

Minutes

Eleventh National ASHA Mentoring Group Meeting

October 29-30, 2013

The Eleventh meeting of the National ASHA Mentoring Group (AMG) was held at the National Documentation Centre, Conference Hall, National Institute of Health and Family Welfare, New Delhi on October 29-30, 2013. ASHAs, ASHA facilitators and ASHA Programme Coordinators from the states of Jharkhand, Assam, Uttarakhand and Maharashtra were also invited to share their experiences.

Nine of the fourteen NAMG members were present at the meeting. Dr. Rajagopal nominated Dr. Binod Hariharan to represent him. Dr. Nerges Mistry sent her report of field visit of the Bihar state, as she was unable to attend the meeting.

The list of participants is attached as Annexure-1 and the agenda for the meeting is attached as Annexure-2.

The inaugural session

The session was chaired by Ms. Anuradha Gupta, Additional Secretary & Mission Director (AS & MD), National Health Mission (NHM), MOHFW, GOI.

Dr. T. Sundararaman, Executive Director, NHSRC welcomed the group and explained the purpose of National ASHA Mentoring Group, for the ASHA and ASHA facilitators.

Ms. Anuradha Gupta, AS-MD, in her inaugural address welcomed the ASHAs, ASHA Facilitators and ASHA Programme Coordinators attending the meeting and highlighted that the ASHA programme was a unique component of the NRHM. She praised the hard work done by ASHAs in community level health care, especially the contribution made in the improving the status of institutional delivery. She underscored the size and the coverage of ASHA programme with about 8.8 Lakh ASHAs spread throughout the country. Except for Himachal Pradesh which is soon going to select ASHAs, and Tamil Nadu with the programme tailored to its context, almost all states have fairly long standing programmes.

She said that the health care challenges of our country cannot be solved by the services of just doctors and specialists. Until now, the emphasis has been on doctors, and we have attributed

the weak status of health services to the lack of doctors and other service providers. However, a substantial part of the disease burden can be reduced by a focus on prevention and promotion activities. The role of people's own behaviours and actions on adopting healthy behaviours and preventive lifestyles has been largely neglected so far. ASHAs can play a major role in enabling preventive care for the community, by taking the messages to the doorstep of the families. Until now increasing institutional delivery has been an important challenge, and ASHAs have been able to contribute greatly to the rise seen in the last two years; however prevention and promotion components of health are still to be achieved.

The AS & MD said that 'ASHA is a messenger' and requested the members of the AMG to reflect on the utilisation of ASHAs in promotion and prevention of health, and stressed on the need to empower ASHAs in Behaviour Change Communication (BCC) and Interpersonal communication (IPC) activities. She said that 'health outcomes are better achieved if strong foundations are laid for prevention'. AMG should deliberate on ways to use ASHAs effectively conveying messages on the issue of age of marriage and need for spacing between children. Stressing on the importance of the issue, she said that child marriages, are still prevalent, especially in states of Assam, Jharkhand, Rajasthan, Madhya Pradesh, Bihar and Chhattisgarh. She stressed that all marriages in the age group of 14 to 18, should be called "Child Marriage", and not early marriage, to underscore the importance of the issue.

Marriage at this age has a significant effect on the health of the girl and contributes to high MMR and IMR, but we have no messages on this till now for ASHAs. She also said that there is still ambiguity on where this issue should be addressed, i.e through the ICDS or Health department. Women and Child Development (WCD) Department has been focusing on prevention of the child marriage. Apart from the message that child marriage is prohibited by law, there is a need to explain to the parents and community at large that it is an important determinant to ensure the lives and health of our daughters. We need to build ASHA's clarity on this issue and highlight the importance and link between the different aspects of early marriage, delay in the first child and spacing between children. Use of IPC tools for health education and BCC tools for preventive and promotive health needs to be taken up on priority, and issues of problems due to child marriage and methods of delay in pregnancy should be included in ASHA training.

The AS&MD said that we tend to view MCH in silos, and drew the attention of the group to the 5X5 Matrix developed recently by the MOHFW, as part of RMNCH+A . ASHA must see

and understand the link between different components. She further talked about following as the key priority areas for the programme –

- Need to re-evaluate the ASHA training modules as per the changed context and new challenges, as institutional delivery has reached the level of 80% at present, from the level of 47% in 2007, and 20000 health facilities are functional as 24/7 delivery points.
- New training modules for new challenges should be added for ASHAs on issues like Gender Based Violence and Non Communicable Diseases and they should also be given refresher courses and sensitisation trainings.
- Quality of training is an area for urgent attention, to address the gaps. Learning from the training conducted by the NGOs should also be considered and methodologies for effective training should be recommended for the programme.
- Need for strengthening the ASHA selection process. This needs to be anchored in the communities with their greater control and ownership of the process, which should also ensure the representation of weaker sections of society among the ASHAs, and greater reach of ASHAs to these sections. We have to ensure now (and it can't be now left to state's discretion only) that the selection process is inclusive, transparent and selection by community is made mandatory. The process for replacement of non-functional ASHAs should also be strengthened.
- Grievance Redressal system must be established all across the states, particularly because the programme has matured now.
- Compliance to the provisions of PCPNDT Act must be monitored actively.
- ASHA should be made aspirational, and be encouraged to get into ANM and GNM courses. But they should be given preference in the recruitment to these courses, rather than making provision for reservation.
- We should not be bound by the structure of four to five hours of work for ASHA, and activities of the ASHAs should be increased with a corresponding increase in the incentives, so that she can get up to Rs. 4000-5000 per month for up to 8-9 hours of daily work.

- Need to strengthen support structures. There are about two to three models for support to the ASHA programme that are operating in the country today and we must find ways of identifying their effectiveness and strengthening them.

She welcomed suggestions and recommendations from the AMG members. She also welcomed the ASHAs participating in the meeting, and asked them to share their experiences and the changes and impacts at community level.

Discussions after the address by AS-MD –

Ms. Indu Kapoor said that ASHA should be empowered and skilled for playing more BCC and IEC roles, and also have incentives for such roles, in addition to service provider roles. On this issue AS-MD responded that Rs. 300-400 per month can be given to ASHA if she is trained for and plays such roles, but such incentive should be linked with outcomes, like 10 to 20 % decrease in Diarrhoea cases, or increase in immunisation. She said that we must also have processes for monitoring non-performers.

Ms. Sulakshana Nandi shared the experience of her ASHA Evaluation study (qualitative phase) visit in Punjab, where 80 ASHAs were dropped from the programme based on a single criteria of earning zero incentives. She suggested that a process of more in-depth enquiry should be adopted to assess non-performing ASHAs, and also include a review of how “enabling” her environment is, such as supportive supervision, regular payments, and timely refill of drug kits. The AS&MD was of the view that termination of ASHAs must be seen through a lens of performance payment, extent of supervision and not be arbitrary.

Mr. Alok Mukhopadhyay shared a concern that ASHA programme should not degenerate like the ICDS programme, and said that the quality of hand-holding is very important. He stressed on the need for synergising ICDS and ASHA interventions and endorsed the need for greater focus on preventive and promotive health. He shared a concern that Malaria and TB programmes are not integrated well within the NRHM, and number of default and resistant cases is large. Systems for incentive payments are complex and the process needs to be simplified. He praised the exemplary role played by ASHAs during disaster in Orissa, when even the doctors and nurses were not available anywhere, and made a request for incentive to be given to ASHA in disaster situations, to which AS-MD responded that this can be considered. Mr. Mukhopadhyay also made a request that special attention to be given to J&K state.

