

## **Meeting Minutes**

### **State Nodal Officers Review Workshop June 3 to June 4, 2011 National Institute of Health and Family Welfare, New Delhi**

#### **I. Summary of Proceedings:**

All states and Union Territories in the country which have an ASHA programme<sup>1</sup>, were invited to the workshop (the North Eastern states which were represented by a team from Regional Resource Centre – North East (RRC – NE). Except for three Union Territories, all participated. The major objectives of the workshop were:

1. Review of the progress of the ASHA and VHSC programmes in the states
2. Orient participants to the monitoring strategy and protocols for Community Processes Interventions
3. Assess / develop mechanisms for Grievance Redressal for ASHA and establishing ASHA database on attrition and drop out
4. Review compliance with parliamentary committee recommendations
5. Review menstrual hygiene scheme and upcoming training programmes for ASHA

The workshop agenda is at Annexure 1 and the participant list is at Annexure 2.

The key note address was given by Mr. P. K. Pradhan, Special Secretary and Mission Director, National Rural Health Mission (NRHM), Govt. of India. He emphasized the criticality of the Community Processes interventions to the NRHM, and said that as NRHM was envisaged as being continued in the XII plan, all interventions including CP would be implemented at a much greater scale. However it was time to take stock of the existing situation, and assess strengths and weaknesses, and the workshop was a good platform to do so.

Dr. T. Sundararaman, Executive Director, National Health Systems Resource Center, (NHSRC), in his welcome address to the two days of the workshop, briefly explained the objectives of the workshop. He said that as part of the role of technical support to the states, this workshop was a follow to the last workshop held in August 2010 to discuss the roll out of Modules 6 and 7 for the ASHA. NHSRC plans to organize semi-annual workshop to serve as a sharing and learning platform. He highlighted the importance of monitoring the ASHA programme and said that the next challenge for the programme was to manage for outcomes and the programme now needs to take that direction. The workshop would also consider the parliamentary committee recommendations and enable states to respond to those issues.

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<sup>1</sup> States and UTs which do not have an ASHA program are: Himachal Pradesh, Goa, Pondicherry, and Daman and Diu.

The participating states presented salient features of the ASHA and Community Processes interventions in their states<sup>2</sup>. The state presentations were chaired by Dr. P.K. Nayak, Deputy Commissioner, Training, MOHFW.

NHSRC presented the key findings of the ASHA evaluation in eight states<sup>3</sup> were presented to the group, and this was followed by a discussion on the implications for the ASHA program. Dr. Ajay Khera, Deputy Commissioner - Child Health, MOHFW, Govt. of India, presented the status of newborn and child health in India and highlighted the critical role of the ASHA in the provision of home based care for the newborn and sick child in order to achieve our goals of reduction in IMR and under five mortality rates. Dr. S. K. Sikdar, Assistant Commissioner - Family Planning, MOHFW, Govt. of India, presented the proposed action plan to revitalize the population stabilization programme, with special reference to the role of the ASHA. Ms. Medha Gandhi, Consultant-ARSH, RCH Division, MOHFW, presented the highlights of the newly launched menstrual hygiene scheme, and elaborated upon the structure and provisions of the scheme which envisages the ASHA as being key to promoting awareness of menstrual hygiene, and the use and proper disposal of sanitary napkins. She also clarified issues related to the Operational Guidelines of the program.

NHSRC also presented a draft monitoring plan and a proforma for monitoring the outcomes of the ASHA programme. In addition a draft grievance redressal note was circulated for comments to all participants. These were discussed with participants and a final draft was developed. States would get back to NHSRC if there were any further inputs by June 15, 2011. NHSRC would then forward these to the MD, NRHM to be issued in the form of guidelines. Copies of the key guidelines of ASHA programme issued by MOHFW since the inception of NRHM, were also distributed to the participants.

## II. Highlights of discussion and key recommendations

- (i) The key highlights of the key note address made by the Mission Director were:
- The Community Processes programme, including training, support and incentive payment structures and mechanisms varied from state to state, and was directly correlated to the performance which showed similar variations ranging from good performing to poor performing states.
  - There is a need to link incentives to outcomes and the new initiatives being considered were incentive payments for home based care of the newborn, early referral, management of childhood illnesses, promoting of spacing methods and use of sanitary napkins,. Additional areas included the involvement of the ASHA in non communicable diseases, mental health, and palliative care.
  - The ASHA should not be overloaded with tasks and it was important not to compromise quality. Many states had not achieved the training days set out in the guidelines, except for Chhattisgarh, where the knowledge levels of the Mitanin were good and commensurate with the training and support that the state had provided. A knowledgeable ASHA was also an “enlightened” ASHA as she would then be a key resource for the community

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<sup>2</sup> State Presentations are available with NHSRC.

