reported attending the VHND held in her village in the last month.

4. Supporting institutional delivery

i. **ASHA 1:** There were three pregnant women with their EDD in April, 2012 and has made birth plans with only two of them.

ii. **ASHA 2:** Of the two pregnant women who have their EDD in April, 2012. ASHA has made birth plan with both of them.

iii. **ASHA 3:** Only one pregnant woman has her EDD in the month of April, 2012 and ASHA has made the birth plan with this woman. Though there are other two pregnant women in her area but their EDD is after three months.

5. Management of childhood illness

i. **ASHA 1:** Of the total 4 sick children, families of two children sought her advice for care of their children.

ii. **ASHA 2:** Out of five cases of childhood sickness, only two families sought ASHA's advice for treatment/care of their children.

iii. **ASHA 3:** ASHA was contacted by all three families whose children had any illness in last one month.

6. Household visits with nutrition counseling

i. ASHA 1 – ASHA reported three households which has children with moderate malnutrition but she visited only two of

such households for nutrition counseling in last one month.

ii. **AHSA 2:** Though there were two households with children 9 months of age and one household with a child with severe malnutrition, ASHA did not make any household visit in last one month.

iii. **ASHA 3:** Of the two households from marginalized sections and one household with a child of 3 months age, ASHA visited all of them in last one month.

7. *Fever cases seen/malaria slides made in malaria endemic area*

i. **ASHA 1:** Made slides in one out of four fever cases.

ii. **ASHA 2:** Made slides for two out of three fever cases.

iii. **ASHA 3:** Her area is not a malaria endemic zone and there were no such cases in last one month.

8. *ASHAs acting as DOTS provider*

i. **ASHA 1:** Not acting as DOTS provider but has 2 TB patients in her area.

ii. **ASHA 2:** Acting as DOTS provider for the recently diagnosed TB patient in her area.

iii. **ASHA 3:** Not applicable as there are no TB patient in her area.

9. *Holding or attending village/VHSNC meeting*

Of the 3 ASHAs, 2 ASHAs are active on this front and have conducted/attended one meeting each in last month. ASHA No, 2, did not conduct any village level meeting in this period.

10. *Successful referral of IUD/female sterilization/male sterilization cases*

i. **ASHA 1:** Successfully referred one case of IUD and 1 case of female sterilization.

ii. **ASHA 2:** Referred two cases for IUD insertions but none of the couple got the procedure done.

iii. **ASHA 3:** Could not refer any case successfully for IUD/female or male sterilization but has provided OCPs to two of the eligible couples in last one month.

Based on format 1, the ASHA facilitator will compile the data in format 2 as give below:

Example Format 2 Reporting format for ASHA Facilitators - Consolidation of the functionality numbers			**Date – 15/03/2012**
A	**Total no. of ASHAs under the facilitator**	**3**	
		Total no. of ASHAs functional	Total no. of ASHAs who did not report/ not known
B	**No.of ASHAs functional on -**		
1	Newborn visits within first day of birth in case of home deliveries	2	
2	Set of home visits for newborn care as specified in the HBNC guidelines	2	
3	Attending VHNDs/Promoting immunization	3	
4	Supporting institutional delivery	2	
5	Management of childhood illness – especially diarrhea and pneumonia	2	
6	Household visits with nutrition counseling	1	
7	Fever cases seen/malaria slides made in malaria endemic area	1	
8	ASHAs acting as DOTS provider	1	
9	Holding or attending village/VHSNC meeting	2	
10	Successful referral of the IUD, female sterilization or male sterilization cases and/or providing OCPs/Condoms	2	
C	**Total no. of ASHAs who are functional on at least 6/10 tasks**	**2**	

Note: In the above example ASHA – 3 did not have any Malaria and TB cases in her area, so the total no. of tasks out of which her functionality is to be determined becomes 8 and not 10. In this case, we find that she is active on all 8 tasks and therefore count her equivalent to the ASHA who is functional on 6 out of 10 tasks. In case she had been active on 5 or 6 or 7 or 8 tasks then also we could count her as being equivalent to the ASHA who are functional on at least 6 out of 10 tasks.

Step 3

The data from all the facilitators will then be compiled by the Block Community Mobilizer/ Coordinator every month. At the end of each quarter the Block Community Mobilizer/Coordinator will take an average for functionality of ASHAs on each task under each ASHA facilitator (Format 3). Eg- If in this quarter, out of 20 ASHAs under facilitator (1), 5 ASHAs were functional on Newborn visits in first month, 7 in 2nd month and11 in 3rd month, then Block Community mobilize/Coordinator will take an average and report 8 ASHAs being functional on this task under facilitator (1) .

Thus Block coordinators will calculate average number of AHSAs functional on each task under each ASHA facilitator. These average numbers of ASHAs functional under each facilitator will then be added task wise - to give a final figure of number of ASHAs in the block who are functional on each task and on at least 6/10 tasks. This report will then be submitted to the District Coordinator/ nodal person on a quarterly basis.

Format - 3 for Block Consolidation of the functionality status

	Facilitator 1	1st month	2nd month	3rd month	Average
	Number of ASHAs functional on -				
1	Newborn visits within first day of birth in case of home deliveries				
2	Set of home visits for newborn care as specified in the HBNC guidelines				
3	Attending VHNDs/Promoting immunization				
4	Supporting institutional delivery				
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 or attending village/VHSNC meeting				
10	Successful referral of the IUD, female sterilization or male sterilization cases and/or providing OCPs/Condoms				
11	**Total number of ASHAs who are functional on at least 6/10 tasks**				
12	**Total Number of ASHAs who did not report/not known**				

Reporting Format - 4 for Block Consolidation of the functionality status

		Facilitator 1	Facilitator 2	Facilitator 3	Facilitator 4	Total for the block
	Average Number of ASHAs functional on -					
1	Newborn visits within first day of birth in case of home deliveries					
2	Set of home visits for newborn care as specified in the HBNC guidelines					
3	Attending VHNDs/Promoting immunization					
4	Supporting institutional delivery					
5	Management of childhood illness – especially diarrhea and pneumonia					
6	Household visits with nutrition counseling					

		Facilitator 1	Facilitator 2	Facilitator 3	Facilitator 4	Total for the block
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 the IUD, female sterilization or male sterilization cases and/or providing OCPs/Condoms					
11	**Total no. of ASHAs who are functional on at least 6/10 tasks**					
12	**Total No. of ASHAs who did not report/ not known**					
13	**Total no. of ASHAs under each facilitator**					

District Coordinator will consolidate the data sent by Block Community Mobilizers/Coordinators on a quarterly basis in a format designed for them.