Dr Amod Kumar shared his experiences from a recent visit of Vidisha, MP. His overall assessment and concern was that the nurses and doctors do not give respect to ASHAs and treat her in rudely. There is a need for sensitising the system's functionaries about the ASHA programme. He said that AMG must develop such a module for sensitisation of doctors and other staff. To this AS-MD responded that in the initial phases, even the technical divisions at MOHFW were sceptical about ASHA programme, but there has since been a transformation, and such a positive shift of attitudes must be enabled at the state level as well. Dr Amod mentioned that efforts should be made to ensure that ASHAs earn about Rs 4000-5000, as it was his view that this reflects the amount of time she spends and is commensurate to prevailing minimum wages. In case her work involves eight-nine hours in a day or she happens to work full time then she should be paid accordingly. There is also a need to respect the opportunity cost of time forgone as a house wife.

Ms. Nupur Basu talked about her visit to Tripura, and talked about an innovative programme of the state called 'Mission 100' which aims at achieving 100% immunisation. She stressed the need for pictorial IEC material, and also shared a concern about inadequacy of funds for IEC.

Dr. Rakhal raised a concern that ASHA programme in Tamilnadu, is seen as a vertical programme. Other interventions like training of VHSNC are run in another silo and the integration between these two related interventions is not being attempted, even where there are ASHAs.

Dr. Sudarshan expressed concern about the increasing workload of ASHA and said that we should consider making her a full time worker. Option for a second ASHA should also be considered. Boys and girls could also be trained as peer educators for adolescent health interventions. Mr. Alok Mukhopadhyay shared that such an intervention is being tried successfully in Ganjam in Odisha.

Mr. J. P. Mishra reiterated the issue of lack of respect in the attitude of health system's personnel towards ASHA. He shared that in Chhattisgarh, in the beginning of the programme, Mitanins (as they are called in the state) received very little monetary incentives, and the focus of the programme was on her role as a social activist. During this phase the attitude of the health system's functionaries was of respect towards Mitanins. Later on when monetary incentives to Mitanins became greater and were paid by the health system's functionaries, disrespect crept into their attitude. He shared the recent initiative of the state, in which

incentives are being paid by the village panchayat, this step has been able to stem the trend of the falling respect in the system's attitudes. He also shared that with village panchayat paying the incentives to ASHAs, the actual average amount of incentives being paid to ASHAs has gone up substantially. He shared that incentives are paid to Mitanins based on the list of activities and payment voucher submitted by the Mitanin, which is approved by the village beneficiaries and panchayat functionaries there itself. He also suggested that village Panchayat should be given the right to pay additional incentive to Mitanin if it deems appropriate for some activities that it finds important.

On this issue AS-MD responded that VHSNC and PRI representatives of the village have a role to play in payment of incentives to ASHA. Verification of activities can be done post-facto.

Dr Lowang from North East shared a concern about the low level of incentive amounts accruing to ASHAs due to smaller population and smaller work-load, which is leading to high attrition rate among ASHAs. She made a request that rates of incentives should be higher in North Eastern states to compensate for the lower average population.

Mr. Binod also shared that rate of attrition is high in Kerala due to lower average incentives being earned by ASHAs, as the RCH work-load is very low in the state. He said that there should be some incentive for ASHA for palliative care. On this AS-MD responded that states were free to design incentives for ASHA as per the local requirements.

Session on Update on Community Processes

Dr. Rajani Ved , Advisor, Community Processes, NHSRC, updated the group on programme interventions under Community Processes. The session was chaired by Mr. Manoj Jhalani, Joint Secretary (Policy), MOHFW, GOI.

The current status of the ASHA selection, training, Performance monitoring, payment, career progression and support structure of ASHA were discussed. The group was also updated on proposed role of ASHA in the new programmes like Rashtriya Bal Swasthya Karyakram (RBSK), community based distribution of Misoprostol for prevention of Post Partum Haemorrhage, National Iron + Initiative (bi weekly iron supplementation of children 6 months to five years, and weekly supplementation for all women in reproductive age). She also shared that NHSRC has developed a Handbook for ASHAs in Disaster Preparedness, and has conducted two TOTs at state level in Dehradun, in collaboration with Doctors, State

ASHA Resource Centre team of Uttarkhand state and faculty of TISS (Tata Institute of Social Sciences). She also presented the progress of Village Health and Sanitation and Nutrition Committees (VHSNCs) across states and said that states are expected to restructure existing VHSNCs to enable active participation of PRIs, and ensure that the role of member secretary is given to ASHAs as per the new VHSNC guidelines released by GOI. She also informed that NHSRC has developed Draft Training Manual for Trainers and VHSNC members.

The JS observed that the right choice in the ASHA selection and active engagement of the community in the selection process, is the key to the programme. Another challenge is for building a robust process for removing non-performing ASHAs. He also emphasised that measures have to be taken for the improvement of quality of training programmes for ASHAs across states.

Dr. T. Sundararaman talked about the problems and roadblocks that ASHA training has been facing across the states. In Rajasthan ASHA training is being delayed inordinately because state government has made the process of annual tendering mandatory for all the activities related to training like food, logistic etc. In UP ASHA training had started without Modules as the printing of module has been delayed badly. He also suggested that rate contract system, based on the principle of reverse tendering, has to be developed instead of tendering, in the activities related to training. He also shared that UP has developed a robust mechanism for removal of non-performing ASHAs, in which a district level person from the ASHA programme would visit the ASHA's village and hold a dialogue with community and Gram Sabha before a decision is taken for removal of a non-performing ASHA. He mentioned that a process for removal of non-performing ASHA has been defined in the ASHA programme guidelines issued recently by MOHFW. He said that 2.5 to 5% turn-over of ASHAs is well within the acceptable limits of the programme, but we also need robust mechanisms for reselection and training against drop-out ASHAs.

Mr. J P Mishra shared that in Chhattisgarh, final call on ASHA selection is taken by the Gram Panchayat, based on a resolution of Gram Sabha.

The JS observed that guidelines are required in this context, and said that the ASHA payments need to be streamlined and systems of on-line payments need to be built, which will make it possible to know which ASHAs have been receiving payments and which have not, disaggregated by activities.

Ms. Indu Kapoor shared that in some places in Gujarat the ASHA training rounds of 5 days have been compressed into one day. Also there is a shortage of training venues at block level, and systems for monitoring of ASHA training and expanding the pool of trainers and improving their skills, are very weak.

Many of the members felt that strong guidelines are required for strengthening the implementation of ASHA training across the states and State Institute of Health and Family Welfare (SIHFWs) and Anganwadi Training Centers (AWTCs) can be used for the training of ASHA if they are available. Some members felt that in many places, SIHFWs are not willing to take the responsibility of the conduct of the entire pyramid of the training.

Mr. J P Mishra shared that in Chhattisgarh, service providers are roped in on agreed rate contracts, to provide the whole package of logistics services for conduct of training. He shared that in states like Chhattisgarh, in some places, not many people know how to apply for and submit tenders, so it is difficult to find providers for logistics management through tendering process.

