UPDATE ON
ASHA PROGRAMME

JANUARY 2014

CONTENTS

INTRODUCTION

In the last six months since the update of July 2013 was issued, there have been some developments that have implications for the Community Processes interventions in general and the ASHA programme in particular. An event of some significance was the approval of the National Health Mission was approved by the Cabinet in October 2013. The umbrella of NHM now has the National Rural Health Mission (NRHM) and the National Urban Health Mission (NUHM) as its Sub-Missions. As we shall see in the Update, the NUHM marks more than an expansion of the NRHM in urban areas. It requires a paradigm shift not only in the organization of services and the optimum use of human resources to achieve key outcomes, but also a radical change in how the programme develops strategies to reach the vulnerable and marginalized in the urban population. The Ministry of Health and Family Welfare (MOHFW) also launched the Rashtriya Bal Swasthya Karyakram (RBSK) a programme that encompasses preventive, promotive and curative services for all children 0-18 years.

The first Mission Steering Group (MSG) meeting of the National Health Mission approved several incentives for the ASHA programme. Most significant is the delinking of incentives for routine activities from programme specific incentives. The MSG approved an incentive amount of Rs. 1000 for a set of routine and recurrent activities[1] regardless of population coverage. Thus an ASHA serving a hamlet of 500 or an ASHA in a population of 1500 will receive Rs. 1000 for conducting a VHSNC meeting, organizing the VHND, attending monthly review meetings at the PHC, and undertaking annual surveys to update her population register. An updated list of incentives is provided in Annexure 1.

The MSG also revised the cost norms for ASHA from Rs. 10,000 per ASHA per year to Rs. 16000 per ASHA per year. These norms include cost towards- ASHA training including refresher training for ASHA certification, post training support and supervision, cost of job aids or tool kits for ASHA and other non-monetary incentives.

This programme update marks the ninth in the series of semi-annual ASHA updates, from the launch of the first issue in January 2010. The update is produced by the National Health Systems Resource Center (NHSRC) for the Ministry of Health and Family Welfare. This update has four sections. In Section 1 of this update we report on the evaluation of the ASHA programme in the non high focus states of Maharashtra, Punjab, Haryana, Delhi and Gujarat. These states were late adopters of the ASHA programmes. The evaluation findings related to ASHA effectiveness and skills reflect the consequences of delays in establishing adequate training systems and

1 Set of routine activities: Include some existing activities coupled with certain new ones. These activities include- mobilizing for Village Health & Nutrition Day (VHND), facilitating or guiding VHSNC meeting, attending PHC review meetings and maintaining village health records (inclusive of- line listing of households done at the beginning of the year and updated every six months, maintaining village health register supporting universal registration of births and deaths, preparation of due list of children to be immunized and updated on a monthly basis, preparation of list of eligible couples updated on a monthly basis). Respective incentive amounts that have been assigned for these activities are Rs. 200 for the VHND, Rs. 150 each for the VHSNC and PHC review meeting and Rs. 500 for maintaining village health records.

instituting adequate support structures. The seventh Common Review Mission was held in November 2013 in fourteen states and this section also captures the major findings and recommendations from the CRM. The CRM report on the Community Processes intervention, led with findings on the Village Health, Sanitation and Nutrition Committees. It is clear that this area needs significant attention by the states, and will need cross sectoral collaboration, as well as a strong support and training system in place.

The paradigm shift needed for successful urban health interventions holds true for the Community Processes components. The programme managers of the urban ASHA and community institutions- the Mahila Arogya Samitis (MAS) will need to innovate in different ways to meet the needs of the vulnerable and marginalized groups in urban slums. This is reinforced by our findings from the ASHA programme evaluation in the urban slums of Delhi. While the three essential roles of the ASHA – the facilitator, service provider and activist roles will continue, the mix will need to be substantially different from her rural counterpart. Critical to the success of community engagement will be the ability of the ASHA and MAS to reach the marginalized by representation, organization, and mobilization. In Section 2 we provide a summary of the findings and recommendations of the Technical Resource Group constituted by the Ministry of Health and Family Welfare for the NUHM. The findings emerge from a series of visits to over 25 cities in different parts of the country, and provide a synopsis of what exists on the ground and a broad outline of what can be done in the area of Community interventions.

In Section 3 we present the status of ASHA the programme and its support structures as of December 2013. As was pointed out in the last update there has been substantial progress in the states on the processes of selection, training, and strengthening of support structures. The last component has consequences on improved monitoring and support. As a result of more accurate data in emerging from the districts. The number of ASHA reported from the states actually shows a decline, with about 8,34,922 ASHA being in place against a country wide target of 9,39,868.

Section 4 is a new addition and one that we hope to continue with support from our state teams. In this issue we bring to our readers two stories of ASHAs from Assam and Gujarat. These stories are reflective of how individual ASHAs exercise their agency and overcome odds to fulfil personal mandates and community expectations.

In April 2015, a little over a year from now, the ASHA programme completes a decade. In India's history of Community Health Worker (CHW) programmes, this is the longest that any has survived. While debates about the ASHA's role and the number of tasks she can actually perform, continue, there is consensus on the fact that she has played an important part in expanding coverage and access for health care services. This consensus comes not just from anecdotal evidence but from evidence gathered through rigorous evaluations, reported in past issues of the Update. Their contributions to not just maternal, newborn and child health but a range of other interventions have been documented. The question that faces us now is: Where do we go from here? Given the persistent shortages of human resources, there are several choices before the programme. The first and which is already in the planning stages is the certification of ASHA in a set of skills related to maternal, newborn, child health and nutrition services. This will ensure the quality of a basic set of skills. An advanced level of certification is also being considered to build the ASHA's competency in areas such as chronic diseases, palliative care, and mental health. This latter provision would be available to those who are interested, and is not mandatory. The next stage would be to consider the gradual transition of ASHA to a community health nurse through a formal competency based programme. Another would be to provide her with avenue for a career progression in ANM and GNM training programmes. This has already taken place in several states and country wide over 1750 ASHA are enrolled in ANM training schools. The third area would be to support ASHA to obtain academic equivalency qualifications through the National Open School System so that other career avenues open up for her. All this necessitates that states now move into ensuring that support structures are trained and skilled to provide the ASHA with on the job mentoring and support she needs.

SECTION 1

FINDINGS FROM RECENT REVIEWS AND EVALUATIONS

This section carries key findings from the recent evaluations and reviews of the ASHA and community processes interventions. The first part includes a summary of the evaluation of the ASHA programme conducted in the states of Delhi, Punjab, Haryana, Gujarat and Maharashtra. That was conducted during 2013-14.

The second part summarizes findings of the Seventh Common Review Mission (CRM), led by the Ministry of Health and Family Welfare and undertaken in fourteen states in November 2013. One of the ten areas of focus of the Common Review Mission is community processes. The findings of the seventh CRM testify to a maturing ASHA programme but also highlight challenges posed on account of variable training quality and supportive supervision. On the front of Village Health Sanitation and Nutrition Committees a substantial effort is required to increase their participation in decentralized planning for health.

Summary of Findings from the Third Round ASHA Evaluation in Five States

The third Round of evaluation was carried out in five states of Delhi, Gujarat, Haryana, Punjab and Maharashtra during the year 2013-14. The first Round (2010-11) of the ASHA evaluation was conducted in eight states (Andhra Pradesh, Assam, Bihar, Jharkhand, Kerala, Orissa, Rajasthan and West Bengal) and in the second Round (2011-12) the ASHA programme in states of Madhya Pradesh, Uttrakhand and Uttar Pradesh was studied. The key findings of these two Rounds were reported in the ASHA Update issue of January 2011 and July 2012 respectively. As in the first two Rounds, the evaluation adopted the Realist Evaluation methodology and used a mix of qualitative and quantitative methods in its two phases v.i.z, *Phase 1*–In depth interviews with key stakeholders and *Phase 2*- structured questionnaire to interview ASHAs, service users (Service user A - Women who delivered in last six months and received services from ASHA and Service User B- Mothers of children between 6.1 months to two years of age who had an episode of illness in the last month and received services from the ASHA), Anganwadi workers, PRI members and ANMs. In addition, two respondents from the above mentioned categories who did not receive services from the ASHAs were interviewed in states of Delhi, Gujarat and Punjab. Two districts2 in each of the five states were selected based on the criteria of one with good performing ASHA programme and second with high proportion of scheduled castes/scheduled tribes.

Key Findings

The support structures for ASHA Programme have been set up at three (district, block and sub block) levels in Maharashtra and Haryana, at two levels– (district and sub block) in Punjab, only at sub block level in Gujarat and is supported by existing staff at these levels in Delhi. State level Community Processes

2 South West and North West (Delhi), Kutch and Rajkot (Gujarat), Rohtak and Ambala (Haryana), SBS nagar and Patiala (Punjab); Amravati and Bhandara (Maharashtra).

Resource Centre exists only in states of Gujarat and Haryana, of which CPRC in Haryana was set up in the year 2012-13 and has about 11 team members. In Gujarat though the State ASHA Cell has been created and is led by Deputy Director Rural Health, it had only one dedicated programme manager till recently. The team in Gujarat however has now been expanded with two additional appointments. In the remaining three states, the programme is managed by a team of members/consultants based within SPMU. While Punjab has two consultants dedicated exclusively for community processes, there is only one programme specific consultant supported by a data assistant in Maharashtra and Delhi has one State programme officer supervising a team of one state ASHA coordinator and two support staff for the ASHA programme. Training of support structures has been completed in Haryana and Punjab and it is underway in Maharashtra and Gujarat while it is yet to begin in Delhi.

These group of states barring Haryana and Delhi launched the training of ASHAs in Module 6 and 7 in 2011 but the pace and quality of training varied across states. The first Round of training of trainers was completed in 2011 for states of Gujarat, Haryana, Maharashtra and Punjab. This was followed by training of ASHAs in all states except Haryana, which initiated the training only in the year 2013. The state of Haryana decided to launch the training of ASHAs in Module 6 and 7 in the year 2013-14 only after the completion of training in HBPNC supported by NIPI in all districts. Delhi also started training its ASHAs in FY 2013-14, only after adapting the modules as per state's context. In an attempt to complete the training of ASHAs at the earliest, state of Gujarat considerably modified the agenda and shortened the duration of training sessions. This affected the training quality across districts and led to some incompleteness. As of now, training of ASHAs in Gujarat has been completed in Round 4 without completing the Round 3 Training of trainers.

Coverage of ASHAs for service users A is found to be quite high in states of Gujarat, Punjab and Maharashtra within the range of 80-90% and is significantly lower in Haryana (53.4%) and Delhi (65%). The functionality of ASHAs in terms of visiting the service users during antenatal period is higher as compared to visits within three days of birth in the post natal period across all states. Lowest figures in these respective categories are 70% in Gujarat for ANC visits and of 49% from Delhi for PNC visits. The functionality further drops if we look at minimum six visits specified under HBNC, in which the highest figure reported is only 39% from Maharashtra followed by 35% in Punjab, 31% in Haryana, 26% in Delhi and only 11% in Gujarat. Such low levels of functionality of ASHAs for HBNC can be linked to the pace and quality of training, post training supervision and non-availability of all components of HBNC equipment kit. Despite a high proportion of service users reporting that ASHAs visited them atleast three times during ANC period and within three days of delivery (except for Delhi with 48%), less than 45% of women who had any maternal complication sought ASHA's advice for care in Delhi, Gujarat and Punjab while this figure was slightly better in Haryana and Maharashtra with 67% and 64% respectively. This is likely a reflection of the ASHAs skill levels. It is further validated as only 47% ASHAs in Punjab and 40% in Maharashtra said that would immediately refer a woman with loss of foetal movements. These figures were 34% in Delhi, 28% in Haryana and only 8% in Gujarat. ASHA's knowledge to classify a newborn as low birth weight with less than 2000 gms of weight at birth is relatively better. It is over 50% in three states (highest being 73% in Haryana) and 48% and 43% in states of Gujarat and Delhi respectively. Also, her knowledge on specifying the actual cut-off date to classify a baby preterm was found to be accurate in less than 20% ASHAs in three states (Gujarat, Punjab and Maharashtra) while it was 42% in Haryana and 52% in Delhi. The effectiveness of ASHAs in terms of access to care for service users is within the range of 78-92% for antenatal care, 78-93% for institutional delivery, 70-99% in seeking care for maternal complications and 82-97% for seeking care for a sick newborn. (See Table 1.1)

ASHA's coverage in providing services to children who had any episode of illness in last one month shows huge variations among states Eg- Coverage for service user Bswas higher than ASHA's coverage in case of service user As in Haryana (92%) and Maharashtra (93%) but in other states a significant drop is noted when compared with service user A. Acceptance of ASHAs in service provision roles for child hood illnesses in states of Haryana, Punjab and Maharashtra can be attributed to better institutional support with improved availability of drugs and accessibility of the SHC/PHC staff. As anticipated out of the service users who approached ASHA, about 82-98% of service users said that

Table 1.1					
	Haryana	Delhi	Gujarat	Punjab	Maharashtra
Access to ASHA services of potential Service user A	53.4	65.4	89.2	80.6	85.9
% of service users A who were visited at least thrice by ASHA during antenatal period	83.4	84.6	70.3	94.4	91.1
% of user A who had complication during pregnancy and sought ASHA's advice for treatment	66.7	34.7	26.5	41.7	64.4
% of service users A who received three ANCs or more	81.8	77.5	83.9	87.1	92.1
% of service users A who went for institutional delivery	96.9	95	94.1	99.1	99.1
% of Service User A who went for institutional delivery and cited ASHA as a motivator	66.2	45.9	33.2	61.4	87.1
% of service users who had any maternal complication and sought treatment	85.2	79.2	98.5	87.5	70.1
% of ASHAs who said that they would refer a pregnant woman immediately to the institution in case of bleeding from vagina	80.9	60.9	21	71.4	60.8
% of ASHAs who said that they would refer a pregnant woman immediately to the institution in case of loss of foetal movements	28.1	33.5	7.5	46.9	40.2
% of user A who were visited by ASHA on day of birth	51.1	19.2	32.4	52	71.7
% of user A who were visited by ASHA within 3 days of birth	80.6	48.7	63.2	73.6	85.6
% of service users A who were visited at least six times by ASHA during post natal period	31	25.7	11.4	35.4	39
% of User A who were breastfed within three hours of birth	86.9	80.5	75.6	83.7	97.6
% of user A who gave no pre-lacteal feeds- exclusive breast feeding on first three days	80.6	79	64	81.6	98.7
% of Service user A with sick new born who sought treatment	89.1	81.6	96.1	96.6	86.9
% of ASHA who knew that newborn with less than 2000gm is a high risk baby	72.9	42.9	48	54.7	55.3
% of ASHA who knew that newborn born before 8 months 14 days of pregnancy	41.7	52.2	9.5	19.3	16.6

ASHAs helped them in seeking care. However better access to care is seen in cases of symptoms with ARI where over 96% sought care as compared to cases of diarrhoea where less than 77% got the ORS (from any source) in three states and only in Maharashtra and Haryana it was made available in 97% and 82% cases respectively. In all states except for Maharashtra, ASHAs could give ORS to the child from her kit in less than 70% of cases. The skill sets of ASHAs are also found to be low (less than 50%) when asked about how they would prepare ORS, advising increased intake of fluids during diarrhoea and to identify chest wall in drawing as a sign in cases of symptoms with ARI.

