Update on the ASHA PROGRAMME July 2015

NATIONAL HEALTH MISSION
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Ministry of Health and Family Welfare
Government of India

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Introduction

This issue is the twelfth in the series of bi-annual ASHA updates. It is produced by the National Health Systems Resource Centre (NHSRC) for the National Health Mission (NHM), Ministry of Health and Family Welfare. The objective of the ASHA update is to report on programme progress, provide information on key events and other relevant information related to the ASHA and Community Processes programme that have taken place in the last six months since the last update. This Update Covers the period between January 2015 and June 2015.

The update is divided into seven sections. In section 2 we provide a state wise report on the status of selection, training, and support structures. We also report on the status of selection of ASHA in urban areas and the extent to which Mahila Arogya Samiti (MAS) have been formed. The picture is mixed, indicating a slowing of training pace in the larger states of Rajasthan, Madhya Pradesh and Bihar. Two reasons that appear to be causing the slowing down, are trainer attrition and delays in fund releases. We also present the status of support systems and personnel in place to support the community processes interventions. While states have been able to appoint staff at various levels, there are high and persistent vacancies in several states which tend to negate the effect on programme management and performance monitoring. Both these aspects need substantial strengthening.

In Section 3 we report on the highlights of a Visioning Workshop of the National ASHA Mentoring Group held in March this year. The workshop discussions were structured around a set of ten questions that aimed at charting a way forward for the ASHA and community processes interventions beyond the first ten years of the National Health Mission. The update reports on the issues discussed and recommendations of the group. These include, inter alia, adaptations of the programme to

varying and evolving contexts in states, including building the capacity of the ASHA as a member of the comprehensive primary health care team, establishing criteria for turn-over and a possible age limit, creating a balance between voluntarism and paying low incentives for numerous tasks, and implications and strategy for programme management and performance monitoring.

Section 4 provides a brief description of the Mother Child Tracking Facilitation Center MCTFC) focusing on the role of the ASHA in the Mother-Child Tracking System (MCTS). The MCTFC represents an alternative, central mechanism to monitor the reach and coverage of frontline workers – ANMs and ASHA to pregnant women and recently delivered questions. The update reports on the status of the process.

Earlier this year the Government of India launched Mission Indradhanush, an initiative to expand immunization coverage. Mission Indradhanush is undertaken in cycles of four months. Identifying children who are due for immunization and mobilizing them to attend the Village Health and Nutrition day, has long been an activity of the ASHA. The special drive while enabling the ASHA to furnish due lists, also ensures that the entire system is geared to provide immunization services. In Section 5, we report on the experiences of the first cycle.

In Section 6, we report on Best Practices from a few states, which were presented at the National Summit of Good, Replicable Practices and Innovations in Health Care Systems, organized by the Ministry of Health and Family Welfare in Shimla in June this year. The three best practices included in this update are the Fulwari scheme in Chhattisgarh- a community managed day care and nutrition centre for children, anchored by the Mitanin and her support structures, the development of a software programme for ASHA monitoring from Rajasthan – ASHA SOFT, and the role of Village Health Sanitation and Nutrition Committees in mobilizing for screening for non communicable diseases from Sikkim. The Chhattisgarh and Sikkim experiences demonstrate possible future roles for the community processes interventions, and the ASHA SOFT from Rajasthan represents an endeavour to use information technology tools to undertake performance monitoring. However the potential to scale up and sustain these practices even within their states of origin requires an ecosystem that is adequately resourced and supported.

Finally in Section 7, we provide an update of the ASHA incentives that are available for states through the National Health Mission. One caution for readers is to remember that not all incentives are universal or applicable to ASHAs across the country. Some incentives such as those for Family Planning and the National Vector Borne Disease are specific to selected districts in states. The amount of selected incentives, such as for example, for the Janani Suraksha Yojana, also varies between high focus and non high focus states. States may also choose to add on incentives to this list through the National Health Mission funds, provided the amount is within their overall resource envelope. In addition to the states provide incentives to ASHAs from state budgets. The latter two amounts are not reflected in the table.

Over the next six months, evaluations of the ASHA programme in the three states of Jammu and Kashmir, Tripura and Mizoram will be conducted, and we are optimistic that we will be able to report preliminary findings in the next update. We also hope to report on the key findings and recommendations of the ninth Common Review Mission, scheduled for November 2015.

Section-2

Progress of the ASHA Programme

This section provides data on three major areas related to the ASHA programme across the country, namely the status of ASHA selection and currently functional ASHA, status of training and status of support structures. The primary source for this data is from state reports related to the ASHA and Community Processes programmes as of June 30, 2015.

Section 2.1 A: ASHA Selection

Since the last update of January 2015, the ASHA Programme has expanded from 32 states and UTs to 35 with Goa being the only state that has no ASHA Programme. Thus in this update we report figures on ASHA targets and selection from states of Himachal Pradesh and Puducherry and UT of Chandigarh.

The total number of ASHAs is 8,56,405 as of 30 June 2015, against the present total target of 9,52,578. Despite an addition of 7752 ASHAs target in Himachal Pradesh there is a reduction in the total target by 8535. This reduction is on account of reporting of figures from Delhi under NUHM ASHAs and also separate reporting of rural and urban ASHAs from states of Chhattisgarh, Uttrakhand, Meghalaya, Sikkim, Tripura, Telangana and Kerala .

Overall achievement of ASHA selection against the present target is 90%, indicating a shortfall of nearly 10%. The targets across most states are consistent with the data reported in the last update data. Marginal increase in target is reported from states of Madhya Pradesh, Odisha, Assam & Arunachal Pradesh. Among the High Focus States, in the state of Uttar Pradesh, with 84% ASHAs in position, the number of functional ASHA appear to have reduced from 1.41 lakhs in January 2015 to

1.35 lakhs in June 2015. The state is yet to complete ASHA selection against its increased target of 1.6 lakhs (based on Census, 2011 population). In Bihar, with 82% ASHAs in place, selection is yet to be completed against the increased target based on Census 2011. Odisha which had 99.6% ASHAs in place against its target in January 2015, has increased its target and thus has a shortfall with 93% ASHAs in position as on June 2015. The gaps in selection across the high focus states, either because of increased targets or higher drop out is a cause for concern. Gaps in selection of ASHA imply that the nearest ASHA is asked to take on the tasks of the missing ASHA. In states like UP and Bihar this has implications on coverage and quality, where ASHA already have a fair sized number of pregnant women, newborns and children to look after. In Odisha, given the geographical dispersion and hilly terrain, this would entail ASHA having to walk long distances to reach mothers and children. Coverage and reaching most marginalized populations or those who live on the outskirts of villages and hamlets has been a vexing issue in the health system. A shortfall of ASHA is likely to affect such populations the most.

In the Non High Focus States, however the news is better, albeit limited to a few states. Andhra Pradesh, Haryana, Punjab, Jammu and Kashmir, Gujarat, Maharashtra have nearly reached selection targets. Himachal Pradesh has also completed selecting ASHA and has achieved 97% selection. In Kerala we see a 16% shortfall, largely due to drop-out of ASHAs. West Bengal has a 24% shortfall. Karnataka, another non-high focus state with 76% ASHAs in position and functional, reflects high dropout in last few years. Among the North-Eastern States, all states barring Mizoram are near completion for their selection targets. Mizoram has a gap of 10% against the revised target.

Population density of ASHA

In terms of population density, the majority of high focus states have one ASHA for a 1000 population or less except for the states of Bihar, Rajasthan and Uttar Pradesh, where the current ASHA density ranges from 1/1086 to 1/1150 in these states. The states of Jharkhand and Uttarakhand have a population density of 1 per 636 and 725 respectively on account of tribal and hilly areas. Similarly NE states except Assam, Nagaland and Sikkim, have a low population density between 276 to 532 . Assam, Nagaland and Sikkim have a population density of 8,75,746 and 713 respectively. The lowest population coverage of 276 is reported from Arunachal Pradesh given its difficult geographic terrain and sparse population distribution and from Chhattisgarh (298) where ASHAs are selected at habitation (para/hamlet) level. On the other hand, four out of eleven Non High focus states report population density of over 1000 with West Bengal having one ASHA for 1343 and Karnataka with 1252. Among non high focus states, the lowest density of 672 is seen in Kerala. Population coverage in the UTs is also less than the one per 1000 norm. In Lakshadweep there is one ASHA per 129 and one per 880 in Dadar & Nagar Haveli. Overall population density of ASHA for entire country is reported less than 1000 (1/926).While the guidelines stipulate a norm of one per 1000, there is also flexibility built in for geographically dispersed areas, hamlets and in hilly terrains, so that the ASHA may not need to walk long distances and is able to ensure that every last household in her coverage area is reached. Prima facie, low population coverage data, implies that this is indeed the case. However as the programme evolves and as a demographic transition occurs, we will need to look at issues such as tasks allocated, time spent and target populations covered.

When programme reviews demonstrated that ASHAs working in low population density areas were disadvantaged with respect to the total incentive earned, given the fewer pregnant women, newborns and children (since a significant part of the ASHA incentives are obtained from programs such as Janani Suraksha Yojana, Immunization, and Home Based Newborn Care), the Mission Steering group of the National Health Mission in December 2013, approved a monthly routine and recurring incentive of Rs. 1000 per ASHA – for five activities, which every ASHA is expected to undertake: mobilize children for the monthly Village Health and Nutrition Day, attend the monthly review meeting at the PHC, convene a meeting of the Village Health, Sanitation and Nutrition Committee, and maintain a population database, with a focus on five key elements - a line listing of households, updated biannually, maintain a Village Health Register with registration of births and deaths, and preparing lists of the three categories she specially addresses, namely - numbers of children to be immunized, pregnant women, eligible couples. However, as the demographic transition is getting underway and Total Fertility Rates decline, the target population of the ASHA is shrinking, not just where she covers smaller populations but even in areas where her population coverage is equal to the norm of one per 1000. This needs policy consideration and perhaps represents a point where the programme needs to be moved into the next orbit.

Section 2.1 B: ASHA Selection under NUHM

In this update we also report on the selection status of ASHAs in Urban Areas as part of the National Urban Health Mission. States have reported the total number of Urban ASHAs across 32 states is 37,617 against the target of 63,459 (59%) as of June 30, 2015. At this phase of the NUHM, only selected cities in each state have been identified for implementation of the community processes intervention.

Among the high focus states, states of Chhattisgarh, Madhya Pradesh and Uttarakhand are near completion of their present targets for selection of ASHAs in urban areas. Odisha has completed the selection of Urban ASHAs as per the initial targets. Bihar, Jharkhand and Rajasthan have also begun the process and selection of urban ASHAs is underway. In UP, the process of selection is yet to begin. Overall the high focus states have selected 57.7% of their urban ASHA target.

In the North East, Arunachal Pradesh, Assam and Manipurhave completed or are near completion of their selection targets for the urban ASHAs. Selection is underway in the remaining states. In Meghalaya, all link workers have been converted to urban ASHAs while in Sikkim and Tripura ASHAs working in urban areas have been identified as urban ASHAs under NUHM.

Among the non-high focus states, Andhra Pradesh, Jammu and Kashmir, Punjab and Telangana have selected more than 80% of their targeted ASHAs. Haryana has selected 77% of its target while Karnataka, Kerala and Maharashtra have reached 38%, 45%and 40% of their urban ASHA target respectively. Delhi which has had urban ASHA since the inception of the National Rural Health Mission in 2005 has selected ASHA only in certain identified clusters, at the level of one for 2000 population. There is still a shortfall of 6%, with the state having selected 94% of its target. Tamil Nadu and West Bengal are yet to begin selection of ASHAs in urban areas.

