Update on
ASHA PROGRAMME

JULY 2016

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INTRODUCTION

This is the fourteenth issue of the biannual ASHA update, produced by the National Health Systems Resource Centre (NHSRC) for the National Health Mission (NHM) Ministry of Health and Family Welfare. This issue spans the period between January 2016 and June 2016.

Section 1 provides an update on the status of ASHA selection, training, and support structures in the two sub missions of the National Health Mission, i.e. the National Rural Health Mission (NRHM) and the National Urban Health Mission (NUHM). The data, as of June 30, 2016, is provided by the states. The status of ASHA selection in rural areas hovers around 90% in the High Focus and Non High Focus states, and nearly 99% in the North Eastern states. However, states such as Uttar Pradesh, West Bengal, Karnataka and Kerala, fall short of the target by over 15%.

In the case of selection of ASHA in urban areas, West Bengal and Uttar Pradesh are yet to select ASHA. ASHA selection is closely linked to mapping of vulnerable populations since ASHAs are intended only for slum and slum-like areas. This is a challenging task for states, particularly in areas where urbanization is growing and new slums, both notified and non-notified, are being added.

Regarding training there has been little progress since the last update. A hallmark of the ASHA programme is the emphasis and resource support for building ASHA skills through a well-structured and systematic training strategy with standardized material and methodology to ensure training quality at scale. The stagnation in training at the ASHA levels implies a lack of resources: both financial and human. Among high focus states, Odisha has made substantial progress since the last update, with over 50% of ASHA competing Round 4 training. Andhra Pradesh, Telangana and West Bengal have made substantial progress compared to other non-high focus states during this period. States such as Chhattisgarh, Tamil Nadu and Kerala follow a different pattern of training. The latter two states train ASHAs based on specific local contexts, and have substantially modified the training content followed in the rest of the states. The sluggish pace of training, as pointed out in earlier issues leads to attrition of knowledge and skills. It also has consequences for the state's readiness to register ASHAs for certification, since one of the pre-conditions for registration is completion of training upto Round 4 of Module 7.

The slow pace of ASHA selection and training in urban areas and the formation of Mahila Arogya Samities, is an area of concern. States such as Maharashtra, Karnataka and West Bengal are struggling with the legacy effect of community level workers created under multiple programmes in the past, notably the India Population Projects and the Reproductive and Child Health programmes. While the framework of implementation for the National Urban Health Mission visualizes a process where community selection of the ASHA is undertaken by a group that subsequently is consolidated into the MAS, this has not happened in most states.

In Section 2 we report on social security schemes for the ASHA. We highlight schemes from Chhattisgarh, which has by far the most comprehensive, well designed and effectively executed schemes, in recognition of the services provided by the Mitanin to the community. In this, as in so many other aspects of the ASHA programme, Chhattisgarh provides us with examples that can be replicated by other states. We also provide data on social security schemes implemented by Assam, Kerala and Jharkhand.

Creating career opportunities for the ASHA is another important avenue not just for recognition, but also to encourage a positive turnover and renewal of the ASHA from the programme and allowing newer selections to be made. In Section 3, we provide data from states on the range of opportunities being created for the ASHA. In the state of Haryana, the ASHA, with no assistance from the state, enrolled for ANM training courses. Several states also support ASHAs to enroll in equivalence programmes. One area of concern is that after completion of ANM or GNM training, states are yet to make adequate provisions to absorb these ASHA trained as ANMs at the sub centre level. This can be demotivating for other ASHAs who want to follow this path.

The National Urban Health Mission was approved on May 2013, with the main objective "to address the health concerns of the urban poor through facilitating equitable access to available health facilities. Community Processes with ASHA and Mahila Arogaya Samiti (MAS) are integral to NUHM, to enable coverage of quality health services for the vulnerable and marginalized. In Section 4 we present best practices related to ASHA and MAS from Odisha, Telengana, and Chhattisgarh.

In Section 5 we provide an update on ASHA incentives.

Readers may recall that in the January 2016, the introduction referred to the Report of the Task Force on Comprehensive Primary Health Care. The Task Force Report recommended that for the country to initiate the delivery of comprehensive primary health care services, a basic package of 12 services be provided at the sub centre level, through the services of a Mid Level Provider (an Ayurvedic practitioner or a Nurse, trained through a Bridge course and skilled in providing primary health care and public health services) who would lead the team of five ASHAs and two Auxiliary Nurse Midwives (or one ANM and one Male worker). The delivery of Comprehensive Primary Health Care from a transformed sub centre into a Health and Wellness Centre, is expected to, inter alia, enhance health prevention and promotion. The introduction of the package of services for non-communicable diseases was formally announced on June 22, 2016 through the launch of the Operational Guidelines for the Prevention, Screening and Control of Non-Communicable Diseases. The guidelines mark yet another milestone for the ASHA programme, in which the ASHA will increasingly begin to work as a member of the Primary Health Care team. The challenge exists in enabling the ASHA to remain embedded in the community through creating the competencies for health promotion and follow up and being able to negotiate better care and services for patients within the health system.

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Currently there is no change in the programme in terms of span across states, since the last update published in January 2016, as the programme is in place in 35 states and UTs. Out of the two latest entrants, Himachal Pradesh has completed its ASHA selection target under the National Rural Health Mission (NRHM) while UT of Puducherry is yet to begin the selection of ASHAs in the urban areas.

ASHA Selection - National Rural Health Mission (NRHM)

Presently a total of 873,759 ASHAs are in position in the country, against the target of 9,52,533 (91.7 % selected), under National Rural Health Mission (NRHM). This reflects that the target for ASHA selection has been revised by 5139 ASHAs since the last update published in January 2016. Of this increase, 3347 is accounted for by the high focus states alone - as Chhattisgarh and Madhya Pradesh have raised their target by about 1778 and 2194 respectively. However, Rajasthan has decreased its target by 635. Non-High Focus states have together increased the target by 1062, and North East States by 756 while Union Territories have increased it by 24 ASHAs.

The total number of ASHAs in position has also increased by 16,404. Of this increase, the addition of 6678 ASHAs comes from the eight high focus states, while another 9085 is from non-high focus states. North Eastern states have added 678 ASHAs to their total, and UTs have added nine ASHAs

Among the high focus states, Rajasthan has selected about 7902 new ASHAs (increased from 44178 to 52080), reducing the shortfall in selection by a significant 16%, and achieved about 96% selection against the new target of 54280 (reduced from 54915). Minimal additional selection has been undertaken in Bihar (increased from 85,387 to 85,555), and in Uttarakhand (increased from 9702 to 9785). Increase of about 1441 ASHAs is seen in Odisha (reduced from 43,154 to 44,595) and about 668 ASHAs in Madhya Pradesh (reduced from 58,333 to 59,001).

States also report that these increases result from selection of new ASHAs in place of drop-outs. In Uttar Pradesh, reports indicate that there are 3584 fewer ASHAs, on account of the state's decision to delink the role of ASHAs and ASHA facilitators in March 2016, (ASHA Facilitators were hitherto playing a dual role of ASHAs as well as ASHA Facilitators). When ASHA facilitators in UP were given the option of choosing between the role of ASHAs or ASHA Facilitators, majority of them chose to work as ASHA facilitators as it gave them an opportunity of career progression.

The marginal increase in the overall target in Non- High Focus states is on account of the additional target of 1064 ASHAs approved for Maharashtra (target increased from 61155 to 62219). In terms of selection nine states have reported selection of additional ASHAs. These include – Maharashtra with 4217 (increased from 54337 to 58554), Telangana with 1593 (increase from 23391 to 24984); Himachal Pradesh with 1213 (increase from 6447 to 7660), Tamil Nadu with 589 (increase from 6204 to 6793), Gujarat with 698 (increase from 35404 to 36102), Kerala with 524 (increase from 26002 to 26526), West Bengal with 451 (increase from 47204

to 47655), Jammu & Kashmir with 116 and Punjab with 108. On the other hand, drop out of 279 ASHAs in Haryana and 145 in Karnataka is noted.

State	Under NRHM					Under NUHM		
	Proposed ASHAs (Target)	ASHA selected/ Working	% of ASHA against target	Rural Population 2011 census	Current Density of ASHAs	Proposed ASHAs (Target)	ASHA selected/ working	% of ASHA against target
TABLE 1 A: STATUS OF ASHA SELECTION AND DENSITY IN HIGH FOCUS STATES								
Bihar	93687	85555	91.32	92341436	1/1079	391	312	80
Chhattisgarh*	70078	65713	93.77	19607961	1/298	3883	3701	95
Jharkhand	40964	39380	96.13	25055073	1/636	246	210	85
Madhya Pradesh	62851	59001	93.87	52557404	1/891	4200	3850	92
Odisha	45812	44595	97.34	34970562	1/784	1482	1413	95
Rajasthan	54280	52080	95.95	51500352	1/989	4679	3957	85
Uttar Pradesh	160185	136587	85.27	155317278	1/1137	6813	0	0
Uttarakhand	10048	9785	97.38	7036954	1/719	1038	1038	100
Total	**537905**	**492696**	**91.60**	**438387020**	**1/890**	**22732**	**14481**	**64**
TABLE 1 B: STATUS OF ASHA SELECTION AND DENSITY IN NORTH EAST STATES								
Arunachal Pradsh	3862	3862	100.00	1066358	1/276	42	40	95
Assam	30619	30619	100.00	26807034	1/876	1336	1336	100
Manipur	3928	3928	100.00	1736236	1/442	81	81	100
Meghalaya	6740	6460	95.85	2371439	1/367	167	167	100
Mizoram	1091	1091	100.00	525435	1/482	79	74	94
Nagaland	1887	1887	100.00	1407536	1/746	41	41	100
Sikkim	641	641	100.00	456999	1/713	35	25	71
Tripura	7367	7367	100.00	2712464	1/368	454	454	100
Total	**56135**	**55855**	**99.50**	**37083501**	**1/664**	**2235**	**2218**	**99**
TABLE1 C: STATUS OF ASHA SELECTION AND DENSITY IN NON HIGH FOCUS STATES								
Andhra Pradesh	39009	37994	97.40	34776389	1/915	2660	2502	94
Delhi*						5567	4911	88
Gujarat	38188	36102	94.54	34694609	1/961	4366	3561	82
Haryana	18000	16677	92.65	16509359	1/990	2676	1767	66
Himachal Pradesh	7750	7660	98.84	6176050	1/806	34	24	71
Jammu & Kashmir	12000	11837	98.64	9108060	1/769	238	193	81
Karnataka	39195	32533	83.00	37469335	1/1152	3474	1537	44
Kerala	30927	26526	85.77	17471135	1/659	4804	1927	40
Maharashtra	62219	58554	94.11	61556074	1/1051	10214	6084	60
Punjab	17360	17080	98.39	17344192	1/1015	2753	2348	85
Tamil Nadu **	6850	6793	99.17			1336	0	0
Telangana	25093	24984	99.57	21585313	1/864	2637	1142	43
West Bengal	61008	47655	78.11	62183113	1/1305	4530	0	0
Total	**357599**	**324395**	**90.71**	**318873629**	**1/983**	**45289**	**25996**	**57**

