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UPDATE
ON ASHA PROGRAMME

JANUARY
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Section

1 Introduction

This is the fifteenth issue of the biannual ASHA update produced by the National Health Systems Resource Centre for the National Health Mission, Ministry of Health and Family Welfare. The first issue of the update was released in October 2009. Since then, every six months the ASHA Update has attempted to capture the activities within the ASHA programme over a six month period. Two updates have been produced every year, once covering the period January to June and the other July to December. This particular issue reports on events that have taken place in the period between July 2016 and December 2016.

In Section 2 we report on the status of ASHA selection, training progress, and status of Support structures for the ASHA. Selection status in the NRHM in non-high focus states is 91%, in high focus states it is 94%, and the NE states it is nearly 95%. The selection target in NUHM is dynamic, given that states are still estimating the numbers of ASHAs required based on listed and unlisted slums. Reports from the field indicate that there are challenges in ASHA selection, given other employment opportunities available to women in urban areas.

Training coverage in Round 4 of Modules 6 and 7, is currently 41.1%, up from 32.5% reported in the July 2016 update. Round 4 training signifies completion of ASHA training for key competencies in maternal, new-born, child health, nutrition, violence against women, and reaching the unreached. Conducted in four five day Rounds, the training essentially covers those skills that are required for the ASHA to deliver against tasks related to the Reproductive, Maternal, New-born, and Child Health. While there is some progress on training, there is still a large backlog in states.

In June, the MOHFW launched Operational Guidelines for Prevention, Screening and Control of non-communicable diseases. The guidelines envisage a role for ASHA in health promotion, prevention and mobilizing all adults of over 30 years of age for screening. This will require skilling the ASHA in a new set of competencies. Unless states complete the training backlog in Modules 6 and 7 it will be difficult for them to initiate this training for NCDs.

As far as support structures are concerned, there has been no major change across states. There is movement for rationalization of human resources to integrate supportive and supervisory functions by consolidating them at district and block levels but there is little apparent change.

In Section 3, we report on two studies undertaken in the period that this update covers. One is a Time-Use study of ASHA through observation undertaken in Jharkhand and Delhi. The findings indicate that in a rural setting such as Jharkhand with wide geographical dispersion an ASHA spends between four to six hours and between one to four hours in an urban location such as Delhi. The assessment reports on the various activities undertaken by the ASHA, the average time spent by the ASHA on various activities, including travel between households and to the health facility. We also report on the ASHA evaluation undertaken

in the state of Jammu &Kashmir. This evaluation followed the same methodology followed in the large scale ASHA evaluation in eight states, and subsequence undertaken in other states in phases. The data collection was undertaken in FY 15-16. Overall the findings demonstrate high levels of coverage in maternal and new-born care and childhood illness management. However only 20% of mothers reported that ASHAs had completed all six home based new-born care visits. While there was proficiency in some skills, in some others such as recognition and referral for high risk and among mothers and newborns was about 60%. The findings from interviewing respondents who had not used ASHA services (and they were few in number) for maternal or child health conditions show that in some cases, geographic distance was a barrier. However, most non-service user cases appear to have been excluded because of their socio economic status, an area of concern. Among all these cases, Out of Pocket Expenditures on care seeking for child hood illness was high, ranging from Rs. 500 to Rs. 10,000.

In Section 4 we report on the findings of the Tenth Common Review Mission. Sixteen states were visited, and the Terms of Reference (TOR) for Community Processes and convergence focus on key issues related to ASHA programme including selection, training, support structure, incentive payments, progress made under NUHM and career opportunities for ASHAs. The TOR also covers the status of VHSNC, RKS and Community Action for Health. Overall there has also been increasing ownership of the ASHA by the health system, and visualization of the ASHA as a key community resource valued for her facilitator role. However, the other two roles perceived for ASHAs in terms of activist/social mobilizer and community care provider are yet to be fully realised. There appears to be a strong positive correlation between the high training frequency and the knowledge and skill levels of the ASHA and ASHA training. Mechanisms for inter-sectoral convergence were noticed to be weak in most states.

In Section 5, we provide an update on the various incentives approved at the national level for ASHAs. During the period that the Update covers, several new incentives were approved for the ASHA. These include incentives to promote breastfeeding, for supporting IUCD insertions among those women who had an abortion, and incentives for promoting adoption of family planning methods such as motivating women to use injectable contraceptives. This last set of incentives are applicable only to 145 districts of those states where the Total Fertility Rate is more than 3.

Section

2 ASHA Programme Progress

Since the last update published in July, 2016, the cumulative target for ASHA selection under NRHM and NUHM from 35 states and UTshas declined marginally from 10,23,254 to 10,18,019. The figures pertaining to the target set for ASHA selection and selection status of ASHAs are dynamic, since states revise their targets based on actual requirements. Over last six months, many states have increased their targets (especially under NUHM) but reduction in targets in a few larger states have led to an overall decrease in target by about 5235. The selection status has improved from 9,16,528 to 9,39,728 indicating 92% completion of selection, nationally for NUHM and NRHM.

ASHA Selection - National Rural Health Mission (NRHM)

The total number of ASHAs working under NRHM presently is around 8,82,947 (an increase of 9188 since the July, 2016 update), against the target of 9,49,030 (a decrease of 3503 over past six months). This reflects nearly 93% of completion of selection process across all states.

The decrease of 3503 in the overall target, is majorly on account of downward revision of target in Rajasthan by 3979 and Maharashtra by 1262. Minor reduction in target is also noted in states of Tripura by 520 as state has revised the division of target between urban and rural areas. Thus, Tripura has a total target of 7367, of which target for rural areas is 6840 and for urban areas it is 527. Madhya Pradesh by 268 and Mizoram by 124. Three states have also increased their targets during this period. These include states of Telangana, Uttar Pradesh and Himachal Pradesh, which have increased their target by 1497, 973 and 180 respectively.

With regards to the selection status, there is an increase of 9188 in total number of ASHAs in position nationally. This is mainly on account of selection of 7531 new ASHAs in high focus states and 2277 ASHAs in non-high focus states and a decrease in selection figures by 620 in North Eastern States, mainly on account of revision of figures from Tripura.

Among High Focus states, the selection status is about 94%. During this period, most states (except Chhattisgarh and Rajasthan) have selected new ASHAs to meet their targets. The highest figures for new ASHA selection are noted from Uttar Pradesh (which has added 7951 new ASHAs), followed by Madhya Pradesh (with 2228 new ASHAs). Routine visits to these states have shown that there are gaps in ASHA selection in vulnerable areas and hence this addition is welcome. Major revision for target as well as selection has been reported from the state of Rajasthan. State has reduced its target by 3979 (from 54,280 to 50,301) as well as in position figures for ASHAs by 3940 (from 52,080 to 48,140). It is important to note that the state has reported an increase in selection figures from 44,178 to 52,080 against the target of 54,820 in the July 2016 update.

The group of eight North Eastern states, have reported a decrease in target of 520 ASHAs and

in position ASHAs by 620.This change is largely due to reduction in numbers by 124 in Mizoram and 520 in Tripura, both for ASHA target as well as selection figures. . In Tripura, the change in target as well selection data is due to re distribution of figures between rural and urban areas. Over past six months, Meghalaya has added 59 new ASHAs while Arunachal Pradesh has reported drop out of 35 ASHAs.

Selection status among Non-High Focus states is about 91% with 3,26,672 ASHAs in position, against the target of 3,58,014. Over last six months, increase in target is noted from Telangana (by 1497) and Himachal Pradesh (by 18) while state of Maharashtra has reduced the target by 1262.The total number of ASHAs in position has increased by 2277 for these states, as nine out of thirteen states (except Andhra Pradesh, Delhi, Punjab and Tamil nadu) have reported selection of new ASHAs. Major increase in selection figures have been reported from Kerala (by 1693), followed by Telangana (by 921) and Karnataka (by 836). Despite reporting increase in number of new ASHAs, West Bengal and Karnataka continue to have selection status in the range of 79% - 85%. State of Tamil Nadu has revised figures for ASHA selection from 6793 to 3905. This has also brought down the selection status from 99% to 57% against the target of 6850 in the state.

Table 1 : Status of ASHA Selection

State	NRHM					NUHM		
	Proposed ASHAs (Target)	ASHA selected / Working	% of ASHA against target	Rural Population 2011 census	Current Density of ASHAs	Proposed ASHAs (Target)	ASHA selected / Working	% of ASHA against target
High Focus States								
Bihar	93687	85879	91.67	92341436	1075	391	312	79.80
Chhattisgarh*	70078	65713	93.77	19607961	298	3883	3701	95.31
Jharkhand	40964	39500	96.43	25055073	634	246	212	86.18
Madhya Pradesh	62583	61229	97.84	52557404	858	4200	4110	97.86
Odisha	45812	45273	98.82	34970562	772	1482	1413	95.34
Rajasthan	50301	48140	95.70	51500352	1070	4674	4076	87.21
Uttar Pradesh	161158	144538	89.69	155317278	1075	6813	4012	58.89
Uttarakhand	10048	9955	99.07	7036954	707	1038	1038	100.00
Sub Total	**534631**	**500227**	**93.56**	**438387020**	**876**	**22727**	**18874**	**83.05**
*Chhattisgarh has selected ASHAs at habitation level.								
North Eastern states								
Arunachal Pradesh	3862	3827	99.09	1066358	279	42	40	95.24
Assam	30619	30619	100.00	26807034	876	1336	1336	100.00
Manipur	3928	3928	100.00	1736236	442	81	81	100.00
Meghalaya	6740	6519	96.72	2371439	364	255	175	68.63
Mizoram	967	967	100.00	525435	543	127	127	100.00
Nagaland	1887	1887	100.00	1407536	746	47	41	87.23
Sikkim	641	641	100.00	456999	713	25	25	100.00
Tripura	6847	6847	100.00	2712464	396	520	492	94.62
Sub Total	**55491**	**55235**	**99.54**	**37083501**	**671**	**2433**	**2317**	**95.23**

State	NRHM					NUHM		
	Proposed ASHAs (Target)	ASHA selected / Working	% of ASHA against target	Rural Population 2011 census	Current Density of ASHAs	Proposed ASHAs (Target)	ASHA selected / Working	% of ASHA against target
Non High Focus states								
Andhra Pradesh	39009	37994	97.4	34776389	915	2660	2502	94.1
Delhi	--	--	--	--	--	5679	5130	90.33
Gujarat	38188	36334	95.15	34694609	955	4408	3717	84.32
Haryana	18000	17298	96.10	16509359	954	2676	2253	84.19
Himachal Pradesh	7930	7684	96.90	6176050	804	34	28	82.35
Jammu & Kashmir	12000	11843	98.69	9108060	769	63	63	100.00
Karnataka	39195	33369	85.14	37469335	1123	3474	1701	48.96
Kerala	30927	28219	91.24	17471135	619	2298	1927	83.86
Maharashtra	60957	58793	96.45	61556074	1047	9554	6857	71.77
Punjab	17360	17071	98.34	17344192	1016	2753	2362	85.80
Tamil Nadu **	6850	3905	57.01			0	0	0.0
Telangana	26590	25905	97.42	21585313	833	3698	2576	69.66
West Bengal	61008	48257	79.10	62183113	1289	6068	6403	105.52
Sub Total	**358014**	**326672**	**91.25**	**318873629**	**976**	**43365**	**35519**	**81.91**
** ASHAs have been selected only in tribal areas (General - 2650+Malaria 1255)								
Union Territories								
Andaman & Nicobar Island	412	407	98.8	237093	583	10	0	0.0
Chandigarh	24	15	62.5		0	25	18	72.0
Dadra & Nagar Haveli	250	208	83.2	183114	880	50	46	92.0
Daman & Diu	98	73	74.5	60396	827	38	7	18.4
Lakshadweep	110	110	100.0	14141	129	--	--	--
Puducherry	--	--	--	--	--	341	0	0.0
Sub Total	**894**	**813**	**90.9**	**494744**	**609**	**464**	**71**	**15.30**
Total All India	**949030**	**882947**	**93.0**	**794838894**	**900**	**68989**	**56781**	**82.30**

Population Density

At the national level, average population being covered by each ASHA under NRHM has not seen any major change in last six months. Presently average population density is around 900 against 910 reported in July 2016.

The average population being covered by ASHA has declined from 890 per ASHA to 876 per ASHA in high Focus states and from 983 to 976 in nonhigh focus states. However an increase is noted in north eastern states, where it has increased from 664 to 671, though as a group it is the lowest average population density.

Over last six months, the number of states where population density per ASHA is over 1000 has increased from six to seven, by inclusion of Rajasthan in the following list of states - Bihar, and Uttar Pradesh among high focus states and Karnataka, Maharashtra, Punjab and West Bengal among the nonhigh focus states.

Among High Focus states, Chhattisgarh remains the state with lowest population coverage at

298. Average population coverage has decreased further in Odisha and Madhya Pradesh to 772 and 858 from 784 and 891 respectively. Bihar, Jharkhand and Uttarakhand have not seen any substantial change during this period and remain at 1075, 634 and 707 (against 1079, 636 & 719 respectively in July 2016).