In this third Round of ASHA evaluation, an additional category of respondents i.e., non- service users – potential beneficiaries who did not receive services from ASHAs were also interviewed. As discussed above we noted that 11-20% of the potential beneficiaries A were not reached by the ASHAs in Gujarat and Punjab and 35% were not reached in Delhi. This is also reflected in the sample coverage, thus out of the estimated 200 non service user A only 31 and 67 were available for detailed interview in Gujarat and Punjab and 108 in Delhi. In contrast a higher sample coverage of 148, 140 and 137 is seen in cases of childhood illnesses which may be linked to low coverage of ASHAs in these states.

Though less than 38% of the non- service user As and less than 65% of non- service users B could correctly tell the name of the ASHA working in their area, about 39%–56% of non- service user As and 68%–89% of non- service users B said that ASHAs visited their household at least once. Despite not receiving any services from ASHAs, a high access to care is observed in both the categories i.e., over

Table 1.2					
Indicator	**Haryana**	**Delhi**	**Gujarat**	**Punjab**	**Maharashtra**
Coverage Service User B	92	46.1	37.1	71.1	92.7
% of user Bs who had diarrhoea and whom ASHA helped in some way	85.5	84.3	87.8	97.3	98.1
% of user Bs with signs of ARI and whom ASHA helped in some way	89	82.3	95.5	96.1	98.2
% of user Bs who had diarrhoea and to whom ASHA gave ORS from her kit	69	44.1	51.2	62	90.1
% of User B with diarrhoea and who overall got ORS	81.2	76.5	53.7	77.3	96.9
% user Bs with ARI who sought treatment	97.8	95.6	95.5	100	97.3
% of ASHA had knowledge of making ORS	43.7	46	22.5	13	53.7
% of ASHAs who said they would give ORS from kit in case of diarrhoea	93.5	87	82	82.3	92
% of ASHA had knowledge of advising fluid intake in case of diarrhoea	12.1	47.8	10.5	14.1	15.1
% of ASHA had knowledge of advising continued feeding for the child who had diarrhoea	16.1	25.5	33.5	25.5	17.6
% of ASHA s who could specify chest wall indrawing as a danger sign to suspect pneumonia	50.3	32.9	12	34.9	39.2

87% of non- service users A opted for institutional delivery and over 90% of non- service users Bs sought treatment for childhood illnesses. However except for state of Delhi where 46% reported going to private sector for institutional delivery and 56% for treatment of childhood illness, in other two states both categories of non- service users predominantly went to private sector. Eg –Delivery in private sector was reported by 71% in Gujarat and 82% in Punjab and over 90% of non-service users B went to private sector for treatment of their child's illness. This is also reflected in the high OOP, the highest being from the state of Punjab – 64% of non- service users A reported an expenditure of Rs. 5000 or more and 46% of non- service user Bs of over Rs. 500. The respective figures were 39% and 29-32% in other two states.

In comparison to access to care, the findings with regards to behaviour change are not found to be as positive. Of the total non- service users As, less than 70% breast fed the newborn within 3 hours of birth and less than 39% said that they did not give any pre lacteal feeds or anything other than breast milk in first three days. Also less than 45% of non- service user Bs said they continued feeding the child during illness and of the total cases of diarrhoea, the child got extra fluids only in up to 42% cases, exclusive breast feeding was followed in 75% of cases and complimentary feeding was started at 6th month in less than 51% cases. Except for Punjab where a very high proportion of Non services user As -57% and 66% Non- service user Bs said that they do not need services from ASHAs only 15%-17% in Delhi and 5-7% in Gujarat said the same. Of these respondents, over 95% in Punjab and 70% in Delhi gave their preference for private sector as a reason for not wanting the services from ASHAs. These findings further raise concerns when analysed with high OOP and a large proportion of non- service users having a household income of less than Rs. 5000 per month.

Irrespective of ASHAs functionality, low levels of skill set across all states highlight the need for regular refresher training for ASHAs to address the low levels of skill attrition. Unlike the High focus states, the ASHA programme did not receive attention of the programme managers in these Non High Focus states till recently. As a result the focus on ensuring quality in trainings, setting up and building capacities of support structures for effective mentoring was limited. However over the last year these states have taken cognizance of these issues affecting the ASHA programme and have also undertaken corrective measures. Setting up of support structures in Haryana, start of training of ASHAs in Module 6 and 7 in Haryana and Delhi,

planning for refresher training of ASHAs in Gujarat and capacity building of the support structures in Maharashtra all highlight such actions. These initiatives are too recent to have a large scale impact on the programme findings at the field level but are very encouraging. States need to strengthen the support structures to ensure regular and high quality of training along with effective field level mentoring support for ASHAs.

Findings and recommendation of the Seventh Common Review Mission on Community Processes

The seventh Common Review Mission was conducted in November 2013 in the states of Andhra Pradesh, Arunachal Pradesh, Bihar, Gujarat, Himachal Pradesh, Haryana, Jharkhand, Jammu and Kashmir, Karnataka, Maharashtra, Meghalaya, Nagaland, Orissa and Uttar Pradesh. The key community processes related findings and recommendations of the CRM are as follows:

Village Health, Sanitation and Nutrition Centre (VHSNC)

- The experience with VHSNC across states is mixed, with substantial variations in the levels at which the VHSNC were established (revenue village versus Gram Panchayat), composition of the committee (representation of the SC/ST, marginalized families, and women), the involvement of the ASHA, the leadership provided by representatives of the Panchayati Raj Institutions, the activities undertaken, and extent of fund utilization.

- Most states are yet to put in place the new guidelines particularly as related to the composition and activities of VHSNC.

- All states have conducted some training of VHSNCs that ranges from a one-day orientation to two – three days training of VHSNC members. However as the findings on functionality demonstrate, this is clearly insufficient.

- VHSNC have been formed at the Gram Panchayat level in Andhra Pradesh, Haryana, Bihar and Uttar Pradesh. In all other states VHSNC have been formed at the village level. In Bihar, while the committees have been formed at GP level, funds are sanctioned for every Nigrani Samiti formed at revenue village level under the VHSNC.

- Across the states visited there is a huge gamut of activities undertaken by VHSNC. These activities include environmental sanitation (cleaning and drainage of water tanks); vector control measures (spraying and fogging activities, chlorination, purchase of bleaching powder); health promotion events (hoardings, wall paintings, rallies, healthy baby shows etc. Some states also use the untied funds to purchase furniture and other equipment for the sub centres, or to pay the ASHA a monthly sum of Rs. 150, or payment for the Ward member to attend the meeting, or purchase sari for the ASHA. Some use it for helping transport a sick patient to the health institution. What does not clearly emerge from this pattern of expenditure, except for Odisha and Jharkhand, is whether the funds are being used in response to local gap analysis, or in an ad hoc manner. Until now VHSNC have not undertaken any activities related to local level planning.

- As far as participation of PRI members is concerned, some form of engagement was reported from all states except in Bihar, Uttar Pradesh, Karnataka, Arunachal Pradesh and Meghalaya. In particular, active engagement was reported from the states of Jharkhand, Odisha, Nagaland and Himachal Pradesh. While low levels of PRI members engagement is evident from all states it is also important to note that efforts for orientation of PRI members were undertaken only in states of Odisha and Jharkhand.

- The pattern of VHSNC functionality that emerges in this review is that active engagement of PRI contributes to processes such as regular meetings, minute records, and to certain extent fund utilization. However VHSNC engagement in local planning, oversight of implementation, purposive action on environmental determinants, such as water, sanitation, and vector control measures, rely on a strong community processes support structure and training of members of the VHSNC. This is clearly seen in states like Nagaland, Odisha and Jharkhand, where there are sufficient support

structures at state, district and sub block levels. In the states of Andhra Pradesh, Karnataka, Gujarat and Himachal Pradesh despite the lack of adequate support structures, a strong PRI system enables regular meetings but with little relationship to any health related outcomes.

- ASHA as a member secretary of VHSNC is seen only in states of Haryana, Arunachal Pradesh, Jharkhand, Maharashtra, and Nagaland (in some cases). The bank signatories to the VHSNC account also varies. In the states where she is member secretary she is likely to be one of the bank signatories. Where cooperation with the PRI exists, there is progress in productive use of funds. In the state of Odisha though ASHA is not a member secretary she is a facilitator and plays an active role in VHSNC.

- Poorly functional VHSNC are seen in the states of Uttar Pradesh and Bihar. In Bihar, despite the existence of a strong support system for ASHA, the limited attention to VHSNCs could be partly because of a lack of commensurate management structure. In Uttar Pradesh, the support system is weak and fragmented, and this is reflected in the functionality of the community processes component, including ASHA training and support.

- VHSNC meetings are held regularly and minutes of proceedings are well maintained in the states of Andhra Pradesh, Karnataka, Jammu & Kashmir, Jharkhand, Odisha and Nagaland. However even here there is variance in districts. Thus, for instance we see that in Mehboobnagar district there are better meeting records than in Chittoor district, in Andhra Pradesh. In Bihar need based meetings were reported while in the PHC areas of Vaishali district no meetings were held since last nine months because of non-fulfilment of quorum.

- The guidelines stipulate a release of Rs. 10,000 annually per VHSNC. States have interpreted this in various ways. Based on the status of fund utilization in previous year some states have released only part amount of the untied fund (Rs. 10,000). These include Bihar, Haryana, Arunachal Pradesh and Jammu and Kashmir; while in Jharkhand fund of Rs. 10,000 was released to only those VHSNCs which reported over 70% utilization in the last fiscal year.

Community Monitoring

Community monitoring has been implemented in five out of 14 states, Jharkhand, Bihar, Maharashtra, Meghalaya and Nagaland. In Jharkhand, the process of CBM is led by the state CP team, with technical support from NGOs only for training while in other states the involvement of NGOs extends from state level to field level implementation of CBM. Positive outcomes in terms of greater community participation and improved health service delivery have been noted in the villages where the process of CBM has been rolled out. In the stated approach of CBM, VHSNC was to be facilitated to undertake CBM as a sustainable process. However, VHSNCs were involved in CBM only in the state of Jharkhand.

ASHA

- As with all CRMs the reports laud the ASHA as being 'vibrant', 'active', 'good interface between community and health system', 'motivators' and 'carriers of change'. The visibility of the ASHA is high with both community members and the officers in the public health system acknowledging her role in better service delivery outcomes.

- ASHA selection is near completion in all states except for the state of Himachal Pradesh where the ASHA programme was launched recently. The selection is complete in Odisha, Jharkhand, Andhra Pradesh, Maharashtra and Meghalaya. It is over 97% in Bihar, Arunachal Pradesh and Nagaland; and up to 90% in Gujarat, Haryana, Jammu and Kashmir and Uttar Pradesh. This gap noticed in 7 states is due to revision in the target as per rural population of Census 2011 or attrition over last seven years. Thus a shortfall of 37,842 ASHAs was reported from Uttar Pradesh, 700 in Chitoor district of AP, and 102 in Dang district of Gujarat. In Bokaro and Sahibganj in Jharkhand about 15% of villages and 286 villages in RiBhoi district of Meghalaya have no ASHAs. The gaps in ASHA selection in poor performing districts continue to exist and these are more likely to be areas with marginalized population or small habitations where mothers and children are more likely to require support.

- Thanks to a well maintained district database which is largely established across all districts it is now possible to track attrition which ranges from 3% -12% across all states. Odisha reported a very low attrition rate of only 0.67%. Attrition is mostly related to ASHAs getting selected in other programmes, voluntarily opting out or being dropped out on account of non performance. Thus, for instance Haryana identified and replaced 3000 non performing ASHAs in last financial year. States are also showing progress on the speed with which ASHA selection is made to compensate for revised targets based on attrition.

- Another area of progress is the establishment of support structures for the ASHA programme. Support structures at all four levels i.e., state, district, block and sub block level are in place in Bihar, Odisha, and Jharkhand; at three levels in Haryana, Karnataka, Arunachal Pradesh, Meghalaya, Nagaland and UP (selection of ASHA Facilitators is under way); at two levels in Andhra Pradesh, Maharashtra, and Gujarat. Only in J &K the programme is managed by existing staff at all levels with one state nodal officer at the state level. The most critical link in the support structure i.e., ASHA facilitator has been put in place in ten states barring Andhra Pradesh, Karnataka, J & K and Nagaland. However poor functionality of ASHA facilitators was reported from Gujarat and Bihar. In Odisha 1 ASHA facilitator is selected for every 25-35 ASHAs, the number sometimes increases to 50 ASHAs making consistent and high quality on the job field level support difficult. The existence of a support structure is not necessarily equivalent to effectiveness, as seen in states such as Bihar, Meghalaya and Uttar Pradesh. Poorly trained support staff are not able to provide adequate on the job mentoring and field based training of ASHAs.

- ASHA training in Module 6 & 7 is underway in all the states and is at varying stages of completion. Training of Round 2 is near completion and Round 3 is underway in Jharkhand, Gujarat, Andhra Pradesh, Odisha and Meghalaya, while all three Rounds have been completed in Arunachal Pradesh and Nagaland. Slow progress of training was reported from Uttar Pradesh, Bihar, Jammu and Kashmir and Haryana. Of these four states, the decision to roll out Module 6 & 7 in Haryana and UP was taken only in FY 2013-14. The state of Uttar Pradesh is hugely constrained by existing norms of procurement related to printing, recruitment of high quality trainers, and the involvement of NGOs, making the pace of training extremely slow.