**Delhi has selected ASHA only in certain identified clusters, at the level of 1 for 2000 population*
*** ASHAs have been selected only in tribal areas.*

State	Under NRHM					Under NUHM		
	Proposed ASHAs (Target)	ASHA selected/ Working	% of ASHA against target	Rural Population 2011 census	Current Density of ASHAs	Proposed ASHAs (Target)	ASHA selected/ working	% of ASHA against target
TABLE 1 D: STATUS OF ASHA SELECTION AND DENSITY IN UNION TERRITORIES								
Andaman & Nicobar Island	412	407	98.79	237093	1/583	10	0	0
Dadra & Nagar Haveli	250	208	83.20	183114	1/880	50	46	92
Lakshadweep	110	110	100.00	14141	1/129			
Daman & Diu	98	73	74.49	60396	1/827	38	7	18
Chandigarh	24	15	62.50			26	21	81
Puducherry						341	0	0
Total	**894**	**813**	**90.94**	**494744**	**1/609**	**465**	**74**	**16**
Total All India	**952533**	**873759**	**91.73**	**794838894**	**1/910**	**70721**	**42769**	**60**

Among North Eastern States, against the target revision by 756 about 678 new ASHA selections have been reported. This is mainly on account of increase of target in Tripura by 527 and increase in selection figures by 602. Target has also been increased in Assam by 221 and in Manipur by 50. These two states also reported marginal increase in ASHA selection, Manipur selected 50 ASHAs while Meghalaya has selected 31 ASHAs. Arunachal Pradesh has reduced the target by 42 ASHAs (from 3904 to 3862).

Overall the drop-outs indicate that several states are actively identifying non-functional ASHAs. The criteria adopted by most states to assess non -functionality relates to their performance on the common tasks linked to incentives and monthly tasks linked with routine and recurrent incentive (ie. - Attendance at Immunization Day, Monthly PHC meeting and conducting a Village Health, Sanitation, and Nutrition Meeting).

Though, overall 91.7 % ASHAs are in position as against the target nationally, most of the major states have more than 90 to 95% ASHAs in place. Uttar Pradesh at 85%, Karnataka with 83%, Kerala with 86% and West Bengal with 78% continue to be the states where the target for ASHA selection is yet to be met.

As a group, High Focus states have 91.6% ASHAs in position. Non-High Focus States, also have 90.71% ASHAs in place against the target. In the eight northeast states (overall ASHA selection at 99.5%), all states have 100% ASHAs in place, except Meghalaya, which has raised its target (from 6519 to 6740) and has 96% ASHAs in place currently. In all states selection gaps are distributed across districts, but field reports show that these gaps continue to exist in difficult and remote areas, where there are a larger proportion of marginalized population and in geographically difficult terrain like forest, hilly or tribal areas.

Population Density – The national average of population being covered by each ASHA in rural areas has seen a slight decline and stands currently at 910, compared to 919 six months back. North East states, retain their position as the group with lowest average population coverage (at 664), while the group average in high focus states and non high focus states is at 890 and 983 respectively.

Presently there are only six states that have above 1000 average population being covered by each ASHA (Bihar and UP among high focus states and Karnataka, Maharashtra, Punjab and West Bengal among the non high focus states).

Among high focus states, Chhattisgarh has the lowest population coverage at 298. Average population coverage has decreased in states of Odisha and MP from 810 to 784 and from 901 to 891 respectively.

The average population covered remains the highest in West Bengal, at 1305, with Karnataka being the second at 1152. Maharashtra has seen a decline (dropping from 1133 to 1051) in average population coverage. The lowest average population coverage in Non-High Focus group remains in Kerala at 659.

Of the eight North Eastern states, Arunachal Pradesh remains state with lowest average population coverage in the country (at 276), Four other states in NE have below 500 average population (Manipur – 442, Meghalaya – 367, Mizoram – 482 & Tripura – 368).

The state average of population coverage by each ASHA masks substantial variations in population density at village level. States are increasingly beginning to maintain block, district-wise and state level database of ASHAs, their profiles, and their population coverage. Many states have also put in place software based database. States should review the average population coverage of ASHAs, especially in difficult and hard to reach areas and areas with vulnerable communities with the help of these database. Reaching the selection target at the national level would imply an average population coverage of 834 per ASHA.

ASHA in the National Urban Health Mission

Within the National Urban Health Mission (NUHM), a total of 42,769 ASHAs have been selected against the target of 70,721 (60% selected). The target has increased by 4903 ASHAs across all states from the target of 65,818 reported in January 2016. This is based on increase of target in ten states and UTs - Maharashtra (by 4370), Karnataka (by 562), Delhi (by 548), Odisha (by 425), Punjab (by 359), Assam (by 155), Rajasthan (by 124), Daman & Diu (by 38), Himachal Pradesh (by 34) and Jharkhand (by 32).

Downward revision in target for urban ASHAs is reported from West Bengal by 1576 (reduced from 6106 to 4530), Meghalaya by 78 (reduced from 245 to 167), Tripura by 73 (reduced from 527 to 454) and Chandigarh by 24 (reduced from 50 to 26). As mentioned above, 34 out of 35 states / UTs which have an ASHA programme in place, are also now implementing the ASHA programme under NUHM. Of these, UTs of Delhi, Puducherry and Chandigarh has implemented the ASHA programme only in urban areas.

Among the high focus states, UP has the highest number of ASHAs approved under NUHM (6813). However, until June 2016, the process of ASHA selection was underway but no formal selections had been undertaken. All other states, have completed about 80% of ASHA selections (Uttrakhand at 100%, Chhattisgarh and Odisha at 95%, Jharkhand and Rajasthan at 85%, and Bihar at 80%). Rajasthan selected the highest number of new urban ASHAs i.e, 915 followed by 356 in Odisha, 268 in Bihar and 135 in Jharkhand in last six months.

In the non-high focus states group, Maharashtra has the highest number of approved ASHA, i.e, 10,214 (increased from 5844) and has completed 60% selection. Kerala, Telangana, Karnataka and Maharashtra, have achieved 40%, 43%, 44% and 71% of their selection targets respectively. West Bengal is yet to initiate ASHA selection with a continuing stalemate on the conversion of existing Link Workers as ASHAs. Remaining states have selected over 80% of ASHAs against the target. Telangana has reported the highest number of drop out of 1495 ASHAs over last six months followed by 484 in Kerala and 102 in Haryana.

Among the NE states, Assam has the highest number of ASHA at 1336 (increased from 1181) and has achieved 100% selection by selecting new 175 ASHAs during this period. All other NE states have completed above 94% selections (except Sikkim, at 71%). Tripura reported a drop out of 69 ASHAs while selection of 74 ASHAs was noted in Mizoram and 11 ASHAs in Meghalaya and Nagaland.

Field assessment reports reflect that a mapping of vulnerable pockets and slums, is pending completion in many states. Unless this is done the ASHA target is expected to increase. In any event, given the growing urbanization and expansion of slum and slum like areas, the target for ASHA is likely to increase across all cities and towns.

In NUHM one ASHA is expected to cover a population of between 1000 to 2500[1] or between 200-500 households. The ASHA is expected to be selected in slum and slum like areas. It is as yet too early to compute average coverage figures in the NUHM, since the programme is yet to stabilize.

