Minutes of the Meeting of the National ASHA Mentoring Group,

National Health Systems Resource Centre (NHSRC), New Delhi, July 28, 2011

The Eighth meeting of National ASHA Mentoring Group (AMG), was held at the National Health Systems Resource Centre (NHSRC) office, at New Delhi, on 28 July 2011. 14 Members of 17 attended the meeting. The participant list is at Annexure 1. The Special Secretary and Mission Director, Mr. P.K. Pradhan was unable to attend on account of a meeting of the working group of the Planning Commission which was re- scheduled for July 28, 2011. The Ministry of Health and Family Welfare (MOHFW) was represented by Dr. P.K. Nayak, Deputy Commissioner, Training. Dr. T. Sundararaman, Executive Director, NHSRC, welcomed the group. Dr. Rajani Ved, Advisor, Community Processes, presented the agenda for the meeting (Annexure 2). The agenda for this meeting also included a presentation of the Mitanin evaluation in Chhattisgarh, and the findings from a study of the ASHA in Ruxaul, Bihar conducted by the Emmanuel Hospitals Association. Dr. Thelma Narayan was one of the mentors of the study team. A film on the ASHA programme in Assam, made by Dr. Sunil Kaul was also screened at the meeting. The minutes document a summary of discussions and key decisions.

1. *Update on action taken from after last meeting of the National ASHA Mentoring Group:* Dr. Rajani Ved reported on the actions taken after the last mentoring group which largely focused on advocacy with states on clarifying the roles of the ASHA through disseminating the findings of the ASHA evaluation at state and national levels including with the planning commission. The second action was the formation of a core team of national trainers to support the states in rolling out ASHA training. NHSRC informed the group that a core team of four national trainers had been recruited and were placed in Bihar, Madhya Pradesh, Rajasthan and Jharkhand. The third action was related to certification and accreditation. While a formal process of accreditation of trainers had not been established, national and state trainings included a rigorous component of evaluation during and at the end of the first Round of training for Modules 6 and 7. Dr. Rajani Ved informed the group that this process would be followed in the next two rounds of training, and requested members for assistance on developing accreditation processes and identifying potential institutions that could manage the accreditation.

2. *Progress of the ASHA and community processes programme in the last six months:* The fourth biannual update of ASHA programme was shared with the members. A brief update of the programme across the states was provided by NHSRC. NHSRC had organized national workshops for the state nodal officers of the ASHA programme (in Delhi and Guwahati), developed the training content and agenda for district and block community mobilizers, and a handbook for ASHA facilitators. NHSRC had also drafted the 12th Five Year Plan Working Group policy note, which includes sections on Community Processes and Social determinants of Health. The note was circulated to members of the National ASHA Mentoring Group for discussion.

3. *Workload of the ASHA:* Members raised the concern that increasingly diverse roles are being thrust on the ASHA in the state and from the center. Examples include disability, menstrual hygiene, and non communicable diseases. Dr. Thelma Narayan raised the concern that this was not ethical and the ASHA was now a “forced volunteer”. The ASHA ends up playing multiple roles and therefore does not have time or the opportunity

to undertake an additional livelihood activity. Dr. Nerges Mistry said that systematic time motion studies of the ASHA need to be undertaken before adding on additional responsibilities. This was being done in the agriculture sector. Dr. Abhay Bang shared his finding that for a population of 1000 the ASHA needs to spend 1.5 hours daily for the MCH related roles, and overall about three hours daily to perform other functions such as VHSC meetings, water and sanitation, and escorting patients to facilities. If additional roles are being assigned to her, she will need to spend increasing number of hours. The issue of several part time workers in a village vs. one full time worker was also discussed by the members from the point of view of desirability, appropriateness and effectiveness. Dr. Indu Capoor said that the ANM and AWW were delegating several of their tasks to her. Dr. Prakasamma was concerned that the high level of attention to the ASHA programme had resulted in relative neglect of the ANM. Dr. Sundararaman said that this may not be a direct cause effect relationship. Dr. Antony said that while there was a tendency to overburden the ASHA there must be clarity on what her priorities are and this would come from a clear understanding of her roles. Dr. Sudarshan was of the view that we should move towards one full time, well trained community health worker, under panchayat management. The group agreed that this was the way forward but that there should also be space for a voluntary part time health worker, if that is warranted. The group also agreed that a set of "qualifiers", should be put in place, and that the focus should be on building skills and capacities of ASHA, ensuring role clarity between ASHA and ANM, and the instituting a robust referral system.