Table 1	Selection Status							
Table 1 A	**High Focus States**							
State	**Proposed ASHAs (Target)**	**ASHA selected/ working**	**% of ASHA in place against proposed**	**Rural Population 2011 census**	**Current Density of ASHAs**	**Proposed Urban ASHA (Target)**	**Urban ASHA selected / working**	**% of ASHA in place against proposed**
Bihar	104239	85018	81.56	92341436	1/1086	391	44	11.25
Chhattisgarh*	68300	65713	96.21	19607961	1/298	3883	3701	95.31
Jharkhand	40964	39380	96.13	25055073	1/636	214	75	35.05
Madhya Pradesh	60105	58981	98.13	52557404	1/891	4200	3876	92.29
Odisha	47082	43862	93.16	34970562	1/797	1057	1057	100.00
Rajasthan	47085	46957	99.73	51500352	1/1096	4555	3000	65.86
Uttar Pradesh	160175	135000	84.28	155317278	1/1150	6813	0	0.00
Uttarakhand	10048	9702	96.56	7036954	1/725	1038	1038	100.00
Sub Total	**537998**	**484613**	**90.08**	**438387020**	**1/906**	**22151**	**12791**	**57.74**
Table 1 B	**North Eastern States**							
Arunachal Pradesh	3902	3869	99.15	1066358	1/276	40	40	100.00
Assam	30619	30619	100.00	26807034	1/875	1181	1161	98.31
Manipur	3878	3878	100.00	1736236	1/448	81	81	100.00
Meghalaya	6519	6314	96.86	2371439	1/376	245	156	63.67
Mizoram	1091	987	90.47	525435	1/532	74	0	0.00
Nagaland	1986	1887	95.02	1407536	1/746	41	30	73.17
Sikkim	641	641	100.00	456999	1/713	35	25	71.43
Tripura	6840	6765	98.90	2712464	1/400	527	523	99.24
Sub Total	**55476**	**54960**	**99.07**	**36017143**	**1/655**	**2184**	**1976**	**90.48**
Table 1 C	**Non High Focus States**							
Andhra Pradesh	40021	37616	93.99	34776389	1/925	2660	2502	94.06
Delhi**	NA	NA	NA	NA	NA	5018	4695	93.56
Gujarat	38188	35259	92.33	34694609	1/984	4366	3493	80.00
Haryana	18000	17410	96.72	16509359	1/948	2438	1872	76.78
Himachal Pradesh	7752	7566	97.60	6176050	1/816	0	0	0
Jammu & Kashmir	12000	11735	97.79	9108060	1/776	238	193	81.09
Karnataka	39195	29916	76.33	37469335	1/1252	2912	1104	37.91
Kerala	30927	26002	84.08	17471135	1/672	4300	1927	44.81
Maharashtra	59203	55000	92.90	61556074	1/1119	5844	2313	39.58
Punjab	17360	17100	98.50	17344192	1/1014	2394	2022	84.46
Tamil Nadu ***	6850	6204	90.57			1336	0	0.00
Telangana	27730	25917	93.46	21585313	1/833	2637	2637	100.00
West Bengal	61008	46303	75.90	62183113	1/1343	4530	0	0.00
Sub Total	**358234**	**316028**	**88.22**	**318873629**	**1/1009**	**38673**	**22758**	**58.85**

Table 1 D	Union Territories							
UTs	**Proposed ASHAs (Target)**	**ASHA selected/ working**	**% of ASHA in place against proposed**	**Rural Population 2011 census**	**Current Density of ASHAs**	**Proposed Urban ASHA (Target)**	**Urban ASHA selected / working**	**% of ASHA in place against proposed**
Andaman &Nicobar Islands	412	407	98.79	237093	1/583	10	0	0.00
Chandigarh	NA	NA	NA	NA	NA	50	46	92.00
Dadra and Nagar Haveli	250	208	83.20	183114	1/880	50	46	92.00
Daman & Diu	98	79	80.61	60396	1/765	NA	NA	NA
Lakshadweep	110	110	100.00	14141	1/129	NA	NA	NA
Puducherry	NA	NA	NA	NA	NA	341	0	0.00
Sub Total	**870**	**804**	**92.41**	**494744**	**1/615**	**451**	**92**	**20.40**
Total All India	**952578**	**856405**	**89.90**	**793772536**	**1/927**	**63459**	**37617**	**59.28**

*Mitanin Selected at Hamlet level

** Figure of ASHAs Selection shifted to NUHM

***ASHAs selected in identified areas for specific conditions

Section 2.2: Status of Training

This section provides a summary on the status of ASHA training across states. In addition to completing the four rounds of Modules 6 and 7, states are currently training newly selected ASHAs in the eight day Induction Module of eight days. Several states that have trained ASHA upto Round 4 have undertaken refresher trainings in key skills for ASHA trainers and ASHAs.

Training of Module 5 is complete in most states. In Bihar, Module 5, is integrated within the four rounds of Module 6&7 training. Across the country, 87.6% of ASHAs have been trained in Module 5. This also includes 7194 ASHAs from Himachal Pradesh who have been trained in Induction Module. Haryana, Nagaland and Madhya Pradesh, remain the states with highest gaps in Module 5 training, which is around 36%, 31% and 29%, respectively. Gujarat and West Bengal report a gap of around 22% and 19% respectively. The reason for these gaps in otherwise well performing states so far as training is concerned, is the drop out of ASHA after Round 5 training was complete, with new ASHA being directly introduced to Modules 6 and 7.

Significant achievements have been made in completing ASHA training in Module 6 & 7 across all states. Across all states, 81%, 67%, 44% and 11% ASHA have been trained in Rounds 1, 2, 3 and 4 respectively. With increasing numbers of states getting state trainers trained in Round 3 training of Trainers at national level, Round 4 training has also gained momentum.

Among high focus states, all states have reached near completion for Round 1 training, except the state of Uttar Pradesh. UP has trained 59% ASHAs in Round 1 and 33% ASHAs in Round 2. Round 2 is also near completion in all other states except Bihar and MP (which are at around 79% each). Rajasthan has trained only 66% of its ASHAs in Round 2. Jharkhand, Odisha and Uttarakhand have completed Round 3 trainings while Bihar, Odisha and Uttarakhand have also begun the round 4 training of ASHAs. Chhattisgarh, which has its own training structure, has completed 19 rounds of training for ASHAs.

(Box 1: Chhattisgarh Modules)

Training Modules for Mitanins - Chhattisgarh				
Training Round	**Name of the training module**	**Topics**	**No. of Days**	**Corresponding ASHA module covering the concerned topic**
1	**Janta Ka Swasth Janta ke Hath**	Understanding Health/Health Services and Child Health & Nutrition	4 days	Module 1-5, 7
	Hamara Hak Hamari Hakikat			
	Hamare Bachche Unki Sehat			
2	**Kahat Hey Mitanin/ Gram Swasthya Register**	Revision of above through a pictorial module	2 days	Module 1-5, 7
3	**Mitanin Tor Mor Goth**	Gender and Health, Adolescent and Maternal health	3 days	Module 5, 6, 7
4	**Chalbo Mitanin Sang-A**	Malaria	2 days	Module 7
5	**Mitanin ke Dawapeti**	Mitanin Drug kit and 1st contact curative care	4 days	Module 7
6	**Chalbo Mitanin Sang-B**	RNTCP and NLEP	2 days	Module 7
7	**Badhbo Aagu Mitanin Sang/ Mitanin Diary**	Panchayats and health : Local Planning	2 days	
8	**Poshan Sehat Samajik Suraksha**	Nutrition Security	2 days	Module 7
9	**Jadi Buti le Kare Ilaj**	AYUSH – local herbal remedies	2 days	
10	**Jug Jug Jiyay Nanheman**	Newborn Care and Survival	5 days	Module 6
		Child illnesses	3 days	Module 7
11	**Jurmil Banabo Swasth Gaon**	Strengthening VHSC and Village health planning	2 days	
12	**Nanheman Ke Palan Poshan aur Paramarsh**	Infant & Young Child Feeding	2 days	Module 7
13	**Sehat ke kitab, Sehat ke Kanwar, Sehat ke Chakra, Sehat ke Patte**	BCC Kit	4 days	Module 1-5, 6-7
14	**Chale Chalo Mitanin Sang**	Role of Mitanin in National Disease Control programmes	3 days	Module 1-4, Module 7
15	**Navjat ke Dekhbhal**	Newborn Care – Focus on screening and referral	2 days	Module 6
16	**Mitanin Tor Mor Goth- Revision**	Revision of Gender and Health	6 days	Module 5, 6, 7

17	**Upay jo Jaan Bachaye**	Revision of Skills and Certification– Pregnancy, Newborn, Diarrhea, Malaria, Pneumonia, Malnutrition	6 days	Module 6, 7
18	**Laika ke Goth Baat Pariwar Ke Saath, Prathmik Sahayata, Gair Sanchari Rog**	(A)Integrated childcare and Development, (B)Non-communicable Diseases, (C) Preliminary care for Emergency	5 days	Module 6, 7
19	**Aao Dohrayen Kuchh Jaruri Batein**	Revision of 18th module	2 days	Module 6, 7
20	**Bimariyon ki Pahchan aur Ilaj**	Sick newbrn, Pnemonia, Malaria, Diarrhea, TB, Malnutrition, Drug kit	3 days	Module 6, 7
21	**Bridge Training**	Essentials skills for new Mitanins introduced in 2011-12	6 days	Induction Module

Among the North Eastern States, all states have completed training of ASHAs up to Round 3 of Module 6 & 7, except Assam, which has trained over half of its ASHA in Round 3. All North Eastern states have also completed training of state trainers at national level in Round 3 TOT. Training of district trainers and ASHAs has been initiated. Four states (Manipur, Mizoram, Sikkim and Tripura) are close to completion of Round 4 training of ASHAs.

Most Non High Focus States have completed Round 1 of Module 6&7 training for ASHAs, with overall achievement of 92% of the target. Completion of Rounds 2, 3 and 4 are at 77%, 52% and 23%. Haryana, Jammu and Kashmir and Telangana are the only states which are yet to start Round 3 trainings. Kerala is adopting a different training system based on state specific needs, and Himachal Pradesh has started the programme recently. This excludes the progress made in Delhi as the figure for the ASHA are now being reported under NUHM about 98% ASHAs in Delhi has been trained in Round 1, 93% in Round 2 and 27% in Round 3 of Module 6 & 7.

State which are near completion of Round 4 training of ASHAs, are preparing for the process of certification of ASHAs and accreditation of trainers and training sites. During the last financial year, most states have faced challenges related to delays in release of funds from the national level due to delayed PIP process, and at state level related to newly adopted mechanisms for routing of NRHM funds through the treasury which has affected the pace of training in the states. A consequence of delays in getting ASHA training off the ground is the attrition of trainers at state and district level. Since most states do not have a cadre of full time trainers for the ASHA training, trainers are either independent trainers or NGO staff or inducted by deputation on a short term, adhoc basis from within the district and block staff. This attrition has the potential to slow the pace of trainings even further. In Chhattisgarh the model followed is that the ASHA support staff themselves undertake the training of the ASHA. Since the support staff are those that provide ongoing field support and mentoring to ASHA, this not only obviates the need to have a separate stream of trainers, it also allows the support staff to follow up during field visits, to assess if skills are being performed to quality standards. It also allows for more oversight and support to ASHA who may not have performed well during the training.