- Observations from the field however have highlighted skill gaps. Thus, ASHA in Arunachal Pradesh, Nagaland and Bihar, ASHAs were not able to identify danger signs among sick newborns. Previous reports from these states have highlighted good quality training. Thus it is clear that one time training is not sufficient. Constant reinforcement of training is necessary in order to improve retention of knowledge and skills. This can best be achieved through structured refresher training and on the job mentoring by ASHA facilitators.

- With the completion of Round 1 training of Module 6 & 7 in most states, Home based New Born care has emerged as a priority task for ASHAs. All states reported that ASHAs were making home visits to the newborns, but the quality of the visits are varied, and are linked to the level of support provided. Reports from Odisha show that 97338 newborns, were visited by ASHAs, 3705 newborns and 1063 mothers were identified with danger signs and about 1963 newborns were referred. In the states of Bihar and Andhra Pradesh though visits are being undertaken ASHAs have not been provided with HBNC equipment kit, which minimizes the effect of such visits.

- ASHA's effectiveness in the field is affected by frequent stock out of drugs and quality of the HBNC equipment provided to ASHAs. Delays in distribution of HBNC kit was reported from Jharkhand, Odisha and Arunachal Pradesh where the kit was distributed after a delay of 2-3 months since the completion of training. The quality of the HBNC kit was found to be variable in Uttar Pradesh and Arunachal Pradesh. In both these states district level procurement with no monitoring of technical specifications was undertaken. In Nagaland, the weighing scale did not conform to the specifications with a result that newborns are not being weighed by ASHAs.

Unavailability of drugs with ASHAs emerges as a common finding and ad hoc replenishment mechanism seems to be the norm in all states. During the visit adequate drugs in ASHA kit were found only in Jharkhand and Haryana. In Andhra Pradesh and Arunachal Pradesh, even a basic drug kit was not available with the ASHAs.

- Almost all states have taken cognizance of the delays in payments of ASHA incentives and have taken steps to streamline the payment process but delays. Over 90% ASHAs have bank accounts across the states. Cash payments were reported from states of Arunachal Pradesh, Meghalaya and Nagaland because of difficult terrain and unavailability of accessible bank branches. Single window payment was observed in Odisha, Uttar Pradesh and Maharashtra. Odisha has been successful in reducing time delays through introduction of single window e-transfers on a fixed date of every month and has also launched CPSMS scheme in four districts. Delays of up to three months were observed in the state of Uttar Pradesh despite the payment being done through a single window mechanism. Huge delay of up to six months was observed in Jharkhand because of delay in release of funds at block level.

- Average incentives earned by ASHAs ranged from Rs. 250-4000. The range is between Rs. 250-600 in the North Eastern states of Arunachal Pradesh and Nagaland with low CBR and sparse distribution of population. The highest incentives, within a range of Rs. 2500 to Rs. 4000 were reported from the states with large population and high fertility rates i.e., Bihar and UP. In the states of Andhra Pradesh and Arunachal Pradesh, low awareness among ASHAs about their incentive entitlements was also observed. These findings emphasize the need for increasing ASHA's role in non RCH related activities specifically in areas with either low population density or with low fertility rates. The recent policy decision to provide all ASHA with incentives for a set of routine activities will also ensure a minimum amount that is not dependent on population coverage or fertility. Meghalaya has recently introduced an incentive scheme to give a matching amount of the incentives earned by the ASHAs on an annual basis.

- Considering the fact that ASHAs are not mandated to accompany pregnant women to institutions for delivery, in most states ASHAs are actually doing so and which is an expression of their agency and the sense of responsibility in ensuring safe institutional delivery. Despite this no provision of separate facilities like as ASHA rest rooms / *Gruhas* were found at facilities except in Odisha and at some DHs and CHCs in Jammu & Kashmir.

- In terms of non-monetary incentives, Jharkhand has launched an Insurance scheme for ASHAs, Odisha has included ASHAs in Swalamban Yojana and Bihar supports ASHAs to pursue higher education - 472 ASHAs have enrolled in NIOS for 10th class in FY 2012-13.

- The performance monitoring of ASHAs based on ten indicators has been introduced in all states except Uttar Pradesh, Andhra Pradesh, Jammu and Kashmir and in the visited districts of Arunachal Pradesh. Reports of performance monitoring for last quarter are available for all the other states. However, effective utilization of performance monitoring system with analysis of the ASHA functionality vis-a-vis health outcomes has been initiated only in the states of Odisha, Jharkhand and Meghalaya.

- Formal Grievance Redressal mechanisms as per the guidelines have been established only in two states i.e., Haryana and Bihar. Even in these states, these committees are yet to become fully functional. In Odisha, ASHAs have been provided with post cards for registering their complaints to CMO.

- Effective convergence with other departments beyond the scope of organizing VHNDs was not evident across any states. The onus of effective convergence between ICDS and Health department at field level seems to have shifted to only with the field level functionaries like ASHAs, ANM and AWW with no inter departmental coordination at block level and above.

Recommendations

- States should consider reconstitution of the VHSNC to ensure representation of the PRI,

Community members, particularly women and the marginalized, and enable a central role for the ASHA in the committee. States need to build mechanisms to support VHSNCs to undertake the five tasks of: a) monitoring and facilitation of access to all health and health related public services- especially of marginalised groups within, b) organizing local collective action for health promotion, e.g. vector control, solid waste disposal, health camps etc. c) facilitating service delivery at village levels by service providers or ASHAs visit d) village health planning, and e) community monitoring of health care facilities. All this will necessitate funds at village levels.

- In addition, states should institutionalise training at both state and district levels, expanding the training cadres at district level to include trainers with a backgRound in social mobilization so that the large numbers of VHSNC members are trained in the set of five tasks.
- Enable a realization of community engagement and ensure that VSHNC serve as an effective forum for addressing environmental and social determinants.
- In order to keep pace with the enthusiasm and commitment of the ASHA, states must build and strengthen the support structures so that a viable structure is created not just to support the ASHA but also the VHSNC and the community base planning and monitoring. Training of such support systems and ensuring regular performance appraisals is just as important as training and demanding accountability for ASHA. For states such as UP this is of critical importance given the scale of the programme, the very slow pace of implementation, and the associated nature of poor governance.
- Ongoing refresher training of ASHA is another important area to ensure that her skills are reinforced. Certification of ASHA is an important step in assisting this process, but this needs to be buttressed by on the job mentoring, and using opportunities such as monthly review meetings and cluster meetings to build capacity.
- Grievance Redressal and planning for career opportunities for ASHA are large unfinished agendas for states.

SECTION 2

KEY FINDINGS FROM THE REPORT OF THE TECHNICAL RESOURCE GROUP FOR THE NATIONAL URBAN HEALTH MISSION

After the notification and finalization of financial sanctions of National Urban Health Mission on 25th July, 2013, the Government of India created a Technical Resource Group (TRG) on National Urban Health Mission with National Health Systems Resource Centre. The members of the TRG included Officers of the Ministry, representatives of the state governments and urban local bodies working on urban health issues, and members of the civil society and academics who had been engaged in urban health for long. The terms of reference of the TRG were wide ranging and called for the TRG to guide the NUHM on key issues that would enable reaching the vulnerable sections of the society. It examined the main strategies and institutional design of NUHM and formulated strategies to reach the vulnerable populations, and the better organization of health service delivery and its governance.

The TRG examined several aspects such as: reaching the vulnerable sections, institutional arrangements, meeting the challenge of convergence, financing Strategies for Urban Health and key challenges in governance. It extensively examined the main strategies and institutional design of community processes in urban context. The section below is an excerpt from "Report and Recommendations of the Technical Resource Group for the NUHM" on community processes:

2.1 The most common observation across all states and cities is that there is really no major programme focussed on strengthening urban community processes in place. This is similar to the situation in rural areas prior to the start of the NRHM. Hospitals and facilities under urban local bodies did not have hospital development societies or un-tied funds, unlike their rural counterparts. Not only were health committees not in place (with some few important exceptions) even the presence of community based organizations and self- help groups is much less. There were however some form of community health volunteer or worker in place.

2.2 There is a further challenge in urban areas, that in settlements of the urban poor, there are fewer organic communities than you find in villages. Even in the countryside, Ambedkar reminded us of the fiction of the idea of the village community, which he said masks the reality of a 'cesspool' of caste and gender inequalities. But the village is at least a settled and stable social entity. In cities, by contrast, people are far more socially isolated and uprooted, and live in settlements in which they lack organic, stable bonds with their co-residents. This has many consequences for health: much greater psycho-social stresses, and the lack of care-givers for many poor migrants. At the same time, this also has great challenges for organising community processes, because there are no organic communities of the urban poor.

2.3 Data from the city reports show in several cities, there is evidence of some form of community health worker, already present in the community, although not ubiquitous, nor necessarily positioned where the needs are the greatest (where there are poor in large concentrations, or among vulnerable populations). They exist either as a legacy of past programmes (the India Population Projects), or a link worker in the RCH 2 interventions (as part of urban RCH interventions in selected cities), or as the ASHA

of the NRHM becoming an urban ASHA as the areas were notified as being urban. The examples include- the Honorary Health Worker-Kolkata, Community Health Volunteer-Visakapatnam (respective Municipal corporations) Mitanins in Raipur and Dhamatari, of Chhattisgarh and ASHAs in Gangtok, Guwahati, Bhubaneswar and Trissur in Kerala.

2.4 **The role of existing urban CHWs:** Regardless of the nature of the intervention or the affiliation of the ASHA (either the Urban Local Body (ULB) or the health system or NGOs), and the context of its origin, the spectrum of services currently offered by these workers is narrow. It is largely limited in scope: facilitation for79 services provided by the facility, and in breadth- immunization, antenatal care and family planning. Given the veritable maze that the facility network currently is, the major felt needs of the community are rarely met – by design. The ASHA/CHW are not equipped to pay the role of either providing the type of information or services they need the most, nor even in facilitating their "navigation," through the maze of health care facilities nor are their provisions in the system to make a facility "ASHA friendly". This is likely on account of the fact that the role of the ASHA was not clarified to include a mix of roles (as has been done in the NRHM) and the level of training input, support (mentoring and drug kit) is low.

2.5 One observation from many towns where urban ASHAs began by incorporation of surrounding rural areas by "notification" the ASHA skill sets and effectiveness are weaker than the rural counterpart, because they lost the attention and support of the larger NRHM programme. Even in Chhattisgarh, where the Mitanins are being seen as playing a key role in community level care, particularly noted for reaching the marginalized; her urban counterpart, although evolving from the same programme does not demonstrate a similar degree of social reach.

Recommendation 1: The roles of the ASHA are dependent to a large extent on the nature of organization of services. Given the need to ensure that 80 per cent of primary care should be provided at the community and outreach or primary care facility, the role of the ASHA as a community level care provider must be defined in such a way that she contributes to the package of care provided at the community level. This needs to be merged seamlessly with her roles as a mobilizer and as a facilitator. There is also a clear need to even at the outset have a greater role in NCDs and particularly in regular drugs supply in many states.

2.6 Poor population coverage results in non-identification of the marginalized, poor detection of mothers and children in need and also case detection in the communicable diseases programmes; and a very limited role beyond RCH. The pulse polio programme through its Social Mobilization Network has shown that the marginalised can be reached better. Balancing population coverage for the ASHA and ensuring reach to vulnerable populations is important and the ASHA represents the first point in the chain to enable effective coverage. In rural areas the population norm was intended to be about one per 1000 to be relaxed in cases of hamlets or dispersed habitations; in urban areas, given geographically compact areas, one ASHA could cover a population of 2500 (or covering 200 – 500 households). However the underlying principle in allocating households or a geographic area to the ASHA must ensure that the vulnerable are reached.

2.7 **Reaching the Vulnerable :** The reach of the ASHA to marginalized communities is critical, particularly in view of the fact that the NUHM lays such substantial emphasis on particularly reaching the invisibles- the destitute, the homeless, the marginalized, those with different sexual orientations, etc. Evidence from the city reports point to the fact that the reach of the ASHA is limited, since she has not been equipped either by mandate or through her training to focus on the health needs of these marginalized groups. Also in some contexts like the Kolkata HHW, a quota of poor households not necessarily all conforming to a geographic areas are assigned to each HHW- and over time the poorest households may not have any assigned HHW.

Recommendation 2: To ensure that marginalized are not left out the ward health committee must divide each ward into clear zones and supervises assignment of areas (by street) and households to specific UPHCs, health stations/ posts or ANMs and ASHAs and people's health committees (JAS – please see below). We should also consider that the fact that the homeless have no designated "residence", and often live in

areas such as - footpaths, by the side of railway tracks, and under flyovers. Though the database of pulse polio programme helps to identify these groups, additional planned, periodic re- mapping of the area, through sensitised facilitators working with the ward committee, providers and ASHAs must be emphasized.

2.8 **Selection of the ASHA:** The important lesson from the rural ASHA programme is that wherever the selection is participatory, and where attention is given to process of selection and endorsement by the panchayat and the health systems, there are fewer drop-outs and better functionality. Community based selection of the ASHA is therefore an important tenet of the NHM. But whereas a relatively greater homogeneity in rural areas facilitates this, the selection of urban ASHA on the other hand poses several challenges due to both the higher heterogeneity and the lack of accepted community leaderships and organisations that cut across the different groups; and indeed the absence most often of real urban communities. Since the emphasis is on the vulnerable and poor, both being marginalized, a sound process of selection is required to ensure both that ASHA understands the needs of the group she represents and has acceptance amongst them. We also need to balance a preference for at least class 10 or even class 12 ASHA (since we are now considering the ASHA as a long term institution providing a certain set of community specific services) against the concern that setting such high entry qualifications would not allow representation from amongst the marginalised.

Recommendation 3: Selection in the urban context will require active facilitation by sensitised facilitators. Where available, the involvement of experienced NGOs and academic institutions in supporting early mapping, identifying and mobilising potential candidates should be considered.

2.9 Facilitation should include the process of identifying representatives of various vulnerable groups in a particular area, consulting them as a collective and 81 selecting candidates from within the group or in that particular geographic precinct to represent them. Either way, the candidate selected must be acceptable to the group, and be accountable to them. This accountability can be further reinforced if the collective then functions as the Mahila/Jan Arogya Samiti (JAS). This is further discussed below.

