Review Workshop of Nodal Officers for Community Processes

July 30-August 1, 2013

National Health Systems Resource Centre; New Delhi

Report on Workshop of State Nodal Officers for Community Processes

National Health Systems Resource Centre, (NHSRC), New Delhi

July 30 to August 1, 2013

1. Highlights of the Inaugural Session

The annual review workshop for state nodal officers for community processes was held from July 30 to August 1, 2013. 52 participants from 27 states, and two union territories attended the workshop. (Annexure 1: List of participants). The agenda for the workshop is at Annexure 2. This report captures the essence of discussion for each session. The concluding section lists issues for discussion and follow up action.

The workshop was inaugurated by the Additional Secretary and Mission Director (AS&MD), Ms. Anuradha Gupta. Welcoming the participants, she stated that the ASHA continues to be the most visible component of the NRHM, and a major singular contributor to NRHM outcomes. She congratulated the nodal officers on their stewardship of this programme, which dealt with an important dimension and acknowledged NHSRC's systematic support to the states. She said that at the country level, there was much expectation of the ASHA and that much hinged on her effectiveness, and questioned whether the states were well equipped to handle the "foot soldiers", now numbering nearly 8.95 lakhs. She said that over the last two years much flexibility had been given to the states in building up the ASHA support structures, but the support systems were not yet equipped to manage the programme. She emphasized that states should standardize the support structures and that the first point of attention should to be to train the ASHA facilitators and the support staff. She acknowledged that there was variance in the nature of support structure between those states where the ASHA programme was more mature and the non high focus states, but emphasized that all support mechanisms for the ASHA must be sensitive to ASHA needs, have a good understanding of the programme and provide effective field based mentoring and support.

The AS & MD pointed out that the early hostility between ANM and ASHA had now subsided, and that it was time to enable the ANM to provide technical leadership to the ASHA since there were common platforms such as the VHND and VHSNC where they are needed to work together. For several functions (immunization, antenatal care, postnatal care, family planning, sick child referral) ASHA and ANM need to play mutually supportive roles, and is not to be seen as role switching. She also said that there is complementarity in the functions of ASHA and ANM and the ANM should not abdicate her responsibility. She pointed out that there is sometimes a feeling of condescension in the health systems towards Women and Child Development Department and said this needs to be addressed to improve coordination between the two departments, since there are many common goals. She also said that ASHAs and AWWs have their individual strengths and should work closely at the field level and not in silos.

She was concerned that the performance monitoring of the programme is weak and this needs to be streamlined. She reminded the nodal officers about various letters sent from MoHFW and

NHSRC over the last two years regarding this issue. Citing the example of Uttarakhand which had as early as December 2012 submitted a performance monitoring report, she said that other states should also prioritize implementing the performance monitoring in a similar manner. Performance monitoring would help in identification of poor performing ASHAs who should then be provided additional intensive mentoring by ASHA facilitators. This would improve the performance and address the specific issues of individual ASHAs. However if over a period of time the performance does not improve even after persistent efforts then such ASHAs should be replaced. She highlighted that if ASHAs in some villages or hamlets are not functional or are indifferent to their roles, then this would limit the reach of health services to such communities. She also mentioned that a strong performance monitoring system will help to correct the flaws of the early selection processes, which may not have conformed to the guidelines of community led selection.

Referring to the findings of the ASHA evaluation which showed that despite being functional, the ASHA is not reaching about 30% of the community; she raised concerns about the most vulnerable and marginalized communities being missed by ASHAs. The burden of mortality and morbidity is also highest among these groups and thus priority must be given to sensitize the ASHAs to this population. All efforts should be to select the new ASHAs from marginalized communities to address their issues.

The MD acknowledged that ASHAs are playing a critical role in Home Based Newborn Care and said that if delivered properly, ASHA provision of HBNC can be a game changer. She highlighted that the quality and pace of training, availability of equipment and on the job mentoring are key factors for effective implementation of HBNC.

She asked states to roll out regular refresher training for ASHAs every year and ensure that quality is adhered to in all trainings so that there is no skill attrition. She emphasized that ASHA effectiveness depends substantially on the quality of training. She asked states to adapt the modules if necessary but more importantly ensure that they are transacted properly.

She referred to the experiences of states where procurement for HBNC kit and drug kit has been a challenge. For instance in many states, drug kit has been provided to ASHAs only once followed by irregular refilling. She further added that states should replenish ASHA drug kits at PHC level during the monthly meetings. This would also make PHC medical Officers more responsive and responsible for ASHAs. She emphasized that monthly meetings should have a structure and should be used as forums for review of ASHAs by PHC Medical Officers and for capacity building on a regular basis. States should develop a calendar of monthly meetings with specific agenda so that meetings become more meaningful for ASHAs. She said she was not clear about how many states had a fixed monthly meeting for ASHAs which are conducted on a regular basis and said that this must be instituted without any delay.

In the context of ASHA interventions, the MD observed that some state nodal officers were not clear about the recent developments or changes in the incentive structure for the ASHAs. She emphasized better communication between the Centre and States. She also said that given the volunteer nature of the ASHA there was no likelihood of her becoming a salaried employee, as this militates against the very spirit of the ASHA. However states have the flexibility to increase the incentive amounts to ensure that every functional ASHA gets a minimum of Rs. 3000 per month. She was very emphatic that all payments to ASHAs should be done in a timely manner

and suggested that states maintain a time log for ASHA payments to identify and eliminate delays. She commended some states (Meghalaya, Tripura and Karnataka) for providing a matching contribution to the ASHAs as incentives earned by ASHAs in a financial year.

Reiterating the important role played by ASHAs in the community, she said that it would be impossible to launch any new initiative without the involvement of ASHAs. Thus ASHA programme nodal officers should develop a comprehensive understanding about all programmes like Janani Sishu Suraksha Karyakaram and Rashtriya Bal Suraksha Karyakaram. Since the conception of ASHAs arise from a rights framework ASHAs should create awareness in the community about health entitlements of people under various schemes. Giving the example of Weekly Iron Folic Acid Supplementation scheme (WIFS) where ASHA has a critical role of counselling girls about the benefits of the supplementation and minor side effects which may arise for some period.

She emphasized the importance of personal and professional growth for ASHAs and said that States should create career opportunities for ASHAs by supporting their admission in ANM and Nursing courses. States could also help ASHAs enhance their educational levels through National Institute of Open Schooling (NIOS) and by paying the fees and facilitating enrolment, such efforts could be supported from NRHM funds. Certification of ASHAs is an important frontier area and she asked States to bring any problems in moving forward on this front to her notice.

Regarding VHSNCs, the AS & MD said that under Community Processes the focus has been on the ASHA programme and little progress has been made in the VHSNC component. We now have about 5 lakh VHSNCs. She suggested that ASHAs should be supported and trained to play a leading role in revitalizing the VHSNC. She also assured that a letter would be sent from MoHFW to reinforce this.

2. <u>Performance Monitoring</u> –

Session chaired by - Dr. Sundararaman – Executive Director NHSRC.

State nodal officers from nine states (Odisha, Uttarakhand, Jharkhand, Chhattisgarh, Nagaland, Tripura, Delhi, Karnataka, Punjab) and Dadar and Nager Haveli shared reports and the processes followed for Performance Monitoring[1] of ASHAs in the state. These presentations also attempted linking the health outcomes and ASHA functionality reports from two districts with the best and poorest Infant Mortality Rates.

A ten indicator based performance monitoring for ASHAs have been implemented in the states of Odisha, Uttarakhand, Jharkhand, Chhattisgarh, Arunachal Pradesh, Manipur, Meghalaya, Mizoram, Nagaland, Sikkim and Tripura, Delhi, Karnataka, Punjab, Dadar & Nager Haveli. Training of ASHA Facilitators in performance monitoring and supportive supervision is underway in Madhya Pradesh, Uttar Pradesh, Bihar, Odisha, Assam, Haryana, Maharashtra, Karnataka, and West Bengal.

[1] Performance monitoring is a tool for supportive supervision for ASHAs where ASHA facilitator has the key role in collecting information from ASHAs through conversations during monthly meetings. The reports are consolidated monthly at the block level and quarterly at district and state level. District grade the blocks and State grade the districts based on functionality of ASHAs on each of the ten indicators. Nodal officers at all levels are also trained to link the functionality of ASHAs with health outcomes and identify key issues so that they can be addressed at the local level.

In Odisha the performance monitoring is currently being done with the help of district and block nodal officers who conduct meetings a block and sector level to collect the information from ASHAs. Training of ASHA facilitators is underway in the state. They would start the process of collection of information from ASHAs in 3-4 months.

The State of Delhi has modified and added indicators as per state's requirements and has designed the data definitions of all twelve indicators on the lines of the ten indicators suggested by MoHFW. These indicators are derived from the diary maintained by ASHAs and checked by ANMs on a monthly basis. The state initially collected information on those activities performed commonly by ASHAs, but based on inputs from state level officers, a decision was taken to monitor only the incentive linked tasks of ASHAs to eliminate any subjectivity from the process.

