Study on Implementation and Gap Analysis of AAA Model (ANM, Aganwadi Worker, ASHA) of District Farrukhabad U.P.

By

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Dissertation submitted for the partial fulfillment of the

MBA Hospital and Health Management

Academic year, 2014-2016

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He comes across as a committed, sincere & diligent person who has a strong drive and zeal for learning

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Abbreviations

TSU	Technical Support Unit
ANC	Ante Natal Check
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AWW	AnganWadi Worker
AYUSH	Ayurveda, Yoga and Naturopathy, Unani, Siddha, SowaRigpa and Homeopathy
BPO	Block Program officer
CHC	Community Health Center
CLMIS	Contraceptive Logistic Management Information System
AAA	Anganwadi ASHA ANM
DHH	District Health Hospital
GIS	Global Information System
GODMAN	Govt. Doctor's Information Management
HBPNC	Home Based Post Natal Care
HRMIS	Human Resource Management Information System
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
IMR	Infant Mortality Rate
ITEMS	Integrated Training & Evaluation Management System
JSSK	Janani ShishuSurakhshaKaryakram
LBW	Low Birth Weight
MAS	MahilaArogyaSamitis
MDG	Millennium Development Goals
MoHFW	Ministry of Health and Family Welfare
NGO	Non-Governmental Organization

NHM	National Health Mission
NHSRC	*National Health Systems Resource Centre*
NRC	Nutrition Rehabilitation Centre
NRHM	National Rural Health Mission
NUHM	National Urban Health Mission
OSMIS	Odisha State Malaria Information System
OVLMS	*Odisha Vaccine Logistic Management* System
PHC	Primary Health Center
PRI	Panchayati Raj Institutions
RKS	RogiKalyanSamiti
RMNCH+A	Reproductive Maternal Newborn Child Health+ Adolescent
SAM	Severe Acute Malnutrition
SC	Sub Center
SDH	Sub Divisional Hospital
SHSRC	State Health Sytems Resource Center
SIHFW	State Institute of Health and Family Welfare
TFR	Total Fertility Rate
IFA	Iron & Folic Acid
TT	Tetanus Toxoid
UHC	Universal Health Coverage
ULB	Urban Local Bodies
UPHC	Urban Primary Health Centre
HPD	High Priority District
VHND	Village Health & Nutrition Day
IHAT	Indian Health Action Trust
VHSNC	Village Health Sanitation& Nutrition Committee
WHO	World Health Organization

1.BACKGROUND OF THE STUDY

1.1 Introduction

Improving maternal, new-born and child health (MNCH) remains an important global health objective, particularly in developing countries with high rates of maternal and neonatal mortality. Scientific evidence for high-impact and low-cost MNCH interventions continues to accumulate but has yet to be adopted in the majority of these high risk settings. Implementing these interventions presents a challenge to the global health community primarily due to weak health systems and human resource constraints. Particularly in Africa, the health worker crisis affects coverage and quality of health services as nurses, midwives, and doctors are being asked to provide an ever-growing, complex package of services with minimal support.

Since the 1978 Declaration of Alma-Ata, the World Health Organization (WHO) has promoted the wider use of community health workers (CHW) to provide select clinical interventions and to promote healthy behaviours at the community-level.5 The current push is to shift high impact interventions to lower cadres of skilled and unskilled workers to optimize the accessibility and efficiency of health services. Promoting engagement of health care workers at both at the community and facility level remains central to this initiative, as it contributes to higher quality of care, increased productivity and lower rates of attrition. An urgent need also exists in the African context to develop models of community health programs that link to the broader public health sector and incorporate performance measures and quality improvement methodology for maximum impact and sustainability.

Also,Village Health and Nutrition Days (VHNDs) are a major initiative under the National Rural Health Mission (NRHM) to improve access to maternal, newborn, child health and nutrition (MNCHN) services at the village level. Across the country, VHNDs are intended to occur in every village level. Village Health and Nutrition Day (VHND), "MamataDiwas", a concept for interdepartmental convergence having desirable health outcomes of children below five years, is being introduced in the State of Orissa by the Department of Health and Family Welfare. This would provide the first point of contact for essential primary health care and would work as the common platform for convergence amongst service providers of Health, ICDS and the community. Strategically, trainings would be given at State, regional district and sector level to various categories of functionaries. Under the programme, the primary clients are pregnant women, lactating mothers, children below five years and adolescent girls. Basic components of primary healthcare services, including early registration, deworming, counselling on early breastfeeding, identification and referral of high risk cases of children and pregnant women, as well as basic ANC and PNC care will be provided at community level in order to address the essential requirements of pregnancy, delivery, referral, childhood illnesses and adolescent health. The programme would be organized for once a month in every Anganwadi Centre on a fixed day basis (either Tuesday or Friday) with joint efforts of ANM, AWW and ASHA. On an average, there are six to eight AWCs under the operational jurisdiction of one Sub Centre and thus there would be about eight fixed days in a month per Sub Centre. There should be an advanced fixation of the day with all AWCs for the entire month, so that the service providers and the community are aware of it much in advance.

1.2Service Package for VHND

A proper VHND should provide following services,

Maternal Health-

Early registration of pregnancies, Focuses ANC, Referral for women with signs of complications during pregnancy and those needing emergency, Referral for safe abortion to approved MTP canters, Counselling on: Education of girls, age at marriage, care during pregnancy, danger signs during pregnancy, birth preparedness, importance of nutrition, institutional delivery, identification of referral transport, availability of funds under the JSY for referral transport, post-natal care, breastfeeding and complimentary feeding, care of new-born, contraception.

Child Health-

Infants up to 1 year: Registration of new births, counselling for care of new-borns and feeding, complete routine immunization, immunization for dropout children, first dose of vitamin A along with measles vaccine, weighing.

Children aged 1-3 years: Booster dose of DPT/OPV, second to fifth dose of vitamin A, table IFA-(small) to children with clinical anaemia, weighing, provision of supplementary food for grades of mild malnutrition and referral cases for severe malnutrition.

All children below 5 years: Tracking & vaccination of missed children by ASHA and AWW, case management of those suffering from diarrhoea and acute respiratory infections, counselling to all mothers on home management and where to go in even of complications, organising ORS depots at the session site, counselling on nutrition supplementation and balance diet.

Family Planning-

Information on use of contraceptives, Distribution- provision of contraceptive counselling and provision of non-clinic contraceptives such as condoms and OCPs, information on compensation for loss of wages resulting from sterilization and insurance scheme for family planning.

Reproductive Tract Infections and Sexually Transmitted Infection-

Counselling on prevention of RTIs and STIs, including HIV/AIDS, and referral of cases for diagnosis and treatment, counselling for premenopausal and postmenopausal problems, communication on causation, transmission and prevention of HIV/AIDS and distribution of condoms for dual protection, referral for VCTC and PPTCT services to the appropriate institutions.

Sanitation-

Identification of households for the construction of sanitary latrines, guidance on where to go and who to approach for availing of subsidy for those eligible to get the same under the total sanitation campaign, avoidance breeding sites of mosquitoes.

Communicable Diseases-

Group communication activities for raising awareness about signs and symptoms of leprosy, suspected cases and referrals, awareness generation about symptoms of TB, provision of anti-TB drugs to patients.

Gender-

Communication activities for prevention of pre-natal sex selection, illegality of prenatal sex selection & special alert for one daughter families, communication on the prevention of violence against women, domestic violence act,2006, age at marriage, especially the importance of raising the age at marriage for girls.

1.3 Issues- Government of India launched a program known as Village Health Sanitation and Nutrition Day under this umbrella program was covering all maternal health services including services as well as health education to both age group Adolescent & Pregnant women's.

A proper Anti Natal Care, Intra Natal Care, Post Natal Care, Proper delay management, vaccination, Nutrition supplementation and management on a single platform which was lacking, these all services was coming under various programme because of that a complete of all services to needy women was lacking which was effecting the overall progress of RCH program in country. But still it is really providing all services in a systematic pattern as what we expected during launching this program. There is still gap lying in availability of services at VHND platform.

From the time of the launch of the National Rural Health Mission in 2005, Community processes have been at the heart of the outcomes of the Mission. The ASHA programme as it stands today is a powerful reflection of this. Undoubtedly, 8.89 lakh ASHAs are the most visible face, and singular achievement, of the Mission. The Village health, sanitation and nutrition committees (VHSNCs) Have grown in number to exceed 5.5 lakh but more importantly, they have Demonstrated unique ability to drive local health agenda.
Since the policy and programme guidelines were issued early on, in the first phase of the NRHM, the programme has expanded and been shaped by the varying contexts in which it is Being implemented. We have been able to understand, in no small measure what the barriers And facilitating factors are, what support requirements are necessary at various levels to yield Outcomes, what is the key set of processes to make an ASHA functional and effective and how to Do so. The knowledge is by no means adequate or sufficient. However, based on the cumulative Experience and understanding of those who are working at the national, state, district, and sub District levels the guidelines issued by the Ministry in 2006 have been updated and expanded. The aim is not limited to reflecting the learning of our experience but to ensure that the ASHA And VHSNC are trained, equipped and supported to provide mutual sustenance to each other to Strengthen community action for health. This set includes revised guidelines for the ASHA and also a more comprehensive set of principles For establishing and strengthening the Village Health Sanitation and Nutrition Committee and the Support structures for community processes in general. The guidelines, developed in consultation With the states, distil the experiences shared by state programme managers over the years, builds On shared problems and common solutions. The document is designed to reflect the fact that Guidelines for implementation must take into account the essence of problematics encountered In the field, the complexity of the intervention, and the day to day challenges that programme Manager's encounter and the strategies they devise to overcome these. We must now continue to strengthen the community processes interventions, motivated by Confidence and optimism, and girded by a caution that successful outcomes are possible onlyBy careful attention to detail. Now that the parameters for the programme have been set, by andLarge, it is the attention to

field implementation that will result in the outcome we envision: which Is that it is ultimately people who should become full-fledged and active stakeholders in achieving Health outcomes. It is our hope that states use these guidelines wisely, temper them with the day to day realities their Sub district and district managers encounter every day and use them to guide their programmes to achieve the result of the programme
One of the key elements of the National Rural Health Mission is the Village Health, Sanitation And Nutrition Committee (VHSNC). As the name suggests this committee is expected to take Collective action on issues related to health and its social determinants at the village level. They Were particularly envisaged as being central to 'local level community action' under NRHM, which Would gradually develop to support the process of Decentralized Health Planning. Thus VHSNCs are Expected to- act as leadership platforms for improving awareness and access of community for health Services, support the ASHA, develop village health plans, specific to the local needs, and serve as a Mechanism to promote community action for health, particularly for social determinants of health. In the past few years VHSNCs have been set up at village level across states. The composition, Capacity, activities and effectiveness of VHSNCs varies across the states, but comparing experiences And effectiveness across different contexts provides valuable learning. In this second phase of the NRHM, it is important to incorporate such learning to streamline the functioning of the VHNSC and Support capacity building so that these institutions can emerge as vibrant village level organizations To improve the health status of their communities. These guidelines are intended to assist states in supporting the constitution, capacity building and Functioning of VHSNC so as to achieve positive outcomes. These new guidelines were developed In consultation with state programme officers and representatives of civil society and NGOs who Have been working on building and guiding VHSNCs. States should utilize the guidelines to improve Functioning of existing VHSNCs and build the confidence and ownership of the community particularly The marginalized over these institutions. The guidelines are flexible and can be adapted to state Context.

1.4Why it's important in health system?

The objective of the Indian Government's National Rural Health Mission (NRHM) is to strengthen the healthcare delivery system with a focus on the needs of the poor and vulnerable sections among the rural population. One of the main tenets of the mission is to identify one ASHA (Accredited Social Health Activist) per 1000 population in the rural areas with the purpose of supporting the community to access public health services. She is expected to create awareness on health and its determinants, mobilize the community towards local health planning, and increase utilization of the existing health services.
The ASHAs represent the cornerstone of NRHM's strategy to address the millennium development goals (MDG) on health related indicators. As a result, in order to maximize India's potential to achieve these goals through the NRHM, it is essential to investigate methods to improve ASHA performance, specifically through the processes of recruitment, training, supervision, provision of incentives, and expansion to greater roles.
Findings from existing literature help provide context for our investigation into the performance of ASHAs in India. A study on community health workers (CHWs, called ShasthyaSebika) in Bangladesh, implemented through a programme to improve rural health in 1972, suggests that financial incentives are the primary motivating factor and that high drop-out rates are largely due to the dissatisfaction with the pay levels in proportion to the amount of time invested. Though China was early to adopt the concept of community health workers (called _barefoot doctors') in the 1950s, structural reforms in 1978 resulted in a health workforce that was uneducated and poorly trained. As a result, the once flourishing community health worker system suffered from low quality healthcare. Iran is an example where thorough training of CHWs has been linked to positive health outcomes including

decreased maternal mortality and increased life expectancy. A two-year, in-depth training has resulted in CHWs who can handle greater responsibilities efficiently while maintaining high quality standards in Iran. Overall, previous research suggests that thorough training, clear supervision structures, and increased economic returns are required for optimal CHW performance. With this context in place, the topic of how to improve ASHA performance in India is examined.

This paper presents findings from data collected through written questionnaires with ASHAs in Bihar, Chhattisgarh, Rajasthan, and UP concerning issues around recruitment, responsibilities, training, incentives, and supervision. Qualitative findings from the state of Assam are also presented. The selected states are regionally representative and are among the poorest and most populous states in the country.

The impact of NRHM and the ASHA is only as strong as the individual ASHAs who are chosen to advocate for use of health facilities and provide knowledge on healthy behaviours and dispense basic health products to their community. Key selection criteria such as education level and representativeness of the local community are extremely critical if we want the ASHAs to retain and communicate information to their community members. However, our findings indicate that selection processes and criteria are not being met in several areas, which leads to the recruitment of ASHAs who may not be able to perform to the level necessary.

