Meeting Minutes - Twelfth National ASHA Mentoring Group Meeting
August 20, 2014, NHSRC, New Delhi

The 12th meeting of the National ASHA Mentoring Group was held on August 20, 2014, at the National Health Systems Resource Center, (NHSRC) New Delhi, which serves as the secretariat of the National ASHA Mentoring Group. The list of participants is at Annexure 1 and the meeting agenda at Annexure 2. Shri. Manoj Jhalani, Joint Secretary – Policy, Ministry of Health and Family Welfare, chaired the inaugural session. Four members (Dr. Vikram Patel, Dr. Armida Fernandez, Dr Amod Kumar, and Dr. Saroj Naithani) were not able to attend on account of other commitments.

Dr. Sanjiv Kumar, Executive Director, NHSRC welcomed the members and in his opening remarks lauded the critical role that ASHA is playing in ensuring access to health services at the community level, and that she has a crucial linkage with the local level institutions particularly the panchayats. He underscored ASHA's activist role, and cautioned against her becoming like an ''employee" of the health department, and said that she should be empowered to take lead role in Village health planning. He emphasized the need for strengthening evaluation processes and feedback to improve her effectiveness. He emphasized the need for providing benefits for ASHAs, like Pension, Death benefits, scholarship etc. He shared that recently a question has been asked in the Parliament about the Grievance Redressal mechanisms in place for ASHA. He mentioned the welfare systems being developed in various states for ASHA, and stressed on the need for improving the support structure for ASHA and VHSNC interventions. He also mentioned the importance of identifying non performing ASHA and building robust performance appraisal structures, and underlined the variations in the selection processes, between districts and across states.

Dr. Rajani Ved, Advisor, Community Processes, provided an update of the ASHA programme, and highlighted the strengths and challenges in various states facing the programme. She shared that state level commitment to ASHA/VHSNC was sustained

and continues to be high. This was reflected in increasing number of states providing additional incentive payment for ASHA over and beyond that provided by the center, (and this itself had increased owing to the MSG approval for routine and recurring payments to ASHA amounting to Rs. 1000), and providing for ASHA welfare and benefits, She shared that mechanisms for grievance redressal of ASHAs are taking off, and many states have their linked toll-free numbers to such mechanisms. Cross learning between states was also taking place through exposure visits. States were also including state, district, and sub district support structures in their Project Implementation plans (PIP).

She shared that the high rate of attrition among the trainers at national, state and district levels was one of the factors affecting the pace of the skill building training of ASHAs in Module 6&7. There is an urgent need to expand the pool of available trainers, as most of them were not contracted full time, but recruited on an adhoc basis with the result that as soon as they got full time jobs, they were lost to the skill pool. She also shared that six full time National Trainers were approved by the NHSRC Executive Committee, but this needed now needed approval from the Governing Body of NHSRC. Non availability of appropriate training sites with adequate infrastructure and facility for residential training, especially for the ASHA at the sub district levels was also a major concern. She also shared that timely procurement of HBNC equipment kits and training modules is emerging as another challenge and often kits were not available at the time of training allowing the ASHA to practice with her own kit, and thus ASHA's skills were poorly developed.

She also shared other operational challenges in conducting training, and cited the example of Rajasthan, where in every **d**istrict, separate tenders need to be issued for food, site, and stationery etc, and this has affected the quality and timeliness of training. Some states were lagging in the task of filling the positions of different cadres of ASHA support structure, like the Facilitator and Block Community Mobilizers and sometimes the huge numbers and challenges of recruitment process have been the main deterrent. In states like UP and Bihar, where huge numbers were particularly a roadblock, NHSRC provided assistance in recruitment but attrition was a regular feature, and no fresh

appointments were made especially in Bihar.. She mentioned that supply constraints for regular replenishment are another area of concern for ASHA's effectiveness, particularly for Nischay Kit, OCPs, Cotrimoxazole and ORS. She also mentioned the challenges being faced in the process of establishing IT enabled monitoring systems and payments systems like Public Finances Monitoring System (PFMS).

