Minutes of the Meeting - Review Workshop for Nodal Officers of Community Processes, 12th-14th August, 2014

Section 1: Background

The Annual Review Workshop of State Nodal Officers of Community Processes was organized by NHSRC from 12th to 14th August at NIHFW Auditorium, New Delhi. The major objectives of this workshop were to enable state wise sharing of community processes interventions in states and have states share specific issues, good practices, innovations and challenges. Another objective was to provide overview on Newer roles for the ASHA, ASHA certification and use of information and communication technology for community processes. A Three member team including State Programme Officer in-charge of the community processes component or Team Leader of the ASHA Resource Centre, Program In-Charge of ASHA/VHSNC and Program In-Charge of Urban Component of NHM were invited. (Participant List attached as Annexure 1)

The major emphasis of this annual review was to share programme status. This was a two and a half day workshop during which all the states made their presentations and shared their program status. In addition, three panel discussions were also organized on Training of ASHA for action on Violence against Women, ASHA and newer roles and Facilitating ASHA functioning through ICT with experts from various fields. (Agenda of the workshop attached as Annexure 2).

The key note address on the opening day was delivered by Mr. C. K. Mishra, AS & MD, MoHFW. He highlighted the fact that the responsibility of NRHM from last 7 to 8 years has rested on the shoulders of the ASHAs of the country. Our objective of providing accessible, affordable and equitable health care to all could not be met without the ASHAs of the country. ASHAs have played key role in the movement towards 'Health for all'. The major advantage or strength of an ASHA is that she is rooted in the community and knows her community well. He acknowledged the hard work that has been put in to establish the program country wide. He emphasized that even more efforts will be required to overcome the emerging obstacles and problems given the size and complexity of the country. He also mentioned that Ministry is aware of the fact that ASHAs are already overburdened and urged that states should maintain a balance between optimum output and the nature of tasks given to her.

He reflected that when the program began, it was envisioned that ASHAs would be essentially Mobilizers who would focus on promotive and preventive health and facilitate families in accessing the healthcare but now we have seen that she has potential to play additional roles. However, institutional mechanisms that have been already put in place to support the ASHA programme need to be strengthened. He mentioned the set of expectations from AHSA as (1) Routine Immunization (2) Antenatal Care (3) Complicated pregnancies and

referral and (4) Management of common diseases- Cure and Referral. He urged to build a system where we help the ASHAs to give their best by building their capacities.

Dr Naithani, ASHA Nodal Officer from Uttrakhand shared her experience and mentioned the fact that getting best out of ASHA would require strengthening of health service system also. Ms. Vasudha, Team Leader for ASHA programme from Bihar raised the issue of regularization of work of ASHA and providing some form of welfare benefits to her. Mr. Sushant, Nodal Officer for ASHA from Odisha suggested providing opportunities for educational advancement and some form of financial assurance to the ASHAs keeping the fact that ASHAs are doing more than what they are paid. This would be a good recognition for ASHA. Mr. Sanjiv Ranjan, State Nodal Officer from Assam raised the issue of overburdening the ASHAs in his state with various reporting formats especially for Menstrual Hygiene and Contraceptives. Ms. Varsha from Rajasthan mentioned that reporting is a challenge in her state also. She further mentioned that process of certification for ASHAs is a progressive idea and we should also actively advocate for reserving certain proportion of seats for ASHAs in ANMs recruitments. Dr. Gunderao from Karnataka mentioned that ASHA can play major role in addressing increasing burden of mental health problems at community level but we should let her do primary duties first otherwise the number of hours she is expected to put in will increase. Dr. Jagadeeshan from Kerala highlighted the need of convergence at the village level and the role of ASHA in convergence. The AS&MD clarified that we would need to bring the convergence not only at the grass root level, but also at the level of Ministries first and state level departments.

Dr. Rajani Ved, Advisor, Community Processes Team from NHSRC in the introductory session briefed the participants on the objectives of the workshop and mentioned that this was the first time when nodal officers from the entire country were invited together, including the North Eastern States which provided a platform for all the teams to share the status of the program at national and state levels, to discuss challenges and issues and to learn, to identify common solutions of and learn about their best practices and state initiatives. This session proceeded with the round of introductions of the state teams.

Dr. Sanjiv, Executive Director, NHSRC shared his views on “Community Participation for Health” with the participants. He explained that interventions for health can be taken at four different levels which are Family level where health system support is not required (First level) like initiation of breastfeeding, second at community level, third at health facility level and fourth is specialist care. He added that as burden of non-communicable diseases is increasing in India, preventive and promotive health action would be required which can be best managed at community level. He shared his experience from 29 countries across the world where he found Ethiopia and Malawi had the best system, in his opinion for Community Level Workers. He further emphasized that the main strength of an ASHA is her belongingness to the community; therefore we should focus on ‘Communitization of ASHA’ and should not let her get sucked into the system. He also mentioned entitlements should reach ASHA first before certification. As ASHA is a social mobiliser at the community level, keeping her motivated by valuing her work is required. He emphasized that ASHA, ANM and

Anganwadi workers are the three key pillars at the community level who need to be trained through a team based approach to ensure health services reach the community.

