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Ministry of Health & Family Welfare
Government of India

UPDATE ON THE ASHA PROGRAMME

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SECTION 1

Introduction

In a few months from now, the ASHA programme reaches a major milestone in the history of India's community health worker programmes - a decade. This is a milestone to be celebrated in honour of the nearly one million women that are the heart and soul of the programme. This milestone represents an opportunity to reflect on the past and on the future of the programme and its institutional characteristics, on the adaptations needed to retain its essence and yet to be able to move forward and continue to remain relevant in the face of rapidly changing environments.

One important consideration that must be kept in mind is that the ASHA and Community processes programme were not meant to be a stand-alone intervention, but designed as part of a larger health systems strengthening effort. Therefore its outcomes must be viewed in relation to the larger Mission. Later this year we expect to design an evaluation that will take stock of programme progress and the external context of operation, so as to provide information on how the programme has been rolled out, and what needs to be done for the next decade.

One of the challanges that faces the programme, especially as indicators related to maternal and child health improve, is the somewhat ad-hoc inclusion of tasks that are not in consonance with the essential roles of the ASHA nor are they in synergy with the time she spends on her work.

Sustaining the gains of the enterprise and ensuring programme resilience for stability in the face of newer developments and initiatives requires consistent advocacy. To some extent the creation of a framework at national level- in terms of operational guidelines, setting standards of training, and support and now the launch of the certification programme has enabled this. At state level there is substantial commitment to the programme, but the next challenge is to build district and sub district capacity to identify problem areas and identify local solutions.

This issue is the eleventh in the series of bi-annual ASHA updates. It is produced by the National Health Systems Resource Centre (NHSRC) for the National Health Mission (NHM), Ministry of Health and Family Welfare (MoHFW). The objective of this update is to report on programme

progress, provide information on assessments, and other relevant information related to the ASHA and Community Processes programme between July 2014 and December 2014.

The update is divided into five sections. In section 2 we provide a state wise report on the status of selection, training, and support structures. In addition in this issue for the first time we report on the status of selection of ASHA in urban areas and the extent to which Mahila Arogya Samitis (MAS) have been formed. The eighth Common Review Mission (CRM), an annual event, first as part of the NRHM and now the NHM, was undertaken in 15 states in November 2014. In Section 3 we excerpt the key findings related to the Community Processes interventions from the CRM. (The findings demonstrate that the programme has reached a level of maturity but also reflect that support structures need strengthening. In some of the non high focus states, findings demonstrate that since the load of maternal and child health activities do not occupy much of her time, the ASHAs role and work allocation need to be reviewed and capacity building and support planned so that she is able to play the role of a community health worker in a broader primary health care context.

In section 4 we report on the role of the ASHA in vector borne disease control initiatives, based on recent reviews. The findings are positive and highlight that the ASHA plays a crucial role to play in prevention, early detection and treatment. While these reviews do not comment on the role of the Village Health Sanitation and Nutrition Committees (VHSNC) in these interventions, state reports and field visits reports demonstrate that source reduction activities form an important part of the expenditure of untied funds allocated to the VHSNC.

Section 5 is a Photo feature on the recent Indian International Trade Fair (IITF) in which the theme of the MohFW pavilion was "ASHA- a change agent". Section 6 includes three state led initiatives which have enabled newer roles for the ASHA. The first initiative is that of the Mitanin programme from Chhattisgarh, in which the Mitnain facilitator as a form of career opportunity can become the first level of support for the ASHA, namely the Mitanin Trainer, and the extent to which high quality mentoring and support can result in positive outcomes. The second initiative is the Sahiya Help Desk, from Jharkhand where ASHAs are trained to play the role of navigation for patients accessing the public health system. The third initiative recognizes the role of the ASHA as a first responder in disaster situations in Assam, Uttarakhand and Jammu & Kashmir. In each instance it was the ASHA exercising her agency and despite not having been formally trained in rescue and rehabilitation efforts was able to provide succor and relief to here community.

SECTION 2

Progress of the ASHA Programme

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

1. ASHA selection and currently functional ASHAs
2. Status of Training
3. Status of Support Structures

We have used data reported by the states, as on December 2014.

Section 2.1: ASHA Selection

Based on the recent data from states, the total number of ASHAs across 32 states and UTs is now 8,59,331 with an increase of about 12,118 ASHAs from the data of July, 2014. Overall achievement of ASHA selection against the revised target of 9,61,113 is 89.4%. The total target of ASHAs as per the population norms has increased in Bihar, Uttar Pradesh, Meghalaya and Gujarat.

In this update, we also report on the status of the ASHA programme in the state of Telangana, which was carved out of Andhra Pradesh in March, 2014. The new state, has a requirement of 28019 ASHAs. Against this target, currently 25,818 ASHAs are working in Telangana. During the last financial year 2014-15, the Union Territories of Chandigarh and Pondicherry have proposed ASHAs in Urban Areas and their selection process has been initiated. Himachal Pradesh has also begun the process of selecting ASHAs in rural areas. This brings the total number of states where ASHA programme is being implemented to 34 including all states and UTs. However, in this update we report on data from 32 states. This excludes data from Himachal Pradesh, Goa, Puducherry and Chandigarh, since the selection of ASHA is underway..

Selection of ASHAs is complete across most states. Except Bihar, Rajasthan and UP, all high

focus states have close to or above 95% ASHAs in place. Bihar has 81% ASHAs in place and has considerably revised its targets since the previous targets were based on the population of Census 2001. Rajasthan has 87% ASHAs in place against the target. The gap in Rajasthan is due to increased targets based on population increase as per 2011 census and identification of non functional ASHAs. Uttar Pradesh identified the gaps in the targets in the last financial year 2014-15 and has expedited the process of recruitment of new ASHAs. This has decreased the gap of ASHAs from 20% to 12% in this period. Chhattisgarh, Madhya Pradesh, Jharkhand and Uttrakhand have over 95% of the ASHAs in place and Odisha has achieved more than 99% of its selection targets.

Of the non-high focus states, Karnataka and West Bengal have major gaps to fill with only three-fourths (approx 75%) of ASHAs in place against targets. West Bengal has a total of 61,008 ASHAs sanctioned, but has only 45,345 in position. Karnataka where the target is 39,195 has a total of ASHAs 29,916. Delhi also has around 85% of ASHAs in place against the target of 5216. Delhi has comparatively high rates of attrition (around 13%) for ASHAs on account of availability of better career opportunities.. Andhra Pradesh, Haryana, Jammu and Kashmir, Gujarat, Maharashtra and Punjab are close to achieving selection targets.

Of the North-East States, Sikkim, Tripura and Manipur have accomplished the selection targets. Assam, Arunachal Pradesh, Meghalaya and Nagaland have also selected over 90 percent of their ASHAs. Only Mizoram has not been able to recruit ASHAs to fill the gap of about 36% that was created after it revised the target as per 2011 census.

Table 2.1 A: Status of ASHA selection in High Focus states

Sl. No.	State / UT	Number of ASHA proposed (Target)	No. selected /working	% (against proposed)
	Table 1A: High Focus States			
1	**Bihar**	104239	84703	81.26
2	**Chhattisgarh***	70000	66220	94.60
3	**Jharkhand**	40964	39380	96.13
4	**Madhya Pradesh**	58245	55541	95.36
5	**Odisha**	43530	43363	99.62
6	**Rajasthan**	54915	47567	86.62
7	**Uttar Pradesh**	160175	141358	88.25
8	**Uttarakhand**	11039	10511	95.22
	Total-1A	**543107**	**488643**	**89.97**

Table 2.1 B: Status of ASHA selection in North East states

Sl. No.	State / UT	Number of ASHA proposed (Target)	No. selected / working	% (against proposed)
Table 1B: North East States				
9	Assam	30508	29694	97.33
10	Arunachal Pradesh	3862	3761	97.38
11	Manipur	3878	3878	100.00
12	Meghalaya	6709	6354	94.71
13	Mizoram	1538	987	64.17
14	Nagaland	1986	1887	95.02
15	Sikkim	666	666	100.00
16	Tripura	7367	7367	100.00
	Total 1B	**56514**	**54594**	**96.60**

Table 2.1 C: Status of ASHA selection in Non High Focus states

Table 1C: Non High Focus States				
17	Andhra Pradesh	40021	40021	100.00
18	Telangana	28019	25818	92.19
19	Delhi	5216	4438	85.08
20	Gujarat	38188	34838	91.23
21	Haryana	18000	17281	96.01
22	Jammu and Kashmir	12000	11214	93.45
23	Karnataka	39195	29916	76.33
24	Kerala	33160	28242	85.17
25	Maharashtra	58945	55975	94.96
26	Punjab	17360	17008	97.97
27	Tamil Nadu	6850	6204	90.57
28	West Bengal	61008	45345	74.33
	Total 1C	**360622**	**315288**	**87.43**

Table 2.1 D: Status of ASHA selection in Union Territories

Table 1D: Union Territories				
29	Andaman and Nicobar Island	412	407	98.79
30	Dadra and Nagar Haveli	250	208	83.20
31	Lakshadweep	110	110	100.00
32	Daman & Diu	98	81	82.65
	Total 1D	**870**	**806**	**92.64**

	Total All India	**961113**	**859331**	**89.41**

Section 2.2: Status of Training

This section provides a summary on the status of training of ASHAs across all states of India. Training of Module 5 is near completion in most states and over 85 percent of ASHAs are trained in Module 5, except in three states. In Madhya Pradesh, Haryana and Nagaland pace of training has been slow with a gap of 24%, 35% and 31% respectively in Module 5 training.

