NATIONAL RURAL HEALTH MISSION

राष्ट्रीय ग्रामीण स्वास्थ्य मिशन

Update on the Asha Programme

July 2012

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Asha Programme

JULY 2012

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Update on the ASHA Programme

Hope Personified

In countless villages, health care begins with ASHAs like Pankajani Behra. She strives to see that it does not end there.

Lean, tall, and with a quiet demeanour, 40 year old, Pankajani Behra looks like any other ordinary woman in the village of Bhanjachura, in Odisha's flood ravaged, coastal district of Balasore. But she's actually quite special. For very often this lady in blue - she is usually dressed immaculately in a sky blue sari, - is the only source of hope in times of illness or any other medical emergency for the people of Bhanjachura.

"She is like an angel for me. And why just me, for most of us here. I am here, alive and talking to you, only because of her. My baby is healthy today all thanks to her," says Tikki Donphat, a young mother.

Behra is an Accredited Social Health Activist (ASHA) of the government's flagship programme, the National Rural Health Mission (NRHM). Her official duties include spreading awareness about good health practices, immunisation campaigns, and assisting the Anganwadi Worker or Auxiliary Nurse Midwives in ensuring that a pregnant woman in the village, and later her child is well taken care of before and after delivery.

Behra's work, however is hardly restricted to any rule book. Says she, "For the village people, I am the most visible and first point of contact for any health related issue. So no matter what the ailment be it a headache, fever, or stomach flu besides pregnancy related issues, I get calls for help at all times"

Azera Parveen Rehman, Women's Feature Service

ASHAs are a central feature of the National Rural Health Mission's (NRHM) community process component. Despite the scepticism of the early years, influenced partly by the memory of the country's not very successful past Community Health Worker efforts, today the ASHA programme has 850,000 ASHAs across the country, and can confidently claim to have contributed in no small measure to the achievements of the NRHM. For every one Pankajani, there are countless other unsung ASHAs. Everyday, in hundreds of hamlets and villages across the country, they care for mothers, newborns and children within their communities.

ASHAs have moved from promoting institutional delivery and immunization to providing home based care and counselling for pregnant women, newborns and children. The portfolio of services that the ASHA offers also includes the promotion of products such as sanitary napkins and spacing contraceptives not as commercial commodities but as behaviour change delivery vehicles. Most states have established the institutional structures for ASHA training and support, but more needs to be done in strengthening these structures to perform effectively. The two key challenges that states face today are in enabling ASHAs to reach the most marginalized and to establish performance monitoring systems.

This issue is the sixth in the series of bi-annual ASHA updates, produced by the National Health Systems Resource Centre, (NHSRC) for the National

Rural Health Mission (NRHM) Division, Ministry of Health and Family Welfare (MOHFW). The objective of the ASHA update is to report on programmatic advancements, provide information on studies and evaluations, and other pertinent information related to the ASHA and Community Processes programme.

The report is divided into five sections. The first section carries a summary on a recent evaluation of the ASHA programme, carried out by the NHSRC, in the states of Uttar Pradesh, Uttarakhandand and Madhya Pradesh. In the second section we provide a status update on ASHA selection and training. This section also reports on the status of support structures in the states. Since its launch, the ASHA programme has generated much attention from parliamentarians, among other stakeholders. The third section is a compilation of parliamentary questions on the ASHA programme. Section four provides an updated list of ASHA incentives approved by NRHM's Mission Steering Group. In Section Five we report on the expenditures incurred on the ASHA programme upto March 2012. We hope that this report is of value to policy makers, programme officers, researchers and others interested in the ASHA programme.

Key Findings from Recent ASHA Evaluation in Madhya Pradesh, Uttar Pradesh and Uttrakhand

The evaluation of the ASHA Programme was commissioned by the National ASHA Mentoring group and coordinated by the NHSRC. The first round of the ASHA evaluation was conducted in eight states[1] and the findings were reported in the ASHA Update issue of July 2010. In this second round, the ASHA programme was evaluated in the three High Focus states of Madhya Pradesh (MP), UttarPradesh (UP) and Uttarakhand (UK). This section presents the highlights from the evaluation, conducted between November 2011 to March 2012. As in the first round, the Realist Evaluation methodology was used, and two districts were purposely selected in each state. One district was chosen for its good performance and the other for its high proportion of scheduled castes/ scheduled tribes. In Uttarakhand, Udhamsingh Nagar belonged to the category of well performing and Pauri Garhwal had a higher proportion of disadvantaged groups. In Madhya Pradesh, Raisen falls into the first category and Bhind in the second. Given the size of the state, four districts (Sonbhadra, Hamirpur, Aligarh and Lakhimpur) were selected in Uttar Pradesh. One additional factor that was considered in the district selection in UP, was the training of ASHA in a state specific module, the Comprehensive Child Survival Programme (CCSP) in 18 of 72 districts. Thus two of the four districts, (Aligarh and Lakhimpur) where CCSP training has been completed were selected based on the above mentioned criteria.