Table: Status of Trainings

State / UT	ASHAs trained up to Module 5		ASHAs trained up to Round 1 of Module 6&7		ASHAs trained up to Round 2 of Module 6&7		ASHAs trained up to Round 3 of Module 6&7		ASHAs trained up to Round 4 of Module 6&7	
	No.	% (against -selected/ working)	No.	% (against -selected/ working)	No.	% (against -selected/ working)	No.	% (against -selected/ working)	No.	% (against -selected/ working)
High Focus States										
Bihar	77034	90.61	77034	90.61	67274	79.13	53770	63.25	923	1.09
Chhattisgarh	State has a different training pattern and is currently completing 19th round training. No. of ASHAs trained - Modules 1 to 12 - 54985, Module 13 - 55630, & Mod 14 & 15 - 54100, Mod 16 - 57701, Mod 17 - 58152, Mod 18 - 62115, Mod 19 - 60110.									
Jharkhand*	40964	104.02	37045	94.07	37271	94.64	35982	91.37	0	0.00
Madhya Pradesh	42098	71.38	55862	94.71	46895	79.51	26895	45.60	0	0.00
Odisha	43370	98.88	42485	96.86	42415	96.70	42597	97.12	4937	11.26
Rajasthan	42133	89.73	45045	95.93	30855	65.71	1764	3.76	0	0.00
Uttar Pradesh	121640	90.10	79624	58.98	44717	33.12	0	0.00	0	0.00
Uttarakhand	8978	92.54	10313	106.30	10064	103.73	10209	105.23	5032	51.87
Sub Total	**376217**	**77.63**	**347408**	**71.69**	**279491**	**57.67**	**171217**	**35.33**	**10892**	**2.25**
North Eastern States										
Arunachal Pradesh	3635	93.95	3669	94.83	3424	88.50	3424	88.50	1185	30.63
Assam	28422	92.82	29560	96.54	29257	95.55	17157	56.03	0	0.00
Manipur	3817	98.43	3804	98.09	3804	98.09	3804	98.09	3756	96.85
Meghalaya	5588	88.50	5891	93.30	5873	93.02	5710	90.43	0	0.00
Mizoram	855	86.63	987	100.00	987	100.00	987	100.00	829	83.99
Nagaland	1296	68.68	1398	74.09	1397	74.03	1624	86.06	0	0.00
Sikkim*	666	103.90	666	103.90	666	103.90	666	103.90	666	103.90
Tripura*	7367	108.90	7257	107.27	7009	103.61	7280	107.61	6595	97.49
Sub Total	**51646**	**93.97**	**53232**	**96.86**	**52417**	**95.37**	**40652**	**73.97**	**13031**	**23.71**
Non High Focus States										
Andhra Pradesh *	42681	113.47	34469	91.63	29851	79.36	29851	79.36	0	0.00
Gujarat	27587	78.24	32451	92.04	31962	90.65	30410	86.25	27377	77.65
Haryana	11112	63.83	16151	92.77	15674	90.03	0	0.00	0	0.00
Himachal Pradesh **	7461	98.61	0	0.00	0	0.00	0	0.00		0.00
Jammu and Kashmir	11200	95.44	8075	68.81	8075	68.81	0	0.00	0	0.00
Karnataka	29916	100.00	29813	99.66	29813	99.66	27873	93.17	27873	93.17
Kerala *	29022	111.61	26684	102.62		0.00	0	0.00	0	0.00
Maharashtra	52247	94.99	53389	97.07	44123	80.22	18252	33.19	0	0.00
Punjab	16403	95.92	16243	94.99	16243	94.99	16363	95.69	15956	93.31
Tamil Nadu	5513	88.86	1657	26.71	1657	26.71	1571	25.32	1343	21.65
Telangana	25818	99.62	23673	91.34	20813	80.31	0	0.00	0	0.00
West Bengal	37577	81.15	46621	100.69	44909	96.99	41042	88.64	0	0.00
Sub Total	**296537**	**93.83**	**289226**	**91.52**	**243120**	**76.93**	**165362**	**52.33**	**72549**	**22.96**

Union Territories										
UTs	ASHAs trained up to Module 5		ASHAs trained up to Round 1 of Module 6&7		ASHAs trained up to Round 2 of Module 6&7		ASHAs trained up to Round 3 of Module 6&7		ASHAs trained up to Round 4 of Module 6&7	
	No.	% (against -selected/ working)	No.	% (against -selected/ working)	No.	% (against -selected/ working)	No.	% (against -selected/ working)	No.	% (against -selected/ working)
Andaman & Nicobar	407	100.00	272	66.83	272	66.83	0	0.00	0	0.00
Dadra and Nagar Haveli	87	41.83	68	32.69	45	21.63	0	0.00	0	0.00
Daman & Diu	69	87.34	55	69.62	0	0.00	0	0.00	0	0.00
Lakshad-weep	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
Sub Total	**563**	**70.02**	**395**	**49.13**	**317**	**39.43**	**0**	**0.00**	**0**	**0.00**
Total All India	**724963**	**84.65**	**690261**	**80.60**	**575345**	**67.18**	**377231**	**44.05**	**96472**	**11.26**

*Mismatch between number of ASHAs trained and selected is on account of drop out of ASHAs after being trained or shifting of selection figures of urban ASHAs under NUHM.

**ASHAs trained in Induction Module

Section 2.3 Support Structures for ASHA Programme

At the state level the programme is expected to be supported by a Community Processes Resource Centre led by a team leader, and a Programme Managers and consultants to manage the ASHA Programme/VHSNC/ Communications and Documentation/Training and Regional/Zonal coordinators. This team composition varies across states. Smaller states have fewer staff- often with just two professional staff and one support staff for data and accounts. A State ASHA Mentoring Group, consisting of NGO representatives, academicians, training institutions and research organizations, is to provide policy guidance and programmatic oversight. At the district level, the team of a District Nodal Officer supported by a District Community Mobilizer and data assistant is expected to manage the programme. A Block Community Mobilizer, and ASHA facilitators at cluster level (one ASHA Facilitator for 10 to 20 ASHAs) are expected to provide support and supervision at block levels and below. The recently revised guidelines envisage that these support structures at all levels would support not just the ASHA programme but the VHSNC and all other community processes interventions.

A robust support structure, at all four levels (State, District, Block and sub-block), with adequate capacity building is essential for effective implementation of Community Processes interventions and to provide adequate support to ASHAs as well as VHSNC. Effective convergence between the management and support structures for ASHA and VHSNC remains a challenge, despite renewed focus from Government of India. With the NUHM interventions starting on the ground, and selection of ASHAs and establishment of Mahila Arogya Samitis (MAS) moving forward, integration of management and support structures under NUHM, with existing ASHA and VHSNC support structures also has emerged as a priority. There is a strong positive correlation of effective support structures with programme progress across the states.

Among the high focus states, all states have a support cadre at all four levels except, UP and Odisha, which remain with no dedicated community processes coordinator at the block level. Chhattisgarh retains its robust support structure at all four levels. Uttarakhand has its support structure in place at all four levels, with 100% filled up positions. Jharkhand too has a support cadre at all four levels. Madhya Pradesh, which started putting in place support structure at all four levels only recently, has now 3480 out of target 3991 AFs and 241 out of 313 BCMs in place, but a major gap exists in recruiting district ASHA coordinators (31/51). Bihar has also strengthened its support cadre at all four levels, but faces high vacancies at district and blocks levels (14/38 at district and 283/534 at block). Percentage of AFs in position against the targets is high in states of Bihar, Chhattisgarh, Jharkhand, MP and Uttarakhand. UP has put in place AFs only in 17 districts in its first phase. Rajasthan has not done any additions to its support cadre (has 1076 AFs at PHC level, 100/249 BCMs and 25/34 DCMs in position) during the reporting period.

All high focus states, except Rajasthan and UP have state trainers who have been trained in all three rounds of Module 6&7 TOT at national training sites. In the North East States, five states (Arunachal, Manipur, Meghalaya, Mizoram, Sikkim) have no dedicated support cadre at block level, mainly on account of small districts and fewer ASHAs. But all states have AFs in place with almost all positions filled, except Nagaland where only Block Coordinators support the programme in the field. District ASHA Coordinators are in place in all states except, Sikkim. Sikkim, the state with smallest number of ASHAs supports them with 71 AFs in place at cluster level. The vacancies against the target/sanctioned nos. are very few across all states of North East. State Trainers from all NE states have been trained up to round 3 TOT of Module 6&7 training.

The non-high focus states are in the process of establishing support structures. Haryana, Karnataka and Maharashtra have dedicated support structure at all four levels. Punjab has a dedicated support cadre at state, district and block levels. Gujarat also has selected ASHA Facilitators at the field level (3323/3751), but at block and district levels, existing full time staff of the health department support the programme. In all other states existing staff cadre supports the programme, though their involvement and effective support provided by them to ASHA and VHSNC programme varies greatly across states. Jammu and Kashmir is using these existing cadre (ANMs and MPWs) as AFs, for supporting ASHAs in the field and strengthening its regular review systems, enabling them to play an effective supporting role. Delhi, which has recruited District ASHA Coordinators in the reporting period, (10/11 in place) continues to use existing ANMs in urban health centres as ASHA mentors, (1005 mentors in place against target 1123). Five states (Delhi, Gujarat, Karnataka, Punjab, and West Bengal) have their states trainers trained in Round 1, 2 and 3 TOTs at national level. Andhra Pradesh, Haryana, Jammu and Kashmir, Maharashtra, and Himachal Pradesh, have also had their state trainers trained in Rounds 1 and 2 of Module 6 and 7 at the national level.

However having a support structure in place alone does not imply effective support, supervision and handholding. Appropriate orientation to their roles and responsibilities, an oversight mechanism from district and state levels, which therefore requires coordination with district and block programme management units, providing for mobility support to undertake field visits, and creating incentive structures for performance, including promotion/career avenues are important. High vacancies in some states are partially on account of the fact that some or all these conditions are not met. Another reason for high vacancies is the state reluctance to engage Human resources on a contractual basis, despite obtaining approvals.

Table 2.3 A: Status of ASHA support structure in High Focus States

States	State Level	District Level	Block Level	Sector Level
Bihar	State AMG constituted in July 2011, only one meeting held in Feb 2011. Five members team of ARC and six (out of 9) Divisional Coordinators in position. State trainers– Round 1 – 28, Round 2 – 22. Round 3 – 16.	14/38 DCMs in place District Trainers - Round 1 -803, Round 2 - 532, Round 3-126	283 / 534.	4068 / 4964 (1per 20 ASHA)
Chhattisgarh	AMG not established. ARC is working under SHRC with a six-member team. State trainers– 46	35 DC / 27 districts (2 per district in some outreach districts), District trainers– 3551	292 / 292.	3150 / 3500 Mitanin trainers (1 per 20 ASHA)
Jharkhand	State AMG reconstituted in 2013, 7 meetings held, last meeting held in April 2015. Three members team of Community Mobilisation Cell in position. State trainers – Round 1 - 13, Round 2 - 13. Round 3 - 12.	21 / 24 District Programme Coordinators. District Trainers -Round 1 -417, -Round 2 – 474.	778/ 844 Block Trainers & DRPs	2175 / 2184 Sahiyaa Saathi (1 per 20 Sahiyas)
Madhya Pradesh	State AMG formed in Oct 2008, now merged with MGCA. Last meeting in May 2015. Four members team of ARC in position. State trainers - Round 1 - 41, Round 2 - 39. Round 3 - 25.	31 / 51 DCMs in place. District Trainers - Round 1 - 496, Round 2 – 300.	241 /313 BCMs	3480/3991 ASHA Facilitators (1 AF per 10 ASHAs in tribal areas)
Odisha	State AMG constituted in 2009, total 4 meetings held, last in 2012,ARC in place with team 6 consultants. State trainers - Round 1 - 26, Round 2 - 21. Round 3 - 11.	29/30 DCMs in place District Trainers - Round 1 - 287, Round 2 – 166.	Existing block PMU staff manages the programme	1494 /1672 Community Facilitators
Rajasthan	State AMG constituted in June 2006, last meeting held in Sep 2011 Team of two consultants working in SPMU. SIHFW extending support for rolling out ASHA Training. State trainers - Round 1 - 20, Round 2 - 25.	25 /34 District ASHA Coordinators District Trainers - Round 1 - 640, Round 2 - 640	100/249 Block ASHA Coordinators.	1076/2066 PHC ASHA Supervisors (1 per PHC)
Uttar Pradesh	State AMG constituted in Aug 2008, last meeting reported in Dec 2013. Community Processes Division led by a Nodal officer works within SPMU, with a team of 10 Consultants. State trainers – Round 1 – 59.	72 / 75 DCPMs in 72 Districts have District AMGs. District Trainers-. Round 1 – 2622.	Existing staff (Block PMUs)	5412/6808 in ASHA Sangini, selected in 17 districts.
Uttrakhand	AMG constituted in 2009, total 21 meetings held, last meeting in May 2015. State has one Nodal Officer in SPMU, and two regional coordinators. State trainers – Round 1 – 6, Round 2 – 5. Round 3 - 5.	District ARCs outsourced to NGOs - 13 / 13 DCMs District Trainers - Round 1 - 165, Round 2 – 156.	101 /101 BCMs placed. (6 in urban areas)	600/ 606 AFs in (550 rural, 56 urban - 1 for 15-20 ASHAs)