The pace of training of Module 6 & 7 has improved across most states. All high focus states have completed training in Round 1 of Module 6&7 except UP where only 23 percent of selected ASHAs are trained in Round 1. Training of state trainers in Round 2 has been completed for state trainers from Jammu and Kashmir, Bihar, Uttar Pradesh and Madhya Pradesh.

In Bihar, Rajasthan and Uttar Pradesh, Round 2 training of Module 6 & 7 is underway. Uttrakhand, Odisha and Jharkhand are near completion for Round 3 training of selected ASHAs. Chhattisgarh training strategy is adapted as per the state requirements under which Mitanins have completed trainings in Modules 1 to 18.

Of the non high focus states, Punjab, Gujarat, Karnataka and West Bengal are near completion of Round 3 training of all ASHAs. Delhi and Maharashtra have just begun Round 3 trainings. In Andhra Pradesh and Telangana, most ASHAs are trained up to Round 2 and Round 3 ToT for district trainers is yet to begin. Pace of training in Jammu and Kashmir has been slow where only 64 percent of ASHAs are trained upto Round 1. This slow pace is on account of devastating floods in the state during last year.

Among the North Eastern States, training of ASHAs in Round 3 of Module 6& 7 is near completion Only Assam is lagging where overall Round 3 training of ASHAs has reached up to 44%. All North Eastern states have completed training of state trainers in Round 3 TOT and training of district trainers and ASHAs has been initiated.

Overall, the pace of trainings has improved in the last six months. Chhattisgarh, Gujarat and Uttarakhand have started refresher trainings of ASHA and the States of Madhya Pradesh, West Bengal, Delhi, Punjab, Odisha, and Gujarat have proposed refresher trainings for ASHAs in the PIP 2015-16 in preparation for ASHA Certification.

Issues related to procurement of equipment kits and printing of modules continues to remain a challenge for many states where trainings are delayed. Another major issue especially from the North-East states is attrition of trainers at state and district levels and non availability of training sites at sub district levels for residential training of ASHA support staff and ASHAs. Delays between the trainings of state trainers and district trainers also hinder the trainings of ASHAs. We find that delay in the financial clearances from districts to blocks and blocks to the facilities also impede the pace of trainings.

Table 2.2 A: Status of ASHA trainings in High Focus States

Sl. No.	State /UT	Number of ASHA working	ASHAs trained up to Module 5		ASHAs trained up to Round 1 of Module 6&7		ASHAs trained up to Round 2 of Module 6&7		ASHAs trained up to Round 3 of Module 6&7		ASHAs trained up to Round 4 of Module 6&7	
			No.	%	No.	%	No.	%	No.	%	No.	%
Table 1A: High Focus States												
1	Bihar	84703	76185	89.94	76185	89.94	63998	75.56	46715	55.15	0.00	0.00
2	Chhattis-garh*	66220	57779	87.25	55630	84.01	54100	81.70	57701	87.14	58152	87.82
3	Jharkhand	39380	40964	104.02	37045	94.07	37271	94.64	35918	91.21	0.00	0.00
4	Madhya Pradesh	55541	42098	75.80	55706	100.30	46283	83.33	25550	46.00	0.00	0.00
5	Odisha	43363	43370	100.02	42478	97.96	40566	93.55	39046	90.04	0.00	0.00
6	Rajasthan	47567	42133	88.58	43545	91.54	24225	50.93	0.00	0.00	0.00	0.00
7	Uttar Pradesh	141358	121640	86.05	32644	23.09	23633	16.72	0.00	0.00	0.00	0.00
8	Uttara-khand	10511	8978	85.42	10313	98.12	10064	95.75	10209	97.13	0.00	0.00
	Total-1A	**488643**	**433147**	**88.64**	**353546**	**72.35**	**300140**	**61.42**	**215139**	**44.03**	**58152**	**12.00**

Table 2.2 B: Status of ASHA trainings in North Eastern States

Table 1B: North East States												
			No.	%	No.	%	No.	%	No.	%	No.	%
9	Assam	29694	28422	95.72	29560	99.55	29257	98.53	13137	44.24	0.00	0.00
10	Arunachal Pradesh	3761	3643	96.86	3632	96.57	3424	91.04	3344	88.91	564	15.00
11	Manipur	3878	3817	98.43	3804	98.09	3804	98.09	3804	98.09	0.00	0.00
12	Meghalaya	6354	5588	87.94	5891	92.71	5873	92.43	5710	89.86	0.00	0.00
13	Mizoram	987	855	86.63	987	100.00	987	100.00	987	100.00	0.00	0.00
14	Nagaland	1887	1296	68.68	1398	74.09	1397	74.03	1624	86.06	0.00	0.00
15	Sikkim	666	666	100.00	666	100.00	666	100.00	666	100.00	665	99.85
16	Tripura	7367	7367	100.00	7155	97.12	7009	95.14	7280	98.82	0.00	0.00
	Total 1B	**54594**	**51654**	**94.61**	**53093**	**97.25**	**52417**	**96.01**	**36552**	**66.95**	**1229**	**2.00**

Table 2.2 C: Status of ASHA trainings in Non High Focus States

Sl. No.	State / UT	Number of ASHA working	ASHAs trained up to Module 5		ASHAs trained up to Round 1 of Module 6&7		ASHAs trained up to Round 2 of Module 6&7		ASHAs trained up to Round 3 of Module 6&7		ASHAs trained up to Round 4 of Module 6&7	
			No.	%	No.	%	No.	%	No.	%	No.	%
Table 1C: Non High Focus States												
17	Andhra Pradesh	40021	40021	100.00	34447	86.07	39009	97.47	0.00	0.00	0.00	0.00
18	Telangana	25818	25818	100.00	24432	94.63	21102	81.73	0.00	0.00	0.00	0.00
19	Delhi	4438	4764	107.35	4324	97.43	3949	88.98	21	0.47	0.00	0.00
20	Gujarat	34838	27587	79.19	30852	88.56	30132	86.49	27068	77.70	24449	70.18
21	Haryana	17281	11112	64.30	16151	93.46	15674	90.70	0.00	0.00	0.00	0.00
22	Jammu and Kashmir	11214	8300	74.01	7248	64.63	0.00	0.00	0.00	0.00	0.00	0.00
23	Karnataka	29916	29916	100.00	29813	99.66	29813	99.66	27873	93.17	27873	93.17
24	Kerala	28242	29045	102.84	26684	94.48	0.00	0.00	0.00	0.00	0.00	0.00
25	Maharashtra	55975	52247	93.34	41359	73.89	26602	47.52	9877	17.65	0.00	0.00
26	Punjab	17008	16403	96.44	16243	95.50	16243	95.50	16363	96.21	0.00	0.00
27	Tamil Nadu	6204	5513	88.86	1657	26.71	1657	26.71	1571	25.32	1343	21.65
28	West Bengal	45345	37577	82.87	45758	100.91	42361	93.42	40726	89.81	0.00	0.00
	Total 1C	**315288**	**287291**	**91.12**	**277732**	**88.09**	**211880**	**67.20**	**123499**	**39.17**	**53665**	**17.02**

Table 2.2 D: Status of ASHA trainings in Union Territories

Table 1D: Union Territories												
29	Andaman and Nicobar Island	407	407	100.00	272	66.83	272	66.83	0.00	0.00	0.00	0.00
30	Dadra and Nagar Haveli	208	87	41.83	68	32.69	45	21.63	0.00	0.00	0.00	0.00
31	Lakshadweep	110	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
32	Daman & Diu	81	63	77.78	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Total 1D	**806**	**557**	**69.11**	**340**	**42.18**	**317**	**39.33**	0.00	**0.00**	0.00	**0.00**

Section 2.3: Support Structures

Composition of Support Structures for ASHA and Community Processes

At the state level the programme is expected to be supported by Community Processes Resource Centre (with different nomenclature across states) led by a team leader, and a team of Programme Managers and consultants (for ASHA Programme/VHSNC/ Communications and Documentation/Training and Regional/Zonal coordinators).CPRC will focus on resource & technical support and training. State ASHA Mentoring Group, consisting of NGO representatives, academicians, training institutions and research organizations, is expected to provide 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 programme.

At the block level, a Block Community Mobilizer 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.

This support structures with adequate capacity building is essential for effective implementation of Community Processes and provide adequate support to ASHAs as well as VHSNC. Many states have made efforts to build convergence between the management structures for ASHA and VHSNC. The learning has been that integration of state management structures leads to improved coherence and better use of resources. It also helps the state in expediting the process of selection and trainings of ASHAs and VHSNC members and utilize the ASHA trainers as trainers for other community processes as well.

Except UP and Odisha, all the high focus states have support structures at all levels. Support structure in UP and Odisha exists at district and village level and existing BPMU staff manages the programme at block level. Overall, the states have made a progress in revising the targets and filling the gaps in required number of ASHA Facilitators as per the revised targets of ASHAs. Of the high focus states, Odisha has completed and Uttarakhand is near completion vis-s-vis the targets for ASHA Facilitators. Rajasthan and Uttar Pradesh have also revised the targets and selected new ASHA facilitators in the last year.

Positions at the district level for ASHA and VHSNC support structure are being filled up in almost all the states. However, gaps in the block level support structure are seen in Bihar, Rajasthan and Uttar Pradesh which is an area of concern. Chattissgarh and Uttarakhand have completed their targets for Block Community Mobilizers and Madhya Pradesh. Jharkhand has made progress in filling the gaps in positions of BCMs while in UP, recruitment of BCMs is yet to begin.