4. *Compensation of the ASHA:* Members raised concerns over a range of payment related issues. The discussion primarily centered around fixed versus performance based incentive payment. Mr. J.P. Mishra argued that the task based incentive payment system shifts the focus of the programme away from health promotion and mobilization. Dr. Indu Capoor felt that given that the remuneration of AWW workers was being increased to Rs. 3000, unless there was parity, retention of ASHAs might become difficult, as many ASHAs are moving towards becoming AWW. Dr. Nupur Basu said that the payment for the ASHA programme should be standardized, similar to that for the AWW programme. Dr. Shyam Ashtekar and Dr. Abhay Bang preferred the blended approach, with Dr. Thelma Narayan expressing her view that fixed payment should be followed. Dr. Antony was of the view that that the payment to ASHAs should be through the Panchayati Raj institutions (PRI) and there should be a movement towards the PRIs playing a greater role and creating a panchayat health worker. The consensus of the group was towards a blended payment system, (including a fixed sum and incentives based on performance on a range of activities) that should be routed through Village Health and Sanitation Committee (VHSC), wherever they exist and are functional. The fixed payment was also performance based but for a set of regularly occurring activities, such as review meetings, VHSC meetings, mobilization for VHND, etc. This component should at the very least be equal to the minimum wages. The composition of the performance based incentive component should be left to the states to decide.

5. *Support Structures for ASHA and Community Processes programme at state levels:* Dr. Sudarshan raised a concern that the attention to establishing support structures in the non high focus states was not sufficient. He said that the experience in Karnataka was that the lack of support structures was hampering programme effectiveness. The ASHA

programme was being managed through existing officers, and this meant that support and supervision, including on the job mentoring was not taking place as envisaged. The group observed that commitment to an effective ASHA programme requires a good support structure, and made a strong recommendation for building and strengthening of support structures in these states.

6. *Future growth of the ASHA:* Dr. Rajani Ved shared that once the ASHAs were certified, there needs to be active advocacy for a bridge programme that would enable suitably qualified ASHAs to enroll in training schools for ANM. This strategy should be included in the country's strategy for building human resources for health. ASHAs could be provided with scholarships to undertake the bridge courses. Members argued that career paths for the ASHAs should not be only that of an ANM. Different approaches to the issue of growth of the ASHA were discussed. Dr. Abhay Bang raised the point that enhancing knowledge and skills of those ASHA who are able to demonstrate a basic level of proficiency to undertake additional tasks such as screening for blood pressure or using injections could be considered as a future growth avenue. The ASHA could opt to become ANM, PRI member, or an AWW. The role of the system should be to enhance her skills and support her aspirations. The need for ensuring mandatory (23 days every year) training to ASHA was underscored, and importance of on the job training was also highlighted. Dr. Indu Capoor said that in the long-term the ASHA programme should be seen as a women's empowerment programme and as a livelihood promotion intervention and her capacity needs to built in this direction. Dr. Nerges Mistry said that the ASHA should be enabled to articulate her own aspirations on her positioning as well as career progression. Dr. Thelma Narayan clarified that ASHA training manuals and reading material should emphasize the effect of social determinants on health and this would contribute to enhancing her understanding, and expand and influence her choice of future growth paths. All members agreed that states should provide for enhancement of skills and knowledge leading to better social recognition and should enable the ASHA to choose future growth prospects based on her aptitude and interest.