Note: that non reporting ASHAs or non reporting facilitators would be counted as non functional.

Step 4

The District coordinator will consolidate and grade the blocks in four grades quarterly based on the functionality of ASHAs on every task in each block (Format 5). The criteria for grading of blocks are defined as –

a. **Grade A:** Blocks where of the total ASHAs >75% ASHAs are functional on each of the tasks 1-10 and the total of at least 6/10 tasks.

b. **Grade B:** Blocks where of the total ASHAs 50-75% ASHAs are functional on each of the tasks 1-10 and the total of at least 6/10 tasks.

c. **Grade C:** Blocks where of the total ASHAs 25-49% ASHAs are functional on each of the tasks 1-10 and the total of at least 6/10 tasks.

d. **Grade D:** Blocks where of the total ASHAs <25% ASHAs are functional on each of the tasks 1-10 and the total of at least 6/10 tasks.

Format 5 – for District Coordinator – Functionality of ASHAs in Blocks

		Block 1		Block 2	
	Percentage of ASHAs functional on – **(Number of functional ASHAs/total number of ASHAs) X 100**	**% of ASHAs**	**Grade of block**	**% of ASHAs**	**Grade of block**
1	Newborn visits within first day of birth in case of home deliveries				
2	Set of home visits for new born care as specified in the HBNC guidelines				
3	Attending VHNDs/Promoting immunization				
4	Supporting institutional delivery				
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 or attending village/VHSNC meeting				
10	Successful referral of the IUD, female sterilization or male sterilization cases and/or providing OCPs/Condoms				
11	**Total no. of ASHAs who are functional on at least 6/10 tasks**				

Step 5

At state level data for all districts will be collected and consolidated on a quarterly basis. Districts will be graded based on the grades of blocks using the criteria –

a. **Grade A:** Districts where of the total blocks >75% blocks are graded A + B based on ASHAs functionality on the total of at least 6/10 tasks.

b. **Grade B:** Districts where of the total blocks 50-75% blocks are graded A + B based on ASHAs functionality on the total of at least 6/10 tasks.

c. **Grade C:** Districts where of the total blocks <50% blocks are graded A + B based on ASHAs functionality on the total of at least 6/10 tasks.

B. Outcomes of the ASHA Programme

Block wise data for outcomes of the ASHA programme will be collated from the HMIS on annually and quarterly basis by District Coordinators. This would help the programme managers to map the level of functionality of ASHAs with the following outcomes for every block.

C. ASHA data base and training registers

These will be maintained at block and district levels by the nodal officers on a yearly basis. These would help in maintaining a comprehensive record of all the ASHAs working in the district as well as drop outs from the programme. **These data bases are explained in this section to inform the facilitators about the type of data that needs to be maintained for every ASHA for effective programme monitoring. However facilitators have no direct role in maintaining these databases.**

(i) ASHA Data base register

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

Format 6 – District Consolidation of the outcomes

	Blocks	Block 1	Block 2	Block 3	Block 4	Block 5
1	Percentage of newborns weighed					
2	Percentage of babies breast fed in first hour of birth					
3	Percentage of Low birth weight babies					
4	Percentage of children who have received full immunization					
5	Percentage of children who have received measles immunization					
6	Percentage of immunization session where ASHA was present					
7	Percentage of women who received 3 ANCs					
8	Percentage of Institutional deliveries					
9	Percentage of JSY payments for I.D.					
10	Percentage of ASHAs who have got incentive under JSY					
11	VHSC fund utilization					
12	No. of children admitted for respiratory infection					
13	No. of children treated for diarrhea/dehydration					
14	Reported still birth					
15	Reported still birth rate					
16	Reported perinatal mortality					
17	Reported neonatal mortality					

Format 7 – ASHA Data base register		Date -		
	Number of ASHAs	1	2	3
1	ASHA Name			
2	Village Name			
3	Name of ANM in charge			
4	Age			
5	Education level			
6	Caste			
7	Marital status			
8	Other sources of income			
9	Date of appointment of ASHA			
10	Date of filling the register			
11	Letter from panchayat			
15	ID card issued			
12	Certificate for any skill, if issued. Date of issue of certificate.			
13	Bank account number			
14	Date of cessation from ASHA work			
15	Reasons for dropout[3]			
	Remarks			

Block community mobilizer/coordinators will also maintain data on –

i. Number of villages without an ASHA in the block.

ii. Number of ASHA who cover a population greater than 1500 in the block.

b. District Coordinators will consolidate data from all blocks and maintain the register on a yearly basis. However in case of any drop out the state officials should be notified of the change of status.

c. At State level– Based on the data collected at block and district levels the following information will be compiled at state level for all districts of state -

i. Total number of ASHAs

ii. Number of drop outs in the 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

(ii) ASHA Training Register

A. At block level – For every block training register will be maintained by the Block Community Mobiliser for all the ASHAs. He/she will also prepare a consolidated status of the training in the block on a quarterly basis. (Format 8 & 9).

3 Any ASHA is to be considered as drop out if – She has submitted a letter of resignation 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 that she is indeed not active. If there is a genuine problem, she should be supported until it is overcome through the ASHA Facilitators, 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.

Format 8 – ASHA Base register format for Block Community Mobiliser					
Date of filling the register-					
	ASHA Name				
1	Village Name				
2	No. of training days completed so far				
3	No. of training rounds attended so far				
4	Completed training of Module 5 or state equivalent				
5	Pass/fail in the training of Module 5 P/F				
6	Completed training of Round 1 of Module 6 & 7 or state equivalent				
7	Pass/fail in the training of Round 1 of Module 6 & 7 P/F				
8	Completed training of Round 2 of Module 6 & 7 or state equivalent				
9	Pass/fail in the training of Round 2 of Module 6 & 7 P/F				
10	Completed training of Round 3 of Module 6 & 7 or state equivalent				
11	Pass/fail in the training of Round 3 of Module 6 & 7 P/F				
12	Completed training of Round 4 of Module 6 & 7 or state equivalent				
13	Pass/fail in the training of Round 4 of Module 6 & 7 P/F				

Format 9 – Training register format for Block Community Mobilizer		
	Date of filling the register-	Block 1
1	Number of training workshops required by state norms	
2	Number of training workshops held	
3	Number of ASHAs trained in Module 5 or state equivalent[4]	
4	Number of ASHAs trained in Round 1 of Module 6 & 7 or state equivalent	
5	Number of ASHAs trained in Round 2 of Module 6 & 7 or state equivalent	
6	Number of ASHAs trained in Round 3 of Module 6 & 7 or state equivalent	
7	Number of ASHAs trained in Round 4 of Module 6 & 7 or state equivalent	
8	Number of ASHAs who were evaluated – (Specify the module)	
9	Of the ASHAs evaluated, Number of ASHAs who failed in the training (Specify the module)	
10	Of the ASHAs evaluated, Number of ASHAs who passed in the training (Specify the module)	

4 If there is a state equivalent for Module 5 or 6 or 7 then enter numbers against the respective modules and specify the modules.

b. At District level – A similar training register (Format 10) will be maintained by the district coordinator.