2.10 **Compensation to the ASHA:** Remuneration packages for the community based workers vary with urban local bodies usually paying more than the NRHM/state department. Compensation packages of link workers and other community health workers engaged through the ULB ranges from Rs. 3000 to Rs. 8000. However in the NRHM/ NUHM architecture, payments are an incentive system that is based on performance for a set of activities- which in many urban contexts leads to very low levels of monetary compensation. A fixed basic salary for ASHAs in urban areas are worth considering, given her larger role including but beyond RCH, as discussed below.

Recommendation 4: The main approach to payment may be retained on the lines of the recently approved guidelines on payment in the Mission Steering Group of NHM. In this approach one set of incentive payments is for a set of tasks with regular predictable periodicity - monthly meeting of MAS, UHND mobilization, attending monthly review meetings, household listing, maintaining lists of eligible couples and children to be immunized with updation on a bi- annual basis. Another set of incentives is for services provided under various programmes and will vary with caseloads and her effectiveness: such as JSY, child immunization, follow up for SAM children, visits to newborns and past partum mothers, promotion of family planning, and her contribution to the vector borne disease control programmes. The principle underlying the incentive structure is that it needs to be linked to an outcome which is defined so as to be compatible with the ASHAs roles, training and her skills. Prompt payment mechanisms should be instituted and access to electronic modes of payment should be facilitated. All of this is with the understanding that the work load is such that it can be done in about 12 to 18 hours in a week. As the package of her work increases and approaches 25 to 30 hours, a regular payment in line with minimum wages at the least becomes necessary. The payment should be graded along with the work they do, since there is a movement along the spectrum from a purely voluntary worker to a regular community health nurse/care provider. Irrespective of all the above if the work requires her to be away from her home/livelihood for

the whole day- as for example when she is attending training, or a full day volunteer in a pulse polio or screening for NCDs survey, then the compensation should be for a full days wage loss.

2.11 **Support Structure:** An important finding from city reports is that there is no support structure in place in urban areas, with the sole exception of the first tier supervisor in Kolkata. The NRHM on the other hand has always supported a strong support mechanism by way of training and on the job mentoring was critical. Experience from rural areas also shows that relying on existing workers in the system may not necessarily yield these results, given existing and potential workloads. The principle of support in conjunction with a strong training system, with opportunity for frequent refreshers, and on the job mentoring is perhaps the main reason why the rural ASHA programme has sustained in rural areas, and this is an important learning for the urban ASHA as well.

Recommendation 5: Where competent and committed NGOs exist, the role of training and supervision can be undertaken by them but coordinated by city/district support teams as established for NRHM. In areas where NGOs do not exist or there is reluctance or problems in engaging them, support structures consisting of ASHA facilitators coordinated by a suitable mid-level coordinator will need to be engaged.

2.12 **Role of ASHA in financial protection:** The use of ASHA to ensure enrolment of the poor into publicly financed health insurance schemes is welcome and could be encouraged. However, paying commissions to them to mobilise case loads for empanelled private sector hospitals under different insurance programmes has had deleterious consequences for patients and must be disallowed. While the possibility of ASHA becoming a commission agent was a risk in the rural areas, it was softened to a large extent by two factors: one that the private sector was largely non-existent in many parts, and secondly, the proportion of ASHAs who undertook this was small. But in some urban areas, "by design" the CHW is expected to recruit patients and refer to empanelled hospitals and is paid a commission for referral and follow up. Arogya Mitra in Vishakapatnam is such an example. The risk of providing ASHA with an incentive designed to encourage and benefit from referrals to private sector for costlier therapeutic procedures, completely runs counter to the expectation and promise of her as a promoter of good health and preventive care. On the other hand, we could explore the role as ASHA as a gatekeeper protecting the interests of the poor from unnecessary charges or providing information on billing etc.

2.13 A more direct way in which the ASHA ensures financial protection is by addressing issues in access to free or subsidised care and protection from inappropriate care. As seen from the city reports, the poorest are incurring considerable expenditure on care for a range of simple acute morbidities (diarrhoea, pneumonia, malaria and other fevers) in the private sector (qualified and non-qualified practitioners) due to access barriers to public health system. When it comes to chronic illness they have to spend time, lose wages and faces expenses in seeking care at crowded public tertiary care centres even when only a prescription refill is needed.

Recommendation 6: Training and skilling the ASHA to provide a range of basic curative services of low complexity and a standardised periodic nature, like the measurement of BP and blood sugar and the provision of drugs (prescription refills) for chronic diseases so that patients do not have to travel far from their residence, will mitigate out of pocket expenditures to a degree. For this role the ASHA should closely coordinate with the nursing stations discussed earlier.

Recommendation 7: The ASHA also has an important role in educating persons on the use of publicly financed insurance for the poor, so that they are able to get cashless services, are not excessively charged and so that they are not sucked into inappropriate care in the private sector. ASHA help desks could be set up in health care facilities and ASHAs empowered to ask for billing and payment details so that they could perform this function. ASHA help desks in secondary and tertiary care centres are also essential to ensure that she helps the referred patient navigate the hospital and to have adequate information and documentation so that follow up at the local level can be ensured. ASHA help desks are also especially needed to arrange for attenders for some category of vulnerable.

2.14 **The Mahila Arogya Samitis:** The city reports testify that where community health workers exist under ULBs, the design as conceived by programme planners, visualizes her only as an instrument to enable target populations to access their programmes, which were largely focused on RCH or TB/Malaria. For bottom up planning to occur -which is the larger vision of the programme-a single community worker alone is insufficient. She needs a group of people- a community collective- who can support the process of local planning, given their knowledge of and familiarity with their community and their environments, and their interest in positive outcomes. The limited case studies on such mechanisms as seen in the city reports demonstrate that community collectives comprised only of women (Kudumbashree in Thrissur and Kochi, Indira Kranti Padham in Vizainagaram and Visakapatnam, Sampoorna Mahila Samiti, Indore, Mahila Arogya Samiti in Bhubaneswar) are effective in articulating the needs of the communities they represent, although this is variable across contexts. The effectiveness of the local collective is quite dependent on the nature of support received by such groups, whether they have other forms of activity such as participating in micro credit programmes, livelihood efforts, and other developmental activities. The proposed Mahila Arogya Samiti under NUHM is also composed of about 15-20 persons, drawn from a neighbourhood cluster, and representatives of the community. The Kudumbashree model seen in the Kerala cities visited have useful learnings on how to make this committee more representative by a drawing one committee member from each cluster of 10 to 20 houses.

2.15 The NRHM also shows us that effective Village Health Sanitation and Nutrition Committees (VHSNC) can undertake village planning, support frontline workers, enable action on social determinants and undertake monitoring of public services as a way of holding the system accountable. A similar structure is desirable in the urban context, particularly as the communities of urban poor and the marginalized; need effective representation and active participation in such collectives.

2.16 There is however one dilemma that the urban health committees have to resolve. A repeated theme and finding of the focus group discussions- that there are many vulnerable groups and many health concerns which are predominantly male issues which women would not be able to address or perhaps even discuss. This makes the case for the introduction of a male ASHA equivalent, or at least some men in what is now a Mahila Arogya Samiti. On the other hand there is a concern, that men could dominate the committee and change the dynamics and the urban male community leader has a different status that the rural counterpart. To guard against this NUHM may prescribe that inclusion of men cannot exceed 25 per cent of any Arogya Samiti. The NUHM should start by permitting a few cities to exercise this option, and then based on experience scale up as a nation-wide.

Recommendation 7: Similar in specific contexts male CHWs- the equivalent of ASHAs would be permitted, but never exceeding 25 per cent of ASHAs in any ward and usually less. Once again we begin carefully, piloting the concept in a few states with clear role allocation and indicators. Again 25% of Nursing stations/health sub-centres should have a male and a female worker instead of two multi-purpose female workers.

Recommendation 8: The basic structure of a health committee would be to identify one member per ten families so that a collective of about ten to fifteen members for 100 families is formed. The number is kept small so as to ensure representation of marginalized groups. Every ASHA would be linked to between two to five such groups. For adequate representation particularly of marginalized men's groups – such as rickshaw pullers, head loaders, men also need to be part of such collectives. Existing CBOs in urban areas are often constituted around micro credit and these tend to be mostly women's groups. In the starting phase of the programme, the involvement of such collectives of women alone, even though they do not include men, could serve as a first starting point and yield lessons for planning in the urban context. As the programme matures, men could be included in the MAS evolving into "Jan Arogya Samitis.", though at all times at least three-quarters in any ward would be women. One possibility is to bring in male peer-educators into their areas MAS. Care is also needed to ensure within the women's representatives adequate numbers of single women, aged and disabled

women, and women from disadvantaged castes and communities like Muslims and DNTs. In areas where CBOs need to be created anew, they should include representatives from marginalized men's groups. ASHA will be the member convenor of the MAS and it would be supported by the FHWs and MHWs. 5.22. At the level of the UPHC, there is a need to have another structure that coordinates and federates the MAS and link it up with occupational groups and their collectives including those composed only of men. This could in the form of a Jan Arogya Samiti. The members would be all the heads or representatives of the MAS of that area, the representatives of collectives of vulnerable groups defined by occupation and the elected member of the ward. it function is to plan for health services in that area, in particular identifying groups who are getting missed out.

Recommendation 9: The TAG would propose two levels of community institutionas- the MAS (Mahila Arogya Samiti) at the neighbourhood level and the JAS (Jan Arogya Samiti) at the UPHC level (or ward level where there is no UPHC) with the ward member as the chairperson. There would be about 100 MAS (each covering a population of 500) that is federated into a JAS (Jan Arogya Samiti). This would build ownership of the ULB, and also ensure that there could be coordinated action between different sectors and ASHAs, MAS and nursing station/health sub-centres/ ANM and Male Multi-Purpose Workers working in that locality. There could be paid social workers assigned to assist these Jan Arogya Samitis.

Recommendation 10: Learning from the roll out of the programme in rural areas the NUHM should specifically ensure that some major weaknesses, gaps and errors are not repeated: These would include:

i. Ensuring that we start with the formation of Jan Arogya Samitis and the selection of ASHAs in parallel- and ASHA is positioned as its convenor. This reinforces her capacity to mobilise and networks her with peer representatives from the various vulnerable groups in her area. It also contributes to making ASHA selection itself more participatory. (In many states in NRHM, the village committees were constituted long after the ASHAs were deployed undermining her mobilization capacity and community ownership).

ii. Ensure quality of training through accrediting training institutions and trainers and introducing training evaluation from the very beginning.

iii. Ensure that we invest early on in well trained support structures to provide supportive supervision.

Recommendation 11: Legacy Management : A non-trivial issue for many municipalities is how to manage existing cadre of link workers and community health volunteers. Where they are women and not paid a regular wage, then one could easily adopt them as ASHAs- but after going through a community consultation process. Where they are paid a regular wage- too they could be kept as ASHAs but with some additional responsibilities and training for the same- thus using to pilot new dimensions like mental health, geriatric care or cancer screening at the community level. Some of them who are qualified and capable could be trained and on a substantial regular wage, could be trained into becoming the facilitator.

2.17 **Grievance Redressal:** One finding from across the urban areas, is that there are no public grievance redressal mechanisms in place. This is true even in the best case scenarios. Part of the problem seems to be a lack of willingness to invite complaints knowing the poor ability to respond where there is such lack of finances and human resources. But an equally important issue is the administrative space to do it. Good grievance redressal mechanisms themselves need human and financial resources.

Recommendation 12: Provide for grievance redressal in the budget, and consider giving this function and budget to the ULB, especially if all facilities are under the state government and vice versa. The Grievance redressal mechanisms should comply with a minimum set of standards and certified as adequate. The minimum processes that should be in place is a well-publicised call number functional at least for 8 hours, well publicised contact email and postal addresses, every grievance being recorded and action taken within a specified time standards. These standards imply a definite HR and budget allocation for this function.

SECTION 3

PROGRESS OF THE ASHA PROGRAMME

This section provides data on three major areas related to the ASHA Programme. The primary source of this data is the ASHA progress monitoring matrix, a quarterly compilation of key indicators related to the ASHA and Community Processes Programme. The data covers the following:

1. Selection
2. Status of Training
3. Support Structures

We have used the data reported by the states for the ASHA Matrix, up to the period of December 2013.

Section 3.1 Selection

During the last year, states have streamlined the mechanisms for- performance monitoring of ASHAs, maintenance of ASHA Data base and regular programme reviews and update. This has enabled states to identify the drop out and non-functional ASHAs. Thus, a majority of the states have now been able to report with a degree of certitude, the number of ASHAs who are actually working on the ground. This explains the overall reduction in number of ASHAs for many states. Thus, as per the recent data, a **total of 8,34,922 ASHAs** are in position across 31 states and union territories[3]. The percentage selection against the present target of 9,39,686 is 89%. In comparison to the previous July-2013 edition of the Update on ASHA Programme, a four percent decrease is observed in the percentage of ASHAs selected across the country. The previous update reported about 8,70,089 ASHAs selected, which was 93% against target set at that period. In many states this lowering of selection achievement could also be due to an upward revision of the target undertaken in commensuration with the increase in rural population as per 2011 Census. States which have increased the target according to 2011 population include: all High Focus States except Jharkhand and Uttarakhand, Assam, Mizoram, Meghalaya amongst the north east states and Haryana, Jammu and Kashmir, Kerala, Maharashtra, Gujarat and West Bengal in the non-high focus category. (see Table 3.1A-3.1D)

In the high focus states, the percentage of ASHAs currently in place is- 99% in Orissa and over 95% in Bihar, Chhattisgarh Jharkhand and Uttarakhand. Madhya Pradesh and Rajasthan have about 86% ASHAs in place, while Uttar Pradesh reports a figure of only about 80%. Drop out figures in high focus states range between 0.8%–11%. Though Madhya Pradesh has increased the selection target to place ASHAs in small and geographically dispersed hamlets, it also shows a highest reduction in figures by 11%. The main reason appears to be delays in filling in many vacant positions that arose due to ASHAs joining as ASHA facilitators and also weeding out of many non-functional ASHAs in the districts. A systematic assessment of the number of ASHAs actually attending the training programme from Module 5 onwards has enabled Jharkhand and Uttar Pradesh to

3 This includes the -eight High focus states, eight north eastern states, the non-high focus states such as- Andhra Pradesh, Delhi, Gujarat, Haryana, Jammu and Kashmir, Karnataka, Kerala, Maharashtra, Punjab, Tamil Nadu, West Bengal and the four Union Territories of Andaman and Nicobar Islands, Dadra and Nagar Haveli, Lakshadweep, Daman and Diu.

identify the number of ASHAs who are non-functional and thus their present number of ASHAs shows a drop of 4% and 5% respectively. Uttarakhand shows a drop out of 4%, partially on account of - ASHAs opting for other careers and a systematic performance monitoring leading to identification of non-functional ASHAs. Drop- out rate is comparatively low for Orissa and Bihar at 0.03% and 0.8% respectively. These states are currently in the process of identifying the non-performing ASHAs,and are also supporting them through refresher trainings, supervision and mentoring to improve their functionality. ASHAs in Rajasthan however, are regarded as "working" only after the completion of their induction training. Thus, 4% who are not functional are actually the newly selected ASHAs who are in the process of getting trained in Induction Round.