7. *Evaluation of the Village Health and Sanitation Committees:* The NHSRC team shared the concept note for the proposed study on VHSC in eight states. The discussion centered on the larger role of VHSC with specific suggestions on the evaluation. Members raised the concern that less attention had been given to the VHSC in the past five years and this needs to be remedied. Dr. Shyam Ashtekar said that District based Zilla Parishads should be taken into the loop to strengthen the functionality of VHSCs. The potential role of NGOs in strengthening VHSCs was also discussed. Dr. Nupur Basu, shared the West Bengal experience where social mapping of villages was done by VHSCs with the support of NGOs specifically for identifying malnourished children in the village. Dr. Thelma Narayan drew the attention of the group to the work of SOCHARA in Tamil Nadu where with the assistance of the government; a six district initiative to strengthen VHSC for community action is underway. She stressed on the need for building linkages between community and health systems, and also between VHSC and community monitoring. Dr. Capoor, shared her experiences from Gujarat, where a VHSC evaluation was funded and supported by the State Government with NGOs taking the lead in conducting the study. She said she would share the report with the group. Dr. Thelma Narayan, emphasized that all the states should be encouraged to conduct the study with

the participation of various academic institutes available within the states. She suggested that state specific issues and community's priorities should be highlighted in the study. Dr. Bang and Dr. Tripathi said that the purpose of the study should be to guide policy makers by providing evidence from field and recommendations for better outcomes of the programme. While Dr. Bang also recommended a mixed approach he said the study should be used to explore what worked and what did not and then a method of ranking VHSCs and highlighting the gaps needed to be used. Dr. Antony shared the processes and learning from Chattisgarh's Sawasthya Panchayat Yojana in which panchayats have been scored on 32 indicators (now consolidated into 12 indicators), ranked and awards given for recognition and motivation. All members recommended a mixed method approach. Members made suggestions for making the study more qualitative (with smaller sample size) and highlighted the role of competent researchers, stressed on need for greater involvement of states in the study, and suggested that various aspects of structures and policies as well as role of VHSCs should be focused in the study. The group felt that objectives of the study should be more specific and also suggested a few additional aspects that should be covered, namely innovations made at village level and focus on community needs. Other areas of questioning included VHSC composition, adherence to national framework, an assessment of utilization of VHSC funds, the extent to which the state had played a facilitatory role. Dr. Indu Capoor said that though the rules on VHSC composition mandate inclusion of women, women members are not very active in VHSC. She also suggested that functioning of VHSC in terms of gender issues – voice of women members and decision making processes should be studied.

8. *Creating state level centers to support and test innovations and serve as demonstration sites for well designed and scalable models for community processes:* NHSRC presented a proposal to establish 'centers of excellence' at the state level. The major objectives of these centers would be to serve as demonstration sites for high quality training at the state level. The centers would also serve to test innovations in community processes including the piloting of approaches for community level screening and care for emerging areas such as NCD, disability and mental health, would enable district and block officers to scale up community process interventions with the same rigour and quality. Three such centers are being proposed to be established in each of these states. Dr. Prashanta Tripathy said that the proposed centers should not be called centre of excellence, because this name may provoke a sense of competition and will also lead to undue expectations. All members agreed with this view and NHSRC agreed that they would look at other names for the intervention. Members suggested that more than just three of these centres in each state should be considered. Members also suggested that the scope of the proposed centres should also test interventions that addressed the social determinants of health. The need for strong NGO support to the ASHA program at block level was also raised. In this context the groups discussed the need to evolve mechanisms for transparent grant making to NGOs to enable committed and competent groups to participate in the programme. Mr. Alok Mukhopadhyay suggested that NHSRC study the model that the Department of Science and Technology uses to fund NGOs, where core support was included with project support. The issue of relationship of the proposed centres managed by NGOs with state governments was discussed. There were mixed opinions on the weightage of relationship with state government versus NGO competency, and NGO accreditation was suggested as a possible way to solve this.

9. *Integration of Feedback from the ASHA Mentoring Group in to decision making process:* Members raised the issue of whether the national ASHA mentoring group's deliberations and recommendations had any impact on programme and policy decisions for the ASHA programme. Dr. Sundararaman briefed the group about the ways in which policy making structures including the Mission Steering Group (MSG - the highest decision making body for NRHM) have been acting upon the AMG's suggestions. They were also briefed on the recommendations of the parliamentary committees regarding ASHA program, and were assured that the AMG's minutes and recommendations were sent to MOHFW and are taken up at policy level in a systematic manner. He also mentioned that the ASHA figured frequently in parliament questions. Last year NHSRC had responded to 148 parliamentary questions related to the ASHA programme.