Operationalising VHSNCs and making them effective was the next frontier for the Community Processes interventions. She mentioned that many states like Uttarakhand, West Bengal and Himachal have closely involved Panchayat Raj Institutions, and have transferred the VHSNC untied funds to Panchayati Raj department. While the experience is mixed, it is a move in the right direction.

On this issue, Mr. Manoj Jhalani, JS-P, MoHFW, made an observation that, Panchayati Raj Institutions need to be given active role and responsibility, particularly in view of the constitutional mandate given to Panchayats in this regard. He said that NHSRC must undertake an assessment of the integration of Panchayat and health department, and identify learnings.

Dr. Nerges Mistry, also expressed a concern about the challenges of convergence between departments. Mr. Jhalani expressed that convergence is much better at the field level. Ms. Nupur Basu, drawing from the West Bengal experience of Community Health Care Management Initiative (CHCMI), expressed that it's a good thing to transfer VHSNC's untied funds to Panchayati Raj Dept. Dr. Prabir Chatterji, shared the positive improvement in process of incentive payment to ASHAs in Chhattisgarh since payment is being done by village panchayats. He shared that earlier, Block Medical Officers had a hierarchical tendency towards ASHAs, but now with village Panchayat representatives making incentives payments to ASHAs, she deals with equals. Mr. Manoj Jhalani suggested that system of incentives payment through PRIs in Chhattisgarh should be studied in detail to identify learning of the processes and possibilities of replication.

Dr. Prabir Chatterji, mentioned that in Chhattisgarh, many of the Mitanins have now become Sarpanch or ward members and this has facilitated payment of incentives being done through panchayat.

Dr. Jagdeesan shared that in Kerala, Rs.10000 is given from Sachitran programme in addition to the untied funds of Rs 10000 though NRHM, and Rs. 5,000 is given from the Gram Panchayat, so a total of 25,000 is given to one VHSNC. Daily monitoring & supervision is done through ASHA diary, and ASHA software is being developed. An initiative for screening of cancer was launched and 210 people were identified for cancers. Three screening camps were held at sub center. ANM has been provided with Glucometre to start NCD interventions at the level of the sub center.

Ms. Nupur Basu, shared CINI's experience of running a NRHM funded project, Community Health Care Management Initiative (CHCMI), in West Bengal for around three years which was implemented in close coordination with Panchayat, and shared that this had provided lessons for positive integration between health and panchayat structures. She shared that the programme was terminated due to the miscommunication between two departments, and suggested that a study should have been conducted to understand the impact of any such programme before such termination.

Ms. Indu Capoor, from Ahmedabad, mentioned that we should not burden ASHA by replicating programmes from other states without looking at their suitability for the local context. For example, Kerala's main problem is not about the RCH indicators, so they are focusing on NCD and palliative care which cannot be replicated in states like UP, Bihar or even Gujarat.

Many members stated that they had seen that ASHAs in the field spent a lot of time on filling format for various services. Dr. Rajani clarified that MOHFW guidelines so far include only one format for HBNC payment which ASHA needs to fill, as part of HBNC guidelines. Mr. Manoj Jhalani's observations about filling of forms by ASHA, was that

ASHA was expected to enter details of her daily work, including those for which she received incentives in her diary which are to be countersigned by ASHA Facilitator. The Facilitator will have to now also facilitate the process for maintaining necessary records and vouchers required for payment of routine & recurring incentive of Rs. 1000/month, which has been approved by Mission Steering Group (MSG)for a set of monthly and periodic activities, like holding monthly VHSNC meetings, attending PHC monthly review meeting, mobilizing children for VHND once a month and updating village household register twice a year. Record keeping of this nature is necessary to ensure that she can be paid in time, without burdening her with too much of paperwork.

Dr. Prashanta Tripathy mentioned that for Anganwadi there are around 22 forms which Anganwadi worker has to fill as a routine, and, this should not happen to the ASHA, and there is an urgent need to undertake an assessment of different forms being used by states.