Of the eight North Eastern states, Arunachal Pradesh remains the state with lowest average population coverage in the country (at 279), and three other states remain at below 500 average population level (Manipur – 442, Meghalaya – 364, & Tripura – 396). Mizoram, which earlier had average population at 482, has moved up to 543.

The state of West Bengal retains the distinction of having the highest average population covered by each ASHA, at 1289 (though it has reduced from 1305). Karnataka remains second at 1123 (compared to 1152 in July 2016). These two states are followed by Maharashtra at 1047 and Punjab at 1016. Kerala remains the state with lowest average population coverage among Non-High Focus states at 619 (against 659 in July 2016), followed by Jammu & Kashmir at 789.

ASHA Selection - National Urbanl Health Mission (NUHM)

Under National Urban Health Mission (NUHM), a total of 56,784 ASHAs have been selected against the target of 68,990 (82% selection). This shows an addition of 14,012 new ASHAs (number of in position ASHA was 42,769 in July 2016). However, the target has been reduced by 1732 (decreased from 70,721 to 68,990). This is because of the downward revision in targets in Kerala (from 4804 to 2298), Tamil Nadu (from 1336 to 0), Maharashtra (from 10214 to 9554) and Jammu & Kashmir (from 238 to 63). Over past six months, many states have also increased their targets for urban ASHAs. such as Meghalaya, Mizoram, Nagaland and Tripura, Delhi, Gujarat, Telangana and West Bengal. Among these states, the highest increase is noted from states of West Bengal and Telangana, which have revised the target by 1538 and 1061 respectively.

The High Focus states have reported an increase in selection status from 64% to 83%, by adding 4393 new urban ASHAs in past six months. Of these, 4012 ASHAs have been selected in UP alone, which has no achieved 59% selection against the target of 6813. States of Madhya Pradesh and Rajasthan have also selected 260 and 119 ASHAs respectively.

Among the North Eastern states, the overall selection is at 95%. Four states (Meghalaya, Mizoram, Nagaland and Tripura) have reported an increase in target and have also added new ASHAs under NUHM . Thus, the target for NE states has increased from 2235 to 2433, against which selection figures have increased from 2218 to 2317.

The Non-High Focus States have reported major revisions during past six months, with the overall target change from 45,289 to 43,365 (reduced by 1924) and increase by 9523 in selection figures (increase from 25,996 to 35,519). Thus, increasing the selection status from 57% to 82%. As mentioned earlier four states have reported an increase in target (West Bengal by 1538, Telangana by 1061, Delhi by 112 and Gujarat by 42) while four states have reduced their target (Kerala by 2506, Tamil Nadu by 1336, Maharashtra by 660,and Jammu & Kashmir by 175). Almost all nonhigh focus states have reported progress in selecting ASHAs (except Andhra Pradesh, Kerala, Tamil Nadu and J &K which has revised its selection figures). Major increase in ASHA selection is reflected in West Bengal (from 0 to 6403 – as the state has eventually been able to co-opt the link workers as ASHAs), Telangana (from 1142 to 2576). Maharashtra (from 6084 to 6857) and Haryana (from 1767 to 2253). State of Tamil Nadu which has received approval for 1336 urban ASHAs has decided not to implement the ASHA programme under NUHM.

With the overall selection status at currently 82% under NUHM, various states like Uttar Pradesh, Meghalaya, Karnataka, Maharashtra and Telangana which have achieved less than 70% selection, need to expedite the selection

process. Frequent changes in target and selection figures reported by states also indicate lack of clarity about the actual requirement of ASHAs in urban areas. As NUHM completes four years, since its launch it is imperative that all states complete the mapping of vulnerable areas and plan for ASHA target and selection accordingly.

Status of ASHA Training

a) NRHM

Table 2 presents cumulative training achievement of States and Union Territories on ASHA Module 6 & 7 up to December 2016. Four rounds of Module 6&7 training aim to develop skills that she requires for playing her role effectively.

Out of 8.8 lakh ASHAs in the National Rural Health Mission (NRHM), 92% of ASHAs have undergone Round 1 training and about 84 % have been trained in Round 2.

In the last six months 79,056 additional ASHAs were trained in Round 4 (increased from 32% to 41%), but the incremental progress in Rounds 1, 2, & 3 was not substantive, as the number of ASHAs trained was only 20361 for Round 1, 4590 for Round 2 and 13,059 for Round 3. This limited progress in training rounds is also significant, as there is still a lot of ground to be covered especially in Round 3 and round 4 (which is currently at 62% and 41%).

The slow pace of training is mainly related to challenges and gaps at the operational level. It is noteworthy that training in four rounds of Module 6&7 started in the year 2010, about seven years ago, and this should now be taken up by states at high priority to complete all four rounds of Module 6&7 training.

Table 2 : Status of ASHA Training - NRHM

	ASHA selected / working	Round 1 of Module 6&7		Round 2 of Module 6&7		Round 3 of Module 6&7		Round 4 of Module 6&7	
	No.	No.	%	No.	%	No.	%	No.	%
High Focus States									
Bihar	85879	78336	91.2	67725	78.9	55818	65.0	7148	8.3
Chhattisgarh*	65713	66169	100.7	66169	100.7	66169	100.7	66169	100.7
Jharkhand	39500	37045	93.8	37271	94.4	37910	96.0	26046	65.9
Madhya Pradesh	61229	58127	94.9	52904	86.4	52371	85.5	18985	31.0
Odisha	45273	42485	93.8	42415	93.7	42597	94.1	30923	68.3
Rajasthan	48140	45231	94.0	38719	80.4	25483	52.9	13374	27.8
Uttar Pradesh	144538	103011	71.3	88575	61.3	4162	2.9		0.0
Uttarakhand	9955	10313	103.6	10381	104.3	10286	103.3	6793	68.2
Total	**500227**	**440410**	**88.0**	**404159**	**80.8**	**294796**	**58.9**	**169438**	**33.9**
North Eastern States									
Assam	30619	29560	96.5	29257	95.6	29215	95.4	29179	95.3
Arunachal Pradesh	3827	3669	95.9	3424	89.5	3424	89.5	2958	77.3
Manipur	3928	3804	96.8	3804	96.8	3804	96.8	3756	95.6
Meghalaya	6519	5891	90.4	5873	90.1	5914	90.7	5414	83.0
Mizoram	967	987	102.1	987	102.1	987	102.1	987	102.1
Nagaland	1887	1398	74.1	1397	74.0	1624	86.1	1593	84.4

	ASHA selected / working	Round 1 of Module 6&7		Round 2 of Module 6&7		Round 3 of Module 6&7		Round 4 of Module 6&7	
	No.	No.	%	No.	%	No.	%	No.	%
Sikkim	641	665	103.7	665	103.7	665	103.7	665	103.7
Tripura	6847	7257	106.0	7009	102.4	7280	106.3	7252	105.9
Total	**55235**	**53231**	**96.4**	**52416**	**94.9**	**52913**	**95.8**	**51804**	**93.8**
Non High Focus States									
Andhra Pradesh	37994	35905	94.5	32331	85.1	21020	55.3	11500	30.3
Gujarat	36334	34680	95.4	34049	93.7	33406	91.9	32538	89.6
Haryana	17298	18418	106.5	18400	106.4		0.0		0.0
Himachal Pradesh	7785	7514	96.5	7469	95.9	6435	82.7	0	0.0
Jammu & Kashmir	11843	11510	97.2	11453	96.7		0.0		0.0
Karnataka*	33369	30547	91.5	30547	91.5	30547	91.5	30547	91.5
Kerala*	28219	26192	92.8	4400	15.6	0	0.0	0	0.0
Maharashtra	58793	57089	97.1	54588	92.8	46121	78.4	11113	18.9
Punjab	17071	16243	95.1	16243	95.1	16416	96.2	16324	95.6
Tamil Nadu	3905	1953	50.0	1953	50.0	1953	50.0	1953	50.0
Telangana	25905	26224	101.2	25159	97.1	14122	54.5		0.0
West Bengal	48257	49155	101.9	48135	99.7	46717	96.8	37314	77.3
Total	**326773**	**315430**	**96.5**	**284727**	**87.1**	**216737**	**66.3**	**141289**	**43.2**
Union Territories									
Andaman & Nicobar Islands	407	272	66.8	272	66.8	0	0.0	0	0.0
Chandigarh	15	0	0.0		0.0	0	0.0	0	0.0
Dadra & Nagar Haveli	208	68	32.7	45	21.6	0	0.0	0	0.0
Daman & Diu	73	55	75.3	55	75.3	0	0.0	0	0.0
Lakshadweep	110	0	0.0	0	0.0	0	0.0	0	0.0
Total	**813**	**395**	**48.6**	**372**	**45.8**	**0**	**0.0**	**0**	**0.0**
Total All India	**882947**	**809466**	**91.7**	**740909**	**83.9**	**550895**	**62.4**	**363176**	**41.1**

The eight High Focus states, together, have shown significant momentum in Round 4, raising the percentage of ASHAs trained from 26% to 34%. The most significant progress is in the Jharkhand (increased from 3% to 66%) Madhya Pradesh (16 to 31%) and Odisha (51 to 68%). However, the progress in Round 1(86 to 88%), Round 2 (decreased from 82 to 81 %) and Round 3 (56% to 59%) is not significant. During last six months, Round 1 training has progressed in states of Uttar Pradesh (from 89,231 to 1,03,011) and in Madhya Pradesh (from 56,457 to 58,127) while round 2 figures have increased slightly in Rajasthan and Uttrakhand. Training of Round 3 has also improved marginally in Madhya Pradesh (from 48701 to 52,371), Rajasthan (from 23,263 to 25,483) and Uttar Pradesh (from none to 4162), this is reflected in progress of 2 % for Round 2.The reduced percentage of coverage for Round 2 is on account of a revision in figures for number of ASHAs trained in Round 2 by Madhya Pradesh. Data from Bihar and Uttrakhand indicate a plateau in the training roll out. For instance, Bihar has reported no training progress for over a year as the percentage of Round 3 and 4 training completion has been stagnant at 79%

and 8% respectively. Similarly, no improvement in Round 4 training is noted in Uttrakhand which is currently at 68% (similar to figures reported in last update).

Among the North Eastern states, substantial progress is noted in Round 4 training, raising coverage from 60 %to 93 %, based on training progress reported from Assam, Meghalaya, Arunachal Pradesh and Tripura during last six months. Training achievement of Rounds 1, 2 and 3 is around 96.4 %, 94.9 % and 95.8 % respectively.

With regards to Non High Focus states, five states have conducted Round 3 and 4 trainings in last six months, leading to an increase of Round 3 training to 66 % (from 61.9 %) and of Round 4 training to 43 % (from 38.4 %). States of Himachal Pradesh, Maharashtra and Telangana have trained about 5976, 7447 and 1747 additional ASHAs in round 3 training. Round 4 training has increased from 0.13% to 18% in Maharashtra, 68% to 77% in West Bengal and 85% to 89% in Gujarat. Slow training progress is noted in case of round 2 training, which has increased from 86% to 87% over past six months while Round 1 status has remained at 96%.

Presently there are nine states which have trained up to 90% of ASHAs in Round 4 of module 6 & 7; Chhattisgarh, Assam, Manipur, Mizoram, Sikkim, Tripura, Gujarat, Karnataka and Punjab. The states which need to prioritize completion of ASHA training in all four rounds of Module 6&7 are Bihar, Rajasthan, Uttar Pradesh, Haryana, Himachal Pradesh, Jammu & Kashmir, Maharashtra and Telangana. These states have less than 30% achievement in Round 4 training. States which have not started Round 4 training are Uttar Pradesh, Himachal Pradesh and Telangana while states which are yet to begin even Round 3 (and also Round 4) training are Haryana and J&K

a) NUHM

The trainings for ASHAs under National Urban Health Mission (NUHM) have been initiated in most states. The overall achievement for ASHA training is around 55% for Induction Training and 32% for Round 1 of Module 6&7. Eight states – Chhattisgarh, Madhya Pradesh, Odisha, Mizoram, Nagaland, Gujarat, Haryana and Punjab have completed over 80% of induction training (except Mizoram which has completed 23% induction training) and have also started Round 1 of Module 6&7. States of Chhattisgarh and Gujarat have also reported over 95% training of ASHAs in Round 1 of Module 6 & 7. State of Delhi which had an ASHA programme in place since 2009 (which has come under NUHM since 2013) has trained 103% ASHAs in Round 1, 95% in Round 2, and 68% in Round 3 of Module 6&7.

States of Bihar, Arunachal Pradesh, Tripura, Andhra Pradesh, Himachal Pradesh, Jammu & Kashmir, Karnataka, Kerala and West Bengal are the only states which have not started any training for ASHAs under NUHM. There is an urgent need for these states to prioritize training of ASHAs selected in urban areas.