The JS highlighted the need to provide support to states on training management issues and guidelines should be released by Govt. of India in this regard. He said that we should look at the best practices on the training management and see the options available for adoption under ASHA programme, particularly for provision of the whole package of logistics services for conduct of training. Training infrastructure and management practices under many different departments and programmes of government should be seen like, Education department, District Training Centres, BRCs & CRCs (Block & Cluster Resource Centres under SSA) BRGF (Backward Regions Grant Fund) and Anganwadi Training Centres (ATCs). He said that approved rates of these training centres will be acceptable for ASHA training, as their rates have been worked out based on tenders of various items. He also shared an example of some trainings done by Education department, in which food coupons were given to participants and some food vendors were organised to provide food outside the training venue, within those rates.

Issues related to the procurement of drug kit and equipments, were also discussed and a particular constraint cited was, the lack of availability of technical specifications. The JS said that one very good example of procurement process is procurement of drugs and HBNC equipment by state of Haryana through UNOPS. Following DGS&D rate contracts is also a good method of procurement. He observed that it is difficult to monitor the specifications and

stressed on the need for written specifications. He also supported use of technology for ensuring availability of drugs with ASHAs, and said that the platform of MCTS can be used for helping in this process. He also mentioned that adequate funding for ASHA drug kit is being provided in the PHC budget.

Dr. Sudarshan, also said that some mobile based systems of update for drug stocks and utilisation should be developed linked with MCTS platform for eg. sending sms to the facility when the stocks of a particular drug is running low. He also made a submission that if states are proposing or giving additional support for enrolling ASHAs in ANM training course, the funds for such support should not be cut down at the time of PIP.

Dr. Nupur Basu raised the issue of VHSNC operationalization in West Bengal, and shared that the elected member of Gram Sansad-Gram Pradhan is the Chairperson of the VHSNC, and the secretary of Gram Unnayan Samiti(GUS). A person from the Panchayat and Rural Development Department is the member secretary. ASHA is one of the members of the same. To this Mr. Jhalani said that routing of the VHSNC funds through the P&RD department is not a negative process in itself, but ASHA should be made the member secretary of the VHSNC to effectively strengthen its processes.

The recent policy initiative for introducing Misoprostol, which is being planned to be distributed by ASHAs to pregnant mothers, was discussed and many members felt that there are risk factors involved in ASHAs being given a role in this process, because it needs judgement on when the mother should take the pill. Mr. Jhalani responded that just providing the pill without adequate support to ASHAs and mothers in delivery care, will not be advisable.

Taking the discussion further, Mr. J P Mishra said that we are moving increasingly towards an institutional delivery regime, and suggested that we should create a sub-set of ASHAs with higher skills set on home delivery, asphyxia management, and management of such cases at home. He also suggested that ANMs in difficult and remote areas should be given incentives for providing such supportive care.

In this context, the recent initiative of NHSRC for training ASHAs in Uttarakhand after the disaster, was discussed and it was agreed that the report of these trainings and Handbook on ASHA's role in disaster management should be shared with AMG members.

Dr. H Sudarshan reiterated his suggestion that ASHA should be made a full time worker, as more and more activities are being added to her work, or a second ASHA should be added.

The JS responded that capacities of ASHAs should be strengthened so that the level of her incentives increases. Her remuneration should increase with the increase in the complexity of her skills, and the basket of her activities should be expanded and the mechanisms of her incentives payment should be strengthened.

Ms. Nupur Basu said that in many geographically difficult areas, positions of ASHA are vacant, particularly because of the eligibility condition of 10th class pass, and modalities for filling such vacancies should be taken up on a priority basis. She also said that joint training for ASHA and ICDS workers should be organised. On this, Mr. J P Mishra shared that HBNC trainings have been given to ICDS workers and the feedback of the process has been very positive. He observed that such a joint training of ASHA and ICDS workers should be made part of the national programme.

Dr. Sudarshan stressed the need for such programmatic convergence at the national level, and said that nutrition related initiatives are well supported in the NRHM, but any such convergence is if difficult to achieve at the state level.

Mr. Jhalani said that under NRHM, MOHFW is ready to support joint trainings of ASHA and AWW, to which Mr. J P Mishra suggested that this should be made part of regular budget-lines under PIP.

Mr. Jhalani said further that, advocacy is required at all levels to promote convergence, and one innovative measures to promote convergence can be; an increased allocation of 2% of the overall budget envelope for states who promote convergence.

Ms. Indu Kapoor said that ASHAs need constant capacity building, and one time training is not enough, and training should be accredited as they go for higher levels of skills. She stressed that activities which are incentivised, get more focus, and IEC / BCC is sidelined as there are no incentives dedicated to them. She said that ASHA needs IPC skills and related training as many of them have low self-esteem. She shared that Chetna has developed a training module on such skills, which has been finalised with technical support from TISS (Tata Institute of Social Sciences) faculty.

It was shared by the members, that National Institute of Public Cooperation and Child Development (NIPCCD) is developing some training content for ICDS workers on Home Based Newborn Care (HBNC), but it has only knowledge part and not skills. To this Mr. Jhalani responded that the skills on HBNC will have to be imparted through the health department only, and for better integration, health department officials should do a visit of ICDS centres every quarter.

Dr. T Sundararaman suggested that some pilot districts should be taken up for giving these inputs on IEC / BCC skills to ASHAs, and these skills should also be built into the certification process. He also shared that under the Rashtriya Bal Swasthya Karyakram (RBSK) programme, a district level centre is being visualised with technical experts in place for disability management.

Ms. Nupur Basu stressed that RRCs should be used for training ASHAs in soft skills and also training VHSNCs, and suggested that this can be taken up at-least on a pilot basis.

Voices from the Field:

Sharing of the experiences from some ASHAs, ASHA Facilitators and Programme Managers

This session was on sharing of the field experiences by some ASHAs and ASHA facilitators, from some of the most remote and outreach areas of Assam, Jharkhand, Maharashtra and Uttarakhand. The session was chaired by Ms. Limatula Yaden, Director (NRHM), MOHFW.

Following ASHAs, ASHA Facilitators and Programme Managers shared their experiences:

Ms. Sita Devi, ASHA Facilitator from Ranchi, Jharkhand:

Rohila khatun, ASHA from Robri district, ASSAM

Dali Rani Banahm, ASHA Robri District, Assam

Meena. G. Patve from Amaravathi District, Maharashtra

Shewantha D Khadkhe from Amaravati District, Maharashtra

Ms. Dashmi Maishan, ASHA from Uttarakhand

Ms. Geetha Rao, ASHA Facilitator from Kedarnath, Uttarkhand

Dr. N. Lowang, District Medical officer, Longding district, Arunachal Pradesh

Responding to the issues raised by Dr. Lowang, Ms. Limatula Yaden said that she knows the problem of North East states, but reiterated the difficulties in fixing a monthly remuneration for ASHAs. But she assured that she will discuss the fixed remuneration issue in the next meeting of the MSG (Mission Steering Group) which will be held in the month of December. She also shared that in tribal area of Andhra Pradesh, fixed remuneration is being given to ASHAs.