On the second day of the workshop, Mr. Manoj Jhalani, JS (Policy), MoHFW participated in a session to discuss the state wide issues. The discussion centred on selection mechanism of ASHAs, status of payments for ASHAs and processes for monitoring her functionality. State teams shared their experiences on specific experiences from their contexts. It was highlighted during the discussion that different states are at different stages, but certain processes will require to be streamlined. The JS suggested four key priority areas which need to be addressed for improving ASHA program are: (a) Framing and implementing clear guidelines for selection of ASHAs (b) Fair and foolproof procedure for removal of non functional ASHA (c) Improving skill sets/ competencies of ASHA and (d) Preventing delay in the payments by streamlining of the payment mechanisms.

Section 2: Key Issues and Highlights from the states

Overall, there has been sustained commitment from the state to ASHA/VHSNC and trend of increased programme strengthening continues. The key issues and highlights from the states are discussed in this section. Overall learning from the states presentations is summarized under different themes below.

- **ASHA Payments:** MSG approval for payment of routine and recurring payments to ASHAs has provided a strong motivation and impetus to the programme managers as well as ASHAs specially hamlet and habitation based ASHAs. Apart from the national incentives, several states are providing honorarium from the state budgets. For example, in Meghalaya and Tripura a matching amount of the incentive earned (33% of the amount earned) is given to the ASHAs. In Karnataka, state has provision to provide 100 % matching incentive in addition to incentives under NRHM programme. Therefore all ASHA will get a minimum of Rs. 2000/- per month for routine activities. In Chhattisgarh, 50% top up in incentives earned are provided. Single Window payments have begun in Odisha, Assam, few districts of Bihar and MP. In West Bengal, incentives are paid from a common pool comprising all national programmes. Moreover, the issue of delay in payments has been addressed and process is being streamlined with the e-transfers mechanisms.

  The state of Bihar has also attempted to streamline the process of ASHA payments. For example : In 2009 a pilot intervention was done in Sheikhpura District with the support of NIPI called Mobile Money Transfer and through -HOPE (Health Operation Payment system) Piloting initially in 5 districts (Patna, Sheikhpura, East Champaran, ,sheohar and arwal) where ASHAs are getting incentives in 22 items, this will now be scaled up across states.

- **ASHA Selection:** Overall, 8.47 lakh ASHAs have been selected across 32 states and UTs– i.e, 90% of the target is achieved (as per census 2011 data, and one ASHA per 1000 population). Tamil Nadu has

proposed to include 10,000 ASHA this fiscal and Pondicherry has also asked for ASHA in urban areas. The experience of selection at field level is varied. States like Chhattisgarh, Jharkhand and Uttrakhand are reported to have selected ASHAs through Panchayats/ Gram Sabhas or through VHSNCs. Some states do not follow the selection guidelines related to selection of ASHAs through open advertisements (West Bengal) or direct selection by ANM and Medical Officers (Tamil Nadu) (without community/gram sabha endorsements) consultation from the community.

Major issue in selection of ASHAs was found in the West Bengal where state has selected ASHAs through a preset criteria based on marks obtained by the candidate in the Madhyamik/10th appeared or equivalent examination (90% weightage) and then an interview with a weightage of 10%. The JS suggested that NHSRC should provide suggestions on selecting the ASHA, to reinforce existing guidelines.

State representatives also shared that the selection process has issues due to the level and structure of selection committee also. Selections are done at sub-divisional level and SDOs involvement is made compulsory. Maintaining presence of public representatives who act as the Chairperson of ASHA selection committee or SDOs for such a large number of selections is a challenge. Representation from community and health department in the selection committee is limited. Similar to other States, West Bengal also faces problems in rational demarcation of population and identifying where there are no ASHA areas.

- **Training:** Module 6 & 7 training is underway in all states with different stages or rounds. Round 3 completed in Uttarakhand, Manipur, Mizoram, Sikkim, and Karnataka. State trainers training for Round 3 is underway in North East, Odisha and West Bengal. In UP, Rajasthan, Jammu & Kashmir, MP, Kerala, Tamil Nadu and Maharashtra, round 1 is yet to be completed. Refresher trainings of ASHAs in Round 1-3 of Module 6 & 7 are planned in West Bengal, Madhya Pradesh, Tripura & Rajasthan and Meghalaya. One of the major issues which many states articulated, specially the North-East states is attrition of trainers at state and district levels and non availability of training sites at sub district levels for residential training of ASHA support staff and ASHAs.

- **Grievance Redressal Mechanisms**: Many states like Jammu and Kashmir, Assam, Haryana, Rajasthan and Karnataka have shown substantial progress over the last year in establishing a Grievance Redressal System for ASHAs. States discussed the data on issues reported, resolved & segregation of most commonly reported issues.