Since the Mitanin programme predates the ASHA programme and has a very strong support structures the indicators and performance monitoring system followed in the state is different from the ten indicator based performance monitoring. State collects information from Mitanins on the number of cases attended to and compares it with the expected level of cases (calculated from rates and ratios like IMR, MMR etc) or total number of cases reported by Mitanins (for indicators where expected numbers cannot be derived eg- cases of childhood illnesses), to estimate the coverage of Mitanins for each indicator.

States of Jharkhand and Tripura also shared their experiences of using this information to overcome the management / logistic or training related issues. For instance, in Jharkhand state nodal officers were able to identify various logistic issues which affected the performance of ASHAs and take corrective actions. In the state of Tripura, ASHA Varsho Divas (local name of ASHA monthly meetings) is used as a forum for refresher training of ASHAs based on their functionality and problems identified by ASHA Facilitators. These efforts made by the state teams were appreciated by the chair – Dr. T. Sundararaman and other state nodal officers. Dr. Sundararaman also suggested that Tripura should write and share their effort as a best practice for better sharing between states.

Nodal officers from states like West Bengal and Madhya Pradesh shared their concerns about the system's limited understanding of the performance monitoring as a supportive supervision tool and the potential of using it to penalize and also remove ASHAs. In response, Dr. Sundararman shared that very few HMIS systems have been able to survive since HMIS creates pressure on the system and people to perform well. He further clarified that the ten indicator based performance monitoring system has been designed to support the ASHAs. It should be used as a management tool to enable programme officers at various levels to devise strategies for improving programme implementation and this fact needs to be reinforced by the programme managers. The key role in the performance monitoring is played by ASHA facilitators and Block nodal officers. It is they, who are in position to understand systemic issues and take corrective actions. Introduction of grades above the block level allows officers at district and state level to only look at gradients and prevents naming in on individual ASHAs and ASHA facilitators, which reduces the risk of punitive action against individuals. Thus if performance of a block is not as per the expectations then the district / state level officers would question the block nodal officer who is in a better position to explain the reasons of low performance, rather than blame the ASHAs or ASHA Facilitators.

He also emphasized that it is important to support poor performing districts and blocks and appreciate that they have submitted honest reports. He also discouraged any state level review meetings where performances of different districts are compared as this can act as a perverse incentive. A separate visit should be planned by the state nodal officers to poorly performing blocks or districts to provide additional support to them. Regular conversations on data at block, district and state level would help the nodal officers to link health outcomes with the ASHA functionality and enable them to identify the critical issues and take action.

3. States efforts to streamline modalities of ASHA Payments:

Session chaired by - Ms. Limatula Yaden, Director NRHM, MoHFW

Overcoming issues related to ASHA payments has been a challenge faced by implementers across the states. Certain States have tried innovations and initiated pilots to streamline modalities of ASHA Payments. This section summarizes the pilot interventions presented by states of Bihar, Chhattisgarh and Orissa and discusses in brief some other ASHA payment related issues shared by the participants from respective states.

a) Gram Panchyat led payment of ASHA Incentives in Chhattisgarh:

Mr Samir Garg from SHRC Chhattisgarh presented the state experience of routing ASHA incentive through Gram Panchayats. He briefly described the state context and explained that unlike other states, selection of Mitanins in Chhattisgarh has been hamlet based and one Mitanin on an average covers a population of 300. Thus the average monthly incentive earned is low and was further reduced due to delayed release of payments for immunisation, VHND mobilisation, HBNC, Family Planning, DOTS, Malaria slides making, Leprosy referrals etc. Although payment of incentives related to JSY was regular, over 50% of Mitanins had to undertake several trips to the block incurring high costs to claim the incentives. These challenges impelled programme officials to pilot payment of incentives through Gram Panchayats in Togpal block of Bastar district in August 2012. He emphasized that the decision to involve Panchayats for Mitanin payments was built on the programme design that promoted convergence of Panchayat with Mitanin Programme, since the beginning of implementation. Several state led initiatives such as-combined training of PRIs with Mitanins, Swasth Panchayat Yojana, active village health monitoring and planning by VHSNCs with participation of PRIs and Mitanins and Mitanin Samman Diwas celebrated each year in which PRIs felicitate Mitanins in each Gram Panchayat have ensured considerable rapport between Mitanains and Panchayat. Around 2,500 Mitanins have also been elected as PRI members. Also, the PRI in Chhsttisgarh are not heavily politicized. These programme features complemented with a strong support and supervisory structure for Mitanins in the state laid strong foundation to pilot this new payment modality. The salient features of the process are:

- District Health Society releases advance to Janpad (Block) Panchayat
- Janpad Panchayat provides Rs.15,000 as advance to each Gram Panchayat
- Mitanain gets paid based on the Claim Form presented by her
- Gram Panchayat makes cash payments to Mitanins on declared monthly Payment Day in an open meeting
- The claim form records each task done by Mitanin during the month, verified by the concerned beneficiary and the Ward Panch. In situations where Mitanin herself is Panch the records are verified by the Sarpanch.

- Utilization Certificates issued by Gram Panchayats, are consolidated by Block Panchayats and given to District Health Society, based on which the funds are replenished

The results of the pilot were encouraging and State Health Society decided to scale it up across all the districts. From July 2013 the initiative was expanded to all 146 blocks of the state. Key positive outcomes of this initiative are that all sanctioned incentives are now getting paid, the average payment to Mitanin per month has increased from Rs.105 in 2012-13 to Rs.534 in April 2013 and in July it has further increased to Rs.650. This increase is partly due to regular payment of incentives like HBNC, Family Planning, Full Immunization, Birth spacing etc. and partly due to addition of new incentives. Now, a Mitanin looking after a population of around 300 is able to earn around Rs.1000 per month. He further mentioned that State Government has also now decided to give 50% top-up to incentives from state budget. The PRI led payment process will be evaluated by Tata Institute Social Sciences as a part of the Mitanin Evaluation 2013.

b) Pilots related to ASHA payments from Bihar:

Ms. Vasudha Gupta, Team Leader ASHA Resource Centre from Bihar discussed three pilot initiatives implemented in different districts. These pilots have common objectives which are to address inconsistencies and delays in ASHA payments, increase transparency and enable systematic financial reporting through a standardized payment process. The first intervention discussed was the Mobile Money Transfer for ASHAs being piloted in Sheikhpura District. The project has been underway since 2009 and is a collaborative effort of State Health Society Bihar (SHSB), State Bank of India (SBI), Eko Aspire Foundation and UNOPS-NIPI Programme. The essential pre-requisites for this system were mobile phones for ASHAs and a common pooled account at district level for incentive funds coming from various programme heads. In this mechanism an ASHA submits information for incentive payment after due validation from ANM to PHC. Activity wise incentives are then verified by the BMOIC and send to District Health Society. The District Health Society further transfers the funds from the District Pooled account to SBI which then transfers the money to 18 SBI-EKO service points (shops/counters) in Sheikhpura. A key feature of this initiative is that ASHAs get information regarding monthly payment deposited on their mobile phones every month. The second initiative was a NIPI supported pilot in four districts (East Champaran, Samastipur, Purnea and Sitamarhi) where NIPI, SBI and SHSB have signed an MOU for enabling ASHA payments through electronic based transfers.

The third initiative that was shared was enabling ASHA payments through Health Operation Payment system (HOPE) which is being piloted in five districts- Patna, Sheikhpura, East Champaran, Sheohar and Arwal. This is an online payment system jointly funded by Bill and Melinda Gates Foundation (BMGF) and International Finance Corporation (IFC). This system uses software primarily designed for -payment processes, beneficiary enrolment, event recording, payment execution, and monitoring and evaluation of health programs. This mechanism is in its initial phase of operationalization and is being studied closely to understand key outcomes.

c) Online Payment of ASHA incentives through Central Plan Scheme Monitoring System (CPSMS) in Orissa:

Mr Susant Nayak, Team Leader, Community Process Resource Centre (CPRC) from Orissa described the online payment of ASHA incentives through Central Plan Scheme Monitoring System which has been piloted in Cuttack district and is to be expanded to three more districts by end of August 2013. As a first step, details of ASHAs are obtained in a prescribed format from each CHC and uploaded into the CPSMS portal for registration. However, state now plans to utilize MCTS for uploading this information. Each activity of ASHA, as approved in State PIP, has been mapped in the portal and linked to its corresponding bank account. Claims of ASHAs, based on the documents obtained in the Sector meeting are entered in to the portal and direct online payment is done through Corporate Internet Banking (CINB) facility / Print advice. This mechanism has reduced the dependency on banks and has eliminated the process of check preparation. Transfer of payments to the bank account of ASHAs from all the bank accounts simultaneously through CINB facility is a key advantage. The system can also provide payment reports CHC wise and district wise against each activity separately and is more effective in tracking payment delays.