Session on Early Childhood Development and role of ASHAs

Dr. Chittaranjan Kaul, Centre for Learning Resources, shared the experiences of an intervention on Early Childhood Development

A documentary was shown of an Early Childhood Care and Education programme intervention, an intervention which is being implemented at Rajnandgaon block of Chhattisgarh. This program attempted to enable various government departments to converge towards a unified effort of promoting integrated health for rural children. Dept. of Health, State Literacy Mission Authority and Dept. of Women and Child Welfare, came together and deployed 33 Master trainers, which included ASHA facilitators in the block and over 600 village communicators including ASHAs and others. Master trainers were trained on holistic child care strategies and participatory communication skills. Master trainers subsequently trained village communicators and village communicators finally carried holistic care message to care givers through home visits and para (hamlet) level meetings within their villages. The documentary showed anecdotal evidence on positive changes in some child care practices as well as child health, and caregivers, Village communicators, Master trainers, and mothers shared stories about spending more time with children and talking to them. They narrated their experiences of the significant and marked improvement in the nutritional status of several underweight children over a short period of time. Dr. Chittaranjan shared that SHSRC, Chattisgarh was involved closely in this intervention in providing training for the Master trainers and Village communicators.

Initiating the discussions on the issue, Ms. Indu Kapoor observed that training is needed not only for the parents but also for the grand-parents and other family members, as most of the parents will be going for work leaving the children behind in the house. However she cautioned that this would be a case of overburdening the ASHA and that the ICDS was the department responsible for this, Agreeing with her, Ms. Nupur Basu appreciated the usefulness of the program, but said that the main responsibility for such child care interventions lies with the ICDS/ Women and Child Development Department, and health department can provide support for such initiatives.

Dr. Sudarshan observed that ASHA is already overburdened with many works and this program will further increase her burden, hence he advised that these roles of education related to childcare and parenting should be played by ICDS department.

Ms. Suparna, from Centre for Learning Resources, agreed with the concerns expressed by members about the limitations of the role that parenting and child care education can play, and said that lot of problems related to health issues have to be solved by other multidimensional interventions.

Dr. Binod observed that this program is useful only for the working parents. Members also wondered about the utility of such an intervention in the Indian context. They also felt that ASHA should not be doing this when it was within the domain of the ICDS.

Session on Urban Health:

Mr. Nikunj Dhall, Joint Secretary, Urban health Mission, MOHFW, briefed the group about the NUHM program and said that all the state capitals and towns with population above 50,000 are covered under the NUHM. He observed that the health status and challenges are different in each city and the society is not as homogenous as in rural population. He shared that NUHM will also focus particularly on the health issues of slums, destitute populations, and people living on streets. ASHA will be put in place at the community level, and each ASHA will cover 200-250 families. In the urban context, problems of Alcoholism and Non-communicable diseases are a major challenge. ASHA has been engaged till now mainly in RCH and nutrition related activities and her capacity has to be built based on above factors. He also shared the strategies under NUHM for building community institutions like Mahila

Arogya Samithis for reaching and mobilizing the community especially the marginalized people.

Dr. Sudarshan said that in urban areas there is an urgent need for building strong communitisation processes. Control of epidemic diseases is an important challenge in urban situation, but comprehensive primary health care also has to be kept in priority, and also there is need for secondary and territory health care. He mentioned that there is need for the construction of new PHCs and FRU in slum areas, and funds should also be pooled from the municipal corporations.

Mr. Rakhal Gaitonde shared a concern about lack of adequate data from the field level on the urban health status. He also mentioned that some health care related data can be collected from the private sector. He stressed that urban health programme has to focus on urban poor, but neglect of middle class in the programme will adversely affect the quality of the programme. Ms. Nupur Basu said that measures have to be taken to reduce out of pocket expenditures.

Mr. Nikunj Dhall also observed that in the next ASHA mentoring group meeting, one session should be kept exclusively for urban ASHA programme.

Day 2: Valedictory Session: Chair: Shri. Keshav Desiraju, Secretary, Department of Health and Family Welfare, GOI.

Dr. Sundararaman introduced the AMG members and ASHAs and ASHA facilitators. First of all, some of the ASHAs shared their experiences with the secretary. Later some of the AMG members also shared their experiences from the field visits and study visits.

Experiences from States - Sharing by AMG Members:

Ms. Sulakshana Nandi, from Chattisgarh, who is an AMG member, briefly shared experiences from her visit to two districts of Punjab, Patiala and Nawanshahar. This visit was done as a part of Qualitative Phase of the ASHA Evaluation study of Punjab. She shared that there was a unanimous appreciation for ASHA's work by the officials from the state, district and block levels, that ASHAs are playing an important role in increase in institutional deliveries, immunization and decrease in infant and maternal mortality, as well as birth rate in the state. For the selection of ASHAs in the state, ANM consulted with community/PRIs, and a clear preference was given to the most educated woman, who was willing. In most of the

villages only one name was forwarded by the village and was subsequently selected as ASHA. Challenges of social and caste exclusion did not come across strongly in two districts visited. 94% of ASHAs were in place and the average population being covered by one ASHA in the state is 1057. ASHA Facilitators are in place, @ one for every 20-25 ASHAs, who have been selected from ASHAs of the same cluster. Again the highest educated, willing and active ASHA was the criteria for selection of facilitators.

GoI Modules on ASHA training have been adopted, & translated, and some additional training have been also conducted for ASHA by Breastfeeding Promotion Network of India (BPNI). Monthly meetings are being done at CHC/PHC level and incentives payments are being done regularly on time, through bank transfers or a single cheque. Grievance Redressal Committees have been set up, but there are no external members in the committee. She shared that Round 1&2 of 6th & 7th training has been done without copies of 6&7 Module and HBNC equipment were also not made available to ASHAs. ASHAs have been given weighing machines only recently. ASHA drug kit has only Paracetamol, IFA and Chloroquine. Home visit forms/registers are not being provided to ASHAs and she has to photocopy or print them at her own expense. Patients and ASHAs have to face rude behavior and there is considerable out of pocket expenditure in the hospital. She said that quality of communication and capacity building at monthly meetings of ASHAs is weak and ASHAs have been playing negligible role in VHSNC. She shared that recently, as per state level instructions, 180 ASHAs were identified as non-performing and 90 of them were dropped out of the programme. She stressed that this is problematic because the ASHAs were identified as non-performing only because they were receiving less than Rs. 100 per month as incentive, and no other analysis was undertaken for the reasons of non-performance. These ASHAs were mostly in underserved districts. Such a process also takes away decision making from community. The state also has a small team at state level for ASHA programme management and resource support, with only 1 program officer for ASHA, and no AMG having been established in the state.

Ms. Nupur Basu, shared her field experience of the programme in Tripura, based on her visit to 2 districts Khowai and Gomati. She shared that almost all target ASHAs are selected in the two districts and they have undergone 3 rounds of training in Module 6 & 7. She talked about Mission 100, a special initiative of the state, which aims at achieving 100% immunization. It