- **VHSNCs Reconstitution and Training:** States like Madhya Pradesh, Chattisgarh, Odisha and Jharkhand have reconstituted the VHSNCs as per the new guidelines with ASHA as member secretary

and joint signatory in the bank accounts. These are also among those states where VHSNCs functionality is really strong. Even though some of the states especially Rajasthan and North Eastern States (except Mizoram) reported that accounting and release of untied funds, conducting regular meetings and mobilising VHSNC members for training is still a challenge. In nine states, VHSNC and ASHAs are managed by separate structures which lead to resistance by sarpanch to making ASHA as Member Secretary and thereby decrease the effectiveness of functioning of VHSNCs. Only some form of orientation has been given to VHSNC members and full training is yet to be given. On the other hand, a few states (Kerala and Karnataka) reported improvements in VHSNC fund utilization. Kerala and Karnataka have provided additional untied grants to the VHSNC from the state budgets and other departments like Rural Development and Panchayati Raj. Karnataka reported using VHSNC untied funds to provide ASHA with sarees.

- **Support Structure:** Overall substantial progress is seen in establishing support structures across states. All high focus states, except Odisha and UP have support structures at four levels. In UP, the process of recruitment is underway. North Eastern states have 3-4 levels of support structures except Sikkim with only one level. Non high focus states like Andhra Pradesh, West Bengal, Tamil Nadu, Kerala, and Jammu & Kashmir have support structures dedicated to ASHA programme only at one level and existing staff managing the programme at other levels. Capacity building of support structures is underway in most states.

- **Procurement of Equipment Kits**: Procurement of equipment kits is a key challenge faced by states which affects quality of ASHA training. Several states were not able to provide kits to ASHA at the time of training- resulting in weak skills for weighing, measurement of temperature and respiratory Rate. States like Uttar Pradesh also reported initial difficulty in printing the modules for ASHAs but this has been resolved recently.

- **Career Opportunities for ASHAs**: Many states reported providing career opportunities for ASHAs. In Bihar, the ASHAs are encouraged to enroll for higher education. In Maharashtra, Chhattisgarh and Assam, many ASHAs are enrolled in ANM schools. Many states like Jharkhand, Chhattisgarh, Bihar and West Bengal also quoted examples where ASHAs have become PRI members, Anganwadi worker or have been promoted to work as ASHA facilitators. One issue highlighted by the Bihar team was that if an ASHA is selected as PRI member, was she to resign from her job of being an ASHA. Similarly, as per the State law, if an ASHA is becoming pradhan in her village, she cannot work as an ASHA. However a contrast is provided from Chhattisgarh where Mitanin who are selected as PRI representatives continue to play the role of Mitanin. This is facilitated by the fact that they cover smaller populations.

- **Welfare Measures for ASHAs:** Many states presented various schemes for welfare of ASHAs. For example, the state of Assam has a scheme known as ASHA Kiron where hospitalization benefit upto Rs 25000/- is given to ASHA or her family member and life insurance for Rs. 100,000/- on the event of death of an ASHA. This applies to the ASHA facilitator also. Meghalaya has a State ASHA benefit scheme and Maternity Benefit scheme for ASHAs. Similarly, in Jharkhand, Sahiya Sahayta Kosh and in Chattisgarh, Mitanin Kalyankari Kosh is put in place for providing various benefits to ASHA and her family. Jharkhand has started a corpus fund to provide financial support to Sahiya in case of death of husband or in case of accident. The corpus fund scheme costs Rs. 10 per Sahiya per year. Representatives of states like J&K, Rajasthan and Bihar showed interest in the corpus fund scheme and hoped that their state would start this scheme or similar as it provides financial assistance to ASHA in case of any sudden crisis. Jharkhand has provided bicycles to all Sahiyas and now planning to provide Scooter (Activa) to few best performing Sahiyas.

- **Newer Roles for ASHAs:** Experience from the state presentations points to the fact that the roles of an ASHA are expanding based on specific needs of the states. Some states have started involving ASHAs in newer tasks. For example, in Kerala, ASHAs are involved in a Pain and Palliative Care Program where ASHAs are incentivized for providing home care to the patients. ASHAs are provided incentives for facilitating obtaining Disability Certificate by the physically challenged. In Sikkim, ASHAs have been trained in facilitating for screening of Diabetes. In Punjab, ASHAs have been involved in Cancer Screening campaign. In Madhya Pradesh, state has a concept of a space called Gram Aarogya Kendra with basic screening and diagnostic (16 types of drugs and tests (Urine, Hb, Malaria, Pregnancy) in the Anganwadi centre ASHAs are required to spend 2-3 hours per day at this site.

Section 3: Panel Discussions

A. Training of ASHA for action on Violence against Women: Ms. Jaya Srivastava

Ms. Jaya Srivastava, Resource Person started the session by asking the State to share their views on GBV and ASHA Programme. The incidence of violence against women is not related to how developed the state is, but rather deep rooted patriarchal attitudes.

Ms. Varsha, Rajasthan shared her experiences of working with victims of violence, its relation with alcoholism, ASHA's involvement and its relationship with economic empowerment. She was of the view that this training needs to be supplemented by empowerment. Ms. Jaya Srivastava brought the example of Self Help Groups which are meant for income generation but were not able to deal with violence at their homes, since violence against women is inter-twined with society, culture, education & economy.