Format 10 – Training register format for Block Community Mobilizer				
	Date of filling the register-	Block 1	Bock 2	Total
1	Number of training workshops required by state norms			
2	Number of training workshops held			
3	Number of ASHAs trained in Module 5 or state equivalent			
4	Number of ASHAs trained in Round 1 of Module 6 & 7 or state equivalent			
5	Number of ASHAs trained in Round 2 of Module 6 & 7 or state equivalent			
6	Number of ASHAs trained in Round 3 of Module 6 & 7 or state equivalent			
7	Number of ASHAs trained in Round 4 of Module 6 & 7 or state equivalent			
8	Number of ASHAs who were evaluated – (Specify the module)			
9	Of the ASHAs evaluated, no. of ASHAs who failed in the training (Specify the module)			
10	Of the ASHAs evaluated, no. of ASHAs who passed in the training (Specify the module)			

c. At State level – A consolidated report for the entire state will be prepared in the following format 11.

Format 11 for State level– Training Status				
Date of filling the register-	District 1	District 2	District 3	Total
Percentage of selected ASHAs who are trained in				
Module 5 or state equivalent				
Round 1 of Module 6 & 7 state equivalent				
Round 2 of Module 6 & 7 or state equivalent				
Round 3 of Module 6 & 7 or state equivalent				
Round 4 of Module 6 & 7 or state equivalent				

ANNEXURE 1

Calculation of Beneficiaries

Data Requirements for Calculation of Beneficiaries

Population of the area and the Birth Rate are required:

- Use the Birth rate. If local not known, the district- level, state- level, National-level figures can be used (in order of preference). Preferably use DLHS, NFHS or Authentic Survey report.
- Use the latest census report to know the exact population of the area under your jurisdiction.

With these two data we can calculate the expected beneficiaries:

1. Number of Pregnant women
2. Number of Live births
3. Number of Neonatal deaths
4. Number of Infants
5. Number of maternal complications cases
6. Number of Referrals

Maternal Mortality Ratio cannot be calculated at the District level since the denominator needs 100000 live births. Hence special surveys are done to determine the Maternal Mortality Ratio.

Calculations

- Multiply the birth rate (per 1000 population) with the population of the area, and then dividing it by 1000.
- As some of the pregnancies may not result in a live-birth (i.e. abortions and stillbirths may occur), the expected number of live births is an underestimation of the total number of pregnancies. Hence, a correction factor of 10% is required, i.e. add 10% to the figure obtained above.
- This will give the total number of expected pregnancies.

Calculations of Pregnancies

Birth rate of Rural Orissa = 22.2/1000 population (SRS 2008)

Population under each ASHA = 1000

Therefore, expected number of live-births = (22.2 x 1000)/1000 = 22.2 births

Correction factor = 10% of 22.2 (i.e. [10/100] x 22.2) = 2.22

Therefore, total number of expected

Pregnancies in a year under one ASHA = 22.2 + 2.22 = 24.42 = 24.44–25 per year

Calculation of Live Births and Referrals

Birth rate = 22.2/1000 population

Population under each ASHA = 1000

Therefore, expected number of live-births = (22.2 x 1000)/1000 = 22.2 births annually under each ASHA.

Hence number of newborns per month = 22.2/12 = 2/mth.

Estimated Maternal Complications is 15% approx.

Hence number of mothers with complications in Pregnancy, Delivery and Post Partum are: Number of pregnant women x 15%.

Number of pregnant women with one ASHA = 24

Number of pregnant women with complications = 24 x 15% = 3.6–4.0 with each ASHA annually.

Hence the expected number of women for Referral in Pregnancy, Delivery and Post Partum are = 4.

Calculation of Infant Deaths

IMR Orissa Rural: 71/1000 live births (SRS 2008)

NMR can be approximately calculated as 2/3rd of the IMR; Hence NMR: 71/1000 (Two third) = 47 approx.

Annual live births in a year at 1000 population or

under one ASHA = 22.

Total number of Annual live births at 5000 population or in each Subcentre = 22 x 5 = 111.

Calculations

Hence number of Infant deaths is equal to number of births annually x IMR and divide by 1000 = 111 x 71/1000 = 7.881 = 8 infant deaths annually at a Subcentre.

Hence Number of Infants = Total number of live births – Infant deaths = 111 – 8 = 103 at a Subcentre.

Hence number of Neonatal deaths is number of births annually x NMR and divide by 1000 = 111 x 47/1000 = 5.217 = 5 neo natal deaths annually at a Subcentre.

Per ASHA: 1-2 Infant deaths annually.

Indicative Figures used for calculations

- Age distribution:
  - 0 to 1 year: 2 to 3%
  - Upto 6 years: 14 to 18 %
  - Upto 14 years: 30 to 35 %.
- Eligible couples: 17%
- Maternal danger Signs: 15%
- Caesarian Rate: 5%
- Neonatal Danger signs: 10 to 12%.

Calculation of Sex Ratio

Requirements

Population of the area: Latest census report.

Sex Ratio = Number of Females per 1000 males in a given population.

Calculations: Multiply the number of females by 1000 and divide by number of males.

Example: Population of Females = 98324.

Population of Males = 114003.

Sex Ratio = 98324 x 1000 = 862.

114003

Use of Calculations for ASHA Facilitators

Some examples

1. Ante-natal care coverage

To find out: How wide is the coverage of antenatal care?

Hence: Percent of pregnancies in the area that received antenatal care:

$$= 100 \times \frac{\text{No. of pregnancies received antenatal care}}{\text{Total number of pregnancies}}$$

Data Sources:

No. of pregnancies received antenatal care- Reports from MPR.

Total no. of pregnancies- Not easily available in service data since all pregnant women are not registered.

Use expected no. of pregnancies instead

This can be estimated from total estimated births adjusted by a factor since all pregnancies do not result in live births. (10% wastage of pregnancy due to Abortions/Still births).

(Assuming that 110 pregnancies result in 100 live births).