1 Guidelines for ASHA and Mahila Arogya Samiti in the Urban Context, Ministry of Health and Family Welfare, Government of India, 2014

Status of Training

State / UT	ASHAs selected /working	Round 1 of Module 6 & 7		Round 2 of Module 6 & 7		Round 3 of Module 6 & 7		Round 4 of Module 6 & 7	
		No.	%	No.	%	No.	%	No.	%
Table 2 A- High Focus States									
Bihar	**85555**	78336	91.56	67725	79.16	55818	65.24	7148	8.35
Chhattisgarh*	**65713**	66169	100.69	66169	100.69	66169	100.69	66169	100.69
Jharkhand	39380	37045	94.07	37271	94.64	37910	96.27	1203	3.05
Madhya Pradesh	**59001**	56457	95.69	55893	94.73	48701	82.54	9633	16.33
Odisha	**44595**	42485	95.27	42415	95.11	42597	95.52	22617	50.72
Rajasthan	**52080**	45187	86.76	37497	72.00	23263	44.67	12128	23.29
Uttar Pradesh	136587	89231	65.33	88575	64.85		0.00	0	0.00
Uttarakhand	9785	10313	105.40	10064	102.85	10209	104.33	6793	69.42
Total	**492696**	**425223**	86.31	**405609**	82.32	**284667**	57.78	**125691**	25.51
Table 2B: North East States									
Assam	30619	29560	96.54	29257	95.55	28886	94.34	12308	40.20
Arunachal Pradesh	3862	3669	95.00	3424	88.66	3424	88.66	2802	72.55
Manipur	3928	3804	96.84	3804	96.84	3804	96.84	3756	95.62
Meghalaya	6460	5891	91.19	5873	90.91	5814	90.00	4587	71.01
Mizoram	1091	987	90.47	987	90.47	987	90.47	987	90.47
Nagaland	1887	1398	74.09	1397	74.03	1624	86.06	1593	84.42
Sikkim	641	665	103.74	665	103.74	665	103.74	665	103.74
Tripura	7367	7257	98.51	7009	95.14	7280	98.82	7061	95.85
Total	**55855**	**53231**	95.30	**52416**	93.84	**52484**	**93.96**	**33759**	60.44
Table 2C: Non High Focus States									
Andhra Pradesh	37994	35905	94.50	32331	85.10	**21020**	55.32	11500	30.27
Gujarat	36102	34312	95.04	33685	93.31	33030	91.49	31758	87.97
Haryana	16677	16151	96.85	15618	93.65		0.00		0.00
Himachal Pradesh	7660	7312	95.46	6715	87.66	459	5.99	0	0.00
Jammu & Kashmir	11837	**11510**	97.24	**11453**	96.76		0.00		0.00
Karnataka	32533	30457	93.62	30547	93.90	30457	93.62	30457	93.62
Kerala	26526	26192	98.74	4400	16.59		0.00		0.00
Maharashtra	58554	56661	96.77	53262	90.96	38674	66.05	77	0.13
Punjab	**17080**	16243	95.10	16243	95.10	16416	96.11	16324	95.57
Tamil Nadu	6793	1953	28.75	1953	28.75	1953	28.75	1953	28.75
Telangana	24984	**24984**	100.00	**24096**	96.45	**12375**	**49.53**		0.00
West Bengal	47655	48576	101.93	47674	100.04	46301	97.16	32601	68.41
Total	**324395**	**310256**	95.64	**277977**	85.69	**200685**	**61.86**	**124670**	38.43
Table 2D: Union Territories									
Andaman & Nicobar	407	272	66.83	272	66.83		0.00		0.00
Dadra & Nagar Haveli	208	68	32.69	45	21.63		0.00		0.00
Lakshadweep	110		0.00		0.00		0.00		0.00
Daman & Diu	73	55	75.34	55	75.34		0.00		0.00

State / UT	ASHAs selected /working	Round 1 of Module 6 & 7		Round 2 of Module 6 & 7		Round 3 of Module 6 & 7		Round 4 of Module 6 & 7	
		No.	%	No.	%	No.	%	No.	%
Chandigarh	15		0.00		0.00		0.00		0.00
Total	**813**	**395**	48.59	**317**	38.99		**0.00**		0.00
	873759	789105	90.31	736319	84.27	537836	**61.55**	284120	32.52

Review of the training figures across states show mixed progress of training rounds of Module 6&7, which are the modules that focus on building competency for maternal, newborn, child health, women's reproductive health and infectious diseases. They are currently underway in several states.

There is little progress in training ASHA in Round 3 and Round 4 since last update. Overall 77194 ASHAs were trained in Round 3 and 76743 ASHAs in Round 4 over last six months, taking the percentage achievement to 62% and 33% respectively from the figures of 54% and 24% reported in January 2016. About 49,875 additional ASHAs have been trained in Round 2, and 29,019 additional ASHAs having been trained in Round 1, during this period of last six months.

The overall achievement in Round 1 presently stands at 90% against the number of ASHAs in position (as per the number of ASHAs currently, which has increased by 16450 during last six months). The achievement of Round 2 training stands at about 84%, Round 3 at 62% and Round 4 at 33%, in terms of overall national level progress.

The details of the progress figures show that the North-Eastern states, which were the first to start and complete the Module 6&7 training rounds, from the very beginning, have not made much progress in last six months. Training achievement of Rounds 1, 2 and 3, stands at 95, 94 and 94 % respectively, which is about the same as in January 2016. Stagnation in training of Round 4 is also noted at 60%. For Round 4, only Arunachal Pradesh (moving from 67% to 73%), and Meghalaya (moving from 65% to 71%), have made some progress. In Assam, no training progress has been reported over last six months.

The eight High Focus states, together, have made little progress on training and have showed only marginal improvement. Round 1 training has progressed from 84% to 86%, Round 2 from 78% to 82%, Round 3 from 53% to 58% and Round 4 from 20% to 26%. Odisha is the only state which has made substantial progress, completing 51% training in Round 4 (up from 22%). Rajasthan has covered 23% in Round 4 (up from 9%), but has not made major progress in Rounds 2 and 3. Uttarakhand also shows a major slack in training progress, despite having been the frontrunner state (having completed first three rounds very early), and has shown only made marginal progress in Round 4 training (moving up from 52% to 69%). Uttar Pradesh, a late starter, has moved up from 62 % to 65 % in Round 1 and from 55 % to 65 % in Round 2 while it is yet to commence training of ASHA in Rounds 3 and Rounds 4. Chhattisgarh, with a different training structure, reports having achieved 100% coverage in all four rounds, based on training content of the four rounds using state specific training modules. Madhya Pradesh, which had completed 95%, 85%, 58% and 12% respectively in Rounds 1 to 4, as on January 2016, has now completed 96%, 95%, 83% and 16% respectively. Jharkhand, which had completed more than 93% coverage in rounds 1, 2 and 3, by January 2016, has made hardly any progress in Round 4 training (stands at 3%, the same as it was six months back). In Bihar, training appears to be at a standstill with no progress being made in the last six months.

The Non-High Focus states, shows some progress in Round 4 training (moving up from 25% to 38%), and Round 3 (moving up from 47% to 62%). However there is little improvement in status of completion of training in Round 2 (moving up from 81% to 86%) and in Round 1 (moving up from 94% to 96%). The figures show that Andhra Pradesh, Telangana and West Bengal have made good progress compared to other states during this period. The state of Andhra Pradesh has completed 55% and 30% respectively in

Rounds 3 and 4 over last six months, against the figures of 11% and 0%. Similarly, Telangana has completed 49% training in Round 3 (had not started in January 2016), though it has still not started Round 4. West Bengal (which had completed Rounds 1 and 2 and had covered 91% in Round 3) has now completed training of 97% ASHAs in Round 3 and 68% in Round 4. Kerala, which plans to conduct only two rounds in Module 6&7 content, has now completed 99% in Round 1 and 17% in Round 2. States of J&K, and Haryana, have made no progress in Rounds 3 and 4 training. Himachal Pradesh, which had not even started the Module 6&7 training rounds in January 2016, has made substantial progress and has covered, 96%, 88% and 6% respectively in Rounds 1, 2 and 3. Karnataka, which had covered about 90% in all four rounds, by January 2016, has now achieved 94% in all four rounds. Training progress in the group of UTs reflects little progress.

Status of ASHA Support Structure in High Focus States

State	State Level	District Level	Block Level	Sector Level
Bihar	State AMG constituted in July 2011, only one meeting held in Feb 2011. ARC set up and registered, as a separate society accountable to State Health Society. Five members team of ARC and 9 out of 12 Divisional Coordinators currently in position. State trainers– Round 1 – 28, Round 2 – 22, Round 3 – 13.	13/38 District Community Mobilizers in place. District Trainers - Round 1 - 803, Round 2 - 532, Round 3 - 190.	273/534 Block Community Mobilizers in place.	4105/4470 ASHA Sahyogin is (ASHA Facilitator) in place, (1 per 20 ASHAs).
Chhattisgarh	AMG not established. ARC is working under SHRC with a team of 6 programme coordinators led by 1 team leader. State trainers – 46 and State Trainers for NUHM - 6	35 District Coordinators in place in 27 districts (2/district in some outreach districts). NUHM – 3/4 District Coordinators in place. District trainers - 3551	292/292 Block Mobilisers in place.	3150 /3220 Mitanin trainers (AFs) in place in rural areas. 202/2014 Mitanin trainers (AFs) in place in urban areas under NUHM (1 per 20 ASHAs).
Jharkhand	State AMG constituted in 2012 and reconstituted in 2013, 8 meetings held, last meeting held in Dec 2015. Community Mobilization Cell working within the SPMU with a team of two consultants. State trainers – Round 1 - 13, Round 2 - 13, Round 3 - 12.	21/ 24 District Programme Coordinators in place. District Trainers - Round 1 - 417, Round 2 - 474 and Round 3 - 185.	688/776 Block Trainers & DRPs in place.	2184 /2184 Sahiyaa Saathis (AF) in place (1 per 20 Sahiyas).
Madhya Pradesh	State AMG formed in Oct 2008, now merged with MGCA. Last meeting in Oct 2015. ARC team led by State Nodal officer with 4 team members. State trainers – Round 1 - 41, Round 2 - 39, Round 3 - 25.	44 /51 DCMs in place. MGCA formed & involved in ASHA training monitoring in all districts. District Trainers - Round 1 - 496, Round 2 - 300, Round 3 - 300.	243/313 BCMs in place. MGCA in place in 313 Blocks.	3846/ 3991 ASHA Sahyogini (AF) in place (1per 2 sub centres and 1 per 10 ASHAs in tribal areas).