The evaluation used a mix of qualitative and quantitative methods in its three phases viz., *Phase 1* – In depth interviews with key stakeholders. *Phase 2* – structured questionnaire to interview ASHAs, beneficiaries or service users, Service user A – Women who delivered in last six months and received services from ASHA and Service User B - Mothers of children 6 months – two years who had an episode of illness in the last month and received services from the ASHA, Anganwadi workers, Panchayati Raj elected members and ANMs.

Key Findings

Institutional arrangements across the three states have significant variations, as reflected in the nature of support systems established, programme management, and influence on ASHA functionality and effectiveness. Uttarakhand was among the first high focus states to set up an ASHA Resource Centre at the state level which was outsourced to an NGO, the Himalayan Institute Hospital Trust (HIHT) in the year 2008. The same pattern was replicated at the district level as well, with the state opting to outsource the District ASHA Resource Centres (DARC) to the Mother NGOs working in districts. The NGOs are expected to ensure the training and provide the field support to the ASHAs through recruiting district and block mobilizers. This facilitated rapid roll out of ASHA training, with the result that Uttarakhand was the first high focus state, (after Chhattisgarh) to complete training in all the modules. However the day-to-day hand holding of the ASHAs, support and mentoring need substantial strengthening. The DARC receive funding from the district health society and technical support from the State ASHA Resource Center. The latter is understaffed, and the technical support role has been compromised. The coordination with the District and State Health Societies also appears to be weak, further undermining the state's pioneering efforts in the ASHA programme which showed such promise in the early years.

In the state of Madhya Pradesh, where the programme was dormant until July 2010, rapid strides have been made in scaling up the training systems, both

[1]*Andhra Pradesh, Assam, Bihar, Jharkhand, Kerala, Odisha, Rajasthan and West Bengal*

training institutions and trainers, given a determined Mission Director and a dynamic state nodal team of a few committed officers. All this took place in the last 15 months. This has resulted in galvanizing the ASHA training in Modules 5, 6 and 7 which has begun earlier this year. However the state still does not have a full complement of staff needed at the state level for the ASHA programme, nor district and sub district support structures. The state is planning to set up the support structures in this fiscal year.

In Uttar Pradesh, the state has appointed one General Manager, Community Processes, who manages the nearly 1,36,000 strong ASHA programme. He also holds additional charge of Training and Child Health for the state. He is supported by a team of three consultants from NHSRC. This is an interim arrangement, since the state has not been able to set up a dedicated state ASHA Resource Center. The state has appointed District Community Mobilisers in 62 out of 72 districts and at the block level the existing Block Extension Educator (BEE) is expected to support the programme. However the orientation of these personnel to the ASHA programme and training in supportive supervision and mentoring is weak, since no specific capacity building workshops have been organized as yet. They have not been trained in the ASHA modules either. Given these institutional constraints, the overall implementation of the programme including training of ASHAs has progressed slowly in the state. The state has adapted the national training modules 1-5 to the state's context. In 2010, the state embarked on training ASHA in state specific module on Child Survival Support Programme (CCSP) focused on improving her awareness on newborn and child health, which is being rolled out in the state. To date, ASHAs in 18 districts have been trained. The state has also recently adapted the national Modules 6 and 7 to build skills of the ASHA. The state is in the process of creating the training systems for scaling up the training.

The section below summarizes the data from the quantitative survey, which included ASHAs and the beneficiaries. The data demonstrate clearly the influence of programme and support structures on the effectiveness and functionality of the ASHA. In all states the two functions of promoting mothers for institutional delivery and mobilizing for immunization appear to be the most common. In Uttarakhand where the training was rolled out and the support structures instituted early on, outcomes appear to be better. However geographic dispersion in hilly districts coupled with poor outreach services limit the functionality of the ASHA. A further compounding factor may be that performance monitoring systems are not in place despite the training and support.

Low coverage figures in Uttar Pradesh and Madhya Pradesh indicate that there may be significant exclusion. The slow pace of implementation particularly in training has limited the functionality and effectiveness of the ASHA in both states.

