Record of discussion of National ASHA Mentoring Group (NAMG)
NHSRC, New Delhi
6th & 7th August 2009

The meeting of National ASHA Mentoring Group was held at NHSRC, New Delhi on 6th and 7th August 2009. The list of participants is annexed.

Dr. T Sundararaman, ED, NHSRC welcomed all the participants, and requested each participant to share their observations on ASHA programme.

Dr. Dinesh Baswal, Assistant Commissioner (Trg.), MOHFW made a presentation on present status of ASHA scheme. He highlighted some of the actionable areas in the ASHA programme including; scaling up of Module -5 trainings in EAG states, accreditation of ASHA and training institutions, expanding ASHA incentive packages, formation and operationalization of State ASHA Mentoring Group, recruitment and training of ASHA support system and operationalization of periodic trainings of ASHAs.

Dr. Manoj Kar, Advisor, Community Participation, NHSRC briefed on the contributions of NHSRC in strengthening community processes.

Presentation by NAMG members

Dr. Nupur Basu, CINI made a presentation on the status of ASHA programme and capacity building of ASHAs in West Bengal. She informed that, ASHA program which was initiated with 22 blocks of 14 districts has now been expanded to 235 blocks of 17districts with 16021 ASHAs selected out of 42650.They are getting maximum incentive of Rs. 800/- including Rs. 2/- per house for household survey

She shared some of the remarkable changes/improvements in certain indicators such as ANC-3 times check up, TT, Institutional delivery and full immunization of children in Kalchini block (Jalpaiguri Dist), Sitalkuchi block (Coochbehar), Nakashapira block (Nadia Dist) and Goalpokhar block (Uttap Dinajpur Dist) after the implementation of this pilot project. Due to effective ASHA Scheme in Kalchini block (Jalpaiguri Dist), the ANC- 3 check up has increased from 60% in first quarter to 98% in 4th quarter.

Dr. Thelma Narayan, CHE briefing members about the ASHA programme in Madhya Pradesh said that, the decision of State AMG mostly do not get converted into actions. There is also no documentation of high drop-out rates of ASHAs in the State. The State has also not agreed to have sector level coordinator for ASHA program.

Mrs. Pallavi Patel,described the work done on Module V and the experience in training of trainers and requested for involvement of CHETNA in rolling out of ASHA book-5 in the State to ensure the quality training.

Dr. Vandana Prasad, PHRN described the situation in ASHA programme in states like Jharkhand, Orissa, Bihar and Chhattisgarh. She expressed the need for involving PHRN especially in training in States like Orissa and other States where it exist.

Dr. H. Sudarshan, Karuna Trust reported on his visit to States viz. Karnataka, Orissa, Andhra Pradesh and Arunachal Pradesh. In his view 90% of the selection of ASHAs was fairly good. Also that the 23 days continuous residential training had worked well in Andhra Pradesh. This could be learning for other States too. In contrast, training quality was poor in Arunachal Pradesh. Incentive payment of ASHAs is a huge issue in all States. Convergence of different vertical departments and having a single window clearance for ASHA to get incentives remains a challenge. Refilling of drug kit needs to be taken care of. ASHA also needs to be trained on VHSC module.

Dr. N. F. Mistry, FRCH visited Uttarakhand, Maharashtra and Andhra Pradesh. Experiences from her visits to the States that she shared include;

- Training up to Module-5 completed in Uttarakhand, and 6th Module will cover the issues such as social welfare, services for physically & mentally challenge, HIV etc.
- Selection of ASHAs in tribal area of Maharashtra is completed. A huge drop out of ASHAs has been observed in the State.
- A comparative study of quality of training done by government and those outsourced to NGOs would be carried out in Maharashtra.
- Block Facilitators has been employed in Maharashtra, but there is less role clarity. Training module for Block Facilitator has been developed, and the State is in the process of appointing Institutions for training.