has been implemented at Teliamura CHC in KHOWAI district as a pilot project. It tracks immunization status of each mother and child in the community. On the basis of the records and database, a phone alert is given to ANM/beneficiary, on previous day if the phone number is available, so that they can inform mothers / ASHA, and it can be ensured that not a single case would be missed out. ANM gets Rs. 50/- for phone calls, and ASHAs make only missed calls to ANMs. She also shared her observation that AYUSH doctors and master trainers of ASHAs act as ASHA Nodal Officers at different levels. The State has taken decision to involve them in those sub centers for ANC where MPW Male is the center in-charge. The baby weighing scale provided by the State are not appropriate for weighing a new born in many cases, and state has taken initiative to replace such machines. She also found in her community visit, that in some instances the ANC visit entries were not marked in MCP card. She also found after making household visits, visiting Gomati DH, and observing from child cards that in some cases, BCG and OPV were being given after 50-60 days of birth along with DPT & Polio 1ST dose. The cards are also the older version. “ASHA Varosha Divas” is observed every 26th day of the month, (earlier it was on 1st Monday) where refresher training of ASHAs is done along-with the disbursement of monthly payment. The training of ASHAs on ARI and diarrhea management was being conducted through video demonstration. She also shared her observations on the process of performance monitoring in the state, based on 10 indicators, which includes, grading (A/B/C/D) for household visits, supporting institutional delivery, attending VHNDs & promoting immunization, ASHAs acting as DOTs providers, successful referral, etc. These reports are filled up through cluster meetings by Facilitator, subsequently checked by Facility ASHA Nodal Officer and are submitted to Programme Managers at Sub-division/District level during monthly meeting every month. She suggested that some measures are required to be taken for ASHA support system staff in the state like, Capacity building on usage of MCP card, WHO growth charts and knowledge of services available at ICDS. Check list for ASHA facilitators has to be developed in order to monitor ASHA’s activity properly. ASHA facilitators require field based training along with hand holding support. Provision of IEC materials such as flip book, cloth posters on various MCH issues should be available to ASHAs & their Facilitators. Involvement of PRI members and AWW is required at ASHA Varosha Divas to strengthen convergence of all departments.

Mr. Sameer Garg, Senior Programme Manager, SHRC, Chhattisgarh, shared his experiences of visit to Amarvathi and Bhandara Districts in Maharashtra. This visit was done as a part of

Qualitative Phase of the ASHA Evaluation study of Maharashtra. He mentioned that there are about 60,000 ASHAs in the state. In the selection process, PRI is playing active role and ASHA is selected in the Gram Sabha based on the education criteria. One ASHA covers 900 population on an average in the state and education criteria has been relaxed in the selection process of ASHA in tribal areas. He also mentioned there is a good support structure for the ASHAs, with one ASHA facilitator for every 10 ASHA in Tribal areas and one ASHA facilitator for every PHC in the non tribal areas. He mentioned that ASHAs are playing important role in the institution delivery and immunization, and state records 96% of institution delivery, and officials appreciate ASHA's role in control of malaria. He further shared that ASHA's work load is quite high as she is maintaining 16 records and information from these registers is being entered in to central web-based data system. ASHAs are receiving incentives for 35 activities in the state. He also observed that refilling system of ASHA Drug-kit should be strengthened in the state.

Taking the discussions further, Mr. Alok Mukhopadhyay, said that NIHFWS must conduct courses for doctors on the issue of sensitivity towards community and ASHA, and should include content on this issue in all of its training for doctors. He also suggested that SIHFWS should also be included in such trainings. He further said that ASHA's capacities should be strengthened in tackling malaria and TB programme, and also in effective implementation of IEC/BCC programmes in the community. He also mentioned that convergence needs to be developed, between ICDS and ASHA programme and also the payment systems for ASHA need to be streamlined.

Ms. Indu Kapoor mentioned that in many areas ASHAs get de-motivated when women supported or escorted by them do not get adequate facilities and services. This has to be avoided and Inter-personal communication skills of ASHAs have to be strengthened. She shared that Chetna has developed a training module on this and would be happy to support such training.

Dr. Rakhal Gaitonde, raised the issue that in Tamilnadu, interventions of community action group on Community Monitoring and, ASHA and VHSNCs interventions are being implemented in complete isolation, in silos, and stressed on the need for coordination.

Mr. Binod said that the roles of ASHAs need a relook, and mentioned that ASHAs in Kerala are involved in palliative care and more training also incentives are needed for ASHAs in palliative care. Kerala has an increasing burden of NCDs and it will help reduce financial

burden of middle class families. He said that his organization Pallium India is ready to support in such a process.

Mr. J.P. Mishra shared that with the newly introduced system of incentive payment through Panchayat, the amount of average incentives being paid to ASHAs has increased up to 4-5 times, within last 3-4 months. It has also helped in better coordination of ASHAs with PRIs and an improvement in communitization process. He stressed on the need for strengthening grievance redressal system for ASHAs.

Session on Gender Based Violence –

A presentation on the issue of gender based violence was made by Ms.Karuna Nandi, an activist on women's issues and an advocate in Supreme Court of India.

She presented different facets of Gender Based Violence and outlined the possible roles that front-line workers especially ASHAs can play in addressing this issue particularly in rural context. She also discussed various possible frameworks for an intervention by Ministry of Health on this issue, and also mentioned that a major corpus of fund that has been earmarked by GOI for interventions on the 'Violence Against Women' (VAW) issues, called Nirbhaya Fund, has not been put to any use till now, and any interventions focused on the ASHA's role in VAW if initiated by MOHFW accesses the Nirbhaya Corpus fund.

Remarks by Secretary, MOHFW,

Mr. Keshav Desiraju, in his concluding remarks, after listening to the experiences of AMG members and ASHAs, stressed upon the need for more comprehensive training for ASHAs. He said that with about 9 Lakh ASHAs working in the country, and after 7 years of NRHM programme period, there is a need now to strengthen the training interventions for ASHAs on a more sustained basis, and with a more permanent structures. ASHA needs more training and more money, 20-25 days of training for ASHAs is not enough, and we must have comprehensive, longer and phased-out training programmes of up to 6-9 months. He said that we have to overcome the challenges of training and have to also fight with the state's view that she is an honorary worker. He said that we need to increase funds for training in the states, and accordingly need to include them in the PIPs, and said that AMG members must advocate for this. He emphasized that a graded and phased out approach of training has to be

adopted. He also mentioned that training should be now designed differently for ASHAs with 6-7 years of experience and the newly inducted ones. He also stressed on the need for promotion of ASHAs to enroll in ANM schools, and said that any such effort can be supported in the PIP.

He also spoke on the problem of Violence against women (VAW), and said that it has very harmful consequences for women's health and also on children. Health department has to take initiative. Guidelines and protocols have to be developed for hospitals on VAW, as to, what law says and what is required to be done at different steps and different situations. When a case of VAW reaches a hospital, what steps are to be taken when the woman does or does not want it to be known to her family, or if she wishes to report or not report it to the Police. ASHA has a role to play not only when it has happened but also in preventing such things to happen, as she knows the families most closely, being an insider in the village. She should build trust with the families and support them on this issue, but we can't expect her to do it on her own. We need to support her for playing this role, and a basic training module on the issue of Gender Based Violence can be a good starting point for this process. He also outlined 2 types of works which are part of this intervention. One part of it relates to building a social consensus on the issue that Violence against women is completely unacceptable and is also quite prevalent in our society in many forms, and this issue should also be discussed openly in the Gram Sabha. The other part of the work related to the role of ASHA in situations when violence against a woman has happened. She should be empowered so that she takes such a woman to the facility and helps her in getting medical help as the first step, and she needs training for playing this role. We should include many different types of illustrations on this issue in our training content: on physical, mental and other forms of violence against women. ASHAs should also help the family when such an incident has happened, and support in taking care of the children. He said that we should also build our understanding and guidelines on what should we do as a collective, as a village, on such issues. He reiterated that ASHAs have a role to play even before actual occurrence of such violence, particularly in prevention of such an incident. Not only a training module on this issue has to be developed, but also this issue has to be included compulsorily in all ASHS training modules. It is also essential that discussions are done with women and men at community level on the issue of treatment of such women.