d) Aadhar enabled micro-ATM based ASHA Payment System from Maharashtra:

Dr G Bhalerao spoke about Maharashtra's efforts to streamline ASHA payment by using a software based monitoring process at PHC, Block, District and State level and elaborated on the mechanism of Aadhar enabled micro ATM based ASHA payment system. The software captures information about the incentive due to ASHA, incentive paid and balance payment if any. District and Block Mentoring Committees monitor the flow of funds in ASHA incentives and ensures timely payment to ASHA. He explained that a biometric System for ASHA payment has been piloted in Thane district, where information about ASHA inclusive of her personal details, Aadhar number and payment due is being uploaded on Central Plan Scheme Monitoring (CPSMS) web-portal by using the software and payment is directly deposited in her bank account. He shared that in Thane, Smart Cards have also been distributed to ASHAs and provision of cash payment at monthly PHC review meeting has been done through an ICICI pot [2]machine.

e) Payment Issues and challenges shared by other states:

- Sikkim shared that in addition to the performance based incentive for ASHAs; state also provides a fixed monthly incentive of Rs 3000 from state funds. It was discussed that ASHAs in Sikkim are involved in many non- health related development activities for which they are provided wage compensation by the respective department. Payments by Zilla Panchyat are delayed as much as three months. The Sikkim team also suggested that since many villages do not have close access to banks and ASHAs and beneficiaries had to travel huge distances for availing the JSY incentive, it would be worthwhile to allow JSY payment transfer to the VHSNC account for further payment to the beneficiaries and ASHAs.
- Nodal officers from Karnataka and Mizoram highlighted the recently introduced system of providing additional top up incentive to ASHAs from state funds matching each performance based incentive availed through NRHM.

[2]Pot machine is a portable ATM machine from which ASHAs could withdraw cash during the meeting at the PHC .

- Madhya Pradesh team shared details on the recently initiated single window payment mechanism for ASHA incentives. The team requested inputs from other states to overcome the long drawn process involved in validation of incentives related to vertical programmes.
- Creation of a separate district pool only for ASHA incentives was shared by West Bengal. The team stated that through this process they could overcome the delay in payment of incentives from vertical programmes. Likewise Delhi has also clubbed a separate pool for ASHA payments at the level of health facilities, in which incentive funds from various sources are transferred.
- Unlike in other states payment, modality for ASHAs in Kerala is still cash based, except in Thrissur district and all payments are done at Sub Centre level by JPHN (ANM). State has recently piloted ASHA Software in Thrissur district and soon plans to scale it in other districts. The software captures information on ASHA profile, their physical performances and helps to monitor the details entered by the JPHN at the sub centre level and assist in electronic transfer of the payments. It also generates the fund disbursement report based on the ASHA circular.

4. <u>Review on status of Grievnace Redressal Committees</u>

Session chaired by - Shri Manoj Jhalani (JS (Policy) MoHFW.

Dr Manoj Kumar Singh from NHSRC presented the current state wise update on Grievance Redressal Cell for ASHAs. He described in brief the Government of India Guidelines on constitution and functioning of Grievances Redressal Cell, shared details regarding the current status of implementation of Guideline and also discussed different mechanisms being used by the states for addressing the grievances of ASHA. The update showed that states are in varying stages of enabling Grievance Redressal for ASHAs and can broadly be grouped under three different categories. The first category involves those who have established district level Grievance Redressal Committees as per the recommended guidelines and have even initiated a systematic documentation of the complaints. These states are Odisha, Uttarakhand, Sikkim, Manipur, Nagaland, Mizoram, Maharashtra, Karnataka and Kerala. District level committees for ASHA grievances have been formed only in four districts of Jharkhand but the state has created a mechanism of Sahiya Samvad, held every Saturday, where Sahiyas directly call Mission Director on a toll free number (18003456524) and grievances are sort out immediately. The second group included those who have tried to address ASHA grievances by using a common Grievances Redressal cell that has been set up for communities. Rajasthan (104) and Uttar Pradesh (18001801900), Assam (104 toll free Number); and Andhra Pradesh (No 104), Haryana (08288014141) and Jammu & Kashmir (18001800102) fall under this category. In this process the complaints of ASHA are forwarded from the call centre to the concerned department for appropriate action. But in this group Assam is seen to be making an extra effort to inform ASHAs about the action taken and programme managers also try to gauge the satisfaction levels of ASHAs after resolution.

The third category involved those states where no separate mechanism for grievance redressal for ASHAs have been formed and they still using the forum of monthly ASHA meetings or verbal communication to the programme managers as means to address ASHA grievances. Bihar, Madhya Pradesh, Arunachal Pradesh, Tripura, Tamil Nadu, Punjab and Gujarat are the states in this group. This category also included West Bengal where ASHAs are encouraged to ask questions in "ASHA Talk show", telecasted weekly on All India Radio. Nodal Officer shared that most of the questions being asked by ASHAs are related to their payment irregularities. Meghalaya intends to roll out these committees but is awaiting approval from the Centre.

State Experiences and Challenges related to GRC:

- The team from Odisha raised several concerns pertaining to ASHA Grievance Redressal in their state. They highlighted that when complains relate to the poor quality of services being provided at healthcare facilities, any action makes the facility staff defensive and often leads to incomplete outcomes. In the majority of these cases the anonymity of ASHAs is not maintained, leaving them vulnerable to the antagonistic behaviour from the health staff and functionaries at the health care facilities. Analysis of these complaints showed that maximum complaints from the ASHAs are related to the work of ANM and AWWs. State right now is receiving very low number of complaints. On an average three complaints per district are received in a month. This is insufficient to motivate the committees to meet and take action. A separate secretary to register the grievances has not been appointed so far and this work undertaken mostly by Assistant ASHA Coordinator in District who is already overburdened. Odisha team also mentioned that telephonic complains are often not taken seriously and ignored by Government officials and there is a need to ensure that this is corrected.
- State ASHA Facilitator from Sikkim cited an example where an ASHA had lodged telephonic complaint against a District Medical Health Officer. But after sometime while attending training programme she decided to withdraw her complaint as she feared being targeted for dismissal.
- According to nodal person from Chhattisgarh maintaining anonymity of ASHAs also has a potential risk. In instances where complains are related to "informal charges" or payments for services sought by health care staff, a proper investigation cannot be undertaken and usually in these circumstances an appropriate action is not possible.
- West Bengal team enquired whether they could continue with grievances redressal mechanism for ASHAs using existing structure or it is mandatory to undertake implementation as per the GOI guideline.
- Haryana team shared that as part of their efforts to inquire about any problems of ASHAs, two people (calling agents) have been engaged to make ten random calls to ASHAs on a daily basis.
- MD-NRHM representing the Union Territories of Daman and Diu and Dadra and Nagar Haveli informed that grievances in Daman and Diu are being addressed through Gram Panchayat. She also said that ASHA be treated with respect and their grievances addresses in a more humane fashion and the UT's experience is that it encourages other ASHAs to file complaints
- Many participants shared the dilemma of unresolved actions on grievance. For instance demand of fixed salary or fixed incentives by ASHAs is common and is usually not in the control of district staff to address. But this is not being taken up at the state level and is left unresolved.
- State of Madhya Pradesh reported that the constitution of district level MGCA is very similar to Grievance redressal cell and hence the state plans to continue using the district MGCA for addressing grievances of ASHAs. However, Dr Sundararaman expressed that state still needs to have a designated secretary for recording the complaints and forwarding it to the committee members for further action.

Dr T Sundararaman said that the mechanism of grievances redressal should not become co-terminus with routine programme implementation processes, mechanisms or be addressed through existing ASHA Support structure. He emphasized that there is a need to establish GRC in accordance with the Government of India Guidelines. He reiterated the key processes involved in functioning of Grievances Redressal Cell. These include- publicising a designated Landline and post box number, appointment of a Secretary to register complains, maintaining register and data base (for complain received, acknowledgement, action taken report and analysis of complains) and action within a specified time framework. The lack of grievances redressal

mechanism for ASHAs is resulting in unionization. Some states are showing complete divergence from the mechanism proposed by GOI for addressing grievances of ASHAs and these states require establishing it on an urgent basis. He emphasized that the focus should be on complaints of the ASHAs and the action taken.

Shri Manoj Jhalani (JS, Policy) endorsed the need to constitute and enable functioning of Grievances Redressal cell according to the MOHFW Guidelines. This would help in addressing independently issues related to payment, supply, record keeping, referral system, service quality at the facility, Gender issues and referral systems etc. He emphasized that all such complaints need to be systematically documented and analysed in detail to establish the nature of complaint and identify the level at which action is needed. ASHAs can approach higher authority if problems persist and are not resolved by Grievance Redressal Committee. This would encompass grievances that require a change in policy decisions. Further responding on Panchayat involvement, he highlighted that panchayat is an empowered body in itself but now there is a need to empower ASHAs. The JS also highlighted the need to publicise the telephone number and post box number among ASHAs and suggested that one way to do this is by sending mobile-sms alerts to ASHAs by the concerned authority in the district. The ultimate test for the system is that ASHAs should feel confident that if they complain their voices will be heard.