The Ministry of Health & Family Welfare (MoHFW) has developed a 23-day training schedule to provide the necessary knowledge & skills to women identified as ASHAs. However,

While majority of the ASHAs who completed the questionnaire claimed to understand their roles and responsibilities, our site visits and qualitative data proved otherwise. ASHAs were unable to specify all their job responsibilities. Without a clear understanding of one‘s own responsibilities as an ASHA, performance and effectiveness cannot be improved. Furthermore, we also believe that there is potential for ASHAs to take on some additional roles outside those originally prescribed, such as helping develop village health plans, registration of vital events with the ANM/AWW, and community based new born care. Inclusion of these additional activities would increase associated financial incentives. Additionally, ASHAs are currently claiming to work approximately 25 hours a week, which provides potential to increase her responsibilities, which would therefore increase her incentives as well. Additional responsibilities within her scope of capabilities should be considered.

Data analysis brought to the forefront that the ASHAs lack knowledge to perform their jobs, as most have not completed the stipulated 23 days of training as recommended by the MoHFW. This issue must be investigated further. It is recommended that an assessment of the information that ASHAs have retained from theoretical and practical training must be conducted before ASHAs are able to work in the field, so that valuable information is not provided in error or omitted when they are counselling pregnant women and mothers on healthy practices. Pictorial job aids and frequent refresher trainings are crucial to ensure that the ASHA retains her skills.

There are several key issues regarding incentives and compensation for ASHAs, which, if mitigated, would greatly contribute to an improvement in ASHAs‘ motivation and performance. At least 25% of ASHAs feel that the monetary compensation they receive isn‘t sufficient for the effort that they put in. Increasing incentives or adding additional incentives to activities should be looked into. Monetary compensation is not the sole motivation factors for the ASHAs. The desire to serve the community, increase their knowledge, becoming a part of the formal health system and the prestige associated with the position are additional reasons for becoming an ASHA. Keeping the above in mind a career progression for the ASHA to become a part of the formal health system should be considered.

The success of the ASHA initiative depends on regular and reliable supervision; however this is a weak link in the system. Clear strategies and procedure for supervision need to be

defined along with a list of supervisory activities and the skills for supervision to be taught to the supervisors or personnel who will conduct these activities.
The ASHAs play a critical & effective role in bridging the gap between NRHM and the communities therefore it's important to keep the ASHA motivated to perform her duties efficiently and address issues related to provision of quality services. We hope that the learnings and recommendations shared in this paper will help in addressing issues related to the provision of quality services by the ASHA to the community and making an effective contribution to the health of their communities.

1.5ASHA –Social mobilizer

The Accredited Social Health Activist (ASHA) represents the pivotal part in the whole design and strategy of the National Rural Health Mission (NRHM), which, in turn, is a critical initiative of the central government to fulfil its promise on inclusive growth. The performance of ASHAs is, therefore, crucial for the success of NRHM and hence of the inclusive growth strategy of the government in India. In the primary healthcare sector, NRHM is the principal programme of the government to achieve the health related millennium development goals such as infant mortality rate (IMR), maternal mortality rate (MMR); as well as control of specific diseases, and improvement of nutrition status of children and mothers. NRHM was introduced in the year 2005 in the 18 high focus states in India and has been expanding in its coverage ever since. Several mid-term appraisals of NRHM have been carried out, the last one having been done by the present team (2009). The present paper is devoted to identifying and suggesting ways in the short to medium term to improve performance of ASHAs under NRHM in India. The purpose of this investigation is not to question the strategy based on ASHAs in the rural setting but to explore and evaluate alternatives. We believe that under the given circumstances it is not only prudent but also most practical and meaningful to concentrate on improving the performance of ASHAs. The present paper, therefore, examines the whole question in terms of current and potential provisions of the recruitment, training and deployment of ASHAs in India. Our paper presents data collected through written questionnaires with ASHAs in Bihar, Chhattisgarh, Rajasthan, and UP. Where appropriate, we have also provided key qualitative insights from the state of Assam, where we conducted a focus group discussion with 25 ASHAs and 4 ASHA facilitators.
All mid-term appraisals of NRHM in India have expressed concerns about role and performance of ASHAs. There is considerable literature and international experience in this regard. A brief review of the literature and international experiences is presented in the second section. The third section discusses current profile of ASHAs in the five selected states and their selection procedure. Further sections then consider the following five questions:
a. Is the recruitment process for ASHAs appropriate to ensure proper selection?

b. Are the roles and responsibilities assigned to ASHAs easily understood and appropriate? Are new responsibilities for ASHAs envisaged?

c. Is the training that ASHAs receive adequate, appropriate for knowledge retention, and of high quality?

d. Are ASHAs'current incentives and compensation structure consistent and adequate for them to perform as per expectations of NRHM?

e. Are supervisory structures currently in place in the rural areas sufficiently detailed and do they effective monitor/track ASHA performance?

The last section summarizes recommendations for the consideration of the International Advisory Panel. A quick sample survey of ASHAs, potential/actual beneficiaries (young mothers) and government officials was carried out during March – May, 2010 in selected

states to get an idea about the ground reality for ASHA‘s role, training, incentives, supervision, effectiveness,

Community health workers (CHWs) became prominentwith the Alma Ata Declaration in 1978 that recognised primary health care as the key element for improving community health . The World Health Organization characterises CHWs as members of the community, selected by and answerable to the community they work for, and supported by the health system but with shorter training than professional health workers .Although these characteristics outline the fundamental relationships informing a CHW’s position, depending on programme goal, they differ both within and across countries in terms of their roles and responsibilities, recruitment, training and incentives .The literature conceptualises CHW programmes through two different sets of discourses: as service extension workers and as activists for social change. As service extension workers, CHWs are incorporated into the health system to assist doctors and nurses in activities such as immunisation and health promotion. In this sense, they are considered ‘another pair of hands.as they are helpful in rendering services to underserved populations and they increase the capacity of the health system to address financial and human resource shortages in a
Resource-poorsetting. As activists, CHWs have beenconceptualised as social and cultural intermediaries strengthening the interface between the existing healths
System and the community. In this sense, their role should facilitate community participation and involve engaging in the necessary actions to address the social and
Cultural barriers that lead to poor health. Cochrane review on lay health workers who worked amongst low-income communities of wealthy countries or amongst communities from poor countries shows evidence of CHWs’ contribution to reducing child morbidity and mortality, increasing uptake of immunisation
And promoting good breast feeding practices. Systematic reviews report that CHWs in low-income countries (such as Bangladesh, Brazil and Nepal) have demonstrated the capacity to improve antenatal, perinatal and postpartum
Service utilisation and to prevent perinatal and maternal deaths by early recognition and referral of complicated pregnancies. Due to these successes and the increasing
Recognition of the crisis in human resources for health, deployments of CHWs have become a popular strategy to delivery primary health care at the community level. Many Countries in Southeast Asia and Africa including India are planning and implementing CHW programmes at a national scale to strengthen primary health care
Systems. Several factors have shaped the experiences of community-based health workers, including the type and quality of supervision, level of linkages with health
System structures, availability of drugs, clarity of the responsibilities, funding patterns and quality of programme management. Studies have shown that CHWs who come from the communities they serve have higher levels of acceptance from within these communities. Personality traits and skills like communication, motivation, leadership and ability to reach out to community members are also important factors shaping the effectiveness of CHWs. Adequate and appropriate compensation of has emerged as an important motivating factor for their continued participation in the programme. In a performance-based remuneration system, CHWs have to promote the use of health facilities in order to receive incentives. But negative experiences of the community with primary health care may discourage use of health services; it could limit CHWs to earn their incentives. There is a growing body of literature that focuses on technical aspects of CHW programme management such as selection, capacity building, supportive supervision and performance basedincentives. However, there are evidence gaps with

respect to the extent to which CHWs can be health activists or agents of change, supporting community participation and empowerment which are crucial aspects of health improvement and sustainability.

2.Review of Literature-

- The 1978 Alma Ata declaration of highlighted the importance of Primary Health Care and critical role played by Community Health Workers (CHW) to link communities to the health system. The use of community members to render certain basic health services to their communities is a concept that has existed for the last 50 years. There have been innumerate experiences throughout the world with programme ranging from large scale, national programmes to community based initiatives.
- Sessions like VHND are organized, in the village at a fixed day, place and time through convergent actions by the departments of health and the department of women and child development. Due to inadequate dissemination of guideline for conducting the outreach sessions, health workers' often locked clarity in understanding their role.
- The data reflects that the VHND sessions are being organized, as per the immunization session roaster of the villages and the service related to immunization are only being provided rather than providing all the basic health services.
- In India VHND is a priority intervention under the National Rural Health Mission (NRHM), Government of India which are emerged from attempts to increase coverage of basic health and nutrition services in rural areas not served by health facilities?
- According to a rapid on VHND was carried out by UNICEF in 2011 indicate that VHNDs are conducted on a designated day. However, discussions and feedback from the community and functions show that quality of interaction during VHND sessions is not up to the mark. This has an impact on the participation on the community in VHND. Quality entails a number of aspects- 1)involvement of the organizations(frontline workers from health , ICDS, panchayat functionaries and involvement of community institutions), 2) common understanding among all stakeholders about how VHND is to be organised and services that are to be offered,3) pre-service mobilization and post service follow up, 4)publicity and preparation for the VHND and 5) instruments and required equipment for VHND, 6)motivation amongst FLWs due to over worked schedules) information's during sessions.
- Inter-sectorial convergence between Health and Nutrition activities is the focus of the Village Health Nutrition Day (VHND) program under NRHM of the Ministry of health and family welfare, Government of India. The ASHAs, AnganWadi Workers, Auxiliary Nurse Midwives and the Panchayati Raj Institute members, work as a team to ensure that services are provided by VHND. The case can be used to discuss the challenges in convergence between various government departments in planning the services tom be offered on the

VHND, generation demand for the services through IEC/counselling and actually providing services on the VHND.

- The decision of spending money received in the scheme by the husband is very big challenge. Most of the time, this money is spent for other purpose rather than for mother. Some in built like pre-paid vouchers could be introduced for ensuring that the basic purpose of the amount provided must be used for the purpose intended. In India, the Government of Gujarat introduced voucher schemes under ChiranjeeviYojana-CY (meaning long life) to increase the access of poor women to antenatal, obstetric and neonatal health care [18]. It is based on a Public-Private Partnership (PPP) model in which poorer people can go to empanelled private nursing homes for delivery, and the cost will be borne by the state [8].
- The 1978 Alma Ata declaration of highlighted the importance of Primary Health Care and the critical role played by Community health Workers (CHW) to link communities to the health system. The use of community members to render certain basic health services to their communities is a concept that has existed for at least 50 years. There have been innumerable experiences throughout the world with programmes ranging from large-scale, national programmes to community-based initiatives.
- We now know that CHWs can play a crucial role in broadening access and coverage of health services in remote areas and can undertake actions that lead to improved health outcomes, especially, but not exclusively, in the field of child health. To be successful on a large scale, CHW programmes need careful planning, secure funding, and active government leadership and community support. To carry out their tasks successfully, CHWs need regular training, supervision, and reliable logistical support. CHWs represent an important health resource whose potential to extend basic health care to underserved populations must be fully tapped.
- CHW programmes have been widely documented in health literature; this background section will review three international experiences in large CHW programmes, and comparatively, available studies on India‘s CHW experiences.

2.2INTERNATIONAL CHW PROGRAMMING

- For the purpose of this paper, we review three large-scale CHW programmes from Bangladesh, China, and Iran that have been relatively successful. While these programmes differ in some programme design from the ASHA, they are relevant in many ways: (a) India and China are rapidly growing economies with enormous populations, (b) Bangladesh shares its borders with India and faces similar health and economic problems as many adjoining states in India, particularly West Bengal and Bihar, and (c) Iran‘s programme has developed at considerable scale and has achieved remarkable coverage in the course of two decades.
- CHW programmes around the world largely focus on primary care services like maternal and child health, nutrition, family planning, immunizations, water and sanitation, communicable disease control, and basic curative care for some common illnesses. Most CHW programmes enrol female health workers, due to the large importance of maternal and child health, but there are also notable programmatic examples of male community health workers in Iran, Egypt, Thailand, Bhutan, and Bolivia (Catalyst 2005, 2007; Brown 2006).
- Selection criteria, especially education levels, vary widely between programmes; SEARCH in India employs largely low-literacy women, while Iran‘s national programme requires Class 11 pass. Quality and productivity of work depend on

quality of training and support received by the CHWs in the field. However, both lack of sufficiently educated candidates and dissatisfaction of overqualified candidates are reasons for attrition. Incentives also vary widely, and include income-generation schemes and social prestige.

- Unfortunately, national health programs in Indiarely too heavily on curative approach and thehealth education efforts does not address theneeds of the rural population.[17] Communitymobilization and participatory, need basedhealth education strategy based on localepidemiology and caregivers perspectivescould improve health care seeking for new-borndanger signs in rural Wardha.[18] Hence,along with the initial two components ofIMCI strategy (improving the skills of healthworkers and improving health system), thethird component of IMCI strategy i.e. householdcommunity IMCI (HH/C IMCI) strategyshould be implemented through communityparticipation. Notably, very few mothers ofsick children consulted *Anganwadi*workersand Auxiliary Nurse Midwives. The role of *Anganwadi*workers and Accredited SocialHealth Activist (ASHA, community level femalehealth worker) can be strengthened underhousehold and community IMNCI to promotedesired practices at household level andbridge gaps in household to hospital care ofcontinuum.