In North East States, the positions for ASHA Facilitators and District Community Mobilizers have been filled. BCMs have been selected in states of Nagaland and Assam. In Arunachal

Pradesh, Manipur, Meghalaya and Sikkim, existing BPMU staff manages the ASHA and VHSNC programme at the block level owing to very few number and small size of blocks.

Of the non-high focus states, Gujarat, Karnataka, Maharashtra and Punjab have almost completed the selection of ASHA Facilitators. Haryana and Jammu & Kashmir have revised their targets for ASHA facilitators and the process of selection is underway. In Andhra Pradesh, Jammu & Kashmir and Tamil Nadu, existing staff manages the programme at the block and district levels. Delhi has recently recruited District ASHA Coordinators and Block ASHA Coordinators, dedicated for managing the CP programme. In West Bengal and Telangana, the selection process of BCMs and DCMs is underway. In all the UTs, where ASHA Programme is in place, existing staff plays the role of BCMs and DCMs for ASHAs and VHSNCs.

All states which selected new ASHA Facilitators last year are near completion to the trainings in Handbook for ASHA Facilitators. Subsequently, the performance monitoring and on-field supportive supervision has improved across the states. However, in states where ASHA Facilitators were trained earlier in the programme, the refresher of the supervision skills is required.

Table 2.3 A: 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 1 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.	15 out of 38 DCMs, 28 out of 38 DDAs, are in place.	295 out of 534 BCMs are in place.	• 4026 out of 4964 ASHA Facilitators (one per 2ASHA) are in place. • 3974 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 (2/district in some outreach districts)	292 Block Mobilisers in place against target of 292	• 3150 Mitanin trainers (AFs) - 1 per 20 ASHA, are in place against target of 3500, and trained.
Jharkhand	AMG was constituted in 2012 and reconstituted in 2013, total Six meetings held, last one in April 2014. VHSRC established as a separate cell within the SPMU with a team of three consultants	21 out of 24 District Programme Coordinators in place	830 Block Trainers & DRPs in place against target of 844	• 2175 Sahiyaa Saathi in place @ 1 per 20 Sahiyas, against target of 2184. • 2076 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. ARC team led by State Nodal officer with 10 team members	35 DCM in place in 51 District MGCAs formed & involved in ASHA training monitoring	259 BCMs out of targeted 313 are in place 313 Block MGCAs in place.	• 3286 ASHA Facilitators in place against target of 3991 (1 AF for 10 ASHAs in tribal areas) • 2440 ASHA facilitators trained in Facilitators Handbook

Odisha	AMG constituted in 2009, total 4 meetings held , last in 2012, 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 Two consultants working in SPMU. SIHFW extending support for rolling out ASHA Training.	25 DCMs in place against 34 districts,	100/249 Block ASHA Coordinators in position presently.	• 1076 PHC ASHA Supervisors (1 per PHC) are in position against target of 2066. •Training of ASHA Facilitators in Handbook for ASHA Facilitators has been done
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)	• 4076 in position out of target of 6808 as ASHA Facilitators selected in 17 CCSP districts. • 1514 AFs trained in Facilitators Handbook.
Uttarakhand	AMG constituted in 2009, total 20 meetings held, last meeting in June 2014. State has one Nodal Officer in SPMU, and two regional coordinators, who works closely with state ARC, which is outsourced to NGO – HIHT	District ARCs outsourced to NGOs. There are 13 DCMs against the target of 13.	101 BCMs placed against target of 101. (6 in urban areas)	• 600 AFs in position against target of 606 (550 rural, 56 urban - 1 for 15-20 ASHAs) • Training in Handbook for ASHA Facilitators completed.

Table 2.3 B: 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 staff	• 347/348 ASHA Facilitators in place. • Training on Handbook for ASHA Facilitators done.
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 in place in all 27 districts	84 Block Community Mobilizers in position against target of 149.	• 2848/2878 ASHA Facilitators in place (One for 10 ASHAs) • ASHA Facilitators 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 staff	• 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 staff	• 312/334 ASHA Facilitators (one for 15-20 ASHAs) • ASHA Facilitators 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	NA since No system of Block unit for program management /health	• 66/76 ASHA Facilitators in place, • ASHA Facilitators 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 Co-ordinators (BACs) in place	• Block ASHA Coordinators play support role • BACs trained in Handbook for ASHA Facilitators
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	• 71/71 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)	District ASHA Coordinators in position in all 8 districts, (4 DCMs in original 4 districts and 4 Sub Divisional Coordinators acting as DCM)	10 Sub divisional ASHA Coordinators in place against 11 required.	• 387/400 ASHA Facilitators in place • All trained in Handbook for ASHA Facilitators

Table 2.3 C: 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.	There is requirement of 13 DCMs recruitment process of which is underway. Project Officer, District Training Team (P.O.DTT) and District Public Health Nursing Officer (DPHNO) involved.	Target: 224 Existing staff of BPMU work as BCMs	Target: 1069 ANM & Health Supervisors at PHC level involved in ASHA support
Telangana	State ASHA Resource Centre and AMG to be constituted	Total Requirement: 10 Recruitment Process undergoing	Target: 151 Existing staff of BPMU work as BCMs	Target: 702 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 in place; with one State level Nodal Officer, two State ASHA Coordinators, two Data Assistants and one Account Assistant	Existing Staff of DPMU but District Mentoring Group in place.	Total 1005 ASHA mentors (ANMs) in place against target of 1123 113 ASHA Units (One unit per 50,000 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	3107/3751 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	109 BACs in place against target of 115.	609 ASHA Facilitators in place against target of 1084. Training for AFs completed
Jammu & Kashmir	ARC and AMG not established 1 ASHA Nodal Officer and 1 state ASHA Coordinator in place	600 ASHA Facilitators against the target of 816 (ANMs work as AFs)	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	30/30 District ASHA Mentors in position as District ASHA Coordinators	176/176 Block ASHA Mobilisers in place. One District Trainer also called as ASHA Mentor supervises ASHAs of two blocks	1588/1960 AFs in place
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 all 33 districts	347/355 BCMs in place. Block AMG formed in 70 tribal blocks and in 281 Non-tribal blocks	2371/2880 AFs in place- (one for 10 ASHAs in tribal districts & at PHC level in non- Tribal districts). Total 1925 trained in performance monitoring.
Punjab	AMG not constituted ARC not established, team of two consultants working in SPMU	13 DCMs in place out of 22 districts	Existing Staff (BEE- Block Extension Educator working as BCM in many places)	852/898 ASHA Facilitators in position at cluster level and have been trained in Handbook for ASHA Facilitators.
Tamil Nadu	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, yet to be recruited)	Existing staff (Deputy CMHO, DPHNO), recruitment for DCMs in process 17 DCMs selected out of 25	Existing staff, recruitment for BCMs in process Target for BCMs is 666	Existing staff (Health Supervisor posted at GP level)

Table 2.3 D: 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	Existing staff	Existing staff	Existing staff
Lakshadweep	AMG and ARC not established Medical officer is in-charge of Island is the nodal officer for the Programme	Existing staff	Existing staff	Existing staff
Daman and Diu	AMG and ARC not established. SPMU is managing the ASHA Programme	Existing staff	Existing staff	Existing staff

Section 2.4 Progress of Community Processes in National Urban Health Mission

In the July 2014 update, we reported on the progress on the Community Processes Programme under National Urban Health Mission with respect to the guidelines and modules for ASHAs and Mahila Aarogya Samitis. In this update, we provide state wise status on the following areas: (i) Convergence in Programme Management Structures, (ii) Progress of selection of ASHAs and MAS, and (iii) Translation of Modules and Status of Training of ASHAs and MAS. The primary source of this data is NUHM-PIP of 2014-15 and information provided by state officials related to the ASHA and Community Processes Programme.

1. Convergence in Programme Management Structures: All high focus states except Jharkhand and Uttar Pradesh, have different management structures for Community Processes (CP) under NRHM and NUHM. This is a key factor that delays the selection and training for ASHA and MAS. Having the nodal officer who is in overall charge of the NUHM and, also manage CP also slows down the process. Although Chhattisgarh also has a different management structure the State Health Resource Centre provides implementation and training support for ASHA and MAS in rural and urban areas. Of the non high focus states, in Andhra Pradesh, Telangana, Gujarat, Jammu & Kashmir and Karnataka, the programme is managed by two different nodal officers. This is also the case for Arunachal Pradesh, Manipur, Mizoram and Meghalaya.

2. Progress of Selection of ASHAs and MAS: Selection of ASHAs and constitution of MAS has been initiated and is underway in most states. Tamil Nadu, Karnataka, Uttar Pradesh, Bihar and Himachal Pradesh have not yet begun the process of ASHA selection and MAS constitution. In Bihar, the process of ASHA selection and MAS constitution is seen only in Patna. In Rajasthan and Haryana, the process of ASHA selection in urban areas has been initiated but the MAS constitution has not begun. ASHA and MAS selection and constitution have not begun in Chandigarh and Dadra &Nagar Haveli.

