Minutes of the meeting of the National ASHA Mentoring Group (NAMG)
National Health Systems Resource Center (NHSRC), New Delhi
Tuesday, December 14, 2010

The seventh meeting of National ASHA Mentoring Group was held at the National Health Systems Resource Center (NHSRC) on Tuesday, December 14, 2010. The minutes document the highlights of the discussions and key decisions taken during the meeting. (The Agenda of the meeting is at Annexure 1 and the Participant list is in Annexure 2)

I. Presentation of actions taken on issues arising from last meeting.

NHSRC provided an update on the actions taken from the last meeting. ASHA Modules 6 and 7, on which several members had provided valuable inputs had been finalized and disseminated to the states. Members had also provided inputs on the note on measurable outcomes. This has also been included in ASHA modules 6 and 7. Regarding the NGO schemes, Dr. Sundararaman informed the group that after the inputs of members were received, NHSRC worked with the MOHFW to finalize and cost the six NGO schemes. This was then presented to the Mission Steering Group meeting on June 15, 2010, which deferred the decision on approval to the next meeting and advised the MOHFW to ensure better integration of the schemes with the Panchayati Raj Institutions. NHSRC is working with the MOHFW on revising these schemes. The ASHA evaluation in eight states was completed and was circulated to all the members. The bi-annual ASHA update report was printed in June and a copy shared with all members and the states.

II. Findings from the ASHA evaluation

The NHSRC team presented the findings of the ASHA evaluation. The report had already been circulated to all AMG members. The data presented evoked significant discussion in the group. The findings were also correlated with the ASHA guidelines developed by the NRHM Task Force in July 2006. The evaluation highlights that across the states, the ASHA are effective in promoting institutional deliveries and immunization. However in terms of provision of community care for childhood illnesses and for counseling on nutrition and post partum care, the limited effectiveness of ASHA represents a missed opportunity in enabling a positive outcome on newborn and childhood illness, nutrition and post partum care and counseling. About 40% ASHA across the states are consulted for childhood illnesses, but their effectiveness on addressing these is limited, on account of lack of skills, supplies and system responsiveness. The activist role of the ASHA has also been filtered out on account of limited civil society engagement with the ASHA programme.

The group spent a substantial amount of time discussing the evaluation methodology and findings. Since the points were quite extensive, it is not possible to list all of them. However, a summary of the discussion and some observations made by the group are as follows:

- Dr. Bhushan desired to know if the programme was worth the investment and if the evaluation had resulted in a conclusion on whether it was working satisfactorily. Dr. Abhay Bang expressed the view that given the multiple dimensions of the programme, the evaluation yielded multiple learning. It was important to understand her effectiveness in different public health interventions.

- Members pointed out that the lack of a support and supervisory structure appears to be a key factor in low effectiveness of the ASHA, and unless the mechanism was instituted at all levels and strengthened, this would continue to hamper her functioning.

- Dr. Bhushan agreed with the description of the ASHA as stated in the point of its three interpretations.

- Non adherence to the sprit of the guidelines was a source of concern and members pointed out that any re-interpretation that portrays her as a link worker was not based on their inputs.

- On the framework of analysis used by NHSRC, members had varying opinions. While some members were comfortable with the framework of the programme theories formulated on the three roles of the ASHA (identified in the guidelines) and emerging from the evaluation, some members felt that to enable clarity, these could be referred to as differing perspectives of stakeholders, rather than as theories.

- Dr. Abhay Bang said that the evaluation findings supported the recommendations made by the Lok Sabha Committee on Empowerment of Women, and there fore should be used to develop policy briefs on the programme to be shared with at state and national levels.

- On the findings related to irregularity of drug kit replenishments, Dr Antony said that the role of District level officer in regulating the drug kit refill and procurement was critical. Drug kit distribution at the district and sub district level appears problematic. There is tremendous oscillation between centralized procurements and district level procurements and leakages in the system require action.

- On incentive payments, findings have shown that while there is a demand for fixed payment, functionality and effectiveness indicators do not seem to correlate with either fixed or performance based incentives. Members felt, as in previous meetings that the MSG should recommend a blended form of payment partly as performance based incentive and partly as fixed payment.