10. *Accreditation of Trainers and Certification of ASHAs:* The need for building systems for accreditation and certification of trainers and ASHAs in the ASHA program was underscored by the members. Some members shared the experiences of accreditation of ASHA Trainers in the ongoing ASHA training in states, particularly ASHA Module 6 & 7 training. Members were briefed about the processes of evaluation of trainers being adopted at different levels. NSHRC requested members to volunteer their time in developing formal mechanisms for accreditation and certification. All agreed that trainer accreditation should be undertaken by NHSRC and ASHA certification should be done at the state level, using standardized guidelines.

11. *Other issues discussed in the group*

Members stressed on the need for developing indicators through which ASHA's success in influencing the quality of the program can be measured. Possible process indicators include: number of ASHAs that are able to demand and access entitlements. Another indicator could be designed to assess if the ANMs performance improved because of ASHA.

The recent instances of Union formation among ASHAs in some states were discussed and the group agreed that it is not a negative development and it can play the role of building corrective pressures on the program.

Dr. Alok Mukhopadhyaya suggested that NHSRC explore the possibility of including a session on the ASHA and community processes programme in training programmes for state level officers in the National Institute of Health and Family Welfare (NIHFW).

There is a need to build synergies between Advisory Group on Community Action (AGCA) and the National ASHA Mentoring Group (NAMG).

The members recommended that guidelines and government orders related to ASHA programme should be provided to ASHAs to help them perform and negotiate better with the system.

Dr. Rajani Ved shared with the group that the state of Himachal Pradesh, which does not have an ASHA programme has requested NHSRC to help develop a strategy for training AWW in undertaking the functions of the ASHA. Some members of the group were concerned that the AWW already had several duties and that adding on the functions of the ASHA would mean

overload. NHSRC said that they would be informing the government of HP that a feasibility study would be undertaken before any discussions on training of AWW was initiated. NHSRC requested members of the ASHA Mentoring Group to be part of the study. Dr. Indu Capoor said that she would be interested in participating in a feasibility study in HP.

The group discussed the rapid progress of program and ASHA Module 5 and Module 6 & 7 training in Madhya Pradesh, and praised the role played by Dr. Ajay Khare in taking the program forward and also the positive support to the program being provided by MD – NRHM, Dr. Agnani. The recent decision of state to route the ASHA payment through VHSCs, was welcomed by the group.

Dr. Abhay Bang said that one mechanism for enabling ASHA to play the activist role better, was to provide pre-printed post cards (addressed to the Medical Officer or CMO of the districts) to the ASHA, in which she could raise issues of concern. A register should be maintained at both the levels for tracking the follow up to the issues raised by ASHAs.

Presentations made by AMG Members and Invited Guests -

Dr. Shyam Ashtekar, member of National AMG -

Dr. Shyam Ashtekar, member of National AMG, made a presentation on the issues related to ASHA program, and underscored the larger program framework issues. He raised his concern on the performance of four components of ASHA - training, remuneration, kit-supply and support system/enabling environment. He also presented a framework for revisiting the construct of ASHA elaborating on different roles of ASHA like – mobilizer role and worker's role. He was concerned that a valuable opportunity was being missed in enabling a community level worker in promoting better health outcomes.

Invited Guest - Dr. Vandana Kant, Emmanuel Hospital Association, Raxaul Bihar

Dr. Kanth made a presentation of a study on ASHA program done by her organization in East Champaran District of Bihar. The study was focused on 'The contribution of Accredited Social Health Activist (ASHA) under National Rural Health Mission (NRHM) in the implementation of Comprehensive Primary Health Care', This cross-sectional study was done in two blocks comprising of 33 panchayats & 137 villages, between February 2009 to August 2010. Both qualitative & quantitative methods were used in study. The study found that all the stakeholders and the ASHAs themselves perceived their role to be mainly related to the delivery of health care services pertaining to maternal and child health – antenatal care, institutional delivery and childhood immunization. The study found that many of the ASHAs perceived that their social activist role was to facilitate poor people to access health services & incentives in the PHC. ASHAs also felt that "moving out in community and out of her home' is her greatest strength. Others saw their strength in bringing awareness among pregnant women regarding their health & facilitating institutional delivery, and only few saw their attachment with the health sector as their major strength.