2.3 Support Mechanism for Asha

- One of the key strategies under the National Rural Health Mission (NHM) is having a Community Health Volunteer i.e. ASHA (Accredited Social Health Activist) for every village with a population of 1000. Detailed guidelines have been issued by the Government of India in matter of selection and training of ASHA. The States have been given the flexibility to relax the population norms as well as the educational qualifications on a case to case basis, depending on the local conditions as far as her recruitment is concerned.
- The above said guidelines also clearly bring out the role of ASHA vis-&-vis that of Anganwadi Worker (AWW) and the Auxiliary Nurse Midwives (ANM). The non-ASHA States (including the NE) have been advised that they could provide for similar link workers at the village level in the revised Project Implementation Plan for RCH-II in the current year. States like Andhra Pradesh and Haryana are already having the link workers. The ASHA scheme is presently in place in 33 states (except Goa, Chandigarh & Puducherry). The states can select ASHAs in urban areas also as link workers subject to similar provisions being made in the State PIP for RCH-II in the current financial year.
- The reports received from the States indicate that over 8.9 Lakh ASHAs have been selected uptill 31st March 2014 and that they are being provided with

orientation training as envisaged in the guidelines issued on ASHA. Now, a careful strategy needs to be devised for providing the necessary management support to ASHA so that she is not left alone in the village without having any linkage with the health system.The following set of guidelines are issued to enable the States to develop and put in place a proper support mechanism for ASHA.

2.4 ASHA Mentoring Group:

The Government of India has set up an ASHA Mentoring Group comprising of leading NGOs and well known experts on community health. Similar mentoring groups at the State/District/Block levels could be set up by the States to provide guidance and advise on matter relating to selection, training and support for ASHA. At the District level, MNGOs and at Block level, FNGOs could be involved in the mentoring of ASHA. The State Govt. may utilize the services of Regional Resource Centre (RRC) and include them in the Mentoring Group at the State level.

2.5 Selection of ASHA

As ASHA will be in the village on a permanent basis, she should be selected carefully through the process laid down in the first set of ASHA guidelines. It is possible that the selected ASHA drops out of the programme. It is, therefore, necessary to keep a record of such cases at Sub-Centre/ PHC level. In the above circumstance, a new ASHA could be selected from the panel of three names previously prepared on the recommendation of the Gram Sabha.

2.6 Training of ASHA

the guidelines already issued on ASHA envisage a total period of 23 days training in five episodes. However, it is clarified that ASHA training is a continuous one and that she will develop the necessary skills & expertise through continuous on the job training. After a period of 6 months of her functioning in the village it is proposed that she be sensitized on HIV / AIDS issues including STI, RTI, prevention and referrals and also trained on new born care.

2.7 Familiarizing ASHA with the village:

Now, that ASHAs have been selected, the next step would be to familiarize her with the health status of the villagers and facilitate her adoption to the village conditions. Although, ASHA hails from the same village, she may not be having knowledge and information on the health status of the village population. For this purpose, she should be advised to visit every household and make a sample survey of the residents of village

to understand their health status. This way she will come to know the villagers, the common diseases which are prevalent amongst the villagers, the number of pregnant women, the number of new-born, educational and socio economic status of different categories of people, the health status of weaker sections especially scheduled castes/scheduled tribes etc. She can be provided a simple format for conducting the surveys. In this she should be supported by the AWW and the Village Health & Sanitation Committee.

The Gram Panchayat will be involved in supporting ASHAs in her work. All ASHAs will be involved in this Village Health and Sanitation Committee of the Panchayat either as members or as special invitees (depending on the practice adopted by the State). ASHAs may coordinate with Gram Panchayats in developing the village health plan. The untied funds placed with the Sub-Centre or the Panchayat may be used for this purpose. At the village level, it is recognized that ASHA cannot function without support. The SHGs, Woman's Health Committees, Village Health and Sanitation Committees of the Gram Panchayat will be major sources of support to ASHA. The Panchayat members will ensure secure and congenial environment for enabling ASHAs to function effectively to achieve the desired goal.

2.8 Maintenance of Village Health Register:

A village health register is maintained by the AWW which is not always complete. ASHA can help AWW to complete and update this register by maintaining a daily diary. The diaries, registers, health cards, immunization cards may be provided to her from the untied funds made available to the Sub-Centres.

2.9 Organization of the Village Health and Nutrition Day:

All State Governments are presently organizing monthly Health and Nutrition day in every village (Anganwadicentres) with the help of AWW/ANM. ASHA along with AWW should mobilize women, children and vulnerable population for the monthly health day activities like immunization, careful assessment of nutritional status of pregnant/lactating women, new-born& children, ANC/PNC and other health check-ups of women and children, taking weight of babies and pregnant women etc. and all range of other health activities. The ANM and the AWW will guide the ASHA during the monthly health days. The organization of the monthly Health and Nutrition Days ought to be jointly monitored by the CDPO, LHVs, and the Block Supervisor of the ICDS periodically.

2.10 Co-ordination with SHG Groups:

ASHA would be required to interact with SHG Groups, if available in the villages, along with AWW, so that a work force of women will be available in all the villages. They could jointly organize check-up of pregnant women, their transportation for safe institutional delivery to a pre-identified functional health facility. They could also think of organizing health insurance at the local level for which the Medical Officer and others could provide necessary technical assistance.

2.11 Meeting with ANM:

ANM should have a monthly meeting with the ASHAs stationed (5-6 ASHAs) in the villages of her work area at the Anganwadi Centre during the monthly Health and Nutrition Day to assess the quality of their work and provide them guidance.

2.12 Monthly meetings at PHC level:

The Medical Officer In-charge of the PHC will hold a monthly meeting which would be attended by ANM and ASHAs, LHVs and Block Facilitator. During this period, the health status of the villages will be carefully reviewed. Payment of incentive to ASHAs under various schemes could be organized on that day so that ASHA need not visit the PHC many times to receive her incentives. States may ensure that payment to ASHA are made promptly through a simplified procedure. During these meetings, the support received from the Village Health and Sanitation Committee and their involvement in all activities also should be carefully assessed. The ASHA kits also could be replenished at that time. Replenishment of kit should be prompt, automatic and through a simplified procedure.

2.13 Monthly meetings of ASHAs:

A meeting of ASHA could be organized on the day monthly meetings are organized at the PHC level to avoid unnecessary travel expenditure and wastage of time. The idea is that apart from the meeting with officials they should be given opportunity to share sometime of their own experience, problems, etc. They will also get an opportunity to independently assess the health system and can bring about much needed changes.

In addition to monthly meetings at PHC, periodic retraining of ASHAs may be held for two days once in every alternate month where interactive sessions will be held to help then to refresh and upgrade their knowledge and skills, as provided for in the original guidelines for ASHA.

2.14 Block level management:

At the block level, the BMO will be in overall charge of ASHA related activities. However, an officer will be designated as Block level organizer for the ASHA to be assisted by Block Facilitators (one for every 10 ASHAs). Block Facilitators could be appointed as provided for under the first set of guidelines on ASHA already issued to the States. The Block Facilitator may be necessarily women. However, male members if any, who may have already been appointed earlier as Block Facilitator may continue. The Block Facilitators would provide feedback on the functioning of ASHAs to the BMO & Block level organizers. They shall also visit the ASHAS in villages.

2.15 Management Support FOR ASHA:

Officials in the ICDS should be fully involved in ASHAs activities and their support should be provided for at every level i.e. PHCs, CHCs, and District Society etc. The management support which would be provided under RCH/NHM at the Block, District & State level should be fully utilized in creating a network for support to ASHA including timely disbursement of incentives, at various levels. This support system should have full information on the number of ASHAs, quality of their output, outcomes of the Village Health and Nutrition Day, periodic health surveys of the villages to assess her impact on community etc.

2.16 Community monitoring:

Periodic surveys are envisaged under NHM in every village to assess the improvement brought about by ASHA and other interventions. The funding for the survey will be provided out of the untied funds provided to the Sub-Centre. The first survey would provide the base line for monitoring the impact of health activities in the village.

2.17 Role of District Health Missions:

The District Health Mission in its meetings will specially assess the progress of selection of ASHAs, their training and orientation, usefulness to the villages etc. They should also have a Cell in the DPU to collect all information related to ASHA and the community which should be available on the computer network. This information should be accessible by the State Health Missions as well as the Mission at the national level.

2.18 Linkage with Health Facility

The success of NHM to great extent depends on performance of ASHA and her linkage with functional health system. The health system has to give due recognition to ASHA and take prompt action on the referrals made by her; otherwise the system cannot be

sustained. Every ASHA must be familiar with the identified functional health facility in the respective area where she can refer or escort the patients for specific services. The persons manning these health facilities should be sensitized to effectively respond to the instant needs of the local people. Funds available under IEC-programme may be used for education and publicity in respect of above services. The role of the State & District level Missions would be to provide support to ASHA from village to the district level without any blockage on the way.

The States may take appropriate steps to locally adopt these guidelines and make the ASHA scheme a complete success.

2.19 **Funding for Support Mechanism of ASHA**

One of the key strategies under the National Rural Health Mission (NHM) is a community health worker i.e., Accredited Social Health Activist (ASHA) for every village at a norm of one per thousand population. Right after the launch of the Mission, detailed guidelines were issued by the Government of India for selection and training of ASHAs. The above guidelines clearly brought out the role of ASHA vis-&-vis that of Anganwadi Worker (AWW) and Auxiliary Nurse Mid-wife (ANM). The guidelines also gave breakup of the expenditure on selection, training and provision of drug kits to ASHAs. The scheme for providing performance linked compensation and the methodology of payment of compensation was also delineated in those guidelines.

In view of the selection of large number of ASHAs, a need for providing a support mechanism for ASHAs has been acutely felt. A set of guidelines was therefore issued to the States to facilitate putting in place a mechanism for this purpose. These guidelines provided for inter-alia ASHA mentoring group at State level, Block Level Facilitators at the rate of one per ten ASHAs, a system of monitoring meetings of ASHAs at the PHC level, coordination with Self-Help Groups etc.

The implementation framework for the NHM has recently been approved. The scheme of ASHA has now been extended to all the 18 high focus States. Besides, the scheme would also be implemented in the tribal districts of the other States. In the new implementation framework, a provision has been made for an expenditure of Rs. 10,000 per ASHA during a financial year. This ceiling does not include the performance-based compensation, which the different programme divisions would disburse from their own funds. The earlier ASHA guidelines had visualized an expenditure of Rs. 7,415/- per ASHA. The increased outlay gives a valuable opportunity to further strengthen the support mechanism.

Over the last one year, the States have selected more than 200,000 ASHAs. The number of ASHAs is likely to be increase very rapidly over the next two years. As a matter of fact, a district alone is expected to have more than 1,000 ASHAs. Obviously, a very strong support mechanism is required at block, district and State level to ensure that the scheme of community health worker meets the objectives, which the Mission has envisaged for it. The support functions which would have to be carried out at these levels include inter-alia, preparation of training calendar for the trainers as well as for ASHAs, monitoring the implementation of the training programmes, adapting the training modules (provided to the States by the GoI) to suit the local conditions, translation in local language, printing and distribution of these manuals, developing ASHA monitoring forms and monitoring her performance, developing IEC materials, addressing grievances of ASHAs if any etc.

In order to provide adequate support to the ASHAs, the following has been provided:

2.20 At State Level:

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

In the smaller States (other than North Eastern States) having less than 20,000 ASHAs, three persons are being provided at the State level i.e. one Project Manager, a Statistical Assistant, and one Office Attendant.

These functionaries together would comprise an ASHA Resource Centre which would ultimately get subsumed in the State Health Resource Centre (SHRC) as and when the SHRC gets off the ground.

In the detailed cost estimates as given in the Guidelines for Community Processes, adequate provisioning has been done for office expenses and other contingent

expenditure. This amount will be provided as a lump sum so that the States have the flexibility to use the amount as per their needs.

2.21 At District level:

In the existing ASHA guidelines, at the district level a District Nodal Officer has been provided. The District Nodal Officer is to be an officer nominated by the Civil Surgeon. Since the guidelines do not provide for additional human resources, it is expected that he/she would be doing the work with the existing human and financial resources. However, as has been mentioned above, managing the various aspects of the functioning of more than 1,000 ASHAs will not be a simple task without adequate human and financial resources. It is, therefore, now proposed that each District Nodal Officer would be supported by a Community Mobiliser who would have the qualification of MSW. A Data Assistant may also be provided to satisfactorily discharge the work.

2.22 At Block Level:

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

2.23 At PHC level:

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

The details of the cost estimates, post and qualification are given in the support structure guidelines detailed in the Guidelines for Community Processes. The appointment to the above positions can only be on a contractual basis

In India, public health nur- sing in the villages today is still limited to services rendered by Multipurpose Health Worker (Female) [MPHW(F)] or Auxiliary Nurse Midwife (ANM). ANMs are regarded as the first contact person between people and organisation, between needs and services and between consumer and provider.

It is through their activities that people perceive health policies and strategies. It is through them that planners at the upper level gain insights into health problems and needs of the rural people. Considering their status as grass-root level workers in the health organisational hierarchy, a heavy responsibility rests on them.

Their services are considered essential to provide safe and effective care and as a vital resource to achieve the health-related targets. The present concern in the country is to provide accessible, affordable, accountable, equitable, effective and reliable health care, especially to poor and vulnerable sections of population in rural areas. It is, therefore, interesting to analyse the role changing with the times. In the ‘50s and ‘60s, training courses for ANMs focused on midwifery and Maternal and Child Health (MCH) as 9 out of 24 months, were earmarked for these subjects. India’s Second Five-Year Plan described the role of auxiliary health workers as those activities that supplemented the contributions made by doctors and other highly trained personnel for promoting preventive and curative health activities (GOI, 1986).

Mukher-jee Committee (1966) recommended a system of targets and incentives and identified ANMs and other village level workers as agents for the popularisation of the programme. In 1973, the Government of India (GOI) integrated the various functions of the health services thereby changing the role of ANMs (Kartar Singh Committee, 1973).