Dr. Rajani also shared the issue of working hours of ASHA in correlation to any additions to her tasks. Most ASHAs are working for more than 5 hours in a day. If this remains same in all the states then we should plan towards having one more ASHA or a second ASHA in a village. Dr. Abhay Bang mentioned that it could be a male worker, as proposed in the HLEG report.

NAMG members requested NHSRC to support states in constituting State AMGs and suggested that NHSRC should send letters to states with the name of the concerned member of NAMG who is assigned to provide support to their state. While this was done last year, NHSRC should repeat this exercise.

Dr. Alok Mukhopadhyay, expressed a concern that we are not being able to achieve MDG goals 4 & 5. He said different departments like, WCD, MOHFW and Rural Development, are working in parallel. A strategy should be devised to ensure use of resources optimally. He also talked about future role of ASHA as every state has different disease pattern, like Kala Azaris a challenge in Jharkhand, while some states

are endemic for Malaria & TB. So we should come out with a strategy which can cater to the need of all states. We should also think about role of ASHA in upcoming National Health Assurance Mission (NHAM). We need to guide ASHA for creating education & awareness for Tobacco control/Alcohol and for NCD in future.

Mr. Manoj Jhalani, shared the recent policy developments initiated by the new government. National Health Assurance Mission (NHAM), which is at the consultation stage, would be anchored within the National Health Mission, with greater resources expected to be pooled in, and with an assurance of services. Strengthened systems of Grievance Redressal, are another key element of this new framework. He shared that NHAM will have strong primary health care component along-with, preventive and promotive care, and provisions for free drugs and free diagnostics. In terms of provisioning, primary and secondary care will be through the government sector and with a supplementary role of not for profit sector and private sector, some purchase of services will be necessary, but the specific structures are yet to be designed. He mentioned that, an expert group has been set up to design the NHAM's framework and its report is being finalized, and would be submitted to the Prime Minister's office soon.

He lauded the important role being played by the ASHA programme, and particularly underscored its wide spread and sheer volume, and said that 'on the whole ASHA programme has done really well, with potential of doing better with right kind of skill, support and motivation being provided'.The JS referred to the question of the balance between service provision and activism as two roles of ASHA, and observed that we have taken a middle ground, but her capacity also improves if she undertakes some service delivery role in the community. He elaborated with the example, when ASHA provides Zinc tablets while counselling for Diarrhea management with ORS. He also cited the examples of Sikkim, where ASHAs are being trained on Non Communicable Diseases (NCDs), and Kerala which is involving ASHAs in Palliative Care. He emphasized that role of ASHAs is influenced by the local context, but all across she needs to be strengthened and skilled.

He highlighted that ASHA's presence and her work are being recognised, but also cautioned that on account of the sheer numbers, there was a demand of an honorarium for ASHAs, and Ministry constantly gets delegations of ASHAs from many states. He observed that we need to give more direction to the programme, and the accreditation and certification process being rolled out through National Institute of Open Schooling (NIOS), will help in this regard.

Discussing further the challenges of ASHA programme, the JS suggested that we need improved guidelines and a more stringent system for the ASHA selection process to ensure that we select the right type of person in the first place, because in the government system, people hired at any level tend to stay and the system also retains them. He also flagged the danger that trained ASHAs can be taken away by the private sector hospitals or can become their touts. Therefore we also need to devise and strengthen systems for identifying non-functional ASHAs and dropping them or easing them out of the programme. This is also important in view of the fact that sometimes after change of state government, there are efforts to replace many ASHAs. He mentioned that the model of ASHA helpline is also proving very useful in this respect, and a system based on toll free helpline number with call centre organised at scale, will help the programme greatly.

He also elaborated on the problems related to inter-departmental conflicts, which have also been spoken about by our Honourable Prime Minister in his 15 August speech. He said that, with the Prime Minister's attention to the issue, the situation will definitely improve, as no department would now like to be seen as deviating from this policy focus on interdepartmental convergence. He reiterated that health outcomes do not depend on the health ministry's work only.

Responding to the issue of India's progress on MDGs, he said that at current rate we are going to achieve MDGs 4 & 5. He shared that process for designing of the 'National Health Policy' has been set rolling. He invited insights and recommendations from the NAMG members to contribute to the policy framework.