Table 3 : Status of ASHA Training - NUHM

State	ASHAs selected/ working	Training Progress - ASHA			
		Induction Module		Round 1 of Module 6&7	
		No.	%	No.	%
High Focus States					
Bihar	312	0	0	0	0
Chhattisgarh	3701	4120	111.32	3730	100.78
Jharkhand	212	211	99.5	0	0
Madhya Pradesh	4110	3700	90.02	2314	56.3
Odisha	1413	1204	85.21	1021	72.26

State	ASHAs selected/ working	Training Progress - ASHA			
		Induction Module		Round 1 of Module 6&7	
		No.	%	No.	%
Rajasthan	4076	4076	100	0	0
Uttar Pradesh	4012	4012	100	0	0
Uttarakhand	1038	90	8.67	0	0
Sub Total	**18874**	**19318**	**102.35**	**7065**	**37.43**
North Eastern States					
Arunachal Pradesh	40	0	0	0	0
Assam	1336	40	2.99	0	0
Manipur	81	81	100	0	0
Meghalaya	175	105	60	0	0
Mizoram	127	29	22.83	29	22.83
Nagaland	41	41	100	41	100
Sikkim	25	0	0	0	0
Tripura	492	0	0	0	0
Sub Total	**2317**	**296**	**12.78**	**70**	**3.02**
Non High Focus states					
Andhra Pradesh	2502	0	0	0	0
Delhi*	5130	Round 1- 103% , Round 2- 95% , Round 3 - 68%			
Gujarat	3717	3671	98.76	3476	93.52
Haryana	2253	1940	86.11	669	29.69
Himachal Pradesh	28	0	0	0	0
Jammu & Kashmir	63	0	0	0	0
Karnataka	1701	0	0	0	0
Kerala	1927	0	0	0	0
Maharashtra	6857	792	11.55	0	0
Punjab	2362	2362	100	1533	64.9
Telangana	2576	2644	102.64	0	0
West Bengal	6403	0	0	0	0
Sub Total	**35519**	**11409**	**32.12**	**10977**	**30.9**
Union Territories					
Andaman& Nicobar Island	0	0	0	0	0
Chandigarh	18	47	261.11	0	0
Dadra & Nagar Haveli	46	0	0	0	0
Daman & Diu	7	0	0	0	0
Puducherry	0	0	0	0	0
Sub Total	**74**	**0**	**0**	**0**	**0**
Total All India	**56784**	**31023**	**54.63**	**18112**	**31.9**

* ASHA programme in place since 2009

Support Structures

The status of support structures across states is largely at the same level, as detailed out in the July update. The integration and coordination between support functions between ASHA programme under NRHM, and ASHA component under NUHM, has further improved during the period.

Presently all High Focus states barring Odisha, have support cadre in place at four levels, state, district, block and sub-block. Odisha continues to manage the programme support through existing cadre at block level. Bihar, which has created support cadre at all four levels, continues to grapple with the problem of high proportion of vacant positions, except at state and sub block level. (Eg- 9 out of 12 Divisional Coordinators positions ,12 out of 38 DCMs are in position (less than one third) and only 277 BCMsout of 534 positions are filled. State of Uttar Pradesh presently has 759 block Community Mobilisers (against the target of 820 - 93 %), 71 DCMs against the target of 75 (95%), and 5971 ASHA Facilitators in position (increased in last six months from 5489 – against the target of 6815 – 88%). This reflects the emphasis the state is placing on the strengthening the support cadre and improving the programme support processes. Odisha has added significant numbers to its cadre of ASHA Facilitators (raising it from 1672 to 1961 – against the target of 2290). Madhya Pradesh has planned to increase the target for ASHA Facilitator from 3991 to 5045 and has selected 4005 facilitators, however the increased target will be proposed in PIP 2017-18.

The support structures in the eight North-East states remain at the same level, with no major additions seen. Sikkim continues to have support cadre dedicated for ASHA programme at state and sub block level, but DPM and BPM units under NHM provide support at district and block levels. Arunachal Pradesh, Assam and Tripura continue to be only three states with support cadre in place at all four levels (from state to sub-block level). Three NE states have seen drop-out at DCM level - Arunachal Pradesh (from 20 to 17 against target of 20), Assam (from 27 to 25 against target of 27) and Meghalaya (from 11 to 10 against target of 11).

In Non High focus states, most states have set up support structures at three to four levels. These are Karnataka, Haryana Maharashtra, Punjab and West Bengal. Haryana has recently re-selected the ASHA facilitators after receiving approvals in ROP 2016-17 (which state had to discontinue because of non-availability of PIP approvals). So far, state has selected 618 ASHA facilitators against the target of 900. States like Andhra Pradesh, Delhi, Gujarat, Himachal Pradesh, Jammu & Kashmir, Kerala, and Telangana use a mix of dedicated and exiting staff to manage the ASHA programme. However over the past few years, these states have invested in clarifying roles of existing cadres and setting up performance monitoring mechanisms.

Status of formation and functionality of State ASHA Mentoring Group (AMG) has remained unchanged, with very little progress across all states. The number of meetings and the pattern of their regularity indicate inability of states to make effective use of this critical advisory platform. Only one state, i.e, Jharkhand has reported conducting a meeting of its AMG in last six months.

Table 4 : High Focus States

State	State Level	District Level	Block Level	Sector Level
Bihar	State AMG constituted in July 2011, only one meeting held in Feb 2011. ARC set up and registered, as a separate society accountable to State Health Society. Seven members team of ARC and 9 out of 12 Divisional Coordinators currently in position. State trainers– Round 1 – 28, Round 2 – 22. Round 3 – 13.	12/38 District Community Mobilisers in place District Trainers – Round 1 -803, Round 2 – 532, Round 3 – 190.	277/534 Block Community Mobilisers in place	4123/4470 ASHA Facilitators in place, (1 per 20 ASHA).

State	State Level	District Level	Block Level	Sector Level
Chhattisgarh	AMG Not established. ARC is working under SHRC with a team of 6 programme coordinators led by a team leader. 2 programme associates in place for NUHM State trainers– 46 and State Trainers for NUHM - 6	35 District Coordinators in place in 27 districts (2/district in some outreach districts). NUHM – 3/4 District Coordinators in place District trainers– 3551	292/292 Block Mobilisers in place for NRHM and 25/25 Block Coordinators for in place for NUHM	3150 /3220 Mitanin trainers (AFs) in place, (1 per 20 ASHAs). Under NUHM- 202/204 Mitanin trainers (AFs) in place (1 per 20 ASHAs).
Jharkhand	State AMG constituted in 2012 and reconstituted in 2013. 9 meetings held, last meeting in November 2016. Community Mobilization Cell/ARC works within the SPMU with a team of two consultants. State trainers– Round 1 – 13, Round 2 – 13. Round 3 – 12.	21/ 24 District Programme Coordinators in place. District Trainers – Round 1 -417, Round 2 – 474, Round 3 – 185	688/776 Block Trainers &DRPs in place	2190 /2200 Sahiyaa Saathi in place (1 per 20 Sahiyas)
Madhya Pradesh	State AMG formed in Oct 2008, later on merged with MGCA. 23 meetings held. Last meeting in April 2016. ARC team led by State Nodal officer with 4 team members. State trainers - Round 1 – 41, Round 2 – 39, Round 3 – 25	39 /51 District Community Mobilisers in place District MGCAs formed. District Trainers – Round 1 - 496, Round 2 – 300, Round 3 -300	248/313 Block Community Mobilisers in place, MGCAs in place in 313 blocks.	4005 / 3991 ASHA Facilitators place (1 for 10 ASHAs in tribal areas, and 1 for 2 sub centres in other areas)
Odisha	State AMG constituted in 2009, 4 meetings held, last meeting in 2012. Community Processes Resource Centre (CPRC) in place with a team of 4 consultants, 5 training coordinators and 1 programme assistant State trainers– Round 1 – 26, Round 2 – 21. Round 3 – 11.	30/30 District Community Mobilisers in place District AMGs constituted. District Trainers – Round 1 -287, Round 2–166, Round 3 - 166	Existing Block PMU staff manages the programme	1961/2290 Community Facilitators (AFs) in place. (1 per 20 ASHAs)
Rajasthan	State AMG constituted in June 2006, last meeting held in Sep 2011 Team of two consultants working in SPMU. State trainers– Round 1 – 20, Round 2 – 25, Round 3- 23	25/34 District Community Mobilisers in place. District Trainers –Round 1 – 745, Round 2 – 587, Round 3- 570	166/249 Block ASHA Coordinators in place	1085 / 2088 PHC ASHA Supervisors in place (1 per PHC)
Uttar Pradesh	State AMG constituted in Aug 2008, last meeting held in March 2016. Community Processes Division led by a Nodal officer works within SPMU, with a team of 10 Consultants. State trainers – Round 1 – 61 and Round 2 - 46	71 / 75 DCMs in position. 72 Districts have District AMGs. District Trainers, Round 1 – 2622	759 / 820 Block Community Mobilisers in place	5971 / 6815 ASHA Facilitators in position. (1 per 20 ASHAs)

State	State Level	District Level	Block Level	Sector Level
Uttarakhand	AMG constituted in 2009, 26 meetings held, last meeting in May 2016. State has one Nodal Officer & 2 programme managers in SPMU. State trainers– Round 1 – 6, Round 2 – 6. Round 3 - 2.	District ARCs outsourced to NGOs. 13 / 13 DCMs in place. District Trainers Round 1 - 165, Round 2 -156, Round 3- 75	101 / 101 Block Community Mobilisers in SPMU, in place NUHM – 6 BCMs in place	606 / 606 AFs in place (550 rural, 56 urban - 1 per 15-20 ASHAs)
North Eastern States				
Arunachal Pradesh	State AMG constituted in Jan 2010, 9 meetings held, last meeting held in Aug 2015. ARC – 3 members team within SPMU. State trainers– Round 1 – 3, Round 2 – 2. Round 3 - 3.	17 /20 District Community Mobilisers in place District Trainers – Round 1 - 22, Round 2 – 28. Round 3 – 28	84 /84 Block Community Mobilisers in place	348/348 ASHA Facilitators in place (1 per 10-15 ASHAs)
Assam	State AMG constituted in 2010-11, 8 meetings held. Last meeting held in Jan 2016. ARC housed in SPMU, with 1 Programme Manager - ASHA, and 1 State Community Mobilizer in place. State trainers - Round 1 - 17, Round 2 - 12. Round 3 - 7.	25/27 DCM in place District Trainers - Round 1 - 447, Round 447 – 28. Round 3 – 437	149/ 149 Block Community Mobilizers in place	2878/ 2878 ASHA Facilitators in place (1 per 10 ASHAs).
Manipur	State AMG constituted in Dec 2008, 11 meetings held, last meeting held in May 2014. ARC led by State cadre officer, housed within SPMU, has 1 ASHA Program Manager, and 1 DEO. State trainers - Round 1 - 3, Round 2 - 3. Round 3 - 3.	9/9 District Community Mobilizers in place. District Trainers - Round 1 - 62, Round 2 - 62.Round 3 – 62	Existing BPMU staff	192/194 ASHA Facilitators in place (1 per 10 to 20 ASHAs).
Meghalaya	AMG formed in Oct 2009. 6 meetings held. Reconstituted recently, last meeting held in Sep 2014. ARC in place, within SPMU with 2 programme managers. State trainers - Round 1 - 3, Round 2 – 3, Round 3 – 2.	10/11 District Community Process Coordinator in place District Trainers - Round 1 - 70, Round 2 – 65, Round 3- 65	Existing BPMU staff	312/334 ASHA Facilitators in place (1 per 20 ASHAs)
Mizoram	State AMG constituted in April 2008, 9 meetings held, last meeting held in Sep 2015. ARC team within SPMU, with a team of three consultants. State trainers - Round 1 - 3, Round 2 - 2. Round 3 – 4.	9 /9 District ASHA Coordinators in place District Trainers -Round 1 - 18, Round 2 – 18, Round 3- 18	Existing staff	109 /109 ASHA Facilitators in place. (1 per 10 ASHAs)
Nagaland	AMG formed in Nov 2009, 5 meetings held, last meeting in Aug 2013. ARC housed under SPMU. State trainers - Round 1 - 1, Round 2 – 2, Round 3 – 2	11/11 District Community Mobilisers in place District Trainers - Round 1 - 63, Round 2 – 63, Round 3- 11	68/68 Block ASHA Coordinators (BACs) in place.	Block ASHA Coordinators provide field level support role

State	State Level	District Level	Block Level	Sector Level
Sikkim	State AMG constituted in 2010, 2 meetings held - 2, last meeting in November 2014. State trainers - Round 1 - 2, Round 2 – 3, Round 3 – 3.	Existing DPMU staff District Trainers - Round 1 - 11, Round 2 – 11, Round 3 – 11.	Existing BPMU Staff	71/71ASHA Facilitators in place, (1 per 10 ASHAs)
Tripura	State AMG constituted in May 2008, 8 meetings held, 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 District ASHA Coordinators in place (4 DACs in original 4 districts and 4 Sub Divisional Coordinators acting as DAC in newly formed district). District Trainers - Round 1 - 65. Round 2 - 87. Round 3 – 89	8 /11 Sub-division level ASHA Coordinators in place	399/ 400 ASHA Facilitators in place.