In 1975, Srivastava Committee called for an expansion of the training to prepare them for multipurpose health work. ANMs were now required to provide child health services and primary curative care to villagers. In turn, the Indian Nursing Council (INC) submitted its recommendations to the Ministry of Health and Family Welfare. However,

only a few states have adopted this course at the higher secondary level as a vocational course.

2.25 Role of ANMs in National Rural Health Mission

National Rural Health Mission, launched on 12 April 2005, to enhance comprehensive primary health care services especially for the poor and vulnerable sections of the society, continues to realise the ANMs as key workers at the interface of health services and the community.

The Mission seeks to provide minimum two ANMs (against one at present) at each Sub-Centre, as one ANM at a sub-centre has not been found adequate to attend to the complete needs of maternal and child care in any village. The Government of India would support the second ANM for appointment on contract basis and apart from fulfilling the other criteria she must be a resident of a village falling under the jurisdiction of the Sub-Centre. The intention is to improve accountability at the local level.

The second ANM would not be In India, public health nur- sing in the villages today is still limited to services rendered by Multipurpose Health Worker (Female) [MPHW(F)] or Auxiliary Nurse Midwife (ANM). ANMs are regarded as the first contact person between people and organisation, between needs and services and between consumer and provider.

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2.26 Key Front Line worker.

The role of ANMs has been The National Education Policy (1986) included the ANM

programme under the stream of Vocational Education. The INC again reviewed the curriculum for the +2 level and transferred before completion of 10 years at the same Sub-Centre and would not be a substitute for Male Health Worker (MHW). An untied fund of Rs.10,000/- per Sub-Centre per annum is being provided by opening a joint account of the ANM and Sarpanch, to meet the emergency type expenditures and to ensure that

Abstract: The Integrated Child Development Service Scheme (ICDS) is one of the initiatives taken up by the Central Government, which provides a package of six services viz., supplementary nutrition, immunization, health check-ups, referral services, nutrition and education for mothers/pregnant women, nursing mothers and to adolescent girls (kishoris) through anganwadi workers. The responsibilities of anganwadi workers are ever increasing these days. They have certain prescribed responsibilities other than the above mentioned services in the anganwadi. The present study has been undertaken with the objective of assessing the role and responsibilities of anganwadi workers in Mysore district. The universe of the study is Mysore District. The tool used for the study is questionnaire. Among 235, around 122 anganwadi workers representinggrama panchayats of each taluk have been covered under the study. The results found that anganwadi workers are very active in rendering their services to the beneficiaries. Words: Initiatives, Supplementary Nutrition, Adolescent girls, Anganwadi. IntroductionICDS is the world's largest community based outreach programme which offers apackage of health, nutrition and education services to the children below six years andpregnant and nursing mothers. The Integrated Child Development Services scheme (ICDS) was started in Karnataka on 2nd October 1975 with a pilot project at T. Narasipura in Mysore District with just 100 Anganwadi Centres. Since then, the programme has expanded to all the revenue taluks in the State. The welfare of pregnant women, nursing mothers, adolescent girls and children below 6 years has acquired a prime place in the programme. The programme is a package of six services viz., supplementary nutrition, immunization, health check up, services, and nutrition and health education for mothers / pregnant mothers, nursing mothers and to adolescent girls (kishoris).

An Anganwadi is the focal point for the delivery of ICDS services to children and Mothers. An Anganwadi normally covers a population of 1000 in both rural and urban areas and 700 in tribal areas. Services at Anganwadicentre (AWC) are delivered by an AnganwadiWorker (AWW) who is a part-time honorary worker. She is a woman of

same locality, chosen by the people, having educational qualification of middle school or Matric or higher. She is assisted by a helper who is also a local woman and is paid honorarium. Being the functional unit of ICDS programme which involves different groups of beneficiaries, the AWW has to conduct various types of job responsibilities. Not only she has to reach to variety of beneficiary groups, she has to provide them with different services which include nutrition and health education, Non- Formal Pre School Education (NEPSE), Supplementary nutrition, growth monitoring and promotion and family welfare services. She also coordinates in arranging immunization camps, health check-up camps. Her functions also include community survey and enlisting beneficiaries, primary health care and first aid, referral services to severely malnourished, sick and at risk children, enlisting community support for Anganwadi functions, organizing women's groups and MahilaMandals, school enrolment of children and maintenance of records and registers (Sunder Lal 1997). Each anganwadi workers receives less than Rs. 3,500/- per month which is very low remuneration, but the responsibilities of these workers are very extensive. Yet, they have been found to be among the most dedicated and committed of public servants who have developed grass root contacts and are able to identify particular individuals and groups in any community, easily.

The anganwadi worker is the most important functionary of the ICDS scheme. The anganwadi worker is a community based front line worker of the ICDS programme. She plays a crucial role in promoting child growth and development. She is also an agent of social change, mobilizing community support for better care of young children (Kant et al. 1984). The partnership at community level, between frontline workers of different sectors and community groups, can make the vision a reality. The Anganwadi Worker is the community - based voluntary frontline workers of the ICDS Programme. Selected from the Community, she assumes the pivotal role due to her close and continuous contact with the beneficiaries. The Anganwadi Worker monitors the growth of children, organizes supplementary feeding, helps in organizing immunization sessions, distributes vitamin A, iron and folic acid supplements, treats minor ailments and refers cases to medical facilities (ICDS report, 1995).

Objectives of ICDS

1. To improve the nutritional and health status of children in the age-group 0-6 years;

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2. To lay the foundation for proper psychological, physical and social development of the
Child;
3. To reduce the incidence of mortality, morbidity, malnutrition and school dropout;
4. To achieve effective co-ordination of policy and implementation amongst the various Departments to promote child development; and
5. To enhance the capability of the mother to look after the normal health and nutritional Needs of the child through proper nutrition and health education.

2.27 Role and responsibilities of Anganwadi Workers

The role and responsibilities of AWWs and Helpers envisaged under the ICDS Scheme is as
Under:-
1. To elicit community support and participation in running the programme.
2. To weigh each child every month, record the weight graphically on the growth card, use Referral card for referring cases of mothers/children to the sub-centres/PHC etc., and Maintain child cards for children below 6 years and produce these cards before visiting Medical and para-medical personnel
3. carry out a quick survey of all the families, especially mothers and children in those Families in their respective area of work once in a year.
4. To organise non-formal pre-school activities in the anganwadi of children in the age Group 3-6 years of age and to help in designing and making of toys and play equipment of Indigenous origin for use in anganwadi.
5. To organise supplementary nutrition feeding for children (0-6 years) and expectant and Nursing mothers by planning the menu based on locally available food and local recipes.
6. To provide health and nutrition education and counselling on breastfeeding/ Infant & Young feeding practices to mothers. Anganwadi Workers, being close to the local Community, can motivate married women to adopt family planning/birth control measures
7. AWWs shall share the information relating to births that took place during the month with The Panchayat Secretary/Gram Sabha Sewak/ANM whoever has been notified as Registrar/Sub Registrar of Births & Deaths in her village.

8. To make home visits for educating parents to enable mothers to plan an effective role in The child's growth and development with special emphasis on new born child.

9.To maintain files and records as prescribed.

10. To assist the PHC staff in the implementation of health component of the programme viz. immunisation, health check-up, ante natal and post-natal check etc.

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11. To assist ANM in the administration of IFA and Vitamin A by keeping stock of the two medicines in the Centre without maintaining stock register as it would add to her Administrative work which would affect her main functions under the Scheme.

12. To share information collected under ICDS Scheme with the ANM. However, ANM will not solely rely upon the information obtained from the records of AWW.

13. To bring to the notice of the Supervisors/ CDPO any development in the village this requires their attention and intervention, particularly in regard to the work of the Coordinating arrangements with different departments.

14. To maintain liaison with other institutions (MahilaMandals) and involve lady schoolWorkers and girls of the primary/middle schools in the village which have relevance to her functions.

15. To guide Accredited Social Health Activists (ASHA) engaged under National Rural Health Mission in the delivery of health care services and maintenance of records under the ICDS Scheme.

16. To assist in implementation of Kishori Shakti Yojana (KSY) and motivate and educate the adolescent girls and their parents and community in general by organizing social awareness programmes/ campaigns etc.

17. AWW would also assist in implementation of Nutrition Programme for Adolescent Girls (NPAG) as per the guidelines of the Scheme and maintain such record as prescribed under the NPAG.

18. Anganwadi Worker can function as depot holder for RCH Kit/ contraceptives and disposable delivery kits. However, actual distribution of delivery kits or administration of drugs, other than OTC (Over the Counter) drugs would actually be carried out by the ANM or ASHA as decided by the Ministry of Health & Family Welfare.

19. To identify the disability among children during her home visits and refer the case Immediately to the nearest PHC or District Disability Rehabilitation Centre.

20. To support in organizing Pulse Polio Immunization (PPI) drives.

21. To inform the ANM in case of emergency cases like diahorrea, cholera etc.

2.28 Study context

Farrukhabad is situated between Lat. 26° 46' N & 27° 43' N and Long. 79° 7' E & 80° 2' E. The district is bounded by Badaun and Shahjahanpur on the north, Hardoi District on the east, Kannauj District on the south, and Etah and Mainpuri districts on the west.
The Ganges River and Ramganga River are located to the east and the Kali River to the south. The district formerly included present day Kannauj District; it was divided into two districts on September 18, 1997. The district consists of
three tehsils, Farrukhabad, Kaimganj and Amritpur. Amritpurtahsil was created from Rajepur Block after the district was split in 1997. The district lies on a plain, varied only by a few gentle undulations and slopes, sometimes abrupt, which lead down to the river valleys. The highest recorded elevation is 167 m above sea level at Mohammadabad and the lowest 145.69 m at Mau Rasulpur in the Trans Ganges flats of Tehsil Farrukhabad. The only marked variation of level is between the two divisions, the upland or bangar, which is a continuation of the doab and the low lands or Tarais, cut away from the upland by the erosive action of the rivers. According to the 2011 census Farrukhabad district has
a population of 1,887,577 roughly equal to the nation of Lesothoor the US state of West Virginia.This gives it a ranking of 250th in India (out of a total of 640).The district has a population density of 865 inhabitants per square kilometre (2,240/sq mi)
.populationgrowthrate over the decade 2001–2011 was 20.2%. Farrukhabad has a sex ratio of 874 females for every 1000 males, and a literacy rate of 70.57%

3. Rationale-

Village Health and Nutrition Day is an initiative taken under NRHM, with a prime motto to deliver basic health services to the last person in the community. The data shows that health service provision has fairly improved but the aim of the program is yet to be achieved. This signifies that there are gaps in the service delivery at VHNDs.

What is AAA PLATFORM?

Govt of Uttarpdesh Health and Family welfare department decided to work primary focus of High priority District to improve health and nutrition indicator of the state

RMNCH+A is the key indicative and comprehensive care in mother and child context

To full fill goal of this programme some co-ordination required in FLW (front line worker) ASHA, AWW, and ANM.

On date 25th September 2015 letter of 7369-25 Govt of UP (Family Welfare/8/Pri Edu)

Stated that one coordination meeting required per month at SC level by ANM, ASHA, AWW it'scalled as AAA platform

Objectives of AAA.

I. To increaseco-ordination between FLW
II. To followrecord of FLW

III. Capacity building of fLW
IV. Well performed VHSC by AAA

Activity conducted at AAA platform

I. Village health and nutrition day planning and issue to be discuss
II. Take home Ration(premixed food) by AWW to Provide to needed beneficiary with due list
III. Due list of services given in VHND like ANC PNC, immunization and FP
IV. Tracking of High Risk Pregnancy and how to identify HRP
V. Birth micro plan to enhance Institution delivery of Area
VI. Resisted and unserved population identification and plan to achieve
VII. Nutrition RehabilitationsCentre, introduction and identification and tracking of SAM child
VIII. Annual target V/s work done in ANC, immunization services
IX. ASHA support to full Village Health Index Register
X. To fill ASHA drug kit
XI. Health and Nutrition related issue and skill building of FLW
XII. IEC and BCC of Health and Nutrition Programme
XIII. Village Health Sanitation and Nutrition Committee,(VHSNC) who to make effective to full fill objective

Time line and Fund

AAA platform organized by SC level ANM and to invites ASHA and AWW of respective area, ANM use fund of Untied SC for make arrangement of sitting Per meeting 150 rsTobepried for the arrangement, per ASHA and AWW 50 rs provided for to patriated in AAA, payment should be given within 10day to respective Account by PFMS.

4.Research Question-

- What are the gaps at the AAA platform at SC level of 4 block of farrukhabaddistrict?

5.Research Objective-

- To identify the gaps at the AAA platform at SC level of 4 block of farrukhabaddistrict.

6.Research Methodology-

- Study Type- cross sectional study, Descriptive, Quantitative study design

- Study Area- The study is conducted Farrukhabad district (Uttar Pradesh) with a sample size of 50 respondents through a Structural questioner
- Study Period- 3 month
- Study Respondents-The respondents for the following were front line workers (ANM, ASHA and AWW) at the various AAA site.
- Sample Size- A sample size of 50is taken. AAA is conducted on Friday of every week.
- Data Collection Technique- Face to face interview and direct observation.
- Data Collection Tool- Structured questionnaire

- Aim of the study-The aim is A Study on Implementation and Gap Analysis of AAA Model (ANM, Aganwadi Worker, ASHA) of District Farrukhabad UP

- The study was conducted in 4 administrative blocks (Badhpur, Kaimganj,Kamalganj,Shamashabad of District Farrukhabad
- We sampled 50 SC , ANM whre AAA meeting conducted in month of Feb to April 2016, and the criteria for remoteness of the village are dependent on the availability of all-weather roads and distance from the highway.