The issues can be grouped in three broad categories. The first comprises issues related to implementation gaps such as supplies of drugs, equipment etc. or delays in payment. Such complaints can be managed very well by a professionally run call centre and can be addressed by a call centre approach. The second category of complaints may involve personal issues or issues pertaining to facility services and need higher level of action. These complain are best resolved by an effective committee meeting that involves representative from NGO or external organization. These members can take a non-biased approach and facilitate action. Third category of issues pertains to demands related with policy modifications which cannot be resolved at the level of District GRC and need a further higher level intervention.

5. Community Monitoring and role of VHSNC:

Session chaired by - Dr. Rajani Ved, Advisor Community Processes, NHSRC

Dr. Bijit Roy and Ms. Sona Sharma from Population Foundation of India, New Delhi, the secretariat, of Advisory Group on Community Action (AGCA) shared the evolution, processes and current focus of the Community Based Monitoring and Planning (CBMP) interventions being implemented under the NRHM.

In the first Phase of CBMP, which was during 2007-2009, nine states, 36 districts and 1620 villages were taken up, with a widespread coverage across the length and breadth of country, from Tamil Nadu in south to Rajasthan in North and Assam in the East.

In the preparatory phase, the focus was on establishing institutional structures and building their capacities ; Advisory Group at state and CBMP committees at district and Block level; and also on developing guidelines and manuals for district & block level CBMP committees as well as the VHSNCs.

In the implementation process a step by step awareness and capacity building was undertaken at community level. Facilitation was done to strengthen regular meetings and other processes of district and block level CBMP committees, and monitoring of services at facilities. As the second step, Public Dialogues – called Jan Sunwai – were organized and the processes therein for engagement of community with the providers were institutionalized and further strengthened.

It was shared that review of SHCs by community led to improvement in range and quality of services of ANC.

The team shared that the processes of Jan Sunwai were the most contested part of the CBMP, for community as well as the service providers. But it proved effective in building the dialogue which led to reconciliation and minimized the blame game on both sides. Gradually even service providers, who were initially sceptical about the credibility and effective utility of the Jan Sunwai, saw the positive side of it and started seeing the community as their support in providing services, and also in demanding better facilities from the system. The CBMP process also made efforts to incorporate issues emerging from the CBMP process into district PIPs. The tools used in the process of CBMP such as, village health report card, and facility report card were shared by the AGCA team.

The outcomes of the CBMP were shared in detail, illustrating CBMP interventions in Maharashtra, which are considered the best managed and most effective. Construction of incomplete SHC buildings and improvements in health services were shared as the first level of programme outputs. Enhanced trust and improved interaction between community and providers, and community based inputs in planning and action were cited as critical outcomes which led to reduction in out of pocket expenditure of families.

Problems related to the interface between the programme implementing NGOs and the Health Department personnel involved in the programme at different levels were shared. Delays in fund flows, tedious reporting and ad-hoc interruption of activities, were shared particularly as the critical roadblocks that need to be improved. The sustained state leadership support, along-with strengthening of institutional mechanisms, makes a critical difference to the success of the programme. They also shared that lack of appropriate strategies for training and mentoring of VHSNCs and RKS is a crucial challenge for the CBMP interventions. Dedicated staff for CBMP at state level and below is required, particularly in the light of the expanding need of the programme in the present phase in which 24 states and UTs have included the CBMP component in their PIPs.

Issues:

Dr. Monika Pathak, Consultant Community Monitoring, Punjab, shared that state had planned to initiate CBM in two districts of the state but could not do so because of limited presence of NGOs in the state. She appreciated the help being provided to the process by Dr. Narendra Gupta, a member of AGCA, but expressed concern that AGCA but said that such support was not consistent and lack of follow up affected support for CBPM. She said that for ASHAs and VHSNC there were continuous inputs which greatly strengthened the programme.

Several states also shared the same concern and made requests for greater support from the AGCA to states in the process of establishing the community monitoring system. Problems in sanctioning of the Community Monitoring proposals were discussed, and more proactive role of the AGCA was requested by states in this process.

The AGCA team shared the problems in expansion of the programme after the initial start-up phase and said that they were awaiting budget approval from GOI . They also emphasized the need to ensure that the active community intervention does not threaten the service providers to the extent of being counter-productive.

Questions were raised by Mr. Bhalerao, Nodal Officer from Maharashtra about the exit strategy and timeframe for implementing NGOs in his state. His perception was that after expansion and maturing of the programme up to a certain level, system's own capacity should be built and the programme should be handed over to the state.

The need for greater involvement of PRIs in the community monitoring process was also suggested by Mr. Bhalerao, to which many state teams agreed.

Mr. Chand Singh Madaan, the Nodal Officer from Haryana said that Haryana's roposal for starting a CBMP intervention has not been sanctioned by the GOI.

AGCA team responded that the programme is evolving and throwing newer challenges, so the NGOs are required to continue as facilitators of the process. Also NGOs, which have lower and human resource costs, and also pool their resources from their community level interventions being run in the area. Most participants felt hat NGOs are required to facilitate and hand-hold the programme. The programme requires community mobilization and need for regularly identifying the issues raised at the village level and taking them up to block, district and state levels. The AGCA team also shared the challenges faced during the expansion phase of the programme, due to rapid pace of scaling up.

6. Role of ASHA in Communicable Diseases

Session chaired by - Dr. Sundararama, Executive Director, NHSRC

Dr. A C Dhariwal, Director and Dr. Munish Joshi, Senior Consultant, National Vector Borne Disease Control Programme (NVBDCP), presented and discussed in detail, the role of ASHA in Communicable Diseases and other programme issues.

Dr. Dhariwal, giving a historical background of the roles envisaged for community health worker in vector borne disease control efforts, shared that Link Worker scheme launched under Malaria programme in 1977 is probably nearest to the concept of present ASHA.

He said that ASHA is also being seen as a critical contributing factor for substantial reductions in the health impact indicators of the country. Encouraged by these trends, the GOI has proposed to utilize the services of ASHAs in other disease prevention programs also, which include communicable diseases, and non-communicable diseases, health education and health promotion and provision of safe drinking water and sanitation services.

Dr. Munish Joshi made a detailed and informative presentation on the existing roles of ASHAs and the prospects of her taking on additional tasks in Vector Borne Diseases like Malaria, Dengue, Chikangunia, Japanese Encephalitis, Kala Azar & Filaria, and existing activities such as RDT tests, facilitation in early diagnosis, referral and follow-up role in both RNTCP and NLEP, and her role as DOTS provider in RNTCP. Her role in prevention and treatment in diarrheal and respiratory diseases, and support in immunisation efforts and the disease surveillance interventions under IDSP were also illustrated in detail. ASHAs role in VHSNC and VHND, particularly in terms of mobilsing community and facilitating and assisting service delivery, were also underscored. Role of ASHA in promoting vector control by use of larvivorous fish in water bodies and bio-larvicides was also explained. Regarding the nature of different diseases and their vectors, it was shared that Dengue mosquito is a domestic and peri-domestic breeder and is found more in urban areas, but recently it is being found in rural areas also.

The systems and processes being adopted like, regular monitoring by MPW and MTS, evaluation through LQAS at sub-district level, and smear quality checks by the LTs were also explained. It was also shared that collaborations with NGOs as local partners have been done in some endemic districts, and a mechanism for "public-private-partnership" is in place that allows state and district level disease control programmes to establish local partnerships with NGOs, particularly for BCC. It was underscored that apart from modular training for ASHAs and

programme specific trainings, regular orientation and refresher in monthly meetings is also very important for their capacity building.

Participants raised concerns about overloading of ASHAs with multiple programme roles, and problems of logistics and supply management, as well as challenges regarding timely payment and the need for payment to be routed through single window system.

Issues:

Mr. Samir Garg, Team Leader, ARC Chhattisgarh, shared the experiences of his state, that ASHAs were trained many times on some of her envisaged roles in communicable diseases, but supplies related to these roles did not reach them, and they could not effectively play their intended roles, leading to waste of resources invested in the trainings. Sometimes, when some supplies reach ASHAs the quantity supplied is quite insufficient. He shared that quality of spray, and its frequency as well as the supplies of bed-nets has improved in last 2-3 years, though gaps in reimbursement of funds from NVBDCP persist.

He also shared a concern that VHSNCs in Chhattisgarh which are playing an active role in health promotion, are compiling the figures on deaths due to Malaria, but the same are not being reflected in the IDSP reporting.

Ms. Vasudha Gupta, Team Leader, ARC Bihar, suggested that in places where ASHA doesnot make slides, she should be continued to be paid incentive for facilitating referral for diagnosis.