Dr. Saroj Naithani , Uttrakhand was of the view that there is no linkage between economic empowerment and violence against women, Also 5-10% of ASHAs may be undergoing some form of violence in their workplace or homes, so, training them on the topic and on counseling skills is crucial. Ms. Akay Minz, Jharkhand shared that the high levels of motivation and empowerment in Sahiyas has resulted in their working on VAW and Public Distribution System (PDS) as well. In Hazaribagh, Sahiyas were invited to schools to train their students on GBV. In Assam where ASHA Round 4 training has started, the state nodal officer showed that acceptance of the module is good and ASHAs were interested in the content and training methodology.

Dr. Jagadeesan, Kerala talked about the structure in place to support ASHA's mobilization for violence against women, State has one designated Gender Resource Centre per district which is now being expanded to block level. An integrated centre at sub district/district level will be formed where cases of GBV can be registered.

Mr. Samir Garg, Chhattisgarh was of the firm belief that in Chhattisgarh, it was not possible to visualize the Mitanins involvement in health issues without their working on GBV. This gives them more credibility and builds their reputation in the community. GBV is one of the issues which are discussed in VHSNC and twelve years after inception of Mitanin programme, they remain deeply involved in dealing with GBV in their communities.

B. ASHA and Newer Roles: Dr. Prasanta Tripathy and Mr. Sameer Garg

For the panel presentation on ASHA and her newer roles, Mr. Prasanta Tripathy from EKJUT and Mr. Sameer Garg from SHSRC, Chhattisgarh were invited. Dr. Tripathy, who is also a member of the National ASHA Mentoring Group, started the session by making a background that ASHAs are already playing various roles and it is time to consolidate her existing skills.

He shared the findings from the EKJUT randomized controlled trial using 'Participatory Learning and Action' Jharkhand conducted from 2005 to 2008. The findings revealed high impact of the group meetings with 45% reduction in the Neonatal Mortality in the experimental areas. Later after 2008, the same model was replicated in control areas where 31% reduction in NMR was recorded. He further mentioned that the same model has been replicated with ASHAs in five districts of Jharkhand and Odisha which resulted in reduction in NMR up to 32%. In areas where reduction in neonatal mortality is recorded, significant reduction in Moderate Maternal Depression was found. He further substantiated the value and effects of PLA by demonstrating the softer effects found on the community during the trial in terms on increase in capability, resilience, change in societal norms, and increase in intergenerational equity and reduction in externalities.

He said that adding PLA skills to the ASHA's capacity would strengthen HBNC as well. He urged that empowering the community and ASHA would be a long term solution for reducing not only maternal and infant mortality but also many other issues of the community. In addition, imparting 'Problem Solving Skills' can benefit the community to major extent.

The presentation invoked high level of interest among the participants. During the interactive session, the participants (from Maharashtra) requested Mr. Tripathy to explain the 'Intervention' in greater detail. Ms. Vasudha from Bihar raised the importance of teaching 'Communication Skills' during the training of ASHAs and ASHA facilitators. Mr. Jagdeeshan from Kerala shared his experience from the state where methods of participatory learning and action are practiced throughout the departments and in the community. States like Nagaland, Meghalaya and Bihar expressed their willingness to include training on PLA methods to their ASHAs. Dr. Rajani Ved said that NHSRC would work with Dr. Tripathy and the MoHFW to take this further.

Dr. Tripathy highlighted that using methods of 'Participatory Learning and Action' would complement the ASHA role as a facilitator. He mentioned the need for 'Circular Model' where community members act as both, planners and implementers and can monitor service providers and service recipients. He defined the four phases of community action as Phase 1: Identify and Prioritize Problems, Phase 2: Plan Strategies, Phase 3: Put strategies into practice and Phase 4: Evaluating together.

The second speaker, Mr. Sameer Garg from Chhattisgarh shared his experience on "Role of ASHA in Community Based Planning and Monitoring" from the state of Chhattisgarh. VHSNC are the main vehicle for CBPM. The VHSNCs programme was over six years old, and out of 20,000 villages, 19,000 have constituted VHSNC. The process of constitution of the VHSNC has been participatory where VHSNC formation is done through Special Gram Sabhas called Gram Niyojan Abhiyan, conducted under an order issued by Directorate of Panchayati Raj. Under this Abhiyan, a film was made on VHSNCs and showed across the state especially to PRIs and ASHAs. Other social communication and mass media methods like Folk Theatre shows (Prerana Dal) in each of the 10,000 Panchayats and radio jingles were used to initiate discussions on health. There is a high involvement of PRI Department since VHSNC is a sub-committee of Gram Panchayat's Standing Committee on Health. The major focus of VHSNCs is preparation and execution of inter-sectoral village health plans to address local health gaps through collective action.

He then discussed the importance of 'Village Health Monitoring Register', Death and Birth Register maintained by VHSNC as part of Community Based Planning and Monitoring. This helps to monitor health inequities in the community. He highlighted how Information on indicators on various determinants of health are collected in VHSNC meetings result in actual 'community watch' rather than just remaining as "collected data". He then mentioned the key role played by the Mitanins in VHSNC where the Mitanin not only helps in mobilizing the members and other community members but also brings 'Cohesiveness in Action'. The ASHA Facilitator helps to conduct VHSNC meeting as well as 'VHSNC cluster meeting' which is a state specific initiative (outside NRHM).