Responding to Mr. Jhalani's remarks, Dr. Sudarshan, observed that with the some element of assurance of services under the new policy framework of NHAM, ASHAs will have greater space to play her role as an activist, and grievance redressal systems will also improve.

Dr. Indu Capoor, made an observation that we need to revisit the vision for the ASHA programme. We keep on adding to her tasks, and also there is some demand from the community as well, for more role for ASHA, so she keeps getting pushed into a spot with being overburdened. Dr Capoor said that ASHA needs skills to negotiate the health system. ASHA also does not yet have the skills to manage the VHSNC. On this issue Mr. Manoj Jhalani responded by saying that this was a difficult balance and there are limitations to how far ASHA can negotiate health entitlements from the system. She was being seen as part of the system, rather than the community, because she is dependent on the health system for payments, referrals and replenishments for her drug kit. Appropriate selection and support could ensure that she can balance her roles better.

Dr. Indu Capoor also raised a concern about the 'over-emphasis' on quantity at the cost of quality, and said that women are in a patriarchal system, so ASHAs need more quality focused support.

Ms. Sulakshana Nandi, raised a concern about the difficulties that states with their different types of programme management systems are facing, in implementing the PFMS (Public Finances Monitoring System), which is being initiated by Government of India, and also raised a question about the benefits of this new system. Mr. Jhalani, responding to her concerns, said that, PFMS will enable the monitoring system to know how much money is going to the ASHA, which will improve transparency. The incentives payment system for ASHAs linked to PFMS will also help in ensuring timely payment of incentives, and identification of non-performing ASHAs. Mr. Prabir Chatterji also shared that the system of account payee cheque payment to beneficiaries for JSY motivation money is posing a lot of operational difficulties, and he wanted to know how

successful this system is in other states. Mr. Jhalani responded, that the larger purpose for these measures is financial inclusion and ensuring bank access for larger sections of population. Bank payment systems for MNREGA and other schemes of Direct Benefit Transfer, are part of this process. He clarified that based on real field level difficulties regarding the availability of bank access, states can make specific requests for relaxation in this process.

In the process of sharing other concerns of their states, by the NAMG members, Ms, Annie from Meghalaya, shared that her state has a unique situation of having Village Darbar, the traditional Panchayat system, instead of elected panchayat. Dr. Rakhal shared his concern that the question of role of ASHAs in terms of Activism vs. Service Delivery should not be seen in isolation, as the practices and behaviours of the people in the health system also affect this process critically. Dr. Tripathy, observed that the community's capacity needs to be built and shared that his organization Ekjut, in its interventions, has been able to do community capacity building and also quantify it. He suggested that ASHAs need to play a nuanced role till the health system also improves.

At the end of the inaugural session, Dr. Sanjiv Kumar, made a request to the NAMG members to develop 'guidelines on how or how not a new role should be given to ASHAs or added to her tasks'.

Taking the discussions further after the inaugural session, members raised their concerns on wide ranging issues. Mr. Alok Mukhopadhyay, again emphasized the need for Epidemiology based local context specific health planning, because of differences in disease pattern and priorities. Referring to the emphasis on Federalism in Prime Minister's speeches, he wondered how Nirman Bhavan can decide what Chhattisgarh should do. In agreement with the question raised, Mr. Abhay Bang wondered, that, under national level community programme, whose needs ASHA is pursuing, and, said that there was limited space for the ASHA to work on local issues. He shared the experience of SEARCH, of conducting health assemblies, in which a huge variety of unexpected health priorities are articulated by the local tribal people. He suggested that

a balance between different types of health needs should be ensured, for example, different types of needs can be prioritized in a proportion of- 30% for community needs, 20% district needs, and rest of the 50% can be based on national priorities, along-with some space for local areas specific needs. He raised concerns about training ASHAsfor a role in gender based violence situations, without any field trial of such interventions, and said that proven programme feasibility and effectiveness is a critical criterion. He also emphasized that ASHA can't do this role without the community support, and any programme for ASHAs must also be backed by support structure. In ASHA programme, the support structure has been built 'brick by brick' till now, but for new programme initiatives it should be mandatory from the day one.