An ASHA Facilitator has this data from 20 ASHAs under her:

Example:

No. of pregnant women getting Antenatal care reported in one year = 244.

Population = 20,000.

Crude birth rate (CBR - from SRS 2008) = 22.2 per thousand.

Estimated births in one year = 20000 x 22.2/1000 = 444.

Hence number of pregnancies = 444 +

(10% of 444) = 444 + 44 = 488.

Percent Covered = 100 x (244/488) = 50%.

2. Institutional Delivery Coverage

To find out: How wide is the coverage of institutional delivery care?

Hence: ~~Percent of all deliveries in the~~ area that are conducted in institutions:

$$= 100 \times \frac{\text{No. of deliveries in institutions}}{\text{Total number of deliveries}}$$

Data Sources:

No. of deliveries in institutions - Reports from institutions or from ASHA register.

Total no. of deliveries - Not easily available in service data since all pregnant women are not registered.

Hence **Use expected no. of deliveries instead**

This can be estimated from total estimated population and the crude birth rate (CBR).

Estimated population is available from population projections and CBR from the SRS

Thus, three sources are used; service statistics, population projections and SRS.

An ASHA Facilitator has this data from 20 ASHAs under her:

No. of institutional deliveries reported in one year (from service statistics) = 350.

Population = 20,000

Crude birth rate (CBR- from SRS 2008) = 22.2 per thousand.

Estimated births in one year = 20000 x 22.2/1000 = 444.

Number of pregnancies =444 + 10% of 444 = 444 + 44 = 488.Percent of institutional delivery = 100 x (350/488) = 71.7%.

ANNEXURE 2

Checklist for Home Visits

Checklist for ASHA Facilitators for Accompanying ASHAs during Home Visits		
	Name of PHC	
	Name of Subcentre	
	Name of village	
	Name of ASHA	
	Date of visit	

	Parameters	Assessment Yes/No/ Partial	Remarks
Assessing Ante natal care priorities during Home visit to Pregnant Women			
1	Did ASHA help the woman in carrying out the Pregnancy Test as per instructions		
2	Did ASHA help the family in making Birth Plan, including details of choice of institution for delivery? *(See annexure 6 for your reference)*		
3	Did ASHA ensure at least 4 Antenatal checkups and two doses of TT?		
4	Did ASHA check the number of IFA tablets remaining?		
5	Did ASHA counsel the women on danger signs of antenatal period?		
6	Did ASHA counsel the woman on adequate nutrition and diet?		
Assessing Newborn care priorities during Home visit to Postnatal Mothers/Newborns and Sick Newborn			
1	Did ASHA ask about the number of times mother is taking full meals?		
2	Did she ask for danger signs of post partum period for the mother?		
3	Did ASHA ask about/observe the mother/family for their hygienic practices in handling the baby?		
4	Did ASHA ask about breast feeding practices and any problems related to breast feeding?		
5	Did ASHA wash her hands before examining the baby?		
6	Has the newborn been given BCG and Zero dose of OPV?		
7	Did ASHA weigh the new born and record its weight?		
8	Did ASHA take the temperature of the newborn and record it?		
9	**Did ASHA demonstrate the correct way of :**		
i	Positioning for breast feeding		
ii	Hand washing		
iii	Wrapping of baby		
10	Did ASHA examine the newborn for any signs of illness and sepsis?		
11	In case of sepsis, did ASHA give Cotrimoxazole correctly and refer the newborn for treatment? *(See Annexure 6 of ASHA Module 7 for dosage of medicines)*		
12	If the newborn is a high risk baby then what actions has ASHA taken in case of any abnormal condition of the baby? *(Refer to Annexure 10 for the actions to be taken by ASHA in case of a high risk baby)*		
13	Did ASHA ask all the points from the home visit form incase of a normal newborn *(see Annexure 9 and Annexure 10 for your reference)*		

	Parameters	Assessment Yes/No/ Partial	Remarks
14	Has the ASHA been doing the home visits as per schedule for a normal newborn (Six visits incase of institutional delivery and seven visits incase of home delivery) and/or a high risk baby (13 visits)?		
15	Has ASHA clearly informed the family on danger signs of diarrhea, pneumonia and sepsis?		
16	Does the family/mother know what is to be done in case of diarrhea, pneumonia and sepsis?		
Assessing identification of malnutrition and appropriate action during Home visit to a malnourished child			
1	Did ASHA ask about the child feeding practices of the family?		
2	Did AHSA counsel on importance of complimentary feeding and continued feeding during any illness?		
3	Did ASHA counsel the mother on measure to prevent any illness?		
4	Did ASHA ensure that child is enrolled with the AWC and is receiving adequate supplementary food?		
5	Did ASHA weigh the child and record it in the growth monitoring form? (to see the status and progress of the child)		
6	Did ASHA examine the child for signs of anemia? In case of anemia did she give pediatric dose of iron to the child?		
7	In case of moderate or severe malnutrition and/or anemia, did ASHA give Albendazole to the child in correct doses? *(See Annexure 6 of ASHA Module 7)*		
8	Did ASHA refer the child with moderate or severe malnutrition?		
Assessing identification of danger signs and appropriate action during Home visit to a sick child			
1	Did ASHA ask about the signs of illness of the child?		
2	Was ASHA able to categories the severity of the illness based on her examination and take appropriate actions according to the condition of the child?		
3	Did ASHA give Cotrimoxazole in correct doses to the child with Acute respiratory infections? Did ASHA refer the child? *(See Annexure 6 of ASHA Module 7)*		
4	In case of diarrhea, did ASHA inform the family on how to prepare ORS form the packet and also home based ORS?		
5	For diarrheal cases did ASHA inform the family on the correct amount and frequency of the ORS to be given?		
6	Did ASHA counsel the family on feeding practices during illness?		
7	Did ASHA counsel the family on measures to prevent recurring illness?		
Assessing Communication on whether the caregiver has understood the messages (Give Information, Show example, Let her Practice and let her repeat the instructions)			
1	Did ASHA greet the family properly/build rapport?		
2	Is the counseling provided by ASHA relevant to the needs of the beneficiary?		
3	Caregivers were asked clearly for regarding the danger signs?		
4	Has ASHA identified referral sites for mother and baby?		

	Parameters	Assessment Yes/No/ Partial	Remarks
5	Has the ASHA identified appropriate referral transport for referrals?		
6	Has ASHA informed the ANM and AWW about the special health needs of the beneficiaries?		
Assessing the Quality of services			
1	Weighing machine in order		
2	Weight taken properly		
3	Thermometer working accurately		
4	Temperature recorded correctly		
Issues related to Record Keeping			
1	Does ASHA update her Village Health Register after every home visit?		
2	Does ASHA have a list of pregnant, post natal mothers and neonates?		
3	Does ASHA have a list of immunized, partially immunized and unimmunized children?		
4	Does ASHA have a list of malnourished children?		
5	Does ASHA have a list of eligible couples for family planning?		