Non- High Focus States

Name of State	State Level	District Level	Block Level	Sector Level
Andhra Pradesh	AMG constituted in May 2015. Functions of ARC managed by a team based in SPMU and Directorate. State trainers - Round 1 - 9, Round 2 – 9, Round 3- 11.	13 /13 District Community Mobilisers in place Project Officer, District Training Team (P.O.DTT) and District Public Health Nursing Officer (DPHNO) also support the programme District Trainers – Round 1-285, Round 2-285	225/225 PHNs designated as Block Community Mobilisers s.	1410/ 1410 Health Supervisors at PHC play the role of ASHA Facilitator
Delhi	State AMG formed in July 2010, 6 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 - 29, Round 2 – 29, Round 3- 59.	10/ 11 District ASHA Coordinators in place District Mentoring Group also in place. District Trainers - Round 1- 255, Round 2- 261 and Round 3- 318.	113 ASHA Units (One unit per 50,000 population.) in place. Each unit has Unit Mentoring Group composed of 4-5 members. 1005/ 1123 ANMs designated as ASHA mentors in place	
Gujarat	State AMG Constituted in Aug 2011, 5 meetings held, last meeting in March 2015. ARC working under the office of Rural Health Department under Commissionerate of Health Office with 2 consultants. State trainers - Round 1 - 7, Round 2 – 7, Round 3- 7.	Existing DPMU staff leads the programme 33/33 Programme Assistants - ASHA in position. District AMG formed in 24 districts District Trainers - Round 1 – 160, Round 2 – 59, Round 3 – 19	Existing BPMU staff	3489/3751 ASHA Facilitators in place (1 per 10 ASHAs).

Name of State	State Level	District Level	Block Level	Sector Level
Haryana	AMG not constituted. ARC in place within the SPMU with 7 members team. State trainers - Round 1 – 22, Round 2 – 18, Round 3 – 14	20/ 21 DACs in place District Trainers – Round 1- 438, Round 2-	104/113 BACs in place. Block ASHA Coordinators in place.	618/900 ASHA Facilitators in place.
Himachal Pradesh	State has started ASHA programme in FY 2014-15. One ASHA Nodal Officer works within SPMU. State trainers - Round 1 – 23, Round 2 – 23,	Existing staff lead with support of 12/ 12 District ASHA Coordinating Assistants. District Trainers - Round 1 – 260, Round 2 – 260	Existing BPMU staff	Existing staff - Female health worker playing role of ASHA Facilitator.
Jammu & Kashmir	State AMG established in 2012-13. 1 ASHA Nodal Officer and 1 state ASHA Coordinator placed within SPMU. State trainers - Round 1 – 15, Round 2 – 12, Round 3 – 9	Existing staff. Total 22/22 in number. District Trainers – Round 1 – 225, Round 2 – 190.	Existing staff - Community Health Officer / ANMs / LHVs designated to support ASHA programme (117/117)	811 / 816 – existing cadre of ANMs/LHVs designated to support ASHA programme - 1per 10 ASHAs in Hard to Reach blocks (44) and 1 per 20 ASHAs in other blocks(73).
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 - 10, Round 2 - 8. Round 3 - 5.	25 / 30 District ASHA Mentors in place. District Trainers- Round 1 – 206, Round 2 – 194, Round 3 – 194.	160 / 176 Block Mobilisers in place One District Trainer known as ASHA Mentor supervises ASHAs of two blocks	1588 / 1800 ASHA Facilitators in place
Kerala	State AMG constituted in 2008, 7 meetings held, last meeting held Dec 2014 State ASHA Team with one Nodal Officer and consultant based within SPMU. State trainers – 7.	13 / 14 District ASHA Coordinators in place District Trainers – 36.	Existing staff -200/214 block level staff engaged.	Existing staff– Junior Public Health Nurse.
Maharashtra	State AMG constituted in Oct 2007, total meetings held – 5, last meeting held in July, 2013 One Nodal Officer-ASHA and one consultant work as ARC team based within SPMU. State trainers –Round 1 - 15, Round 2 - 13. Round 3 – 13.	31/34 District Community Mobilisers in place. District AMG formed in all districts. District Trainers - Round 1 - 1476, Round 2 – 1404, Round 3-1380.	326/355 Block Community Mobilisers in place. Block AMG formed in 70 tribal blocks and in 281 Non-tribal blocks	2804 / 3562 AFs in place. 1 per 10 ASHAs in tribal and 1 per 20 in ASHAs non- Tribal districts).

Name of State	State Level	District Level	Block Level	Sector Level
Punjab	State AMG constituted in Oct 2014. One meeting held in Oct 2014. One consultant working in SPMU. State trainers –Round 1 - 5, Round 2 - 7. Round 3 – 6.	13 / 22 District Community Mobilisers in place. District Trainers Round 1 - 307. Round 2– 305, Round 3 - 302	Existing Staff (Block Extension Educator working as BCM in many places)	857 / 898 ASHA Facilitators in place
Tamil Nadu	State AMG not formed, but NGOs are involved in ASHA support. Institute of Public Health, Poonamallee is working as ARC.	Existing staff (DPMU and Deputy Director of Health Services and District and Maternal and Child Health Officers (DMCHO)	Existing staff - Community Health Nurse	Existing staff - Sector Health Nurse
Telangana	State AMG formed in May 15 but meetings not held. ASHA Resource Team has 2 programme managers. State trainers –Round 1 - 4, Round 2 – 4, Round 3-8	31 DCM positions approved. Recruitment not done. District Trainers – Round 1 - 326. Round 2– 326. Round 3– 29.	Existing BPMU staff CHO/PHN coordinates the works at block level.	702 /1387 Multi Purpose Health Supervisor (MPHS-F), 1 per PHC designated as ASHA Facilitator.
West Bengal	State AMG formed in Sep 2010, total 4 meetings held, last meeting held in Dec 2011. Programme managed by two consultants within SPMU. Training is managed by Child In Need Institute (CINI). State trainers - Round 1 - 22, Round 2 - 18. Round 3 – 12.	22 /26 DCMs in place District Trainers – Round 1 - 1377. Round 2– 1016, Round 3 - 82	413 / 666 BCMs in place (2 per block).	Existing staff (Health Supervisor at Gram Panchayat level) supports ASHA programme

Union Territories

Name of UT	State Level	District Level	Block Level	Sector Level
Andaman & Nicobar Island	Programme managed by SPMU	Existing staff	Existing staff	Existing staff
Chandigarh	UT has started ASHA programme in FY 2014-15. Nodal Officer– NRHM is in-charge of ASHA programme and VHSNC	Existing staff	Existing staff	Existing staff
Dadra and Nagar Haveli	Programme managed by SPMU	Existing staff	Existing staff	Existing staff
Daman and Diu	Programme managed by SPMU	Existing staff	Existing staff	Existing staff
Lakshadweep	Medical officer is in-charge of Island is the nodal officer for the Programme	Existing staff	Existing staff	Existing staff

Section

3 Findings from recent studies

In this section, we present the key findings from two recent studies Time Use Study of ASHAs conducted in Jharkhand and Delhi and Evaluation of the ASHA programme in Jammu & Kashmir.

Time Use Study – Jharkhand and Delhi

Background

Over the past 12 years ASHAs have emerged as an important human resource at the community level, as the key frontline health worker who is able to deliver health services at the village level, even in the most remote areas and to the marginalized. With the increase in number of tasks being undertaken by ASHAs commensurate with new initiatives, and the recent policy initiative to strengthen the Comprehensive Primary Health Care services where ASHA is viewed as a key member of the primary health care SHC team, it is important to understand how ASHAs use their time vis-a vis their current work load.

Currently, most data available on time spent by ASHAs, is obtained from large scale evaluations or field reviews. For instance, the findings of ASHA evaluation conducted in eight states in 2011, showed that 61% to 87% of ASHAs reported that they spend three to five hours per day on ASHA work. Research has been conducted to assess how other Frontline workers like ANMs in India and Community Health Workers in countries like Cameroon, Ethiopia and South Africa, utilize their time with respect to their tasks. However, no such study has been conducted for ASHAs so far. With this background, a Time Use study was conducted in two states of Jharkhand and Delhi in the year 2016-17.

Methodology

Key objectives of the study were to assess the - amount of time spent by ASHA to complete her tasks, to understand the range of activities and to assess the inputs received by an ASHA that are essential for her functionality. The study was qualitative in nature and used data collection methods including direct continuous observation for a fixed duration, in-depth interview of selected ASHAs and FGDs with other ASHAs of that PHC. The states of Delhi and Jharkhand were selected to capture divergences in contexts, namely rural and urban. Delhi was selected as it has the longest experience of implementing the ASHA programme in urban areas. State of Jharkhand was selected as it presented diversities, both in terms of geographical dispersion and health indicators. The selection criteria for ASHAs were - experience as an ASHA for five years or more and trained in first round of Module 6 & 7.

Though the key objectives and study design was same in both states, a larger sample was studied in Jharkhand and duration of direct observation of ASHAs was increased from 3 days (in Delhi) to 5 days in Jharkhand. Box 1 summarizes the sample size used in both states –

Delhi	Jharkhand
❖ 1 district ❖ 2 ASHA units ❖ 4 sub unit urban health centres ❖ 4 ASHAs each from sub unit urban health centre **Observed for 3 fixed days (total 12 days)** ❖ Total of 4 ASHAs observed & interviewed ❖ 2 FGDs: each in one main ASHA unit	❖ 2 districts: Palamu and Simdega – selected based on RCH indicators ❖ 4 blocks: nearest & farthest from district head quarters ❖ 8 villages: nearest & farthest from block head quarters ❖ 8 ASHAs – one from each village **Observed for 5 fixed days (total 40 days)** ❖ 4 FGDs: one per block ❖ Support staff interviewed: AF-8, BTT-6, STT-2, DPC-2.

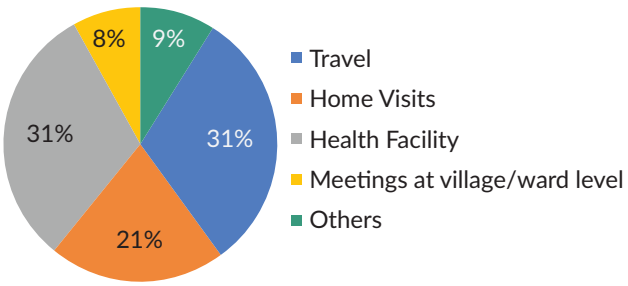
Key Findings

The time spent by ASHAs during the observation days was used to estimate the total time spent, average time spent and proportion of time spent on different activities. Though the study captured data on various components, in this section we report only key findings pertaining to time utilization by ASHAs.

Jharkhand

The total (cumulative) time spent on their work as ASHAs over five days was about 19-28 hours in both districts. The average time spent per day by ASHAs in four blocks of two districts was in the range of nearly 4-6 hrs. Of the total time spent by ASHAs, highest proportion i.e, 31% was spent on health facility visits and travel each, followed by home visits with 21%, village level meetings at 8% and other activities at 9% (*attending VHND, duty at Sahiya help desk and specific filling of register).* The maximum average time was recorded for an ASHA from Medini nagar block of Palamu district while the minimum time of 4 hours was recorded for an ASHA of Simdega Sadar block. These variations were on the account of the nature of activities carried out by ASHAs during the observation period and the geographic terrain where they resided, which varied significantly. For instance, ASHA from Palamu district made numerous health facility visits and thus spent a high proportion of time in travelling as well at the health facilities while the ASHA from Simdega Sadar block lived closer to the block/ district headquarters, which reduced her travel time substantially.

Fig 1.1: Production of total time spent by ASHAs



Most of the ASHAs reported that they work for six days in a week. However, they were available 24X7 on call in case of any emergency. It was observed that most ASHAs plan to finish their work between 9.00am and 5 :00pm, such that they can return home before it gets dark. The work day also included a quick break, when she returns home to prepare lunch for her family.

As anticipated the range of activities undertaken by ASHAs was primarily in the area of RCH, followed by disease control such as supporting Indoor Residual Spray for prevention of malaria and participating in Village Health and Nutrition Days and village level meetings including VHSNC meetings.

Large proportion of time (31% of total time) was spent on travel – which include travel within the village as well as out of the village. The travel time has been categorized and analysed separately to understand the amount of travel that an ASHA has to undertake to perform her activities. Therefore, travel time is not included in the analysis of individual activities like health facility visits and home visits, which only reflect the amount of time that ASHA spent on the task itself. It was noted that ASHAs spent about 20-40% of total time on travelling and in absolute terms total travel time

ranged from 4hr 9min to 11hr 23min. Travel time is dependent on factors like non -availability of transportation facility, large distances between health facility and village, widely dispersed hamlets in the village and mode of transportation used. This variation in findings linked with varying context can be noted in the table below. The data from table shows that about four ASHAs spent almost equal amount of time on travelling within and outside of village while four ASHAs spent higher proportion of time on travelling within their villages.