Sharing experience of seeing ASHA programme in Gujarat, he said that currently ASHAs in the state are doing 34 activities. He shared his concern about the increasing workload of ASHAs, and suggested that it's high time that we start talking about the second ASHA, who he suggested should be a male ASHA. He also referred to HLEG recommendation for second ASHA, and also the SEARCH's own time motion studies on the Arogya Doot, to support the argument about the second ASHA. He also welcomed the recent decision of Mission Steering Group (MSG) to increase the budget for ASHA training and support to Rs. 16000 / ASHA / year.

Dr. Nerges Mistry raised a concern that we do not have epidemiological prevalence data, which is crucial for specific local context based health planning. Dr. Abhay Bang shared that the Agriculture sector had conducted time motion studies about 40 years back, and health sector would need current epidemiological tools to conduct such study.

On the issue of GBV module for ASHAs, Dr Rajani Ved shared that the module had been shared with all NAMG members. She also said that the GBV module was shared in the last NAMG meeting, and states were also part of the process. In fact the demand had come form some states who felt that ASHA needed to be equipped on issues of gender based violence, since many cases had been surfacing in their states. It was part of a planned continuum of interventions for orienting ASHAs as well as the whole

health sector staff, on the issue of violence against women. This was initiated by Mr. Keshav Desiraju, then Secretary MOHFW, GOI, under the ministry's response to the infamous Nirbhaya incident in Dec 2013, in Delhi. She also shared that in Jharkhand, ASHA was already involved in GBV activities without any formal training, and in Kerala too, ASHAs refer such cases for counseling on gender sensitization.Dr. Jagdeeshan, shared that Kerala has district level centres for intervening on GBV issues, called Jagriti Samiti, which work in close coordination and integrated with the PRIs. Dr Sudarshan also made an observation that GBV module developed for ASHAs was a useful module.

Dr. Prabir Chatterji shared that in Chhattisgarh, Mitanin is selected at the level of a population of 300 so in a village of 1000 population, there are 3 Mitanins, and it helps in building her support base in the village for undertaking GBV related initiatives. He elaborated the active role that Mitanins are playing on the GBV and VAW related issues, and shared that in the Swastha Panchayat Meetings, a number of VAW related issues come up. He also raised another concern as to how the existing urban health workers in some cities, who are getting Rs. 4000 to 7000/month, will be integrated with the NUHM.

Dr Sanjiv Kumar underscored the need for prioritizing ASHA's roles. He also observed that 50% of the VAW cases reported to Police are family related, and gender based discrimination starts at the household level. So if we want to stop violence against women, then first step should be at family level.

Session on ASHA Evaluation –

A presentation on the third phase of ASHA Evaluation studies conducted in states of Punjab, Haryana, Maharashtra, Gujarat and Delhi, was made by Dr Garima Gupta, Senior Consultant, Community Processes. After a brief introduction of the previous two phases, findings from the third phase evaluation - quantitative phase and qualitative phase - conducted in states of Maharashtra, Punjab, and Maharashtra,

were presented before the group, elaborating on the coverage, service access and performance effectiveness issues.

In course of the observations made by the members during the presentation, relating to the issue of high attrition rate of ASHAs and need for better training, Dr. Abhay Bang, suggested that peer training can be an effective strategy, and every new ASHA should be attached with an experienced and functional ASHA. Issue of some states issuing orders to not allow the new ASHA to work till she gets the training, also came up for discussion. It was in relation to Induction training of ASHAs, where states are not able to conduct training, because in many places there are not enough numbers of ASHAs to form training batches, and ASHAs find it difficult to go to other block or district to attend training. Dr. Abhay Bang said that this would mean that ASHAs are not being allowed to save lives of children. State like Gujarat have high IMR, and still have not included Cotrimoxazole in the ASHA drug kit.