Mr. J.P. Mishra, Executive Director, SHRC, Chhattisgarh

Mr. JP Mishra presented the findings of the Mitanin Evaluation from Chhattisgarh. The evaluation used a mixed method evaluation (similar to that used in the NHSRC led eight state evaluation) and was conducted in eight districts. A total of 1280 Mitanin, 2560 Women with a child less than six months, 5120 women with a child less than two years, and 640 each from the following categories: ANMs, AWW and PRI were interviewed. Field work for the evaluation was undertaken between November 2010 to January 2011. The findings from the qualitative phase show that the programme has had the positive impact that was envisaged in promoting good practices and utilization of public health services. The Mitanins have effectively played the role of an activist in raising community awareness about their rights. However, the assessment has raised the potential risk that the introduction of task based incentives may affect the ability of the Mitanins to play their activist role. Findings from quantitative phase show that Mitanin were the main source of advice for the service users, particularly for IFA tablets, institutional delivery, and weight and blood pressure measurement and TT injection. More than 80% respondents reported that institutional delivery was promoted by Mitanin. However, about 50% deliveries were home deliveries owing to unavailability of transport and large distances of facility. Over 90% beneficiaries reported initiating breast feeding within 4 hours and exclusive breastfeeding for 6 months was reported by 87%. Overall, 85% service users confirmed receiving supplementary food / ration on a regular basis and 77% reported Mitanin help in enrolling the child with the AWC.

- Dropouts from the programme has been very low as the about 82% of Mitanins reported to be working for more than 5 years at the time of survey. Nearly 90% of the Mitanins spend, on an average, up to 3 hours a day on Mitanin related work.The average incentive amount received by them was found to be very low - less than Rs 200/- per month. 95% of the Mitanin had the drug kit but only 54% reported regular replenishment. The knowledge levels of Mitanins on critical aspects like care during pregnancy, post-natal care, immunization, complementary feeding, diarrhea and malaria management etc. were found to be adequate for most of the Mitanins

- About 90% ANM, AWW and PRIs reported that Mitanins have helped increase institutional deliveries and immunization coverage. Other impact areas identified include increasing mother and child attendance in the VHNDs, increase in the utilization of public health services and better hygiene in the community.

At the end of the meeting members commended NHSRC for its contributions to strengthening the content and improving the pace of the programme. At the suggestion of Mr. Alok Mukhopadhyay, and in memoriam to the passing away of three doyens of public health in India, Sadhana Tai, Dr. Raj Arole, and Sujit Ray[1], the group observed a moment's silence.

[1] Sadhana Tai was wife of Baba Amte, and an equal partner in his life-long work. Dr. Raj Arole was the founder of Jamkhed community health program, and Dr. Sujit Ray, has worked extensively on Rational Drug use.

National ASHA Mentoring Group Meeting, NHSRC New Delhi, July, 28, 2011 – List of Participants				
Sl. No.	**Name**	**Designation, Name of Organisation and Address**	**Email ID**	**Phone/Cell No.**
1	Dr. Shyam Ashtekar	Bharat Vaidyaka Sanstha, 21 cherry Hills Society, Anandwalli, Pipeline Rd, Nashik 422013	shyamashtekar@yahoo.com	9422271544, 0253-2342447
2	Ms. Indu Capoor	Centre for Health Education, Training and Nutrition Awareness (CHETNA), Supath-II, B Blcok, 3rd Floor, Opposite Vadaj Bus Terminal, Ashram Road, Vadaj, Ahemadabad, Gujarat-380013,	chetna456@gmail.com	079-27559976/77, 2561167, 09824021686
3	Dr. Nupur Basu	Child In Need Institute (CINI), Vollage & PO Daulatpur, Via Joka, Dist South 24 Pargana, West Bengal	nupur@cinindia.org	0-9831105836, 033-24978641/42, 24978192
4	Dr. N F Mistry	Foundation for Research in Community Health (FRCH), 84 A, RG Thadani Marg, Worli, Mumbai- 400018, Maharashtra	fmr@fmrindia.org	022-22662707, 022-24934989, 022-24938601, 09892274743
5	Dr. Alok Mukopadhyay	CEO, Voluntary Health Association of India (VHAI), B-40, Qutab Institutional Area, New Delhi- 10016	vhai@vsnl.com	011-26518071/72
6	Dr. M. Prakasamma,	Director, ANSWERS, 215, Ammtaville Apptts, Rajbhawan Road, Hyderabad - AP. 500082	mytrii1@yahoo.com	9440065707
7	Dr. H. Sudarshan	Karuna Trust, 686, 16th A main, 38th Cross, Jayanagar, T Block, Banglore-560041	hsudarsan@vsnl.net	080-22447612, 0-9448077487
8	Dr. Abhay Bang	Society for Education, Action and Research in Community Health (SEARCH), Shodhgram, P O & District- Gadchiroli (Maharashtra)- 442605	search@satyam.net.in	07138-255407
9	Dr. Prashant K Tripathy	Ekjut, Plot 556B, Potka, Chkradharpur, West Singbhum-833102 Jharkhand	prasanta.ekjut@gmail.com	06587-239625, 9431153434