Table 2.3 B: Status of ASHA support structure in North East States

States	State Level	District Level	Block Level	Sector Level
Arunachal Pradesh	State AMG constituted in Jan 2010, total meetings held – 12, last meeting held in Aug 2014. ARC – 3 members team within SPMU. State trainers– Round 1 – 3, Round 2 – 2. Round 3 - 3.	17/17 DCMs District Trainers - Round 1 - 22, Round 2 – 28.	Existing BPMU staff	347/348 ASHA Facilitators
Assam	State AMG constituted, total meetings held - 6, last meeting held in July 2011. ARC housed in SPMU. State trainers - Round 1 - 17, Round 2 - 12. Round 3 - 7.	27/27 DCMs District Trainers - Round 1 - 447, Round 2 – 447.	58/ 149 Block Community Mobilizers.	2848/2878 ASHA Facilitators (1 per 10 ASHAs)
Manipur	State AMG constituted in Dec 2008, total meetings held – 11, last meeting held in May 2014. ARC housed within SPMU, has 1 ASHA Program Manager. State trainers - Round 1 - 3, Round 2 - 3. Round 3 - 3.	9/9 DCMs District Trainers - Round 1 - 62, Round 2 – 60.	Existing BPMU staff	194/194 ASHA Facilitators (1 per 20 ASHAs)
Meghalaya	AMG formed in Oct 2009. Reconstituted recently, 1st meeting after reconstitution held in Sep 2014. ARC in place, within SPMU with 2 consultants. State trainers - Round 1 - 3, Round 2 - 3. Round 3 – 2.	7/11 DCPC District Trainers - Round 1 - 70, Round 2 – 65.	Existing BPMU staff	312 /334 ASHA Facilitators (1 per 15-20 ASHA)
Mizoram	State AMG constituted in April 2008, total meetings held – 8, last meeting held in Feb 2014. ARC team within SPMU. State trainers - Round 1 - 3, Round 2 - 2. Round 3 – 4.	9/9 DAC District Trainers - Round 1 - 18, Round 2 -18.	No system of Block unit for program management /health	109 /109 ASHA Facilitators
Nagaland	AMG formed in Nov 2009, 5 meetings held, last meeting Aug 2013. ARC housed under SPMU. State trainers - Round 1 - 1, Round 2 - 2. Round 2 - 2.	11/11 DCMs District Trainers - Round 1 - 63, Round 2 – 63.	68 /77 Block ASHA Coordinators (BACs).	Block ASHA Coordinators play support role for ASHAs.
Sikkim	State AMG constituted in 2007, total meetings held - 2, last meeting held in Nov 2014. ARC does not exist (designated State ASHA Nodal Officer in place). State trainers - Round 1 - 2, Round 2 - 3. Round 3 – 4.	Existing staff of DPMU. District Trainers - Round 1 - 23, Round 2 - 23.	Existing Staff of BPMU	71/ 71 ASHA Facilitators
Tripura	State AMG constituted in May 2008, total meetings held - 8, last meeting held in Nov 2013. ARC constituted (1 state ASHA Programme Manager). State trainers - Round 1 - 2, Round 2 - 5. Round 3 - 4.	8/8 DAC District Trainers - Round 1 – 65. Round - 65.	8/11 Sub-division level ASHA Coordinators	398/ 400 ASHAFacilitators.

Table 2.3 C: Status of ASHA support structure in Non- High Focus states

States	State Level	District Level	Block Level	Sector Level
Andhra Pradesh	AMG constituted-Functions of ARC are managed by a small team based in SPMU and Directorate and IIHFW.. State trainers -Round 1 - 12, Round 2 - 11.	Recruitment for 13 DCMs are underway. Project Officer, District Training Team (P.O.DTT) and DPHNO involved. District Trainers– 285.	Target: 224 Existing staff of BPMU work as BCMs	Existing ANM & HS at PHC level.
Delhi	State AMG formed in July 2010, total meetings held –, last meeting held in Jan 2015. ARC in place; with one State level Nodal Officer, two State ASHA Coordinators, two Data Assistants and one Account Assistant. State trainers - Round 1 and Round 2 (Joint) – 29, Round 3 - 59.	10/11 DAC . District Mentoring Group also in place. District Trainers– 363.	113 ASHA Units in place.	1005/1123 ANMs act as ASHA mentors
Gujarat	State AMG Constituted in Aug 2011, total meetings held – 5, last meeting in March 2015. ARC established under the office of Rural Health Department under Commissionerate of Health Office. State trainers -Round 1 - 9, Round 2 - 9. Round 3 - 1.	Existing staff supported by a Data Assistant in all districts 24 Districts have constituted AMG. District Trainers – Round 1 & 2 - 160	Existing staff	3323 /3751 ASHA Facilitators (1 per 10 ASHAs)
Himachal Pradesh	State has started ASHA programme in FY 2014-15. ASHA Nodal Officer works within SPMU. State trainers - Round 1 - 36, Round 2 - 23.	Existing staff	Existing staff	Existing staff
Haryana	AMG not constituted ARC in place within the SPMU with 10 member team. State trainers -Round 1 - 20, Round 2 - 17.	21/21 DACs. District Trainers – Round 1 - 438	103/115 BACs	610/ 1084 ASHA Facilitators
Jammu& Kashmir	State AMG established in 2012-13. In Feb 2015, 2 members of national AMG co-opted in state AMG. 1 ASHA Nodal Officer and 1 state ASHA Coordinator in place, within SPMU. State trainers Round 1 - 15, Round 2 - 12.	Existing staff. District Trainers – Round 1 - 225	Existing staff	773 / 816 ASHA Facilitators.

Karnataka	State AMG constituted in Oct 2012, last meeting held in June 2013. One ASHA Nodal Officer based in the Health Directorate. Deputy Director for ASHA Training based within SIHFW. State trainers - Round 1 - 15, Round 2 - 10. Round 3 - 3.	30/30 District ASHA Mentors District Trainers Round 1– 240 and Round 2 - 203	176/ 176 Block ASHA Mobilisers One District Trainer also called as ASHA Mentor supervises ASHAs of two blocks	1588/1960 AFs
Kerala	State AMG constituted in 2008, total meetings held – 6, last meetings in held Dec 2014 State ASHA Team with one Nodal Officer and consultant based within SPMU. State trainers – 6.	14/14 District ASHA Coordinators . District Trainers – 36.	Existing staff	Existing staff
Maharashtra	State AMG constituted in Oct 2007, total meetings held – 16, last meeting held in July, 2013. State ASHA Team with one Nodal Officer and consultant based within SPMU. State trainers - Round 1 - 15, Round 2 - 13.	31/34 DCMs District AMG formed in all districts. District Trainers – Round 1 - 1476 and Round 2 - 1404	339/ 335 BCMs Block AMG formed in 70 tribal blocks and in 281 Non-tribal blocks	2717/2880 AFs
Punjab	State AMG constituted in Oct 2014. ARC not established, team of two consultants working in SPMU. State trainers - Round 1 - 5, Round 2 - 7. Round 3 - 6.	13 /22 DCMs. District Trainers – Round 1 - 326 and Round 2 - 311	Existing Staff (BEE- Block Extension Educator working as BCM in many places)	869 / 898 ASHA Facilitators
TamilNadu	State AMG not formed, but NGOs are involved in ASHA support Institute of Public Health Poonamallee is working as ARC.	Existing DPMU staff	Existing staff (Community Health Nurse)	Existing staff (Sector Health Nurse)
Telangana	State ASHA Resource Centre and AMG to be constituted. State trainers - included in the figures for Andhra Pradesh.	Total Requirement: 10 Recruitment Process underway. District Trainers– 285.	Target: 151 Existing staff of BPMU work as BCMs	Existing MPHS-female given the role of ASHA support
West Bengal	State AMG formed in Sep 2010, total 4 meetings held, last meeting held in Dec 2011. ARC-ASHA training outsourced to CINI. State trainers - Round 1 - 22, Round 2 - 18. Round 3 - 12.	18/26 DCMs District Trainers Round 1 & 2 – 1377	Existing staff supports, recruitment for BCMs in process, 12 selected, against target of 666 (2 per block).	Existing staff (Health Supervisor posted at GP level)

Table 2.3 D: Status of ASHA support structure in UTs

Name of UT	Status of Support Structure for ASHA			
UTs	**State Level**	**District Level**	**Block Level**	**Sector Level**
Andaman & Nicobar Island	AMG not established. ARC doesn't exist and SPMU manages the programme	Existing staff	Existing staff	Existing staff
Dadra and Nagar Haveli	AMG and ARC not established. SPMU is managing the ASHA Programme	Existing staff	Existing staff	Existing staff
Lakshadweep	AMG and ARC not established Medical officer is in-charge of Island is the nodal officer for the Programme	Existing staff	Existing staff	Existing staff
Daman and Diu	AMG and ARC not established. SPMU is managing the ASHA Programme	Existing staff	Existing staff	Existing staff
Chandigarh	UT has started ASHA programme in FY 2014-15. Nodal Officer – NRHM is incharge of ASHA programme and VHSNC as well.	Existing staff	Existing staff	Existing staff

Visioning Workshop-ASHA Mentoring Group

The year 2015 marked a decade of ASHA and Community Processes programme. The National ASHA Mentoring Group members thought it to be an opportune time to take stock of achievements made, unresolved and evolving challenges and to discuss the future of the ASHA programme. A visioning workshop for ASHA programme was organized at Jan Swasthya Sahyog (JSS), Ganiyari, Bilaspur between March 9th to 10th, 2015.Key objectives of the workshop were to review current status, and develop a vision for planning the future of ASHA and Community Processes interventions.

To facilitate the discussions the secretariat team at NHSRC developed the following guiding questions:

1) Situating the ASHA in varying contexts – What should be the general trend- over the next ten years? What are likely scenarios that would affect the current role of the ASHA

   Role clarity and mix/match of roles: member of a primary health care delivery team; screening and health education, mobilizers, facilitator to service access- including enrolling/registering, navigator of facilities; first responders in situations of disaster.

2) ASHA in perpetuity? What should the criteria be for turn-over and renewal? Upper age limit? Should less qualified ASHA be replaced by more qualified ones?