State	State Level	District Level	Block Level	Sector Level
Odisha	State AMG constituted in 2009, total 4 meetings held, last in 2012. Community Processes Resource Centre (CPRC) in place with a team 4 consultants. State trainers– Round 1 - 26, Round 2 - 21. Round 3 - 11. Presently 16 are actively engaged.	29/30 DCMs in place District AMGs constituted. District Trainers - Round 1 - 287, Round 2 - 166, Round 3 - 166.	Existing Block PMU staff manages the programme.	1672/2290 Community Facilitators (AFs) in place. (1 per 20 ASHAs).
Rajasthan	State AMG constituted in June 2006, last meeting held in Sep 2011. Team of two consultants working in SPMU. State trainers – Round 1 - 20, Round 2 - 25, Round 3 - 23.	25/34 DCMs in place. District Trainers - Round 1 - 745, Round 2 - 587, Round 3 - 570	166/249 Block ASHA Coordinators in place.	1058 / 2088 PHC ASHA Supervisors in place (1 per PHC).
Uttar Pradesh	State AMG constituted in Aug 2008, last meeting held in March 2016. Community Processes Division led by a Nodal officer works within SPMU, with a team of 10 Consultants. State trainers – Round 1 - 61, Round 2 - 46.	71 / 75 District Community Process Managers in place. 72 Districts have District AMGs. District Trainers, Round 1 - 2622	759 / 820 Block Community Process Managers in place.	5489 / 6815 ASHA Sangini (AF) in place. (1 per 20 ASHAs).
Uttarakhand	AMG constituted in 2009, total 21 meetings held, last meeting in May 2015. State has one Nodal Officer in SPMU, and two regional coordinators. State trainers – Round 1 – 6, Round 2 - 5, Round 3 - 2.	District ARCs outsourced to NGOs. 13 / 13 DCMs in place. District Trainers - Round 1 - 165, Round 2 -156, Round 3- 75.	101 / 101 BCMs in place. NUHM – 6 BCMs in place.	600 / 606 AFs in place. 550 rural and 56 urban (1 per 15-20 ASHAs).

Status of ASHA support structure in North East States

State	State Level	District Level	Block Level	Sector Level
Arunachal Pradesh	State AMG constituted in Jan 2010, total meetings held – 9, last meeting held in Aug 2014. ARC – 3 members team within SPMU. State trainers– Round 1 – 3, Round 2 – 2. Round 3 - 3.	20 /20 DCMs in place District Trainers - Round 1 - 22, Round 2 – 28. Round 3 - 28.	84 /84 BCMs in place.	348/348 ASHA Facilitators in place (1 per 10-15 ASHAs).
Assam	State AMG constituted in 2010-11, total meetings held – 8. Last meeting held in Jan 2016. ARC housed in SPMU, with 1 Programme Manager - ASHA, and1 State Community. State trainers - Round 1 - 17, Round 2 - 12, Round 3 - 7.	27/27 DCMs in place District Trainers - Round 1 - 447, Round 2 – 447, Round 3- 437.	149/ 149 BCMs in place	2878/ 2878 ASHA Facilitators in place (1 per 10 ASHAs).

State	State Level	District Level	Block Level	Sector Level
Manipur	State AMG constituted in Dec 2008, total meetings held – 11, last meeting held in May 2014. ARC led by State cadre officer, housed within SPMU, has 1 ASHA Program Manager, and 1 DEO. State trainers - Round 1 - 3, Round 2 - 3. Round 3 - 3.	9/9 DCMs in place. District Trainers - Round 1 - 62, Round 2 - 62, Round 3 - 62.	Existing BPMU staff	194/194 ASHA Facilitators in place. (1 per 10 to 20 ASHAs).
Meghalaya	AMG formed in Oct 2009. Reconstituted recently, Last meeting held in Sep 2014. ARC in place, within SPMU with 2 programme managers. State trainers - Round 1 - 3, Round 2 - 3. Round 3 - 2.	11/11District Community Process Coordinators in place District Trainers - Round 1 - 70, Round 2 – 65, Round 3 - 65.	Existing BPMU staff	312/334 ASHA Facilitators in place (1 per 20 ASHAs).
Mizoram	State AMG constituted in April 2008, total meetings held – 9, last meeting held in Sep 2015. ARC team within SPMU, with a team of three consultants. State trainers - Round 1 - 3, Round 2 - 2. Round 3 - 4.	9 /9 District ASHA Coordinators in place. District Trainers - Round 1 - 18, Round 2 -18, Round 3-18.	Existing staff	109 /109 ASHA Facilitators in place. (1 per 10 ASHAs)
Nagaland	AMG formed in Nov 2009, 5 meetings held, last meeting Aug 2013. ARC housed under SPMU. State trainers - Round 1 - 1, Round 2 - 2. Round 3 - 2.	11/11 DCMs in place District Trainers - Round 1 - 63, Round 2 - 63, Round 3 - 63.	68/77 Block ASHA Coordinators in place.	Block ASHA Coordinators provide field level support to ASHAs.
Sikkim	State AMG constituted in 2010, total meetings held - 2, last meeting held in Nov 2014. One State ASHA Nodal Officer in place. State trainers - Round 1 - 2, Round 2 - 3. Round 3 - 3. Three trainers active now.	Existing DPMU staff District Trainers - Round 1 - 11, Round 2 – 11, Round 3 - 11.	Existing BPMU Staff	71/71 ASHA Facilitators in place, (1 per 10 ASHAs).
Tripura	State AMG constituted in May 2008, total meetings held - 8, last meeting held in Nov 2013. ARC constituted (1 state ASHA Programme Manager). State trainers - Round 1 - 2, Round 2 - 5. Round 3 - 4.	8/8 District ASHA Coordinators in place (4 DAC in original 4 districts and 4 Sub Divisional Coordinators acting as DACs in newly formed district). District Trainers - Round 1 - 65. Round 2 - 65. Round 3 - 65	8 /11 Sub-division level ASHA Coordinators in place.	398/ 400 ASHA Facilitators in place.

Status of ASHA support structure in Non-High Focus states

State	State Level	District Level	Block Level	Sector Level
Andhra Pradesh	AMG constituted in May 2015. Functions of ARC are managed by a team based in SPMU and Directorate. State trainers - Round 1 - 9, Round 2 –9 and Round 3 - 11.	13 /13 DCMs in place Project Officer, District Training Team (P.O.DTT) and District Public Health Nursing Officer (DPHNO) also support the programme. District Trainers – Round 1- 285, Round 2 - 285.	225/225 PHNs designated to support the programme at block level.	1410/1410 Health Supervisors at PHC designated to play the role of ASHA Facilitator.
Delhi	State AMG formed in July 2010, total meetings held 6, last meeting held in Jan 2015. ARC in place; with one State level, Nodal Officer, two State ASHA Coordinators, two Data Assistants and one Account Assistant. State trainers - Round 1 and Round 2 - 29, Round 3 - 59.	10/ 11 District ASHA Coordinators in place. District Mentoring Group also in place. District Trainers – Round 1- 255, Round 2 - 261.	113 ASHA Units (One unit per 50,000 population) in place. Each unit has Unit Mentoring Group composed of 4-5 members which includes MOIC, PHN, NGO Representatives and 5 ANMs. 1005/ 1123 ANMs designated to play the role of ASHA mentors.	
Gujarat	State AMG Constituted in Aug 2011, total meetings held – 5, last meeting in March 2015. ARC working under the office of Rural Health Department under Commissionerate of Health Office with 2 consultants. State trainers - Round 1 - 7, Round 2 - 7, Round 3 - 7.	Existing DPMU staff leads the programme with the support of Programme Assistants in place in all 33 districts. District AMG formed in 24 districts. District Trainers – Round 1, Round 2 -160, Round 3 -19.	Existing BPMU staff	3498/3751 ASHA Facilitators in place (1 per 10 ASHAs).
Haryana	AMG not constituted ARC in place within the SPMU with 10 member team. State trainers - Round 1 - 22, Round 2 - 18, Round 3 - 14.	21/ 21 District ASHA Coordinators in place. District Trainers – Round 1- 438	115/198 Block ASHA Coordinators in place.	Existing Staff
Himachal Pradesh	State has started ASHA programme in FY 2014-15. One ASHA Nodal Officer works within SPMU. State trainers - Round 1 - 23, Round 2 - 23.	Existing staff leads the programme with support of District ASHA Coordinating Assistants – in place in 11/12 districts.	Existing BPMU staff	Existing staff Female health worker.
Jammu & Kashmir	State AMG established in 2012-13. 1 ASHA Nodal Officer and 1 state ASHA Coordinator placed within SPMU. State trainers - Round 1 - 15, Round 2 – 12, Round 3 - 9	Existing staff. District Trainers - Round 1 – 225, Round 2 – 190.	Existing staff - Community Health Officer or ANMs / LHVs designated to support the programme at block level.	808 / 816 ANMs designated to play the role of ASHA Facilitators.

State	State Level	District Level	Block Level	Sector Level
Karnataka	State AMG constituted in Oct 2012. Last meeting held in June 2013. One ASHA Nodal Officer based in the Health Directorate. Deputy Director for ASHA Training based within SIHFW. State trainers - Round 1 - 15, Round 2 - 10, Round 3 - 8.	30 / 30 District ASHA Mentors in place. District Trainers- Round 1 - 240, Round 2 - 203.	176 / 176 Block Mobilisers in place. One District Trainer known as ASHA Mentor supervises ASHAs of two blocks.	1588 / 1960 ASHA Facilitators in place.
Kerala	State AMG constituted in 2008, total meetings held – 7, last meeting held Dec 2014. State ASHA Team with one Nodal Officer and consultant based within SPMU. State trainers – 6.	14 / 14 District ASHA Coordinators in place. District Trainers – 36.	Existing staff	Existing staff – Junior Public Health Nurse (JPHN)
Maharashtra	State AMG constituted in Oct 2007, total meetings held – 1, last meeting held in July, 2013. One Nodal Officer-ASHA and one consultant work as ARC team based within SPMU. State trainers Round 1 - 15, Round 2 - 13, Round 3 - 13.	30/34 DCMs in place. District AMG formed in all districts. District Trainers - Round 1 - 1476, Round 2 - 1404, Round 3 - 960.	331/355 BCMs in place. Block AMG formed in 70 tribal blocks and in 281 Non-tribal blocks.	2764 / 3562 ASHA Facilitators in place. (1 per 10 ASHAs in tribal and 1 per 20 in ASHAs non- Tribal districts).
Punjab	State AMG constituted in Oct 2014. One meeting held in Oct 2014. One consultant working in SPMU. State trainers-Round 1 - 5, Round 2 - 7, Round 3 - 6.	13 / 22 DCMs in place District Trainers Round 1 - 307, Round 2– 305, Round 3 - 302.	Existing Staff (Block Extension Educator working as BCM in many places).	865 / 898 ASHA Facilitators in place.
Tamil Nadu	State AMG not formed, but NGOs are involved in ASHA support. Institute of Public Health, Poonamallee is working as ARC.	Existing staff (DPMU and Deputy Director of Health Services and District and Maternal and Child Health Officers (DMCHO).	Existing staff- Community Health Nurse	Existing staff- Sector Health Nurse
Telangana	State AMG formed in May 15 but meetings have not been organized. ASHA Resource Team has 2 programme managers. State trainers – Round 1 - 4, Round 2 - 4	10 DCMs position approved – recruitment is yet to be done District Trainers – Round 1- 326. Round 2- 326.	Existing BPMU staff	702 /1387 Health Supervisors at PHC designated to play the role of ASHA Facilitator.
West Bengal	State AMG formed in Sep 2010, total 4 meetings held, last meeting held in Dec 2011. Programme managed by two consultants within SPMU. Training is managed by Child In Need Institute CINI. State trainers - Round 1 - 22, Round 2 - 18, Round 3 - 12.	18 /26 DCMs in place District Trainers – Round 1-1377, Round 2-1016, Round 3- 82.	209 / 666 BCMs in place (2 per block).	Health Supervisor at Gram Panchayat level designated to play the role of ASHA facilitators.