Profile of the ASHAs

Most of the ASHAs in all districts are educated up to class VIII and above; and reported family income between Rs.1000-5000 per month. In terms of representation of SC/ ST communities in selection of ASHAs, the selection was found to be equitable in all sample districts except District Sonbhadra of UP. However the representation of minorities was found to be significantly lower than the proportion of minority populations in all districts. The population coverage of ASHAs varied across and within states. However, majority of the ASHAs in five of the sample districts reported covering between 501-1000 population. The density was reported to be higher in the three districts of UP – Hamirpur, Sonbhadra and Aligarh where ASHAs reported covering between 1001-2000 population.

Functionality and Effectiveness of the ASHAs

The majority of the ASHAs reported being functional on promoting institutional deliveries and Immunization. About 82-95% ASHAs across the three states reported accompanying women at the time of delivery, 72-82% reported providing

counselling to pregnant women and 87-92% said that they promoted and coordinated the immunization days. Regarding household visits 68% of ASHAs in UP, 53% in Bhind District of MP and fewer than 40% in UK and Raisen district of MP, reported making such visits. Newborn visits were reported by 81% ASHAs in Aligarh, 52-62% in Bhind, Udhamsingh Nagar and the three remaining districts of UP as compared to only 37% in Raisen and Paurigarhwal. The lower reporting of home visits in Pauri despite the training could be due to geographic dispersion and weak support and mentoring.

In terms of coverage, as reported by Service Users A, access to ASHA services was highest in Pauri Garhwal and Hamirpur with 88%. In the remaining districts this was 65-75% except for Raisen district where coverage was reported to be lowest with 44%. The functionality of ASHAs in terms of promoting institutional delivery and counselling during ANC was 70% in UK as compared to 56% in UP and 48% in MP. But only 56% of Service Users A in UP, 44% In MP and 29% in UK reported getting three or more ANCs, which reflects the poor outreach services. A high proportion of Service Users A reported delivered in institutions, - 89% in MP, 79% in UP and 70% in UK, over 70% cited ASHAs as the main motivator, and more than three quarters reported that ASHAs accompanied them to the institution.

For early initiation of breast feeding the functionality was between 65-70% but the effectiveness was even higher as 80% of the service users reported that they started the breast feeding within three hours of birth. For post partum care however, ASHA functionality on knowledge of an important message such as foul smelling discharge as a sign of post partum complication drops considerably, with about 32 % ASHAs in UK, and less than 20% in UP and MP.

Home visits by ASHAs for post natal and newborn care were reported to be highest in UK; where 61% Service User (As) reported that ASHA had visited them more than three times during the first one month of the delivery. The respective figure was much lower with 40% in UP and 32% in MP.

Coverage by ASHAs in case of a sick child was highest in UK with 41% followed by 32% in UP and 17% in MP. The functionality of ASHAs i.e. Service User (Bs) who reported that ASHAs helped them in managing the child hood illness was between 78-93% across

Table 1A : Pregnancy and Newborn care

	1	2	3	4	5	6	7	8	9
	Access to ASHA services of potential Service user A	% of service users A who were visited at least thrice by ASHA during antenatal period	% of service users A who received three ANCs or more	% of service users A who went for institutional delivery	% of Service User A who went for institutional delivery and cited ASHA as a motivator	% of service users who were counseled on post partum care	% of ASHAs who knew about Foul smelling discharge as danger sign to look for.	% of service user A reporting they received advice from ASHA for early initiation of breast feeding	Of User A who were breastfed within three hours of birth
MP	54.5	48.4	44.3	88.8	75.7	18	17.4	65.1	90
UK	79.2	70.3	56.2	70.3	68.2	26.3	32	64.9	80
UP	72.7	55.6	28.8	78.8	84.2	23	16.8	70.9	79.7

Table IB : Common Childhood Illness and Management								
	1	2	3	4	5	6	7	8
	% of all mothers with a child between 6.1 months to 2 yrs of age with an illness in last one month and received services from ASHA	% of user Bs who had diarrhea and whom ASHA helped in some way	% of user Bs with signs of ARI and whom ASHA helped in some way	% of user Bs who had diarrhea and to whom ASHA gave ORS from her kit	% of User B with diarrhea and who overall got ORS	% user Bs with ARI who sought treatment	% of ASHA had knowledge of making ORS	% of ASHA s who could specify chest wall indrawing as a danger sign to suspect pneumonia
MP	16.5	78.4	85.2	46.7	63.3	98.1	46.7	53.3
UK	41.2	89.7	93	56.4	71.8	98.2	53.5	64.5
UP	31.7	81.6	89.8	49.4	78.8	97.1	35.3	38.6

