Minutes

Tenth National ASHA Mentoring Group Meeting March 5, 2013

The tenth meeting of the National ASHA Mentoring Group was held on March 5, 2013, and marked the first meeting after reconstitution of membership by the Ministry of Health and Family Welfare. The list of participants is at Annexure 1 and agenda for the meeting is at Annexure 2.
The inaugural session of the meeting was chaired by Shri Manoj Jhalani, Joint Secretary(Policy-NRHM)MOHFW,andincluded a welcome address by Dr. T. Sundararaman, Executive Director, NHSRC.Dr. Sundararamanunderscored the need forintensive support forthe ASHA programme at state level to overcome existing challenges andto address the emerging priorities in the course of the Twelfth Five Year Plan. He informed the group that this rationaleformed the basis of reconstitution of the Mentoring group NAMG by the Ministry of Health and Family Welfare, which brings together experts from varying constituencies, with wide-ranging experience in areas such as ASHA training, Home Based New born Care, palliative care, mental health and urban health. TheNational Mentoring Group isa forum which sharesaccountability for ASHA Programme implementation.

The highlights of the discussions and key decisions taken during the meeting are as follows-

1. **Experience from states- Sharing by AMG members:**
   - Dr. Nupur Basu, CINI, shared a brief presentation on ASHA training- mechanisms and progress in the state of West Bengal. During her presentation,Mr. Jhalani, requested clarification on mechanisms for ensuring training effectiveness. Dr. Basu responded that there were stringent mechanisms which included pre and post training evaluation of both trainers and ASHAs, which comprises written and oral tests and testing of competencies. To maintain high quality, non-qualifying trainers are not engaged in training ASHAs. ASHAs not clearing the testare furthersupported through comprehensive feedback or refresher training. She also said that it was now necessary to orient trainers in Round 2 –Module 6 and 7, given that the majority of ASHAs in the state were now trained in the first two Rounds of Modules 6 and 7. She also requested NHSRC to repeat the ASHA Evaluation for West Bengal, which was last done in 2010, when the programme had just begun.

   - Dr Rakhal Gaitonde, SOCHARA, shared his experience of the programme in Tamil Nadu. He emphasized that the ASHA programme in Tamil Nadu follows a different trajectory and life cycle.The resistance from the cadre of Village Health Nurseand high political interference has hampered the progress of the programme. A step wise scaling up of programme was initiated since ASHAs were initially deployed only in tribal areas, followed by their gradual placement in inaccessible and regions with poor health indicators. A strict adherence to educational criteria in selection is observed even in tribal areas and asa result state has been able to select only 3905 ASHAs from the targeted 6850. He pointed out that in a tribal block of Gudalur, of 200 ASHA only 12 were from the tribal community. Other concerns that he shared included-lack of ownership of the programme by State Health Society, an inactive state ASHA Mentoring Group, absence of dedicated support structure at district and sub-district level and little interdepartmental synergy between VHSNC and ASHA programme management. The state had also articulated a policy of disease specific ASHA (focused on blindness control, and for outbreaks of Dengue and Chikungunya) , but training was yet to begin. The state also had a policy of providing incentives for ASHA only if the delivery took place in the General hospital, even if it was much further away than a PHC which also

provided safe delivery, thus unnecessarily imposing a burden on the woman, the ASHA and the health facility. He spoke about the community monitoring intervention in TN and the state's flip flop over support to SOCHARA. He also suggested that the VHSNC guidelines under preparation include best practices from states. One such example is that of VHSNC monitoring domestic violence.

- Dr H Sudarshan, KarunaTrust shared his insights on the ASHA programme in Karnataka, Arunachal Pradesh, Manipur, and Meghalaya. Implementation of RKS, Community Based Planning and Monitoring and Home Based New Born Care has been reasonable in Karnataka. In KarunaTrust managed PHCs, ASHAs from 29 PHCs havebeen trained on screening patients for mental health, eye ad hearing problems. The state has introduced an incentive from the state budget of Rs. 300 to ASHAs for registering complicated casesneeding surgical intervention under the Vajpayee Arogyashree Scheme. ASHA programme in certain urban areas of Karnataka is functioning well but Drug kit replenishment is a major limitation noticedin the state. Aworrying issuethat he highlighted was that in eight districts of the state, where the Karnataka Health Promotion Trust was undertaking interventions, there was a huge burden of record keeping on ASHAs.They are feeding village wise information in the records of ANM. He expressed the necessity forfurther evaluation and action on this issue.As regards North East states, he identified poor quality of training in Arunachal Pradesh, Meghalaya and Manipur and low incentives particularly in Arunachal Pradesh (on account of scattered hamlets and low population coverage) as areas that need attention.