Status of ASHA support structure in UTs

Name of UT	State Level	District Level	Block Level	Sector Level
Andaman & Nicobar Island	Programme managed by SPMU	Existing staff	Existing staff	Existing staff
Chandigarh	UT has started ASHA programme in FY 2014-15. Nodal Officer – NRHM is incharge of ASHA programme and VHSNC	Existing staff	Existing staff	Existing staff
Dadra and Nagar Haveli	Programme managed by SPMU	Existing staff	Existing staff	Existing staff
Daman and Diu	Programme managed by SPMU	Existing staff	Existing staff	Existing staff
Lakshadweep	Medical officer is in-charge of Island is the nodal officer for the Programme	Existing staff	Existing staff	Existing staff

Support Structures

The model of support designed for the ASHA programme has been described in Guidelines for Community Processes and previous updates. Overall the status is similar to the data presented in January 2016 update. State ASHA mentoring groups have not been set up in most states, and in some states where they have been set up, they are hardly functional. The experience at the national level suggests that the inputs provided by the National ASHA Mentoring Group are extremely helpful. The collective experience of members of the National Mentoring Group enriches programme support and also expands ownership of the programme allowing debate and dialogue over critical programmatic aspects. States where the mentoring groups are active also experience this.

Currently all high focus states have support cadre in place at all four levels, except Odisha (where existing staff managed the programme at block level). Uttar Pradesh has during the last six months put in place, 759 Block Community Mobilisers in position (against the target of 820 - 93 % recruitment), and it now has the support cadre at all four levels. State has 71 DCMs in position against the target of 75 (95%), and 5489 ASHA Facilitators in position against the target of 6815 (81%).

Other six states already had a dedicated support cadre at all four levels. Bihar, though has the support cadre in place at all four levels, but most positions are vacant at district and block levels, with about 51% positions of BCMs and 66% positions of DCMs being vacant. The number of ASHA Facilitators has however increased marginally from 4091 to 4105, in last six months, against the present target of 4470 (92%).

In some states, the integration and coordination between support functions for NRHM programme activities and those within the NUHM has been streamlined during this period. In Madhya Pradesh, the ASHA programme team within the SPMU, has been managing the ASHA and VHSNC components under NRHM, has also been given the management of ASHA under NUHM, which was till now being looked after by a separate NUHM team working under Nodal Officer NUHM.

No new additions have been made to the support cadres in the eight North East States where support structures have been set up at three to four levels across most states except Sikkim (with two levels at state and sub block level).

Among Non High Focus States, four levels of support structures are in place in most states except in five Kerala, Gujarat, Himachal Pradesh, Punjab and Tamil Nadu. In contrast to the high focus states, where dedicated separate staff have been recruited to support the ASHA programme, most non-high focus states (barring Haryana and Maharashtra), it is either the existing health department cadres or contractual staff at two or more levels that support the programme level. Over the last few years these states that utilize

the existing cadres to manage the ASHA programme have put in efforts to designate the nodal officers at different levels and specify their roles and responsibilities with regards to the ASHA Programme. This was reported from states of Andhra Pradesh, Delhi, Gujarat, Jammu and Kashmir, Telangana and West Bengal

Certification **–** In last update we presented a comprehensive update on the progress made for ASHA Certification Process. During the period from January to July 2016, two Refresher training and Certification workshops were organized for state trainers from Arunachal Pradesh, Assam, Jharkhand, Karnataka, Punjab, Sikkim, Tripura, Uttrakhand and West Bengal. About 39 state trainers were accredited by National Institute of Open Schooling (NIOS) at the end of the workshop.

Section 2

SOCIAL SECURITY MECHANISMS FOR ASHAs

Over the last five years, several new incentives such as incentives for routine and recurring activities and follow up of SNCU discharged / LBW newborns have been introduced. The unit rate of a few incentives have been revised upwards, in order to increase the average monthly incentives to compensate for the time and effort of the ASHA. As an additional measure to support the ASHA and recognize her for the work she does, selected states have introduced social security schemes. Examples of social security schemes include medical and life insurance, educational support to children, pension and maternity leave,

In this section, we provide details and an update of the schemes that have been designed and implemented by states to specifically support the ASHA. About nine states support ASHAs through social security measures. Of these, four states i.e, Chhattisgarh, Jharkhand, Kerala and Assam have introduced new schemes designed specifically to cover ASHAs and ASHA facilitators. In remaining six states (Delhi, Gujarat, Madhya Pradesh, Odisha and Sikkim), states facilitate enrolment of ASHAs in the existing schemes such as NPS – Swamlamban yojana, Atal Pension yojana, Pradahan Mantri Jeevan Jyoti Bima Yojana or any state specific Chief Minister Rajya Bima Yojana.

1. Mukhyamantri Mitanin Kalyan Kosh - Chhattisgarh

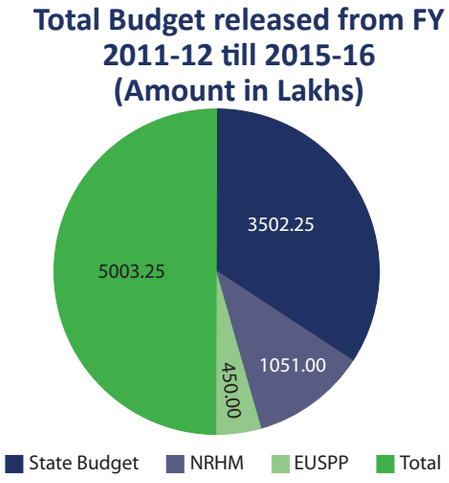
Chhattisgarh introduced the social security scheme known as "Mukhyamantri Mitanin Kalyan Kosh" (MMKK) in the year 2011. The scheme was designed based on inputs received from 500 Mitanins through meetings held in Bastar and Sarguja districts. Some of the benefits of the scheme such as the Maternity Benefit scheme have also been extended to Mitanin trainers and Block coordinators. In 2013, the scheme was revised and six additional benefits were introduced. MMKK comprises of several benefits, of which four benefits i.e, Swavlambhan Pension Yojana, Student scholarship, Life insurance, Livelihood Promotion and Skill development are delivered through the Life Insurance Corporation. The premium for Life insurance and student scholarship is Rs. 150 per person enrolled per annum.

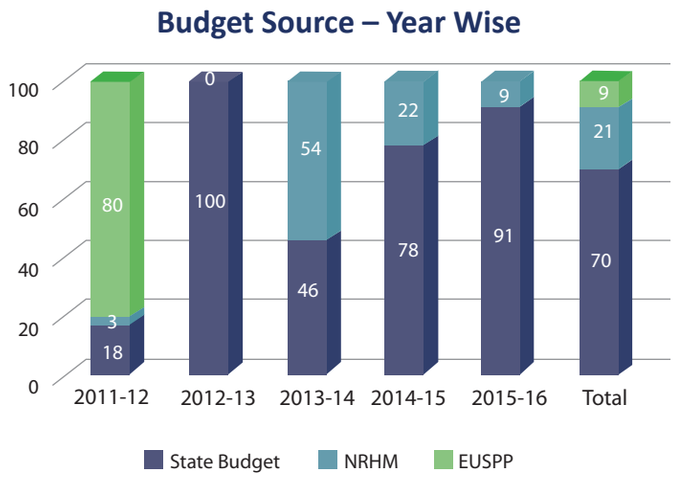
	Benefits		Expenditure				
			2011-12	**2012-13**	**2013-14**	**2014-15**	**2015-16**
1	Life insurance cover and scholarship for children by LIC (Premium of Rs. 150 per person enrolled)	Life insurance cover for husband of the Mitanin – Rs. 50,000. For the Mitanin who is single, insurance for herself.	92.08 L 61388 Mitanins covered	98.11 L 65404 Mitanins covered	104.25 L 69502 Mitanins covered	99.89 L 66594 Mitanins covered	96.97 L 64647 Mitanins covered
		Scholarship of Rs. 1200 per annum for children who are studying in 9th till 12th class.	154.66 L 12888 students	124.43 L 10369 students	71.78 L 5982 Students	117.6 L 9938 students	196.24 L 10183 students