3) More skilled roles- should there be different categories of ASHA: Generalist ASHA and Specialist ASHA (disease control ASHA, Mental health ASHA)? Three – five hours versus full time? Or a combination of both?

4) Sustaining the spirit of voluntarism– Performance payments and the danger of allocation of numerous tasks- low payment and increasing work hours. Danger of advocating for a full time worker without commensurate increase in skills.

5) Career opportunities for ASHA - advocate moving towards a Community Health Nurse as articulated in several policy formulations– in that case- should there be ASHA in these areas- who fills the gap?

6) Multiple roles and mechanisms to institutionalize systems for training and skill building on an ongoing basis? What are the implications for training: institutions, trainers, accreditation, certification, initial and in service, and higher levels of skill building

7) Ensuring community embeddedness - Is a pragmatic approach of strengthening technical roles and enabling village platforms (VHSNC) for service delivery – the first step? How do we move beyond?

8) Programme management structures needed- How would the reliability of supplies, referral, and information systems be sustained? As ASHA technical skills expand what are the implications for the nature of supervisory support? What would be the implications for existing cadres - Facilitators, BCM/DCM? Their skills? Need to visualize the district and sub level support structure as part of the institution of the district health society.

9) Strategy for performance monitoring: appropriateness of current linking of performance to payments;

10) ICT tools: what is our vision of what they should do? what is the experience of what they can they do and cannot?

The key recommendations that emerged after the two day workshop are as follows –

- ASHA to be viewed as an integral part of the comprehensive primary health care team. If work load of ASHA crosses six hours per day then a second ASHA should be introduced.
- ASHA's work should not be seen in isolation as her effectiveness depends on responsiveness of the system. Therefore smooth functioning of system needs to be emphasized first.
- With regard to the mix of roles of ASHAs, the three roles suggested are – a) Service provision – depending on public health needs, b) Community action on social determinants of health – Village level convergence and c) Strengthening VHSNC for community based planning and monitoring. However the priority accorded to each of these roles would depend on the state context.
- Generalist ASHA would be required in all contexts but more specialist roles would depend on state specific contexts:
    a) High load of RCH with minimal action for chronic diseases – questionnaire based screening, raising awareness about lifestyle changes and facilitating referral
    b) Mid range RCH load with additional opportunities for chronic diseases : – opportunistic/ targeted population screening, BP measurement and follow up of referrals
    c) Low RCH with more action on chronic diseases: regular BP monitoring, glucometer use, treatment adherence and palliative care
- With regard to the turnover of ASHA the group suggested that a retirement age of 60 years would be proposed, with a two year overlap period. During this period the senior, outgoing

ASHA could mentor the new ASHA and would be adequately compensated for such support and mentoring.

- The term "Voluntarism" should not be confused with compensation for time spent as volunteers can be paid, but their work is to be seen in the spirit of social service. Voluntarism also means going beyond the defined roles and being an agent of social change. Asking for voluntarism and paying poorly to compensate for their time would not be fair to the ASHA, so adequate recompense should be made.
- In order to preserve voluntarism of ASHAs, it was suggestedthat the ability of ASHA to interact with VHSNC and also at PHC / CHC level should be strengthened as that could provide her with social credibility and reinforce hermotivation. The following suggestions were made to strengthen the spirit of voluntarism and increase acceptance of ASHAs in the community-
  a) ASHA Help Desks which have proved to be effective as the ASHAs feels respected when she is given space to contribute in ASHA Help Desk at facility level.
  b) Sensitization of the service providers to the role of the ASHA should be prioritized
  c) Annual Block Level health assembly on lines of - Swasthya Panchayat Sammelan conducted in Chhattisgarh as a federation of VHSNCs
- Regarding payment, the group observed that payment of incentives through panchayat would facilitate better accountability of ASHAs with the community. However, some of the group members suggested that payment can be made through block PHC but a mechanism should be set up to share the details of ASHA's performances (physical and financial) with the respective panchayat. This can further be discussed during the next VHSNC meeting and also with the MO of the PHC/CHC, if there is any issue of delay or denial.
- For career opportunities of ASHAs, the following avenues were discussed –
  a) Promotion to ASHA Facilitator based on experience /competency and lateral entries of non-ASHAs to ASHA Facilitator's position to be prevented. Once selected as ASHA Facilitator, she should not continue to work as an ASHA.
  b) Senior community health worker / Senior ASHA after a minimum of 6 months bridge course
  c) Opportunities through courses - ANM/ GNM / other professional courses – for those ASHAs who have minimum required qualification – the process to be aided by reservation of seats and other facilitating support.
- To improve the quality of training it was suggested that only credible organizations are to be entrusted with the responsibility of training so as to provide quality training in content, skills, and also have good training infrastructure. The group also felt that role of trainers should not be restricted to provide technical training but should also be strengthened to provide post training hand holding support on an ongoing basis as part of the ASHA support system. Referring to the need of institutionalizing and strengthening training mechanisms for ASHAs, it was discussed that a consortium of agencies with one or more of these three

components should be built since it may not be possible to have all these components in one single agency / NGO. At state level, there can be more than one agencies / NGOs while at district level an agency consortium could be identified.

- In response to the critical question of community embeddedness, the group recommended that ASHAs should play a lead role in VHSNC and be facilitator for all VHSNC processes. ASHA facilitators should be trained to adequately support ASHAs in this task. Active participation of the community members in VHSNCs should be ensured for ASHAs to be effective. Members also agreed that the VHSNC undertake a review using the public service monitoring tool and annual health planning should be institutionalized and integrated through a federation of VHSNCs and annual block level health assemblies
- Re-emphasizing the point of strengthening the system to support ASHAs, it was recommended that there is a great need for making the existing health system "ASHA Worthy". To achieve this, a modular training framework targeted at enabling relevant service providers and programme management cadres at all levels was suggested. Training of ASHA Facilitator should be done in a more systematic manner to enable her to work as a mentor not only for ASHAs but for other community processes like VHSNC and CBM. Capacities of DCM and BCM should also be built in the content of ASHA trainings to enable them to work effectively as ASHA mentors.
- While highlighting the poor status of State ASHA Mentoring Groups, it was recommended that all states should constitute State ASHA Mentoring Group immediately and ensure regular bi-annual meetings.
- Relationship between ANM and ASHA needs to be strengthened through joint trainings, meetings and enabling ANM to be a technical mentor of ASHA. As a tool to monitor and improves the system's responsiveness for referrals made by ASHAs the use of JSS's three part referral slip was suggested.
- Performance monitoring of ASHAs, should be viewed in the nature of performance improvement with emphasis on using fewer measurable indicators that assess the functionality of ASHA at facilitator and sub-center level rather than as a punitive instrument at the block and district levels.
- ICT tools for ASHAs should be introduced if it helps in skill building of ASHAs and enables her in care provision and it is undesirable to use ICT for data generation by ASHA. ASHA facilitator should be empowered with ICT tools to support her in mentoring ASHAs and in compiling data for feedback to the block regarding drug supplies, payment issues, grievances, and to ASHA for performance improvement.

  It was also reiterated that ASHA's time is a precious and limited resource, therefore she must not be burdened with data collection, filling long formats, maintaining too many registers and records. ASHA should only maintain a village health register that includes population based data and any format for ASHA should be introduced only after consultation with State ASHA Resource Center for appropriateness and relevance and should be linked to a specific outcome or incentive.

Mother and Child Tracking Facilitation Centre (MCTFC)

The Ministry of Health and Family Welfare launched the Mother and Child Tracking Facilitation Centre (MCTFC) on 31st March, 2014 with an aim to reach every pregnant woman and child to ensure that they receive a complete package of antenatal/ postnatal and immunization services. MCTFC software captures details of women and children through pregnancy till the child is of 5 years and tracks their access to services. It also aims to generate awareness about their entitlements under various government programs and schemes.

In addition to the beneficiary, MCTFC also collects information from field level functionaries/service providers i.e ASHAs & ANMs through a phone call. Specific formats and modules have been designed for callers to collect this information.

The module for ASHAs is designed to capture information about their knowledge, health services availabilityand status of support received by them. ASHA modules cover - 1. ASHA Training and Drug kit; 2. Roles and Responsibilities; 3.Payment System; 4. Support Structure and 5. Grievances and Suggestions.

In order to review the ongoing process and improve its effectiveness an orientation for tele-callers was organized by the National Health Systems Resource Center on January 7th, 2015 in collaboration with the MoHFW. About 80 tele callers were trained in two batches of 3 hours each. The callers were given a brief overview of ASHA Programme to help them understand and build their perspective about their respondent – the ASHA. During the orientation the callers were briefed about – ASHA's profile, skills and role of ASHA, training modules and rounds, drug and equipment kits available with ASHAs, support structures for the ASHA and grievance redressal and incentive payments.

To facilitate the call process, callers were also briefed about some common terminologies used in ASHA programme such as names of common incentives, variations in general terms and abbreviations that were

used across states for the Village Health and Nutrition Day (VHND) ASHA facilitators and Mother and Child Protection (MCP) card etc. Subsequent to this workshop the ASHA modules were modified with detailed instructions and removal of some repetitive questions. The revised module was deployed on 30th March, 2015.

The caller data also enables the MCTFC team to generate state wise report from the information captured during the calls made to beneficiaries, ASHAs and ANMs. The exhaustive list of indicators which were used to assess the knowledge and performance of ASHA programme was reviewed and five key indicators were finalized for analysis of calls made to ASHAs. These indicators are:

1. **Maternal Health**
- Percentage of ASHAs, who are able to list two or more danger signs of pregnancy.
- Percentage of ASHAs who advise the JSSK scheme to the pregnant women

2. **Child Health**
- Percentage of ASHAs who are able to correctly respond to the number of visit required for Home Based New born Care in case of a new born at Home.

3. **Immunization**
- Percentage of ASHAs, aware about schedule of giving 1st dose of Measles

4. **Family Planning**
- Percentage of ASHAs, who maintain a list of eligible couple
- Percentage of ASHAs getting successful sterilization (both male and female) done during the year

5. **Adolescent Health**
- Percentage of ASHAs conducting monthly meeting with adolescent girls

About 70,823 ASHAs were called across 13 states between the period of January till June, 2015.

State	No. of ASHA called
Bihar	1411
Chattisgrah	1329
Delhi	459
Gujarat	959
Haryana	9701
Himachal Pradesh	634
J &K	1530
Jharkhand	648
Madhya Pradesh	637
Maharashtra	21231
Punjab	8875
Uttar Pradesh	18796
Uttrakhand	4613
Total	**70823**

The MCTFC has the potential to serve as an additional mechanism to validate data on access to health care services and entitlements by pregnant women and children. It can to a limited extent serve to assess the functionality of frontline workers and level of support that they receive from the health system. In order to achieve this, regular refresher trainingsof callers and MCTFC managers to provideupdated information on the programmes and newly launched schemes/ initiatives. One of the major problems faced by the callers is the language barrier where even in Hindi Speaking states – different dialects spoken by ASHAs affects the quality of dialogue between the caller and ASHAs. However basing any programmatic response based on MCTS data alone would be a mistake and the MCTS is not intended to serve as any sort of central surveillance.




ASHAs in Mission Indradhanush

The Ministry of Health and Family Welfare launched Mission Indradhanush (MI) in December 2014 with the aim to expedite immunization coverage of all children across India by year 2020. The Mission Indradhanush, depicting seven colours of the rainbow, targets to immunize all children against seven vaccine preventable diseases namely Diphtheria, Pertussis, Tetanus, Childhood Tuberculosis, Polio, Hepatitis B and Measles.