- Dr Amod Kumar, St. Stephen Hospital, highlighted issues pertaining to faulty selection of ASHAs in Delhi. Educational qualification has been givenclear predominance over dedication, aptitude and training in selection and has resulted in many non-functional ASHAs. The Staff in PHCs needs to be oriented with the programme to leverage better support to ASHAs. He also suggested the development of advocacy pamphlets and briefs onthe role and importance of ASHA in urban areas to sensitize stakeholders. He drew the attention of the group towards the serious issue of homelessness in urban areas and reflected on the need to promote Male Community Health Workers for ensuring better reach to this sub population.

- Dr. Prashant Tripathy, EKJUT presented an update on the Sahiyya programme in Jharkhand. He explained the progress on Sahiya training in Jharkhand and appreciated the efforts of Jharkhand'steam in taking the programme forward, despite frequent changes in the stateleadership. He also said that the state Village Health and Sahiyya Resource Center (VHSRC) which played an important role in programme support and management needed to be re-vitalized. He said that the district training teams were effective and training quality was good. He highlighted the state's focus on selection and training ofwomen belonging to the Primitive Tribal Groups as Sahiyas, inensuring reach to the most marginalized sections of the community. He also shared that VHSNCs were functioning as MaithriBaithaks to undertake Ekjut's Participatory Learning and Action approach, for reducing newborn morbidity and mortality. Challenges to the programme mainly include procurement issues leading to considerabledelays in the distribution of HBNC equipment kits to Sahiyas.

- Ms Alison DemboRath, OdishaTechincalAssitnace and Support Team, shared results of a pilot study in Keonjhar district of Odisha, on using male community workers. The group felt that the study did not demonstrate additional advantages over the ASHA and could in fact be disempowering to the ASHA. This could likely be on account of the fact that the additional male worker was allocated the same responsibilities as the ASHA. However, the group felt that there was a role for a male activist in addressing particularly vulnerable populations such as homeless men.

- Dr Rajagopalan, Pallium India discussed the role of ASHAs in Kerala in palliative care and said that they had a limited involvementalthough there was potential for them to get more actively engaged. Pallium India had developed a cadre of honorary volunteers for providing community level palliative care. When ASHA programme was implemented, there were conflicts in state regarding involvement of ASHAs on this task. The state continued to lean towards the volunteers and not ASHAs for delivering palliative services. These volunteers are generally highly motivated and charismatic individuals of the community.But when they leave, these services are provided by workers from the system like ANMs and MPWs, who are unable to replicate the same rigour, dedication and effectiveness in offering these services. Finally, going by this experience, the government is now slowly drifting towards using ASHAs for this work.Dr T. Sundararaman agreed on this aspect and explained that role definitions for ASHAs in Kerala were unclear from the very inception of the programme. Though ASHAs were sanctioned for NCD so farthey have been engaged onlyfor RCH related issues. All participants agreed that the preventive and promotive services for NCD at community level needs to be prioritized and involvement of ASHAs in Kerala in NCD care should be considered more seriously.

- Details on VHSNC and Mitanin programme in Chattissgarh were shared by Dr J P Mishra, ED SHRC-Chhattisgarh. He briefed the participants on the selection of Mitanins in remote hamlets as well as their expansion in urban areas. Some state specific reforms discussed were- Mitanin payments through Panchayat,record of births and deaths and service delivery tracking by VHSNCs, and the Panchayat led Crèche initiative. Dr T Sundararaman, drawing on his recent visit, said that the role of VHSNC in maintaining birth and cause wise death records of the communityhad potential for village health planning.Dr J P Mishra expressed a concern that reporting of deaths by VHSNC, HMIS and IDSP requires validation and triangulation. NHSRC's support was sought on this aspect and Dr T Sundararaman agreed that NHSRCcould help in building skills of the district and block level staff on better analysis of this information.