10	Dr. Thelma Narayan	Centre for Health and Equity, CHL-Sochara, 359 1st Main, 1st Block, Koromangala, Bangalore, Karnataka	thelma.narayan@gmail.com , thelma@sochara.org	M-09341257911, 080-41280009, Fax-080-25525372
11	Dr. J.P. Mishra,	Director, SHRC, Chhattisgarh, Kail Badi Chauk, Raipur, CG	jaypmishra@gmail.com	0771-2535305, 09899315900
12	Dr. P.K. Nayak,	DC (Training), MOHFW, New Delhi	dctrg.mohfw@gmail.com	011-23062091
13	Dr. Vandana Kanth	Director Doctor Associate Project, Duncan Hospital, Raxual, Motihari, Bihar	dr.vandanakanth@gmail.com	9431204772
14	Ms. Madhurima Nundy	Sr. Programme Coordinator, PHRN, 5A, Jungi House, Shahpur Jat, New Delhi	madhurima.nundy@gmail.com	9810773058
15	Dr. K. R. Antony	Add: B-6-B,Chackola's Habitat, Ferry Road, Thevara, Cochin-682013.	krantony53@gmail.com	08547503922, 918547503922, 914842663922
16	Mr. Biraj Kanti Shome .	Regional Resource Centre for North Eastern States (RRC-NE), Assam Medical Council Bhawan, Six Mile, Khanapara, Guwahati – 781022	birajshome@yahoo.com	9435172953
17	Dr. T. Sundararaman	E.D, NHSRC, New Delhi	sundararaman.t@gmail.com	9971415558
18	Dr. Rajani Ved,	Advisor (CP), NHSRC, New Delhi	rajani.ved@gmail.com	9810333771
19	Dr. Manoj Kumar Singh	Consultant (CP), NHSRC, New Delhi	manojkumar.nhsrc@gmail.com	9891195001
20	Mr. Arun Srivastava	Consultant (CP), NHSRC, New Delhi	arunrewa@gmail.com	9999026999
21	Dr. Garima Gupta	Consultant (CP), NHSRC, New Delhi	drguptagarima@gmail.com	9899114279

Agenda for National ASHA Mentoring Group Meeting

National Health Systems Resource Center (NHSRC)

Thursday, July 28, 2011,

Time - 10:00 am to 5:30 pm

Agenda

Welcome and Introductions

Address by Shri P.K. Pradhan, SS and MD, National Rural Health Mission

1. Update on ASHA programme

- Report on progress of ASHA and VHSC programme
- Launch of ASHA update: July 2011

2. ASHA and VHSC evaluations

- Evaluation of the Mitanin Programme: Presentation by State Health Systems Resource Center, Chhattisgarh:
- ASHA evaluation in Ruxaul, Bihar: Presentation by Emmanuel Hospitals Association
- ASHAs in Assam: Film (To be confirmed)
- Update on NHSRC led ASHA evaluations in states
- Proposed methodology for VHSC evaluations

3. Sharing by AMG members

- Experiences from states

4. Looking to the future: Community Processes in the 12th Plan

- ASHA- Career Progression
- Centers of excellence for community processes