3. Translation of Modules and Status of Training of ASHAs and MAS: The pace of training is slow in most states even where selection has taken place, except Chhattisgarh. In West Bengal, Punjab, Gujarat, Maharashtra and Assam the process of translation of modules in the local languages has been initiated. Punjab, Madhya Pradesh, Gujarat and Assam have begun the process of training of trainers for ASHAs but MAS trainings are yet to be initiated. In Andhra Pradesh and Telangana, ASHA training has not begun, but a training of trainers (ToT) has been conducted for resource persons for MAS training. In rest of the states, the training process for MAS members has not started at all. In the North-East states, Assam and Mizoram has initiated the training of ASHAs in Urban Areas and MAS Module has also been translated in the local language.

SECTION 3

Key Findings of Eighth Common Review Mission

This section carries key findings from the Eighth Common Review Mission (CRM), led by the ministry of Health and Family Welfare and undertaken in 15 states in November 2014. One of the major terms of reference of the common review mission are community processes.

The Community Processes component in the Eighth Common Review Mission encompasses the role of Panchayati Raj Institutions (PRI) related to the functioning of the Village Health, Sanitation and Nutrition Committees, (VHSNC) the Rogi Kalyan Samitis (RKS), Inter-sectoral Convergence, Community Action for Health and the ASHA programme. In addition, the ASHA and Mahila Arogya Samiti interventions under the National Urban Health Mission were also reviewed.

While the VHSNC component was expected to be implemented universally, the ASHA programme was intended primarily for the high focus states and tribal areas of the non high focus states. Of the 15 states that were visited as part of the CRM the six high focus states and the two states of the North East have been implementing the ASHA programme since 2005. Among the non high focus states visited, the Union territory of Chandigarh does not currently have an ASHA programme although the UT is now selecting ASHAs as part of the NUHM. The state of Tamil Nadu opted to select a limited number of ASHA oriented largely to disease specific interventions.

1. Panchayati Raj Institutions (PRI):

- Substantial variations were observed across all states in the level of involvement of PRI representatives in the functioning of VHSNC, RKS, and the District Health Society (DHS). PRIs play an active role in VHSNC in many states, with Kerala reflecting the most well defined and institutionalised systems. PRI involvement in the RKS was seen only in Odisha, Kerala, Chhattisgarh, Mizoram and Tamil Nadu. Mizoram is an exception with 'strong involvement' of PRIs in functioning of health institutions, VHSNCs and RKS.
- It appears that where PRIs are better nurtured with systematic training, and supported by decentralization of funds, functions and functionaries, as in Kerala and Mizoram, a

[1]Odisha, Bihar, Uttar Pradesh, Rajasthan, Chhattisgarh, Madhya Pradesh, Mizoram, Chandigarh, Uttarakhand, Telangana, Punjab, Maharashtra, West Bengal, Tamil Nadu and Kerala

more active role in health and other social sector interventions is seen. Also in states such as Odisha which have made determined efforts to engage PRIs in community platforms, particularly the VHSNC, there is more active participation. Tamil Nadu has made councillors of district Panchayat and the president of village / town panchayat, members of the Governing Board of RKS at all levels.

- Institutional Convergence between committees under the NHM and other departments has been reported by a few states. West Bengal reports 'Convergence Committees' with representation from PRI, Department of Women and Children, and Public Health and Engineering Department and others from block to the State'. However the level of active PRI participation is low. Madhya Pradesh, Kerala and Rajasthan also report institutional convergence. Madhya Pradesh has merged the three village level committees related to WATSAN, ICDS & Health, to build concerted action on health and its social determinants.

2. Village Health Sanitation and Nutrition Committees (VHSNCs):

- VHSNC have been constituted in all states. In Bihar, UP, Telangana, and West Bengal, VHSNCs are constituted at the level of Gram Panchayat, with bank accounts being operated by Sarpanch / Panchayat Secretary and ANM. In the rest of the states, the VHSNC are at the level of the revenue village. In West Bengal VHSNC has no separate account and the funds go to the bank account of the pre-existing Gram Unnayan Samiti, operated by Gram Pradhan. Bihar has constituted VHSNCs at the GP level, but receives untied funds @ Rs 10000/year for each of its revenue villages.

- The process of restructuring of VHSNCs as per the new GOI guidelines, which requires the local GP representative to be its Chairperson, the ASHA its member secretary, and expanding the membership to allow for more inclusion of marginalized groups and women, is yet to be undertaken in several states. Uttarakhand, Punjab and Rajasthan are the only states which report having restructured VHSNCs as per the new GOI guidelines.

- In Rajasthan, though the ASHA has been made the member secretary and signatory of the VHSNC, new accounts have been opened for only 35000 out of the total 43440 VHSNCs, with discrepancies in VHSNC fund flows of VHSNCs. Contrary to the state report of about 77% fund utilisation in FY 2013-14, the CRM team found in some blocks that no VHSNC funds were disbursed in last two years. However, regular monthly meetings of VHSNCs were reported from these blocks.

- Kerala, building on its strong local self governance institutions, has systemic integration of both Panchayati Raj Department and elected Panchayat Representatives with VHSNCs (known as Ward Health Sanitation and Nutrition Committee). State's initiatives on Palliative Care and Mental Health, are well integrated with the PRI obtaining funds and strong community support from elected representatives. The WHSNCs also obtain funding from sources other than the untied funds – Rs 10,000 from Sanitation

Programme and Rs 5000 from Panchayat grants. PRIs support routine maintenance of health facilities using their funds.

- Well functioning and active VHSNCs have been seen in Odisha and Chhattisgarh at revenue village level and works with strong involvement of Panchayat at ground level. In Odisha, low performing VHSNC (about 45% of total) were identified and were given focussed capacity building inputs on roles and responsibilities, effective need based fund utilization and Village Health Plan preparation. Swasthya Gaon Puraskar is awarded to better performing GKS committees.

- The Sarpanch and ANM are joint signatories of VHSNC account in Bihar and UP, and the role of ASHA in VHSNC in these two states appears to be weak. In West Bengal, in the early years of NRHM, Gram Unnayan Samitis which existed at the level of Gram Panchayat, were co-opted as VHSNC, with funds being routed through Panchayat Department. PRI members and ASHAs were found to be not aware of VHSNCs, though the ANMs had some knowledge about the committees and the untied fund allocated. Funds have not been transferred to VHSNCs over the past two years. In Bihar, untied funds appear to be spent by the Sarpanch with little consultation.

- VHSNCs are reported to be taking local initiatives around issues of water and sanitation, spray of DDT and Gammaxine. In MP, supporting purchase of equipments and supplies for sub centre through a state directive is another area of fund expenditure, under its Gram Arogya Kendra initiative (GAK). Uttarakhand reports an innovative support from VHSNC funds for providing locally made 'Doli' for transport of patients to nearby hospitals.

- VHSNC members in many states reported that they have been given orientation on VHSNC ranging between one to two days (Bihar and Madhya Pradesh particularly report this). Awareness and knowledge levels of the PRI representatives were reported to be weak across many states. An exception in this regard is the state of Odisha where training of members follows a systematic process. The CRM report of MP particularly observes that, despite an expenditure of Rs. 8.9 Crores on capacity building of PRIs, in FY 2013-14. Awareness and knowledge levels of the PRI representatives was weak. No state reports issuing of state specific guidelines or training material for VHSNCs except for states of MP and CG which have developed their own training module for VHSNCs. Tamilnadu also reports having trained VHSNC members three years ago.

- VHSNC processes on the ground are reported to be weak, in regularity and quality of monthly meetings in most of the states. For example, in Punjab no VHSNC meeting has been held in one of the districts visited since July 2014. In Uttarakhand, findings from Almora district indicate that VHSNC meetings are irregular, with no involvement of ASHAs and ANMs. No systematic health planning roles were seen being played by VHSNCs.

- GPs in Chandigarh were oriented on their role and the CRM report highlights 'enthusiastic' involvement of PRI representatives in VHSNC processes, in health schemes

and in building awareness regarding the national health programmes. Tamilnadu has formed 12524 VHSNCs at Village Panchayat level and 2540 at Town Panchayat level.

3. Convergence

- Kerala has established institutionalised decentralisation mechanisms and convergent processes. State has a nodal officer to look after convergence measures at state level, and local bodies have been given additional dedicated funds and flexibility for plan formulation with mandatory ceilings on infrastructure projects. In an innovative measure, 10% funds have been earmarked for women welfare and 5% for children, elderly and other vulnerable population groups. Palliative care is now mandatory for all Gram Panchayat/ Municipalities/ Corporations. Comprehensive Health Plan has been prepared for a period of five years under the leadership of Local Self Governance Department (LSGD) and Department of Health in FY 2012-13, with intersectoral convergence. Health plans have been prepared and vetted at district level for assessing local relevance. For Palakkad district a total of 784 health projects and 63 health-related projects (to be implemented by line departments) have been approved. School children have been involved in Sanitation, and Vector control activities and generating awareness on hazards of alcoholism among students.

- While good convergence is reported in MP and Telengana (and also in many other states), between the front line workers at the ground level, between, ASHA, ANM and AWW, for organising VHSNC meetings, VHND, convergence between the Health, ICDS and PHE departments is reported from many states as a challenge at the block and district level. In UP a AAA (ASHA, ANM and AWW) platform is being implemented in 25 high priority districts for effective convergence between frontline workers.

4. Village Health and Nutrition Day (VHND)

- Across the states, the focus of VHND appears to be on immunisation. Where ANC is provided, the quality of services is weak, and the full complement of ANC services, like, Hb test, BP check-up, and abdominal examination is not being provided in most states.

- No specific mechanisms for monitoring of VHNDs have been reported from most states. West Bengal reported monitoring mechanisms to be in place, however, major discrepancies were found between the number of VHNDs planned and held and those attended by ANM, AWW and ASHAs.