An evaluation of VHSNC has also been done by SHRC with 320 VHSNCs across the state. The findings revealed that around 74% of VHSNCs are carrying out village health planning and almost equal attention is paid to

Health (25%), Nutrition (25%), Sanitation (21%) and miscellaneous (29%) issues. In terms of action for village health planning, for 43% of actions, Mitanins took the lead.

Another level of action for health is done through *Jan Samvads* which are held at Block level annually. A major objective of this community level activity is to address those Issues which do not get addressed by village or cluster level community action these issues are raised by community representatives and ASHA to Officials and MLAs/MPs who are present in Jan Samvads.

After the presentation, nodal officers from the states like Bihar, North East and Kerala shared their experiences related to current status and functioning of VHSNCs in their respective states. Mr. Biraj from NE-RRC pointed that in North East, the situation of VHSNCs is completely different where meetings and community based action and planning are being undertaken but nothing substantial has been achieved in this direction. Dr. Tripathy from EKJUT also supported the fact that community level meetings and planning can make a huge difference in addressing various issues of the community. He was however concerned that Jan Samvad's may be counterproductive with officials turning hostile.

C. Facilitating ASHA functioning through ICT: PFMS, GramVani, Mobile Kunji, Chaired by – Dr. Sanjiv kumar, Executive Director NHSRC

The session started with Mr. Sandeep Dash, Dy.CGA, Ministry of Finance, introducing the Public Finance Monitoring System (PFMS) and outlining its key objective which was to effectively manage funds for GOI sponsored schemes - There are about 66 centrally planned schemes and 800 sector schemes that are directly supported by Government of India. In addition GOI also supports some state schemes. Total expenditure on these schemes has more than have doubled from 200 lakh crore to 500 lakh crore for about over 900 such schemes. The major objectives of the scheme are to limit the amount of unutilised funds in the system / banks for a long time and to oversee the utilization of funds.

GOI launched PFMS for efficient management of funds. Roll out of PFMS is planned to coincide with 12th plan. It would provide a computerised solution where all the Plan components could converge and allow assessment of the overall performance of all horizontal and vertical programmes at district level. PFMS is a potential solution to track the status of release of funds based on transaction id (after verification of RBI) from GOI to state treasury Since it is not possible to computerize this in all 25 lakh institutions, a better way would be to synchronize systems with the banking systems. PFMS is akin to an ATM where all transaction are controlled by central branch through a network.

Currently about 79000 institutions are registered with PFMS portals including various nationalized, Gramin and selected private banks which handle government business. This would allow nodal officers at all levels to track the balance of VHSNC accounts. With regard to the process of ASHA payments he informed the participants that like JSY, Direct Bank Transfers would be expanded to ASHA payments also. This would

require all ASHA accounts to be linked with MCTS but in cases where ASHA account is not linked with the MCTS then there is a provision to directly upload the excel files on the PFMS. PFMS is bank neutral and instantly checks and sends the files to banks to check for validation of accounts before payment is made. This information on status of payments can be then uploaded on the public portal.

Following this discussion, some concerns were raised by participants:

State Nodal Officer from Chhattisgarh reported that PFMS was piloted in two districts of Koriya and Dhamtari about 2 years ago. But since bank density is very low and Gramin Coopertative banks do not provide core banking services, there were problems. These included difficulty in opening accounts and beneficiaries having to spend a large amount of time on travelling to about 200 kms to open a SBI account rather than accessing other services such as ANC. Eventually after a year state decided to give bearer cheques again and also implemented payment of ASHA incentives through Panchayats. ASHAs get their incentive payments on a fixed day in her village so she does not have to travel which saves time and money. He also highlighted that this is in accordance with NRHM framework which outlines that payments of ASHA incentives can be done through panchayat. He shared that state has received a GO to implement PFMS by September, 2014 and raised concerns that if state was asked to replace Panchayat based payments with PFMS that would be problematic.

State Nodal Officer from Odisha shared that payment of ASHA incentives are currently being paid through PFMS directly from block to ASHAs after proper verification. However in certain areas there are issues of poor connectivity and unavailability of core banking services at local banks.

State Nodal Officer from Delhi, Haryana and Manipur also raised issues with the processes of PFMS. For instance in Manipur the incentivized activities listed in the system were very few while in Haryana the team encountered problems while linking ASHA accounts in seven districts where PFMS was under trial. In Delhi the poor responsiveness from NIC team was the problem as state team has informed the NIC team on many occasions about correcting the number of districts from 9 to 11 and changing the bank details but these changes are yet to be done. Dr. Monica Rana added that system should have options for – a) mapping every ASHA according to ANM and health centre, b) calculating incentive amounts as per state specific incentive packages and generating reports for state's team.

Consultants from NE RRC and State Facilitator from NERRC for Sikkim said that since the system of DBT was introduced for payments of JSY incentive to beneficiaries denials of payments have increased because of limited access to banks. In many instances, ASHAs have to bear the brunt of complaints from the community. They suggested that given the size of the NE states some other options should also be explored.