The north east states on the other hand, show that 98% of ASHAs have been selected. Most of these states such as-Manipur, Nagaland, Sikkim and Tripura have not revised their target, but Assam, Mizoram and Meghalaya have increased the target for selection. Numbers of ASHAs working in these latter three states are reported to be more than 95%. Overall drop-out rates in north east are low and the time gap for replacing ASHAs is not as much, which explains why the numbers remain constant.

The non-high focus states have a total of 87% ASHAs currently working and show higher variation in selection figures. Haryana, Punjab, Tamil Nadu show an increase in the number of ASHAs selected. In other states there is a drop in figures ranging between 2.5–22%, being lowest for Jammu and Kashmir and highest for Delhi. Comparatively higher educational qualification of ASHAs than their rural counterparts and availability of several alternatives for career growth in urban context, contributes to a high turnover in Delhi. This trend also point towards the need for better strategies to ensure retention of ASHAs in urban context. It particularly gains more importance in light of the recently launched National Urban Health Mission which aims to establish ASHAs as a long term institution to support the marginalized and vulnerable groups in urban areas. Other states which show significant decrease in figures include Kerala, West Bengal and Andhra Pradesh. Reason for 11% drop out in Kerala is similar to that of Delhi. ASHAs have comparatively higher educational qualification, higher career aspirations and progress to become staff nurses, ANMs, GNMs, AWW etc. West Bengal shows a reduction of 10% and is mainly due to two reasons. First being an identification of non-functional ASHAs, which gained more impetus after the state government's decision to provide a fixed honorarium of Rs. 1500 to all ASHAs from state funds. Secondly, though state has selected more new ASHAs, it includes their name in the database for functional ASHAs, only after they complete training in induction and the first Round of Module 6 and 7.On the other hand, Andhra Pradesh shows a drop out of 8% which as per the state reports, is related to the demographic pattern in the state. The districts and blocks with low fertility have fewer cases for ASHAs to mobilize for institutional delivery, immunization and family planning or for undertaking home based new born care. This reduces the average incentive earned by ASHAs and prompts their withdrawal from the programme. Though Karnataka has been able to fill the vacant positions recently and shows a gap of only 2%, six months back it reported a huge drop out of 17% in the July 2013 update. Reasons of drop out were same as that of Andhra Pradesh. These cases highlight a need to train and incentivize ASHAs from these areas in other non-RCH interventions such as-non-communicable diseases, palliative, geriatric care, mental health etc., so as to ensure-their motivation, engagement and a long term sustainability of the programme.

The issue of density also has a significant impact on incentives and the recent decision of the Mission Steering Group on providing an incentive to ASHA for a set of routine and recurring activities regardless of population coverage and demographics is also likely to be an important motivation.

As regards density of ASHAs, among the high focus states Bihar, MP, Rajasthan and Uttar Pradesh average density covered by AHSAs is above the 1000 population norm. Except Bihar, these states are also those which show a comparatively larger gap in the placement of ASHAs. The lowest density within this group is seen in Chhattisgarh followed by Jharkhand at 296 and 636 respectively. Uttarakhand and Orissa maintain the density at one ASHA for 806 and 662 population respectively. All north east states have a density well below 1000, ranging between 284 and 900. In the non-high focus group average density is below 1000 for Andhra Pradesh, Haryana, Jammu and Kashmir and Kerala. In other states it is slightly more than the recommended norm.

Table 3.1A: Status of ASHA Selection in High Focus States							
State	**Proposed No. of ASHAs as on July 2013**	**Number of ASHAs in place as on July 2013**	**Proposed No. of ASHAs as on December 2013**	**Number of ASHA selected and working as on Dec 2013**	**% of ASHA in place against proposed as on Dec 2013**	**Number of ASHAs identified as drop out/Non-functional in the last six months**	**% of ASHAs identified as drop out or non-functional**
Bihar	87135	84501	87135	83826	96.2	675	0.8
Chhattisgarh	66092	66092	70000	66179	94.54	Number of ASHAs selected has increased	Not applicable
Jharkhand	40964	40964	40964	39380	96.13	1584	3.87
Madhya Pradesh	56941	56188	58245	50571	86.82	5617	11.11
Odisha	43530	43374	43530	43363	99.62	11	0.03
Rajasthan	54915	51624	54915	46773	85.17	4851	9.40
Uttar Pradesh	159482	136094	159482	128611	80.64	7483	5.50
Uttarakhand	11086	11086	11086	10608	95.69	478	4.31
Total	**520145**	**489923**	**525357**	**469311**	**89.33**	**20612**	**4.21**

Table 3.1B : Status of ASHA Selection in North East States							
State	**Proposed No. of ASHAs as on July 2013**	**Number of ASHAs in place as on July 2013**	**Proposed No. of ASHAs as on Dec 2013**	**Number of ASHA selected and working as on Dec 2013**	**% of ASHA in place against proposed as on Dec 2013**	**Number of ASHAs identified as drop out/Non-functional in the last six months**	**% of ASHAs identified as drop out or non-functional**
Arunachal Pradesh	3862	3761	3862	3761	97.38	No change reported	Not applicable
Assam	29693	29172	30508	29694	97.33	Number of ASHAs selected has increased	Not applicable
Manipur	3878	3878	3878	3878	100	No change reported	Not applicable
Meghalaya	6258	6258	6530	6258	95.83	Target increased	Not applicable
Mizoram	987	987	1090	987	90.55	Target increased	Not applicable
Nagaland	1887	1854	1887	1887	100	Number of ASHAs selected has increased	Not applicable
Sikkim	666	666	666	666	100	No change reported	Not applicable
Tripura	7367	7367	7367	7367	100	No change reported	Not applicable
Total	**54598**	**53943**	**55788**	**54498**	**97.69**	**Number of ASHAs selected has increased**	**Not applicable**

Table 3.1C: Status of ASHA Selection in Non-High Focus States							
State	**Proposed No. of ASHAs as on July 2013**	**Number of ASHAs in place as on July 2013**	**Proposed No. of ASHAs as on December 2013**	**Number of ASHA selected and working as on December 2013**	**% of ASHA in place against proposed as on Dec 2013**	**Number of ASHAs identified as drop out/ Non-functional in the last six months**	**% of ASHAs identified as drop out or non-functional**
Andhra Pradesh	70700	70700	70700	64827	91.69	5873	8.31
Delhi	5616	5216	5216	4044	77.53	1172	22.47
Gujarat	35237	31841	35237	33117	93.98	1276	4.01
Haryana	17000	14972	18000	16841	93.56	Number of ASHAs has increased	Not applicable
Jammu and Kashmir	12000	10960	12000	10683	89.03	277	2.53
Karnataka	39195	30979	39195	30175	76.99	804	2.60
Kerala	32854	31868	33160	28242	85.17	3626	11.41
Maharashtra	58945	58897	58945	55975	94.96	2922	4.96
Punjab	17360	16383	17360	16812	96.84	Number of ASHAs selected has increased	Not applicable
Tamil Nadu	6850	5405	6850	6204	90.57	Number of ASHAs selected has increased	Not applicable
West Bengal	61008	48185	61008	43387	71.12	4798	9.96
Total	**356765**	**325406**	**357671**	**310307**	**86.76**	**15174**	**4.66**

Table 3.1D: Status of ASHA Selection in Union Territories							
Union Territory	**Proposed No. of ASHAs as on July 2013**	**Number of ASHAs in place as on July 2013**	**Proposed No. of ASHAs as on December 2013**	**Number of ASHA selected and working as on December 2013**	**% of ASHA in place against proposed as on Dec 2013**	**Number of ASHAs identified as drop out/Non-functional in the last six months**	**% of ASHAs identified as drop out or non-functional**
Andaman and Nicobar Islands	412	407	412	407	98.79	No change reported	Not applicable
Dadra & Nagar Haveli	250	208	250	208	83.2	No change reported	Not applicable
Lakshadweep	110	110	110	110	100	No change reported	Not applicable
Daman & Diu	119	92	98	81	82.65	11	11.96
Total	**891**	**817**	**870**	**806**	**92.64**	**11**	**1.35**

Grand Total For All States and Union Territories							
Total	**932399**	**870089**	**939686**	**834922**	**88.85**	**35167**	**4.04**

Table 3.1E: Density of ASHAs in High Focus states				
Name of State / UT	**Proposed No. of ASHAs (Target)**	**Number of ASHA selected / working**	**Rural Population as per 2011 census**	**Current Density of ASHAs**
Bihar	87135	83826	92075028	1/1098
Chhattisgarh	70000	66179	19603658	1/296
Jharkhand	40964	39380	25036946	1/636
Madhya Pradesh	58245	50571	52537899	1/1039
Odisha	43530	43363	34951234	1/806
Rajasthan	54915	46773	51540236	1/1102
Uttar Pradesh	159482	128611	155111022	1/1206
Uttarakhand	11086	10608	7025583	1/662
Total	**525357**	**469311**	**437881606**	**1/933**

Table 3.1F: Density of ASHAs in North East States				
Name of State / UT	**Proposed No. of ASHAs (Target)**	**Number of ASHA selected / working**	**Rural Population as per 2011 census**	**Current Density of ASHAs**
Arunachal Pradesh	3862	3761	1069165	1/284
Assam	30508	29694	26780516	1/902
Manipur	3878	3878	1899624	1/490
Meghalaya	6530	6258	2368971	1/379
Mizoram	1090	987	529037	1/536
Nagaland	1887	1887	1406861	1/746
Sikkim	666	666	455962	1/685
Tripura	7367	7367	2710051	1/368
Total	**55788**	**54498**	**37220187**	**1/683**

Table 3.1G: Density of ASHAs in the Non-High focus states				
Andhra Pradesh	70700	64827	56311788	1/869
Delhi*	5357	4044		0
Gujarat	35237	33117	34670817	1/1047
Haryana	18000	16841	16531493	1/982
Jammu and Kashmir	12000	10683	9134820	1/855
Karnataka	39195	30175	37552529	1/1244
Kerala	33160	28242	17455506	1/618
Maharashtra	58945	55975	61545441	1/1100
Punjab	17360	16812	17316800	1/1030
Tamil Nadu**	6850	6204		0
West Bengal	61008	43387	62213676	1/1434
Total	**357671**	**310307**	**312732870**	**1008**

* Delhi has selected 1ASHA per2000 population in certain identified clusters
** ASHAs have been selected only in the tribal areas

Table 3.1H: Density of ASHA in Union Territories				
Andaman and Nicobar Island	412	407	244411	1/601
Dadra and Nagar Haveli	250	208	183024	1/880
Lakshadweep	110	110	14121	1/128
Daman & Diu	98	81	60331	1/745
Total	**870**	**806**	**501887**	**1/623**
Total All India	**939686**	**834922**	**788336550**	**1/944**

Section 3.2: Training of ASHA

Module five training is near completion in all the high focus states and north east states. Even states like Bihar, Madhya Pradesh and Rajasthan where pace was slow have now trained about 90% ASHAs. In the non-high focus states except Haryana, Gujarat and Jammu and Kashmir module 5 training for other states is near completion.

States such as-Madhya Pradesh, Uttar Pradesh, Rajasthan, Haryana, Maharashtra and West Bengal have also started training their newly selected ASHAs in Induction Module, which is a consolidated version of Modules one to five. This module is to be transacted in eight days. Experiences of trainers from Uttar Pradesh and Rajasthan highlighted a need to increase the duration of the induction Round from eight days to ten as the current duration appears inadequate.

The trainer pool for ASHA training has been expanded and strengthened. Training of state trainers in Round 1 and Round 2 for Modules 6 and 7 is complete in all the states. All states have also completed training their district/ASHA trainers in Round 1. Round 2 training for these trainers has been completed in Bihar, Jharkhand, Orissa, Uttarakhand and all north east states and is underway in Madhya Pradesh. In the non- high focus states Round 2 for district trainers has been completed in Gujarat, Karnataka, Maharashtra, Punjab and West Bengal. Total number of qualified state trainers in Round 1 and Round 2 is 414 and 309 respectively. Overall, 12966 and 7483 ASHA trainers have undergone training in Round 1 and Round 2 respectively and have also successfully passed the evaluation bench mark.

The learning from the last three years of Module 6 and 7 training implementation prompted the need for modifying the agenda for Round four training of ASHAs. Thus, this training Round for trainers and ASHAs now builds on the training needs of ASHAs that emerged from the field level assessment and experiences of various state and national level stakeholders. It now includes topics for which refresher training is needed such as-management of High Risk Baby, IYCF, and Women's Reproductive Health. Apart from this content it also includes one new module which provides trainers with the skills to train ASHAs in mobilizing for action on Violence against women.

Module 6 and 7 training for ASHAs is now in its consolidation phase for a majority of the states and about 20 states have either commenced or completed ASHA training in Round 3.

In high focus states Uttarakhand maintained a comparatively better pace of training from the beginning and has completed Round 3 training for ASHAs. Other states showing good pace are Jharkhand and Orissa. Both these states have-completed Round 1, trained 95% and 88% ASHAs respectively in Round 2 and have achieved more than 52% completion in Round 3. With near completion of Round 1, 79% achievement in Round 2 and recent initiation of Round 3, Madhya Pradesh also shows a reasonable progress. Bihar started its training slightly later than the above states and shows an achievement of 87%, 66% and 19% in the first three Rounds respectively. Uttar Pradesh being a late starter elected to train its ASHAs trained in Comprehensive Child Survival Programme (CCSP) in modified version of Module 6 and 7 called "Skills that Save Lives". This training was initiated in July 2013 and shows an achievement of more than 10% in the first two Rounds. However, Rajasthan shows a comparatively slow progress as it has been able to train only 72% and 17% ASHAs in Round 1 and 2 respectively. Mitanain programme in Chhattisgarh predates the ASHA programme and follows a different training strategy. Content of Module six and seven is included in Module 14 and 15 for the Mitanins. The state completed training all Mitanins in these modules much earlier and subsequently undertook a post training field level evaluation of the skills of Mitanins. Based on the results of this assessment, Module 16 and 17 for Mitanins were developed by the state, which served as a bridge course for their refresher training. The duration of this training was six days of which two days were assigned for systematic skill and knowledge evaluation. The entire process of evaluation was made more robust by involving a team of 40 supervisors from outside the programme. The Mitanins scoring more than 70% in this evaluation have also been certified by the state.