- Dr Sharad Iyengar suggested that ASHAs should be given coupons or vouchers to collect the payment. He said that limiting them to a link worker role would make them vulnerable to becoming commission agents rather than as change agents

- Dr. Prashant Tripathy observed that it would be important to note that the beneficiaries who were not reached by the ASHA should also be interviewed and that this could be considered under Phase 3.

- Members raised the issue that in some states ASHAs are expected to maintain records even though this was not part of the job description.

- Before recommending the ASHA's involvement in newer thematic areas, such as non communicable diseases (NCD) members suggested that pilots are required, and the roles need to be linked to measurable indicators.

- Members recalled that the original guidelines were developed after representation to the Prime Minister's office and that in fact several members of the committee were also members of the National ASHA Mentoring group. They reminded the group that the vision of the ASHA in the guidelines should be reinforced and represented through active advocacy.

In conclusion, members said that the study was useful and had thrown up several insights on the way the ASHA programme was being implemented in different states. They also felt that the findings needed to be shared with a larger group. Members suggested that NHSRC develop an executive summary with specific recommendations to be shared with the group. NHSRC would also complete the process of sharing findings with each of the states, obtain feedback and finalize recommendations. NHSRC would then organize a meeting with the group to share the outcomes of discussions in the state. NHSRC was also considering more in-depth analysis of the data using statistical techniques and additional patterns identified thereof could also be discussed. .

II. Members reporting from the states

Dr. Smitha Bajpai from Chetna, reported that in Rajasthan, there was a backlog of the training. IEC material was required for the ASHA, there was little clarity on the role of untied funds. In Gujarat, the ASHA training had been completed only upto Module 4, and the ASHA needed more input on maternal and child health. She also shared that the ASHA incentive was lower than compared to the wages under MNREGA and this should be increased especially in the high focus districts.

Dr. Vandana Prasad raised the issue of delays in training in Modules 2-4 in Bihar, and the need for clarity on whether this needs to be completed before Module 6 and 7 training is initiated. This was in the context of Bihar. Some members felt that this may not be necessary and the training of those ASHAs could actually begin from training in Modules 6 and 7. However the contents of Module 5 need to be integrated in every round of training. Members also said that planning for new ASHA recruited in the system in lieu of drop outs

needs systematic planning. Since the new ASHA had not been trained, they were not getting JSY incentives either.

Dr. Thelma Narayan reported that the Tamil Nadu government is interested in expanding the ASHA programme, in implementing community action for health and in looking at the issue of community mental health. For Madhya Pradesh she said that the state had not used the specified training days, training quality was poor and there were long lags between training rounds. Facilitators at various levels also need training inputs. She also said that payment delays appeared to be less common. She also raised the concern that minutes from the meetings of the State ASHA mentoring group were not shared in time.

Dr. Nerges Mistry shared that in Uttarakhand the training in Module 6 and 7 was already underway. Ms. Shilpa Deshpande shared that in Jharkhand, the Sahiyya Help desk was functional in 84 Community Health Centers (CHC). A process for selecting Sahiyya facilitators was underway, and the process of conducting block level Jan Samwad had been initiated. Dr. Antony shared that in Chhattisgarh there have been delays in payment. Guidelines for untied funds were being drawn up in a way that restricted their flexibility. VHSC meetings do not occur periodically and ASHA are being made responsible for the utilization certificates of the VHSC.

III. Training

NHSRC provided an update on ASHA training in Modules 6 and 7, and shared the material developed, including the trainer manual and the communication material. Dr Abhay Bhang suggested that every state should have an operational plan for the training. He also emphasized that the field supervisors are lacking and equipment supplies are not regular. He was of the view that given the large numbers of ASHA the center should actively consider a permanent training structure for ASHA. Given that ASHA are expected to play a role in several other programmes including non communicable diseases a second ASHA would need to be considered. Dr Sundararaman shared with the National ASHA Mentoring Group, the recent circular from the MOHFW stating that the ASHA should not be burdened with any clinical role and about their decision not to teach neonatal resuscitation to the ASHA.

Key Decisions:

- The civil society view of ASHA has not actualized and she is just been projected as a link worker. Members felt that it was necessary for high level advocacy meeting for this. Formulating the advocacy message is important. It is important to emphasize the effectiveness of the ASHA which has enabled strengthening health systems in poor performing districts.
- NHSRC to circulate an executive summary of the evaluation with specific recommendations and send to members for feedback.