Some other issues shared and discussed by the nodal officers were as following-

- Kala Azar payments are not reaching the districts from the NVBDCP programme.
- Within the present syndromic IDSP approach, ANM takes the report from ASHA, and it was shared by many that ASHA should get some incentive for support she provides.
- Integration of different VBD programmes is still a problem.
- Incentive should be paid to ASHA for sputum positive cases.
- There is a big time lag from preparation of malaria slides by ASHA to the test report from the lab reaching ASHA and beneficiary, which needs to be reduced.
- In some places NREGA works are being utilized for source reduction.
- Dr. Monika Rana, Nodal Officer-ASHA from Delhi shared that ASHAs in Delhi are not involved as DOTs provider in the TB programme.
- Dr. Jagdeesan, the Nodal Officer-ASHA from Kerala, shared that his state adds Rs 10000- from the state funds to VHSNC funds.

On some of the issues raised, Dr. Dhariwal clarified RDK kits are supposed to be used only in situations where no labs are available for conducting tests. He also clarified that in Malaria endemic areas, LLINs are to be made available to all households without any distinction of APL and BPL, and sub centre is the unit for planning and management of logistics and supplies.

Regarding the challenges related to the procurement and supplies, he mentioned that states and districts are empowered to directly procure and ensure proper supplies, but the challenges still exist at various levels. RDK and LLINs however are provided at present from central supplies. He also said that death audits being adopted by different states is a good practice and urged all states to encourage such practices. He also shared that communicable disease funds have been merged and funds are being released accordingly. Con and the confusions still existing are part of the transition phase and are being sorted out.

7. Role of ASHA in Rashtriya Bal Surakhsha Karyakram:

Session chaired by - Dr. Rajani Ved, Advisor Community Processes, NHSRC.

Dr Arun Singh Senior Advisor, Child Health; MOHFW gave a broad overview of the newly launched Rashtriya Bal Surakhsha Karyakram (RBSK) and elaborated on the role of ASHAs in early childhood screening. RBSK is a new initiative aimed at screening over 27 crore children from 0 to 18 years for 4 Ds - Defects at birth, Diseases, Deficiencies and Development Delays including Disabilities. He explained that the first three years of a child's life are critical for the cognitive development, which is dependent on his/her sensory perception. Thus early screening of children becomes essential for ruling out diseases, defects or deficiencies that may affect sensory organs. He shared data depicting the high magnitude of 4Ds in India. It showed that an estimated 17 lakh babies are likely to be born with a birth defect and this account for 9.6% of all newborn deaths. Likewise the proportion of children suffering from diseases, deficiencies and developmental delays is also high and further rationalize implementation of an intervention such as RBSK. He described that under this programme screening of the new-born will occur both at public health facilities and at home and is an important component of the strategy.

During the period from 48 hours after birth to six weeks of a new borns life, ASHA can play a vital role in identifying these defects as they are already undertaking six to seven new born visits to provide home based new born care. Thereafter regular health screening of pre-school children from six weeks up to 6 years of age is planned through using Aganwadis as a platform. Since children from 6 to 18 years of age are school going and will receive regular health check-ups in both Government and Government aided schools. This screening would allow early diagnosis of any of the 30 pre-identified illnesses and for which patients would receive follow-up referral support and treatment including surgical interventions at tertiary level, free of cost under this Programme.

Dr Singh stated that the programme aims to achieve a block level aggregation of data of the children identified with defects. Analysing this data would enable programme managers to understand the local/area specific concerns, which would further help in identifying any environmental risk factors that could be associated with some of the commonly occurring defects. Thus, the blocks become the headquarters for screening where every six months a four member Mobile Health team comprising of doctors, male/female nurse, pharmacist and female doctor will undertake screening of children from six weeks to six years of age in a camp mode in the AWC. Even here ASHAs can play a major role in explaining about the screening programme to parents/caregivers of children upto 6 years and in mobilising them to attend the screening camps. At least three dedicated Mobile Health Teams in each Block will be engaged to conduct screening of children. Screening for school children will be conducted at least once a year.

Each district will have a District Early Intervention Centre which would act as the first referral point for confirmation, evaluation and management of the children with defects. This centre will comprise of a 14 member team of experts consisting of paediatrician, medical officers, dentists, optometrists, audiologists, psychologists, physiotherapists, lab technician etc. He mentioned that standardized training modules/tools are being developed in partnership with technical support agencies and collaborative centres and tools for ASHA would be developed in consultation with the NHSRC.

All Participants were extremely enthused by the presentation and said they looked forward to roll out of RBSK training. Dr. Monika Rana from Delhi was of the view that ASHAs could be involved in screening less than two years, since children begin attending Anganwadi centres only at the age of 3 years and children under two are a priority group for ASHAs.

8. Progress of Home Based New Born Care in states

Session chaired by - Dr. Prabhakar, Deputy Commissioner (CH), MOHFW.

Nodal officers presented the status of HBNC implementation in their states. This included a status update on training of ASHAs, availability of HBNC kit with ASHAs, payment of HBNC incentives to ASHAs and proportion of home visits made by ASHAs. Key findings emerging from the discussion are listed below-

Training :-

HBNC training for ASHAs is largely transacted in first three rounds of Module 6 &7[3] of five days each. Training of ASHAs in Module 6 &7 is underway in all states except Kerala and T &N and most of the states are in process of completing round 2 and 3 training. Training in three rounds has been completed in Uttarakhand and Chhattisgarh and states have also started refresher training in Module 6 & 7 for ASHAs.

However systematic monitoring of training to assure quality was reported only by Chhattisgarh, Bihar, Madhya Pradesh, Jharkhand and West Bengal. All states expressed the need to strengthen the monitoring mechanisms to ensure the quality of training.

Among the high focus States , training of ASHAs in round 1, 2 and 3 is underway simultaneously in Jharkhand and Odisha while in Madhya Pradesh and Bihar Round 1 and 2 are under way. These States have completed over 70% training in Round 1 and over 40% in Round 2. Round 3 has begun in Odisha and Jharkhand upto 20% are trained in round 3. State of Uttarakhand has completed three rounds of Module 6 &7 and refresher training for ASHAs is underway. Chhattisgarh has conducted two rounds of refresher training on newborn care, the first was done in 2010-11 but based on field mentoring findings of low levels of skills of Mitanins for recognizing sepsis, a second Refresher training was done in 2012-13.States of Rajasthan and Uttar Pradesh show the slowest progress in training i.e, in Rajasthan only 36% of ASHAs have received training in Round 1 despite the training being rolled out since 2011-12 while in Uttar Pradesh only 5% ASHAs are trained in Skill that save lives. Uttar Pradesh decided to train only CCSP trained ASHAs of 17 districts in an adapted version of Module 6 &7 in 2012-13 and has planned to train all ASHAs in Module 6 &7 across the remaining 58 districts in FY 2013-14.

Non High focus states show relatively slow progress with respect to roll out of Module 6 &7 training. Thus training of round 1,2 and 3 is undergoing simultaneously in Maharashtra, West Bengal, Karnataka. Round 1and 2 have been completed for all ASHAs in Punjab while they are underway in Delhi. All four rounds of Module 6 &7 have been completed in Gujarat however the duration of training varied across districts raising concerns about quality of training. Haryana has completed training in Phase 1 & 2 of HBPNC for 76-81% ASHAs and has recently started the training in Module 6 &7 across all districts. In Kerala and Tamilnadu training in an adapted version of Module 6 &7 which included additional state specific topics was started in 2012-13. Across all NE states over 90% ASHAs (or all) have been trained up to 3rd Round of Module 6 & 7 except in Nagaland where training round 2 is near completion and Assam where round 1 is 91%

[3] Module 6 & 7 is transacted in four rounds of five day each while the first three rounds focuses on Maternal, Newborn and Sick Child management, round 4 covers communicable diseases and state specific topics.

completed. All NE states started ASHA training in 2010-11 while in Assam the training of ASHAs began only in 2012-13 despite state trainers being trained in 2010-11.

Procurement

Except for Northeastern states, Haryana, Uttarakhand and Chhattisgarh, all states reported challenges related to procurement of equipment for ASHAs. This either led to delays in roll out of training or resulted in training being conducted without sufficient equipment kits for all ASHAs as observed in, Bihar, Jharkhand, Odisha, Maharashtra, Delhi, Karnataka, Punjab and West Bengal. The existing mechanism of procurement using tendering process was reported as a major hurdle by all the states

Out of the eight High Focus States, the entire component of HBNC drug kit was provided to ASHAs only in Madhya Pradesh, Odisha and Chhattisgarh i.e, cotrimoxazole was also added to the ASHA kit. States of Bihar, Jharkhand, Odisha and Uttar Pradesh grappled with issues of procurement and distribution of the HBNC kit. For instance in Jharkhand and Bihar, kit was provided after completion of Round 1 training, the process of distribution is over in Jharkhand while it is yet to start in Bihar. In Odisha, though Round 2 training is 51% complete, the procurement of HBNC kit yet to be completed. Faced with a similar challenge, state of Uttar Pradesh decided to procure the kits in a decentralized manner. However this has significantly affected the quality of equipment procured at district level. In the state of Chhattisgarh, ASHAs have been provided with Cotrimoxazole since 2005 and equipment like weighing machine, digital thermometer were provided by UNICEF in 2010-11. Since the equipment in Chhattisgarh and Uttarakhand were provided in 20101-11, states have planned for replacement of damaged equipment in Uttarakhand and all equipment in Chhattisgarh. NHSRC Nodal person shared that in Rajasthan, Weighing Machine was provided to only IMNCI trained ASHAs about 2 years back while the remaining components of the kit was provided to all ASHAs during Round 1 training. Procurement of weighing machine for remaining ASHAs is underway in the state.