MI is a special drive undertaken to vaccinate all unvaccinated and partially vaccinated children to increase full immunization coverage from 65% in 2014 to at least 90% in the next five years. The first phase of MI focused on 201 high focus districts which have 50% of all unvaccinated or partially vaccinated children. Out of these 201 districts, 82 districts are from four states of India namely, UP, Bihar, Madhya Pradesh and Rajasthan. Nearly 25% of the unvaccinated or partially vaccinated children of India live in these 82 districts. During the second phase, another 297 districts will be will be covered. The four catch up drives were planned in consecutive months from April to July' 2015. During these drives national monitors were deployed across districts to monitor the activity in highest priority blocks/ urban areas.

One of the critical components of Mission Indradhanush was Communication and Social Mobilization so that all target children are covered. As a part of this, all frontline workers including ASHAs were oriented / trained in people friendly, need-based communication strategies and social mobilization initiatives to generate mass awareness and demand immunization services. In this section we discuss the role and contribution of ASHA to in the first round of MI.

ASHAs were provided posters, hoardings and flip books to facilitate social mobilization and inter-personal communication. ASHAs were particularly engaged to mobilize the community for increased participation in the immunization programme.

During Mission Indradhanush, ASHAs were expected to reach the last household of the community and to bring un-immunized and left out children with a special focus on children from marginalized communities, and children living in hard-to-reach areas, who are often missed during routine vaccination. A first step to doing this was micro planning – undertaken atthe sub-center and PHC, using a bottom up approach with participation of ANM, ASHA and AWW. ASHAs were trained to assist ANMs in preparing target due list based on head-counts using specific formats. The ASHAs were trained by female health workers / ANMs at block / facility level, who were trained at the district and block levels.

Field visit reports of early rounds reveal that ASHA's played a significant role in mobilizing the community and reaching unreached children. Reports of national monitors and proceedings of the meetings held at national, state and district levels, validate the substantial contributions of ASHAs, in making this first Round a successful event. Reports from Bihar, Odisha, West Bengal and North Eastern States highlight that during the MI Drives, where ASHAs were well oriented on the aim and process of the programme, they went a step ahead and tried to reach the children of families who are living in difficult terrain or circumstances.

"ASHAs were actively involved in conducting headcount survey and her effort on social mobilization was remarkable. As per the due list, there were 17 children and 4 ANC mother in her area which were due for the services. ASHA went door to door and visited the houses twice for informing and mobilizing the families. Out of all due mothers and children, she was able to bring 14 children and 3 ANC out of four to MI site". MI Report of Alirajpur district.

ASHAs were incentivized for their involvement under MI and their incentives were made available under regular incentives of ASHA program -:

1. Line listing of households done twice a year at six months interval- Rs 100
2. Preparation of due list of children to be immunized updated on monthly basis- Rs 100
3. Mobilization of beneficiaries to session sites- Rs 150
4. Incentive for full immunization per child (up to 1 year age)- Rs 100 per child for full immunization in 1st year of age
5. Incentive for full immunization per child up to 2 years age (all vaccination received between 1st and 2nd year of age after completing full immunization at 1 year age)- Rs 50 per child for ensuring complete immunization up to 2nd year of age of Child

In addition an incentive of Rs. 150 was divided between ASHA and AWW (if present in the session site) for mobilization.

Status of awareness of ASHAs about the MI incentives and receipt of these on time varied across the states. For instance, in the states of Punjab, Karnataka and West Bengal, ASHAs were aware about these incentives and reported getting the incentives on time while in states like Bihar, Rajasthan and

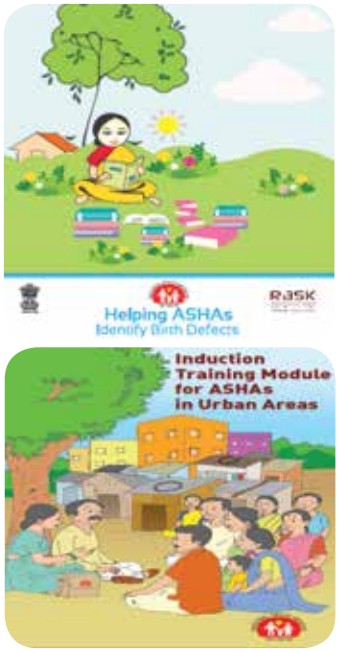
Jharkhand delay in payment was reported. In Northeastern States, few ASHAs were aware about the incentives. Issues of backlog were also reported.

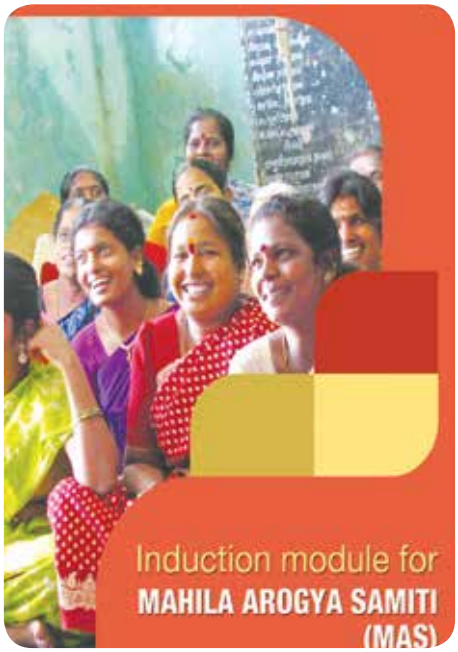
The level of the system's response and readiness to support the MI drives also affected the performance of ASHAs. For instance in Bihar, ASHAs were supported with survey registers and flip books for IPC on immunization. On the other hand, reports from states like UP and MP reflect that lack of availability of adequate training support and communication material with ASHAs which affected her functioning in some areas.

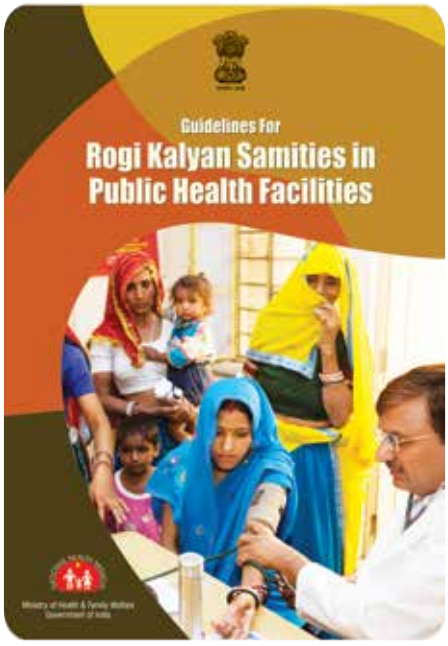
The issue of poor immunization coverage in slum pockets and poor urban areas emerged as a major concern in many states and was linked to lack of adequate number of ASHAs as per the population norms. Feedback of ASHAs on Mission Indradhanush has also been very motivating. ASHA from Petalwada Block of Jhabua district said that "Due to Mission Indradhanush, I became confident about conducting door to door headcount, types of vaccine to be given to save the children from seven diseases, advising mothers and building rapport with the community. Due to MI, I got oriented and sensitized towards unreached and marginalized children and started reaching families which I never used to visit earlier".

The role of a comprehensive due list to ensure maximum coverage and follow up appears to be a driving factor for improving coverage. For instance, in some cases, a few children mobilized by ASHAs were refused immunization and were asked to come to the regular VHND in their village. Due list was observed to be incomplete in many cases as names of children mobilized by ASHAs were found missing from the list. Tracking of children between successive MI rounds was also found to be inadequate. Another issue that emerged in some areas which appeared to limit the ASHA's effort in mobilization was that the ANMs were apprehensive in vaccinating the child if there was report of some symptom of illness from the mother or caretaker. They refused point blank to immunize the child without taking an adequate history or doing a clinical assessment to ascertain nature of illness.

Overall, across the states, ASHAs were found to be enthusiastic and well connected with both the communities and health system. The recommendations made in the field reports based emphasize the need of intensive training of ASHAs and ANMs to prepare due lists based on headcounts and training of ANMs, sensitization of all staff and field level functionaries on mapping, identification and reaching the unreached and underserved children. This is an extremely important task of the frontline workers and is by no means new. MI has likely given it a focus and direction. However its effectiveness can be sustained beyond immunization to other services, only if the need to reach every last household becomes an integral part of programming, capacity building monitoring and incentivization, from district to hamlet level.



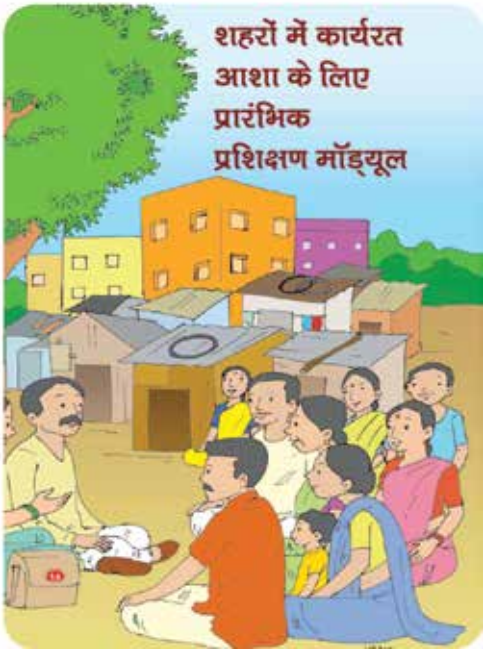




Newly Developed Modules and Guidelines

During last two years new training modules pertaining to ASHAs, Mahilla Arogaya Samiti and guidelines for Rogi Kalayan Samitis were issued by MoHFW. This section provides brief introduction to these modules and guidelines.

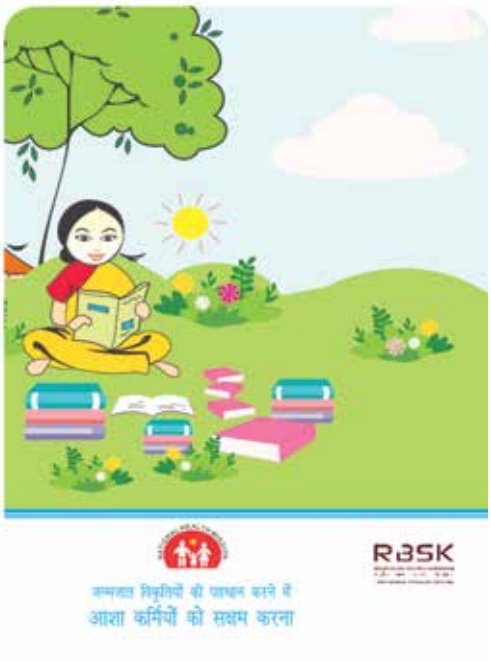
1. Induction Training Module for ASHAs in Urban Areas- The Induction training module for ASHAs in Urban Areas is largely based on the Induction Module for rural ASHAs, emphasizing the particular health issues and needs of the urban poor. Given that the problems of the marginalized population are much higher in urban areas and these are the communities that need attention by ASHAs, an additional skill of "Vulnerability Assessment and Mapping" is included. Apart from this, role of ASHA in addressing common non-communicable diseases, such as Hypertension and Diabetes, navigating public health facilities and convergence are key additions to this module. The module was developed in English, translated into Hindi and disseminated to states. Most ASHA modules have a companion module for trainers- called: Notes for ASHA Trainers.This trainer guide is designed for the use of trainers who are responsible for training ASHAs. urban areas. This book describes the standard principles to be followed for conducting ASHA training workshops, ways to ensure participatory training, agenda to be followed and



methodology of conducting each session presented in the Induction Module. The book also includes various group activities in the form of games, role plays, case studies, quiz, chart presentations and situational cards to make the training interactive and interesting for the participants. Notes for Trainers for the Induction Module for ASHA in Urban Areas was also developed in English and translated into Hindi.