The North East states have covered substantial ground. Round 3 training for ASHAs is now completed in all states except Assam, Arunachal Pradesh, Meghalaya and Nagaland. Progress is also reasonable in these remaining states as latter three have trained more than 85% ASHAs up to Round 3. Even Assam a late starter, has completed training its ASHAs in Round 1, shows coverage of 90% for Round 2 and has also initiated Round 3.

In the non-high focus, states which have initiated Round 3 for ASHAs include: Gujarat, Punjab, Karnataka, Maharashtra and West Bengal. All these states have trained 90-96% ASHAs in Round 1 and above 80% in Round 2. In other states there is a steady increase in the number of ASHAs trained in first two Rounds of Module 6 and 7. Progress is also noted in certain states such as- Delhi, Kerala and Tamil Nadu which started training ASHAs in an adapted version of Module 6 and 7 only in the last financial year. Tamil Nadu has trained more than 25% ASHAs in first three Rounds of this training, an achievement of 70% and 45% in first two Rounds is observed for Delhi, while Kerala has completed training 87% ASHAs in first Round. Haryana had initially trained ASHAs for two days in Home Based Post Natal Care module but started training its ASHAs in Module 6 and 7 only from August last year. However, it now shows a significant progress with about 76% and 14% ASHAs trained in the first two Rounds. On the other hand, slow progress is seen in Jammu and Kashmir where only 67% ASHAs have so far been trained in Round 1.

Though a majority of the states made an effort to ensure quality trainings; gaps are noted in knowledge and skills of ASHAs. This is not surprising considering the levels of literacy and limited on the job mentoring. To address this issue states such as Uttarakhand and Jharkhand have planned systematic refresher training for ASHAs who have been trained up to Round 3 of Module 6 and 7.

Another training development that is worth highlighting here is the training of ASHAs from Uttarakhand in disaster response. In June 2013 a massive flood had hit the state. This disaster led to the state decision of training ASHAs in appropriate disaster response. Thus 2283 ASHAs and 154 ASHA Facilitators in the four disaster affected districts of Rudraprayag, Chamoili, Uttarakashi and Pithoragarh completed training in disaster response by October 2013.

Table 3.2A: Training Status for High Focus states

State Name	No. of ASHAs Selected/ working	Training Status			
		Number of ASHAs Trained in			
		Less than Module 4	Up to Module 4	Module 5	Module 6 and 7
Bihar	83826	52859 (63%)	52859 (63%)	• 19 state trainers trained in Round 1 and 14 trained in Round 2 • 4 State Training sites and 14 District Training Agencies are functional, being run by NGOs. • 803 District Trainers, have been trained in Round 1 training of trainers, and 533 in Round 2. • Module 5 Training of 4 days merged with 4 Rounds of Module 6 & 7 training, making it 4 Rounds of 6 days each. • No. of ASHAs trained - • Round 1 - 73235 (87%) • Round 2 - 55527 (66%) • Round 3 – 16296 (19%)	
Chhattisgarh	66179	57779 (87% of present numbers) The state's training structure has been different. Mitanins trained in Module 1 to 12.		• 41 State trainers and 3551 district trainers in position 55630 Mitanins (84%) trained in Module 13. • 54100 Mitanins (82%) trained in Module 14 and 15 • 57701 Mitanins (87%) trained in Module 16 (mainly a refresher Round) • 57542 Mitanins (87%) trained in Round Module 17	
Jharkhand	39380	39214 (99%)	35675 (91%)	39380 (100%)	• 14 State trainers trained in Round 1 and2 • 407 District Resource Persons trained in Module 6A; 417 trained in Module 6B and 474 trained in Module 7A • 36717 (93%) Sahiya trained in Module 6A equivalent to Round 1 of Module 6&7 and 37246 (95%) Sahhiya trained in Module 6B equivalent to Round 2. • 20973 (53%) trained in Module 7A equivalent to Round 3

State Name	No. of ASHAs Selected/ working	Training Status			
		Number of ASHAs Trained in			
		Less than Module 4	Up to Module 4	Module 5	Module 6 and 7
Madhya Pradesh	50571	47022 (93%)	45777 (91%)	45885 (91%)	• 39 state trainers trained in Round 1 and 20 in Round 2. 826 district trainers have been trained in Round 1 training of trainers and 215trained in Round 2 • 48431 (96%) ASHAs trained in Round 1, 39320 (78%) in Round 2 and 6249 (12%) trained in Round 3
Orissa	43363	43027 (99%)	43014 (99%)	43370 (100%)	• 22 state trainers trained in Round 1 and 15 in Round 2. • 312 District Trainers have been trained in Round 1 and 166 in Round 2 • 42478 (98%) ASHAs trained in Round 1 • 38456 (88%) Trained in Round 2 • 22762(52%) Trained in Round 3.
Rajasthan	46773	34776 (74%)	45110 (96%)	42113 (90%)	• 11 state trainers trained in Round 1 and Round 2 • 699 District Trainers trained in Round 1 • 28970 ASHAs (62%) trained in Round 1 and 7860 (17%) trained in Round 2
Uttar Pradesh	128611	129150 (100%)	129150 (100%)	121640 (95%)	• 56 state trainers trained in Round1 • 674 district trainers trained in Round 1 training of trainers • 21206 ASHA (16%) trained in Round 1 and 10506 (8%) in Round 2
Uttarakhand	10608	9927 (93.6%)	9927 (93.6%)	8978 (85%)	• 6 state trainers trained in Round 1 and 5 in Round 2. • 231 District trainers trained in Round 1 and 203 in Round 2 • 10313 ASHAs (93%) trained in Round 1, 10064 (95%) in Round 2 & 10209 (96%) in Round 3 • Refresher Training of Trainers for Round 1 and 2 completed

Table 3.2B: Training Status for North Eastern states

State Name	No. of ASHAs selected	Training Status			
		Number of ASHAs Trained in			
		Less than Module 4	Up to Module 4	Module 5	Module 6 and 7
Assam	29694	28544 (96%)	28497 (96%)	28422 (96%)	• 17 State trainers trained in Round 1 and 14 trained in Round 2. • 437 District trainers trained in Round 1 and Round 2. • 29116 (98%) ASHAs trained in Round 1 • 26667 (90%) trained in Round 2 • 6124 (21%) trained in Round 3
Arunachal Pradesh	3761	3559 (95%)	3606 (96%)	3643 (97%)	• 4 State trainers trained in Round 1 and Round 2 • 28 District trainers trained in Round 1 training of trainers and 22 in Round 2 • 3629 ASHAs (97%) trained in Round 1 • 3303 (88%) ASHAs trained in Round 2, • 3125 (83%) trained in Round 3. • 66 ASHAs (2%) trained in a refresher Round

State Name	No. of ASHAs selected	Training Status			
		Number of ASHAs Trained in			
		Less than Module 4	Up to Module 4	Module 5	Module 6 and 7
Manipur	3878	3878 (100%)	3878 (100%)	3817 (98.4%)	• 3 State trainers trained in Round 1 and 2 • 62 District trainers trained in Round 1 and 2 • 3804 (98%) ASHAs trained in Round 1, 2 and 3
Meghalaya	6258	6250 (99.9%)	6250 (99.9%)	5588 (89%)	• 3 State trainers trained in Round 1 and 2 • 66 District Trainers trained in Round 1 training of trainers and in Round 2 • 5891 (94%) ASHAs trained in Round 1, 5873 (94%) in Round 2 and 5121 (82%) in Round 3.
Mizoram	987	987 (100%)	987 (100%)	855 (87%)	• 3 State trainers trained in Round 1 and 2 • 28 District Trainers trained in Round 1 and Round 2 • 987 (100%) ASHAs trained in Round 1 and Round 2 &Round 3,
Nagaland	1887	1700 (91%)	1700 (91%)	1700 (91%)	• 3 State trainers trained in Round 1 and 2 • 66 District Trainers (who are also Block ASHA Coordinator) trained in Round 1 and 2 • Of the total 1887 ASHAs at present (after drop-out ASHAs replaced) 1388 (74%) are trained in Round 1, 1407 (75%) in Round 2 & 1624 (86%) are trained in Round 3.
Sikkim	666	666 (100%)	666 (100%)	666 (100%)	• 4 State trainers trained in Round 1 and Round 2 • 20 District Trainers trained in Round 1 and 2 • 666 (100%) ASHAs trained in Round 1, 2 and 3.
Tripura	7367	7367 (100%)	7367 (100%)	7367 (100%)	• 3 State trainers trained in Round 1 & 2 • 89 District Trainers trained in Round 1 and 2 • 7155 (97%) ASHAs trained in Round 1, 7009 (95%) in Round 2 and 7021 (95%) trained in Round 3

Table 3.2C: Training Status for Non High Focus states

State Name	No. of ASHAs selected	Training Status			
		Number of ASHAs Trained in			
		Less than Module 4	Up to Module 4	Module 5	Module 6 and 7
Andhra Pradesh	64827	30 days training as the programme preceded NRHM, but covered women's and children's health.			• 12 State trainers trained in Round 1 and 11 in Round 2 • 654 District Trainers trained in Round 1 • 57643 (89%) ASHAs trained in Round 1 • 45449 (70%) ASHAs trained in Round 2
Delhi	4044	Module 1-4 clubbed as Module 1, 2, 3 – 3426 (85%) ASHAs trained Module 5 as Module 4 – 4505 (111%) ASHAs trained			• State has adapted Module 6 and 7 to suit local context which is to be completed in two separate Rounds of five days each. • 63 state and 363 district trainers trained • 2796 (69%) trained in Module 6 • 1827 (45%) trained in Module 7

State Name	No. of ASHAs selected	Training Status			
		Number of ASHAs Trained in			
		Less than Module 4	Up to Module 4	Module 5	Module 6 and 7
Gujarat	33117	27763 (84%)	27724 (84%)	28066 (85%)	• 4 state trainers and Five trainers from Deepak Charitable Foundation trained in Round 1 and 2 • 160 district trainers trained in Round 1 and 2 training of trainers • 30253 ASHAs (91%) trained in Round 1, 28532 (86%) trained in Round 2 • 23423 ASHAs (71%) trained in Round 3, 21103 (64%) in Round 4
Haryana	16841	17193 (102%)	16752 (99%)	11112 (66%)	• 19 state trainers trained • 434 district trainers trained in Round 1 • 12719 (76%) ASHAs trained in Round 1 and 2317 (14%) trained in Round 2
Jammu and Kashmir	10683	9500 (89%)	9000 (84%)	8300 (78%)	• 6 State Trainers trained in Round 1 and 2 • 225 District Trainers trained in Round 1. • 6921 (65%) ASHAs trained in Round 1,
Karnataka	30175	Up to Module 5 - 33750 ASHAs were trained			• 15 State Trainers trained in Round 1 and 10 in Round 2 • 240 District Trainers trained in Round 1 and Round 2. • 29679 (98%) ASHAs trained in Round 1 and 2 • 26760 (89%) ASHAs trained in Round 3 and 4.
Kerala	28242	28946 (91%)	29043 (103%)	29045 (103%)	• State has developed a four days state specific module for ASHAs covering the issues covered in Module 6 & 7 • 24571 ASHAs (87%) ASHAs trained in state specific version of Module 6 and 7
Maharashtra	55975	57308 (102%)	56604 (101%)	52247 (93%)	• 12 state trainers trained in Round 1 and 2 • 1459 district trainers trained in Round 1 training of trainers and 295 trained in Round 2 • 34348 (61%) ASHAs trained in Round 1 & 15739 (28%) trained in Round 2 and 5677 (10%) trained in Round 3
Punjab	16812	16375 (97%)	16375 (97%)	16403 (98%)	• 5 State trainers trained in Round 1 and 7 trained in Round 2 • 326 District Trainers trained in Round 1 and 2 • 16243 ASHAs (97%) trained in Round 1 and Round 2. • 10714(64%) ASHAs trained in Round 3
Tamil Nadu	6204	2650 (43%)	5513 (89%)	5513 (89%)	• State has trained ASHAs in an adapted version of Module 6 and 7. • 1657 (27%) ASHAs trained in Round 1, &Round 2, 1571 (25%) trained in Round 3, & 1343 (22%) trained in Round 4
West Bengal	43387	39163 (93%)	39163 (90%)	37577 (87%)	• 17 State Trainers trained in Round 1 and 13 trained in Round 2 • 1091District trainers trained in Round 1and 2 training of trainers • 41423 (95%) ASHAs trained in Round 1 & 35719 (82%) trained in Round 2. 19479 (45%) trained in Round 3.

Table 3.2D: Training Status for UTs					
State Name	No. of ASHAs selected	Training Status			
		Number of ASHAs Trained in			
		Less than Module 4	Up to Module 4	Module 5	Module 6 and 7
Andaman and Nicobar Island	407	407 (100%)	407 (100%)	407 (100%)	State has trained 53 ASHAs
Dadra and Nager Haveli	208	135 (41%)	87 (42%)	87 (41%)	68 ASHAs have been trained in Round 1 and 45 trained in Round 2. Additionally, orientation of 81 ASHAs on HBNC (through state specific mechanism) done for three days.
Lakshadweep	110	83	-	-	No data available
Daman and Diu	81		63		No data available

Section 3.3: Support Structures

Composition of Support Structures for ASHA and Community Processes

At the **state level** the programme is expected to be supported by a Community Processes Resource Centre led by a team leader, has a team of Programme Managers and consultants for ASHA Programme, VHSNC, Communications and Documentation, Training and Regional/Zonal coordinators. In addition the state nodal officer with his/her small team will be located separately in SPMU, and will focus on programme management and issuing orders and guidelines. CPRC will focus on resource, technical support and training. State ASHA Mentoring Group, consisting of NGO representatives, academicians, training institutions and research organizations, provides policy guidance and programmatic oversight.