Travel time	ASHA 1	ASHA 2	ASHA 3	ASHA 4	ASHA 5	ASHA 6	ASHA 7	ASHA 8
Total travel time	7 hr 56 min	5 hr 59 min	10 hr 50 min	11 hr 23 min	7 hr 17 min	6 hr 42 min	4 hr 9 min	10 hr 56 min
a) Within Village	7 hr 28 min	4 hr 28 min	4 hr 40 min	6 hr 41 min	5 hr 2 min	3 hr 20 min	2 hr 40 min	5 hr 39 min
% of total travel time	94.1%	74.7%	43.1%	58.7%	69.1%	49.8%	64.3%	51.7%
b) To health facility	28 min	1 hr 31 min	6 hr 10 min	4 hr 42 min	2 hr 15 min	3 hr 22 min	1 hr 29 min	5 hr 17 min
% of total travel time	5.9%	25.3%	56.9%	41.3%	30.9%	50.2%	35.7%	48.3%

With regard to time spent on key activities, about 31% of the total time was spent by ASHA in visiting health facilities. This ranged from 16% to 54% per ASHA, according to activity carried out during her visit. Majority of visits were made either to Community Health Centre (CHC) or District Hospitals (DH). Most common activity was accompanying pregnant women for delivery(46.3%), attending various meetings (27%) and accompanying pregnant women for antenatal care checkups (16.7%). Reasons for health facility visits also included accompanying sick child or other community members, drug kit replenishment and following up on payment of JSY incentives to beneficiaries. Total time spent at health facility during five days varied from 4 hr 8 mins to 11 hrs 29 mins. The maximum time was spent as waiting time at the health facility during ANC check-ups or institutional delivery, which ranged from 2hrs to 7hrs.

About 12 % of the total time was spent on home visits over five days. Total time spent on home visits by ASHAs ranged from 2hrs 41 mins to 8hrs 30mins and total number of households (HH) visited ranged from 11 to 53, over five days. Proportion time spent per day on home visits by ASHAs ranged from 8% to 34% of their time. Table below highlights the variation time spent on household visits. Similar to the finding of health facility visits, time spent on home visits depended on type of activities undertaken by ASHAs during the visit, scatter of households within the village and also on the proportion of time spent on health facility visits. It was noted that ASHAs who spent a larger percentage of time on health facility visits and attending meetings at village level, were spending less time on home visits. This was noted in two cases, namely ASHA 3 and 7. As anticipated, the primary focus of the home visits was on provision on services related to maternal, newborn and child care and family planning. In some cases, ASHAs also performed activities related to disease control.Eg- one ASHA visited total of 53 households during five days, of which 41 were visited to facilitate indoor residual spray of DDT as part of malaria control drive in the village.

ASHA ID	Total time on home visit (5 days)
1	5 hr 27 mins
2	5 hr 40 mins
3	2 hr 41 mins

ASHA ID	Total time on home visit (5 days)
4	3 hr 44 mins
5	6 hr 39 mins
6	8 hr 30 mins
7	5 hr 2 mins
8	3 hr 22 mins

ASHAs also participated in village level meetings, which was about 8% of their total time. (ranged from 0-18%). These village level meetings included VHSNC meetings, panchayat level meetings, Sahiya Maitre Bhaitak and SHG meeting etc. Field observations highlighted the important role played by ASHAs during these meetings, as community representatives to highlight important issues pertaining to their coverage area/ villages.

In addition to home and health facility visits and village level meetings, the other activities which ASHAs performed were – managing the Sahiya help desk, participating in VHNDs and record filling etc. These accounted for 9% of their total time (0-21%) and ranged from 15 mins to 3 hr 52 mins. Time spent per VHND or Sahiya help desk ranged 3 hrs to 4 hrs while very little time was spent on record keeping. ASHAs shared they prefer to fill their formats during home visits and their registers/ records during the weekly report submission or prior to monthly meetings.

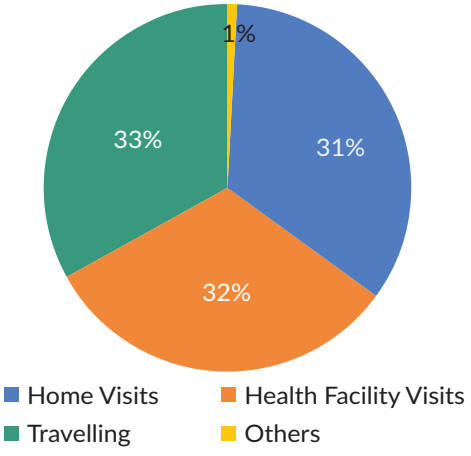
Delhi

Total time, as observed over three days, spent by four ASHAs ranged from about 2 hrs to 12 hrs. The average time varied from 1 hr to 4 hrs. Out of the total time, about 34% was spent on home visits, followed by 33%on travelling (within the catchment area and outside) and 32% on health facility visits and less than 1% on other activities.

The proportion of time an ASHA spent on home visits ranged from 9%- 63%. In absolute terms, it was about 1 hr to 3hrs. Major focus of the household visits was to provide Maternal and Child Health care services but some ASHAs also updated the household survey during the observation. Thus, it was observed that the ASHA (4), who spent the maximum of 3hrs on home visits, spent a high proportion of time on survey updation.

Higher proportion of time spent on travel (30% of the total time) contradicts the perception that ASHAs in urban areas require relatively less time for travel due to densely populated areas and close proximity to health facilities. This ranged from 28-35% of the total time per ASHA i.e, 36 mins to nearly 4 hrs total travel time. The ASHA who spent the maximum time of 4hrs on travelling was mainly on account of her visit to the tertiary care hospital for ANC visits with pregnant women. Two out of four ASHAs also participated in review meeting and refresher training at the dispensary during the observation, leading to the travel time of about 30 mins to 1 hour. The time spent within the coverage area was in the range of 28 mins to 2 hours, which varied according to the activity undertaken and scatter of population. Eg- two out of four ASHAs conduced household survey during the study, spending about 1hr on travelling to cover the entire catchment area, while one ASHA served a relatively scattered population and had

Proportion of total time spent by ASHAs



to travel larger distance each day compared to other three ASHAs.

Nearly 32 % time was also spent on health facility visits (ranging from 9-56%). This translates to 14 mins to 6 hr 37 mins on account of participation in refresher training and review meeting at dispensary and accompanying pregnant women for ANC and delivery during the observation days. Significant amount of time (1 hr -2 hrs) was recorded as waiting time during ASHA's visits at the health facility.

Discussion

The findings from Jharkhand indicate that in a setting of moderate performance level of RCH indicators and caseloads, across tribal and rural settings, ASHAs on an average spend about 4-6 hours per day on ASHA related work. While in case of urban setting of Delhi, the average time spent is in the range of 1-4 hours per day. However, in both settings, ASHAs reported that they are on call 24x7 for community members.

In terms of planning for their work, ASHAs in both states displayed effective organizational skills which helped them in completing the wide range of tasks efficiently. All ASHAs maintained a calendar of all pre-scheduled activities like meetings, ANC visits, HBNC visits, Immunization days and Sahiya help desk duty etc. Home visits were planned as per the schedule. However houses with any sick person/ child who needed immediate attention and pregnant woman with approaching EDD were prioritized. While planning for home visits, distance of the beneficiary's house from ASHA's house also acted as a critical factor, as all ASHAs preferred to cover the farthest house first such that they can return home in the evening. Since the data collection for Delhi and Jharkhand was conducted during the month of Ramzan and monsoon season respectively, it was noted that during such special occasions where local rituals were followed, ASHAs often changed their visit timings as per the convenience of beneficiaries as well for themselves. Such planning and coordination between ASHAs and community allowed them to effectively complete their work.

However, the large proportion of time that ASHAs have to spend in travel (nearly one third of their time) emerges as an area of concern. It was observed that ASHAs also faced several challenges while travelling, which included safety concerns especially when travelling during odd hours, high amount of expenditure being borne by ASHAs and unavailability of proper transport.

Overall the findings of average time spent per day conform with the guidelines, that suggested that ASHAs would work for 3-5 hours per day. The guidelines also suggest that ASHAs would work for 3-5 days per week but in practice it was observed that ASHAs worked for a minimum of five-six days per week, keeping Sundays and festivals as "off days". Even on these days they reported as being on call.

Key Findings from ASHA Evaluation Jammu & Kashmir

The fourth round of the ASHA evaluation was conducted in three states in the year 2015-16 in Jammu & Kashmir and in Mizoram and Tripura in 2016-17. In this section, we are presenting the key findings from Jammu and Khasmir. Findings from the first three rounds of evaluation conducted in sixteen states have been shared in previous updates. The fourth round of evaluation also adopted the Realist approach and used a mix of qualitative and quantitative methods for data collection. Phase 1 of the evaluation was qualitative where in depth interviews were conducted with all the stake holders. Phase 2 of the evaluation was quantitative where interviews were conducted with ASHAs and with two categories of service users who received services from ASHAs (A- Women who had delivered in last six months and B – Children between 6.1 months–2 years of age who had any episode of illness during last one month) and also nonservice users from these categories i.e, potential beneficiaries who did not get services from ASHAs. In addition, structured interviews were also conducted with AWW, ANMs and PRI representatives.

Key findings

The programme was launched in the year 2006 in the state. Currently the target of ASHAs is about 12,000, against which 11,735 were in position at the time of evaluation. State has taken a policy decision to fix the target set for ASHA selection in the state. Since J&K is a hilly state with a high proportion of area being a hilly and difficult terrain, this decision has affected the coverage of ASHAs. Though the decision was taken to keep the process of selection transparent, following few episodes on political influences in nominating ASHAs for difficult villages which did not have a resident ASHA. Thus, at present there are 5-10% ASHAs who are not considered part of the formal ASHA figures and are known as "Surplus ASHAs" at local level. These ASHAs continue to receive programme based incentives but they do not receive the routine and recurring incentives. District and block officials also expressed the need of additional ASHAs to cover the difficult villages (usually with small population) as the practice of linking these areas with ASHAs from neighbouring villages is not adequate to improve health care access of the residents. This is a major concern for coverage of nomadic tribes and seasonal migrants in the state.

The support structures for ASHA programme have been created utilizing the existing staff of the health system at all levels. Therefore, ANMs play the role of ASHA facilitator at SHC level, block coordinators are nominated by BMOs at block level and district coordinators are nominated by CMO at district level. These officials also receive small token honorarium for these additional tasks that they are expected to undertake by devoting four days every month for ASHA programme. Though this has led to an increased ownership of the ASHA programme at all levels, the support staff, with their existing roles and responsibilities find it difficult to balance the dual roles and support the programme effectively. The officials at block and district level and ANMs at SHC level, expressed the need for better allocation of work which would allow them to invest more time in supporting the ASHA programme through more field visits. State has implemented the performance based ten indicators for ASHAs which are also used to review the performance of districts on a regular basis. However, variation in understanding and interpretation of the indicators was noted across block and districts.

Training of ASHAs in Module 6 &7 was launched in the year 2011-12, but slow pace of training was evident since state has been able to complete only two (combined as one round -10 days of training) out of four rounds of ASHA training. District officials shared that the gap between two rounds of TOT has also been very long, as the round 2 TOT was completed about two years ago while round 3 TOT is yet to start.

Payment process of incentives is yet to be streamlined and delay of 2-3 months in payment was common in both the districts. Delays were more common for incentives of HBNC, immunization and routine and recurring tasks. Lack of clarity about pooling of incentives approved under different programme budgets for ease of payments and delay in release of funds from state to district level, emerged as the major bottlenecks for timely payments.