Dr Alok Mukhopadhyaya observed that most of the economically well established states are not doing well in these studies, so it may not be reflecting the real health seeking behavior, and actually they may be accessing private sector services. He also suggested that 2-3 members of the NAMG should take a look at the ASHA Evaluation data, and compare with the NSSO data.

It was suggested by the members that an evaluation should be done for tribal population separately to understand their issues and needs. They also suggested that the NHSRC team should present the findings of ASHA Evaluation Study at the state level, so that states could revisit their programme challenges and devise corrective measures. Dr. Rajani Ved said that this was in fact the process being followed. Findings were presented at the state level for the state to formulate corrective action.

It was suggested by the NAMG members that the NHSRC consultants who liaise with states, should involve NAMG members from that state, whenever they visit their respective states.

Sharing of state observations by NAMG members –

In the context of the review of community processes programmes, Dr Sudarshan suggested that NAMG members could participate, in the meeting.

Dr Rakhal shared that TN has proposed 10,000 more ASHAs in the PIP, so it is time to strategize for ASHA programme in the state, making use of the learning from other states. He mentioned that state has ASHAs in those villages where VHSNC is not constituted yet and there are no ASHAs in some places where VHSNCs are already functioning.

Ms. Indu Capoor, observed that in the state of Gujarat, focus is on private sector facilities, and in the public health facilities the focus is mainly on the building infrastructure. She shared that generally, about 1500 population is being covered by one ASHA. Attrition rate among ASHAs is high, and they are also being hired by private sector institutions. She often gets incentives from the private facilities too. She shared that with regard to the ASHA training, Chetna has found that there is poor training infrastructure, and that the number of training days were reduced. There are also higher vacancies in the remote and underserved areas. Position of ASHA is quite weak within the health system and ANM as well as other staff see her as a subordinate. She observed that data quality was also poor. She observed that in rural areas, incentives are low and workload is higher. She shared her concern that ASHA support system which is already highly overloaded, would collapse if training of Peer Educators (PEs) under the RKSK (Rashtriya Kishor Swasthya Karyakram) programme is implemented through it. The state AMG also functions on quite ad-hoc basis, and has failed to provide any real support. She said that despite CHETNA being a member of the State AMG, no reports or information was provided by the

Gujarat Government. Government of Gujarat is using ASHA for RKSK activities without any formal training. Replenishment of drug kit was an issue, and Dr. Capoor shared that if the ASHA discusses the issue of Anemia in the community and identifies anemic women, her not having IFA tablets to distribute, diminishes her then credibility in the community.

Dr. Abhay Bang, observed that the discussion reflects issues related to the processes of the programme. ASHA is not getting as much visibility, so the challenge is to make the states see her as the centre of village / community programmes. Ms. Sulakshana Nandi responding to the issue raised, said that states know what the ASHA represents, and that in many ways she is being seen as central to community level work, which is why they want to bring ASHA in every work. However they were compromising on building and strengthening ASHA support systems and this should be highlighted as a non-negotiable.

Dr Jagdeesan, shared that the Kerala state has done a study of ASHA programme in collaboration with Acyuta Menon Centre for Public Health, Trivandrum, and findings would be shared soon. Dr. Prabir Chatterji shared a concern that if ASHA Facilitator earns less than the ASHA, problems arise in the support process, and facilitator should be given a higher salary than ASHA. In case of more than one ASHA being in a village, there are likely to be problems in distribution of routine & recurring incentive. Ms. Nupur Basu felt the need for intervention on sexual harassment cases and suggested that these cases should be handled at the state level, and there should be a protocol for such cases. Dr Sudarshan also underscored the need for synergy between ASHA and VHSNC.

Ms. Akay Minz, state nodal officer in Jharkhand, mentioned that ASHA help desks are being run very well in district hospitals. In areas of Left Wing Extremism (LWE) help desks are not working properly, and they are being used for mainly registration of patients. They are getting hospital related grievances also. She observed that 4 days training is required for VHSNCs. State is focusing on Particularly Tribal Groups

(PTGs), and ASHAs are selected from within the same community only. Ekjut is helping the state by designing Participatory Learning and Action (PLA), pictoral modules keeping the visual literacy of non literate ASHAs from the same communites in mind. PVTG ASHAs will be able to conduct participatory meetings within their communities, where the health indicators are poor.
They included ANMs in ASHA trainings.