Among the non high focus states only Haryana has been able to procure HBNNC kits through UNOPS. Nodal officers from other states shared issues related to procurement. The procurement process for all districts is yet to be completed in Delhi while it is yet to start in Maharashtra. Only 66% ASHAs in Karnataka and 29% in West Bengal have got the HBNC kits as compared to 91% and 80% ASHAs who are trained in Round 1 respectively. In Punjab where two rounds of training have been completed, the vendor for HBNC kit was selected only recently and state has started the distribution of only weighing machine. While in Gujarat only two components of the kit (Weighing machine and digital thermometer) were given to ASHAs and the process of procurement of digital watch is under way. As compared to High and Non High focus states, fewer challenges were reported from NE states. HBNC kit has been provided in all NE states except digital watch which was not provided in Arunachal Pradesh, Mizoram, Nagaland and Tripura.

HBNC Visits

HBNC visits started in the year 2012-13 across all states except for Uttarakhand where HBNC visits started in 2011-12 but the payments to ASHA started in 2012-13. The actual initiation of HBNC visits by ASHAs varied across states depending on completion of Round 1 training for ASHAs. However states are yet to streamline the processes for monitoring HBNC implementation. Thus the information shared by states for HBNC visits and incentives was from different time periods depending on availability of the data.

Among high focus states- A total of 96,870 HBNC visits were conducted by ASHAs in Odisha (Nov, 2012-Mar, 13), 1,94,516 in 17 CCSP districts of UP in (till March 2013), 71,118 in Uttarakhand (Apr12- June13), 11,689 in Jharkhand (Jan- June, 2013), 75,503 in Bihar (2012-

13) and about 3 lakh+ newborns in Chhattisgarh (2012-13). In Madhya Pradesh, the coverage of newborn visits on first day of birth in case of home deliveries is 54.4% while for all HBNC visits it was 44.4% (till June,2013) . An increase in the referrals of sick newborn was reported in Chhattisgarh, at around 5% of newborns (i.e, 5,000 cases) in Jan-March 2013. In Odisha 2406 (2.8%) newborns were referred by ASHAs for care.

About, 3,23,140 (29%) newborns were visited in Gujarat; 9,03,574 in West Bengal, and 48820 in Haryana during FY 12-13. In Maharashtra about 79,505 were newborns were visited by ASHAs during Apr'12 – June'13. About 60% of newborns born at institution were visited by ASHAs as against only 8% of the newborns who were born at home in Karnataka and 41,873 newborns were visited in Punjab during the first quarter of 2013-14.

States like Maharashtra, Karnataka and Haryana reported increase in referrals for newborn care. In Maharashtra about 2290 Low Birth Weight babies, 446 Pneumonia and 416 babies with sepsis were referred and 521 babies with hypothermia were identified by ASHAs during Apr, 12- June,13 and in Karnataka about 1518 Low Birth weight newborns out of 40884 and 627 sick new borns were referred, during the period Apr, 13 – June , 2013. Positive findings from the analysis of 48820 HBPNC forms were reported from Haryana where 92% of Home Delivered Newborn babies were visited on 1st day by ASHA, Birth weight was Taken in case of all 100% babies, 11% of Newborn were identified as being LBW & counselled by ASHA on for KMC, and 85% of Newborn babies were breastfed within 1st hr of birth.

About 71,751 newborns have been visited by ASHAs in Assam, 165 in Arunachal Pradesh, 813 in Manipur; 1,110 in Meghalaya; 5,378 in Nagaland; 2,377 in Sikkim and 8,723 in Tripura (2012-13).

HBNC payments

Payment of HBNC incentives is being provided to ASHAs in all states except Mizoram where the incentive proposal was not approved in PIP for the year 2013-14. Nodal officers from various states raised concerns with the conditions linked to HBNC incentive like insisting that ASHAs make sure that a birth certificate is issued, ensuring that mother and newborn are alive at the end of 42nd day – were conditions that seemed impractical based on field experiences. Some practical issues with payment like payment to ASHAs in cases where mother and newborn return home from health facility or maternal house 7-10 days after childbirth, in latter case two ASHAs conduct the HBNC visits, or cases where there is more than one childbirth (twins or triplets), were also raised.

An expenditure of Rs. 486.29 lakhs for ASHA HBNC incentive till March-13 was reported from UP; Rs. 14,78,250 in MP (till June, 2013), Rs. 3,36,63,250 in Odisha (Nov, 2012- Mar,13), Rs. 1,94,84,000 in UK (2012-13) and Rs. 1,88,75,929 in Bihar (2012-13). Delays in payments were reported from Jharkhand since payments were made only 613 cases against 11,689 HBNC claims submitted by ASHAs. State team explained that the delay was largely due to lack of clarity amongst block officials on validation mechanisms and in cases where Sahiyas have directly submitted the forms at Block CHC without prior validation from ASHA Facilitators or the ANM; they also assured that measures have been taken up to address this issue. Nodal officers also said that in cases where conditionality of ensuring birth certificate for the new born is being strictly imposed, it further restricts the payment of HBNC incentives to Sahiyas.

With regard to payment for HBNC visits, all states reported that payments are made once the HBNC forms are submitted by ASHAs. As per state reports, Rs. 1.67 crores was paid as HBNC incentive in Maharashtra in FY 2012-13, in Gujarat this figure is Rs. 80,784,903 (61.74% of Budget) for FY 12-13 and Rs. 12,094,162 (10% of Budget) for March, 13 to May, 13; in Punjab a total of Rs.1,04,68,250 was paid between April to June 2013. HBNC incentive payment has

started in five districts of Delhi and a total of Rs. 52,000 was paid to 208 ASHAs in June, 2013. Payment of HBNC incentive was started in Chhattisgarh 2012-13 after completion of second round of refresher despite ASHAs being trained in equivalent modules in 2008 and one refresher training in 2011-12. In West Bengal ASHAs are given HBNC incentive of Rs. 175 for first 14 visits and Rs. 75 for the remaining visits till 42nd day, for the financial year 2012-13 an amount of Rs. 12,98,24,550 was paid.

Delays in payments were reported from NE states as payments have been made in only 41% cases out of the total newborn visits made by ASHAs in Manipur, 39% in Tripura, 29% in Sikkim, 23% in Nagaland, 19% in Assam and 12% in Meghalaya. State Facilitator from Mizoram shared that HBNC incentive for ASHAs has not been approved in PIP FY 2013-14.

9. National Urban Health Mission (NUHM) for Universal Health Coverage

Shri Nikunj Dhal Joint Secretary Urban Health discussed with the participants an outline of the National Urban Health Mission (NUHM) and explained the role of community processes in addressing health concerns of the urban poor. He explained that the Government of India has launched the NUHM as a sub-mission under the overarching umbrella of the National Health Mission. Various health programmes have now been merged within the National Health Mission that covers flexible pool for different programme such as-NHM-RCH, NUHM, Communicable Diseases (Disease Control Programmes), Non- Communicable Diseases and Trauma Care, Infrastructure Management, Family Welfare etc.

He emphasized that the NUHM specially focusses on improving health status of the urban poor and other vulnerable sections particularly the slum dwellers and aims to facilitate equitable access for quality health care with the active involvement of the urban local bodies. Explaining the rationale behind the NUHM he quoted that "In urban areas prosperity of few hides the poverty of many" and stressed on the need to overcome a common misconception that people living in urban area are economically better off and do not need any public health support. He also highlighted that growth of urban population is double of rural population and by 2030 about 46% population will be residing in urban areas which further mandate a committed action to address the urban health needs. Urban Family Welfare Centres of 1970s or Urban Health Hospitals established between 1980s- 90s (albeit limited to few cities), suggest that efforts to improve urban health were indeed undertaken in the past but were either not comprehensive or largely unorganized. All this necessitated the government to evolve a comprehensive programme for increasing access of health services to urban poor.

He described that the NUHM will cover all cities with a population of above fifty thousand and all the district and state headquarters (irrespective of the population size).Urban areas with population less than 50,000 will be covered through the health facilities established under the National Rural Health Mission (NRHM). The NUHM will leverage the institutional structures of NRHM for administration and operationalization of the Mission.