Table 1.1 Indicator	Jammu & Kashmir (%)	Baramulla (%)	Reasi (%)
Access to ASHA services of potential Service User A	91.3	88.4	94.8
% of service user A who were visited at least thrice by ASHA during antenatal period	95	92.4	96.7
% of user A who were helped by ASHA in making a birth plan	91.5	92.1	91
% of user A who had complication during pregnancy and sought ASHA's advice for treatment	83.5	83.2	84.1
% of service users A who received three ANCs or more	93.9	93.2	94.3

Table 1.1 Indicator	Jammu & Kashmir (%)	Baramulla (%)	Reasi (%)
% of service users A who went for institutional delivery	83.5	98.2	73.3
% of Service User A who went for institutional delivery and cited ASHA as a motivator	93.7	92.3	94.9
% of Service users who had any maternal complication and sought treatment	98.8	100	96.8
% of ASHAs who said that they would refer a pregnant woman immediately to the institution in case of bleeding from vagina	91.1	92.2	90.1
% of ASHAs who said that they would refer a pregnant woman immediately to the institution in case of loss of foetal movements	57.1	52	62.4
% of user A who were visited at least six times by ASHA during post-natal period	20.2	21.8	19.2
% of User A who were breastfed within three hours of birth	91.5	86.6	95.1
% of Service user A who gave no pre-lacteal feeds- exclusive breast feeding on first three days	78.7	79.7	78
% of Service user A with sick new born who sought treatment	99.5	99.2	100
% of service user A who took ASHA's help in seeking care for new born	81.1	79.8	83.3
% of ASHA who knew that new born with less than 2000 gm is a high-risk baby	64	59.8	68.3
% of ASHA who knew that new-born born before 8 months 14 days of pregnancy is a pre term baby	24.6	24.5	24.8

Coverage of ASHAs for service users A was very high and ranged from 88% in Baramulla to 95% in Reasi. The functionality of ASHA was quite high in terms of facilitating antenatal care and institutional delivery. Over 90% of service users reported that ASHAs supported them in making birth plans and visited them over 3 times during antenatal period. Of the 98.2% service user A (274) in Baramulla and 73% (294) in Reasi, over 90% quoted ASHA as the motivator for institutional delivery. Out of 164 respondents who reported having any complication during pregnancy, delivery and postpartum period, 83.5% sought ASHA's advice for treatment. The functionality was however very low in the case of post natal care. About 64% of respondents reported that ASHAs were present at the institution during delivery and 15% mentioned that ASHAs visited on first day after delivery, but functionality for at least six visits during the postpartum period dropped to 21% in both districts. However, in cases of a sick newborn, out of 196 cases, 82% of the respondents sought advice from ASHAs. With regards to skills sets of ASHAs, average levels of skills were noted both in cases of identifying danger signs in pregnant women and in a new born. Thus over 91% ASHAs said that they would immediately refer a pregnant woman in case of bleeding but only 57.1% said that they would refer immediately in case of loss of foetal movements. In case of assessing a new born as high-risk baby 64% ASHAs knew that newborns weighing less than 2000gm are high risk but only 25% said that a newborn born before 8 months 14 days is at high risk. ASHAs effectiveness in terms of access to care for service users was very high i.e, more than 90% for ante natal care, 83% for institutional delivery, 99% in seeking care for maternal complications and for a sick new-born.

ASHA's coverage in cases of service provision to children who had any illness in last one month was also very high. (91% in Baramulla and 99% in Reasi). In cases of symptoms of diarrhoea and ARI, over 90% of services sought ASHA's advice and received support from her in seeking care, indicating high levels of functionality. Access to care was also found to be good as almost

all children received treatment (97% in cases of diarrhoea and 100% in ARI). Though overall 97% children with diarrhoea received ORS, ASHAs could provide ORS only to 61% children in Baramulla and 43% in Reasi. This reflects the frequent stock outs of ORS with ASHAs, validating the finding of adhoc replenishment processes highlighted in phase 1. The skill of ASHA in terms of knowledge of making ORS was at average levels with 64% who could specify correct steps of preparation of ORS at home. While 62% ASHAs said that they would advise for continued feeding in case of diarrhoea, only 8% said that they would advise the family to increase the fluid intake of child. In case of identifying a child suffering from ARI, 56% ASHAs could correctly tell that chest wall indrawing is a danger sign to suspect pneumonia.

Table 1.2 Indicator	Jammu & Kashmir	Baramulla (%)	Reasi (%)
Coverage Service User B	99	90.7	99.4
% of user B who had diarrhoea and whom ASHA helped in some way	92.5	93.5	91.8
% of user B with signs of ARI and whom ASHA helped in some way	96.2	98.1	92.3
% of user B who had diarrhoea and to whom ASHA gave ORS from her kit	50	61.3	42.9
% of user B with diarrhoea and who overall got ORS	96.3	96.8	95.9
% of user B with ARI who sought treatment	100	100	100
% of ASHA had knowledge of making ORS	64	62.8	65.4
% of ASHA had knowledge of advising fluid intake in case of diarrhoea	8.4	9.8	6.9
% of ASHA had knowledge of advising continued feeding for the child who had diarrhoea	61.6	52	71.3
% of ASHA who could specify chest wall indrawing as a danger sign to suspect pneumonia	55.7	54.9	56.4

As the coverage of ASHAs for both categories of services users was found to be over 90%, very few respondents could be interviewed as Non service users i,e 34 as Non Service Users A and 110 as Non Service Users B against the target of 200 in each category from both districts. Over 60% respondents from both category could correctly tell name of the ASHA while 70% of the non-service users B reported interacting with ASHAs as compared to only 38% of non-service users A.

Out of 110 non-service users B, 40% felt that ASHA did not want to visit (34% Baramulla and 53% in Reasi) while 43% said that they did not want ASHAs to visit them. Of the respondents who said that ASHAs did not want to visit them, nearly 60-70% shared that it was because of their low socio-economic status and only 16% in Reasi said that this was on account of long distance. On the other hand among the respondents who said that they did not want ASHAs to visit them, about 57.4% (67% in Baramulla and 27% in Reasi) said that they do not services from ASHAs as they directly seek care from private sector, about 34% (28% in Baramulla and 55% in Reasi) felt that ASHAs were not equipped to respond to their needs, 15% (11% in Baramulla and 27% in Reasi) reported the reason of bad experience of their friends/relatives with ASHAs while 18% in Reasi reported their own bad experience as the one of the main reasons. Similar findings were also noted among the non service users A about seeking services from ASHAs.

Among the Non-service users B, 56% children were immunized at PHC level while 5% got the immunization at private clinic compared to only 11% who received immunization at VHND and 27% at SHC level. In case of childhood illness 38% sought care at private clinic (44% Baramulla and 25% Reasi). This is reflected in the high OOPE on treatment of childhood illness of more than Rs. 1000 reported by 59% in Baramulla and 25%

in Reasi and Rs. 500-1000 in 37% of the cases. In contrast to the high access to care in case of childhood illness, about 50% of the non-service users A reported home deliveries, 18% got less than 3 ANC check ups, about 47% reported high OOP of over Rs. 5000 on delivery services (65% in Baramulla and 21% in Reasi) and about 38% were not aware about JSY (45% in Baramulla and 29% in Reasi). In terms of newborn care, 91% gave pre-lacteal feeds (95% in Baramulla and 86% in Reasi). In case of sick newborn (13) about 46% sought care in private sector (56% in Baramulla and 25% in Reasi) with high OOP of over 500 was reported by 85% (89% in Baramulla and 75% in Reasi). Findings of low access of services from ASHAs on basis of socioeconomic status and high utilization of private sector and high out of pocket expenditure, among group of non-service users where 66% respondents reported average family monthly income of less than Rs. 5000 pm are major areas of concern.

Overall the findings from evaluation indicate high levels of functionality of ASHAs. However, findings also highlight the need for regular refresher training and better on the job mentoring support. Despite high levels of coverage, findings from non-service users reflect the need for improved sensitization on the issue of vulnerability. The state also needs to review the issue of difficult areas still not having a resident ASHA. State's effort of utilizing existing staff for supporting the ASHA programme has been applauded as one of the good practices, especially in context of Non High Focus states. The findings, however show gaps in this arrangement at field level. The principal gap is the current workload of exiting staff and thier ability to allocate time to ASHAs.

Section

4 Key findings from Tenth Common Review Mission

This section provides summary of findings and recommendations on Community Processes made by the 10th CRM across 16 states and UTs- Andhra Pradesh, Arunachal Pradesh, Bihar, Chandigarh, Delhi, Gujarat, Himachal Pradesh, Jammu & Kashmir, Jharkhand, Kerala, Madhya Pradesh, Maharashtra, Tamil Nadu, Tripura and Uttar Pradesh.

Of the 16 States visited during the Tenth Common Review Mission, eight belong to theNon-High Focus state category, three to the North-East, one Union Territory and the remaining three to the High Focus States. Of the community processes component, the state of Chandigarh has ASHA in urban areas, and Tamil Nadu has ASHA in selected tribal blocks/pockets. In Himachal, the ASHA programme is still at a relatively nascent stage. Village Health, Sanitation and Nutrition Committees (VHSNCs) are however expected to be formed and be made functional across States, as are the Rogi Kalyan Samities (RKS). The Terms of Reference for state teams visiting the States, therefore covered key details of all three components.

Overall the picture that emerges from the state reports is that of a motivated ASHA and acknowledgement among programme managers that the improvement in indicators related to immunization, increased institutional delivery and indeed increased care seeking behaviour is on account of the facilitatory role played by the ASHA. There is also increasing ownership of the ASHA by the health system, and visualization of the ASHA as a key community resource, valued for her facilitatory role. The other two roles, emphasized in design and training content, of activist/social mobilizer and community care provider are yet to be fully realized. A related overarching finding is the high variability in skills among ASHA related to nutrition, family planning, danger sings in pregnancy, and signs of sickness in new-borns and children. Unsurprisingly there also appears to be a strong positive correlation between the high training frequency and the knowledge and skill levels of the ASHA.

As the following sections demonstrate, the implementation of the programme at district and sub district levels, the manner in which it is supported at state and district levels, the capacity for application of field learning and changing contexts, particularly in non-high focus States, by senior programme mangers requires substantively greater effort. This is needed in order to fully realize, not just the potential of the ASHA, but also of the broader community level mechanisms that encompass the National Health Mission's (NHM) community platforms for public participation, the VHSNC and the RKS and the outreach health care components.

Regarding the VHSNC and RKS, the findings demonstrate that progress on both components is slow and irregular, although variable. The slow pace has affected convergence for action on social and environmental determinants on which several health outcomes depend. This is a significant missed opportunity and requires concrete actions.

With regard to the Community processes components in the National Urban Health Mission (NUHM), while the functions of selection and training are picking up speed, clarity in the role and support for the ASHA, including low incentive payments and relatively higher rates of attrition need attention.

ASHA Selection and Training

- Overall selection in several States exceeds 90% of the target. However, in Uttar Pradesh, Chandigarh, and Delhi, there is still a shortfall. Intra district shortfalls were noted in Uttar Pradesh, Maharashtra and Andhra Pradesh. In Kerala, a decision was taken despite a significant shortfall, that no new ASHA would be selected, given the widespread availability of Kudumbashree volunteers.
- However, the report from Uttar Pradesh indicate that the ASHAs are covering populations over 1500 or there are several villages in which ASHA selection is pending, either not having been selected at all or because of drop-out. This is particularly an area of concern, since the existing ASHA have to cover populations of over 3000, which is likely resulting in reduced coverage affecting those living on the margins. As RCH indicators improve, last mile coverage becomes expedient, and thus ASHA selection in marginalized areas is important. In remote geographies like Arunachal, ASHAs cover smaller populations. The implications of population coverages reflected in incentive amounts earned. Thus, the UP report which notes high population coverage by some ASHAs, States that, "substantially high amounts of incentive being earned every month by a substantive number of ASHAs warrants that the details of this important trend need to be reviewed". In Arunachal, the report notes that the amount of incentive given in low populations allocated to the ASHA result in small incentive amounts.
- In all States, urban ASHA selection is underway and yet to reach targets. For those selected, induction training is reported to have begun in all States except Uttar Pradesh.
- In rural areas, attrition levels were reported to be lower than 2%, except in the case of Tamil Nadu where attrition levels of about 23% are reported and Madhya Pradesh – 10% (in Dindori). Kerala also reports high attrition. Attrition appears to be higher in urban and peri-urban locations due to better opportunities and insufficient incentives.
- In 2010- 11, the competency based modules (Modules 6 and 7 to be covered in four rounds separated by six to eight weeks) were launched. While most States, except Uttar Pradesh, Himachal and Chandigarh, initiated Module 6 and 7 training for ASHA in FY 11-13, completion of training was reported from Tripura, Arunachal Pradesh, Nagaland, and Kerala. Training lags behind significantly in all other States, notably Bihar, Uttar Pradesh, Andhra Pradesh, Jammu & Kashmir, Madhya Pradesh, and Maharashtra. There is in particular a lag between training rounds, which leads to attrition of skills and knowledge, resulting in poor quality services including counselling by the ASHA. Tripura and Andhra Pradesh report attrition of trainers and in Andhra, reduction in training sites after division of the state, was proffered as a reason for slow progress. Uttar Pradesh and Madhya Pradesh also report a similar problem. In Bihar, the state has not paid the state training agencies, nor selected new district training agencies, as a result of which there is very nearly a standstill of ASHA training. There is also quite a time lag between new ASHAs selection and induction training. This is noted in Delhi, Chandigarh, Uttar Pradesh, and Andhra Pradesh.
- States such as Tripura and Maharashtra have developed innovative methods such as conducting quizzes to assess knowledge and skills of ASHA periodically. This enables regular refresher training of ASHA. From the reports, it appears that only Tripura has undertaken refresher training for its ASHAs.