Analysis sheet from the check list

Problems with ASHAs	Issues	Names of ASHAs
Problem that are common across many ASHAs		
Specific problems		

ANNEXURE 3

VHND Checklist

Checklist for ASHA Facilitators for VHNDs			
	Name of block		
	Name of PHC		
	Name of Subcentre		
	Name of village		
	Name of ASHA		
	Date of visit		
S. 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 anemia using Hemoglobinometer		
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?		
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 – 2 years of age?		
5	Did AWW give take home rations to adolescent girls?		
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 (Sphygno manometer) was working accurately		
5	Supplementary food was available		
6	Hemo globino meter was working accurately (to test for Anaemia)		
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 at least 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?		
3	Were VHSNC members present during VHND?		
4	Was group meeting held with adolescent girls during or after VHND?		

ANNEXURE 4

Checklist for Cluster Meeting

Checklist for ASHA Facilitators for cluster meeting			
	Name of block		
	Name of PHC		
	Name of Subcentre		
	Name of village		
	Name of ASHA		
	Date of visit		
	Parameters	Assessment Yes/No/Partial	Remarks
Support during Ante natal period			
1	Is the ASHA regularly making visits to the house holds with pregnant women?		
2	Has she helped in making birth plans for all the pregnant women in her area?		
3	Has she helped in making arrangements for transport at the time of delivery in all the cases?		
4	Has she counseled all of the pregnant women for ANC?		
Support during intra partum and post partum period			
1	Did the ASHA support to the institutional delivery (ensured ANC, counseling, birth plan) or escort the women to the institution?		
2	Has all the beneficiaries received JSY money (institutional and home delivery)?		
3	Has ASHA made the Post natal visits to all the households with recent delivery?		
4	Has ASHA visited all the newborns as per the HBNC schedule (seven visits in case of a home delivery and six visits in case of an institutional delivery)		
5	Has ASHA counseled all the women who recently delivered on suitable family planning methods?		
6	Has ASHA referred all the newborns who were sick and needed care?		
7	Has she received her JSY incentive for all the cases promoted and escorted by her?		
Family Planning			
1	Does she have a list of all the eligible couples in her area?		
2	Has she successfully referred couples for IUD and/or female or male sterilization?		
3	Is she providing OCP and CC to the couples in her area?		
Management of Childhood illnesses			
1	Has she made home visits to families with sick child (0-5 yrs of age)?		
2	Did she provide appropriate advice to the family/mother for care of the child – this may include giving medicines and/or referral?		

	Parameters	Assessment Yes/No/Partial	Remarks
3	Was she able to identify the severity of the illness based on her examination?		
4	Did she counsel the family on continued feeding and measures for preventing illness?		
Identification of Malnutrition			
1	Has ASHA identified malnourished children in her area?		
2	Has she made home visits for counseling to these house holds?		
3	Did she ensure enrollment of these children at AWC?		
4	Has she referred all the children with moderate or severe malnutrition?		
5	Has she provided counseling and IFA tablets to all identified Anemic cases?		
Disease out break			
1	Has ASHA referred all the cases suspected for Leprosy?		
2	Has ASHA made slides for all fever cases?		
3	Has she given anti malarial drugs to these cases?		
4	Is she acting as DOTs provider for all the TB cases?		
VHSC			
1	Are the VHSC meetings conducted regularly?		
2	Are the untied funds received regularly?		
3	Have the funds been utilized?		
4	Was the Village health plan made?		
Immunization			
1	Was the VHND held in the last month?		
2	Did she encourage all those who needed services from ANM and/or AWW to attend the VHND?		
3	Did she get the incentive for ensuring immunization?		
4	Does she has a record of all the children due for immunization, partially immunized and fully immunized?		
5	Did VHSC member participate in all the VHNDs?		
Maternal and child death			
1	Was there any infant death in her area?		
2	Was ASHA able to identify the reasons for the infant death?		
3	Was there any maternal death in her area?		
4	Was ASHA able to identify the reasons for the maternal death?		
5	Did she notify ANM or you about all the deaths?		
Administrative Issues and Availability of Supplies			
1	Does she has a drug kit?		
2	Is there a stock out of any drug? (Check the Drug kit stock card-annexure 5)		
3	Is the drug kit refilled every month?		
4	Does she face any problem in refilling of the drug kit?		

	Parameters	Assessment Yes/No/Partial	Remarks
5	Does she has equipments – a) Weighing machine b) Thermometer – Digital c) Digital watch d) Warm bag e) Blanket small f) Mucus Extractor		
6	Immunization cards/MNH cards avialable		
7	Register available		
8	All formats (as per the Guidelines and Modules) available in adequate numbers		
9	Counseling material available (flipbook/cards)		
10	Are there any pending payments for more than 2 months?		
11	Are there any pending grievances of the ASHAs?		

ANNEXURE 5

Drug Kit Stock Card

Month & Date of Refill			(1)		(2)		(3)		(N)	
S. No.	Name of Drug	Symbol*	Balance	Refill given	Balance	Refill given	Balance	Refill given	Balance	Refill given
1										
2										
3										
4										
5										
'n'										

Balance: This is what was left in kit at the time of refill - after recovering explained drugs/supplies.

Refill: This is what was put into the kit.

*Symbol is a pictorial symbol that could be used to denote a drug, since often, the drugs comes labelled only in English.

Card is to be updated by person providing the refill.

ANNEXURE 6

Format for Individual Plans
(Birth Preparedness)

Name: Age:

Husband's name:

HH income

LMP

EDD

Past pregnancy history (Include abortion, if any):

Order of pregnancy	Date of delivery (Month and Year)	Place of delivery: Home, SC, PHC, CHC, DH, Private Nursing Home	Type of delivery: Natural, Forceps, C-section	Birth Outcome: Live Birth, Stillborn,	Age and Status of child currently	Any other complications: Fever, Bleeding
First						
Second						
Third						

- Any risk factors:
- Nearest SBA: Phone:
- Nearest 24X7 PHC: Distance: Time: Cost
- Nearest Sub-centre with a Skilled Birth Attendant
- Nearest CHC with facilities to manage complications: Distance: Time: Cost
- Distance to District Hospital:
- How much is transport going to cost?
- Is the vehicle fixed: Owner:
- Will we need extra money for the treatment? How to organise it?
- Who will take care of the children when mother goes to the facility?
- Who will accompany her to the facility?
- Where will they stay?
- How will they finance their stay?
- Have they organised clothes and blankets for the baby?