- Activities related to nutrition, adolescent health and follow-up visits at village level are weak in many states. In UP it appears that the focus is entirely on immunization. The ASHAs have been provided with a flip chart but no evidence of this being used for counselling was observed'. In Chhattisgarh, VHNDs have been reported to have good participation from ANMs, AWW, Mitanin (as ASHA is called in the state) and PRI members, and the state also has its own initiative called Health Wednesday Programme, where AWW brings malnourished children and their mothers to nearest facility. Madhya Pradesh is the only state which reports a set of tests being provided (Hb,

Urine test for pregnancy & Albumin, Antigen test for P, Vivax), and 16 drugs through the Gram Arogya Kendras in AWC, which function as the VHND site. However MCP cards were not being filled, and counselling and IEC efforts, were identified as needing improvement. Mizoram in a noteworthy aberration reports very little involvement of ASHAs in VHND, and also that they were not even fully aware of the incentives for mobilising children for VHND.

- While in all other states, immunisation session and VHND are being organised together, Tamil Nadu reports holding immunisation day for children every Wednesday separately as well, apart from the VHND on Fridays which includes immunisation for women and children. VHNDs provide ANC & PNC care, immunisation as well as nutrition counselling and support for birth planning. The state report highlights the key role of Village Health Nurse (equivalent to ANM), her close coordination with AWW and ASHA (where present), and monitoring of VHND by VHSNC members.

5. ASHA Training & Performance:

- ASHAs have been, once again, recognized across the states as 'the most prominent face' of the NRHM, who are 'very active in implementing various health programmes', and the critical role that they play is also being recognised by the health system. While CRM report of Chhattisgarh calls ASHAs, 'backbone of the community based health programmes', the Telangana team observes that 'beneficiaries had a very positive outlook about the ASHA'. Uttar Pradesh team also observes that 'across the facilities visited ASHA were very active, motivated and knowledgeable' and they have become 'Carriers of Change' in the community. Assam also reports ASHAs as being 'enthusiastic and vibrant'. In Kerala, the report highlights a general reluctance (at state level) towards the programme. One reason for this was reported to be the belief that Kudumbashree health volunteers have already been performing the role of heath activists in the community and ASHAs are seen as duplicating this role.

- Selection of ASHAs is complete across most states. Except UP, that has only 81% and Rajasthan that has 87% ASHAs in place against the target, all high focus states have close to or above 95% ASHAs in place. The gap in both these states is based on revision according to the 2011 census and identification of non functional ASHAs, but their inability to recruit new ASHAs to fill this gap in the last two years, is an issue of concern. Mizoram also has not been able to further recruit ASHAs to fill the gap of about 37% that was created after it raised the target as per the 2011 census. In Bihar, delays in nomination of new ASHA by village Pradhans, was reported as causing the gaps in selection, In Madhubani, 3734 ASHAs were in place against target of 4487 in district Madhubani. West Bengal also has major gaps to fill with total 61,008 ASHAs sanctioned, but has only 45250 in position. In Hemtabad block of Uttar Dinajpur, no ASHAs had been selected. In Ganganagar district, Rajasthan, a gap of 20.1 %, with resultant high population coverage of upto 2000 per ASHA was reported.

- In West Bengal ASHA selection is based on marks obtained by the candidate in the Madhyamik or equivalent examination (90% weightage) and Score in the interview

(10% weightage). District officers felt that this distribution skewed in favour of exam marks results and led to inappropriate selection. In Kerala, the existing mechanism of ASHA selection is reportedly robust and includes selection through PRI member, members from civil society organization and representatives from community.

- Tamil Nadu has an entirely different programme design, and has selected ASHAs for specific programmes, like HBNC, Leprosy and Malaria, with ASHAs having an average coverage population of 700-800 households and 4-5 villages, and process of ASHA selection has been led by the village panchayat.
- The database of the ASHA programme across states has become more robust with information on selection, training, ASHA drop-out, and incentive payments. A number of states, like, Rajasthan, Punjab and Maharashtra, have developed a web-based software for database management and updating, but the field experience reflected limitation of these systems. In Punjab, though the web based software has been in place for over two years, it is not being updated regularly, due to technical limitations and problems of skills and logistics like power availability etc.
- The average drop-out rate of ASHAs is reported to be in the range of 2-5% per annum across the states.
- Across the states the following roles of ASHAs are reported: support to pregnant women, counselling for birth preparation, serving as facility escort, post-partum visits for providing care of mother and newborn, supporting diseases control programmes, mobilising families, supporting VHND and Immunisation services. The focus and skills of ASHAs in undertaking Nutrition counselling for mother and child differs across states and is generally reported to be weak. In Kerala, ASHA play a key role in Palliative Care (under the leadership of the Gram Panchayat Nurse) and Non Communicable Diseases. Madhya Pradesh also reports registration of birth and deaths, listing of high risk pregnant women and low birth weight and malnourished children, referral and escort through Janani Express/EMRI. The UP CRM team reports lack of clarity among ASHAs about their roles, and low levels of motivation.
- Module 6&7 training is still in its initial phase in UP, although the momentum has increased. Rajasthan has also only recently stepped up the pace of Module 6&7 training and has trained 87% ASHAs in round 1 and 57% in round 2, with Round 3 yet to start. Refresher training on the skills taught in Module 6&7 training rounds, have been planned across many states. Uttarakhand has started refresher trainings. The pace of training in Module 6&7 training has also slackened in Bihar and MP, which were near completion in Dec 2013 in round 1 and 2 training for ASHAs, and had trained 19 and 12 percent respectively in round 3, but have been able to train only 54 and 40 percent respectively at the time of CRM visits. Madhya Pradesh is also training their ANMs along-with the ASHAs. Bihar which showed good progress over the last three years has lost momentum due to large delays in fund releases.

- Eight days Induction Training for new ASHAs, which replaces the Module 1 to 4 training rounds, has been initiated in Madhya Pradesh (428 ASHAs trained). A challenge in MP and other states is that in absence of a systematic training structure in district and sub district levels, it is difficult to organize training for newly recruited ASHAs since they are few in number.

- The pace of Home Based New born Care (HBNC) interventions and related ASHA skills is variable, but steadily improving in most states. While in some states (Punjab, Rajasthan) ASHAs are aware of the key elements of HBNC, several states report a low level of HBNC skills among ASHAs is clearly being identified as a major challenge, particularly in states where Module 6&7 training rounds have been conducted without giving HBNC kits to ASHAs during training (MP, WB, and Bihar), preventing ASHAs from getting enough opportunity for practicing of skills. In Bihar, roughly 10% of the total newborns have been visited under HBNC in 2013-14, but more than double the number, in the first six months of this year. In Kerala ASHAs were conducting home visits for newborn care, but implementers questioned the need for this In Karimganj district, Assam no HBNC visits were reported to be taking place. In MP the role of the ASHA in HBNC was compromised due to her having to stay in the Gram Arogya Kendra for most of the day. HBNC in Chhattisgarh was initiated earlier as the state follows a different pattern of training, albeit with the same content.

- In Kerala the knowledge and skills of the ASHA on basic RCH issues were found to be weak. Reports from Assam, Chhattisgarh, Mizoram, Telengana, and UP indicate that ASHA are not able to identify pregnant women with complications.

- The role of the ASHA in the disease control programmes especially malaria and leprosy was well appreciated in West Bengal, Odisha, and Tamil Nadu (for leprosy). The supply of RDT kits and drugs are regular and this facilitates the role of the ASHA in these states. In MP and Chhattisgarh irregular supply was reported.

- No state reports specific involvement of ASHAs in sanitation related programmes and the ASHA's role is limited to awareness building as part of her work in the community, through the platform of VHSNC and VHND. Odisha reports that ASHAs are not even aware of the incentive for motivating household to build toilets under the Nirmal Bharat Abhiyan. Menstrual Hygiene programme was reported from Uttarakhand and Chhattisgarh, but quality of the napkins supplied was reported by the community as a major concern and the reason for low uptake. In Bihar ASHA reported not having received supplies of sanitary napkins.

- States of Uttarakhand, Mizoram, Assam, Punjab and Odisha, report the 'Performance Appraisal System' for assessing ASHA Functionality on ten indicators, being in place. Odisha also shared a state level analysis of ASHA functionality, which shows only 44% ASHAs being functional as DOTs provider and 57% on Family Planning related roles, while their functionality is much higher in all other indicators.

- Across the states, problems in drug kit replenishment were reported. Delays in drug replenishment from sub centre were reported from Chhattisgarh and Bihar. In Shrawasti in UP, replenishment of drugs and family planning related supplies was being done from PHC, and the process was quite irregular, due to which even ASHAs were reportedly losing interest in asking for replenishment. In Madhya Pradesh, ASHAs were asked to replenish the drugs from the Gram Arogya Kendra. In Punjab, Uttarakhand and Odisha, drug kits and HBNC equipment kits have been given to all ASHAs. West Bengal reported that 'ASHAs have not been provided with the HBNC kit' in both districts.