<sup>3</sup> [http://www.nhsrcindia.org/thematic\\_data.php?thematic\\_resources\\_id=1](http://www.nhsrcindia.org/thematic_data.php?thematic_resources_id=1)

- All states must set up the systems for training and support for the ASHA and Village Health and Sanitation Committees, for effective performance.
- Performance Monitoring was important to enable the ASHAs to be more effective, and states would need to set up an ASHA data base to track poor performers, and drop outs.
- States should rapidly facilitate opening of bank accounts for the ASHA to improve the payment systems including reduction of leakages.
- The programme now needs to focus on active community mobilization and participation of community in VHSC and RKS, and the states should enhance the role of NGOs in community processes.
- States need to involve ASHA in the RSBY programme, and some states such as Chhattisgarh were making a beginning.
- States need to consider career progression of ASHAs, as has been done in Chhattisgarh, with ANM training schools reserving a proportion of seats for the Mitanin. They should be encouraged to study further.
- To a response from the Chhattisgarh representative on payment to the ASHA through the community, the SS and MD said that this was the ideal to be attained with the payments being routed through the VHSC/PRI. This would also minimize the likelihood of unionization of the ASHA.
- States need to strengthen ASHA program support mechanisms and expand the scope of ASHA Resource Centre, to include all dimensions of Community Processes. He called upon the states to share their experiences with the center to better enable MOHFW to provide inputs to the states to strengthen the programme.

In conclusion the MD expressed his best wishes for a useful two day interactive process and hoped that the proceedings would enable a stronger programme.

- (ii) Menstrual Hygiene Scheme: Ms. Medha Gandhi, consultant MOHFW, presented the salient features of the scheme and an update on the operational guidelines. For the present, the scheme would be operationalized in 152 districts in 20 states. The supply in about 45 of these districts would be through Self Help Groups, and states were encouraged to link up with schemes such as the Total Sanitation Campaign, National Rural Employment Guarantee Scheme (NREGS), and the newly launched National Rural Livelihoods Mission (NRLM). This would require convergence with the DWCD and Rural Development and the health department would be required to take a leadership role. The convergence would need to be speeded up to get the scheme off the ground. The MOHFW was also exploring linkages with the CAPART. NHSRC has been designated as the technical support agency for the scheme. ED, NHSRC said that the menstrual hygiene scheme

should be considered as part of a larger framework for adolescent health and the menstrual hygiene scheme provided an opportunity to institutionalize systems for the involvement of ASHA in adolescent health programmes. It was necessary to position the program in a rights based framework, and cautioned against the approach of seeing ASHA as a commission agent in this program. He also said that in the case of SHGs, the quality of the supplies was likely to improve over a period of time as production became more streamlines. To reduce production costs of the napkins by SHGs, a mechanism should be evolved to enable the provision of good quality raw material to SHGs. Some states raised the issue that proper disposal of sanitary napkins would pose a major challenge. Ms. Medha Gandhi informed the group about the availability of Incinerators, which are being promoted in the program, and cost as low as Rs. 5000, and are easy to install and maintain.

- (iii) Child Health: Dr. Ajay Khera presented the status of newborn, infant, and child health in India. He said that home based newborn care was important for all newborns regardless of whether they were born in institutions or in the home, and the ASHA was key to the provision of home based newborn care and managing childhood illnesses and their training in Modules 6 and 7 needs to be expedited.
- (iv) Population Stabilization: In his talk, Dr. Sikdar provided the key features of the proposed Government of India action plan to revitalize the population stabilization programme, in which ASHAs are expected to play a prominent role and which also provides for incentives for promotional activities. A total of 401 districts are being covered. In 11 states all districts would be covered and in the rest only the high focus districts. The action plan involves celebrating World Population Day, with organizing 'Jan Sankhya Sthirta Pakhwada' with one week for mobilization, followed by a service week. ASHAs are expected to be involved in promotion of spacing and limiting methods. Based on past experience of wastage of free condoms and pills, it is planned that ASHA would distribute condoms, Oral Contraceptive Pills (OCPs), and Emergency Contraceptive Pills (ECP) at a rate of Re. 1 (for one pack of condoms and one cycle of OCPs) and Rs. 2 for ECP and the money would accrue to her as an incentive. The supplies would be sent to districts directly by the centre. The ASHA will also be expected to undertake a systematic follow up of cases of IUD insertions, and receive an incentive of Rs. 100 for each IUD retained for a period of twelve months. ASHA will also maintain and update the eligible couple register for her village.
- (v) Monitoring and Management Information System:

Dr. Sundararaman presented a framework of MIS for ASHA program and draft formats on different components of this monitoring system. He clarified the

difference between data elements and indicators, and hierarchy of data sets at different levels. He stressed on the fundamental premise of the proposed MIS that while all data at the block be analysed for a set of pre defined indicators of functionality and effectiveness for the ASHA, the data sent to the district should be focused on the functionality of the block as a whole. So in such a system the block would for example send the percentage of its ASHAs who are functional on a defined set of indicators. The district in turn will send to the state the percentage of its blocks which are functional on the defined set of indicators. Such a system will promote local level analysis and actions for programme management. He also elaborated that the benchmarks should be designed based on the present status of the area in such a way that the bar is neither set very high to look unachievable nor set so low that it becomes uninspiring. The benchmarks and goalposts should also be changed with time and progress of the program.

- (vii) Implementation of Recommendations of Parliamentary Committee on “working Conditions of ASHAs” and setting up of Grievance Redressal Mechanism –

Dr. Sundararaman discussed the issues raised by the JS (AMP) in his letter to the state Mission Directors, dated February 15, 2011, relating to the Implementation of Recommendations of Parliamentary Committee on “working Conditions of ASHAs”. The status of progress on compliance to these recommendations clarifications was reviewed. A draft note on ‘Instituting a Grievance Redressal Mechanism for the ASHA’ (which is part of the parliamentary committee recommendation was also discussed. He stressed that setting up of this redressal mechanism is binding on the states’, since this was a parliamentary committee recommendation. He also underscored that the people included on the committee at the district level, should be persons with maturity and fairness. On another recommendation of the committee, he said that a Register for ASHAs should be maintained which would also track dropouts needed to be maintained at block and district levels. A draft format is included in the MIS forms. Due process must be followed before taking the decision of the ASHA to be dropped out, which should include field level verification. He called upon the states to take up the compliance of these recommendations on a priority basis and report back to the MOHFW and NHSRC in this regard.

Other highlights from the two day discussion:

All states presented the key features of the ASHA and VHSC programme. The presentations are attached herewith. During the course of discussions, it became clear that several states have developed local innovations and that the ASHA and VHSC are integral to the state’s health care programmes. Some states also have monitoring mechanisms in place, but these need to be streamlined. Payment mechanisms to ASHA also need strengthening in some states. The issue of fixed payment to ASHAs was raised by many states. Many states felt the need for a fixed payment. Some of the states which have made system for a fixed payment explained that they have lumped together a number of incentives, particularly for fixed village level monthly activities, to form a monthly fixed payment, which is also monitored based on the activities performed. All participants felt that there should be a discussion on the modification of structures for the next phase of the NRHM.

Follow up actions and recommendations:

1. Nodal officers would report back to implementers at state and district levels, the role clarity of the ASHA, (as defined in Chapter 1 of Module 6, and the respective roles of the ANM, and AWW as discussed in the recommendations of the ASHA evaluation, so that there is a common understanding and that these are immediately implemented.
2. States would put into effect a performance monitoring system for the ASHAs, based on the discussions of the workshop.
3. States would ensure that district level grievance redressal committees would be set up as a priority.
4. On the issue of recent reports of a transaction cost being deducted by the banks from the ASHAs payments, in case of ASHAs who have their account in a bank other than the bank of the NRHM, the issue should be taken up at local level, and the District Collector should use his discretionary powers to ask the banks for waiver of any such deduction.
5. For newly recruited ASHAs, training could begin from Module 5, since this dealt with the basics of building community rapport and leadership. Since Modules 6 and 7 build on Modules 1-4, and are more competency based, they would now serve as the basic books, which would be supplemented by topics such as ARSH, AYUSH and HIV/AIDS. (in Books 3 and 4)
6. The Bihar state representative requested a clarification from the SS and MD on whether ASHAs can continue their working as an ASHA after being elected as panchayat representatives. It was clarified that their work as panchayat member, (particularly as a member of gram panchayat), does not hamper the work of ASHA which is voluntary and part time in nature.