Its proposed service delivery framework targets to either establish or strengthen the Primary and secondary Health care facilities. Unlike rural areas, Sub-centres will not be set up in the urban areas as distances and mode of transportation are much better and the outreach services

will be directed to the target groups comprising of slum dwellers and other vulnerable groups. Drawing attention of the group towards the utilization pattern of health services in cities, he pointed out the existing gap in accessing primary health care and highlighted that even in tertiary care hospitals such as AIIMS or Ram Manohar Lohiya more than 40-50% patients seek treatment only for minor ailments. There is a need to change the health seeking behaviour of the people which is where community processes in the form of ASHAs and Mahilla Aarogya Samitis (MAS) can play a vital role. The women self -help groups in the form of MAS (covering 50-100 households) and ASHAs covering 200-500 households will be used for empowerment of community through awareness generation which will increase demand of services by the community from the Health System. He also said that it is necessary to develop the norms for selection and training modules as well as training structures for ASHAs and MAS.

Some specific challenges for community process in urban areas were mentioned. These include- lack of social compatibility demanding extra efforts for community mobilization, complicated health issues like- substance/alcohol abuse, rampant migration which makes tracking of families difficult by frontline workers and further hamper monitoring of health services.

During the discourse Dr Jagdishan from Kerala wanted to understand the implications of NUHM on pre-existing urban health programme being instituted through urban local bodies in Kerala. In response Shri Dhal clarified that the implementation model for NUHM is highly context specific and can vary from states to states. States having a well- equipped municipal body as the one existing in Kerala, can continue to implement primary health care services through these bodies using NUHM funds. However, he cautioned that NUHM funds should not substitute for the health funds of these bodies. Rather it is suggested that NUHM funds should augment the financial resources available within these organizations for strengthening primary and public health care services for the urban poor. He reiterated the need for having an active resource centre for supporting urban community processes, which will allow effective devolution of funds, function and functionaries through capacity building and extensive support. Representatives from few states sought guidance for commencing selection of urban ASHAs. It was clarified that in initial phase states may prioritize selection of ASHAs only in slum areas for large cities, while in the smaller cities ASHAs can be uniformly selected in all areas following the suggested population norms.

Haryana team proposed to substitute the Ward Swasthya Samitis for MAS and Karnataka shared that the state Public Health Act mandates ULB to take an active role in health care in urban slums.

10. <u>Maternal Health</u>:

Session chaired by - Ms. Limatula Yaden, Director NRHM, MoHFW

This session involved presentation by Dr. Himanshu Bhushan, Deputy Commissioner, MoHFW. His presentation highlighted several gaps that limit achieving the desired maternal health outcomes. He illustrated this through a comparative analysis on indicators of maternal health, from sources such as-HMIS, DLHS, NFHS and AHS. The analyses showed that though institutional delivery coverage has increased substantially in last three to four years period and increase is also noted in 1st trimester registration in all the states (except in Bihar), progress on increasing the proportion of women availing three or more ANC with full complement of services has not been significant. In fact there has been a drop in 3 ANC in Bihar, Chhattisgarh, MP, Odisha, Uttar Pradesh and West Bengal. The data also showed the existing gaps in ensuring skilled home delivery.

He also presented an analysis of Maternal Death Review conducted for state of Gujarat, for the period April –December 2012. The analysis revealed important findings with reference to the place, time and causes of the 345 maternal deaths that were reviewed. It showed that in Gujarat, Private hospitals contribute to 41% of delivery but the maternal death share of these hospitals is 24%. While on the other hand District hospitals contribute a smaller proportion of deliveries at 19%, they add a higher proportion of maternal deaths at 27%. Clearly, District hospitals receive complicated cases both from other public facilities or CHCs and private facilities. The analysis also showed that of the mothers who delivered at CHC/FRU 43% died during transportation and 34% died at DH/Medical College. Thus, a key concern highlighted here was that of the total 345 maternal deaths, 114(25%) occurred on the way to hospital, 107 (24%) died in private hospital and 120 (27%) died at District Hospital/Medical Colleges. The path way analysis showed that a minimum of five inter-facility referrals were required to enable mothers reach a facility which was equipped to manage delivery related complications. Even in cases of mothers who delivered at home 36% died at home and 33% died during transportation. With regard to the time of death, majority of the maternal deaths (70%) occurred in the post-partum period. The proportion of maternal deaths within 48 hours of delivery is very high and contributes to 61% of total deaths. PPH and Sepsis are the most common cause contributing to 37% and 12% of total maternal deaths in Gujarat respectively. Among the pregnant women who died 98% had taken 1 or more ANC services but only 73% had undergone 3 or more than 3 ANC with full package of services. Among 58/345 maternal deaths for home deliveries, 95% were conducted by unskilled birth attendant.

Dr Bhushan mentioned that both the analyses shared indicate that greater action is needed on behalf of ASHAs to improve maternal health status. Many of the participants however raised concerns that many gaps highlighted in the presentation relate to systemic gaps and onus of which cannot rest on ASHA alone. For instance Dr Ajay Khare from Madhya Pradesh mentioned that ensuring ANC with full package of essential services is the responsibility of ANM and ASHA can only facilitate this by mobilizing women to attend VHND. Mr H. Nongyai from NEERC emphasized that ASHAs have their limitation in pursuing a women to stay in the hospital for up to 48 hours delivery. Once the ASHA has ensured a pregnant woman to reach the public health care facility for delivery, the stay of the woman for an adequate time after the delivery, largely depends upon the quality of services offered and on counseling by the healthcare staff and on the situation of the woman and her family.

Dr Bhushan emphasized that states should institutionalize maternal death reviews that involve systematic analysis to identify the various factors and causes attributing to maternal deaths, which would help in necessary corrective action. Dr Rajani Ved, Advisor Community Processes specified that there is also a need to better integrate programme efforts by states through increased coordination between State ASHA Nodal officers and the state maternal health team. This would also promote dialogues on maternal death analyses and allow effective planning to better leverage services of ASHAs for addressing the community level maternal health challenges, leading to improved outcomes. Dr Bhushan endorsed this statement and reiterated that maternal health outcomes can be improved by simultaneous action both at the level of facility and community. At the level of facility it would mean ensuring complete package of health services, equipping CHC/FRU to manage complications and building capacities of the medical staff to successfully stabilize the patients before referral. And at the level of the community, ASHA support structure should ensure that ASHAs make greater efforts to mobilize cases for full ANC, make micro-birth plans with all pregnant mothers, and refer complicated cases only to a well- equipped and functional health facility. He said ASHAs are a big force in enabling behavior change for breastfeeding, staying at health institution for 48hrs after delivery and KMC etc.

Dr Bhushan updated the participants regarding a policy decision on involving ASHAs in undertaking distribution of misoprostol to pregnant women for self- administration to prevent Post-Partum Haemorrhage. The participants' inputs were requested and they agreed to respond and provide feedback after closely studying the draft Operational Guidelines.

11. <u>ASHAs in Kerala:</u>

Dr Jagdeeshan Assistant Commissioner Public Health and ASHA Nodal Officer, Kerala spoke about the unique features of ASHA programme in Kerala. His presentation included a synopsis of plans from the state to involve ASHAs in new, non-RCH initiatives. He shared that though Kerala has attained its RCH indicators; ASHAs continue to play an important role in maternal and newborn care in tribal districts and are crucial in sustaining the RCH achievements. Apart from RCH and Communicable diseases, state has trained and involved ASHAs in various new interventions such as-Non Communicable Diseases, Pain & palliative care, Gender Issues and health, Social Security Mission etc. Accreditation of ASHAs in Pain and Palliative Care, geriatric care and home nursing, community mental health work and childhood disability is also intended. Dr Jagdeeshan elaborated that state has a palliative care policy and 137 ASHAs have completed one month Basic Course in Community Based Interventions in Palliative Care and Long Term Care. The selection of these ASHAs is through Kudumbashree funding and the training support is provided through NRHM. The District Panchayat undertakes placement of these ASHAs.

In addition to this all ASHAs have received training in palliative care which involved capacity building in skills for home nursing; follow up of bedridden patients, forming a support group for the bed ridden patients and acting as support for community nurse. In 2012-13 Kerala rolled out state wide NCD Programme through Sub Centres and PHCs. Under this initiative weekly NCD clinics are organized at these health care facilities. ASHA is a key member of the team involved in mobilization of patients for Sub –Centre based programmes. There are plans to have

second stage accredited ASHA for specialized areas of care in NCD like foot care of diabetics, diet counseling, life style modification counselling etc.

The presentation offered learning for other non-high focus states, where RCH is not a key priority, to experiment with approaches for using ASHAs in other newer interventions.

12. <u>Open Discussion on State Specific Issue:-</u>

1. A key challenge expressed by Kerala team was removal of non-functional ASHAs, which in context of the state is difficult due to their high social and political empowerment. The team also shared some other challenges such as- how to undertake second stage certification of ASHAs, development of Community Health Innovations and Learning and Training Sites and mechanisms to synergize role of ASHA with pilot interventions in chosen UHC districts.