Responding to these concerns, Dr. Dash said that he was aware of challenges in implementation of PFMS but also re emphasized that PFMS is the only way for financial inclusion as without this, no bank would open

bank accounts for poor with low balance. He also informed the participants that PMO would soon announce opening bank accounts for increasing financial inclusion. He shared that MOHFW's vision was to merge all data with MCTS for better monitoring. If a state found that the names of ASHA were not being reflected in PFMS it could be because her name was not registered in MCTS. He also said that he is cognizant of state specific systems and reassured participants that the architecture of PFMS allows it to comply with other existing systems given that they are web enabled and that PFMS is designed as a supplementary system and not a substitute.

Regarding the poor support provided by the Local NIC team, he clarified that it could be because of their limited capacity building with regard to PFMS. However since it is a web based system the grievances could be shared online. He informed the participants that given the pace of implementation all components of PFMS may not become fully functional by September, 2014. He assured the states that they have the option of customizing the PFMS to modify the quantum of incentive or add state specific incentives. Since PFMS is aligned with the census data, the whole system is automated to allow an update if any change is made in the village data. He concluded by urging participants not to lose faith in the system because of initial teething problems with PFMS. He reassured participants that till the time PFMS becomes fully functional, account payee cheques could be given, and the system is bank neutral. There is no need to open accounts with any specific bank.

B. Gram Vaani – Dr. Aaditeshwar Seth from IIT, Delhi shared the details of the project GramVaani. Gram Vaani is based on IVR technology and is an interactive tool designed with the objective of enabling behaviour change, empowerment and accountability in the community. Gram Vaani provides a platform for interaction by uploading questions for discussion posed by community members. Findings of the impact assessment of Gram Vaani showed positive findings confirming that when people are actively engaged in discussion, it enables behaviour change. As part of the project, campaigns on early marriage were conducted. Gram Vaani also has a provision for ASHAs to leave a message. Interactions with ASHAs revealed that this has empowered them by enabling social recognition. Gram Vaani also allows the community to demand accountability, crowd sourcing and collecting data from large number of people. In addition Gram Vaani has partnered with a large number of NGOs which further put pressure on system to improve access to services.

Dr. Seth also shared that in Jharkhand, Gram Vaani has launched IVR in collaboration with CINI. Under this project ASHAs give a missed call and receive a return call from the system with audio learning packs. These packs can be updated as per state's priorities and has the potential to be used as training and assessment tool. CINI is also utilising this forum as a helpline, where ASHA can leave a voice recording and CINI can respond to ASHA's question and grievances. He concluded with a message that mobile technology has the potential to be used in several ways for increasing the ASHAs skill of Inter personal communication and to improve service access.

C. BBC Media and Action - Building on the deliberations on Gram Vaani, Ms. Priyanka shared details of Mobile Kunji and Mobile Academy.

She explained that Mobile Kunji was designed for Front line Workers because of their outreach and covering a range of family health behaviours. Kunji was designed with a focus on developing a tool that would be easy to carry for Front line Workers and would create enthusiasm in FLWs.

Mobile Kunji includes a deck of illustrated cards. Each card is based on specific health issues including ANC to Immunization, Nutrition, FP etc. Content of Mobile Kunji has been revised in accordance with ASHA modules in coordination with NHSRC and MoHFW. Every card has a number that is linked to a pre recorded message as the voice of Dr. Anita in local dialect which compliments ASHA's counselling and the message displayed on the card. Audio recording was developed to act as a trigger for dialogue and for effective quality control that same message goes to all people. "Dr. Anita" was created after assessing the shortage of doctors and the lack of linkages of doctors with the community. This has created interest in the community. FLWs are trained in three day training on the use Kunji. The project was launched in Bihar in May, 2012 in and since then 1.48 lakh unique callers have used the system.

Ms. Priyanka shared that different models of training are being considered and one of them includes training the ASHAs through BCMs assisted by master trainers to ensure quality. In Odisha plan is to use state trainer pool i.e, 50 % ASHA trainers and 50% Government staff. She emphasized post training support as a critical factor to deliver the programme effectively and shared that ASHA support structure were leveraged to provide feedback through existing platform of meetings and MIS. Mid line evaluation shows encouraging results.

Mobile Academy for FLWs focuses on "tips and tricks" of Inter Personal Communication skills and how to communicate with families. It is delivered through IVR i.e, FLW has to call and the entire content is delivered over 240 minutes of talk time. At the end of the course (completion of the entire time) a certification of completion is given if she gets 50 % marks on a set of objective questions.

She informed that payment modalities for the call charges for Mobile academy would vary across states, Eg- ASHAs bear the cost for calls in Bihar while in states of UP and Odisha different modalities are being discussed with state health departments

Nodal officers from J &K and Meghalaya inquired about the type of speaker phone that can be used for Mobile Kunji and raised concerns about poor connectivity of networks in hilly areas. Nodal officer from J &K also inquired about unit costing per ASHAs for Mobile Kunji. In response, Ms. Priyanka informed the participants about some nationally approved costs and about the possibility of devising costs in coordination with states. Addressing participants reservations about type of mobile phone, she informed that both Kunji and Academy

have been designed taking in to consideration that technology is not a challenge as any phone with speaker facility can be used and in case there is no speaker then the phone can be handed over to the listener.

The workshop concluded with a vote of thanks by Dr. Rajani Ved.