7.Scope of the Study-

Platform to be prepare for to identify gap of front line worker at door step ASHA and AWW and to improve services with both to gather and insureknowledge and skill Tobe build up during AAA

In 2005 with the launch of the National Rural Health Mission, we committed ourselves to a vision of universal access to health, with a strong focus on community engagement to ensure people's participation in health and to enable action on the social determinants of health. The key instruments were the ASHA and the Village Health, Sanitation and Nutrition Committees. In the last seven years, the ASHA has proven to be a key pillar of this process. This process has not been easy, and was rendered complex by the fact that in 2005 there was little experience with implementing large scale community health worker programmes, much less with creating community institutions such as Village Health, Sanitation and Nutrition Committees. Despite this, most states have overcome steep learning curves to lay the foundations for a viable ASHA programme. The outcome for VHSNC is less satisfactory. The key tasks for the next phase of the NRHM are to equip the ASHA with additional skills to enable an active role for her in not just Reproductive and Child Health but also to undertake action for prevention and community level care for Noncommunicable Diseases. This can be achieved through high quality training and field support and mentoring, through strengthening the VHSNC as an institution for community action and enable both, the ASHA and VHSNC to function in a coordinated manner to ensure achievement of positive health outcomes at the community level. We must not underestimate the significant challenges to achieving this. As we have in the past, the centre and states must work in collaboration to undertake this journey forward. One means of enabling effective implementation is this revised set of guidelines for NRHM's Community Processes. These guidelines encapsulate the learning of the last few years. They areintended to provide not a rigid framework but a guidance document as we jointly embark on thesecond phase fo the programme. In this second phase efforts under the National Rural Health Mission will also be directed

towards the identification, diagnosis and long-term management of Noncommunicable Diseases. This will require new learnings, especially in those public health workers whose energies have so far been focussed only on Communicable Diseases or on issues of Maternal and Child Health. India's path to achieving universal Health Coverage is long and paved with challenges. Investing in a programme for disease prevention and health promotion through the ASHA and VHSNC holds substantial promise in realizing this vision. I hope that states will find these guidelines useful and will work closely with the MOHFW in adapting the guidelines to specific contexts, but retaining the heart and spirit of the community processes interventions.

7.1 Use of the study- After the study if results are satisfactory in those particular areas then no further changes are required. If it is not, then we need to be focus on the following aspects like, Supportive supervision at AAA sessions, capacity building of frontline workers, strengthening monitoring and motivate the workers to perform better by introducing an award for best AAA site.

7.2Demographic Profile – Demographic profile of Farrukhabad district.

Map3:

- In 2011, Farrukhabad had population of 1656616 of which 881776 male and female were 774840 and respectively. In 2001 census, Farrukhabad j had a population of 1388923 of which males were 744170 and remaining 644753 were females

a) There was change of 19.27 percent in the population compared to population as per 2001. In the previous census of India 2001, Farrukhabad j District recorded increase of 20.16 percent to its population compared to 1991.
b) Average literacy rate of Farrukhabad District in 2011 were 77.70 compared to 61.88 of 2001. If things are looked out at gender wise, male and female literacy were 80.91 and 63.33 respectively. For 2001 census, same figures stood at 72.76 and 61.88 in Farrukhabad District. Total literate in Farrukhabad District were 1192763 of which male and female were and respectively. In 2001, Farrukhabad had in its district.
c) With regards to Sex Ratio in Farrukhabad, it stood at 879 per 1000 male compared to 2001 census figure of 866. The average national sex ratio in India is 943 as per latest reports of census 2011 Directorate. In 2011 census, child sex ratio is 898 girls per 1000 boys compared to figure 912 of girls per 1000 boys' of2001 census data.

8.Results and finding

To fill questioner and field observation some table and graph are prepared for the finding.

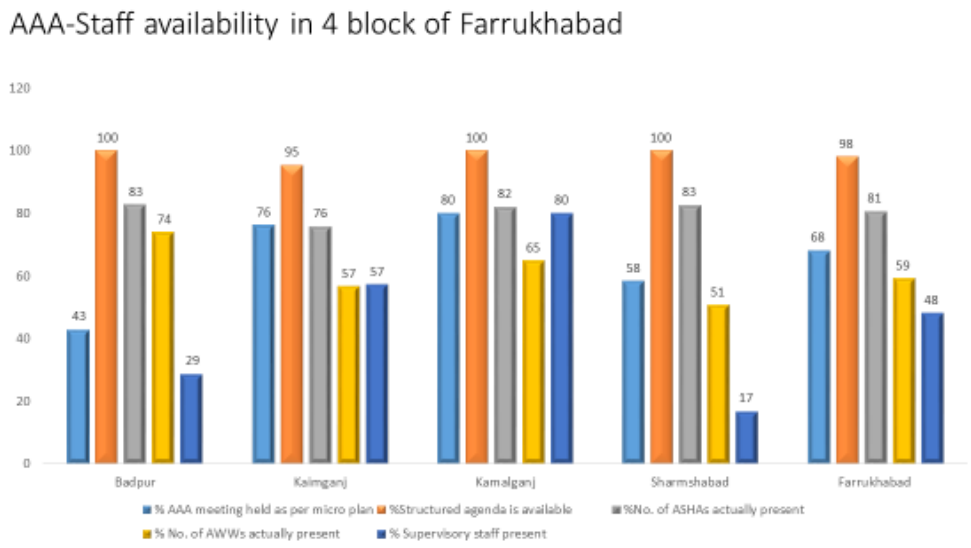
Table 1.1 Presence of Supervisory staff and ASHA and AWW at AAA platform Table suggested that out of 50 AAA 24 site supervisors staff present 48% presence of supervisory staff.Out of 50 meeting 38 meeting done as per micro plan suggested 34%, only 1 meeting as no structural agenda, 283 ASHA supposed to be present but 238 present in 50 AAA platform its show 81% of ASHA attendance, presence of AWW supposed to be present 380, actually present 213 its 59 % present in AAA plat form.

AAA-Staff availability in 4 block of Farrukhabad

Block	N	AAA meeting held as per micro plan	% AAA meeting held as per micro plan	Structured agenda is available	%Structured agenda is available	No. of ASHAs supposed to be present	No. of ASHAs actually present	%No. of ASHAs actually present	No. of AWWs supposed to be present	No. of AWWs actually present	% No. of AWWs actually present	Supervisory staff present	% Supervisory staff present
Badpur	7	3	43	7	100	52	43	83	42	31	74	2	29
Kaimganj	21	16	76	20	95	74	56	76	145	82	57	12	57
Kamalganj	10	8	80	10	100	94	77	82	88	57	65	8	80
Sharmshabad	12	7	58	12	100	63	52	83	85	43	51	2	17
Farrukhabad	50	34	68	49	98	283	228	81	360	213	59	24	48

Data source-Compilation of Questionnaire

Graph 2.1



Data source-Compilation of Questionnaire

Table 1.2

Table 1.2 show that VHND wise service follow up and activity related different component like due list of immunization, ANC services and PNC services and FP counselling,

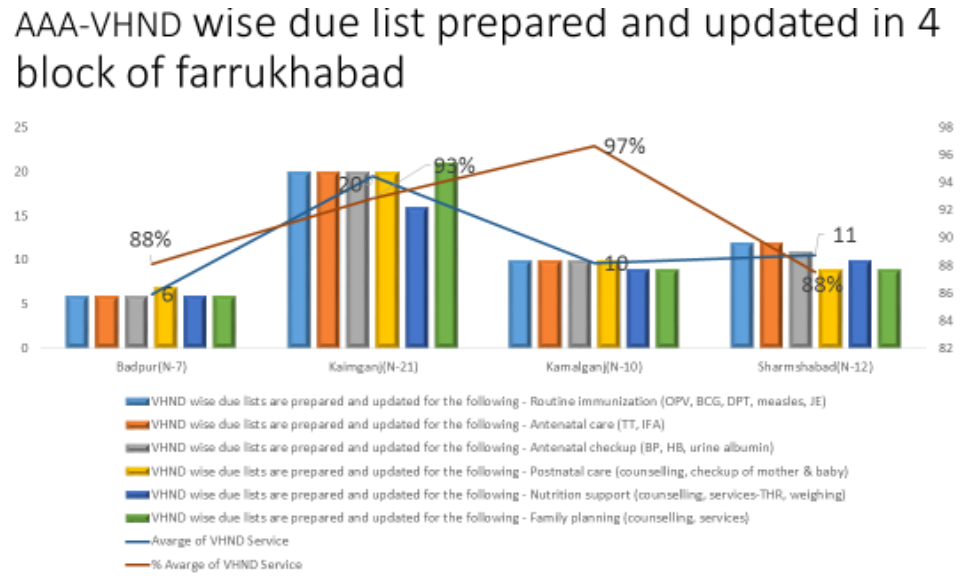
Researcher do average work done for all VHND services data show that out of 50 , 46 component to be revived in the AAA platform its suggest 92 % of work

AAA-VHND wise due list prepared and updated in 4 block of farrukhabad

Block	N	VHND wise due lists are prepared and updated for the following - Routine immunization (OPV, BCG, DPT, measles, JE)	VHND wise due lists are prepared and updated for the following - Antenatal care (TT, IFA)	VHND wise due lists are prepared and updated for the following - Antenatal checkup (BP, HB, urine albumin)	VHND wise due lists are prepared and updated for the following - Postnatal care (counselling, checkup of mother & baby)	VHND wise due lists are prepared and updated for the following - Nutrition support (counselling, services- THR, weighing)	VHND wise due lists are prepared and updated for the following - Family planning (counselling, services)	Avarge of VHND Service	% Avarge of VHND Service
Badpur	7	6	6	6	7	6	6	6	88
Kaimganj	21	20	20	20	20	16	21	20	93
Kamalganj	10	10	10	10	10	9	9	10	97
Sharmshabad	12	12	12	11	9	10	9	11	88
Farrukhabad	50	48	48	47	46	41	45	46	92

Data source-Compilation of Questionnaire

Graph 2.2



Data source-Compilation of Questionnaire

Table 1.3 AAA platform strengthen activity like follow of for next AAA, mitting minute and Achievement of last VHND to be taken

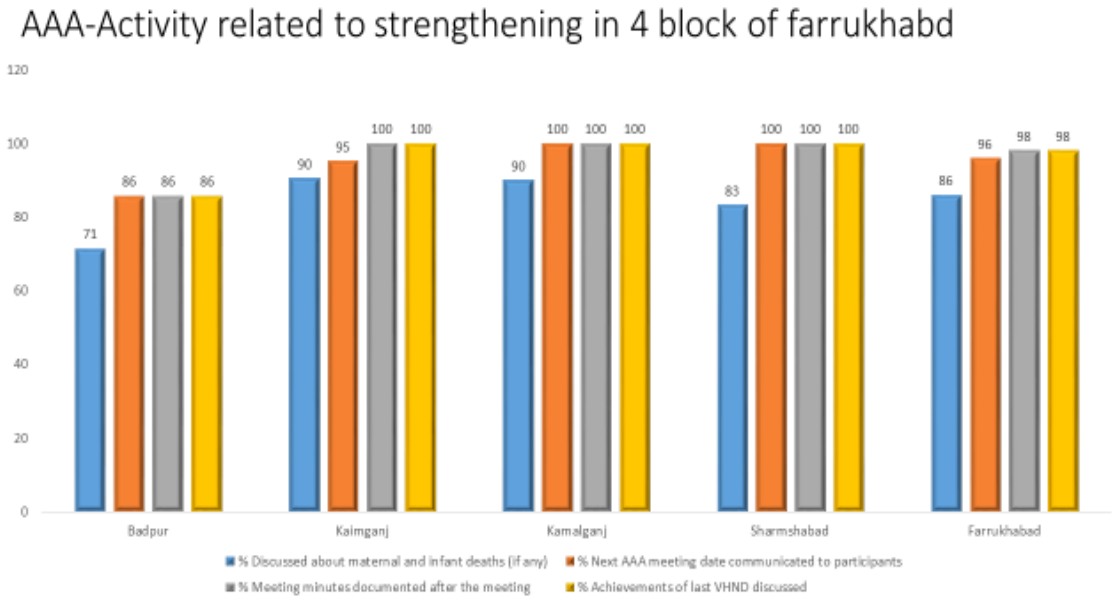
86% AAA meeting discuss about infant and mothersdeath and causes of that ,96 % AAA given next day of meeting date,98% meeting of minute prepared and shared for further improvement of work, 98% discus last VHND improvement

AAA-Activity related to strengthening in 4 block of farrukhabad.