	Benefits		Expenditure				
			2011-12	2012-13	2013-14	2014-15	2015-16
2	Health insurance	All Mitanins irrespective of BPL/ APL status have been covered under the Rashtriya Swasthya Bima Yojana (RSBY)					
3	Educational incentive	Cash incentive for Mitanin - Rs. 2000 for clearing Class 8th Rs. 5000 for clearing Class 10th Rs. 10,000 for clearing Class 12th Rs. 10,000 for completing Graduation and Post Graduation (2013)	–	100.43 L 1734 Mitanins covered	229.7 L 4433 Mitanins covered	224.71 L 3981 Mitanins covered	162.89 L 1619 Mitanins covered
4	Emergency Assistance	Financial assistance is provided to Mitanins in cases of emergency situations after approval from state.	1.534 L 24 cases handled	2.05 L 64 cases handled	0.591 L 275 cases handled	0.815 L 363 cases handled	1.314 L 254 cases handled
5	Free treatment	All Mitanins are eligible for free treatment at all Government Health facilities.					
6	Maternity Benefit	Mitanin trainers, Block Coordinators and Swasthya Panchayat Coordinators are eligible for this incentive since 2011 and Mitanins since 2013 - Six months leave starting from 9th month of pregnancy. Financial incentive of Rs. 15,000 for up to 2 children with a gap of 3 years between two children. Financial incentive of Rs. 10,000 in case the conditionality of 2 children and gap of three years in not fulfilled.		5.5 L 46 cases	128.54 L 1326 cases	192.54 L 3519 cases	341.13 L 3819 cases
7	Higher Education support for Mitanin's children	Financial assistance for Mitanins whose children secure over 75% marks in Class 10th or 12th – Rs. 25,000 for class 10th Rs. 50,000 for class 12th	–	–	–	210.0 L 210 Mitanins covered	189.0 L 189 Mitanins covered
8	Kanya Vivah	Financial assistance of Rs. 10,000 is provided for marriage of daughters of single (widowed or separated) Mitanins (2013).	–	–	0.1 L 1 case	5.3 L 53 cases	6.5 L 65 cases
9	Old age assistance	Mitanins who are currently of 55 years of age and have not been covered under Swavlambhan Yojana are provided financial assistance of Rs. 20,000 after completion of 60 years.	–	–	4.8 L 24 Mitanins covered	59 L 295 Mitanins covered	19.6 L 98 Mitanins covered
10	Support to families in case of death of Mitanin	Financial assistance of Rs. 20,000 to families in case of death of Mitanin who are not covered under Life insurance.	–	–	0.8 L 4 cases	18.4 L 92 cases	24.4 L 49 cases

	Benefits		Expenditure				
			2011-12	2012-13	2013-14	2014-15	2015-16
11	Swavlambhan Pension Yojana	Mitanins are enrolled in Swavlambhan Pension Yojana	440 L 44000 Mitanins Covered	598.89 L 59889 Mitanins Covered	593.08 L 59308 Mitanins Covered	593.08 L 59308 Mitanins Covered	540.13 L 54013 Mitanins Covered
12	Livelihood promotion and skill development	Mitanins are supported to enrol in livelihood promotion activities.	–	1.122 L 264	18.698 L 5841	6.789 L 1739	0

The total budget approved for MMKK since FY 2011-2012 till FY 2015-16 is around Rs. 5003.25 Lakhs against which Rs. 5043.81 Lakhs have been spent by the state. In the initial phase, the state received a contribution of Rs. 440 Lakh from the European Union for MMKK in addition to the funds received from the State budget and NHM. The EU funding was discontinued in 2011-12. The major source of the funding since then has been the state budget. In 2012-13, the entire cost was met through state funds. In 2014, partial support was provided through NHM i.e, - 46% in 2013-14 which reduced to 22% in 2014-15, and 9% in 2015-16. The funding under NHM has declined over the last four years and state budget is used to fill the gap. Overall the share of budget contribution from state, NHM and EUSPP in the cumulative budget of MMKK since 2011-12 till 2015-16 is around 70%, 21% and 9% respectively.





TOTAL BUDGET AND EXPENDITURE (AMOUNT IN LAKHS)					
Year	Budget Source	State	NHM	EUSPP	Total
2011-12	Budget	100	15	450	**565**
	Expenditure	100	5.94	457.97	**563.91**
2012-13	Budget	812.44	0	0	**812.44**
	Expenditure	809.72	8.89	0	**818.61**
2013-14	Budget	550	656	0	**1206**
	Expenditure	355.21	655.22	0	**1010.43**
2014-15	Budget	1000	280	0	**1280**
	Expenditure	1114.09	279.04	0	**1393.14**
2015-16	Budget	1039.81	100	0	**1139.81**
	Expenditure	1157.72	99.99	0	**1257.71**

TOTAL BUDGET AND EXPENDITURE (AMOUNT IN LAKHS)					
Year	Budget Source	State	NHM	EUSPP	Total
2016-17 (till 31.10.16)	Budget	0	100	0	**100**
	Expenditure	41.11	99.39	0	**140.5**
Total	**Budget**	**3502.25**	**1051**	**450**	**5003.25**
	Expenditure	**3536.75**	**1049.08**	**457.97**	**5043.81**

With the wide range of benefits available under Mukhyamantri Mitanin Kalyan Kosh, it has become a major source of motivation and social security measure for Mitanins.

2. ASHA Kiron – Assam

ASHA Kiron scheme was launched in the year 2010-11 in the state of Assam to provide life insurance and medical cover to ASHAs and ASHA Facilitators. The scheme is funded entirely by the state budget under the Assam Bikash Yojana (ABY). About Rs. 50 Lakhs are allocated per year for this scheme. The total budget allocation for ASHA Kiron since inception is around Rs. 2.5 Crore (since 2011-2016), against which 1.46 Crores have been spent and about Rs. 21.10 Lakhs are available with the account as on April 1st, 2016.

BENEFITS		EXPENDITURE				
		2011-12	**2012-13**	**2013-14**	**2014-15**	**2015-16**
Life Insurance	Compensation of Rs. 1,00,000/- given to the next of kin in case of natural or accidental death of ASHA and ASHA Facilitators.	1.27L 9 cases	11.01 74 cases	15.35 103	6.43 43	13.08 105
Medical Reimbursement	Medical expenses up to Rs. 25, 000/- per year are reimbursed in case of hospitalization (for 24hrs or more) in Government health facilities. Services covered are - Ectopic Pregnancy, Dysfunctional uterine bleeding / Menorrhagia, Fibroids Uterus, Endocytosis, Ovarian Tumour, Cervical Cancer, Breast Cancer, Prolapsed Uterus, TB (Pulmonary / Extra Pulmonary), Heart Disease (Cardiac Failure, Heart Stroke), Tonsillectomy, Surgery of Appendix, Surgery of Eye, nose, ear, throat; Kidney/ gall stones removal, fracture and injury both external & internal and any other medical procedure which is not provided free in Govt. hospitals.	17 L 17 cases	22 L 22 cases	32 L 32 cases	28 L 28 cases	13 L 13 cases

3. Sahiya Sahayta Nidhi – Jharkhand

The model adopted by the State of Jharkhand in providing social security to ASHAs is by creating a corpus fund at the state level @ Rs. 10 per Sahiya in the year 201-11. This was which was later increased to Rs. 50 per Sahiya in the year 2014-15. The scheme is entirely funded through the NHM. This fund is utilized to provide financial assistance to families of ASHAs in case of accident of ASHA while she is performing her tasks i.e, travelling to attend meeting, training or visiting health facility etc. Total budget approved under NHM for Corpus fund is around Rs. 53.16 L from 2010-11 till 2016-17.

BENEFITS		EXPENDITURE				
		2011-12	2012-13	2013-14	2014-15	2015-16
Accidental cover	◆ Financial assistance of up to Rs. 25,000 in case of accident ◆ Financial assistance of Rs. 50,000 in case of death or disability after accident	2.65 ◆ 8 accidental claims ◆ 1 death claim ◆ 2 disability claims	0.75 ◆ 1 accidental claim ◆ 1 disability claim	0.50 ◆ 1 death claim	1.00 ◆ 2 death claims	0.50 ◆ 1 death claim

4. ASHA Kiranam – Kerala

Accident insurance scheme was launched recently in Kerala in the year 2015. The scheme is funded through the state budget and provides personal accident Insurance to ASHAs for accidental death/injury. ASHA Kiranam has been rolled out through The United India Insurance Company Ltd. at the premium Rs. 80/ per ASHA per year. Total expenditure of the scheme in the first year is about Rs. 7.13 Lakh.

BENEFITS		EXPENDITURE
		2015-16
Personal Accident Insurance	Personal Accident Death - Rs.2 Lakh	4 Lakh - 2 cases
	Permanent Total Disability - Rs.2 Lakh	0.613 - 7 cases
	Permanent Partial Disability - Maximum up to the Full Sum Insured of Rs. 2 Lakh, depends on the % of Partial Disablement.	0
	Hospitalisation Due to Accident - Reimbursement of up to Rs.10,000	0
	Education Grant for Student in the event of ASHA's Death (up to two Children) - Rs. 2,000 (Each)	0.02 - 1 child supported
	Cremation Expense (Natural Death) - Rs.50,000	2.5 Lakh-5 cases

Section 3

CAREER PROGRESSION: CAREER OPPORTUNITIES FOR ASHAs CREATED BY STATES

In order to expand the career opportunities for ASHAs, various states have made provisions for giving weight age to ASHAs for enrolment of ASHAs in ANM / GNM schools. These include states of Chhattisgarh, Jharkhand, Madhya Pradesh, Uttarakhand, Jammu & Kashmir, Maharashtra, Arunachal Pradesh, Assam, Mizoram, Nagaland and Tripura.

About 2103 ASHAs have been enrolled in ANM and GNM courses across these states (except J&K, Mizoram, Nagaland and Tripura) and 34 in BSc nursing in Chhattisgarh. Of the total 2103 ASHAs, 1396 have completed their courses and 626 have been employed as ANM and Nurses in Government as well as private sector. In addition, about 431 ASHAs in Haryana have obtained admission in ANM/ GNM courses through their own efforts without any facilitation from the state, 229 of these have completed their courses and 52 have received employment.