6. ASHA Incentives & Support Systems:

- The strength of the ASHA programme correlates directly to the support provided. Support structure at all four levels (state, district, block and ASHA Facilitator levels) is in place only in states of Bihar, CG, MP, Rajasthan & Uttarakhand, but Chhattisgarh and Uttarakhand are the two states with no vacancies at any level. In Madhya Pradesh despite filling in vacancies, gaps are persistent. The state of Bihar also had large gaps and the report observes that the supervisory and handholding support to ASHA was weak. MP has a cadre of 80 Facilitators called Social Mobiliser (SM) to support ASHAs under NUHM. No recruitments were seen despite major vacancies in Rajasthan and Bihar. Both Punjab and Mizoram retain the same support structure at three levels, with none at block level, but report better retention. All other non high focus states have only existing health system staff to support the programme, but this is not proving to be effective on account of poor orientation and limited time. The CRM team of Odisha has appreciated as a 'best practice', the monthly evaluation to test knowledge and skills, followed by refresher training and repeat testing of ASHA facilitators.

- Incentive payment – Most state reports state that the average incentive an ASHA earns is between Rs 1500 to 2000 per month. In Madhya Pradesh, average incentive reported in both districts visited, was 1500 to 2000, and about 94% ASHAs have bank accounts. In Odisha average take home incentive of ASHAs has been reported as 1735. Electronic transfer or direct bank transfer based incentives payment system is reported from most states and that the payments are regular. Problems of delay of between three to over six months was specifically reported from Shrawasti of Uttar Pradesh (in the other district payment were being done on time on monthly basis) and Chhattisgarh. In Chhattisgarh the system of incentives payment in cash, through panchayats, has been reported as a concern and a cause for delays in incentives, and need for direct bank account based payment system has been suggested in the state CRM report. Delays were reported from Kerala with no incentives paid from NHM funds since April 2014, Uttarakhand also reported average incentive of Rs 1500 to 2000, but problems in payment of some incentives has been reported. West Bengal pays its ASHAs a fixed incentive of Rs. 1500 per month from state funds, with average incentive varies in the range of Rs 1500 to Rs. 4000, made via electronic bank transfer. In Rajsamand district of Rajasthan, a local innovation is the ASHA Diary, in which details of beneficiary families, and a record of activities is used as the basis for making payments and assessing ASHA performance. States are yet to begin paying the routine and monthly recurring incentive of Rs. 1000.

- Grievance Redressal Mechanism - Systems of Grievance Redressal Mechanism are in place, but structures vary. A committee with intersectoral representation from exists in Punjab, and an average of 8-10 cases per block were reported during last year, and resolved at block level. Madhya Pradesh has merged Grievance Redressal Committees with Monitoring Group on Community Action (MGCA), but no system /mechanism was found in place on the ground. In many other states such a system is not very structured and formal. West Bengal did not have any grievance redressal mechanism in place, and also the LHVs, who are field level supervisors of ASHAs reportedly do not listen to the complaints of the ASHAs. In Uttar Pradesh, a toll free helpline was in place as a part of grievance redressal system, and information about it was displayed as wall paintings, but the number of grievances being handled was very small. In Assam misbehaviour of hospital staff was reported, but no mechanism for redressal was seen.

- ASHA Rest Rooms: While in some states, ASHA Ghar are in place mainly in district and block level facilities (in Madhya Pradesh 35/50 DHs have it in place, but none were found at CHC/PHC level in Panna, one of the districts visited), states like Odisha have taken a different approach, and set them up in all 143 L3 delivery points of state, managed by ASHA, are well set up and functional. Chhattisgarh has ASHA Help Desks, where the Mitanin provide navigation support to patients. In Assam and West Bengal no rest rooms were found in place.

- Career Progression: Among the states visited, Chhattisgarh, Madhya Pradesh and Odisha have a provision in place for reservation of a percentage of seats in the ANM schools for ASHAs. States of Bihar and Chhattisgarh also support ASHAs for enrollment in education equivalency programmes in National Open School, to help them study further. Chhattisgarh and Odisha also have a system for support to ASHAs to enrol in National Pension Scheme called Swavlamban Yojana. Other benefits, life insurance cover for ASHAs and their spouse, and maternity benefit as well as scholarship for various studies are also in place in Chhattisgarh. The CRM team also met a batch of ANM trainees in Chhattisgarh, which included a number of ASHAs. In several states, selection of ASHAs as ASHA Facilitator is also a mode of career progression.

7. Community Action for Health

- Punjab has initiated interventions under the Community Action in FY 2014-15, for Health programme in two pilot districts of SBS Nagar and Ropar. State level advisory group and technical advisory groups have been formed, and NGOs have been roped into the programme. Bihar CRM report has shared that state had undertaken a pilot initiative on community action for health in 2013-14, but it was not proposed in FY 2014-15 PIP. From among nine states which were part of the pilot phase, in Madhya Pradesh, CAH intervention is in the initial phase of implementation in five districts (covering a total of 225 villages). Rajasthan team reports finding no CAH programme interventions on the ground, though state has funding for initiating the process in three districts. No CAH interventions have been reported from Assam. Odisha has planned to implement CAH interventions in five districts during FY 2014-15.

- Chhattisgarh has a variant of community action for health since the 2007. From an NGO led pilot in 135 villages, the programme has now been rolled out across the state by the State Health Resource Centre (SHRC), and integrated with other ASHA and VHSNC interventions that it manages. Community Based Monitoring is now a part of VHSNC monthly meetings using a public services monitoring tool. Social audit of deaths related to maternal, child, fever, TB etc, and community feedback regarding services being provided by government health facilities and block level public hearings are undertaken. No CAH related programme interventions were reported from Odisha, Mizoram, Chandigarh, Uttarakhand, Telanagana, West Bengal and Kerala.

Recommendations

1. Engaging representatives of Panchayati Raj institutions in health committees at various levels is an area that needs action by the Departments of Health as well as by the Department of Rural Development/PRI. District and sub district implementers in the health department will not be able to promote PRI participation or build capacity to understand and take action on health issues unless there are proactive efforts to strengthen and involve institutions that are involved in PRI training and support. The Punjab, West Bengal and Kerala experiences while following different paths have demonstrated that this is possible.

2. The persistent and wide spread finding of varying and limited functionality and limited or misuse of untied funds of VHSNC is partly a result of the lack of effort at systematic capacity building, but also a matter of the human resources required to support the committees and facilitate regular meetings and action on local issues. The Odisha and Chhattisgarh experiences show that functional VHSNC are possible with active and sustained facilitation. Indeed, strengthening PRI knowledge and understanding of health issues are also likely to benefit VHSNC functioning. Building capacity of VHSNC is a mammoth effort and states will need to involve NGOs and other training institutions to undertake training of VHSNC members and continuous support provided by frontline workers appropriate to state contexts.

3. A conscious attempt to address the stalled efforts or non starters in community action for health requires sensitization of not only state level policy makers but also district and sub district implementers on the necessity of such action and how this can be leveraged to improve outcomes on social and environmental determinants and accountability. This would also necessitate linking with existing community structures such as the ASHA and the VHSNC thereby mutually strengthening both efforts, and ensuring that the support of this intervention is provided by teh management structures created for community processes.

4. The "presence and visibility" of the ASHA in the face of systemic gaps related to selection, skill building, supportive supervision, payment and replenishment of kits, is a testimony to the exercise of individual agency by the ASHA themselves. This year's findings pertaining to the ASHA programme are mixed, highlighting that more of the same may not work in all contexts.

5. ASHA selection must be expedited especially in the underserved areas. Learning from the past, where the pressure of time resulted in inappropriate and patronage based selections, and the fact that such ASHAs tended to drop out anyway, the opportunity to use community based selection and the "right fit" ASHA must not be squandered. States must prioritize the selection of ASHA and household allocation so as to ensure appropriate population coverage so that there are no left-outs..

6. The finding of weak skills and poor performance among the ASHA relates to the need to improve training quality, post training assessments, refresher trainings, and ongoing field level mentoring. This requires that urgent attention be paid to training structures and systems and to strengthening the support structures created. States need to use conventional (audiovisual/print) and newer methods of technology to enable refresher training for additional skill building.

7. While on the training front, substantial progress is reported from most states, barring a few, the need for continuous refresher training even where "training is completed" is the next step forward. Adhoc training systems will need to be replaced by institutionalized mechanisms for ongoing training. The certification process planned for this year provides an opportunity for states to initiate this process.

8. Progress on recruitment of support staff for the ASHA is notable across all high focus states, but states in this category would need to undertake serious efforts to build on the opportunity provided. The support staff at all levels need to be sensitized to their roles, and provided with appropriate support by their district counterparts in NHM to undertake their tasks of mentoring and supporting the ASHA and VHSNC. In non high focus states, existing staff who are expected to provide the potential outcomes need to be strengthened to undertake this additional task through appropriate training and monetary/non monetary incentives. States need to undertake an analysis of the existing HR at block and district level, develop appropriate job descriptions and allocate work equitably.

9. A linked recommendation to this is that states must ensure provision of kits, drugs and communication material to serve as aids to the ASHAs work in order to strengthen her role in motivation for behaviour change and to provide community level care. Strengthening her in both these roles will serve to enhance her effectiveness as a social mobiliser.

10. A decade after the launch of the ASHA programme, particularly in non high focus states especially those such as Kerala and Tamil Nadu where there is evidence of the ASHA being an underused human resource, states must seriously start thinking of engaging ASHA in areas such as screening, preventive and promotive measures for chronic diseases and palliative care linked to certification in a set of relevant skills. Viewing the ASHA as a frontline worker located in her community and supporting the Primary health care team offers an important a venue to facilitate universal health coverage.