Section 4: Follow up Actions

1. Support states to follow guidelines on selection process of ASHAs to enable selection of appropriate candidates.
2. Supporting states in planning for refresher trainings for support staff and ASHA.
3. Initiating process of trainer accreditation and ASHA certification after states express readiness.
4. Planning and providing support to the states enabling refresher training of state trainers.
5. Providing support to the states for strengthening the ASHA Mentoring Group in the states.
6. Follow up with North East States on identification of district training sites and ask for approvals in next year PIPs.
7. Planning and facilitation for national and state level training of VHSNCs.
8. Follow up with the states to take a considered approach on adding new tasks to ASHA work under various programmes so that her working hours may not increase more than 5 hours a day.
9. Advocating with states to avoid burdening of ASHA with new formats which do not add value to the programme.

Section 5: Annexures

Annexure 1: Participant List

S.NO	Resource Persons
1	Shri C.K.Mishra, AS & MD, MoHFW, Government of India
2	Mr. Manoj Jhalani, Joint Secretary (Policy), MoHFW
3	Dr. Sanjiv Kumar, Executive Director, NHSRC
4	Ms. Lima Tula Yaden, Director, NHM
5	Dr. Rajani Ved, Advisor, Community Processes, NHSRC
6	Dr. T.Sundararaman, Advisor, PHRN
7	Dr. Prasanta Tripathy, EKJUT
8	Mr. Sandeep Tash, MoFinance
9	Mr. Aaditeshwar Seth, Gram Vaani
10.	Mr. Sameer Garg, SHRC, Chattisgarh
11.	Ms. Radharani, BBC Media Action, Mobile Kunji
12.	Ms. Priyanka, BBC Media Action, Mobile Kunji
13.	Ms. Ragini, BBC Media Action, Mobile Kunji

Participants from the states		
S. No.	Name of the State	Name of the Participants
1	Uttar Pradesh	Dr. Rajesh Jha
2	Bihar	Ms. Vasudha Ms. Anju
3	Jharkhand	Dr. Anuradha Kashyap, (Dep. Director, NHM) Dr. Manju Kumar (NUHM Cell) Ms. Akai Minz (SPC, VSRC)
4	Uttarakhand	Dr. Semwal Mr. Suraj Tomar Dr. Naithani
5	Rajasthan	Ms. Varsha, Ms. Richa Chabbra, SIHFW
6	Madhya Pradesh	Dr. Dilip (Dep director, ASHA), Dr. Vinay (DD, Urban)

		Ms. Aarti (State Comm. Mobiliser)
7	Chhattisgarh	Mr.Sameer Dr. SonwanI
8	Odisha	Sh. Susanta Nayak, Senior consultant, CP-NRHM Mr. Sukant (NUHM), Mr. Rafiquiddin (Consultant)
9	Delhi	Dr. Monika Rana Dr. Swarn Alawadi Ms. Deepmala Mr. Roopak Vishwakarma
11	Telangana (AP)	Dr.K.Kalpana, APO, O/o CH&FW, Dr.Mahipal Reddy, APO, O/o CH&FW
12	West Bengal	Ms. Srabani Majumbar, State ASHA Nodal Officer Dr. T.K.Saha (NUHM-CP)
13	Karnataka	Dr. Gunderao(DD-Community Monitoring) Dr. Sudha (SPO) Dr. Radha Reddy (NUHM)
14	Kerala	Dr. Jagadeeshan, State Nodal Officer, ASHA Shri. Ramachandran, Head, Social Development, NRHM Smt. Seena K.M., Sr. Consultant Social Development , NRHM
15	Tamil Nadu	Dr. Ralph selvin, JD NRHM, Nodal officer Dr. Arul Anand, programme officer in charge, NUHM Dr. Ragunath. K, Programme officer in I/C, ASHA / VHWSNC
16	Jammu & Kashmir	Dr. Jitendra Mehta, (State Nodal Officer for ASHA) Dr. Ajay Khajuria Mr. Sadiq Khan
17	Punjab	Ms. Monica Babbar, Manager ASHA Manager, NUHM
18	Gujarat	Mr. Dipesh Dave, State NGO Coordinator
		Mr. Randhir Patil, Project Officer, Rural Health
		Ms. Deepshikha Sharma, Project Manager-ARC
19	Haryana	Sh. Chand Singh Madaan, Dr. Naresh Mr. Krishan Lal
20	Maharashtra	Dr. Sadhna Tayde, Dr. Vaibhav Rao Patil (NUHM)

		Ms. Swati Patil (VHSNC)
22	Pondicherry	Dr. USHA
23	Andhra Pradesh	Dr. Padmavati (SPM, CHN) Dr. Aruna Devi (SPM, NUHM)