About eleven of the remaining states i.e., Bihar, Odisha, Uttar Pradesh, Andhra Pradesh, Gujarat, Karnataka, Punjab, Telangana, Haryana, West Bengal and Meghalaya, are also in the process of finalizing the proposal of giving preference to ASHAs for admission in ANM/ GNM courses.

	Name of States	Measures taken for ASHAs creating career opportunities through ANM & GNM training courses	No. of ASHAs enrolled in ANM/ GNM courses - Total Cumulative	No. of ASHAs who have received employment on completion of course - Total Cumulative	No. of ASHAs elected as PRI / urban local body representatives - Total Cumulative	No of ASHAs enrolled in NIOS for Equivalency Programme
STATES WHERE SUPPORT IS PROVIDED TO ASHAs FOR CAREER PROGRESSION						
1	Arunachal Pradesh	Priority of ASHA for ANM Training schools.	7 (3 in 2015-16 & 4 in 2016-17)	Nil	25	—
2	Assam	10% reservation in ANM training course. The age relaxation for ASHAs to undergo.	92	92	78	—
3	Chhattisgarh	In 2009 12th Science pass Mitanins were encouraged to apply for BSc (Nursing) courses. In 2010, reservation 50% seats in private ANM schools for Mitanins In 2011, reservation of 40% seats in Govt. ANMTC for Mitanins.	1746 till now (1302 completed the course)	532	2404	
4	Jharkhand	Priority to Sahiya for ANM Training course.	32 Sahiya's enrolled in ANM/GNM courses.	Nil	335	—

	Name of States	Measures taken for ASHAs creating career opportunities through ANM & GNM training courses	No. of ASHAs enrolled in ANM/ GNM courses - Total Cumulative	No. of ASHAs who have received employment on completion of course - Total Cumulative	No. of ASHAs elected as PRI / urban local body representa-tives - Total Cumulative	No of ASHAs enrolled in NIOS for Equivalency Programme
5	Jammu & Kashmir	10th pass ASHAs to be nominated to ANM course & 12th pass with science for GNM courses.	—	—	—	—
6	Madhya Pradesh	10% reservation in ANMTC.	129	Process underway	110	815 for 10th and 789 for 12th will be enrolled
7	Maharashtra	Approval in August 2013 for ASHA's preferential admission in ANM / GNM courses.	97	02	855	—
8	Mizoram	10% weightage to ASHA who apply for admission in GNM/ANM courses.	Nil	Nil	05	—
9	Nagaland	10% reservation in ANM/GNM courses.	Nil	Nil	—	—
10	Tripura	Preference to ASHAs in selection of MPW (Female)/ ANM Training Course - minimum 10% seats subject to meeting the present educational qualification criteria and 5 (five) years experience as ASHAs.	Nil	Nil	112	—
11	Uttarakhand	15% seats reserved in ANM & GNM Training schools.	18	Nil	79	—
STATES WHERE PROPOSAL OF FACILITATING CAREER OPPORTUNITIES FOR ASHA IS UNDER CONSIDERATION						
1	Andhra Pradesh	10% reservation under consideration.	—	—	—	—
2	Bihar	Cabinet approval is awaited since two years for 10% reservation in ANM training course.	—	—	—	474
3	Gujarat	Reservation for ANM/GNM is under consideration.	—	—	—	—
4	Haryana	Under consideration	431(229 have completed training course) due their own efforts without any system of reservation)	52	71	—
5	Karnataka	Proposal to reserve 5-10% seats in GNM training course for ASHAs is under consideration.	—	—	—	—

	Name of States	Measures taken for ASHAs creating career opportunities through ANM & GNM training courses	No. of ASHAs enrolled in ANM/ GNM courses - Total Cumulative	No. of ASHAs who have received employment on completion of course - Total Cumulative	No. of ASHAs elected as PRI / urban local body representatives - Total Cumulative	No of ASHAs enrolled in NIOS for Equivalency Programme
6	Meghalaya	Under consideration	—	—	—	—
7	Odisha	10% reservation under consideration.	—	—	153	—
8	Punjab	Under consideration	—	—	21	—
9	Telangana	10% weightage to seats for eligible candidates under consideration.	—	—	—	—
10	Uttar Pradesh	Under consideration	—	—	—	Under considera-tion
11	West Bengal	Under consideration	—	—	—	—
	STATES WITH NO FORMAL PROVISION BUT SOME PROGRESS IS NOTED					
1	Delhi		—	—	—	348 ASHAs enrolled under NIOS
2	Manipur		—	—	21	—
3	Sikkim		—	—	17 ASHAs in 2011-12	—

States of Bihar, Chhattisgarh, Delhi, Jharkhand, Madhya Pradesh and Uttar Pradesh also support ASHAs for enrolment in education equivalency programmes to help them study further through National Institute for Open Schooling (NIOS). ASHAs also have successfully contested Panchayat elections, mainly at Gram Panchayat levels, but also in some cases at block and district levels. The states also preferentially supported them in selection in ICDS programme as Anganwadi worker and Para worker positions in educational programmes. As per reports from 13 state about 4286 ASHAs have been selected in Panchayat elections in the states of Arunachal Pradesh, Assam, Chhattisgarh, Jharkhand, Madhya Pradesh, Odisha, Uttarakhand, Haryana, Maharashtra, Manipur, Mizoram, Sikkim and Tripura.

About 1945 ASHAs have been selected as AWW in Jharkhand, Madhya Pradesh, Uttarakhand, Haryana, Maharashtra, Punjab, Assam and Mizoram; and 576 ASHAs in Maharashtra and 101 in Haryana were selected as Anganwadi Helpers; and 75 ASHAs were selected as Shiksha Mitras; and 29 ASHAs were selected as Family Planning and RKSK counsellors in Uttar Pradesh and Uttarakhand.

Since ASHA facilitators are selected from amongst the ASHAs themselves where the best performing ASHA with the aptitude for leadership and mentoring is selected as ASHA facilitator, being selected as an ASHA facilitator also provides an opportunity for career growth of ASHAs. In addition to this, eight ASHAs in Uttar Pradesh, six in Haryana and two in Maharashtra have been selected as Block Community Mobilizers.

Section 4

BEST PRACTICES UNDER NATIONAL URBAN HEALTH MISSION

In this section we present the best practices from states of Chhattisgarh, Odisha and Telangana with regards to Community Processes interventions under NUHM.

Convergent efforts for strengthening Mahila Arogya Samiti (MAS) through Mission for Elimination of Poverty in Municipal areas (MEPMA) in Telangana

Mission for Elimination of Poverty in Municipal Areas (MEPMA), the poverty elimination programme implemented by Government of Telanagana, aims at improving people's lives through multi-sectoral interventions, with community participation as its central strategy. MEPMA's vision aims at reducing poverty and vulnerability of the urban poor, with a focus on enabling people 'to build strong institutions for assertion of their rights and entitlements and attaining quality life in a sustainable manner'. MEPMA was registered in 2007 as a society under Department of Municipal Administration & Urban Development, and envisages convergence with National Urban Livelihood Mission (NULM), National Urban Health Mission (NUHM) and other relevant programmes.

MEPMA's convergent approach focusses on effecting a process of change at four levels, a) engaging community groups and seeking feedback – ensuring active people's participation b) empowering communities to choose the service basket and mechanisms – ensuring provision of comprehensive, and high quality primary healthcare services c) introducing community health risk fund for mitigating catastrophies – ensuring reduced OOPs, risk sharing and reduced catastrophic health expenses d) Improving Governance – by forming a small team of health department & government, with a representation from communities and other departments, and empowering it to monitor, sanction and reward.

When NUHM was launched, 10-15 members of existing slum level federations (SLFs), under MEPMA were grouped to form a MAS in a particular area. The SLF president and ASHA were made the joint signatories of the account. 3020 MAS are presently involved in supporting outreach health services, with MEPMA facilitation. MEPMA has mobilised 14.10 Lakh urban women into Self Help Groups (with a corpus and savings of Rs. 659 Crores), 4579 Slum Level Federations (SLF) and 104 Town Level Federations (TLFs), who are now involved in supporting the MASs under NUHM. Strengthening MASs and building their capacities is the key strategic focus of MEPMA's interface with health interventions.

The MEPMA programme uses the following approaches for strengthening of MAS - MAS trainings (Outreach and Prevention), strengthening of MAS monthly meeting records, data collection by MAS, Awards and recognition, Continuous monitoring by NUHM & other departments involved and Supervision and social audit. MAS members were trained to maintain 14 registers on various health aspects. The town level federations (TLFs) and ULBs played a key role of monitoring MAS meetings.

The programme has documented clearly identifiable health services impacts (based on third party evaluation), achieved through strengthening of MAS, in terms of; a) increase in regularity of MAS meetings (urban health centers with 100% MAS meetings rose from 48% in 2015-16 to 76% in 2016-17), b) better mobilization for Urban Health Nutrition Day (with average participation going up from 18 in 2015-16 to 42 in 2016-17), c) improvement in delivery of complete ANC services by UPHCs, and d) increased % of UPHCs achieving complete immunization. Toilet coverage also went up in the programme area from 15% to 36%.

Leveraging Community Processes in NUHM to improve access to health for urban slum population: Chhattisgarh

Slums constitute 32% of the 6 million urban population in Chhattisgarh and Primary healthcare facilities and outreach services were absent in them till 2012. The State Government of Chhattisgarh launched Urban Health Program in year 2012 with a focus on urban slum population. It was subsumed under the National Urban Health Mission (NUHM) from January 2014. Community Health Workers (CHWs) known as Mitanins were selected through community consensus. Community Health Committees known as Mahila Arogaya Samitis (MAS) were organised. Primary healthcare facilities were set-up. State Health Resource Center, an autonomous technical body fostered the roll-out. 3775 Mitanin (ASHA) CHWs were selected in slums of 19 towns and 3699 MAS were constituted, covering more than 2 million population in urban slums and vulnerable areas and adjoining households. Mitanins received 25 days of training over 3 years. ANMs were appointed for urban slums and urban PHCs were started.