- Dr Vikram Patel, SANGATH, specified that the role of the ASHA in NCD needs to be conceptualized further in light of numerous conditions, which can be dealt with atthe community level.Clarity should be established on potential roleof ASHA, who could play the following roles: mobilization for services, follow up for long term treatment, providing palliative care, screening and referrals for mental health and disability etc. It is also important to ensure coordination between the community component of NCD and other related programmes. He cautioned that currently there are many parallel NCD related initiatives being undertaken by different departments. And there is an urgent need to build an interface and synergy, to avoid duplication of efforts and establish consensus on possible roles of Frontline Workers.He explained that ASHAs while delivering community level care for maternal and child health can be easily utilized to address early childhood development concerns.

2. **Update on the ASHA program:**

Dr Rajani Ved Advisor, Community Processes, NHSRC updated the group on ASHA programme. In order to brief the new members, role definitions, training strategy, prior trainingsand key developments of ASHA programme were shared. The current status of the programme on keyparameters,selection, training and support structure of ASHA, was also discussed during this session. She appraised them of the status of five documents (which have been circulated to the group already for inputs) and that were submitted to the MOHFW for approval. They include the revised ASHA guidelines, guidelines for support structures for the community processes interventions, an induction module for the ASHA, NGO guidelines and the guidelines for the VHSNC. NHSRC is following up with the MOHFW to facilitate approval. New members would besent these documents for review and inputs.

3. Performance Monitoring of ASHAs:

Dr Garima Gupta, Senior Consultant, NHSRC discussed the performance monitoring system for ASHAs as included in Handbook for ASHA Facilitators to assess the functionality of ASHAs. She shared with the group that this is as yet in a very nascent stage and states are just beginning to train facilitators to report on the indicators. While participants agreed in general that it was important to measure ASHA functionality, some members raised concerns that the nature of data collection and analysis was complicated, on the fact that what is intended to be a tool for supportive supervision could turn into a punitive instrument for the ASHA, and that distortions in data collection and analysis could discredit the programme itself. Dr. Sudarshan was concerned that the formats and data definitions were too complicated for the field level workers such as ASHA facilitators.It was clarified that the tool was developed to enable better comparison between the functionality and effectiveness of ASHAs which has been a challenge so far. In essence, the real usefulness of the tool is atblock level and would enable the programme managers to identify and explore the causes of non-functionality of ASHAs and take corrective actions. NSHRC was undertaking training of state and district level staff in the performance monitoring system and handholding as states begin the process.

4. Discussion on Draft Proposal to streamline ASHA Incentives:

Dr. Shalini Singh, Consultant, Community Processes, shared the key features of a draft proposal to realign ASHA incentives to ensure congruency with time spentwas prepared by NHSRC on request from MOHFW, to be presented before the Empowered Programme Committee of NRHM. In order to achieve uniformity of compensation, the proposal suggests monetary incentives to be structured in such a way that monthly compensation for ASHA is derived from two approaches of payment.In the first approach, the ASHA gets an incentive linked to certain recurrent tasks that are to be undertaken on a periodic basis, regardless of population size or demographic or epidemiologic profile.The second part of her compensation is as per varying demographics and would be obtained from incentives such as JSY, Home Based New Born Care, Immunization, DOTS provision for Tuberculosis patients, and successful motivation for adopting any family planning method. The proposal was discussed and inputs were sought. Overall, the participants agreed with the aims and objectives. Dr Sudarshan commented that that assured sum of Rs 1000 per month is low for ASHAs and it is not justified to link ASHA payments with measureable task outputs and make it performance based. Similar restrictions are not imposed on other health professional like doctors or nurses and should not be there even for ASHAs. Dr Abhay Bang and others agreed that linking this with performance is important as the focus ison ensuring reach to the beneficiaries.

Dr J P Mishra was of the view that states should be free to decide on payment modalities, and that per capita funds should be made available to State/ Districts who can then accordingly plan and incentivize ASHA based on their priorities and interests. Most members however did not concur with this view. Members suggested that the following factors need to be included in the incentive policy:

- Prepare states to strengthen systems so that payment to ASHA can be made through panchayats/ VHSNC.
- Expand the 'Routine and recurrent activities' and add first contact care for symptomatic cases by ASHA as a fifth activity, forming a part of the Assured Monthly Package Incentive.
- Provision of passbooks for ASHAs so that she is aware f the break up of payments every month.
- In areas where the ASHAs work exceeds five hours a day, a second ASHA be seelcted
- In areas where institutional delivery is over 90%, and where immunization coverage is over 90%, NCD can be included.