Participants from North East

Sl. No	State	Name	Designation
1.	Manipur	Dr. Kh. Usha	SANO – ASHA / Consultant - RCH
2		Dr. S. Manikanta	SNO – Urban Health
3		Mr. Harris Chongtham	State ASHA Program Manager
4	Arunachal Pradesh	Dr. Tara Taku	Nodal Officer, ARC & Training
5		Dr. Raja Dodum	Nodal Officer, Urban Health
6		Ms. Dagyir Esse	SCM, ARC, Arunachal Pradesh
7	Meghalaya	Dr. P.Dohtdong	Jt Director of Health Services(MCH&FW) cum State ASHA Nodal Officer NRHM, Meghalaya
8		Dr. P.Nongrum	Sr. Medical & Health Officer (MCH&FW) cum State Nodal Officer NUHM, Meghalaya
9		Mrs. Annie Suchiang	State ASHA Programme Manager, NRHM Meghalaya
10	Nagaland	Dr. Sukhato A Sema	Director, Family Welfare, Nagaland
11		Dr. Joel Koza	Deputy Director, NHM, Nagaland
12		Ms. Chubala Pongen	SPM (Community Processes), NHM
13	Mizoram	Dr. R. Lalchhuanawma	SNO (ASHA and HMIS), NHM, Mizoram
14		Dr. T. C. Hmingthangi	SNO (Community Monitoring, VHSNC)
15		Dr. Hmingthansiami	Program Officer (Urban Health), Mizoram
16	Tripura	Dr. Pranadish Das	BO, NHM & State ASHA Nodal Officer, Tripura
17		Mr. Rajib Ghosh	State ASHA Programme Manager, NHM, Tripura
18	Sikkim	Dr. (Mrs). M.L. Lepcha	Nodal Officer CP cum NHM, Sikkim
19		Dr. (Mrs). P. Kothari	(M/O IC) Urban Health Mission
20	Assam	Dr. Deep Jyoti Beka	ASHA Program Manager
21		Mr. Sanjeev Ranjan	Programme Executive
22		Mr. Pratha Saikia	State Community Mobilizer

List of Participants (RRC-NE)

Sl. No	Name	Designation
1.	Dr. Biraj Kanti Shome	Regional Coordinator, RRC-NE - HQ
2.	Ms. Arpana Barman	Consultant – Community Mobilization, RRC-NE – HQ
3.	Mr. Devajit Bora	Consultant - Community Mobilization, Arunachal Pradesh
4.	Mr. Diganta Sarma	Consultant - Community Mobilization, Assam
5.	Dr. Supratim Biswas	Consultant - Community Mobilization, Tripura
6.	Ms. Mousumi Roy	Consultant - Community Mobilization, Meghalaya
7.	Mr. Nabin N Sarma	Consultant - Community Mobilization, Sikkim
8.	Mr. Keema	Consultant - Community Mobilization, Mizoram
9.	Mr. Imo Singh	Consultant - Community Mobilization, Manipur

Annexure 2: Agenda

Day and Timing	Session
Day 1	**Tuesday, August 12, 2014**
9.30 AM - 10.30 AM	• **Welcome Address** –Dr. Sanjiv Kumar, Executive Director, NHSRC • **Objectives of Workshop** –Dr. Rajani Ved, Advisor, Community Processes, NHSRC • **Keynote Address** – Shri C.K.Mishra, AS & MD, MoHFW, Government of India
10.30 AM – 11: 00AM	Tea
11:00AM– 1.00 PM	**State Presentations:-** Meghalaya, Uttarakhand, Uttar Pradesh, West Bengal & Punjab Chair: Dr Sanjiv Kumar, Executive Director, NHSRC
1.00 PM – 2.00 PM	Lunch
2.00 PM – 3:30 PM	**State Presentations:** Orissa, Jharkhand, Delhi, Maharashtra, Bihar Chair: Dr. Rajani R. Ved, , Advisor, Community Processes, NHSRC
3.30 PM – 4.00 PM	Tea
4.00 PM – 5.00 PM	**Training of ASHA for action on Violence Against Women:** Ms. Jaya Srivastava
Day 2	**Wednesday, August 13, 2014**
9.30 AM – 11.00 AM	**State Presentations**: Nagaland, Madhya Pradesh, Arunachal Pradesh, Assam, Tripura, Gujarat Chair: Ms. Lima Tula Yaden, Director, NHM
11.00 AM – 11.30AM	Tea
11.30 AM – 1.00 PM	**Panel presentation: ASHA and newer roles:** Dr. Prasanta Tripathy; Mr. Sameer Garg Chair: Dr Rajani Ved, Advisor, Community Processes, NHSRC
1.00 PM – 2.00 PM	Lunch
2.00 PM – 3.30 PM	**State Presentations**- Rajasthan, J&K, Mizoram, Manipur & Karnataka Chair: Dr. T. Sundararaman, Health Systems Strengthening, Public Health Resource Network
3.30 PM – 4:00 PM	Tea
4:00 PM – 5.30 PM	**Keynote Address**: Mr. Manoj Jhalani, Joint Secretary (Policy), MoHFW and
Day 3	**Thursday, August 14, 2014**
9.30 AM – 11:30 AM	**State Presentations:** Kerala, Chhattisgarh, Haryana, Sikkim, Andhra Pradesh, and Tamil Nadu, Chair: Dr. R. C. Danday, Director, NHM, MoHFW
11.30 AM – 12.00 PM	Tea
12:00 PM- 1:00 PM	**Facilitating ASHA functioning through ICT: PFMS, GramVani, Mobile Kunji** Chair: Dr. Sanjiv Kumar, Executive Director, NHSRC
1.00 PM	Closing Session followed by Lunch