- NHSRC should ensure a core of national trainers for supervision of state trainers
- Accreditation systems for ASHA trainers and ASHA need to be developed.

Annexure 1:

Agenda For National ASHA Mentoring Group Meeting

National Health Systems Resource Centre(NHSRC)
Tuesday, December 14, 2010
Time –9:30am to 5:30pm

Issues for Discussion

1. **Review of Action taken report from past AMG meeting held on April 7, 2010.**

2. **Presentation of ASHA evaluation.**

3. **Presentation by AMG members.**

4. **Scaling up ASHA training in Module 6 and Module 7.**

Annexure:2			
List of participants			
Sl. No	**Name**	**Org/address**	**Email ID**
1	Dr. Himanshu Bhushan	Assistant Commissioner, Maternal Health, MOHFW, New Delhi	Dr_hbhushan@hotmail.com 011-23062930, 9868071145
2	Dr. Praful Kumar Nayak	Assistant Commissioner (Training), MOHFW, New Delhi	Pknayak55@gmail.com 011-23062091
3	Mr. Naresh Kumar	Consultant, Training Division, MOHFW, New Delhi	Naresh_pottar@yahoo.com 09414016715
4	Dr. Abhay Bang	Society for Education, Action and Research in Community Health (SEARCH), Gadchiroli, Maharashtra	search@satyam.net.in 07138-255407
4	Dr. Thelma Narayan	Centre for Health and Equity, Bangalore, Karnataka	thelma@sochara.org 080-41280009
9	Dr. N F Mistry	Foundation for Research in Community Health (FRCH), Mumbai, Maharashtra	fmr@fmrindia.org 022-22662707, 9892274743
10	Dr. Vandana Prasad	Public Health Resource Network , New Delhi	chaukhat@yahoo.com 9891552425
11	Dr. K. R. Antony	State Health Systems Resource Centre, Chhattisgarh	krantony@rediffmail.com 0771-2236175
12	Ms. Shilpa Deshpande	ICICI Centre for Child Health and Nutrition, Mumbai, Maharashtra	shilpa.deshpande@icchn.org 022 2653 7093
13	Dr. Prasanta K Tripathy	Ekjut, Jharkhand	prasanta.ekjut@gmail.com 06587-239625,0-9431153434
14	Dr. Alok Mukhopadhyay	Voluntary Health Association of India, Delhi	vhai@vsnl.com 011-26518071/72
16	Dr. Smita Bajpai	Centre for Health Education, Training and Nutrition Awareness (CHETNA), Ahemadabad, Gujarat	chetna456@gmail.com 079-27559976/77.079-2561167
17	Dr. Sharad Iyengar	Action Research and Training for Health (ARTH), Udaipur , Rajasthan	sdiyengar@gmail.com
18	Ms. Sarover Zaidi	ICICI Centre for Child Health and Nutrition(ICCHN)	sarover@gmail.com 9821920550
19	Dr. T Sundararaman	Executive Director, NHSRC,	sundararaman.t@gmail.com

		New Delhi	011-26108982/83/84
20	Ms. Sushma Rath	Principal Administrative Officer, NHSRC, New Delhi	sushma2764@yhaoo.com 011-26108982/83/84
21	Dr. Rajani R. Ved	Advisor, Community Processes, NHSRC, New Delhi	rajani.ved@gmail.com 011-26108982/83/84
23	Dr. Manoj Kumar Singh	Consultant, Community Processes (Prog.), NHSRC, New Delhi	manojkumar.nhsrc@gmail.com 011-26108982/83/84
24	Mr. Arun Srivastava	Consultant, Community Processes, NHSRC, New Delhi	arunrewa@gmail.com 011-26108982/83/84
26	Dr. Garima Gupta,	Consultant, Community Processes, NHSRC, New Delhi	drguptagarima@gmail.com 011-26108982/83/84
27	Ms. Samatha	Consultant, NHSRC, New Delhi	samathamjnu@gmail.com 011-26108982/83/84
28	Dr. Shalini Singh	Fellow, NHSRC, New Delhi	Shalini.singh.1903@gmail.com 011-26108982/83/84