ANNEXURE 7

Delivery Form

(Fill in the form completely even in the case of a stillbirth)

1) When did ASHA arrive at the hospital/woman's home: Date:	**For Supervisor#**
Time: Hrs_____ Min_____ Early morning/morning/afternoon/evening/night	Correct/Incorrect
2) When did woman's mild labour pain starts? Date:	
Time: Hrs_____ Min_____ Early morning/morning/afternoon/evening/night	Correct/Incorrect
Look for the following danger signs and if present, shift mother immediately to hospital	Action taken

	Danger sign		
1) Delivery does not occur within 24 hrs of onset of mild labour	Yes/No		Yes/No/NA
2) Any part of the baby other than head comes out first	Yes/No		Yes/No/NA
3) Mother is having excessive bleeding	Yes/No		Yes/No/NA
4) Placenta is not delivered within 30 mins after delivery	Yes/No		Yes/No/NA
5) Mother is unconscious or is getting fits	Yes/No		Yes/No/NA

TBA/Neighbour or family member/Skilled Birth Attendant/Nurse/Doctor	Correct/Incorrect
Name: _____	Correct/Incorrect
3) Where was the delivery conducted?	Correct/Incorrect
Name of the village/town:_____	Correct/Incorrect
Home/Sub-centre/PHC/CHC/District Hospital/Private Hospital	Correct/Incorrect
4) Nature of delivery: Normal/Caeserian	Yes/No/NA
5) Which part of the baby's body came out first? Head/Cord/Other	Correct/Incorrect
6) Was the amniotic fluid thick and green/yellow? Yes/No	#: Mark 'Yes' if necessary and possible action has been taken without any mistake.
If yes, was the mouth cavity of baby cleaned with a gauze piece immediately after head came out? Yes/No	
7) When did the baby come out fully? Date:_____	
Record the time of birth: Early morning/morning/afternoon/evening/night	
Time: Hours:_____ Minutes_____ Seconds_____	
Name of the ASHA:_____ Date:_____	
Name of Trainer/Facilitator: _____	
Total Score: _____ Block Name: _____	

8) Immediate actions: Was action taken:	**For Supervisors#**
Dry the baby: Yes/No	Yes/No/NA
Cover the baby: Yes/No	Yes/No/NA
9a) Observe the baby at birth:	Was ASHA present when the baby came out?

	At 30 seconds	At 5 minutes	
a) Cry	No/Weak/Forceful	No/Weak/Forceful	
b) Breathing	No/Gasping/Forceful	No/Gasping/Forceful	Yes/No/NA
c) Movement of limbs	No/Weak/Forceful	No/Weak/Forceful	Correct/Incorrect

9b) Diagnosis - Normal/Stillbirth	Correct/Incorrect
9c) If stillbirth - Fresh/Macerated	Correct/Incorrect
10) Sex of the child: Male/Female	
11) Number of baby/babies born: 1/2/3	
12) **Actions:**	
Give the mother something to drink immediately after the delivery: Yes/No	Yes/No/NA
13) Time at which placenta came out fully? Hrs_____ Min_____	Correct/Incorrect
Immediate breastfeeding reduces mother's bleeding and helps to quicken delivery of placenta	
14) Actions:	
Cover the baby: Yes/No	Yes/No/NA
Keep close to mother: Yes/No	Yes/No/NA
Early and exclusive breastfeeding: Yes/No	Yes/No/NA
15) Special features/Comments/Observations, if any	Other Information #: Mark 'Yes' if necessary and possible action has been taken without any mistake
_____	
_____	

ANNEXURE 8

First Examination of the Newborn (Form)

(Examine one hour after the birth but in any case within six hours from the birth. If ASHA is not present on the day of delivery then fill the form on the day of her visit and write the date of her visit).

Part I:	**For Supervisor#**
1) Date of Birth_____	Correct/Incorrect
2) Pre-term cut-off date:_____ Is baby pre-term? Yes/No	
3) Date of first examination_____	First examination done
Time: Early morning/Morning/Afternoon/Evening/Night_____ Hrs_____	Days:____ Hrs: ____
4) Does mother have any of the following problems? a. Excessive bleeding Yes/No b. Unconscious/fits Yes/No	After birth Yes/No/NA
Action: If yes, refer immediately to hospital Action taken Yes/No	Correct/Incorrect
(In case of stillbirth, do not perform further examination but complete the examination of the mother as per home visit form on day 1, 3, 7, 14, 21, 28, 42)	Correct/Incorrect
5) What was given as the first feed to baby after birth?_____	
6) At what time was the baby first breastfed? Hrs_____ Min_____	
How did baby take feed? Mark ☑	
6.1) Forcefully	Correct/Incorrect
6.2) Weakly	Correct/Incorrect
6.3) Could not breastfeed but had to be fed with spoon	Yes/No/NA
6.4) Could neither breastfeed nor take milk given by spoon	Yes/No/NA
7) Does the mother have breastfeeding problem? Yes/No	
Write the problem_____	
If there is problem in breastfeeding, help the mother to overcome it	Correct/Incorrect
Part II:	
First examination of the baby	
1) Temperature of the baby (Measure in axial and record):_____	Correct/Incorrect
2) Eyes: Normal Swelling or oozing pus	Correct/Incorrect
3) Is umbilical cord bleeding: Yes/No	Yes/No/NA
Action: If yes, either ASHA, ANM or TBA can tie again with clean thread. Action taken: Yes/No	
Name of ASHA:_____ Date:_____ Name of trainer:_____ Total Score:_____	# Mark yes if necessary and possible action has been taken without any mistake
Block:_____	

4) Weight: Kg_____ Gm_____ Colour on scale: Red/Yellow/Green

5) Record ☑ ☒

1. All limbs limp	
2. Feeding less/stop	
3. Cry weak/stopped	

Routine Newborn Care Whether the task was performed	
1) Dry the baby	Yes/No
2) Keep warm, don't bathe, wrap in the cloth, keep closer to mother	Yes/No
3) Initiate exclusive breastfeeding	Yes/No

6) Anything unusual in baby? Curved limbs/Cleft lip/Other _____
_____

For Supervisors

Weighing matches with the colour?
Yes/No

Correct/Incorrect

Action taken?
Yes/No/NA
Yes/No/NA
Yes/No/NA

Yes/No

Yes/No

Yes/No

For Supervisor

Form checked by: Name:_____ Date:_____

Corrections: _____
_____
_____

Unusual or different observation:_____

Whether the form has been completed? Yes/No

Signature_____

ANNEXURE 9

Home Visit Form

(Examination of Mother and Newborn)