Mr. V. R. Raman, Jharkhand, special invitee, while talking about the present scenario of the ASHA program in the State of Jharkhand said that, the State had not been able to roll out training of Module-5. Sahhiya Resource Centre has been constituted, and recruitment for District level is completed. Orientation of District level staff has been conducted, and training will be rolled out with involvement of 22 NGOs.

As shared by Dr. K R Antony, Director, SHRC Chhattisgarh has been working on the career progression of Mitanin. There are 1279 Mitanins who are 10th Std pass, 725 are 12th Std pass, and also few Mitanins having BSc. and MSc degree, and are eligible for ANM/GNM/BSc. nursing course. Some innovations that the State has initiated are; insurance for Mitanin, and education scholarship for children of best performing Mitanin from 'Mitanin Welfare Fund'.

Dr. Abhay Bang, SEARCH Gadchiroli said that the ASHAs' work has become defined by the targets of health department rather than based on the community's needs. He stressed on the need for involvement of beneficiaries in incentive payment, and said that some payment could come from the family/beneficiaries to bring accountability and ownership of community. He expressed the need of studying expansion mechanism of IT centers to handle the need of training centers for ASHAs (as nearly 1500 – 2000 training centers are needed for training of ASHAs).

Response from Joint Secretary, (NRHM) MOHFW.

Shri Amarjit Sinha, Joint Secretary, (NRHM) MOHFW said that NRHM has been giving stress on internalization of communitization, and have been orienting State Mission Directors on community processes. He highlighted some of the issues requiring attention such as the need for institutional arrangement/space of VHSC, a clear strategy so as to have better utilization of untied funds, government understanding on the issues of performance based incentive payment

to ASHAs as compared to fixed remuneration, creating a synergy between ASHAs and VHSCs, need for e-learning materials and identification as well as involvement of NGOs.

JS (NRHM) requested AMG member (especially Dr. Abhay Bang and Dr. Vandana Prasad) to conduct an evaluation in 4 blocks of West Bengal where pilot phase of ASHA program was implemented successfully with improved health indicators, the finding of which could be a learning for other States also. He also more frequent visits to the field by state facilitators and AMG members and regular feedbacks from them. He requested for covering the issues of disability as well as adolescent health, mental health and geriatric care in the future training modules for ASHAs.

Subsequently detailed discussions were held on six issues for which agenda notes had been circulated earlier. The decisions taken on each of these issues are listed below-

Agenda I- Training of ASHAs beyond Module V

It was felt that training of ASHAs is a continuous process. Currently, training is very discontinuous and infrequent, and most States do not even reach a minimum of 12 days training per year. The main reason for this is the weak training and support structure. The desirable number of training days of ASHAs is 4 weeks (28 days) in a year, and the training should be residential. The content of this 4 weeks residential training would be decided by the State. Field work/field visits to be an important part of the training. There is a need for emphasizing e-learning and on the job training of ASHAs. Prior to developing the 6th Module, there is need for a review of the field level outcomes of the previous training modules so as to understand the topics covered in past, the competencies that are built up, and those which are deficient requiring strengthening, and to find out the newer areas that need to be covered in the new modules. Where States needs assistance on this, they would approach NHSRC, and NHSRC would take the help of partner organizations involved in the National training team or AMG to provide support for this.

Agenda II- Accreditation/Certification of ASHA

It was agreed that ASHAs need certification for attending the training programs which would motivate her as well protect her while performing her responsibilities. It would also increase her self confidence/esteem. Such certification should be voluntary and not mandatory. This would enhance her role as service provider, but how it would affect her role as activist was uncertain. There were many other concerns expressed. Hence, this would be discussed further by the group, a note prepared and put up to ministry for its response. It may be useful to pilot this in a few States first. There was consensus that we should move towards accreditation for the training institutes that provides training to ASHAs, and for trainers of ASHAs.

Agenda III- Issues in Expansion of ASHAs to non-high focus states

In some of the non-focused State there is an ASHA functioning in remote areas or tribal areas (at least 20% of State population). Now ASHA has been expanded for every village in all states. Role definition may change between states. The process of monitoring and support to these states by the AMG and NHSRC was discussed.