SECTION 4

Role of ASHAs in National Vector Borne Disease Control Programme

The role of the ASHAs in the National Vector Borne Disease Control Programme (NVBDCP) has been significant. The recently held Common Review Mission and Joint Monitoring Mission for NVBDCP both validate the significant role of ASHAs in Vector and Disease Control Measures at the community level. We highlight findings from the draft reports pertaining to the role of ASHAs. Interestingly and contrary to the popular perceptions, the findings demonstrate that it is the training and support in terms of diagnostic kit, slides and drug supplies which helped ASHA perform her role in Vector Borne Disease Control effectively.

CRM Findings

The role of ASHA in the disease control programmes especially in malaria control was well appreciated in West Bengal, Odisha and Tamil Nadu. Regular supply of RDT Kits and Drugs has facilitated her role in these States. Tamil Nadu has selected ASHAs in many areas for malaria control to utilize her effectively for early identification of cases and ensure complete and timely treatment.

In most States, ASHAs are trained in NVBDCP through two modes- Utilizing the channel of District ASHA trainers available across the States who train ASHAs on content of Induction module and module 6&7 which includes building her knowledge of vector borne disease and making her skillful in preparation of blood slides testing through RDT Kits, providing treatment and referral to identified cases. To reinforce her skills, ASHAs are also trained in NVBDCP through District Programme Officers/Medical Officers- NVBDCP.

ASHAs were found functional in their task of slide preparation in most of the States. However, irregular supply of kits and drugs in Chhattisgarh, Assam, Mizoram and MP hampered her performance to some extent. While ASHA incentive payments linked to these tasks are being streamlined in most of the states, ASHAs from Mizoram reported delay in incentives.

Many States are utilizing VHND to discuss issues of hygiene, sanitation, cleanliness and Malaria with active participation of ASHAs, ANMs and AWWs in holding these discussions. However

Chhattisgarh has much smoother processes and these discussions have become a routine in VHND.

JMM Findings

The introduction, availability and functioning of ASHAs is seen as a game changer in the control of vector borne diseases and is reported as the most encouraging finding from all state visits. ASHAs are performing a range of tasks from informing communities about vector control services, facilitating acceptance of IRS and LLINs, linking with staff that could provide the RDK or drugs as needed, doing blood smear collections and to provide drug care. Across the states, ASHAs were found to be enthusiastic and well connected with both communities and the health system. However, few challenges hampering ASHA's performance is scarcity of RDK kits and drugs and unmet training need.

Findings from JMM also reflect strong presence of ASHAs as a mode of community based IEC/ BCC for Dengue and Chikungunya. In some districts, the contribution of community volunteers (like ASHAs) and VHSNC is also encouraging for acute encephalitis syndrome as they are contributing to identification and referral of severe cases. However, there is a state wide training need for all cadre including ASHAs.

The current strategy fragments the disease control process at level of ASHAs in discrete activities with attached monetary incentives. The information of many of these incentives is yet to reach the ground. ASHA incentives under NVBDCP include:

1. Rs. 15 per slide for preparing Blood Slides
2. Rs. 75 for providing complete treatment to positive Pf and Pv case
3. Rs. 300 per case for referring a case of Kala Azar and ensuring complete treatment for endemic districts in 4 states (Bihar, Uttar Pradesh, West Bengal & Jharkhand)
4. 200/- Per day for maximum of 3 days to cover 50 houses or 250 persons for Annual Mass Drug Administration for Lymphatic Filariasis for 250 endemic districts.
5. Rs.200/- one time for line listing of lymphoedema and hydrocele cases

The recommendations made in draft report based on the findings include a need for clear guidelines for task allocation among ASHAs, ANMs, MPWs, FPWs where work priorities and schedules vary as per endemicity of the area, strengthening of ASHA training, supportive supervision and drugs supply. Revisiting the "incentivization" approach to provide ASHA an assured return for a package of regularly carried out activities and rewarding her more for prevention of disease and good surveillance is also seen as a point of further discussion. The report also narrated the need for integration of interventions by providers (pediatricians, health workers, ASHAs) and ancillary services (blood transfusion, dietary services, ambulance services, laboratory services, bio-waste management).

SECTION 5

PHOTOFEATURE: The ASHA at the India International Trade Fair

The **34th Annual India International Trade Fair (IITF)** was organized by India Trade Promotion Organisation (ITPO), a Goverment. of India Enterprise from November 14th - 27th, 2014. The theme for this year's IITF was "Women Entrepreneur" to celebrate the contribution of women entrepreneurship and promote new avenues for such efforts. The Ministry of Health and Family Welfare participates at the IITF every year by setting up a pavilion showcasing new programmes and efforts of MoHFW. To synergize with the overall theme of the event, the focus of the Ministry's theme this year was "ASHA – a Change Agent", to introduce the concept of the ASHA programme, show case the multiple aspects of the ASHA's work and highlight key achievements of the ASHA programme to visitors. An entire floor of the pavilion was dedicated to the ASHA programme with several posters that captured the genesis of the programme, the main roles of the ASHA and her contributions, and two dioramas depicting the key functions of ASHAs in a community setting.

In addition a desk – "Main ASHA Hoon" was set up for the participants to help them interact with visitors and respond to their queries about the programme. All material and modules related to the ASHA programme were displayed. In order to enable visitors to interact with ASHA, beyond the posters, and other visuals and material, ASHA facilitators (who had previously been ASHAs) and Block/District Community Mobilizers from four Hindi speaking states of Jharkhand, Chhattisgarh, Odisha and Uttrakhand were invited to participate at the pavilion. Participants included Ms. Anita Sahu, Ms. Anita Verma & Ms. Lata Verma from Chhattisgarh, Ms. Beena Rana, Ms.Indra Thapa & Mr. Dinesh Pandey from Uttrakhand, Ms.Roshan Aara, Ms. Jasmani Susana Aind & Ms.Pushp Lata Tigga from Jharkhand and Ms. Madhusmita Ojha, Ms. Sanjukta Sahu & Mr. Taranisen Pradhan from Odisha.

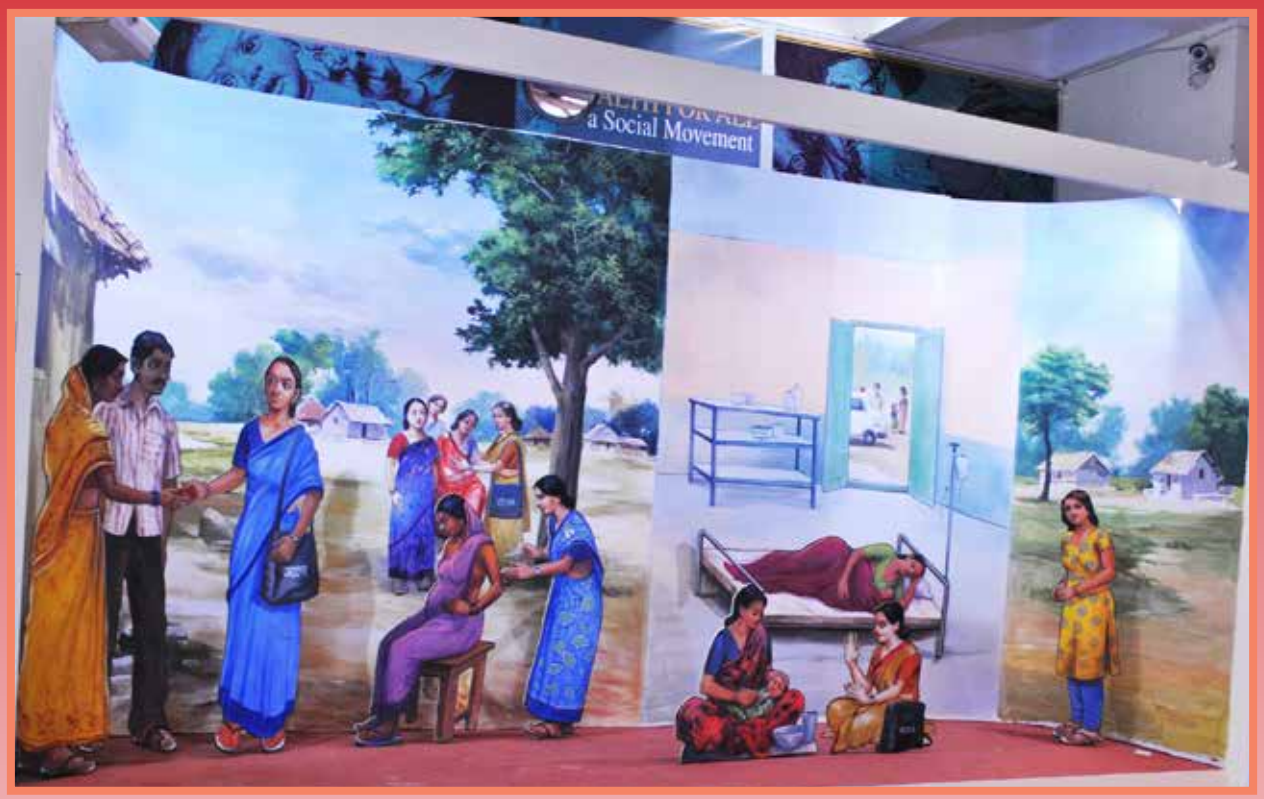
The Fair was inaugurated by the Hon'ble President of India Shri Pranab Mukherjee and the MoHFW pavilion was inaugurated by Hon'ble Health Minister Shri J. P. Nadda on November 14, 2014. ASHA facilitators and District/ Block Mobilizers from the states participated actively in all events organized everyday by pavilion staff. They enthusiastically explained all sections of the floor dedicated to ASHA programme and responded to queries of all visitors. MoHFW's pavilion bagged the Gold Medal for Best Pavilion in the Ministries and Departments category.