At the **district level,** the team of a District Nodal Officer supported by a District Community Mobiliser and data assistant is expected to manage the community processes implementation.

At the **block level,** a Block Nodal Officer and ASHA facilitators (one ASHA Facilitator for 10 to 20 ASHAs) are expected to provide support and supervision.

The recently revised guidelines envisage that these support structures at all levels will support ASHA programme, VHSNC and all other community processes interventions.

The presence of a well-trained support structures is critical for the success of community processes interventions under the National Health Mission. Many states have made efforts to create organizational structures such as ASHA Mentoring Group, Community Processes Resource Centres and have built partnerships with NGOs to contract out some of the support functions at different levels.

All High Focus States have constituted state ASHA mentoring group (SAMG) and Community Processes Resource Centre. While Jharkhand reconstituted its mentoring group in the last six months, other states such as Bihar, Chhattisgarh, Orissa and Rajasthan are in the process of doing so. Regular meetings of the mentoring group have been reported from Jharkhand, Madhya Pradesh, Uttar Pradesh and Uttarakhand. In Madhya Pradesh, the state ASHA mentoring group is called State Mentoring Group for Community Action (SMGCA) and extends support for ASHA, Village Health Sanitation and Nutrition Committees and Community Based Planning and Monitoring. It leverages extensive support from NGOs and other community based organizations to strengthen community processes even at the district and block levels. This group serves as an invaluable adjunct to the ASHA programme monitoring.

Though all High Focus States have established the ASHA/Community Processes Resource Centres, there is a need to expand their teams to ensure effective programme management. This holds true for states such as- Rajasthan, Uttar Pradesh and Jharkhand which have fewer personnel to manage the programme. District, block and sub block level support structures have been created in all these states, except Orissa which is yet to recruit block coordinators. Uttar Pradesh started the recruitment

for these positions only in the last six months and has now selected 88% District coordinators and 26% ASHA facilitators, while the selection of block coordinators is also underway. Substantial vacancies in the district and block support team are observed in few of these states. For example- Madhya Pradesh, Bihar and Rajasthan show 50%, 45% and 25% vacancies for posts of District coordinators respectively. The respective gap for block positions in these three states is 16%, 36% and 60%. Though Bihar and Rajasthan originally had a larger team, in Madhya Pradesh vacancies are on account of delays in selection process.

States such as Bihar, Madhya Pradesh, Orissa and Uttar Pradesh which started recruiting ASHA facilitators only last year are now on the verge of completing their selection. Training of ASHA facilitators in the Handbook for ASHA facilitators has also now been completed in all the high focus states except Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh.

All North East states have formed state mentoring groups but holding regular meetings remains an area of concern for Assam, Meghalaya, Nagaland and Sikkim. Programme specific support structures for community processes have been formed in all NE states, except Mizoram. Programme in Mizoram is currently being supported by one state facilitator from North East Regional Resource Centre. Meeting of the state mentoring groups have been held in the last one year only in Arunachal Pradesh, Tripura and Mizoram. All these states except Sikkim have district coordinators at the district level. Sikkim has only 660 ASHAs and the existing programme support structures manage community processes at district and sub district levels. A dedicated mechanism for block level support does not exist in these states except in Nagaland and would suffice considering the small size of their districts and lesser numbers of ASHAs. ASHA Facilitators are in place in allNorth East states except Nagaland, where Block ASHA Coordinators extend direct field support for ASHAs and have also been trained to undertake these functions. ASHA facilitators in all these states and block ASHA coordinators in Nagaland have been trained in Handbook for ASHA facilitators.

In the Non-High Focus States, state mentoring groups for community processes have not been constituted in Jammu and Kashmir, Haryana and Punjab. In Tamil Nadu, NGOs supporting the state ASHA resource centre (Institute of Poonamallee) serve this purpose. Even in other remaining states where mentoring groups have been formed their meetings are irregular and they have low functionality. In all high focus states except Delhi, Haryana, Maharashtra and West Bengal full complement of staff within the state community processes resource centre is currently missing. Maharashtra, Haryana and Karnataka are the only states which have made efforts to create dedicated support structures at all four levels in the form of functional resource centre, DCMs, BCMs and ASHA Facilitators. Punjab has support structures at three levels and is yet to place a dedicated support for block level. Delhi and Gujarat have established support mechanisms only at two levels, which is State and District for Delhi and State and Sub-block level for Gujarat. The remaining states -Andhra Pradesh, Jammu & Kashmir, Kerala, Tamil Nadu and West Bengal have programme specific support structure only at state level. Systematic training for ASHA Facilitators in handbook has so far been undertaken only in Haryana, Punjab and Maharashtra.

During the last year about 170 personnel from the High Focus, North East and Non High Focus states (except Kerala, Tamil Nadu and Jammu and Kashmir) were trained to undertake training of support staff at various levels in- Performance Monitoring of ASHAs, data base management and on all the aspects of supportive supervision. 15 out of 31 States and Union territories are now regularly undertaking performance assessment of ASHAs and submitting reports on district grading for ASHA functionality.

Table 3.3A: Status of ASHA support structure in High Focus States				
State Name	**State Level**	**District Level**	**Block Level**	**Sector Level**
Bihar	AMG constituted in July 2011, only one meeting held in Feb 2011. ARC established, registered as a separate society accountable to State Health Society. Six members within ARC and six Divisional Coordinators currently in position.	19 out of 38 DCMs, 28 out of 38 DDAs, are in place.	326 out of 534 BCMs are in place.	• 3995 out of 4150 ASHA Facilitators (one per 20 ASHA) are in place. • 3654 AFs Trained in Handbook for ASHA Facilitators.
Chhattisgarh	AMG proposed ARC is working under SHRC with a six member team	35 District Coordinators in place in 27 districts	292 Block Mobilisers in place	• 3150 Mitanin trainers (AFs) - 1 per 20 ASHA, are in place and trained.
Jharkhand	AMG constituted in 2012, reconstituted in 2013, five meetings held, last one in Aug 2013. VHSRC established as a separate cell within the SPMU with a team of three consultants	22 out of 24 District Programme Coordinators in place	840 Block Trainers & DRPs in place	• 2184/2184 Sahiyaa Saathi in place at 1 per 20 Sahiyas. • All trained in Handbook for ASHA facilitators
Madhya Pradesh	AMG formed in Oct 2008, now merged with MGCA. 12 meetings held. Last meeting in June 2013. MGCA members allocated districts for monitoring and hand holding ARC team led by State Nodal officer with 10 team members	DCM in place in 24 out of 50 districts 50 District MGCAs formed & involved in ASHA training monitoring	261 BCMs out of targeted 313 are in place 313 Block MGCAs in place.	• 3232 / 3797 ASHA Facilitators in place • Training of 1800 facilitators has been completed so far.
Orissa	AMG constituted in 2009, CPRC in place with a team of 7 consultants	DCM in place in 27 out of 30 districts District AMGs constituted	Existing block PMU staff manages the programme	• 1227 Community Facilitators (AFs) in place against target of 1227. • Training of Community Facilitators in Handbook for ASHA Facilitators is complete
Rajasthan	AMG constituted, last meeting held in Sep 2011 2 consultants working in SPMU. SIHFW extending support for rolling out ASHA Training.	25 DCMs in place against 34 districts, DPMs / District Monitoring Officer looking after ASHA programme as additional charge in other districts	109/249 Block ASHA Coordinators in position presently. Originally 237 were selected against the target.	• 931 PHC ASHA Supervisors (1 per PHC) are in position. Originally 1321 were selected against target of 1503. • Training of PHC-Supervisors in Handbook for ASHA Facilitators for is underway.
Uttar Pradesh	AMG constituted in Aug 2008, last meeting in Dec 2013. Community Processes Division led by a Nodal officer works within SPMU, with a team of 4 Consultants.	66/75 DCMs are in position 72 Districts have District AMGs	Existing staff (Block PMUs)	• ASHA Facilitators being placed only in 17 CCSP districts. 1776 in position out of target of 6808. Process underway for other districts.

State Name	State Level	District Level	Block Level	Sector Level
Uttarakhand	AMG constituted in 2009, 18 meetings held, last meeting in Oct 2013. State has one Nodal Officer in SPMU who works closely with ARC. ARC is outsourced to NGO – HIHT	District ARCs outsourced to NGOs in all 13 districts. DCMs in position in all 13 districts.	91 BCMs placed against target of 101. (6 are in urban areas)	• 660 ASHA facilitators (1 for 15-20 ASHAs) • 30 ASHA Facilitators in place in urban areas. • Training in Handbook for ASHA Facilitators has been completed.

Table 3.3B: Status of ASHA support structure in North East states

NE States	State Level	District Level	Block Level	Sector Level
Arunachal Pradesh	AMG constituted in Jan 2010, total meetings held – 8, last meeting held in Aug 2013, ARC in place with 3 members team	16/17 DCMs and DDAs in all districts.	Existing BPMU	• 347/348 ASHA Facilitators in place. • Training on Handbook for ASHA Facilitators completed.
Assam	AMG constituted and last meeting held in 22nd Nov 2011. ARC housed in SPMU (1 Program Executive in place) Recruitment process of State ASHA program Manager and SCM is on process.	DCM placed in all 27 districts and managed by ARC	Existing BPMU (Recruitment of Block Community Mobilizer is on process)	• 2838/2878 ASHA Facilitators placed (One for 10 ASHAs) • All ASHA Facilitators have been trained in Handbook for ASHA Facilitators
Manipur	AMG constituted in Dec 2008, total 10 meetings held, last meeting held in March 2013, ARC formed, has 1 ASHA Programme Manager	DCMs in place in all 9 districts	Existing BPMU	• 194/194 ASHA Facilitators (One for 20 ASHAs) • All facilitators have been trained in Handbook for ASHA Facilitators
Meghalaya	AMG formed and last meeting held in Aug 2012, being re-constituted, ARC in place, within SPMU with 2 consultants	DCPC (District Community Process Coordinator) in place in 7/11 districts	Existing BPMU	• 312/327 ASHA Facilitators (one for 15-20 ASHAs) • All ASHA Facilitators have been trained in Handbook for ASHA Facilitators
Mizoram	AMG formed and last meeting held in 28th June 2013 ARC not established. Programme is supported by state facilitator from NERRC	All 9 Districts have District ASHA Coordinator	(No system of Block unit for program management / health)	• 66 ASHA Mobilizer/ Facilitators in place, • All ASHA Facilitators have been trained in Handbook for ASHA Facilitators
Nagaland	AMG formed in Nov 2009, 5 meetings held, last meeting- Nov 2012 ARC functional under Directorate of Health services.	DCMs in place in all 11 districts	66/76 Block ASHA Coordinators (BACs) in place	• Block ASHA Coordinators play support role • All BACs have been trained in Handbook for ASHA Facilitators

NE States	State Level	District Level	Block Level	Sector Level
Sikkim	AMG formed and last meeting held in Nov. 2011 ARC does not exist (designated State ASHA Nodal Officer in place)	Existing staff of DPMU	Existing Staff of BPMU	• 70/70 ASHA Facilitators in place • All trained in Handbook for ASHA Facilitators
Tripura	AMG formed and last meeting held on March 2013 ARC constituted (1 state ASHA Programme Manager)	8 District ASHA Coordinators in place and 11 Sub divisional ASHA Coordinators in place	None (No block level unit for program management/ health)	• 387/400 ASHA • Facilitators in place • All trained in Handbook for ASHA Facilitators

Table 3.3C: Status of ASHA support structure in Non- High Focus states

State	State Level	District Level	Block Level	Sector Level
Andhra Pradesh	AMG constituted Functions of ARC are managed by a small team based in SPMU and Directorate and Indian Institute of Health and Family Welfare.	Project Officer, District Training Team (P.O.DTT) and District Public Health Nursing Officer (DPHNO) involved	Existing staff of BPMU	ANM & Health Supervisors at PHC level involved in ASHA support
Delhi	AMG formed in July 2010, total meetings held – 5, last meeting held in Feb 2013 ARC established; One State level Nodal Officer, one state ASHA coordination, one Data Assistant and one Account Assistant	Existing Staff of DPMU but District Mentoring Group in place.	Total 1123 ASHA mentors (ANMs) in place 103 ASHA Units (One unit per 100,000 population.) in place. Each unit has Unit Mentoring Group composed of 04-5 members, which includes MOIC, PHN, NGO representatives and 5 ANMs as facilitators.	
Gujarat	AMG Constituted in Aug 2011, total meetings held – 3, last meeting in Aug 2013 ARC established under the office of Rural Health Department under Commissionerate of Health Office.	No DCM in place, existing staff is supported by a Data Assistant in all districts 24 Districts have constituted AMG	Existing staff	2806/3454 ASHA Facilitators (one for ten ASHAs) in position
Haryana	AMG not constituted ARC in place within the SPMU with 10 member team	DACs in place in 21/21 districts	BACs in place in 97/113 blocks	471 ASHA Facilitators in place against sanctioned 465 positions. Training for all ASHA Facilitators has been completed
Jammu & Kashmir	ARC and AMG not established 1 ASHA Nodal Officer in place	Existing staff	Existing staff	Existing staff
Karnataka	AMG constituted and last meeting held in June 2013. One ASHA Nodal Officer based in the Health Directorate Deputy Director for ASHA Training based within SIHFW	26/30 District ASHA Mentors in position as District ASHA Coordinators	170/176 Block ASHA Mentor in place. One ASHA District Trainer also called as ASHA Mentor supervises ASHAs of two blocks	1800/1800 ASHA Facilitators selected

State	State Level	District Level	Block Level	Sector Level
Kerala	AMG constituted in 2008, total meetings held – 5, last meetings in held May 2012 State ASHA Team with one Nodal Officer and consultant based within SPMU	Existing staff	Existing staff	Existing staff
Maharashtra	AMG constituted in Oct 2007, total meetings held – 16, last meeting held in July, 2013 One Nodal Officer-ASHA & one consultant work as ARC team based within SPMU	DCMs in position in all 33 districts District AMG formed in 15 tribal and 18 Non –tribal districts	305/355 BCMs in place. Block AMG formed in 70 tribal blocks and in 281 Non-tribal blocks	2402/2480 ASHA Facilitators in place - 952/984 ASHA Facilitators (one for 10 ASHAs) in tribal districts 1450/1496 (at PHC level in non- Tribal districts). Total 1646 ASHA Facilitators have been trained.
Punjab	AMG not constituted ARC not established, team of two consultants working in SPMU	15 DCMs in place out of 22 districts	Existing Staff (BEE-Block Extension Educator working as BCM in many places)	860/898 ASHA Facilitators in position at cluster level and have been trained in Handbook for ASHA Facilitators.
TamilNadu	AMG not formed, but NGOs involved in ASHA support Institute of Public Health, Poonamallee is working as ARC	Existing staff (DPMU & Deputy Director of Health Services and District and Maternal and Child Health Officers (DMCHO)	Existing staff (Community Health Nurse)	Existing staff (Sector Health Nurse)
West Bengal	AMG formed in Sep 2010, total 4 meetings held, last meeting held in Dec 2011. ARC – with respect to ASHA training outsourced to CINI (Support structure at three levels, district, block and sector sanctioned in FY 2013-14, Batcine yet to be recruited)	Existing staff (Deputy CMHO, DPHNO)	Existing staff	Existing staff (Health Supervisor posted at GP level)

Table 3.3D: Status of ASHA support structure in UTs

	Status of Support Structure for ASHA			
UTs	**State Level**	**District Level**	**Block Level**	**Sector Level**
Andaman & Nicobar Island	AMG not established ARC doesn't exist and SPMU manages the programme	Existing staff	Existing staff	Existing staff
Dadra and Nagar Haveli	AMG and ARC not established SPMU is managing the ASHA Programme	Not Applicable	Not Applicable	Existing staff
Lakshadweep	AMG and ARC not established Medical officer is in-charge of Island is the nodal officer for the Programme	Not Applicable	Not Applicable	Existing staff
Daman and Diu	AMG and ARC not established. SPMU is managing the ASHA Programme	Not Applicable	Not Applicable	Not Applicable

SECTION 4

ASHA SNAPSHOTS FROM ASSAM AND GUJARAT

This section features the three snapshots of individual ASHAs from the states of Assam, Gujarat and Maharashtra. A common feature emerging from these diverse cases is how ASHAs exercise their agency and is likely a key driving force behind the many accomplishments of ASHAs across the country.