Block	N	Discussed about maternal and infant deaths (if any)	% Discussed about maternal and infant deaths (if any)	Next AAA meeting date communicated to participants	% Next AAA meeting date communicated to participants	Meeting minutes documented after the meeting	% Meeting minutes documented after the meeting	Achievements of last VHND discussed	% Achievements of last VHND discussed
Badpur	7	5	71	6	86	6	86	6	86
Kaimganj	21	19	90	20	95	21	100	21	100
Kamalganj	10	9	90	10	100	10	100	10	100
Sharmshabad	12	10	83	12	100	12	100	12	100
Farrukhabad	50	43	86	48	96	49	98	49	98

Data source-Compilation of Questionnaire

Graph 2.3



Data source-Compilation of Questionnaire

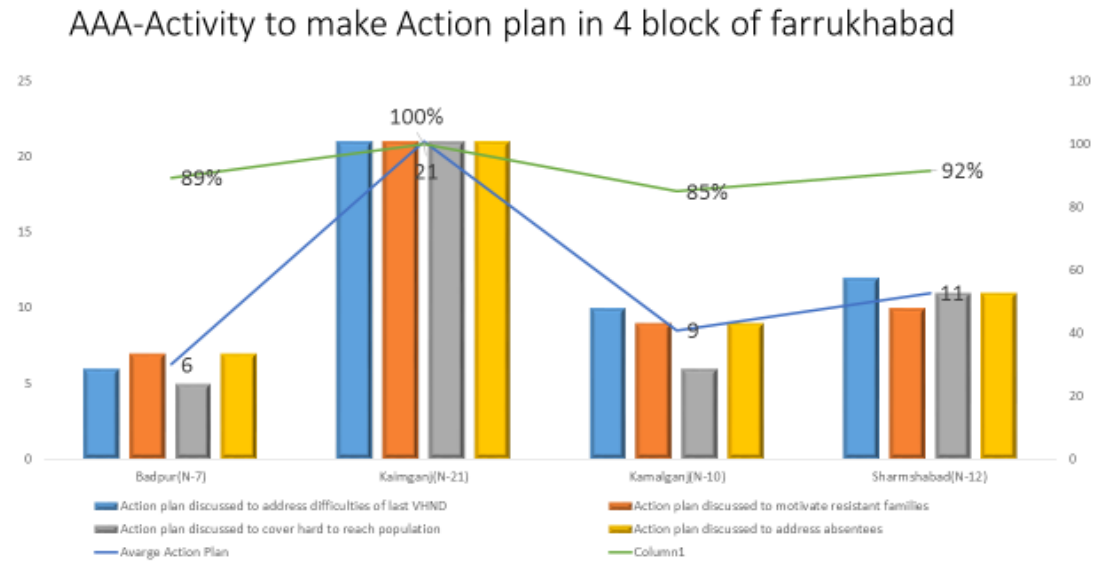
Table 1.4 Action plan for various work like address difficulty in VHND, hard to rich area and Resisted family and absentees in meeting , data suggested that out of 50 AAA , 47 AAA done all the things its show 94%

AAA-Activity to make Action plan in 4 block of farrukhabad

Block	N	Action plan discussed to address difficulties of last VHND	Action plan discussed to motivate resistant families	Action plan discussed to cover hard to reach population	Action plan discussed to address absentees	Avarge Action Plan	% of Work done for Action Plan
Badpur	7	6	7	5	7	6	89
Kaimganj	21	21	21	21	21	21	100
Kamalganj	10	10	9	6	9	9	85
Sharmshabad	12	12	10	11	11	11	92
Farrukhabad	50	49	47	43	48	47	94

Data source-Compilation of Questionnaire

Graph 2.4



Data source-Compilation of Questionnaire

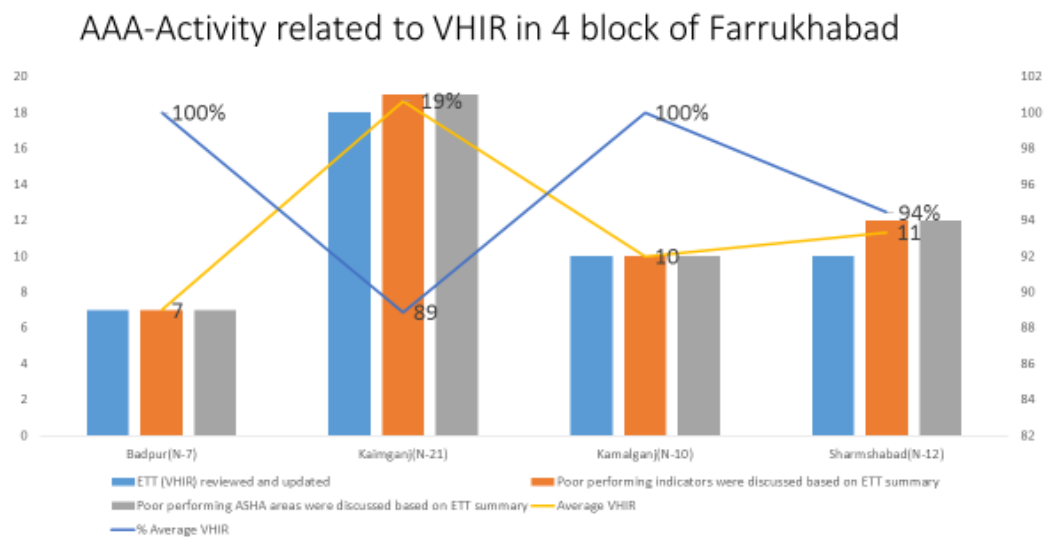
Table 1.5 about Village health index register to be discuss and updating and poor indicator of village to be discuss during meeting. Data suggested out of 50 meeting 47 meeting 94% done VHIR work up to date.

AAA-Activity related to VHIR in 4 block of Farrukhabad

Block	N	(VHIR) reviewed and updated	Poor performing indicators were discussed based on (VHIR) summary	Poor performing ASHA areas were discussed based on (VHIR) summary	Average VHIR	% Average work done for VHIR
Badpur	7	7	7	7	7	100
Kaimganj	21	18	19	19	19	89
Kamalganj	10	10	10	10	10	100
Sharmshabad	12	10	12	12	11	94
Farrukhabad	50	45	48	48	47	94

Data source-Compilation of Questionnaire

Graph 2.5



Data source-Compilation of Questionnaire

8.1Discussion:

The study findings show that the ASHAs understanding about their roles and responsibilities is very limited. The recruitment, training and on going support to the ASHAs is inadequate for them to play a comprehensive role as conceived by the NRHM. While the The study also brings out the fact that even the other stakeholders like the ANM, Anganwadi worker; have not been educated about the various work done in VHND and also effective VHSNC, Still nutrition related activity missing in the system, how to identify SAM children, how to make effective IYCF. Participation of AWW is less its Tobe strengthen for nutrition related work.

9.Observations of field Visits

a) During my visits to SC, PHC, CHC OR FRU in general all of them were maintained properly. When TSU come into action and starts providing technical support the quality of service is much improved.
b) Role of AWW & ASHA is not visible & they needs to be oriented on health & nutrition issues in various sites.
c) Expired medicines were found in the medicine stock and sometime medicines with short expiry are given to FLW.
d) Safe disposal of BMW is not implemented in VHND
e) Toilet facility was not available at VHND site
f) Hardly any issues are discussed as per guidelines.
g) Most of the VHND sites all the vaccines were available.
h) Height of the children is not measured.
i) Banner /poster was not displayed in various sites.
j) Counselling is not observed.

10Challenges and Lessons Learned

10.1 Systems strengthening leads to programme Improvements at scale:

It is important to strengthen multiple systems to achieve improvements in AAA Efforts focused on frontline workers to the guidelines and their roles, strengthening supervision, using a structured checklist to monitor AAA, using data for programmatic decision-making and ensuring platforms for convergence. All of these aspects collectively will contribute to increase the coverage and quality of AAA.

10.2 Inter-departmental convergence at various levels:

Convergence meetings institutionalized at the block and district level have proved a very effective mechanism is addressing gaps in AAA services. Joint problems-solving is improving the quality of AAA. Visible improvements at the field level have encouraged government officials to continue with these convergence meetings on a regular basis.

10.3 Supporting frontline workers is critical for ensuring AAA are reaching the community with needed services:

Support frontline workers to knew their roles and responsibilities during AAA and received the support they needed from supervisors to perform these functions. Supervisory support from ICDS supervisors and ANMs helped AWWs and ASHAs to appreciate the importance of their roles and helped them with problem-solving and motivation. Supervisory visits contributed to improved performance of frontline workers, who are motivated by the fact that someone cares about their performance.

This study is to attempt to find out the effectiveness of factors for strengthening on important to strengthen multiple systems to achieve improvements in AAA. Effectiveness on frontline workers.

11.CONCLUSION

- Supportive supervision and on the spot training at AAA sessions.
- Capacity building of frontline workers and frequent training of the same.
- Proper planning and implementation of AAAs.
- Strengthening monitoring and supervision of AAAs.
- Community awareness and proper IEC should also be done to encourage health seeking behaviour among the masses.
- Motivate the workers to perform better by introducing an award for the best AAA site
- Cluster meetings should be properly arrange
- AAA meeting platform should be properly utilize, it will help to develop the coordination between ASHA, Anganwadi worker and ANM. So main moto behind VHND will be fulfilled.

Monitoring and evaluation of programs Linkages with formal health care system Training (including refresher trainings) Supervision and feedback Incentives or motivational component Advancement opportunities Common challenges and weakening characteristics that influence the functionality and sustainability of AAA programs were also identified through this review of the literature.Poor initial planning (disconnect between program developers, program managers and volunteers, failure to consider true costs of program – training, supervision, etc.) Unrealistic expectations or undefined job descriptions Lack of community involvement in design, recruitment and implementation Inadequate training (too complex, not tailored to volunteers' educational level, lack of refresher training, etc.) Difficult to scale up due to tailoring required for programs Lack of resources or inconsistency of resources (funding, supplies, etc.) Problems with sustainability Lack Poor supervision and support (by MOH, supervisors, local community)

These factors, combined with a weak management and organizational structure, contribute to high rates of attrition, absenteeism, low work morale, and poor quality of work for community health volunteers. Such factors should be taken into consideration when assessing the functionality and sustainability of AAA programs. Evaluating AAA programs using these criteria can provide insight into the functionality of the program, as well as help program managers identify key areas for improvement.

. Anganwadi workers play a role of bridge between the community and the ICDS.They play an active role in bringing the services to the door step of the beneficiaries. But

theDepartment of Women and Child Welfare has to look into the matter of remuneration andvery importantly providing accurate knowledge with regard to the responsibilities ofanganwadi workers through organizing all the anganwadi workers under one roof. So that theanganwadi workers will be enhanced with the knowledge and their doubts will be cleared andthey can deliver the services in a better manner

10.1 Overview.

In the context of our literature review, our study sample50, our analysis of the findings, and on the basis of the broad knowledge and experience of the authors, we suggest the following recommendations for the improvement of AAA platform performance in Farrukhabad , Note that given our sample size of four Block, the quantitative findings have limitations in their representative power and are primarily qualitative.

Recruitmentcommunity involvement in selection of ASHAs, Ensure ASHA is motivated, has leadership skills, and perhaps most importantly, has the ability to communicate ideas and learnings in a way that is comprehendible and accepted by the community, Consider implementing a knowledge test for hiring of new ASHAs
• Given that mere education level as a recruitment criteria has often not shown to be indicative of a community health worker‘s capability to perform her work, a brief aptitude test can be considered. Candidates can be provided with brief reading materials in advance, and be tested on these materials to determine comprehension and communication. If proven to be a successful criteria of selection, this may eventually replace the education criteria.

Roles And ResponsibilitiesDevelop a clearly defined, finite list of responsibilities for the ASHA so that she is fully aware of the roles and activities she must fulfilEnsure that distinct roles and responsibilities are clearly communicated between the ASHA, ANM, and AWW, to avoid overlap and increase efficiency

TrainingInduction training should be decentralized to the district level to ensure that all new ASHAs receive training before working in the field A full-time training structure and full-time trainers should be implemented in order to ensure that there are no gaps in training in each state.

Implement ASHA Mobile Kunji ,‖ an innovation seen in UP, in all states in order to provide ASHAs with a new and interesting avenue through which they receive on going on-the-job training as well as information about new illnesses and important events to self and beneficiary. Also take certification of courses

Revamp training for use of medical kits, in order to ensure ASHAs are aware of how and when to use each medicine, how to ensure constant supply of medicine, and how to use the medical kit in a way to complement their work

Increase compensation for travel-related and other miscellaneous expenses
Derive an algorithm for providing compensation for travel based on cost of transportation methods and distances to cover; for example, AWW,ASHAs in rural areas will have fewer methods of transportation and longer distances to travel

Assign a specific supervisor for AAA , that there is specific oversight and monitoring of performance, MO/IC insure staff will reach at site and monitored the activity and fill report.

Given that ANMs have a critical working relationship with ASHAs and AWW, it is also imperative that they be provided support to make this relationship an effective one, both in terms of data reporting as well as task defining; for example, ANMs should not only be trained on technical activities, but also on how to manage and follow up on data that the receive from ASHAs

Institute a formal review process every six months so that AWW,ASHAs performance is monitored and tracked, This can perhaps form the basis for performance/growth related bonuses and upward movement in their careers Ensure that this additional monitoring is done with minimal additional paperwork

Since there were a lot of shortcomings in the whole AAA programme, the study was unable to identify any major factors responsible that would enable or bar an AAA being effective.

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Appendix-1

STATE_____

DISTRICT_____

THESIL/TALUKA/BLOCK_____

VILLAGE_____

NAME OF THE INVESTIGATOR

……..