He shared that as a first step, guidelines and protocols are being issued by MOHFW for health workers, which will be issued to all government and private hospitals.

He sought the opinion of the AMG members on what can be the ASHA's role on violence against women issues in urban setting, because the social matrix and situations in urban context are quite different. He said that if AMG feels, ASHAs who are more experienced can be involved in VAW issues in urban settings.

AMG members expressed their opinions and views on the issues raised by Secretary. Ms. Nupur Basu said that some of the best exemplars of interventions and initiatives by VHSNCs on the issue of violence against women need to be seen.

Mr. J P Mishra said that Institutionalized response systems should be established for dealing with the VAW issues, and also the system's responses should be strengthened. He also asked whether we can think of a state level resource centre on the issue.

Ms. Sulakshana wanted to know if ASHA Facilitators and Block Community Mobilisers can be designated as protection officers, as first contact persons for action on violence against women. It was also shared by members, that to deal with any potential backlash, we need to involve more people, and ASHAs have to map out all their support on this issue. Ms. Sulakshana also shared that the World Health Organisation has provided guidelines for GBV, and in Chattisgarh, panchayats are involved in helping women to fight against VAW at village level, but the coordination between ASHA and Anganwadi worker is important in this process.

Dr. Rakhal Gaitonde stressed on the need for standard treatment guidelines for handling the people affected due to Gender based violence and also what is required of protection officers and other mainstream systems and processes. He also commented that for ASHA as a person it's very difficult to handle the gender based violence and she needs support of community and VHSNC. Mapping of women who are vulnerable to GBV and creating forum where she can discuss the problem of GBV is required to be done. This can be initially implemented on a pilot basis, by providing support structures.

Mr. J P Mishra suggested that; the processes that can be organized or triggered at community level should be mapped out and listed, and panchayats should be involved in a big way. He said that small pockets can be taken up for trying out these strategies. He also said that along-with the training module on this issue and training of ASHAs, setting up a process to address this issue is also equally important.

Mr. Binod suggested that these strategies should be tried out in places where ASHA's workload is not very high, and Kerala can be one suitable state to try it out.

Ms. Indu Kapoor shared that Modules prepared on this issue have been prepared by those working on this issue for a long time, and we need to see those modules and review. She particularly mentioned the Module prepared by WHO on the issue, which is about 10 years old. She also said that the protocols should also suggest, that if the woman who has faced violence is not willing actively to come to the forefront, where she can go.

Ms. Shalini Singh observed that the protocols and system's responses as being discussed, can be made part of the guidelines, and may not come in the training module being prepared on this issue.

Ms. Sulakshana observed that in many states work is already being done on this issue, so no pilot may be required.

Mr. Rakhal said that we need pilots to be done, not for studying whether such interventions should be done or not, but for collating good experiences and documenting them for learning.

Dr T Sundararaman suggested that;

- ASHA should be seen at-least as an entry into a network of people of influence and power
- No simple rule will fulfill the need, as a judgement call is to be made based on a number of factors
- Judgment call to be made by ASHA is in terms of provision of care, and navigation, which is a complex task. Bringing up a child is also a complex task, and ASHA is trained in such complex tasks and so can be trained better to take a judgment call.
- Situation of violence against women are different and subjective.

Ms. Nupur Basu also observed that decline in Child Sex Ratio is related to increase in Violence Against Women.

Concluding the valedictory session, Mr. Desiraju, presented mementos to the ASHAs and ASHA Facilitators from the states who were participating in the meeting.

Concluding session

A session for sharing of some new programme initiatives was held after the Valedictory session. In the session Dr. Rajani Ved thanked members for feedback on the hand book on ASHA's role in Violence Against Women, and also requested inputs to the Training Module for VHSNC members and Handbook for members of the VHSNC. She also shared the key questions for formative research on new roles for ASHA.

Dr. Sundararaman explained to the group about the background of this initiative of the formative research for engaging frontline workers in chronic diseases. He further explained that ANM is over- burdened with many activities and she has very little time for the clinical practice. So ASHA can be engaged for screening activities for some emerging new health challenges related to Non Communicable Diseases (NCDs). He said that we need to undertake a time motion study to assess the time taken by an ASHA to complete screening for individual cases in her coverage area using a pre-designed algorithm for history taking, using point of care diagnostics, and asking some questions and referring the suspected cases for confirmatory tests.

The second question was effective community level approaches for detection, support and follow up for three common forms of cancer, i.e. cancer of the cervix, breast and oral cavity. He stressed on the need for literature review to assess the strength of evidence for the use of lugol's iodine over acetic acid and for visual inspection of the cervix.

He also observed that, as a pilot intervention, mechanisms need to be built to enable integration of the triad of early identification, referral and management of four childhood disabilities, diseases, defects and development delays, into tasks of frontline workers.

Dr. Sundararaman also observed that instead of registers as a mechanism for record keeping, new mechanisms like tablets can be tried which would be designed as per the specific information needs for frontline providers. It would enable improved quality of follow up and also generate a collateral, population based, data for that level and system of development, which will also be open ended and dynamic, and will allow for changes as per the requirements of the local suitability, and will allow for testing the feasibility of introducing electronic health records

Ms. Nupur said that the data has to be simple so that ANMs/ASHAs do not have difficulties in reading and recoding the data.

Dr. Rakhil shared an initiative in Tamil Nadu for training being conducted at PHC level for entering data into a software program that has been built in collaboration with IIT Chennai.

In the end of the session, priority next steps were discussed as; the need for modification of existing modules recommending on work load and incentives for ASHAs, and module on BCC/IPC for the ASHAs.

Ms. Indu Kapoor observed that ASHA training modules must be developed in Hindi or other regional languages and then be back translated into English, as otherwise the essence of the messages is diluted. She also observed that the issue of Nutrition has to be elaborated better in the existing modules or a separate module on Nutrition should be developed. She also remarked that early childhood care should be handled by WCD. She also shared with the members, the module 'Women and Health' developed by Chetna some years ago, and which she felt still had relevance in the present context.

The meeting concluded with Dr. Rajani Ved thanking all participants who attended the meeting.

Key Recommendations and Follow-up Action on NAMG meeting – October 29-30, 2013

Role of ASHA

- Strengthen the role of ASHA in providing preventive and promotive health care, with strong focus on BCC and IPC activities, particularly on the issues of age at marriage, nutrition, home based care delay in first child and spacing between first and second birth, and appropriately incentivize these roles.
- Build the capacity of the ASHA to address issues of Violence against Women
- In areas where RCH challenges have been addressed, the exact role of the ASHA and training needs, in areas such as prevention of non- communicable diseases, disaster management and palliative care needs to be studied and designed with a perspective on establishing functional referral linkages.
- Activities of the ASHAs should be increased with a corresponding increase in the incentives, so that she can get up to Rs. 4000-5000 per month.
- Some pilot districts should be taken up for giving these inputs on IEC / BCC skills to ASHAs, and these skills should also be built into the certification process.
- A sub-set of ASHAs should be created with higher skills set on home delivery, asphyxia management, and management of such cases at home.

- ASHA's understanding should be developed on 5x5 matrix of MOHFW on RMNCH+A, and also on the link between its different components.