Ask/Examine Date of ASHA's visit	Day 1	Day 3	Day 7	Day 14	Day 21	Day 28	Day 42	Action by the ASHA	Supervisory Check	
A. Ask Mother									**Action Take**	
No. of times mother takes full meal in 24 hrs								If less than 4 times or if meals not full, advise mother to do so	Y/N	Y/N
Bleeding: How many pads are changed in a day								If more than 5 pads, refer mother to hospital		
During the cold season is the baby being kept warm (near mother, clothed and wrapped properly)	Yes/ No/NA	Yes/ No/NA	Yes/ No/NA	Yes/ No/NA	Yes/ No/NA	Yes/ No/NA	Yes/ No/NA	Advise the mother to do so, if not being done		
Is the baby being fed properly (whenever hungry or at least 7–8 times in 24 hrs)	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Advise the mother to do so, if not being done		
Is baby crying incessantly or passing urine less than 6 times a day	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Advise mother to feed the baby after every 2 hours		
B. Examination of Mother										
Temperature: Measure and record								Temperature up to 102 degree F (38.9 degree C) - treat with paracetamol, and if the temperature is above it, refer to hospital		
Foul-smelling discharge and fever more than 100 degree F (37.8 degree C)	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	If yes, refer the mother to hospital		

Ask/Examine Date of ASHA's visit	Day 1	Day 3	Day 7	Day 14	Day 21	Day 28	Day 42	Action by the ASHA	Supervisory Check	
Is mother speaking abnormally or having fits?	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	If yes, refer the mother to hospital		
Mother has no milk since delivery or if perceives breast milk to be less	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No			
Cracked nipples/painful and/ or engorged breast	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No			
C. Examination of Baby									**Action Take**	
Are the eyes swollen or with pus									Y/N	Y/N
Weight (on day 7, 14, 21, 28 and 42)										
Temperature: Measure and Record										
Skin: Pus filled pustules										
Cracks or redness on the skin fold (thigh/Axilla/Buttock)										
Yellowness in eyes or skin: Jaundice										

D. Check now for the following signs of sepsis: If sign is present mention - Yes, if it is absent, mention - No Record the observations on Day 1 from the first examination of newborn form

Ask/Examine	Day 1	Day 3	Day 7	Day 14	Day 21	Day 28	Day 42	Action by the ASHA	Action Take	
All limbs limp									Y/N	Y/N
Feeding less/Stopped										
Cry weak/stopped										
Distended abdomen or mother says 'baby vomits often'										

Ask/Examine	Day 1	Day 3	Day 7	Day 14	Day 21	Day 28	Day 42	Action by the ASHA	Action Take	
Mother says 'baby is cold to tough' or baby's temperature >99 degree F (37.2 degree C)										
Chest indrawing										
Pus on umbilicus										

Supervisor's note: Incomplete work/incorrect work/incorrect record/incorrect record

Name of ASHA:_____Date:_____

Name of Trainer/Facilitator:_____

ANNEXURE 10

Home Visit Form for the High Risk Baby

Home visit form (Examination of Mother and Newborn)-ASHA should make 13 visits								
Ask/Examine Date of ASHA's visit	**Day 2**	**Day 3**	**Day 4**	**Day 5**	**Day 6**	**Day 7**	**Action by the ASHA**	**Supervisory Check**
A. Ask Mother								**Action Take**
No. of times mother take full meal in 24 hrs							If less than 4 times or if meals not full, advise mother to do so	Y/N
Bleeding: How many pads are changed in a day							If more than 5 pads, refer mother to hospital	
During the cold season is the baby being kept warm (near mother, 2 clothed and wrapped properly)	Yes/ No/NA	Yes/ No/NA	Yes/ No/NA	Yes/ No/NA	Yes/ No/NA	Yes/ No/NA	Advise the mother to do so, if not being done	
Is the baby being fed properly (whenever hungry or at least7–8 times in 24 hrs)	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Advise the mother to do so, if not being done	
Is baby crying incessantly or passing urine less than 6 times a day	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Advise mother to feed the baby after every 2 hours	
B. Examination of Mother								
Temperature: Measure and record							Temperature up to 102 degree F (38.9 degree C) - treat with paracetamol, and if the temperature is above it, refer to hospital)	
Foul-smelling discharge and fever more than 100 degree F (37.8 degree C)	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	If yes, refer the mother to hospital	
Is mother speaking abnormally or having fits?	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	If yes, refer the mother to hospital	

Ask/Examine Date of ASHA's visit	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Action by the ASHA	Supervisory Check
Mother has no milk since delivery or if perceives breast milk to be less	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	If yes, take action for breast feeding management	
Cracked nipples/painful and/or engorged breast	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	If yes, take action for breast feeding management	
C. Examination of Baby								
Are the eyes swollen or with pus	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	If yes, ask mother to put tetracycline ointment in baby's eyes twice a day, for five days	Yes/No
Weight (on day 7, 14, 21, 28 and 42)							If weight gain every week after first week is less than 100 gm, then take action (for breastfeeding)	Yes/No
Temperature: Measure and Record							If baby's temperature is more than 99 degree Fahrenheit (37.2 degree Celsius), treat with Paracetamol If it is between 95.1–97 degree Fahrenheit (35.1–36.1 degree Celsius), ask mother to feed baby frequently, keep the baby warm If temperature of baby is less than 95.9 degree F (35.5 degree Celsius), do hypothermia management	Yes/No
Skin: Pus filled pustules	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No		Yes/No
Cracks or redness on the skin fold (thigh/Axilla/Buttock)	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Keep baby clean and dry	Yes/No
Yellowness in eyes or skin: Jaundice	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	If it is on the first day or beyond 14th day, then it is abnormal jaundice. Refer the baby to hospital	Yes/No