Analysis of activities reported by Mitanins during 2015 showed that,

- Mitanins were able to mobilize 80% of expected deliveries to institutions with 76% of them being in government facilities.
- 82% of newborn received designated home visits from Mitanins and 16% referred to health facilities after Mitanin identified signs of sickness.
- 87% of pregnant women received more than three home visits from Mitanin.
- 63% of children under-3 years age received home visits on nutrition and prevention of infections
- 68400 cases of diarrhea given ORS.
- More than 120000 other patients treated by Mitanins using drug-kits.
- 155 TB suspects per 100000 population screened per quarter and referred for sputum examination per quarter resulting in 2140 confirmed cases.
- 2796 Leprosy suspects screened and referred resulting in 611 confirmed cases.
- Mitanins and MAS intervened in 4540 cases to oppose violence against women.
- Water testing using H2S kits by Mitanin.
- Mitanins identified around 3000 homeless population and tried to link them with health services. Assessment of homeless shelters was also carried out.

The MAS worked on Social Determinants of Health like drinking water, sanitation and monitoring the functioning of health and nutrition programmes, and a listing of the most vulnerable households in their areas. Community Monitoring by MAS included cause of death reporting. It helps in analyzing the likely causes due to which child deaths occur in urban slums. The analysis shows that nearly four-fifths of the under-5 deaths are of newborn amongst whom birth asphyxia is the most common condition followed by low-birth weight. Pneumonia is the main cause in post-neonatal deaths. Other major morbidities in urban slum population where community processes are playing an important role are TB, Leprosy and Sickle cell disease. In Bhilai town, an experiment was done to identify the existing cases of sickle cell disease (SS) and to link them with healthcare services. Mitanins listed 126 Sickle Cell disease (SS) cases and tried to link them

with healthcare services. This process will now be expanded to more cities and community demand for expansion of services in all districts is being expressed.

Expansion of Mitanin CHW and ANM network in urban slums improved access to Government health services dramatically. Having a Support structure for CHWs in form of ASHA facilitators and Area coordinators, timely training, provision of drug-kits, emphasis on home visits in CHW role, focus on social determinants of health in role of MAS were key facilitating inputs. Provision of ANMs and linkage with urban-PHCs were also important. NUHM can be valuable for bridging the gap in access to health for urban poor. Community processes and outreach through ANMs are crucial for urban-slums

Mahila Arogaya Samitis (MAS) in Odisha

The state of Odisha invested in setting up mechanisms for the constitution, capacity building, handholding and monitoring of MAS, to enable high levels of community engagement yielding positive dividends. Early findings indicate that these efforts have led to improved functionality of the MAS across the state. Against the target of 3132, the state has already constituted 2840 MAS. While the state has undertaken innovations in selection and training of MAS, in this narrative we focus on the practice of scoring and grading MAS on a set of indicators. The grading is done by the ASHAs who is trained for this purpose. The grading is undertaken on a quarterly basis. A set of ten indicators each with a weight of ten points has been developed. The MAS is ranked on each of these. Based on a cumulative score of 100, the MAS could be graded in one of three categories:

- Green – 80 and above
- Yellow – 50-79
- Red – Less than 50

List of ten indicators for MAS (10 marks each) -

1. Meetings held regularly each month
2. Universal Coverage with Ante-Natal Care
3. No home delivery conducted in the MAS operational area
4. All beneficiaries attend Urban Health and Nutrition Day
5. All children as per due list attend immunisation sessions
6. Regular cleanliness of slum
7. Additional resources mobilised from other sources
8. Utilisation of untied fund
9. Mobilise cases to outreach camp/MHU
10. No dengue/ diarrhoea case found in the MAS area

The institutionalizing of grading system has facilitated regular monitoring and feedback mechanism for MAS. Preliminary field findings/ reports reflect positive impact of intensive inputs provided to MAS, v.i.z - nearly 88% MAS conduct regular meetings and are actively engaged in various slum development activities and about 28% MAS have prepared slum resource map. MAS members have also undertaken community mobilization to raise awareness for Dengue, Diarrhoea, Hepatitis and conducted sanitation drives, in various cities. Positive trends are also seen with regard to immunization coverage during Mission Indradhanush, institutional delivery, UHND attendance and OPD attendance at UPHC. This can be correlated well with the mobilization and facilitation role played by MAS. The state is now considering awards for selected MAS from amongst those that fall in the green category.

The mandate of MAS defined as per state guidelines are -

- » Ensure 100% institutional delivery
- » Ensue 100% immunisation of the child
- » Family planning awareness to all Eligible Couple
- » Construction/use of toilet, ensure open defecation free and slum cleanness
- » Full attendance of beneficiary in UHND and immunisation session
- » Understand all schemes, programs and entitlement
- » Planning and proper utilisation of untied fund
- » Co-ordination with front line workers and line departments

UPDATED LIST OF 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**			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	Maternal Health- NRHM-RCH Flexi pool	
	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[2]	250	Child Health-NRHM-RCH Flexi pool	HBNC Guidelines –August 2011 and Revised HBNC Guidelines 2014
2.	For follow up visits to a child discharged from facility or community Severe Acute Malnutrition (SAM) management centre	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 newborns discharged after treatment from Specialized New born Care Units	50		Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV
4.	Child Death Review for reporting child death of children under 5 years of age	50		Operational Guidelines for Child Death Review 2014
5.	For mobilizing and ensuring every eligible child (1-19 years out-of-school and non-enrolled) is administered Albendazole.	100		Operational Guidelines for National Deworming Day
6.	ASHA incentive for prophylactic distribution of ORS	Re 1 per ORS packet		Operational Guidelines for Intensified Diarrhoea Control Fortnight - June 2015

2 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 up-to two years age (all vaccination received between 1st and second year of age after completing full immunization after one year	50	Routine Immunization Pool	
3.	Mobilizing children for OPV immunization under Pulse polio Programme	100/day[3]	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 – NRHM RCH Flexi Pool	Order No- D.O – N-11012/11/2012 – FP, May 31st, 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		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		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	150/case		- 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 Scheme – NRHM RCH Flexi pool	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	
3.	Incentive for support to Peer Educator (for facilitating selection process of peer educators)	100 per PE	RKSK - NRHM Flexi pool	Operational framework for Rashtriya Kishor Swasthya Karyakram - Jan 2014
4.	Incentive for mobilizing adolescents for Adolescent Health day	150 per AHD		
VI	REVISED NATIONAL TUBERCULOSIS CONTROL PROGRAMME[4]			
	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
1.	For Category I of TB patients (New cases of Tuberculosis)	1000 for 42 contacts over six or seven months of treatment		
2.	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		
3.	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		

3 Revised from Rs 75/day to Rs 100/day

4 Initially ASHAs were a 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
4.	For notification if suspect referred is diagnosed to be TB patient by MO/Lab[5]	100		Revised National Tuberculosis Control Program- national Guidelines for partnership 2014
VII	NATIONAL LEPROSY ERADICATION PROGRAMME[6]			
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)		
VIII	NATIONAL VECTOR BORNE DISEASE CONTROL PROGRAMME			
A)	**Malaria[7]**			
1.	Preparing blood slides	15/slide	NVBDCP 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		
B)	**Lymphatic Filariasis**			
1.	For one time line listing of lymphoedema and hydrocele cases in all areas of non-endemic and endemic districts	200	NVBDCP funds for control of Lymphatic Filariasis	Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV
2.	For annual Mass Drug Administration for cases of Lymphatic Filariasis[8]	200/day for maximum three days to cover 50 houses and 250 persons		
C)	**Acute Encephalitis Syndrome/Japanese Encephalitis**			
1.	Referral of AES/JE cases to the nearest CHC/DH/Medical College	300 per case	NVBDCP funds	Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV
D)	**Kala Azar elimination**			
1.	Involvement of ASHAs during the spray rounds (IRS) for sensitizing the community to accept indoor spraying[9] (New incentive)	100 per round during Indoor Residual Spray i.e. 200 in total for two rounds	NVBDCP funds	Minutes Mission Steering Group meeting- Feb- 2015

5 Provision for Rs100 notification incentive for all care providers including ASHA/Urban ASHA /AWW/ unqualified practitioners etc if suspect referred is diagnosed to be TB patient by MO/Lab.

6. 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 were Rs 500 incentive was given to ASHA before and has now been revised to-Rs 250 and Rs 600.

7. 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.

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

9 In order to ensure vector control, the role of the ASHA is to mobilize the family for IRS. She does not carry out the DDT spray. During the spray rounds her involvement would be for sensitizing the community to accept indoor spraying and cover 100% houses and help Kala Azar elimination. She may be incentivized of total Rs 200/- (Rs.100 for each round) for the two rounds of insecticide spray in the affected districts of Uttar Pradesh, Bihar, Jharkhand and West Bengal.

S. NO.	HEADS OF COMPENSATION	AMOUNT IN RS/ CASE	SOURCE OF FUND AND FUND LINKAGES	DOCUMENTED IN
E)	**National Iodine Deficiency Disorders Control Programme**			
	ASHA incentive for salt testing	25 per month for testing 50 salt samples	NIDDCP Funds	National Iodine Deficiency Disorders Control Programme - Oct, 2006
IX	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**	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		
3.	Attending monthly meeting at Block PHC/U-PHC	150		
4.	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		
X	MINISTRY OF DRINKING WATER AND SANITATION			
1.	Motivating Households to construct toilet and promote the use of toilets.	75 per household	Ministry of Drinking Water and Sanitation	Order No. Jt.D.O.No.W-11042/7/2007-CRSP-part Ministry of Drinking Water and Sanitation - 18th May, 2012
2.	Motivating Households to take individual tap connections	75 per household	Ministry of Drinking Water and Sanitation	Order No. -11042/31/2012 -Water II Ministry of Drinking Water and Sanitation – February 2013

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Ministry of Health & Family Welfare
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