Hitherto the NHSRC had been channelizing technical assistance to high focus states through a state facilitator. But this arrangement would not be extended to all states. It was decided that,

selected NGOs could take up the responsibility in one state or a group of States to improve ASHA programmes in these States. The NGO could have one person supported by NHSRC for the work. Alternatively, the concerned NGO could sponsor the person through its own resources with technical support provided by NHSRC viz. in West Bengal; CINI is providing support to ASHA program in the State. NHSRC would take up the task of identifying the NGOs and building the MOU that would enable this task.

Agenda IV- Building up Support Structure

It was informed that, only three EAG States have State ASHA Resource Centre and even these have varying functionality. ASHA Resource Centre (ARC) in Orissa is actively involved in implementation as a part of the SPMU and its Resource Centre role needs to be enhanced, while ARC in Uttarakhand is involved less in implementation and acting as a Resource Centre for some tasks. In Rajasthan ARC has not been active in implementation nor as Resource Centre, but it has recently been brought under the SHSRC and is being revitalised. The consensus was that for both ASHA and VHSCs a common state level community processes resource center, preferably integrated with SHSRC or an existing institutional space that can support such a center, is mandatory to have a vibrant programme of communitisation in each state. Though ARC guidelines provide enough space to State level innovation, still a fresh letter, from the ministry, emphasizing the role of ARC would be helpful.

Most important cadre for support of ASHA programme is facilitators at block and sub-block/sector level directly providing continuous support to the ASHAs. One ASHA facilitator for every 20 ASHAs or 30 ASHAs should be decided on by the States. Most ASHA facilitators should be women. Those ASHAs having higher educational qualification and better performance should be preferred. She would receive Rs.150 per day for field visit (as TA+DA), and would have a maximum of 20 field visits in a month. This is provided for in the guidelines but is not implemented in any state except Assam, Chhattisgarh and Maharashtra. Both national and international experience testifies that without such support community health worker programmes fare poorly. Where states have adequate human resource, they could assign an existing employee for this task- but most states would need to add human resource for this purpose. Wherever possible, the task of supporting ASHAs of a block could be outsourced to an NGO, and a model MOU and grants-in –aid mechanism may be prepared for this purpose.

Mr. Susanta Nayak, State Facilitator, Orissa and Mr. Biraj Shome, Consultant- CP, NE –RRC spoke about the existing ASHA support structure in Orissa and Assam respectively, which are the current benchmarks in this area of the ASHA programme..

Agenda V- Evaluation of ASHA Programme:

The evaluation plan would be a formative evaluation that would provide an opportunity for dialoging with programme management at all levels, leading to better understanding of the processes and programme improvement. The evaluation would look at the multiple understandings of ASHA programme, and their implications for the evolution of programme mechanisms and achievement of outcomes in different contexts. The evaluation would thus lead to answering the questions “what works, where, within what circumstances?” rather than merely asking “ Is ASHA programme working?”. Data of other studies, already available would be incorporated into the design of this study. It would be important to review lessons, findings and recommendations of recent evaluations of the ASHA scheme, in preparation for this study.

The evaluation would see ASHA in the context of communitization process. Looking at the program from perspective of beneficiaries- the communities- would also be necessary for the evaluation. Conducting separate in-depth interaction with ASHAs during the evaluation is needed. There is a need for knowing the link between ASHA and the systems, and also to find out - what make her empowered or dis-powered, and how? Participatory methodology would be one of the methods used for data collection.