She also shared the system of grievance redressal which was started by previous MD NRHM, with a weekly phone-in programme, and many complaints related to bribes and sexual harassment. She also shared that ANMs are showing willingness to be trained, so they are included in the refresher training being conducted now. Convergence meetings with other departments for inter-sectoral coordination have started at state level.

Session on Technical Resource Group (TRG) for NUHM

A presentation on the learning emerging from the process of TRG, particularly in respect of Community Processes components, was made by Ms. Shikha Gupta, from the CP division of NHSRC. The session was chaired by Dr. T. Sundararaman, who briefed the group on different dimensions of urban health as encountered during city visits under TRG. He narrated TRG experiences on how Public Health Officers cadre in different municipal corporations had been visualizing their role and how their systems are equipped to handle such roles. He lauded Kolkata and Chennai as good examples where public health cadre was aware of their roles beyond the routine water sanitation and de-fogging type activities. It was expressed by the members that in urban Areas, ASHA should not focus only on NCD, but also on other problems in urban areas. Involvement of Men as community health worker to cater to the diversity of population was also underscored. There was debate among all members regarding selection process for urban ASHA. Capacity of the ULBs to run health programmes is generally very weak.

Sharing of findings from Ekjut Trial, and several studies involving Community mobilization through PLA - by Prasanta Tripathy

Dr. Prasanta Tripathy shared findings from Ekjut's field trials, involving community mobilization for health of mothers and newborns, through the Participatory Learning and Action approach. . Through this process a series of monthly participatory meetings with women's groups were held that led to very sharp improvements in mother and child health indicators. (between 2004-2013) The findings have been published in peer reviewed respected journals such as The Lancet (2010),WHO Bulleting(2013),International Journal of Epidemiology (2012) etc.

In their latest study (JOHAR Trial) one hour every month was spent by tan incentivized ASHA trained to facilitate these monthly participatory meetings in her village in study areas in five districts of Jharkhand and Odisha...

The PLA approach has now been recommended by WHO (2014) and the "Every Newborn Action Plan" has recommended introduction of PLA in conjunction with approaches involving home visits. (2014)

Appreciating the model, Dr Sanjiv Kumar cited the example of Bangladesh, which has been able to achieve their MDG, 3 years before the target, with only 24% institutional delivery. It was agreed that team from NHSRC will visit Jharkhand to see this work

Concluding session –

In the concluding session, possibility of holding the next AMG meeting at some other location was discussed. Dr. Abhay Bang said that SEARCH would be glad to host the meeting.

A suggestion was made by Dr Abhay Bang that at this stage of the programme, visioning exercise would perhaps be an appropriate step.

Regarding the strengthening of ASHA training and expanding the infrastructure pool, Dr. Sudarshan suggested making use of SIHFWs and their infrastructure and human resources. Dr. Rajani Ved replied, that in states with most challenge, UP, Bihar and Rajasthan, SIHFWs are not very well functioning.

ED NHSRC requested the members to give their inputs regarding the community processes interventions for the upcoming health policy.

Follow Up Actions by NHSRC

1. Facilitate a process of visioning exercise for ASHA programme.
2. Draft letter for MOHFW to write to states for constituting and strengthening State AMGs and including NAMG members as members of state AMGs.
3. Facilitate a process by NAMG members to develop 'guidelines on how or how not a new role should be given to ASHAs or added to her tasks'.
4. Involve NAMG members of a particular state when on programme support visits
5. Invite NAMG to the next Nodal Officers Review Workshop.
6. Undertake field visit Jharkhand to see the Ekjut's programme on PLA.
7. Enable NAMG members to provide inputs to the community process components in the upcoming health policy.
8. Mr. Manoj Jhalani requested members to provide inputs on a mechanism for performance monitoring which would allow every ANM / ASHA Facilitator to score the ASHA's performance and attest the same.