2. Induction Module for Mahila Arogya Samities- Induction Training Module for Mahila Arogya Samities outlines the key objectives functions of MAS and lays special emphasis on monitoring and facilitating access to essential public health services. Other topics that have received additional emphasis in the module are building the skills of MAS on convergence functions with Municipal Corporations, vulnerability assessment and mapping to reach the marginalized in urban areas. This module is also been developed in English and translated into Hindi. A Notes for Trainers- Induction Training Module for Mahila Arogya Samities has also been developed.

3. Helping ASHAs in Identify Birth Defects- One of the key responsibilities of ASHAs is to provide care for newborns through home visits from the first day of birth (in the case of home deliveries) for the first day of discharge from the health facility upto 42 days of life. Home visits, particularly in the case of home deliveries are an opportunity for the ASHA to identifybirth defects and motivate the family for referral. Early identification of such children can help the families to seek early intervention and prevent long term debilitating conditions.This handbook has been developed in consultation with the Rashtriya Bal Swasthya Karyakaram (RBSK) team. It consists of pictorial representation of various birth defects, major signs and symptoms and key actions to be taken. This handbook is currently available in English and Hindi.



4. Guidelines for Rogi Kalyan Samities in Public Health Facilities- The revised guidelines for Rogi Kalyan Samities were issued by the Ministry of Health and Family Welfare on July 2nd, 2015. The guidelines have been revised based on experiences of states and include changes in composition of RKS to make it more participatory. The guidelines also lay out the mechanisms to steer RKS Functioning in enabling responses to local needs, enhance accountability, transparency and improve service delivery. The guideline outlines the key objectives of RKS, its legal framework and governance mechanisms, utilization of RKS funds, delegation of powers & capacity building of members and grievance redressal mechanism




Good Practices

The National Rural Health Missionand now the National Health Mission, affords states the flexibility to tailor solutions to context specific challenges. This flexibility has encouraged many states to demonstrate successful models or schemes with the potential to be scaled up in states with similar context and needs nad adapted for others. However most of these initiatives are not shared widely and remain limited to the state where they are being implemented. To provide a platform for wider dissemination and sharing of best practices, Ministry of Health Family welfare has organized two National Summits between 201 and 2015. –The first one was held in n Srinagar, Jammu and Kashmir in July 2013 and second one in Shimla, Himachal Pradesh in July 2015. During these two meetings states submitted best practices under various programme themes which were reviewed based on certain criteria designed to assess the nature of evidence of outcomes, and potential for scale. Those that met the criteria were selected for presentation during the summit.

Best Practices published in July 2015 are –

1. Role of Mitanin in Community Managed Nutrition Cum Day Care Centers – Fulwari Scheme in Chhattisgarh
2. ASHA Soft – online payment and Monitoring system for ASHAs in Rajasthan
3. Role of VHSNC members for improving health seeking behavior of the Community in Sikkim
4. Sahiya Help Desk in Jharkhand
5. Streamlining of ASHA payment through PFMS in Odisha

We have also attempted to share best practicesto enable cross learning between states, through previous editions of Updates of ASHA Programme. These include:

1. ASHA Facilitator- Backbone of the ASHA programme – Chhattisgarh Experience - January 2015
2. Sahiya Help Desk in Jharkhand- January 2015
3. Role of ASHAs in Disaster - January 2015
4. ASHA payment through PFMS in Odisha–July 2014
5. Gaon Kalyan Samitis in Odisha - January 2013
6. Role of ASHAs in State wide Cancer Awareness and Symptom Based Household Level Early Detection Campaign in Punjab - July 2013
7. Involving ASHAs to Overcome Gender Based Violence in Kerala - July 2013
8. Implementation of Participatory Learning and Action through Sahiyas in Jharkhand - July 2013
9. Chhattisgarh experience with community process components – Village health planning and Mitanin Welfare funds- January 2012
10. Documented stories from field – ASHA snap shots from Assam and Gujarat in January 2014.

In this update we share the two initiatives from Chhattisgarhand Sikkim that demonstrate the strength of community participation in addressing community health needs, and one from Rajasthan about streamlining ASHA payments.

1. The Role of the Mitanin (ASHA) in Community Managed Nutrition cum Daycare Centres – Fulwari Scheme of Chhattisgar

Nutrition and birth weight related indicators are poor in the state of Chhattisgarh, for a variety of factors including gaps in food security, feeding and health care behaviours care including care-seeking for infants and young children, poor access to protective foods and poor childcare on account of mothers and caregivers with high workloads. To address the issues of maternal nutrition and care of children below age three years of age, a Nutrition and Daycare initiative called Fulwari was piloted in 2012 in Surguja district 300 centres covering around 5000 children and pregnant women. In 2013, Fulwari Programme was expanded to cover 35,000 children and 17, 000 pregnant/lactating women using the existing state-wide Mitanin network. There are currently 2850 Fulwari centres operational across 85 tribal blocks, with a proposal to double this coverage in 2015. The objective of this scheme is to provide Nutrition Support to children between 6 months to three years of age and lactating mothers. The functioning of a Fulwari relies largely on 'community participation'. The space for setting up the Fulwari is a voluntary contribution of a resident of the habitation. This scheme runs on a "Voluntary" basis where group of mothers make a collective effort and take rounds of their turn where each time any one or two mothers bring all the children to the Fhulwari.

Fulwari is a demand based programme, which is started only in those habitations where there is commitment by parents/mothers to contributing their time. This is obtained through habitation level meetings facilitated by Mitanin Trainers. Habitations with poorer communities are prioritized for starting Fulwaris. Once the community agrees to start a Fulwari, the Gram Panchayat

representatives and community send a demand note to the Block Panchayat. The funds for buying food items are then given by Government through Gram Panchayats. Currently 3000 Fulwaris are running in the state. All purchases for Fulwari are handled by the mothers themselves, who also decide the menu, which includes the addition of eggs, oils and vegetables to meet the dietary requirements. Mothers also contribute the Take Home Rations of the ICDS in turns, which is also used to prepare meals for children.

Fulwari initiative is anchored by the ASHA support structure as Mitanins and Mitanin trainers play a crucial role in bringing the group together and support the management of the Fulwari, in maintaining accounts and records and overall management. Mitanins also provide information to mothers on health and nutrition practices. Health related behaviours such as hand washing, proper handling of drinking water, covering foodstuffs, cleanliness and hygiene are promoted through demonstration in the Fulwari.

Regular weight monitoring is also one of the key components of the program where every child is weighed every month. For recording purposes, five registers are maintained which include Budget Utilization Register, Weight Monitoring Register, Attendance Register, Meeting Minutes register and feedback registers. Monthly recording of the weights of the children is done to find out any growth faltering. This mechanism also serves as a day care 'crèche'' for the children that enable other mothers to go for their work for their livelihood.

The funds for the scheme are given by gram panchayat. Yearly budget of the scheme is 50,000 which flows through the route of Zila Panchayat to janpad to gram panchayat and lastly to VHSC which release budget to the fund committee (which is the part of para committee) of the village. The para committee runs the scheme. There are 30 fulwaris per block and one fulwari per panchayat.

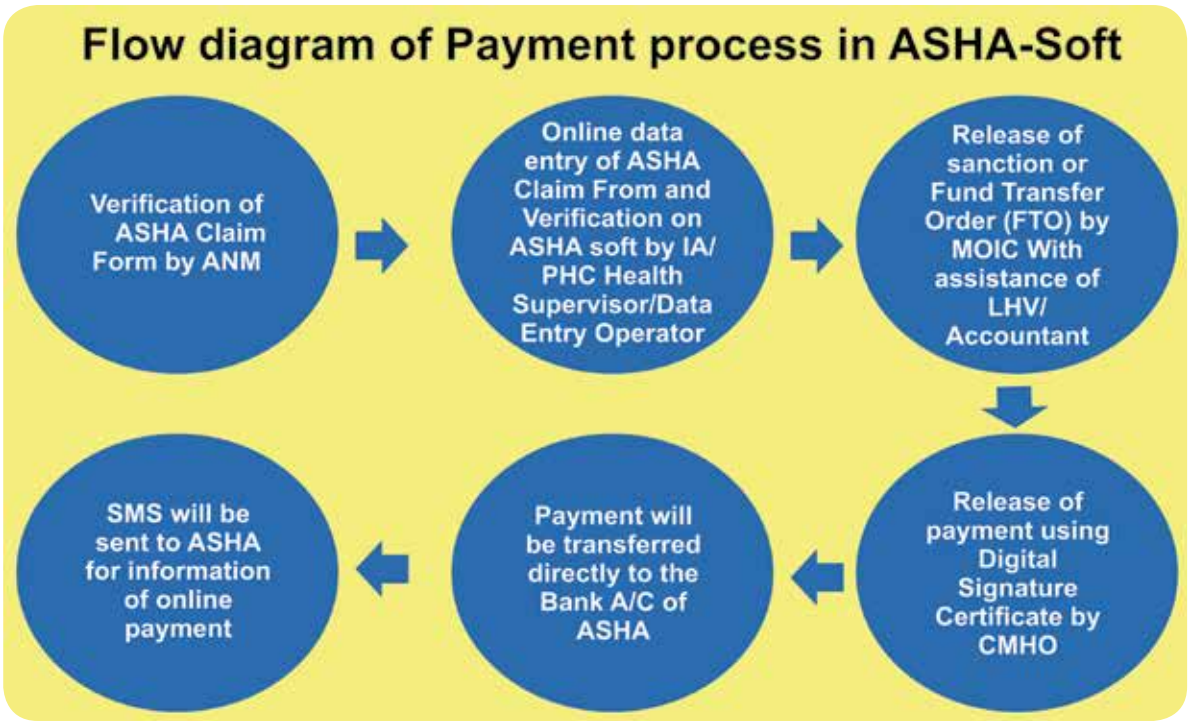
The Fulwari provides three hot cooked meals daily to children aged 6 months to 3 years. Pregnant and lactating women also get one meal a day at the Fulwari. There is no provision for a paid worker in Fulwari and two mothers volunteer each day to take care of children for 6-7 hours. These volunteers do not get any wages for contributing their time but are allowed to have a meal in the Fulwari. This organization of work, allows the rest of the mothers to go for work by leaving their children in the Fulwari.

Children who attend Fulwaris regularly showed significant improvements in their health and nutritional status. Fulwaris have enabled Mitanin to undertake closer monitoring of illnesses amongst children and thus reduced the episodes of illnesses (diarrhoea, malaria, ARI). It has also made it easier for ANM and AWW to reach these children, leading to improved growth monitoring, de-worming and Iron and Folic Acid (IFA) supplementation. The initiative recently won the Prime Minister's Award.

Fulwaris have proved that community managed feeding and care centres can be effective in addressing nutritional requirements of children between 6 months – 3 years and providing good child care, especially in cases where mothers have high workload, working outside homes for income generation. It demonstrated that Panchayats can be involved in health and nutrition issues of the community. Fulwaris also draw attention to the fact that there is a need for an adjunct intervention to the ICDS in areas with high malnutrition to enable a special focus on children under-3.

2. ASHA Soft- The Online Payment and Monitoring System for ASHAs

Complexities of fund flow for ASHA incentives for 26 activities from different budget heads led to delays and lack of transparency in payments for ASHAs in many states. Recognizing this problem and in an attempt to address this, government of Rajasthan launched ASHA Soft on December 26th 2014 in the state.