Snapshot 1: Rohilla Khatun from Dhubri District in Assam

In the year 2007, Rohilla Khatun, serving as a voluntary medical assistant in the local government dispensary, was selected by her village community as the ASHA. Becoming an ASHA was a dream come true for Rohilla as her service to the community enabled her to reach every household, every family, every mother, every new born and every child of her village. Life as an ASHA was satisfying and peaceful until the night of 21st July 2012, when a conflict suddenly erupted between the Bodo tribal and Bengali Muslims in her village. Continuous fights between the two groups, led to families being shifted from Rohilla's village to rehabilitation camps. Like others she was shifted with her husband and children to a relief camp. The initial days in the camp were of full of panic, uncertainties and apprehensions. Rohilla, with the confidence that her people reposed in her, set about identifying pregnant women, sick children and referred women to hospital for institutional delivery. One day she was approached to support a woman in labour. She identified that it as a case of prolonged labour and immediately escorted her to the district hospital for delivery. The hospital authorities told her that to save the baby, the mother will need to undergo an urgent caesarean section but since she is severely anaemic and she will require blood transfusion. Unfortunately the required group of 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 woman.

A relief agency, Doctors for You, working in the camps trained her in conducting deliveries, given the lack of access to medical care. Rohilla delivered two babies and provided newborn care for over 43 babies. In consultation with VHSNC members she use VHSNC untied- fund to purchase food for children in the camps. All this took place over a period of nine months, rife with ethnic tension. Except the allowance for transport and mobile recharge provided by Doctors for You provided, Rohilla did not receive any incentives. Her moment of elation was shaking hands with Rahul Gandhi during a camp visit.

Snapshot 2: Hajara Ben and Dhaniben Koli from Kutch district in Gujarat

In the year 2001 an NGO called "AWAG-Ahmedabad Women's Action Group" started a campaign to sensitize the rural women on the issue of Violence against Women, in Rapar block of Kutch district. Hajara Ben and Dhaniben Koli volunteered in becoming community leaders for spreading awareness and taking action on issues of violence.

Two rounds of training equipped them with skills in building community awareness on factors contributing to violence and its consequence. They were able to undertake primary counselling, extend immediate support to survivors of violence and inform them about the legal measures. It also built their skills to negotiate, build rapport with police and other organizations and individuals who could support the survivors of violence. One strategy to gather community support was to build collectives of women; but finding allies was not easy. So instead, they began by supporting neighbours and friends who were subjected to violence, and built a collective of survivors of violence. The collective grew bigger and emerged as a locus for change within the village community.

When Gujarat introduced the ASHA, the community selected these local leaders as ASHAs. In this thirteen year journey of working with the community, both Hajara Ben and Dhaniben Koli have prevented about 10-15 child marriages, including one as recently as late as 2012. During a "Samooh Lagan", Community Marraige) two of the 20 brides were younger than ten years of age. Hajara Ben and Dhaniben Koli mobilized 40 women at the police station, and compelled the police personnel to take action. These collectives provide solidarity to women in neighbouring villages and are able to mobilize at their own cost, for an incident in any of the villages. In one case of gang rape in 2009 in Nakhat Rana, 90 kms away from Rapar Block, the women of the group travelled at their own cost to seek speedy justice for the rape survivor. In a case of rape involving a family member, where the family and the police were reluctant to file a case, the women led by the two ASHAs went ahead and filed a court case on behalf of the girl and are still actively engaged in seeking justice.

The constant guidance and mentoring provided by AWAG and introduction of the leaders to the police has enabled sensitization, with the result that these ASHAs are confident in seeking police assistance. The commitment, pro-active involvement of Hajara and Dhaniben Koli in building awareness and to respond to any case of violence, has rightfully conferred the title of an "activist". No marriage in the village is finalized until Hazara ben or Dhaniben Koli check with the girl on whether she approves of the alliance.

ANNEXURE

UPDATED LIST OF ASHA INCENTIVES

S. No.	Heads of Compensation	Amount in Rs./case	Source of Fund and Fund Linkages	Documented in
I	**Maternal Health**			
1	JSY financial package		Maternal Health-NRHM-RCH Flexi pool	MOHFW Order No. Z 14018/1/2012/-JSY JSY -section Ministry of Health and Family Welfare- 6th Feb 2013
	For ensuring antenatal care for the woman	300 for Rural areas 200 for Urban areas		
	For facilitating institutional delivery	300 for Rural areas 200 for Urban areas		
2	Reporting Death of women (15-49 years age group) by ASHA to U-PHC Medical Officer.	200 for reporting within 24 hours of occurrence of death by phone	HSC/ U-PHC-Un-tied Fund	MOHFW-OM -120151/148/2011/MCH; Maternal Health Division; 14th Feb 2013
II	**Child Health**			
1	Undertaking six (in case of institutional deliveries) and seven (for home deliveries) home- visits for the care of the new born and post- partum mother[4]	250	Child Health-NRHM-RCH Flexi pool	HBNC Guidelines –August 2011
2	For follow up visits to a child discharged from facility or community SAM management centre (New Incentive)	150 only after MUAC is equal to nor more than 125mm		Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV
3	Ensuring monthly follow up of low birth weight babies and new borns discharged after treatment from Specialized New born Care Units(New Incentive)	50		Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV

4 This incentive is provided only on completion of 45days after birth of the child and should meet the following criteria-birth registration, weight-record in the MCP Card, immunization with BCG, first dose of OPV and DPT complete with due entries in the MCP card and both mother and new born are safe until 42nd of delivery.

S. No.	Heads of Compensation	Amount in Rs./case	Source of Fund and Fund Linkages	Documented in
III	**Immunization**			
1	Complete immunization for a child under one year	100.00		Order on Revised Financial Norms under UIP- T.13011i01/2077-CC-May 2012
2	Full immunization per child upto two years age (all vaccination received between 1st and second year age after completing full immunization after one year	Rs. 50	Routine Immunization Pool	
3	Mobilizing children for OPV immunization under Pulse polio Programme	100/day[5]	IPPI funds	Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV
IV	**Family Planning**			
1	Ensuring spacing of 2 years after marriage	500	Family planning Compensation Funds	Minutes Mission Steering Group meeting- April- 2012
2	Ensuring spacing of 3 years after birth of 1st child	500		
3	Ensuring a couple to opt for permanent limiting method after 2 children	1000		
4	Counselling, motivating and follow up of the cases for Tubectomy	150	Family Planning Sterilization compensation funds	Revised Compensation package for Family Planning- September 2007- No-N 11019/2/2006-TO-Ply
5	Counselling, motivating and follow up of the cases for Vasectomy/ NSV	200		
6	Social marketing of contraceptives- as home delivery through ASHAs	1 for a pack of three condoms 1 for a cycle of OCP 2 for a pack of ECPs	Family planning Fund	Detailed Guidelines on home delivery of contraceptives by ASHAs-Aug-2011-N 11012/3/2012-FP
7	Escorting or facilitating beneficiary to the health facility for the PPIUCD insertion(New Incentive)	150/case	Family planning Fund	- Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV
V	**Adolescent Health**			
1	Distributing sanitary napkins to adolescent girls	Re 1/ pack of 6 sanitary napkins	Menstrual hygiene- ARSH	Operational guidelines on Scheme for Promotion of Menstrual Hygiene Aug 2010
2	Organizing monthly meeting with adolescent girls pertaining to Menstrual Hygiene	50/meeting	VHSNC Funds	
VIII	**Revised National Tuberculosis Control Programme[6]**			
	Honorarium and counselling charges for being a DOTS provider		RNTCP Funds	Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV

5 Revised from Rs. 75/day to Rs. 100/day

6 Initially ASHAs were eligible to an incentive of Rs. 250 for being DOTS provider to both new and previously treated TB cases. Incentive to ASHA for providing treatment and support Drug resistant TB patients have now been revised from Rs. 2500 to Rs. 5000 for completed course of treatment

S. No.	Heads of Compensation	Amount in Rs./case	Source of Fund and Fund Linkages	Documented in
a)	For Category I of TB patients (New cases of Tuberculosis)	1000 for 42 contacts over six or seven months of treatment		
b)	For Category II of TB patients(previously treated TB cases)	1500 for 57 contacts over eight to nine months of treatment including 24-36 injections in intensive phase		
c)	For treatment and support to drug resistant TB patients	5000 for completed course of treatment(2000 should be given at the end on intensive phase and 3000 at the end of consolidation phase		
IX	**National Leprosy Eradication Programme[7]**			
1	Referral and ensuring compliance for complete treatment in pauci-bacillary cases of Leprosy	250(for facilitating diagnosis of leprosy case)+ 400(for follow up on completion of treatment)	NLEP Funds	Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV
2	Referral and ensuring compliance for complete treatment in multi-bacillary cases of Leprosy	250(for facilitating diagnosis of leprosy case)+ 600((for follow up on completion of treatment)		
X	**National Vector Borne Disease Control Programme**			
A)	**Malaria[8]**			
1	Preparing blood slides	15/slide	NVDCP Funds for Malaria control	Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV
2	Providing complete treatment for RDT positive Pf cases	75		
3	Providing complete radical treatment to positive Pf and Pv case detected by blood slide, as per drug regimen			
4	For referring a case and ensuring complete treatment	300		

7 Incentives under NLEP for facilitating diagnosis and follow up for completion of treatment for pauci bacillary cases was Rs. 300 before and has now been revised to- Rs. 250 and Rs. 400 now.
For facilitating diagnosis and follow up for completion of treatment for multi-bacillary cases was Rs. 500 incentive was given to ASHA before and has now been revised to- Rs. 250 and Rs. 600.

8 Incentive for slide preparation was Rs. 5 and has been revised to Rs. 15. Incentive for providing treatment for RDT positive Pf cases was Rs. 20 before and has been revised to Rs. 75. Incentive for providing complete radical treatment to positive Pf and Pv case detected by blood slide, as per drug regimen was Rs. 50 before. Similarly-incentive for referring a case of malaria and ensuring complete treatment was Rs. 200/case and has been revised to Rs. 300 now.

S. No.	Heads of Compensation	Amount in Rs./case	Source of Fund and Fund Linkages	Documented in
B)	**Lymphatic Filariasis**			
5	For one time line listing of lymphoedema and hydrocele cases in all areas of non-endemic and endemic districts (New Incentive)	200	NVBDCP funds for control of Lymphatic Filariasis	Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV
6	For annual Mass Drug Administration for cases of Lymphatic Filariasis[9]	200/day for maximum three days to cover 50 houses and 250 persons		
C)	**Acute Encephalitis Syndrome/Japanese Encephalitis**			
7	Referral of AES/JE cases to the nearest CHC/DH/Medical College (New incentive)	300 per case	NVBDCP funds	Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV
XI	**Incentive for Routine Recurrent Activities**			
1	Mobilizing and attending VHND or (outreach session/Urban Health and Nutrition Days)	200 per session	NRHM - RCH Flexi pool/ NUHM Flexi pool	Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV
2	Convening and guiding monthly meeting of VHSNC/MAS	150		
	Attending monthly meeting at Block PHC/U-PHC	150		
	a) Line listing of households done at beginning of the year and updated every six months b) Maintaining records as per the desired norms like –village health register c) Preparation of due list of children to be immunized updated on monthly basis d) Preparation of due list of ANC beneficiaries to be updated on monthly basis e) Preparation of list of eligible couples updated on monthly basis	500		

9 Incentive has been revised from Rs. 100 to Rs. 200 per day for maximum three days to cover 50 houses or 250 persons

ABBREVIATIONS AND EQUIVALENT TERMS

Abbreviations	Equivalents
AMG – ASHA Mentoring Group	MGCA- Mentoring Group For Community Action
CPRC- Community Processes Resource Centre	VHSRC- Village Health Sahiya Resource Centre CPRC- Community Processes Resource Centre
ASHA Facilitators	ASHA coordinator Mitanin trainers PHC ASHA Supervisor Sahiyaa Saathi
BC- Block Coordinators	
BCM- Block Community Mobiliser	BAC- Block ASHA Coordinators BF- Block Facilitators BTT- Block Training Team
BPM- Block Programme Manager	
DCM- District Community Mobiliser	APM - ASHA Programme Managers DAC - District ASHA Coordinators DNO- District Nodal Officer DPC-District Programme Coordinators
DDA – District Data Assistant	
DPM- District Programme Manager	
DRP – District Resource Person	
SHRC – State Health Resource Centre	
SPMU-State Programme Management Unit	
SCM- State Community Mobiliser	