Ask/Examine Date of ASHA's visit	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Action by the ASHA	Supervisory Check
Give health education to the mother on day 2 Give high risk baby information sheet on day 2					Yes/No Yes/No	Give danger sign information sheet to parents on Day 2- Yes/No		
D. Sepsis Diagnosis: Check now for the following signs of sepsis: If sign is present mention - Yes, if it is absent, mention - No Record the observations on Day 1 from the first examination of newborn form								
All limbs limp							Consider the first three signs as criteria for diagnosing sepsis only if the sign was absent previously and then it newly developed	Yes/No
Feeding less/Stopped							If at least two criteria are present on the same day, diagnose as sepsis, and proceed with sepsis management	Yes/No
Cry weak/stopped								
Distended abdomen or mother says 'baby vomits often'								
Mother says 'baby is cold to touch' or baby's temperature >99 degree F (37.2 degree C)							Even if no sign is observed, ask the mother to keep a watch and call ASHA	Yes/No
Chest in-drawing							If only one sign is present, visit every day to check appearance of another sign. Meanwhile provide management for the existing problem (See the box at the bottom)	Yes/No
Pus on umbilicus								
Total number of criteria present								
Is it Sepsis		Yes/No	Yes/No	Yes/No	Yes/No	Yes/No		Yes/No Yes/No

Which management was accepted by the family? (Circle the correct answer)

1. No treatment 2. Referral 3. Other treatment (specify)

Note:

- For feeding problem, provide breast feeding management.
- For only chest in-drawing treat with cotra syrup.
- For the pus on umbilicus, treat with gentian violet paint.
- For hypothermia, provide hypothermia management.
- For fever, provide fever management.

If the baby's weight on 28th day is less than 2300 grams or weight gain over birth weight is less than 300 grams, continue to visit baby in 2nd month. Record the observations on the home visit form.

Supervisor's note: Incomplete work/Incorrect work/incorrect record/incorrect record

Name of ASHA:_____ Date:_____

Name of trainer/Facilitator:_____

ANNEXURE 11

Information from the family on infant death

Part A: From where did the ASHA Facilitator obtained information pertaining to the infant death?

1. Who gave the information…… Address ……
2. Date of reporting …… Time ……

Part B: Information regarding the infant death

1. Name of the village/area where infant death has taken place ……
2. Name of the Gram Panchayat …… Dev. Block …… District ……
3. Information about the infant
   a) Name of the deceased infant …… Sex ……
   b) Date of birth …… Time of birth ……
   c) Place of birth Home/Institution ……

   [If the birth has taken place in the institution then when were the mother and child discharged.
   a) Name of the mother …… Caste ……
   b) Number of children in the family …… Number of children alive ……
   c) Age of the interviewee …… Relation …… Employment ……
   d) Annual income of the family …… Total members in the family ……
   e) Family is BPL …… YES/NO ……
4. **Information on the Causes of deaths:**
   a) Date of death…… Age…… Place of death……
   b) Was the child ill before the death? Yes/No, if yes then for how many days did the child suffer from the illness ……?
   c) Was the child being treated for the illness? Yes/No, if yes then where did the treatment occur……? Who did the treatment …… if no, then specify the reason ……
   d) Was the ASHA/Aganwadi workers informed about this? Yes/No ……
   e) Was the child referred? Yes/No, if yes then did the family have an idea about this? Yes/No.
   f) Was a transport made available for the referral? Yes/No After what time was the treatment initiated?
   g) How much money was spent in the treatment?
   h) Cause of the death [according to the interviewee] ……
   i) Distance form the area – SHC …… PHC …… CHC ……
   j) Who are present in the area 1) ANM 2) Registered practitioner 3) Unregistered practitioner

Date……

Name of the facilitator……

ANNEXURE 12

Information from the family on maternal death

Part A: From where did the ASHA Facilitator obtained information pertaining to the maternal death?

1. Who gave the information…….. Address ……..
2. Date of reporting…….. Time ……..

Part B: Information regarding the maternal death

1. Name of the village/area where infant death has taken place……..
2. Name of the Gram Panchayat……..Dev.Block……PHC……. SHC……..District…….
3. Information about the woman
   a) Name of the deceased woman
   b) Name of husband/other (father, mother)
   c) Date of woman's death
   d) Age at death
   e) Gravida
   f) Para
   g) Abortions
   h) Previous stillbirths
   i) Living children
   j) Week of pregnancy (if applicable)
   k) Age at marriage
   l) Religion
   m) Caste

4. Information on the Causes of deaths:

a) Death during Antenatal Period

i. No. of antenatal check ups received

ii. Did she have any complications during antenatal period?…….

iii. Did she seek care for these complications? If yes, write the name of institution…….. and if no, then write the reasons for not seeking care……..

b) Death due to Abortion

i. Did she die while having an abortion or within 6 weeks after having an abortion?

ii. If during an abortion, was the abortion spontaneous or induced, including MTP?

iii. If induced, then how was the abortion done? Write the name of the institution…….. ?

iv. How many weeks of pregnancy completed at the time of abortion?

v. Was there any complication after abortion?

vi. Did she seek care for these complications? If yes, write the name of institution…….. and if no, then write the reasons for not seeking care……..

c) Death during Intra partum period

i. Where did the delivery take place?

ii. Time interval between onset of pain and delivery (in hours)

iii. How much time did it take to travel to the institution for delivery? What was the mode of transport used? Was there any delay in arranging the transport?

iv. Who conducted the delivery- if at home or in institution (Not applicable for transit delivery

v. Type of delivery – Normal/assisted/C- section

vi. Outcome of the delivery

vii. During the process of labor/delivery did the mother have any problems?

viii. Did she seek treatment, if yes by whom and what was the treatment given by the ANM/ Nurse/LHV/MO/others? (Give details)

ix. Was she referred? Did she go to the referral center? Was there any delay in arranging the transport while going to the referred institution? In case of non compliance to referral, state the reasons?

x. Was there any type of delay in getting care at the referral centre?

d) Death during Post partum period?

i. Where did the delivery take place?

ii. Type of delivery – Normal/assisted/C- section

iii. Outcome of the delivery

iv. During the process of labor/delivery did the mother have any problems

v. No. of Postnatal checkups

vi. Did the mother had any problem following delivery ?

vii. Did she seek care for these complications? If yes, where did she go for treatment (write the name of institution) and if not, then write the reasons for not seeking care. Also ask about the problems related to arranging the transport and time taken to reach the referred insitution?

Also note any other important information shared by the family and friends of the deceased woman.

Date ……

Name of the facilitator ……

ANNEXURE 13

Guidelines for Selection of ASHA

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 recruitment every year. States need to recruit 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 appointed. 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 100,000 or less, ASHAs will be selected as in rural 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 Extension Educator (BEE) or Block Medical Officer. The Bock 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 facilitators should be oriented to the selection process as part of their training in the Facilitator Handbook. Training the BCM and facilitator is the responsibility of the state ASHA Resource Centre (ARC).

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 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 . This should ensure their understanding of the roles and responsibilities of the ASHA, their involvement in the selection, and subsequent support to the ASHA. 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 District 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.