Support Structures

- Structures to support and mentor the ASHA exists in nearly all States. While several States have recruited new staff at district and sub district levels Andhra, Delhi, J &K, Himachal, TN, Chandigarh, and Kerala, use existing staff such as ANMs or District Public Health Nurses. The state report from UP with the largest number of ASHA, acknowledges that having such a structure in place is critical to laying a strong foundation for the ASHA programme. However, vacancies in support staff at all levels were reported except in Uttar Pradesh. Even in States such as Madhya Pradesh, where the support staff are in place, the orientation and understanding of the staff needed strengthening.
- In Bihar and Jharkhand ASHA facilitators continue to also work as ASHA, despite recommendations from several quarters to the contrary, compromising their functions in both roles. In Uttar Pradesh, which also followed a similar model till recently, the state asked ASHA facilitators to choose between functioning as an ASHA or as an ASHA Facilitator. Most AFs chose to remain as facilitators indicating that they appreciated and recognized the need for effective mentoring of ASHA.
- Several States also recognize effective partnerships between ASHA and ANMs. This is seen in Andhra, Nagaland, J&K and UP. This improved coordination between the two frontline workers results in better outcomes in respect of outreach services. The J&K and the Uttar Pradesh reports also note effective functioning of the triple AAA platform, indicating convergent planning and action between the Health and ICDS departments.
- State ASHA mentoring groups, which are an important support mechanism—are active in Uttar Pradesh.

Incentives

- Most States are now providing both financial and non-financial incentives to the ASHA. Payment mechanism have been streamlined, in most States, with a majority of ASHA now having bank accounts. Most States also report reduced payment delays. However, in Andhra Pradesh delays of between one to three months have been reported. PFMS linkage is reported from Madhya Pradesh, Uttar Pradesh, and through RTGS in J&K. Average monthly incentive amounts ranged from Rs. 2350 in Jharkhand (inclusive of routine and recurring), Rs. 900 in Nagaland, Rs. 1000 in Kerala, plus a state stipend of Rs, 1500, Rs. 1500 to Rs. 2000 in Andhra Pradesh, Rs. 1500 In Tamil Nadu, Rs. 3200 in Tripura including the 33% state provided top-up amount, Rs. 4250 in Anant Nag district of Jammu &Kashmir, Rs. 4000 in Gandhi Nagar, Gujarat, and Rs. 2200 in Navsari, Rs. 2224 in Madhya Pradesh, and Rs. 1358 in Uttar Pradesh. Routine and Recurring incentives have been reported to be provided in Maharashtra, Himachal Pradesh, J&K, UP and AP.
- UP has provided mobile phones to all its ASHAs, mobile talk time to ASHAs in Upper Siang, J&K, ASHA awards in Madhya Pradesh and Uttar Pradesh, and ASHA uniforms in MP and J&K. States such as Maharashtra, Kerala, Jharkhand, Bihar and Madhya Pradesh have provided insurance cover to the ASHA as part of social security schemes.
- States such as Kerala, Bihar, Tripura, Maharashtra and Jharkhand have made provision for preferential selection of ASHA in ANM/GNM training schools. In some States, ASHA are also being promoted to the post of an ASHA facilitator or Block Mobilizer (UP).

Grievance Redressal Mechanism

- Grievance redressal mechanisms are reported from Kerala, Andhra, MP, Maharashtra, Jharkhand, Delhi, and UP. However, systems for feedback and action are yet to be developed in the States visited.

Drug and Equipment Kit

- Most State reports indicate problems with availability and replenishment of drug and equipment kits- Andhra, Delhi, Gujarat, J&K, Nagaland, and Tripura. In Bihar, while replenishment is expected to be from the sub -centre, ASHA did not have any drug supply at the time of the visit. IFA had not been provided for the last two years to ASHA and ANM in Bihar. No drug or equipment kits were available with ASHA in Chandigarh, Himachal Pradesh, Nagpur district of Maharashtra, Kerala and Tamil Nadu. Short supply of Nischay kit was noted in UP. This is reflective of the implementers' perception of the role of the ASHA, even though anecdotal evidence and evaluation findings from the field indicate active use of basic drugs and diagnostic kits when the ASHA has a supply.

Functions and Functionality

- In most States, reports indicate that there is a need to improve the quality of skills of the ASHA. These particularly relate to nutrition, counselling for family planning, recognition of danger signs of pregnancy, understanding of early recognition of first contact care for sick new-borns and children. In Nagaland, ASHA reportedly support home deliveries. The Maharashtra report highlights, using the example of the ASHAs role in promoting family planning methods that ASHAs tend to promote methods that are advocated by service providers and programme managers, but are not oriented to issues of reproductive rights and choice. This is likely to be the consequence not only of the legacy effect in the larger family planning method of focusing on selected family planning methods, but may also be due to the fact that the ASHA training itself tends to focus less on the mobilizer/activist role, and emphasizes the facilitator role. In high focus States and non-high focus States alike the predominant emphasis is on RCH. However, the Kerala report notes that ASHAs are involved in raising awareness about Non-communicable diseases and serving as a member of the palliative care team. Her role in providing follow up care in these contexts is limited for want of adequate knowledge and skills, a point that is highlighted in the report. Home based newborn care is reported from all States, except Chandigarh and Kerala. Although Idukki has pockets of high neonatal mortality, ASHAs are neither trained nor equipped to undertake HBNC.
- One issue that has been raised from Arunachal is that older ASHAs are unable to perform the village and house visit functions effectively. Under NUHM, some States are considering outsourcing of PHC functions. The Andhra Pradesh report indicates that neither the state nor the outsourced partner has considered the role of outreach and frontline workers such as the ANM or ASHA in the package of services to be provided.

Performance Monitoring

- The reports from States on this component are mixed. Some reports state that such performance monitoring is being undertaken, but ASHA facilitators' knowledge and experience in using the tool seemed low. This was seen in Bihar, Madhya Pradesh, while in Jharkhand, even though the ASHA facilitators were actively involved In other States such as Kerala, the quantum of incentive is used as an indicator of performance, regardless of population coverage or disease profile.

Status and Functioning of Village Health Sanitation Nutrition Committee (VHSNC), Mahila Arogya Samiti and Rogi Kalyan Samities

- Reports regarding the functionality of VHSNCs varies across all 16 States visited, and take into account VSHNC constitution as per guidelines, timely fund flow and fund utilization, orientation of VHSNC members regarding their roles and responsibilities and

involvement of ASHAs and PRIs in VHSNCs. Overall the impression from the reports is that functioning of VHSNC do not reflect the vision of VHSNCs as envisaged under the NHM.

- Most States have constituted over 95% of VHSNCs against their state targets. These include Arunachal Pradesh, Bihar, Chandigarh, Gujarat, Jharkhand, Jammu & Kashmir, Kerala, Maharashtra, Tamil Nadu and Tripura. Among the remaining States, Andhra Pradesh, Arunachal Pradesh and Uttar Pradesh have constituted about 76%, 84% and 87% VHSNCs respectively. In contrast, Himachal Pradesh has been able to constitute only 5% VHSNCs i.e, 400 against the target of 8000 VHSNCs. The Village Health Committees formed as part of communitization in Nagaland before the launch of NRHM have been co-opted as VHSNCs but the committees, do not function as per the principles of VHSNCs.
- Among the States visited, VHSNCs have been constituted at revenue village level in Andhra Pradesh, Arunachal Pradesh, Chandigarh, Gujarat, Jharkhand, Maharashtra, Madhya Pradesh, Nagaland and Tamil Nadu; at ward level in Kerala (known as Ward Health Sanitation and Nutrition Committees – WHSNC); and at Gram Panchayat level in Bihar, Jammu & Kashmir, Himachal Pradesh, Tripura and Uttar Pradesh.
- With regard to the membership of VHSNCs, the guidelines recommend that ASHAs should be made member secretary of VHSNCs. However, this finding has been highlighted only in the Jharkhand report. State reports from AP, HP, J &K, Kerala and MP indicate that ASHAs act as joint signatories for VHSNC accounts. The ANM has been reported to be the member secretary of VHSNCs in AP, HP and Kerala. ANMs continue to act as member secretary and joint signatory in the States of Bihar, Tripura and UP.
- Reconstitution of VHSNCs was reported to be underway in Jharkhand and Chandigarh. Reports from Chandigarh, HP, MP and Kerala, have highlighted that over 50% of the VHSNC members were women. In Madhya Pradesh, the village level committees for various sectors have been merged. Thus the committee has representation of general community, service users, PRI representatives and ICDS staff. Membership of VHSNCs in UP was limited to ex-officio members like ASHA, ANM, AWW and teachers with no community member representation. Lack of conscious efforts to ensure adequate representation of marginalized and service users were reported from AP and Chandigarh.
- Lack of effort and commitment to build capacity of VHSNCs was observed across all States except Chandigarh, Jharkhand and Tripura where training of VHSNC members has be n undertaken during the last one year. In the remaining States, training of new VHSNC members has not been prioritized. This was evident in state findings, E.g.- In Bihar, Maharashtra, Gujarat and TamilNadu, where no training of VHSNC members has been conducted over last 2-4 years and slow pace of training of VHSNC members was reported from MP where majority of VHSNC members have not received any training. In Himachal Pradesh and Kerala new VHSNC members have not been trained. Level of awareness among the members and their competencies in organising the affairs of VHSNC was identified as a weakness across most States (except Chandigarh).
- Issues related to VHSNC untied funds have been largely unresolved over the last few years in most States. The major challenges include delay in release of untied fund release, utilization and management of untied funds. State reports of AP, Arunachal Pradesh and MP reflect that untied fund for the current financial year is yet to be released while amount of Rs. 6906 /- and Rs. 7500/- was released in Arunachal Pradesh and Tamil Nadu respectively. This could be linked to poor utilization of untied funds, which was noted in Jharkhand, Madhya

Pradesh and Andhra Pradesh. Timely fund flow was observed in Gujarat, HP, Jharkhand and Kerala. High levels of convergence and strong panchayat system has led to pooling of resources of funds in Kerala from NHM (10,000), State Suchithra Mission (Rs. 10000) and Local Self Government Department (Rs. 5000), which amounts to Rs. 25,000 per year for WHSNCs.

- Untied funds are largely being used for activities related to water and sanitation, purchasing of drugs and equipment for AWC and SHCs, registers for VHSNCs etc. and not as envisioned at the time of design of NRHM. Directives for utilization of untied funds are being issued in Jharkhand and MP from the district/ state level undermining the spirit of VHSNCs. In Kerala, the untied fund is also utilized for paying incentive to ASHAs for household visits.
- Most States report that regular meetings are not being undertaken except in Tripura and Kerala.

Mahila Arogya Samiti (MAS)

- MAS have been formed in Andhra Pradesh, Gujarat, Maharashtra, Jammu & Kashmir (Anantnag district), Jharkhand, Nagaland (except Mon district), Tamil Nadu (Chennai Corporation areas) and Tripura while it is underway in Delhi, Bihar, Madhya Pradesh and Jammu & Kashmir (except Anantnag). No MAS has been formed till date in Chandigarh, Kerala, Uttar Pradesh, Nagaland (Mon district), Tamil Nadu (except Chennai Corporation areas).
- In Andhra Pradesh, MAS formation in Kadapa district is facilitated by an NGO and in Krishna district by MEPMA. Similarly, in Maharashtra, SNEHA, a NGO has been given responsibility for forming and implementing MAS. In Bihar, NUHM is in working in coordination with National Urban Livelihood Mission for the formation of MAS, however, no MAS has been formed yet. In Kerala, district level officials informed that state planned to co-opt the existing Kudumbashree groups as MAS but no formal guidance/ communication from the state is issued till date. MAS in Chandigarh has not been formed due to absence of committed people to work as MAS members despite of intense efforts taken by the UT in forming MAS. Hence, ASHAs were identified in urban slums for community mobilization.
- MAS formation in Andhra Pradesh is not in accordance to the guidelines as the chairperson and member secretary were both ASHAs. In Tuensang district, Nagaland it was reported that the ASHA, Aanganwadi worker and mothers from the ward constitute MAS. The member with higher educational qualifications is appointed the chairperson.
- MAS has received training in Arunachal Pradesh according to the guidelines. In Gujarat, training of MAS is to be facilitated by Chetna. Training of MAS is complete in Jharkhand and Tripura. No training and capacity building activities have been conducted for MAS in Jammu & Kashmir.
- MAS accounts have opened in Gujarat, Jammu & Kashmir Nagaland, and Tripura. The bank account of MAS and fund transfer has not initiated in Andhra Pradesh and Madhya Pradesh.

Rogi Kalyan Samitis (RKS)

- RKS have been constituted in all States but the level of functionality was different across States on account of limited or no capacity building, delay in fund release and limited involvement of PRI representatives.
- No state reports discussed the constitution of RKS except in Andhra Pradesh, Arunachal Pradesh, Jharkhand and Tamil Nadu. Of these States, the RKS are in synergy with the guidelines in Arunachal Pradesh and Tamil Nadu. In AP, state has constituted Hospital Development Society (HDS) with no separate executive and governing body and membership is not in accordance with guidelines. The process of reconstitution

of RKS is underway in Jharkhand to enable greater representation of PRI members.