SIGNATURE OF THE INVESTIGATOR

Interview

DATE	MONTH	YEAR	DAY

TIME

Start of interview:-……

End of Interview:----------

Apendix 2

चेक लिस्ट – ए.ए.ए. बैठक

जिले का नाम	**जिले का कोड:**		**क्लस्टर का नाम**	**क्लस्टर का कोड**	
ब्लाक का नाम	**ब्लाक का कोड**		**उपकेन्द्रका नाम**	**उपकेन्द्र का कोड**	

दिनांक: _____/_____/_____ (दिन/माह/वर्ष)

निर्देश:कृपया अपने उत्तर में 'हाँ' के लिए (1)और'नहीं'केलिए(2), और'लागू नहीं' के लिए (0) लिखें

क्र.सं.	ए.ए.ए. बैठकका आंकलन	
1	क्याए.ए.ए. बैठकमाइक्रोप्लान के अनुसार आयोजितकिया गया ?	
2	AAA बैठक का स्थान कोड लिखें. 1. उप केंद्र 2. आंगनवाडी केंद्र 3. स्कूल 4. किसी का घर 5. अन्य	
3	क्याबैठक का एजेंडा उपलब्ध है?	
4	बैठक में भाग लेने वाली अपेक्षित आशाएं [संख्यालिखें]	
5	बैठक में उपस्थित आशाएं [संख्यालिखें]	
6	बैठक में भाग लेने वाली अपेक्षित आंगनवाडी कार्यकत्री [संख्यालिखें]	
7	बैठक में उपस्थित आंगनवाडी कार्यकत्री [संख्यालिखें]	
8	क्यापूर्व बैठक में लिए गए निर्णयों की प्रगति पर चर्चा हुई?	
9	क्यासरकारीपर्यवेक्षीकर्मचारी/अधिकारी उपस्थित है ?	
10	क्याइस बैठक में टी.एस.यू. की ओर से सहयोगातामक पर्यवेक्षण हेतु कोई और भी उपस्थित हैं?	
11	यदि हाँ,कौन? (बी.सी.एस./नर्स मेंटर/ डी.सी.एस) या अन्य	
12	निम्न के लिए सभी वी. एच. एन. डी. वार डीयू लिस्ट बनाया/ अपडेट किया गया :	
	12.1नियमित टीकाकरण (ओ.पी.वी, बी.सी.जी, डी.पी.टी, मीसल्स, जे.ई)	
	12.2प्रसवपूर्वजाँच और देखभाल (बी.पी,एच.बी,यूरिन एल्ब्यूमिन, टी.टी,आई.एफ.ए)	
	12.3प्रसव पश्चात देखभाल (माँ एवं बच्चे की जाँच और परामर्श)	
	12.4पोषण सम्बन्धी सेवाएँ –(टेक होम राशन, वज़न, कुपोषित बच्चों का संदर्भन और परामर्श)	
	12.5परिवार नियोजन (सेवाएँ और परामर्श)	
13	इस उपकेन्द्र के अंतर्गत कुल कितने VHND आयोजित किये जाते हैं? [संख्यालिखें]	
14	इस बैठक के दौरान कुल कितने VHND के लिए सभी प्रकार की डीयू लिस्ट बनायीं/अपडेटकी गयी? [संख्यालिखें]	
15	क्या वंचित आबादी को आच्छादित करने हेतु कार्य योजना पर चर्चा हुई?	
16	क्या पिछले वी. एच. एन. डी. की समस्याओं को हल करने हेतु कार्य योजना पर चर्चा गयी?	
17	क्या AAA बैठक में सभी आशा और आंगनवाडी कार्यकत्री कीउपस्थितिकोसुनिश्चित करने हेतु योजनाबनायीं गयी?	

18	क्या माँ अथवा शिशु मृत्यु पर चर्चा हुई[यदि कोई मृत्यु हुई है तो]	
19	क्याअमोक्सीसिलिन, ओ. आर. एस. एवंजिंककीउपलब्धता एवं आपूर्ति से संबंधित मुद्दों पर चर्चा हुई	
20	क्या निमोनिया एवं डायरिया सेसंक्रामित बच्चों का चिन्हिकरण एवं रिपोर्टिंग औरप्रतिमाहअनुमानितएपिसोडपर चर्चा हुई l	
21	क्या ई.टी.टी. [वी.एच.आई.आर.] की समीक्षा की गयी एवं अपडेट किया गया ?	
22	क्या ई.टी.टी. समरी के आधार पर 50% से कम प्रगति वाले संकेतकों वालेआशाक्षेत्र पर चर्चा हुई	
23	क्या बैठक के पश्चात बैठक की कार्यवाही को लिखा गया	
24	कितनी आशाएं VHIR के साथ बैठक में आई हैं	
25	क्या ANM द्वारा उपस्थित आशा और आंगनवाडी कार्यकत्री के भुगतान हेतुप्रपत्र तैयार किया गया?	

Appendix 3

चेकलिस्ट भरने के लिए निर्देश :-

प्रश्न संख्या 1 से 6 तक की जानकारी बैठक की कार्यवाही शुरू होने से पहले अवलोकन कर के लिखें I

1. -यहसुनिश्चित करें की AAA की बैठक CHC द्वारा बनाये गए माइक्रोप्लान/कार्ययोजना के अनुसार ही आयोजित की गयी है I

3. -देखें क्या ANM ने बैठक शुरू होने से पहले बैठकका एजेंडा बनाया है I

5, 7 –उपस्थित होने वाली आशा और आगनबाडी कार्यकर्ताकी संख्या बैठक के दौरान या अंत में भी लिखा जा सकता है I

8. यह अवलोकन करें की क्या पिछली बैठक की कार्यवाही को पढ़ कर निश्चित किये गए मुद्दों की प्रगति पर चर्चा हुई या नही I

9. क्या पूरी बैठक के दौरान कभी भी कोई सरकारी कर्मचारी या अधिकारी जैसे BCPM, BPM, MOIC, CDPO, मुख्य सेविका आदि कोई भी उपस्थित थे I

12. बैठकके अंत में लिखेंक्याउसउप-केंद्रके अंतर्गत होने वाले सभी VHND के लिए VHNDवार सभी 5 प्रकार की डीयू लिस्ट बैठक के दौरान बनायीं गयी या पहले से बनी डीयू लिस्ट को अपडेट कियागयाI उदहारण के लिए- अगर उस उप केंद्र में कुल 5 VHND आयोजित किये जाते हैं और नियमित टीकाकरणके लिए सभी 5 VHNDहेतु डीयू लिस्ट बनायी या अपडेट की गयी तो हाँ लिखें I

14. उदहारण के लिए- अगरउस उप केंद्र के अंतर्गत कुल 5 VHND आयोजित होते हैं और सिर्फ3 VHND के लिए सभी प्रकार की डीयू लिस्ट बनाई गयी, 1 VHND के लिए 3 प्रकार की डीयू लिस्ट बनाई गयी और 1 VHND के लिए 2 प्रकार की डीयू लिस्ट बनायी गयी तो उत्तर में 3 लिखा जाना चाहिए I

प्रश्न 15 से 23 तक के प्रश्नों के उत्तर बैठक के अंत में लिखाजाना चाहिए I

19. आशा के पास प्रतिमाह 25 डायरियाएपिसोड के लिये ओ. आर. एस. एवं जिंक तथा 5 निमोनिया एपिसोड के लिये अमोक्सीसिलिन की आपूर्ति होनी चाहिए l

22. देखेंकितनीआशाएं अपने VHIR के साथ बैठक में आयी थीं I

23. बैठक के अंत में ANM को प्रपत्र 1 में उपस्थित आशाएं और आगनबाडी कार्यकर्ताओं की संख्या लिखनी है ताकि उन्हें भुगतान हो सके I यह अवलोकन करें कि क्या ANMद्वाराबैठक के अंत में यह जानकारी भरी गयी I

Appendix 4

संलग्नक–"3"

पर्यवेक्षण प्रपत्र

पर्यवेक्षक का नामः..... पदनाम.....

ब्लॉक का नामः ..... जनपद का नामः .....

उपकेन्द्र का नामः ..... दिनांकः ..... समयः .....

कार्यरत् आशाओं की सं0		कार्यरत् आँगनवाड़ी की सं0	
उपस्थित आशाओं की सं0		उपस्थित आँगनवाड़ी की सं0	

क्र. सं.	गतिविधि	हाँ / नहीं
1	बैठक में प्रतिभागियों के बैठने एवं पीने के पानी की उचित व्यवस्था थी	
2	बैठक में गत माह आयोजित ग्राम स्वास्थ्य एवं पोषण दिवस की उपलब्धियों एवं कठिनाइयों पर चर्चा	
3	प्रतिरोधक एवं असेवित परिवारों तक स्वास्थ्य सेवाओं की पहुँच नहीं हो पा रही है, के बारे में चर्चा की गयी?	
4	बैठक में आगामी ग्राम स्वास्थ्य एवं पोषण दिवस के आयोजन हेतु स्थल एवं प्रदान की जाने वाली सेवाओं हेतु ड्यू लिस्ट पर चर्चा की गयी?	
5	स्वास्थ्य से सम्बन्धित सामाजिक एवं आर्थिक कारकों पर चर्चा की गयी?	
6	समुदाय स्तर पर पोषण से सम्बन्धित पोषण के स्रोतों को चिन्हीत कर इसके उपयोग पर चर्चा	
7	अति जोखिमपुर्ण गर्भवती महिलाआ की पहचान एवं प्रबंधन पर चर्चा	
8	कुपोषित बच्चों एवं एन0आर0सी0 से डिस्चार्ज हुए बच्चों का फॉलोअप	
9	स्व निर्धारित लक्ष्य का निर्धारण एवं तदानुसार प्राप्त करने हेतु कार्ययोजना	
10	आशा के द्वारा सम्पादित गतिविधियों का वी.एच.आई.आर आदि के माध्यम से सत्यापन	
11	आँगनवाड़ी व आशा की स्वास्थ्य एवं पोषण सम्बन्धी योजनाओं पर समझ बनाना एवं क्षमतावर्द्धन करना	
12	बैठक में ग्राम स्वास्थ्य, स्वच्छता एवं पोषण समिति की बैठकों एवं समिति को प्रदान किये गये अन्टाइड धनराशि की उपयोगिता स्तर पर चर्चा की गयी?	

टिप्पणी–अन्य बिन्दु

पर्यवेक्षक का हस्ताक्षर

8

Appendix 5

संलग्नक- 4"

ब्लॉक स्तरीय ए0ए0ए0 रिपोर्टिंग प्रपत्र

ब्लॉक का नाम..... जनपद का नाम ..... माह .....

कुल उपकेन्द्र की संख्या ..... कुल बैठकों की संख्या .....

क्र.सं.	उपकेन्द्र का नाम	ए0ए0ए0 की बैठक हुई हाँ/नहीं	आशाओं की सं0		आँगनवाड़ी की सं0		माह में आयोजित ग्राम स्वा0पो0दि0 की संख्या		वी0एच0एस0एन0सी की संख्या	
			कार्यरत	उपस्थित	कार्यरत	उपस्थित	नियोजित	आयोजित	नियोजित	आयोजित

अधीक्षक/ब्लॉक स्तरीय प्रभारी चिकित्सा अधिकारी

9

Appendix 6

संलग्नक– 5'

जनपद स्तरीय ए0ए0ए0 रिपोर्टिंग प्रपत्र

जनपद का नाम ..... माह .....

कुल ब्लॉक की संख्या ..... कुल बैठकों की संख्या .....

क्र.सं.	ब्लॉक का नाम	ए0ए0ए0 की बैठक हुई हाँ/नहीं		आशाओं की सं0		आँगनवाड़ी की सं0		माह में आयोजित ग्राम स्वा0पो0दि0 की संख्या		वी0एच0एस0एन0सी की संख्या	
		नियोजित	आयोजित	कार्यरत	उपस्थित	कार्यरत	उपस्थित	नियोजित	आयोजित	नियोजित	आयोजित

मुख्य चिकित्सा अधिकारी

10

Appendix 7

प्रेषक,

महानिदेशक,परिवार कल्याण,
परिवार कल्याण, महानिदेशालय
जगत नारायण रोड, उ0प्र0 लखनऊ।

सेवा में,

मुख्य चिकित्सा अधिकारी,
जनपद–इलाहाबाद, बदायूँ, बहराइच, बलरामपुर, बाराबंकी, बरेली, एटा, फैजाबाद, फर्रूखाबाद, गोण्डा, हरदोई, कन्नौज, कासगंज, कौशाम्बी, लखीमपुर खीरी, महराजगंज, मिर्जापुर, पीलीभीत, रामपुर, संतकबीरनगर, शाहजहाँपुर, श्रावस्ती, सिद्धार्थ नगर, सीतापुर एवं सोनभद्र।

पत्रांक: प0क0/08–प्रशि0/आ0यो0/दिशा–निर्देश/2015–16/7369-25 दिनांक: 22-.09.2015

विषयः उपकेन्द्रों पर आयोजित ए0एन0एम0, आँगनवाडी एवं आशा की मासिक बैठक (AAA Platform) हेतु दिशा–निर्देश के सम्बन्ध में।

महोदय,

समुदाय स्तर पर आर0एम0एन0सी0एच0ए0 की गतिविधियों में गति लाने के लिये स्वास्थ्य एवं आई0सी0डी0एस0 के प्रथम पंक्ति के कार्यकर्ताओं का समन्वय अत्यन्त आवश्यक है। प्रथम पंक्ति के कार्यकर्ता यथा ए0एन0एम0, आँगनवाड़ी व आशा, सामुदायिक स्तर पर स्वास्थ्य एवं पोषण सम्बन्धित विभिन्न गतिविधियों को संचालित करने के लिये उत्तरदायी हैं। इन प्रथम पंक्ति के कार्यकर्ताओं में आपसी समन्वय को बढ़ावा देने से सामुदायिक स्वास्थ्य एवं पोषण कार्यक्रमों में उत्तरोत्तर सुधार लाया जा सकता है।

उपरोक्त को दृष्टिगत् रखते हुये प्रदेश के 25 उच्च प्राथमिकता वाले जनपदों में उपकेन्द्र स्तर पर ए0एन0एम0, आँगनवाड़ी व आशा की बैठक का आयोजन प्रतिमाह किया जा रहा है।

उद्देश्य–

1. ए0एन0एम0, आँगनवाड़ी व आशा के मध्य संवाद एवं समन्वय स्थापित करना।
2. ग्रामीण स्वास्थ्य एवं पोषण दिवस के प्रभावी आयोजन हेतु प्रत्येक माह सूक्ष्म स्तरीय योजना (Micro Plan) एवं संभावित लाभार्थियों की ड्यू लिस्ट तैयार करना।
3. प्रथम पंक्ति के कार्यकर्ताओं के रिकार्डों में एकरूपता लाना।
4. प्रथम पंक्ति के कार्यकर्ताओं की क्षमता वृद्धि सुनिश्चित करना।
5. ग्राम स्वास्थ्य, स्वच्छता एवं पोषण समिति की नियमित बैठकों में सहयोग प्रदान करना एवं समिति के अन्तर्निहित उद्देश्यों की पूर्ति तथा समिति को प्राप्त धनराशि को क्षेत्र की आवश्यकता अनुरूप व्यय सुनिश्चित कराना।