5. **Discussion on note for ASHA Certification**:

Ms. Abha Tewary, Consultant Community Processes presented a summary of the proposal for ASHA Certification. Dr Abhay Bang suggested that it would be appropriate to standardize the core curriculum, rather than develop new study material, as is stated in the proposal. The NHSRC team clarified that this was the spirit, but the language would be modified. Dr. Bang also suggested that since the certification of ASHAs is of huge magnitude, the use of technology such as video conferencing for skill test would add value and likely be cost effective. Some participants felt that the process needed to be speeded up since, PhaseI of certification starting from June 2013 to March 2015 and Phase II from April 2015 to March 2016, implied that the process would be completed only by the end of plan period. Corrective actionwould also be taken for ASHAs who are unable for achieve certification.Dr Sundararaman responded to the above concern by saying that according to the results of pilot phase, forwardplanning will be done for scaling up certification of ASHAs.Dr Bang also clarified that it is more important to advocate the benefits of certification to ASHAs rather than emphasizing the downside of non- certification.A simultaneous consideration on implications of certification on training and support systems is needed. Concern on means of certifications for ASHAs with low literacy levels were raised by Ms Alison Dembo Rath, It was clarified that these ASHAs can enrol with the NIOS in upgrading their educational qualifications, and would be supported by NRHM. Dr Sulakshana Nandi,stated that the state of Chhattisgarh has introduced an educational incentive to promote up-gradation of educational qualification for Mitanins. The incentive is Rs 3000/- for passing 8th class, Rs 5000/- for passing 10th class and Rs 12000/- for passing 12th class. Similar incentive can be introduced by other states. Dr JP Mishra added that if ASHAs are unable to attain certification, the system should support themto build their capacity. He furthershared Chhattisgarh experience where 300 Mitanins had passed ANM exams and were awarded by a direct appointment as Community Nurse under Panchayat. . Finally, reflecting on the long term vision for ASHAs, Dr Sundararamansaid that the ASHA could evolve into a Community Health Nurse and more space should be created by implementers for such transition.

6. Role of ASHAs in NCD:

Dr. Rajani Ved briefed the group on the recently held consultative workshop on the role offrontline workers in NCD, and the experiences that were shared on a few models. Dr Abhay Bang said that thus far, while there is clinical evidenceon community level interventions for NCD, effectiveness and feasibility trials were important. The group welcomed the idea that formative research would be undertaken and expressed interest in partnering in the research.

7. Support to states:

As per the objectives of NAMG, all members were requested to identify a few states for supportive supervision. Members affirmed that they would make available the time to visit the states and support implementation of the community processes interventions. Members also requested NHSRC to facilitate their support to states by informing Mission Directors of the mandate of the NAMG. Some members observed that state ASHA Mentoring Groups also needed strengthening and barring in a few states, most were inactive. NHSRC assured members of follow up with MOHFW to enable a letter to states asking them to strengthen the SAMG and to include representative of the NAMG.

Follow up actions:

1. NHSRC to send the five guidelines to new members for review and inputs.
2. NHSRC would facilitate the issue of a letter from MOHFW to state Mission Directors, - NRHM informing state allocation of NAMG members for supportive supervision, and to strengthen the State ASHA Mentoring Groups

3. NHSRC would share the topics for formative research for NCD and explore interest for partnerships.

Annexure 1

List of Participants

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Annexure 2

National ASHA Mentoring Group Meeting: Agenda

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

Tuesday, March 5, 2013

Time - 10:00 am to 5:30 pm

Address by Shri Manoj Jhalani, Joint Secretary, (Policy) Ministry of Health and Family Welfare

National ASHA Mentoring Group: Roles and Responsibilities: Dr. T.Sundararaman, Executive Director, National Health Systems Resource Centre

Update on the ASHA Programme

- Report on progress of ASHA and VHSNC
- Launch of ASHA update: January 2013
- Introduction of Guidelines and Training Material
- Performance Monitoring Review
- Incentive note for ASHA

Sharing by AMG members

- Experiences from states

Discussion on contribution of members

- ASHA Certification:
- Support to strengthening State Community Processes Programmes
- Role of ASHA in Non -Communicable Diseases and Palliative Care

Next Steps and Closing: Dr. T. Sundararaman, Executive director, National Health Systems Resource Centre