Selection Process

ASHA selection and removal process must ensure –

- Greater control of community on the process, and transparency in all processes
- More socially inclusive representation in ASHA selection.
- Robust mechanisms for assessment of enabling factors and programme, in-depth enquiry, and active consultation with ASHA and community before replacement of non-performing ASHAs

Training

- Re-evaluate ASHA training content and modules as per the new programme challenges and new roles.
- ASHA trainings should be done on more sustained and rigorous basis, and more permanent training structures should be established. Such trainings need to be accordingly included in the PIPs.
- Training should be now designed differently for ASHAs with 6-7 years of experience and the newly inducted ones.
- Quality of training needs strengthening. Methodologies for effective training should be recommended for the programme. Learning from the training conducted by the NGOs should also be considered.
- Rate contract system, based on the principle of reverse tendering, needs to be developed for the activities related to training - hiring of venue, food, etc.
- Examine best practices on the training management and consider the options of the whole package of logistics services for conduct of training
- State Institute of Health and Family Welfare (SIHFWs) and Anganwadi Training Centers (AWTCs) can be used as venues for the training of ASHA if they are available.
- Training infrastructure and management practices under many different departments and programmes of government like, Education department, District Training Centres, BRCs & CRCs (Block & Cluster Resource Centres under SSA) BRGF (Backward

Regions Grant Fund), , Anganwadi Training Centres (ATCs) should be seen. The approved rates of these training centres should be acceptable for ASHA training.

- ASHA facilitators require substantial training to better and hand holding the ASHAs.

Support System

- All states must have in place an ASHA and VHSNC support system with all personnel sensitized to, and trained in the community processes component of NHM. Support systems must also be standardised based on the learning of what works, with active dissemination of the existing models currently being implemented.
- Best practices of Procurement of drugs and HBNC equipment (Haryana experience through UNOPS, Following DGS&D rate contracts) could be followed by other states. Specification of equipment must be provided to states.
- Mobile based systems of update for drug stocks and utilisation should be developed linked with MCTS platform for eg. sending sms to the facility when the stocks of a particular drug are running low.
- Aspirations of ASHA for higher learning and opportunity for career building should be encouraged: e.g. admission to ANM and GNM courses. Any such effort can be supported in the PIP.
- Grievance Redressal system must be established all across the states and be made to function effectively.
- ASHA payments need to be streamlined and systems of on-line payments need to be built,
- VHSNC and PRI representatives of the village should have a role to play in payment of incentives to ASHA

Convergence

- To promote convergence, joint training of ASHA and ICDS workers should be done, and made part of the national programme.
- An extra allocation of 2% of the overall budget envelope could be considered for states who promote convergence.
- Training of medical officers by NIHFWS (and SIHFWS) should include a component of sensitization to the ASHA and her role in strengthening community processes.

Violence Against Women (VAW) initiatives

- Training of just the ASHA on issues of VAW is insufficient, Guidelines and protocols need to be developed for hospitals and all other stakeholders on VAW.
- A state level resource centre on the issue of VAW should be considered
- Mapping of women who are vulnerable to GBV and strengthening the VHSNC as a forum for building social consensus and serving as a safe space for the ASHA can discuss the problem of GBV is required.
- The issue should also be discussed openly in the Gram Sabha. Processes that can be organized or triggered at community level should be mapped out and listed, and panchayats should be involved actively in this process.
- ASHAs who are more experienced can be involved in VAW issues in urban settings.

Annexures:

Annexure 1: List of Participants-11th National ASHA Mentoring Group Meeting, October ,29-30,2013

Sl.No	Name	Designation, Organisation & Address	E-mail Id	Phone/Mob No.
1	Dr.H.Sudarshan	Karuna Trust, 686, 16 th A main, 38 th cross Jayanagar, T Block Bangalore-560041	drhsudharshan@gmail.com	0-9448077481
2	Mr.Binod Hariharan	Pallium India , s-10,vrindavan gardens, opposite pattom traffic police station, pattom Trivandrum-695004	binod@palliumindia.org	0-9400059990
3	Dr. J.P.Mishra	Executive Director(ex-officio), SHSRC, Bijlichowk , Kalibari ,Raipur< Chhattisgarh	jaypmishra@gmail.com	0771-2535305, 09899315900
4.	Dr.Nupur Basu	Child In Need Institute (CINI), Village& PO Daulatpur, Via Joka, Dist South 24 Pargana, West Bengal	nupur@cinindia.org	0-9831105836 , 033-24978641/42
5	Dr. Alok Mukopadhyay	Voluntary Health Association of India (VHAI), B-40, Qutab Institutional Area, New Delhi- 10016	vhai@vsnl.com	011-26518071/72
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7	Dr. Rakhal Gaitonde	SOCHARA, C/o Balamandir Research Foundation, 31, Balamandir Compound, Prakasam Street, Chennai, PIN-600017	rakhal@sochara.org	M-9940246089 Tel: +91-44-45502438
8.	Ms. Sulakshana Nandi	Public Health Resource Network 28, New Panchsheel Nagar, Near KatoraTalab, Civil Lines, Raipur, Chhattisgarh-492001	sulakshana.nandi@gmail.com	0-9406090595
9	Ms. Indu capoor	CHEटना, Supath-II,B-block, 3 rd floor, Ahmedabad Gujarat-380013	Chetna456@gmail.com	0-9824021686
10	Mr. Samir Garg	Program Manager, SHRC, Chattisgarh, Kali Badi Chowk ,Raipur	koriya@gmail.com	0-94255583395
11	Dr.N.Lowang	District Medical officer, Longding district, Arunachal Pradesh	nlowang_99@rediffmail.com	0-9436272926

12	Ms.Sita Devi	ASHA, Ranchi District, Jharkhand		0-9934348766
13	Ms. Jacinta ainod	ASHA Facilitator, Ranchi District, Jharkhand	Jacinta.aind@gmail.com	0-9835858299
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16	Ms. Geeta Rawat	ASHA, Uttarkhand		0-9627437789
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19	Ms.Meena .G.patve	ASHA , Amarwathi district, Maharashtra		0-7220218289
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22	Ms.Rohila Khatm	ASHA, Assam		----
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Annexure 2:

Agenda for National ASHA Mentoring Group Meeting October 29 -30, 2013	
National Documentation Centre(NDC); Auditorium, First Floor, National Institute of Health and Family Welfare Munirka ; New Delhi	
Time : 10:00 am to 5:00 pm	
Day 1:29-10-2013 ,	
Welcome	
1.	Update on Community Processes
-	Report on Progress of ASHA & VHSNC
-	Sharing by NAMG Members
2.	Voices from the Field
-	Sharing experience of ASHA & ASHA Facilitator
3.	ASHAs in Early Childhood Development, Centre for Learning Resources
4.	Review of Guidelines and Modules and discussion on VHSNC training strategy
Day-2:30-10-2013	
5.	Secretary, MOHFW Interaction with members of the National ASHA Mentoring Group and ASHAs /ASHA Facilitators
6.	Discussion on Violence Against Women, and the role of frontline workers
7.	Discussion on Formative Research proposals for new roles for ASHA
8.	Closing and Next steps

Annexure 3-Voices from the Field:

Sharing of the experiences from some ASHAs, ASHA Facilitators and Programme Managers

This session was on sharing of the field experiences by some ASHAs and ASHA facilitators, from some of the most remote and outreach areas of Assam, Jharkhand, Maharashtra and Uttarakhand. The session was chaired by Ms. Limatula Yaden, Director (NRHM), MOHFW.