- Meetings of RKS were reported to be irregular across all States, as they are organized only in case of specific requirement and not on a routine basis. Poor record maintenance of RKS was observed in Arunachal Pradesh, Bihar, Himachal Pradesh and Kerala.
- Delay in release of RKS funds was reported from States-AP, Jammu & Kashmir, Kerala, Madhya Pradesh and Tripura.
- In Kerala, the main source of funding is NHM untied funds and additional grants are received from local self-government. In Delhi, RKS members have been able to mobilize resources for GTB hospital. However, report highlights that the untied fund received from NHM has largely been unspent since 2012.
- The reports indicate that the RKS funds are mostly being used for maintenance activities in most States which could be due to lack of orientation about the objectives and scope of RKS to take initiatives for improving quality of services and patient grievance redressal. Only in Delhi, the fund is being utilized to set helps desks for patients and electric cart for patient's movement within the hospital premises.
- Non-existence of grievance redressal system and no provision of providing feedback by the patients was reported in Arunachal Pradesh, Bihar, Himachal Pradesh and Kerala. In Jharkhand and Delhi measures have been taken to seek feedback and complaints from patients.

Convergence

- Mechanisms to establish convergence with departments like ICDS, SHGs, Water and sanitation and PRI are weak across most States except in AP, Chandigarh, Kerala and Gujarat. In AP, initiatives such as Mana Bhavitha and Anna Amrutha Hastam provide good convergence platform at GP and PHC level. In Kerala, strong convergence between NHM, Local Self Government (LSG) and other line departments was reported as part of Comprehensive Health Plan (CHP). This has resulted to huge amount being earmarked by LSG for health care improvement to be carried out through different health facilities (DH, CHC, PHC, SC).

Community Action For Health

- In Arunachal Pradesh (one district - East Siang), Kerala, Madhya Pradesh and Tripura (one district -Gomati), Community Action for Health programme has recently been rolled-out. Tripura plans to undertake scaling of CAH in the near future.
- In Kerala, Arogya KeralamPuraskaram has been awarded to best performing PRIs under CAH which has infused a sense of competition among PRIs.
- Poor utilization under Community action for Health was reported from Gujarat since 3 years despite support from Advisory Group on Community Action (AGCA). This has led to lapse of funds in Gujarat. Madhya Pradesh has implemented Community Action for Health programme started in 7 districts, however CAH could not be observed in the two visited districts.

Recommendations

- Implementation experiences of the past decade, require that the community processes component not only in urban areas but also in rural areas, now needs a design modification, to enable integrating it within comprehensive primary health care. This will provide an additional mooring for the programme, enabling the ASHA to function as a member of the frontline worker team, and facilitate the implementation of the promotive, preventive, rehabilitative components of primary health care.
- Given the experience of the past several years, States should now undertake a mapping exercise to assess gaps and prioritize selection only in such areas where there are vulnerable and marginalized populations. States should

also assess population coverage of the ASHA and ensure that there are no missed out households.

- Non-high focus States now need to factor in the changing epidemiologic and disease patterns and project newer roles for ASHA. One direction in which this can be undertaken is to build on the comprehensive primary health are rollout announced by the MOHFW. ASHA should be considered a part of the frontline worker team.
- ASHA training in Module 6 and 7 needs to be expedited so that ASHA may be equipped for other roles. This is also a pre- requisite for Level 1 certification.
- Given that several indicators related to RCH have improved, States now need to realign their incentive structures and correlate them with the revised roles of the ASHA. This will require extensive consultations with district and sub district stakeholders including, most importantly the ASHAs themselves.
- States need to expedite selection and training in urban areas under the NUHM. The NUHM offers an opportunity to immediately link the ASHAs as members of the primary health care team. This will require a review of roles and incentives.
- For VHSNC and RKS, a key step to ensuring functionality is to build the capacity of the members and create systematic training structures as was done in the case of the ASHAs. The active engagement of Panchayat Raj Institutions is required and States should consider leveraging the capacity building funds awarded to Gram panchayats under the 14th Finance Commission.
- The RKS requires to be strengthened as an accountability structure for quality of care. The current push for certification and accreditation under the Quality assurance framework, should engage proactively with RKS members to leverage mutual objectives and to strengthen the RKS as a mechanism to sustain the quality standards.
- Given the myriad concerns with release of untied funds and the state findings of the multiple yet seemingly ineffective use to which funds are put, the process for release of untied funds for VHSNC, MAS and RKS need to be reviewed and streamlined. States should consider leveraging GP funds as Kerala has done.

Section

5 Update on ASHA incentives

Since the last update of July 2016, several new incentives have been approved for ASHAs under Child health and Family planning programmes. The MAA (Mother's Absolute Affection) Programme was launched in the year 2016. Under this programme ASHAs would be incentivized to promote breast feeding through quarterly meetings. During last six months several new initiatives were launched under family planning programme viz. Incentive for escorting or facilitating beneficiary to the health facility for the Post Abortion IUCD insertion was introduced and Mission Parivar Vikas. Mission ParivarVikas was also launched in 2016- to improve access to contraception services in 145 districts, selected on the basis of TFR of 3 or more in seven states (Assam, Bihar, Chhattissgarh, Jharkhand, Madhya Pradesh, Rajasthan, Uttar Pradesh). As part of this mission, new incentives have been introduced for ASHAs of these districts for – a) Facilitating Injectable Contraceptive MPA, b) Conduct eligible couple survey, c) Distribution of Nayi Pahel kit to newly married couples and d) Mobilization for Saas Bahu Sammelan. Table 5 provides an updated list of ASHA incentives.

Updated list of ASHA Incentives			
Heads of Compensation	**Amount in Rs/case**	**Source of Fund and Fund Linkages**	**Documented in**
Maternal Health			
JSY financial package			
For ensuring antenatal care for the woman	300 for Rural areas 200 for Urban areas	Maternal Health- NRHM-RCH Flexi pool	MOHFW Order No. Z 14018/1/2012/-JSY JSY -section Ministry of Health and Family Welfare- 6th. Feb 2013
For facilitating institutional delivery	300 for Rural areas 200 for Urban areas		
Reporting Death of women (15-49 years age group) by ASHA to HSC/U-PHC	200 for reporting within 24 hours of occurrence of death by phone	HSC/ U-PHC-Un-tied Fund	MOHFW- OM -120151/148/2011/ MCH; Maternal Health Division; 14th Feb 2013
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	250	Child Health-NHM-RCH Flexi pool	HBNC Guidelines –August 2014

Updated list of ASHA Incentives			
Heads of Compensation	**Amount in Rs/case**	**Source of Fund and Fund Linkages**	**Documented in**
For follow up visits to a child discharged from facility or community Severe Acute Malnutrition (SAM) management centre	150 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 quarterly 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-Z.28020/187/2012-CH, MoHFW
Child Death Review for reporting child death of children under 5 years of age	50		Operational Guidelines for Child Death Review 2014
For mobilizing and ensuring every eligible child (1-19 years out-of-school and non-enrolled) is administered Albendazole.	100		Operational Guidelines for National Deworming Day 2015
Week 1- ASHA incentive for prophylactic distribution of ORS to families with under-five children	1 per ORS packet for 100 under five children		Operational Guidelines for Intensified Diarrhoea Control Fortnight - June 2015
Week 2- ASHA incentive for facilitating growth monitoring of all children in village; screening and referral of undernourished children to Health centre; IYCF counselling to under-five children household	100 per ASHA for completing at least 80% of household		
MAA (Mother's Absolute Affection) Programme Promotion of Breastfeeding-Quartely mother meeting	100/ASHA/ Quarterly meeting		Operational Guidelines for Promotion of Breastfeeding-MAA - 2016
Immunization			
Complete immunization for a child under one year	100	Routine Immunization Pool	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	50		
Mobilizing children for OPV immunization under Pulse polio Programme	100/day[1]	IPPI funds	Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV
Family Planning			
Ensuring spacing of 2 years after marriage	500	Family planning – NHM RCH Flexi Pool	Order No- D.O – N-11012/11/2012 – FP, May 31st, 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		

1 Revised from Rs 75/day to Rs 100/day

Updated list of ASHA Incentives			
Heads of Compensation	**Amount in Rs/case**	**Source of Fund and Fund Linkages**	**Documented in**
Counselling, motivating and follow up of the cases for Tubectomy	200 in 11 states with high fertility rates[2] (UP, Bihar, MP, Rajasthan, Chhattisgrah, Jhakhand, Odisha, Uttrakhand, Asam, Haryana and Gujarat) 150 in remaining states		Revised Compensation package for Family Planning- September DO-N 11026/11/2014-FP – 2014
Counselling, motivating and follow up of the cases for Vasectomy/ NSV	300 in 11 states with high fertility rates[3] (UP, Bihar, MP, Rajasthan, Chhattisgrah, Jhakhand, Odisha, Uttrakhand, Asam, Haryana and Gujarat) 200 in remaining states		
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		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 Post Partum IUCD insertion	150/case		Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV
Escorting or facilitating beneficiary to the health facility for the Post Abortion IUCD insertion	150/case		Order on revised rate of ASHA Incentives -2016
Injectable Contraceptive MPA - Incentive to ASHA	100 per dose	Family planning- RCH- NHM Flexi Pool	D.O.No.N. 110023/2/2016-FP
Mission Parivar Vikas Campaigns Block level activities- ASHA to be oriented on eligible couple survey for estimation of beneficiaries and will be expected to conduct eligible couple survey	150/ ASHA/round		
Nayi Pahel- an FP kit for newly weds- be given 2 kits/ ASHA)	100/ASHA/Nayi Pahel kit distribution		
Saas Bahu Sammelan- mobilize Saas Bahu for the Sammelan	100/ per meeting		

2 Revised from Rs. 150 to Rs. 200

3 Revised from Rs. 200 to Rs. 300

Updated list of ASHA Incentives			
Heads of Compensation	**Amount in Rs/case**	**Source of Fund and Fund Linkages**	**Documented in**
Adolescent Health			
Distributing sanitary napkins to adolescent girls	Re 1/ pack of 6 sanitary napkins	Menstrual hygiene Scheme –RCH – NHM Flexi pool	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	
Incentive for support to Peer Educator (for facilitating selection process of peer educators)	100 per PE	RKSK- NHM Flexi pool	Operational framework for Rashtriya Kishor Swasthya Karyakram - Jan 2014
Incentive for mobilizing adolescents for Adolescent Health day	150 per AHD		
Revised National Tuberculosis Control Programme[4]			
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		
For notification if suspect referred is diagnosed to be TB patient by MO/Lab[5]	100		Revised National Tuberculosis Control Program-national Guidelines for partnership 2014
National Leprosy Eradication Programme[6]			
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

4 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

5 Provision for Rs.100 notification incentive for all care providers including ASHA/Urban ASHA /AWW/ unqualified practitioners etc if suspect referred is diagnosed to be TB patient by MO/Lab.

6 Incentives under NLEP for facilitating diagnosis and follow up for completion of treatment for pauci bacillary cases has been revised to Rs 250 and Rs 400 from the earlier amount of Rs. 300 Incentive for facilitating diagnosis and follow up for completion of treatment for multi-bacillary cases has now been revised to-Rs 250 and Rs 600 from the earlier amount of Rs 500

Updated list of ASHA Incentives			
Heads of Compensation	**Amount in Rs/case**	**Source of Fund and Fund Linkages**	**Documented in**
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)		
National Vector Borne Disease Control Programme			
a. Malaria[7]			
Preparing blood slides	15/slide	NVBDCP 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[8]	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[9] (New incentive)	100/- per round during Indoor Residual Spray i.e. 200 in total for two rounds	NVBDCP funds	Minutes Mission Steering Group meeting- Feb- 2015
e. National Iodine Deficiency Disorders Control Programme			
ASHA incentive for salt testing	Rs. 25 a month for testing 50 salt samples	NIDDCP Funds	National Iodine Deficiency Disorders Control Programme - Oct , 2006
Incentive for Routine Recurrent Activities			
Mobilizing and attending VHND or (outreach session/Urban Health and Nutrition Days)	200 per session	NHM- Flexi Pool	Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV

7 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.

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

9 ASHA would be incentivized forRs 200/- (Rs.100 for each round) for two rounds of insecticide spray in the affected districts of Uttar Pradesh, Bihar, Jharkhand and West Bengal.

Updated list of ASHA Incentives			
Heads of Compensation	**Amount in Rs/case**	**Source of Fund and Fund Linkages**	**Documented in**
Convening and guiding monthly meeting of VHSNC/MAS	150		
Atte4nding monthly meeting at Block PHC/5U-PHC	150		
a) Lin6e 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		
Drinking water and sanitation			
Motivating Households to construct toilet and promote the use of toilets.	75 per household	Ministry of Drinking Water and Sanitation	Order No. Jt.D.O.No.W-11042/7/2007-CRSP-part Ministry of Drinking Water and Sanitation - 18thMay , 2012
Motivating Households to take individual tap connections	75 per household	Ministry of Drinking Water and Sanitation	Order No. -11042/31/2012 -Water II Ministry of Drinking Water and Sanitation – February 2013

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