It is web-based software with key objectives to ensure timely and transparent online payment to ASHAs and to improve the system of monitoring. ASHA Soft was developed by NIC, Rajasthan state unit in collaboration with NHM core group under the leadership of the Mission Director. It has been implemented across all 38 districts except urban areas where required infrastructure for data entry is not available.

The software not only makes the payment process simpler and transparent but also captures beneficiary wise details of services given by ASHA to the community and generates various reports to monitor the progress of the program. ASHA soft has led to fixed day payment of ASHA incentives, reducing delays and establishing transparency in the payment process in the state. It has also improved entry of beneficiaries in PCTS as both softwares are interlinked for verifying payments. This software has also enabled programme managers to capture the performance of ASHAs based on incentives earned for a range of activities and also maintain detailed database of ASHAs.

Initial review of ASHA Soft indicate that it has been successful to an extent in streamlining payment of ASHA incentives and generating

interest of programme managers at all levels in monitoring the ASHA programme. Though the software has been able to achieve its primary objective of transparency in payments, it faces initial hurdles of HR shortage for data entry and skills of HR to effectively use the reports. ASHA Soft can be used for producing various reports that can prove more useful in monitoring and improving the programme functionality but this potential of the software is yet to be fully developed and utilized.

3. Role of VHSNC members for improving health seeking behavior of the community in Sikkim

A cause of death analysis in 2012 by the state showed that over half of deaths were on account of complications of non communicable diseases. Given that life styles are a key contributor in the etiology of several NCDs, the state undertook training of VHSNC members in the year 2014 in order to improve the community's health seeking behavior through community participation.

VHSNC members including the PRI representative, ASHAs, AWWs, NGO members, representatives from Self Help Group, teachers and religious leaders were trained at the PHC level. This was done by using existing funds for VHSNC training. The state already has in place a CATCH scheme (Chief Minister's Comprehensive Annual and Total Checkup for Healthy Sikkim).

The scheme involves community mobilization by the ASHA, a screening tool administered by the ANM, followed by an examination conducted by the Medical officer, and then provided with medication or referred The state assures treatment for all patients requiring services at no cost, either within or outside the state. The CATCH survey is conducted annually. The survey includes questions related to Family History, lifestyle related (diet, tobacco and alcohol consumption), insurance coverage, Reproductive history, and includes all family members including infants. Diagnostic screening tests include: Hb, Random Blood glucose, Serum Cholesterol/Triglycerides, and Creatinine. EHR cards have also been issued.

During the training the roles and responsibilities of VHSNC using the ward wise/sub center wise presentation on findings of the CATCH scheme/ and RMNCH +A indicators were discussed. The trainees were presented with the data on pockets of home delivery, major diseases according to CATCH and causes of death. This enabled the development of action plans with the ASHA and PRI member taking ownership for the actions that were decided by the group.

Increased community participation led by ASHAs resulted in increase in institutional deliveries and improved reporting and detection of NCDs. There is some evidence to show that secondary prevention measures are working as well. The positive results of the intervention have demonstrated that it is feasible to address local challenges faced by the community by strengthening community participation. Joint training facilitated better coordination between PRI members, Health workers, ASHA, NGO representatives and other community members. While not directly attributable change in health behaviors fostered by such community action and planning, could lead to positive impact.

Section-8

Updated List of Incentives

Updated List of Incentives

S. No.	Heads of Compensation	Amount in Rs/case	Source of Fund and Fund Linkages	Documented in
I	Maternal Health			
1.	JSY financial package			MOHFW Order No. Z 14018/1/2012/JSY -section Ministry of Health & Family Welfare -6th. Feb 2013
	For ensuring antenatal care for the woman	300 for Rural areas 200 for Urban areas	Maternal Health-NRHM-RCH Flexi pool	
	For facilitating institutional delivery	300 for Rural areas 200 for Urban areas		
	Reporting Death of women (15-49 years age group) by ASHA to U-PHC Medical Officer	200 for reporting within 24 hours of occurrence of death by phone	HSC/ U-PHC- Untied Fund	MOHFW- OM -120151/148/2011/MCH; Maternal Health Division; 14th Feb 2013

S. No.	Heads of Compensation	Amount in Rs/case	Source of Fund and Fund Link-ages	Documented in
II	Child Health			
	Undertaking six (in case of institutional deliveries)and seven(for home deliveries) home- visits for the care of the new born and post- partum mother[1]	250	Child Health-NRHM-RCH Flexi pool	HBNC Guidelines – August 2011
	For follow up visits to a child discharged from facility or community Severe Acute Malnutrition (SAM) management centre	150 only after MUAC is equal to nor-more than 125mm		Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV
	Ensuring monthly follow up of low birth weight babies and newborns discharged after treatment from Specialized New born Care Units	50		Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV
III	**Immunization**			
	Complete immunization for a child under one year	100.00		Order on Revised Financial Norms under UIP-T.13011i01/2077-CC-May 2012
	Full immunization per child up-to two years age(all vaccination received between 1st and second year of age after completing full immunization after one year	Rs 50	Routine Immunization Pool	
	Mobilizing children for OPV immunization under Pulse polio Programme	100/day[2]	IPPI funds	Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV
IV	**Family Planning**			
	Ensuring spacing of 2 years after marriage	500	Family planning Compensation Funds	Minutes Mission Steering Group meeting- April- 2012
	Ensuring spacing of 3 years after birth of 1st child	500		
	Ensuring a couple to opt for permanent limiting method after 2 children	1000		
	Counselling, motivating and follow up of the cases for Tubectomy	150	Family Planning Sterilization compensation funds	Revised Compensation package for Family Planning- September 2007-No-N 11019/2/2006-TO-Ply
	Counselling, motivating and follow up of the cases for Vasectomy/ NSV	200		

[1]This incentive is provided only on completion of 45days after birth of the child and should meet the following criteria-birth registration, weight-record in the MCP Card, immunization with BCG, first dose of OPV and DPT complete with due entries in the MCP card and both mother and new born are safe until 42nd of delivery.

[2]Revised from Rs 75/day to Rs 100/day

	Social marketing of contraceptives- as home delivery through ASHAs	1 for a pack of three condoms 1 for a cycle of OCP 2 for a pack of ECPs	Family planning Fund	Detailed Guidelines on home delivery of contraceptives by ASHAs-Aug-2011-N 11012/3/2012-FP
	Escorting or facilitating beneficiary to the health facility for the PPIUCD insertion	150/case	Family planning Fund	- Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV
V	**Adolescent Health**			
	Distributing sanitary napkins to adolescent girls	Re 1/ pack of 6 sanitary napkins	Menstrual hygiene- ARSH	Operational guidelines on Scheme for Promotion of Menstrual Hygiene Aug 2010
	Organizing monthly meeting with adolescent girls pertaining to Menstrual Hygiene	50/meeting	VHSNC Funds	
VI	**Revised National Tuberculosis Control Programme[3]**			
	Honorarium and counselling charges for being a DOTS provider		RNTCP Funds	Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV
	For Category I of TB patients (New cases of Tuberculosis)	1000 for 42 contacts over six or seven months of treatment		
	For Category II of TB patients(previously treated TB cases)	1500 for 57 contacts over eight to nine months of treatment including 24-36 injections in intensive phase		
	For treatment and support to drug resistant TB patients	5000 for completed course of treatment(2000 should be given at the end on intensive phase and 3000 at the end of consolidation phase		

[3]Initially ASHAs were eligible to an incentive of Rs 250 for being DOTS provider to both new and previously treated TB cases. Incentive to ASHA for providing treatment and support Drug resistant TB patients have now been revised from Rs 2500 to Rs 5000 for completed course of treatment

[4]Incentives under NLEP for facilitating diagnosis and follow up for completion of treatment for pauci bacillary cases was Rs 300 before and has now been revised to-Rs 250 and Rs 400 now.

For facilitating diagnosis and follow up for completion of treatment for multi-bacillary cases were Rs 500 incentive was given to ASHA before and has now been revised to-Rs 250 and Rs 600.

VII	**National Leprosy Eradication Programme[4]**			
	Referral and ensuring compliance for complete treatment in pauci-bacillary cases of Leprosy	250(for facilitating diagnosis of leprosy case)+ 400(for follow up on completion of treatment)	NLEP Funds	Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV
	Referral and ensuring compliance for complete treatment in multi-bacillary cases of Leprosy	250(for facilitating diagnosis of leprosy case)+ 600((for follow up on completion of treatment)		
VIII	**National Vector Borne Disease Control Programme**			
A)	**Malaria[5]**			
	Preparing blood slides	15/slide	NVDCP Funds for Malaria control	Order on revised rate of ASHA incentives- D.O. No. P17018/14/13-NRHM-IV
	Providing complete treatment for RDT positive Pf cases	75		
	Providing complete radical treatment to positive Pf and Pv case detected by blood slide, as per drug regimen			
	For referring a case and ensuring complete treatment	300		
B)	**Lymphatic Filariasis**			
	For one time line listing of lymphoedema and hydrocele cases in all areas of non-endemic and endemic districts	200	NVBDCP funds for control of Lymphatic Filariasis	Order on revised rate of ASHA incentives- D.O. No. P17018/14/13-NRHM-IV
	For annual Mass Drug Administration for cases of Lymphatic Filariasis[6]	200/day for maximum three days to cover 50 houses and 250 persons		
C)	**Acute Encephalitis Syndrome/Japanese Encephalitis**			
	Referral of AES/JE cases to the nearest CHC/DH/ Medical College	300 per case	NVBDCP funds	Order on revised rate of ASHA incentives- D.O. No. P17018/14/13-NRHM-IV
D)	**Kala Azar elimination**			
	Involvement of ASHAs during the spray rounds(IRS) for sensitizing the community to accept indoor spraying[7](New incentive)	Rs 100/- per round during Indoor Residual Spray i.e. Rs 200 in total for two rounds	NVBDCP funds	Minutes Mission Steering Group meeting- Feb-2015

IX	Incentive for Routine Recurrent Activities			
	Mobilizing and attending VHND or(outreach session/ Urban Health and Nutrition Days)	200 per session	**NRHM-RCH Flexi Pool**	Order on revised rate of ASHA incentives- D.O. No. P17018/14/13-NRHM-IV
	Convening and guiding monthly meeting of VHSNC/ MAS	150		
	Attending monthly meeting at Block PHC/U-PHC	150		
	a) Line listing of households done at beginning of the year and updated every six months b) Maintaining records as per the desired norms like –village health register c) Preparation of due list of children to be immunized updated on monthly basis d) Preparation of due list of ANC beneficiaries to be updated on monthly basis e) Preparation of list of eligible couples updated on monthly basis	500		

[5]Incentive for slide preparation was Rs 5 and has been revised to Rs 15. Incentive for providing treatment for RDT positive Pf cases was Rs 20 before and has been revised to Rs 75. Incentive for providing complete radical treatment to positive Pf and Pv case detected by blood slide, as per drug regimen was Rs 50 before. Similarly-incentive for referring a case of malaria and ensuring complete treatment was Rs 200/case and has been revised to Rs 300 now.

[6]Incentive has been revised from Rs 100 to Rs 200 per day for maximum three days to cover 50 houses or 250 persons

[7]In order to ensure vector control, the role of the ASHA is to mobilize the family for IRS. She does not carry out the DDT spray. During the spray rounds her involvement would be for sensitizing the community to accept indoor spraying and cover 100% houses and help Kala Azar elimination. She may be incentivized of total Rs 200/- (Rs.100 for each round) for the two rounds of insecticide spray in the affected districts of Uttar Pradesh, Bihar, Jharkhand and West Bengal.

Ministry of Health and Family Welfare
Government of India