Ms. Sita Devi is an ASHA Facilitator from the Jharkhand: she comes from Karla Block of Ranchi district, and is responsible for supporting and mentoring 23 ASHAs and 20 VHSNCs . She shared with the group that HBNC training was very useful for the ASHAs in her area and institutional deliveries have increased substantially in her block, due to good work done by ASHAs. Initially ASHAs were facing problems in weighing of the children and

filling the form and writing work, particularly those Sahiyas (ASHAs) who have lower educational qualifications. She informed that ASHAs are making seven newborn visits in case of home delivery and 6 visits in case of institutional delivery. She also shared that they are referring the underweight children to RIMS hospital Ranchi, because there is no facility at Karla block. She is happy about her work and feels proud to be an ASHA.

Rohila Khatun, an ASHA from ASSAM: she comes from the Robri District and serves a village population of 900. She is involved in the early identification of pregnancy and their registration, for ANC and PNC check-ups, Immunisation etc. In her District last year there was a communal riot, after which government established rehabilitation camps for the people affected by the riots. In this camp she was involved in the monitoring of pregnant women and children, and she referred some women to Hospital for institutional delivery and in some cases of emergency situations, she also conducted 48 deliveries in the camp itself. She had earlier undergone HBNC training. She had consulted VHSNC members and purchased biscuits and bread from the untied funds, and distributed them in the camp. She also shared her experience when, she had taken a pregnant woman to the district hospital for delivery, and was told by the hospital authorities that blood is needed for the pregnant woman, but the required blood was not available in the hospital. After coming to know that pregnant woman's blood group and her blood group was same, she donated her own blood and saved the life of pregnant women.

Dali Rani Banahm, an ASHA from the Assam, Robri District: her area was also affected by the communal riots and she also visited 3 rehabilitation camps and was involved in looking after the health status of the pregnant women and referring them for the dispensaries and PHCs for the institutional delivery. She once accompanied a woman to the district hospital, just then riots broke out in the area and she stayed with the woman for three days without any food. She shared her experiences of another instance when she referred a pregnant woman for delivery to district hospital, and the district hospital referred her to other district hospital, but they subsequently referred her to other private nursing home and finally delivery took place in the private nursing home.

Meena. G. Patve from Amaravathi District, Maharashtra started working as ASHA in the year 2008, she is presently involved actively in promoting Institutional delivery, ANC, PNC and immunisation program. She narrated one experience from early stage of her career, when one pregnant woman in her area had delivered at home and the baby didn't cry after birth,

and no one could anything and it was realised after some time that the baby had died. The mother also became serious, she was referred to the hospital, and ASHA also accompanied her there, she was recovering well, but after three days in the hospital, their family had fed her something against the advice of doctors and she died. The family members of the woman were very angry with the ASHA and blamed her for the woman's death, and also beat the ASHA. Despite all this ASHA continued her work and now people in the community approach her for support in various health services and she is happy about her work. She also expressed satisfaction about the trainings provided to her.

Shewantha D Khadkhe from Amaravati District, Maharashtra, she became ASHA Facilitator in 2010. She shared that she prepares monthly work plan and makes her plan in such a way that she can do more than one visit to ASHAs whose performance is very low, and where there is a problem. After the Module 6&7 training, she particularly observes skills of ASHAs in the field, guides them and solves their problems. Even though the number of her field visits, as provisioned for in the programme is limited to only 20, she conducts more than 25- 30 visits every month. She shared some of the stories of good work being done by ASHA under her supervision. One ASHA in the field had recognised danger signs of delivery and referred the woman to the hospital. But because the family members believed in superstitions, they brought 4 traditional healers, and started performing pooja. ASHA saw that woman's health was worsening and she challenged the family members and traditional healers, and tried to convince them to take the woman to the hospital to save her life. Finally, the family got convinced, and took the woman to Amaravati district hospital. The doctor there told them that even one hour's delay in hospitalisation would have been fatal for the woman, and appreciated the efforts of ASHA. Another ASHA found in her village, a child with severe malnutrition and suspected the mother to be suffering from TB. She informed the ASHA Facilitator and both of them together referred and convinced the family to take both mother and child to PHC, where the mother was diagnosed as positive for TB. With regular follow up of ASHA, mother took the treatment and ate the medicines properly and ultimately recovered from TB. In the mean-time ASHA regularly monitored the child also and supported the family with nutrition counselling, and subsequently child improved from severe to moderate malnourished status.

Ms. Dashmi maishan, ASHA from the Uttarakhand: she shared her experiences from the recent disaster due unexpected floods, that brought heavy damage in their villages, and narrated how, in one family 6 persons were washed out in the floods. ASHA provided

accommodation for the one person, who had survived. She also shared the very difficult situations in the area due to the break-down of transportation and communication facilities. She shared that after the training to ASHAs provided by the Medical officer of the area, she was involved in the efforts for prevention of communicable diseases, by distributing chlorine tablets in the community. She was also involved in care of pregnant women and the providing support in deliveries that were happening at home due to difficulties of transportation. She shared that she was receiving more respect now as an ASHA in her village.

Ms. Geetha Rao, ASHA Facilitator from Uttarkhand: her village was 30 km away from the Kedarnath , her relatives were lost in the flood and in nearby village the village ASHA had lost her husband and son, and she provided help to her in recovering from the shock. She narrated the difficulties of the situation, as there was no food and roads had been washed out in the floods. They used the forest roads to reach the people, but still it was very difficult as the houses are so scattered. She also narrated that another ASHA had kept one pregnant women in her own house and delivery was carried out at her house itself, and the mother and child were kept in the house for 5 days. She also shared that many ASHAs provided accommodation to the people in her own house. She also shared her experiences of being involved in community level efforts for prevention of communicable diseases after she had received the training from the Medical officer. She also shared how a pregnant woman was airlifted from the village to the hospital. She shared that training given to ASHAs on disaster management was very helpful for them as their villages are always vulnerable to natural calamities.

Dr. N. Lowang, District Medical officer, Longding district, Arunachal Pradesh: she presented the status of ASHA programme and challenges in her state. She shared that the average population being covered by ASHAs in the state is quite low, and brought the attention of the NAMG members to the problems of ASHAs in the field. She narrated the case of Ms. Mai, a 55 year old ASHA from Chaglagaeh village, who had earlier been working as a Village Dai and joined as ASHA in 2006. She has got the JSY incentives only for 4 cases, since her joining, till date, as the only PHC of her area, Chaglagam PHC functions from a single room premises, and is sometimes completely non-functioning, due to un-availability of technical manpower. She emphatically expressed that the case load is very low in the area in general, and in some cases it is extremely low, with one ASHA in the state covering a village population as low as total 98. Another ASHA, named Ms. Binasai Awailiang from Khalega village is working as ASHA since 2006, and covers only 110

population. Working at 10,000 feet above sea level, till now she has not received any incentive, as there is no road literally to reach to the hospital or to any modern place. These problems severely restrict the earning potential of the ASHAs and make it difficult for them to continue as an ASHA. She made a strong pitch for paying a minimum fixed remuneration of Rs .1000/month to ASHAs in her state.

Responding to the issues raised by Dr. Lowang, Ms. Limatula Yaden said that she knows the problem of North East states, but reiterated the difficulties in fixing a monthly remuneration for ASHAs. But she assured that she will discuss the fixed remuneration issue in the next meeting of the MSG (Mission Steering Group) which will is going to be held in the month of December. She also shared that in tribal area of Andhra Pradesh, fixed remuneration is being given to ASHAs.