

| ASHA | Global Evidence | Recommendation |
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| <p><u>Roles and Responsibilities</u> create awareness on existing health services and the need for timely utilization of services.</p> <p>counsel women on MCH.</p> <p>mobilize the community and facilitate them in accessing health services.</p> <p>work with the Village Health & Sanitation Committee of the Gram Panchayat.</p> <p>escort/accompany pregnant women & children requiring treatment.</p> <p>provide primary medical care for minor ailments.</p> <p>act as a depot holder for ORS, IFA, chloroquine, DDK, Oral Pills & Condoms, etc.</p> <p>subsequently provide newborn care and management of a range of common ailments.</p> <p>inform about the births and deaths in her.</p> <p>promote construction of household toilets under Total Sanitation Campaign.</p> <p>Many of the activities envisaged for the ASHA actually overlap with those already assigned to the ANM/AWW.</p> <p>The ASHA is supposed to support the ANM/AWW on a part-time basis, and be guided/trained/supervised by them in her activities.</p> | <p>Global evidence indicates that CHWs are effective in delivering one or more of the following:</p> <p>increasing access to basic health services by bringing services to the doorstep of those in need.</p> <p>referring serious cases promptly.</p> <p>providing program support to over-burdened health facilities.</p> <p>mobilizing communities to enhance health-seeking behavior through effective information, education and communication (IEC).</p> <p>In all cases reviewed, the peer worker/CHW has been a full-time dedicated position.</p> | <p>ASHA needs to be a full-time worker.</p> <p>Overlaps between the roles of ANM and AWW and the ASHA need to be examined; and eliminated.</p> <p>It is important to identify a limited set of measurable goals that the ASHA will focus on achieving. The multiple activities currently envisaged, with diverse goals, will dilute the impact of the program. For example, in the states where ASHA workers will be deployed, if the overwhelming need is for increasing ANC and institutional delivery, then that could be the sole objective of the ASHA worker, for which she would be provided all necessary inputs (HBLSS training kits, referral transport fund, IFA etc.)</p> |
| <p><u>Selection</u> The basic criteria for an ASHA are being a woman volunteer with minimum education up to VIII class and that she would be a resident of the village.</p> | <p>CHWs typically share a similar background to those living in the neighborhoods they serve and, thus, serve as a bridge between medically vulnerable residents and primary care services.</p> | <p>The criterion of VIII class education is less important; the ASHA being a member of the community being served, and empathizing with their socio-cultural situation, is probably more critical.</p> |

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| <p><u>Training</u> After selection, ASHA will have to undergo series of training episodes. Considering range of functions, induction training may be completed in 23 days spread over a period of 12 months.</p> <p>Periodic re-training will be held for about two days, once in every alternate month.</p> <p>On the job support will be provided by ANM while she is conducting outreach sessions at the village level.</p> | <p>Training programs have generally been a combination of the following:</p> <p>In-service training - rigorous, and of fairly long duration, with intensive reinforcement of knowledge.</p> <p>Module-based training: several well accepted training modules have been developed for community-based care.</p> <p>Certification</p> <p>Twinning relationships</p> | <p>Given the pressure the ANM is already under in accomplishing all the tasks assigned to her, it seems unlikely that she will be able to provide the ASHA with technical support as well. Focusing the role of the ASHA will also help improve the focus and quality of training. Intensive induction training should be the starting point – spreading it over a year in bits and pieces means that the ASHA will be functioning for a substantial period without having been trained for many of her functions.</p> |
| <p><u>Monitoring</u> A list of process, outcome and impact indicators has been drawn up; data on these indicators would be self-reported, with the ASHA providing the data to the ANM at regular intervals. Methods for validating the data have not been described; follow-up, feedback and supervision appear to be the responsibility of the ANM.</p> | <p>Monitoring methodologies that have been used effectively include: supportive supervision, fostering a close relationship of troubleshooting and handholding between the supervisor and the CHW.</p> <p>using monitoring modules that include indicators, methods for achieving those indicators, have a training package associated etc.</p> <p>provider accountability, with remuneration tied to specific verifiable outcomes.</p> <p>community participation, whereby the community is actively in monitoring the activities of the CHW, and is responsible for ensuring that the CHW is provided with necessary support in order to perform satisfactorily.</p> | <p>Supportive supervision of the ASHA is essential – but who will provide it? Not the ANM, who is already overburdened. Could it be made the responsibility of the PRI? If the Gram Panchayat were oriented towards the program, they could involve the community in monitoring the ASHA's performance, and also identifying gaps where the ASHA requires further support. Oversight by the PRI/community would also enhance the accuracy of the data being reported by the ASHA to the ANM.</p> <p>Holding the ASHA responsible for the impact indicators identified is just unfair!</p> |
| <p><u>Incentives</u> Payment out of a fund available at the village level for each service target reached.</p> <p>Group recognition/awards may also be considered.</p> <p>Non-monetary incentive e.g. exposure visits, annual conventions etc can be considered.</p> | <p>Monthly remuneration, supplemented by monetary/non-monetary incentives such as hazard allowance, educational benefits, eligibility for civil service, preferential access to housing loans etc.</p> | <p>Providing monetary incentives for achievement of individual targets has not been attempted earlier. Providing the ASHA with a regular remuneration, with non-monetary incentives for achievement of targets would be a less complex system to manage and monitor.</p> |