Entrance of the MoHFW pavilion at IITF

ASHAs Facilitators from Uttarakhand and Chhattisgarh with Hon'ble Health Minister at the inaugration

Hon'ble Health Minister visiting the pavilion

ASHA Facilitators and DCMs from Jharkhand and Odisha



Diaroma depicting the multiple roles of ASHA- the Activist, the Mobilizer and Provider of the Community Level Care

Panels showing ASHAs from various states

And the Gold Medal for the best pavilion goes to the MoHFW...

Posters displayed at the IITF for visitors information

SECTION 6

Reporting on Best Practices from States

i) ASHA Facilitator- Backbone of the ASHA Programme (Chhattisgarh Experience)

ASHA evaluations from over 13 states of India demonstrates that there is a high correlation, inter-alia, between ASHA functionality and on-going mentoring and support provided to her. Field mentoring and support are important for building confidence and improving competency in the ASHA's skills. However, building and sustaining an effective mechanism for such onsite mentoring is a challenge as ASHA facilitators need not only to be aware of the local context and technical skills of the ASHA but also to be able to help ASHA resolve practical issues in the field.

Chhattisgarh's Mitanin programme which predates the ASHA programme was initiated as a state government initiative, was integrated into the NHM in 2005, and is recognized to have made significant positive contributions. One of the factors that has proven to be a critical factor in nurturing the Mitanin in the field is the Mitanin Trainer (MTs), similar to the ASHA Facilitator in the rest of the country. Each Mitanin Trainer (MT) is expected to support about 20-30 Mitanins.

Several of the Mitanin Trainers have themselves been a Mitanin and thus have a good understanding of the job responsibility and training content. This is a significant advantage. The key responsibilities of the MT are a review of the Mitanin's performance and regular inputs to refresh her knowledge and skills. The mechanism for this is the monthly cluster meetings – which have five components, namely a solidarity building exercise through songs and sharing of successes, refresher training and recapitulation of selected topics, sharing of new information, reviewing the work done in last month, by collecting data and on field supportive supervision through home visits to newborn and pregnant females. Knowledge and skills are reinforced through the use of training modules, brochures and pamphlets.

During these monthly meetings, the MT also visit selected households with the Mitanins to provide her guidance and help in critical cases. She also collects the data from the Mitanin on 17 indicators. These indicators are broadly related to her functionality. The MT consolidates this data and provides this information to the block coordinator. The mode of refresher training is through

role plays, reading from the module and reinforcing content. The small group in the cluster allows individual practice with one on one mentoring, and feedback. These cluster meetings also provide the Mitanins an opportunity to reflect on reasons for lower performance on the 17 indicators. The MT also plays a key role in the VHSNC meeting. The Mitanin undertakes the role of mobilization, attendance, etc, but it is the MT who effectively facilitates the meeting including review of pertinent village level issues. While most states now have ASHA facilitators, concerns have been raised on the weak supportive supervision, on-the-job mentoring and in general low effectiveness of the ASHA Facilitators. The example of Chhattisgarh's Mitanin Trainer should serve as a model for states to consider incorporating facilitatory into their programmes.

ii) Sahiya Help Desk: Experience from Jharkhand

One of the essential roles expected from the ASHAs is to help patients in navigating complex health facilities, often culturally alien and overcome other access barriers to health facilities. In Jharkhand the state identified the following barriers:

- Lack of awareness about the types of services and those which are free and for which user fees are charged.
- Long waiting times
- Lack of awareness on how and where to lodge complaints or provide feedback regarding services offered in Government hospitals.
- Insufficient advice and support within health facilities

The Sahiya Help Desk in Jharkhand was designed to provide guidance within health facilities through the Sahiya (as the ASHA in Jharkhand is called). The main purposes in setting up Sahiya Help Desk were:

a) Provide Guidance to the patient and Sahiya those visiting health facilities

b) Help pregnant women from remote area in reaching to the concerned department in hospital.

c) Register grievances by patient

d) Help Sahiya in getting incentive on time

e) Help hospital administration to improve health services

One of the key roles of the Sahiyas is to build community awareness on various health services offered in health facilities and motivate improved care seeking behaviours. The Sahiya help desk reinforces this role. To improve patient experience and to create an atmosphere of trust in public health facilities, a Sahiya Help Desk has been established in 98 public health facilities which include PHC/CHC and District hospitals. The Sahiya is trained to register patient grievances, listen patiently, and enable appropriate action. The Sahiya help desk also serves as a point for facilitating Sahiya payments. The Sahiya Help Desk also has a prominent display of the health scheme/incentives of Sahiya. Sahiyas are posted on a rotation basis for a maximum of four

days and receive an amount of Rs.150 per day. All services rendered by the Citizens Health Help Desk are free of cost to the public. There is a close monitoring of the initiative at the district and state levels. The Sahiya help desks are expected to guide patients who seek health care. For proper functioning of these desks officials have been instructed to provide identity cards and dedicated phone lines. "Bano" a Sahiya working in Sahiya Help Desk from Simdega district had played a vital role in giving patients information regarding prevention of Anthrax at the time of an anthrax outbreak in Simdega district.

iii) Role of ASHAs in Disasters

Over last few years ASHAs have demonstrated individual agency, going beyond their call of duty. In the last two years, ASHAs have made their presence felt by serving as first responders in disaster situations- natural or manmade. Though there is anecdotal evidence where ASHAs have shown exceptional commitment in difficult situations and supported their communities, such stories are rarely documented.

Since 2012, selected states have decided to train ASHAs in Disaster preparedness. This would enable ASHAs to play an effective role at community level in rescue, relief and rehabilitation measures in cases of a disaster. In this section we share some experiences from states of Assam, Uttrakhand and Jammu & Kashmir.

Role of ASHAs in Conflict Situation[2] - In July 2012, conflict between Bodo and Muslim communities caused about 100 deaths and displacement of about 4,00,000 people in districts of Chirang, Kokrajhar and Dhubri of western Assam. In addition to the relief and health camps set up by the Government, a team from Doctors For You (DFY) supported by Tata Institute of Social Sciences, Mumbai provided medical services at the camp. The key strategy of the group was to train the ASHAs[3] as MISP – Minimum Initial Service Package providers[4]. The MISP providers were trained by DFY- TISS team in the use of MISP box[5] and their activities during distribution of the box, and during subsequent visits while reaching out to the displaced communities with information on reproductive health. The experiences from this effort demonstrated that ASHAs were successfully able to counsel and ensure access to reproductive services to the women living in the relief camps. Taking cognizance of the fact that ASHAs were also victims of the crisis, incentives were introduced for ASHAs, based upon four milestones – registration of pregnant women, 1st and 2nd ANC check-up for all identified women, institutional delivery, and perinatal

[2]Excerpted from implementing minimum initial service package 'MISP' in humanitarian crisis learning from experiences, a process report from Assam, India – DFY and TISS

[3]ASHAs were the first choice to act as MISP providers, where ASHAs were not available - ANMs, AWWS or other volunteer women were trained as MISP provider

[4]MISP is a set of priority activities to be implemented from the onset of a humanitarian crisis (conflict or natural disaster), and further scaled up and sustained to ensure equitable coverage throughout protracted crisis and recovery while planning is undertaken to implement comprehensive RH as soon as possible - WRC (2011) Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations: A Distance Learning Module

[5]MISP box included - Safe-Delivery Kit, Ante-Natal Care Kit, Family Planning Kit, Menstrual Management Essentials

care. Till November 10th, 2012, over 400 pregnant women were registered across 70 camps in 3 districts while out of 32 deliveries 24 used safe delivery kits provided by the MISP Providers and 23 successful referrals were facilitated through DFY-TISS team. The story of Rohilla Khatun from Dhubri District in Assam has already been shared in ASHA update of January 2014. Rohilla Khatun helped in conducting safe delivery of a pregnant women in absence of any medical services at the camp, provided new born care services to 43 newborns and used VHSNC funds for providing food to children at camps during the conflict The project demonstrated that ASHAs are well suited to play the role of a first responder. Investing in capacity building and incentivizing the ASHA, can ensure this vital support during periods of crisis.

In June 2013, heavy rainfall and cloud bursts led to flash floods in areas settled on the banks of river Ganga, Alknanda and Mandaknai across four districts of Uttarakhand – Rudra Parayag, Uttarkashi, Chamoli and few blocks of Pithoragarh. Soon after the disaster, reports of ASHAs helping communities despite being a victim of the disaster emerged. About 2283 ASHAs and 154 ASHA Facilitators in the four disaster affected districts were trained in disaster response by October 2013 with support of Doctors for You and Lady Hardinge Medical College, New Delhi. The MoHFW provided funding for the effort and technical support was provided through NHSRC.

In September 2014, massive floods hit the valley of Jammu & Kashmir, affecting about 10 million Recognizing the contribution of ASHAs in disaster response, the state of Jammu & Kashmir decided to train and certify ASHAs as first responder and to provide first aid in emergencies to the community till external help arrived. Training of trainers of state trainers was conducted by the resource team of DFY and ASHA training is underway. The state of Assam also started training of ASHAs in Disaster preparedness after the floods hit 16 districts of Assam affecting 12 lakh people in 2014. Since most of the North Eastern states are hilly states and are prone to land slides or floods, other NE states have also planned to begin this training for ASHAs.

ASHA training on Disaster Management in Uttarakhand

Ministry of Health & Family Welfare

Government of India, New Delhi