गतिविधियाँ–

- उपकेन्द्र क्षेत्र के अंतर्गत ग्राम स्वास्थ्य एवं पोषण दिवस की गत माह की उपलब्धियों एवं कठिनाइयों पर चर्चा करना।
- समस्त ग्राम स्वास्थ्य एवं पोषण दिवस के अंतर्गत दी जाने वाली सेवाओं विशेषकर पुष्टाहार का वितरण सुनिश्चित कराना।
- गर्भवती महिलाओं, प्रसव पश्चात माँ एवं शिशु देखभाल, पोषण, परिवार कल्याण आदि से सम्बन्धित लाभार्थियों की ड्यू लिस्ट को अद्यतन करना एवं तदानुसार के अनुसार योजना बनाना।
- गर्भावस्था के दौरान जटिलता की पहचान करना एवं उसके अनुसार प्रसव हेतु योजना (Birth Plan) बनाना।
- प्रतिरोधक एवं असेवित परिवार अर्थात वे परिवार जो विभिन्न प्रकार के स्वास्थ्य सेवाओं यथा टीकाकरण, प्रसव पूर्व देखभाल, संस्थागत प्रसव, कुपोषण, परिवार नियोजन आदि सम्बन्धित सेवाओं को

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किसी कारणवश नहीं प्राप्त कर पा रहे हैं, उनके लिए विशेष कार्ययोजना विकसित कर सेवा प्रदान कराना।

- उपकेन्द्र क्षेत्र के अंतर्गत ऐसे क्षेत्रों को चिन्हित करना जहाँ आशा/आँगनवाड़ी द्वारा स्वास्थ्य सेवायें नहीं पहुँचायी जा पा रही है।
- उपकेन्द्र क्षेत्र में समस्त कुपोषित बच्चों एवं एन0आर0सी0 से डिस्चार्ज हुए बच्चों की सूची तैयार करना एवं फॉलोअप हेतु कार्ययोजना विकसित करना।
- उपकेन्द्र क्षेत्र में दी जाने वाली स्वास्थ्य सेवाओं हेतु स्व निर्धारित लक्ष्य का निर्धारण एवं तदानुसार प्राप्त करने हेतु कार्ययोजना विकसित करना।
- उपरोक्त बिन्दु में दिये गये लक्ष्य के सापेक्ष उपलब्धि की बिन्दुवार समीक्षा करना एवं उपकेन्द्र क्षेत्र में गत माह हुए मातृ एवं शिशु मृत्युओं पर चर्चा करना।
- आशा द्वारा माह में किये गये गतिविधियों का वी.एच.आई.आर आदि के माध्यम से सत्यापन करना जिससे कि आशा को प्रतिमाह प्रतिपूर्ति राशि प्रदान की जा सके।
- आशा के ड्रग किट में समस्त सामग्रियों की उपलब्धता की समीक्षा करना।
- बैठक के माध्यम से ए0एन0एम0, आँगनवाड़ी व आशा की स्वास्थ्य एवं पोषण सम्बन्धी योजनाओं पर समझ बनाना एवं क्षमतावर्द्धन करना।
- स्वास्थ्य अधिकार एवं स्वास्थ्य से सम्बन्धित सामाजिक एवं आर्थिक कारकों की समझ विकसित करना एवं आवश्यकतानुसार योजनाओं का निर्माण करना।
- क्षेत्र में आयोजित विशेष स्वास्थ्य एवं पोषण सम्बन्धित गतिविधियों यथा स्वास्थ्य शिविर एवं प्रचार–प्रसार इत्यादि पर चर्चा करना।
- ग्राम स्वास्थ्य, स्वच्छता एवं पोषण समिति की बैठकों एवं समिति को प्रदान किये गये अन्टाइड धनराशि की उपयोगिता पर चर्चा करना।

बैठक का आयोजन–

यह बैठक माह में एक बार किसी भी शुक्रवार को स्वास्थ्य उपकेन्द्र पर आयोजित की जायेगी, इस बैठक हेतु ए0एन0एम0 संयोजक का कार्य करेगी। यदि किसी उपकेन्द्र में ए0एन0एम0 का पद रिक्त है तो प्रभारी चिकित्सा अधिकारी/अधीक्षक का दायित्व होगा कि अन्य उपकेन्द्र की ए0एन0एम0 को नामित कर बैठक कराना सुनिश्चित करें। बैठक में उपकेन्द्र क्षेत्र की समस्त आशायें एवं आँगनवाड़ी कार्यकर्ती को आमंत्रित किया जायेगा। सम्बन्धित आशा संगिनी, सी0आर0पी0 (यू0पी0–टी0एस0यू0) भी यथा सम्भव इन बैठकों में प्रतिभाग करेंगी।

बैठक का आयोजन माह के नियत शुक्रवार (यथा प्रथम शुक्रवार, द्वितीय शुक्रवार आदि) को किया जायेगा। ब्लॉक के सभी उपकेन्द्रों की अगले माह की कार्ययोजना 20 तारीख तक सभी स्वास्थ्य एवं महिला बाल विकास विभाग के जिला स्तरीय एवं ब्लॉक स्तरीय अधिकारियों को अवश्य प्रेषित कर दी जाय। केवल अपरिहार्य परिस्थितियों में ही जिला स्तर से अनुमोदन के उपरान्त ही स्थान अथवा तिथि में परिवर्तन किया जा सकता है, परन्तु इसकी सूचना सम्बन्धित अधिकारियों के साथ–साथ क्षेत्र की आँगनवाड़ी व आशा को समय से देना अनिवार्य है।यदि कार्ययोजना के अनुसार किसी कारणवश निर्धारित शुक्रवार को बैठक न हो पाये तो बैठक आगामी शुक्रवार को आयोजित की जाये। बैठक की कार्यवृत्ति ए0एन0एम0 द्वारा संलग्नक–1 के अनुसार मीटिंग रजिस्टर में अंकित की जायेगी एवं पर्यवेक्षक द्वारा सत्यापित किया जायेगा।

AAA बैठकों की कार्ययोजना ब्लॉक स्तर पर ब्लॉक कम्युनिटी प्रोसेस मैनेजर द्वारा ब्लॉक प्रभारी चिकित्सा अधिकारी के निर्देशन में किया जायेगा। ब्लॉक कम्युनिटी प्रोसेस मैनेजर द्वारा गत माह की 21 तारीख से माह की 20 तारीख के मध्य आयोजित ब्लॉक के समस्त उपकेन्द्रों से AAA बैठकों की रिपोर्ट का संकलन

कर माह की 30 तारीख तक संकलित रिपोर्ट जिला स्तर पर प्रेषित करना होगा। जिला स्तर से जिला कम्युनिटी प्रोसेस मैनेजर आगामी माह की 5 तारीख तक रिपोर्ट राज्य स्तर पर कम्युनिटी प्रोसेस अनुभाग, राज्य कार्यक्रम प्रबंधन इकाई एवं महानिदेशक, परिवार कल्याण को प्रेषित करना होगा।

वित्तीय व्यवस्था–

1. ए0एन0एम0 द्वारा बैठक में प्रतिभाग करने वाले प्रतिभागियों (क्षेत्र की समस्त आशायें, आँगनवाड़ी, स्वास्थ्य एवं आई0सी0डी0एस0 विभाग के पर्यवेक्षक आदि) की संख्या के आधार पर बैठने की उचित व्यवस्था हेतु दरी, कुर्सी, पानी हेतु जग, गिलास, व्हाइट बोर्ड, चार्ट पेपर, मार्कर आदि का क्रय उपकेन्द्र की अन्टाइड राशि से अवश्यकतानुसार किया जाये।
2. बैठक के आयोजन हेतु ए0एन0एम0 द्वारा प्रति बैठक अधिकतम् रू0 150.00 का व्यय किया जा सकता है। यह उसके द्वारा प्रस्तुत बिलों के वास्तविक मूल्य के आधार पर व्यय होगा।
3. बिन्दु संख्या 1 व 2 में उल्लेखित व्यय के अनुमोदन हेतु ए0एन0एम0 सम्बन्धित ग्राम स्वास्थ्य, स्वच्छता एवं पोषण समिति की बैठक में प्रस्ताव लाना होगा। उक्त प्रस्ताव में बिन्दु संख्या 1 में उल्लेखित सामग्रियों का क्रय एवं बिन्दु संख्या 2 में उल्लेखित प्रति बैठक रू0 150 की दर से पूरे वर्ष हेतु कुल रू0 1800 का अनुमोदन प्राप्त कर लिया जाना चाहिए। ए0एन0एम0 द्वारा AAA बैठक में किये गये व्यय की सूचना प्रतिमाह ग्राम स्वास्थ्य, स्वच्छता एवं पोषण समिति की बैठक में उपलब्ध करायी जायेगी।
4. बैठक में प्रतिभाग करने वाली उसकी क्षेत्र की समस्त आशा एवं आँगनवाडी कार्यकत्री को प्रतिमाह रू0 50 प्रत्येक आशा या आँगनवाड़ी को भुगतान किया जाना है। बैठक के पश्चात् ए0एन0एम0 द्वारा आशा या आँगनवाड़ी की सूची बैंक खाता के विवरण के साथ सामुदायिक/प्राथमिक स्वास्थ्य केन्द्र को उपलब्ध कराये जिसका भुगतान सामुदायिक/प्राथमिक स्वास्थ्य केन्द्र द्वारा 10 दिन के अन्दर PFMS के माध्म से भुगतान किया जायेगा।
5. यह सम्बन्धित चिकित्सा अधीक्षक/प्रभारी चिकित्सा अधिकारी की पूर्ण जिम्मेदारी होगी की आशा एवं आँगनवाड़ी को उपरोक्त दिशा–निर्देशों के अनुसार ए0एन0एम0 द्वारा उपलब्ध करायी गयी सूची के आधार पर 10 दिन के अन्दर भुगतान सुनिश्चित करें।

अनुश्रवण एवं रिपोर्टिंग व्यवस्था–

इस बैठक का अनुश्रवण जिला एवं ब्लॉक स्तरीय अधिकारियों द्वारा किया जायेगा। इस हेतु ब्लॉक स्तर पर एक विस्तृत अनुश्रवण कार्ययोजना बनाई जायेगी जिसमें ब्लॉक स्तर के स्वास्थ्य एवं आँगनवाड़ी के पर्यवेक्षकों (यथा स्वास्थ्य शिक्षा अधिकारी, स्वास्थ्य पर्यवेक्षक/पर्यवेक्षिका, मुख्य सेविका आँगनवाड़ी, बी0पी0एम0यू0 के ब्लॉक स्तरीय अधिकारी आदि) का एक रोस्टर इस प्रकार विकसित किया जायेगा कि प्रत्येक उपकेन्द्र की बैठक में कम से कम एक पर्यवेक्षक उपस्थित रहे। इसके अतिरिक्त जनपद एवं राज्य स्तरीय पर्यवेक्षकों द्वारा समय–समय पर बैठकों का पर्यवेक्षण किया जायेगा। पर्यवेक्षक द्वारा संलग्नक–5 के अनुसार पर्यवेक्षण आख्या प्रेषित की जायेगी।

बी0सी0पी0एम0/ब्लाक आशा नोडल अधिकारी द्वारा समस्त उपकेन्द्रों से रिपोर्ट प्राप्त की जायेगी एवं संकलित रिपोर्ट अधीक्षक/प्रभारी चिकित्सा अधिकारी द्वारा प्रत्येक माह की 30 तारीख तक मुख्य चिकित्सा अधिकारी/जनपदीय कार्यक्रम प्रबन्धन इकाई को प्रेषित की जायेगी। जनपद के समस्त समस्त ब्लाकों की संकलित रिपोर्ट मुख्य चिकित्सा अधिकारी द्वारा अगले माह की 5 तारीख तक महानिदेशक, परिवार कल्याण एवं कम्यूनिटी प्रोसेस अनुभाग, राज्य कार्यक्रम प्रबन्धन इकाई को प्रेषित की जायेगी।

उक्त गतिविधि के लिए जनपदों को निम्न तालिका अनुसार राष्ट्रीय स्वास्थ्य मिशन के स्तर से धनराशि अवमुक्त की गयी है–

मिर्जापुर, पीलीभीत, रामपुर, संतकबीरनगर, शाहजहाँपुर, श्रावस्ती, सिद्धार्थनगर, सीतापुर एवं सोनभद्र।

6. निदेशक (मा0शिक0), परिवार कल्याण महानिदेशालय, उ0प्र0 लखनऊ।
7. निदेशक, बाल विकास एवं पुष्टाहार, उ0प्र0, लखनऊ।
8. निदेशक, राज्य स्वास्थ्य एवं परिवार कल्याण संस्थान, लखनऊ।
9. मण्डलीय अपर निदेशक, चिकित्सा स्वास्थ्य एवं परिवार कल्याण, मण्डल–इलाहाबाद, बरेली, लखनऊ, देवीपाटन, अलीगढ़, फैजाबाद, कानपुर, मिर्जापुर, मुरादाबाद एवं बस्ती।
10. मण्डलीय कार्यक्रम प्रबन्धक, मण्डल–इलाहाबाद, बरेली, लखनऊ, देवीपाटन, अलीगढ़, फैजाबाद, कानपुर, मिर्जापुर, मुरादाबाद एवं बस्ती।
11. जिला कार्यक्रम प्रबन्धन इकाई, जनपद– इलाहाबाद, बदायूँ, बहराइच, बलरामपुर, बाराबंकी, बरेली, एटा, फैजाबाद, फर्रूखाबाद, गोण्डा, हरदोई, कन्नौज, कासगंज, कौशाम्बी, लखीमपुर खीरी, महाराजगंज, मिर्जापुर, पीलीभीत, रामपुर, संतकबीरनगर, शाहजहाँपुर, श्रावस्ती, सिद्धार्थनगर, सीतापुर एवं सोनभद्र।

महानिदेशक,
परिवार कल्याण