Evaluation has to be done focusing on 5-6 domains of the program in general, and there could be other State specific additionalities/issues. Areas for inclusion in the study suggested were: a) Operationalization, including monitoring systems for the scheme in different states, b) ownership and management of scheme at State, NHSRC and MOHFW levels, c) governance environment in the States, including frequent leadership changes and its impact on the scheme, d) assess the mechanisms, roles, experiences and outcomes of NGO involvement in the States, e) study the extent of social change that has taken place as a result of the ASHA scheme, f) assessing nature of involvement of ASHA with the "communitization process of NRHM, g) extent to which participatory processes were used in the selection, training and support systems for ASHA, and the extent to which these processes have been effective h) impact of being an ASHA on the individual woman- transformation of status in family and the community, i) and the extent to which participation in the programme has empowered her (focused on : leadership, training, empowerment and linkages to the system) and time management by ASHA with reference to arrangement for transport and ensuring entitlements, such as JSY actually reach the women.

It was decided that, expression of interest would be called from those organizations/institutions who had adequate experience of such work or who had done similar type of evaluation in the past. A detailed Term of Reference would be developed.

Agenda VI- Incentive under various program of ASHA (Supplementary Agenda)

Discussion on incentive payments covered three areas- measures of streamlining existing payments making such payments prompt and with dignity, improving on the package of schemes for which she is incentivised and the issue of a fixed incentive.

All States has been informed to have an integrated list of incentive packages for ASHAs, and shared with different stakeholder including ASHAs herself to make them aware of the program and incentive attached to it. It was also suggested to States to expand the activities and attached incentive to it. However, in most States, ASHAs are getting incentive mostly in JSY and immunization, and there is an issue of payment mechanism such as; late payment of incentives as well as transparency issues.

Single window clearance for incentive payment for ASHAs as in Orissa is prerequisite for success of the program. Mr. Susant Nayak, SF, Orissa presented the incentive payment mechanism of ASHAs in the State of Orissa. The major reasons for success in streamlining ASHA incentive payment in Orissa are; payment by cheque, a designated point person at district, block and sector level to handle issues relating to ASHA incentive payment, and tight monitoring of payments by PHC, and certification of those PHCs having no backlog of incentive payment to ASHAs

The earlier majority recommendations of the AMG for considering a fixed payment had been conveyed to ministry, and this was reiterated in the meeting. The members were briefed on the

discussion in the MSG of NRHM on a fixed monthly payment to ASHAs, in addition to the performance based incentives, and the follow up to this. Though the MSG recommended it, the finance ministry had not approved the same.

Increase in incentive amount attached to each activity could also be proposed as an alternative, along with compensation of at least minimum wages for a full day activity/training done by ASHAs. There was also the view that if a fixed payment was introduced there would have to be as a corollary, major changes in the way the programme was designed and supported. Since, there were divergent views on this issue; a group was assigned to prepare the recommendatory note on incentives.

Six sub groups were formed for drafting final conclusion on each of the agenda items as follows;

Training of ASHAs beyond Module 5 • Mrs. Indu Capoor • Dr Abhay Bang • Mrs. Shilpa Deshpande • Dr. Nupur Basu	**Certification/ Accreditation of ASHAs** • Dr. Abhay Bang • Dr. Nergis Mistry • Dr. Nupur Basu	**ASHA in non EAG states** • Dr Sudarshan • Dr Thelma
Building up Support Structure • Mr. V. R. Raman • Dr. K. R. Antony	**Evaluation of ASHA Program** • Dr. Rajni Ved • Dr. Thelma Narayan • Ms. Sarover Zaidi	**Incentives under various program of ASHA** • Dr Sudarshan • Mr. V.R. Raman • Dr Tripathi

The groups would submit their report on the respective 'Agenda Items' by 15th September, 2009.

A presentation on "Safe Adolescent Transition and Health Initiative", an innovative model of communitization with involvement of ASHAs was made by Dr. Anil Paranjape, IHMP Pachod. IHMP has piloted the model since 2003 with five components viz. surveillance (clients identification), micro-planning with ANMs, BCC through need specific IPC strategies and social norm approach, ASHA linked to primary health care services and community based monitoring by VHSCs through ASHAs. A quasi-experimental research design has been developed for evaluating the impact of the model. Support was requested for the evaluation of the model to assess its potential for replication in EAG States.

ED, NHSRC thanked all the AMG members for attending the meeting and giving valuable suggestions.

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