2. Dr Rajesh Jha, ASHA Programme Manager shared challenges related to programme implementation with regards to the state of UP. He said that in order to meet the health goals as envisaged under NRHM, the state should be given an urgent and distinct priority on account of its sheer size and population density.

As of date, state level support for the programme is provided by one GM Community Processes, one consultant recruited by the state and by additional two consultants supported by NHSRC. Considering that state has largest number of ASHAs (1.5lakhs) in the country, there is an urgent need to strengthen programme support at the State level by increasing manpower resources functioning exclusively under the State ASHA Resource Centre. He mentioned that state is facing multiple challenges related to printing of modules and procurement of equipment kits due to the complicated tendering mechanism and sought the support from centre in resolving these issues.

Concerns related to the recently sanctioned ROP were also raised, where he shared that despite verbal approval in NPCC, position of BCMs was not sanctioned in ROP for FY-2013-14. They have also not received budget approval for incentives to ASHA for filling the Village Health Information Register. He also highlighted that ASHAs are not receiving any incentive for holding community level meetings with the mothers and adolescent girls. As per the orders from MOHFW the incentive for this activity is to be provided to ASHA from the VHSNC Untied funds.

In UP, VHSNC have been set up at the level of Gram Panchayats and thus cover many ASHAs. Providing monthly incentives of Rs 150 to 20-25 ASHAs would exhaust the untied funds only on this activity. Irrational conditionalities such as showing marriage certificate of the couple to avail incentive for ensuring birth spacing by ASHA is demotivating and limits their functionality on such tasks. The GOI guidelines are taken too literally by the district and block level staff and cannot be superseded.

3. Nodal Officers from states of Uttarakhand and Bihar requested technical support from MOHFW and NHSRC to develop CPSMS linked payment software for ASHAs.

4. Madhya Pradesh sought support to overcome the tedious validation process for incentives of Disease Control Programme. In response West Bengal suggested that this issue can be dealt effectively by creating a separate district pool for ASHA incentive. The state agreed to provide a write-up on creation of this mechanism.

5. Team from Jharkhand shared challenges related to drug kit replenishment and payment of ASHAs. Drug kit replenishment is not regular due to delays in drug procurement at the district level. They expressed a concern that the uniform package of JSY incentive for Sahiyas is yet to be implemented. State Maternal health team is trying to mandate a conditionality where Sahiya is entitled for an incentive of Rs 300 for ANC component only after she has ensured complete package of ANC services for the pregnant women and mere mobilization of the beneficiary for availing ANC is not enough. The state Village Health Sahiya Resource Centre is debating this issue as accountability for ensuring this outcome rests with the ANM and the health system and not just on ASHAs alone.

6. Mr Biraj Kanti Shome from NERRC expressed concern over the conditionality of mandatory escort by ASHAs to avail JSY incentive. He said this condition should not be there as motivating pregnant mothers for institutional delivery involves hard work of ASHAs during the entire period of pregnancy, which is overlooked and many times demotivates them.

7. Representatives from Rajasthan being new to the programme did not share any issues but NHSRC team involved in the state shared a concern that state ASHA Resource Centre needs to be revitalized and strengthened as presently there is no ASHA Nodal person at SPMU/ARC to manage the programme. ASHA supervisors placed at PHC level have been given additional responsibilities to support other programmes. This is undermining their effectiveness in supporting ASHAs.

13. <u>Discussion on Round Three Training for Trainers</u>:

Dr Rajani Ved, Advisor, Community Processes, NHSRC discussed a draft agenda for Round 3 Training of State and District Trainers. She updated the participants about the strategy for Round three training of trainers in Module 6 and 7. She highlighted that agenda for Round three has been modified based on learning of the last three years of Module 6 and 7 training implementation. It largely builds around the training needs of ASHAs which have emerged through the field level assessment and experiences of various state and national level stakeholders. Some of the topics for which refresher training is needed are -management of High Risk Baby, IYCF, and Reproductive Health. Broadly Round three TOT will comprise of five days and its content would be a blend of new topics such as Gender based violence and Reaching the Unreached with some previously taught skills needing further reinforcement. State specific topics based on the identified needs can be included and covered in one and half days. Reaching the Unreached training was originally envisaged to be held as part of monthly review meeting of ASHAs. Since this skill is critical for improving the functionality of ASHAs and considering the paucity of time during these meetings, it was decided to include this topic in Round 3 TOT. Training of Trainers in Round 3 should be held soon as per requirement of Uttarakhand, Odisha, Bihar North-Eastern states and Maharashtra.

She asked participants to help in developing the module for Gender based violence and five participants volunteered for the task - Dr. Monika Rana from Delhi, Dr. Saroj Naithani from Uttrakhand, Mr. Sameer Garg from Chattisgarh, Mr. Maneer Ahmed from Jharkhand, and Ms. Arti Pandey from Madhya Pradesh. It was decided that NHSRC team would coordinate and

work with these volunteers to prepare the module.

The meeting ended with an appreciation from all the participants pertaining to the new structure of the Nodal officers' workshop. All Nodal Officers found topic wise review to be more informative and useful and suggested that thematic projection of state wise status of the states followed by discussion (as undertaken during the Grievance Redressal session) is a good model and should be used more frequently in the future.

Annexure 1: List of Participants

Review Workshop of Nodal Officers for Community Processes from 30 July to 1 August, 2013				
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Annexure 2:

Review Workshop for Nodal Officers of Community Processes

30 July – 01 August 2013, New Delhi

Venue – NIHFW Auditorium, New Delhi

Objectives of Workshop:

1. Sharing of state progress on selected components of Community Processes Interventions
2. Orientation to Community Processes Component of National Urban Health Mission
3. Update of new initiatives in NRHM

Agenda:

Day and Timing	Session
Day 1	**Tuesday, 30 July 2013**
9.30 AM To 10.30 AM	Welcome Address – Mr. Manoj Jhalani, Joint Secretary (Policy), MoHFW & Dr T Sundararaman, Executive Director, NHSRC Objectives of Workshop –Dr. Rajani Ved, Advisor, Community Processes, NHSRC Keynote Address – Ms Anuradha Gupta, AS & MD – NRHM, MoHFW
10.30 AM – 10.45 AM	Tea
10.45 AM– 1.45 PM	Performance Monitoring Reports from States on ASHA Programme and linking Functionalities to Outcomes using HMIS Chair: Dr T Sundararaman, Executive Director, NHSRC
1.45 PM – 2.15 PM	Lunch
2.15 PM – 3.30 PM	Performance Monitoring Reports from States on ASHA Programme and linking functionalities to Outcomes using HMIS Chair: Dr T Sundararaman, Executive Director, NHSRC
3.30 PM – 3.45 PM	Tea
3.45 PM – 5.30 PM	Discussion on States efforts to streamline modalities of ASHA Payments Chair : Ms Limatula Yaden, Director (NRHM), MoHFW

Day 2	**Wednesday, 31 July 2013**
9.30 AM – 11.00 AM	Review Status of ASHA Grievance Redressal Cell in States

	Chair: Mr. Manoj Jhalani, Joint Secretary (Policy), MoHFW
11.00 AM – 11.15 AM	Tea
11.15 AM – 1 PM	(i) Community Monitoring and the role of VHSNC - Mr Bijit Roy & Ms Sona Sharma (Population Foundation of India, Secretariat, Advisory Group on Community Action (ii) Technical Update Session - ASHA's Role in Communicable Diseases - Dr Akshay Dhariwal, Director, NVBDCP Chair: Dr T Sundararaman, Executive Director, NHSRC
1 PM – 1.30 PM	Lunch
1.30 PM – 2.30 PM	Technical Update Session - Rashtriya Bal Swasthya Karyakram (RBSK) – Prof (Dr) Arun Kumar Singh, Advisor RBSK Programme, Govt of India Chair : Dr. Ajay Khera, Dy. Commissioner (MCH)
2.30 PM – 3.30 PM	Training ASHA in Disaster Management - Dr. Garima Gupta, NHSRC
3.30 PM – 3.45 PM	Tea
3.45 PM – 5.30 PM	Progress of Home Based New Care in states Chair : Dr.P.K Prabhakar

Day 3	**Thursday, 01 August 2013**
9.30 AM – 10.30 AM	National Urban Health Mission for Universal Health Coverage - Mr Nikunj Dhal, Joint Secretary (Urban Health), MoHFW Chair: Dr T Sundararaman, Executive Director, NHSRC
10:30 AM – 11:15 AM	Technical Update Session Maternal Health - Dr. Himanshu Bhushan, Assistant Commissioner(MH-II) Chair : Ms Limatula Yaden, Director (NRHM), MoHFW
11.15 AM – 11.30 AM	Tea
11.30 AM – 12.30 PM	Innovations and Best Practices in Community Processes from states Chair : Dr Rajani Ved, Advisor, Community Processes, NHSRC
12.30 PM – 1.00 PM	Wrap up and Next Steps - Dr T Sundararaman, Executive Director, NHSRC
1.00 PM – 1.30 PM	Lunch