states, while it was highest in UK with over 90%. However this is not translated in to high levels of effectiveness as ASHAs were able to give ORS to in only 46-56% of cases. This reflects problems with supply and replenishment. In cases where she was not able to supply ORS directly she was referring the child for treatment, even then about 22% to 37% children who had diarrhoea did not get ORS from any source. In case of ARI about 98% of the Service Users B sought treatment reflecting high referral rates of ASHAs. The knowledge of ASHAs about identifying chest indrawing as a danger sign for ARI and about making ORS was found to be low in UP and MP, and about 54% and 65% in Pauri Garhwal and UdhamSingh Nagar respectively in UK.

ASHAs in all three states are more functional and effective on tasks related to promotion of institutional delivery and immunization which are also the most commonly incentivised tasks for ASHAs. The effectiveness of ASHAs in other areas such as ensuring three or more ANCs, providing appropriate advice in case maternal and newborn complication and community mobilization was found to be low in UP and MP. Skills levels of ASHAs for identifying danger signs of pregnancy and sick child were found relatively better in UK where ASHAs have completed training in two rounds of Module 6 and 7. But even here the high levels of day to day mentoring could have yielded better outcomes, particularly with regard to home visits.

Clearly, in Madhya Pradesh and Uttar Pradesh there is a great urgency to rapidly establish and strengthen support structures and step up the pace of the programme. In Uttrakhand the priority is for the state to take ownership of the programme and work closely with the NGO support structures to make them more effective, by enabling quality standards of skill based training and effective performance monitoring. All three states also need to institutionalize a system of monitoring the functionality and outcomes of the ASHA programme. This is even more important in UP and MP, in order to identify and support poorly performing ASHAs, where the selection of ASHAs in the early phases was not community led and was influenced by vested interests. All three states, and more particularly MP and UP stand to benefit greatly from having a skilled ASHA at the community level to promote maternal, newborn and child health, and family planning.

Progress of the ASHA program

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

1. Selection and recruitment
2. Status of training
3. Support structures

The matrix also provides information on modes of payment to the ASHA, and drug kits. We have used the data reported by the states for the ASHA Matrix, for the period of June 2012.

SECTION 2.1 SELECTION AND RECRUITMENT

In the first phase of NRHM about 95% of the selection target has been achieved for the entire country. In most high focus states except Rajasthan and to a certain extent in Madhya Pradesh, the required number of ASHA as per the 2001 population, are already in place. In the North Eastern (NE) states, 99% of the ASHA have been selected. In the non-high focus states, Delhi, Karnataka, West Bengal, Tamil Nadu and Gujarat are in the process of selecting additional ASHAs to meet the target.

However, when the population data from Census 2011 is considered, it appears that states need to recruit ASHAs to retain the requisite population coverage of 1000 per ASHA (Tables1E-1H). This holds true for majority of the states except Kerala, Nagaland and Sikkim where the rural population has actually decreased in comparison to 2001 population. The deficit varies considerably amongst the states, being largest for states like Bihar, Uttar Pradesh, Rajasthan and Madhya Pradesh.

TABLE 2.1A : STATUS OF ASHA SELECTION IN HIGH FOCUS STATES (JUNE, 2012)

State	Proposed No. of ASHAs	No. of ASHAs Selected	% OF ASHA Selected
Bihar	87135	83872	96.26
Chhattisgarh	60092	60092	100.00
Jharkhand	40964	40964	100.00
Madhya Pradesh	56941	52481	92.17
Odisha	43530	43373	99.6
Rajasthan	54915	51265	93.35
Uttar Pradesh	136174	136094	99.94
Uttarakhand	11086	11086	100.00
Total	490837	479227	97.63

TABLE 2.1B : STATUS OF ASHA SELECTION IN NORTH EAST STATES (JUNE, 2012)

State	Proposed No. of ASHAs	No. of ASHAs Selected	% OF ASHA Selected
Arunachal Pradesh	3862	3757	97.28
Assam	29693	29172	98.4
Manipur	3878	3878	100.00
Meghalaya	6258	6258	100.00
Mizoram	987	987	100.00
Nagaland	1700	1700	100.00
Sikkim	666	666	100.00
Tripura	7367	7367	100.00
Total	**54411**	**53785**	**98.85**

TABLE 2.1C : STATUS OF ASHA SELECTION IN NON HIGH FOCUS STATES (JUNE, 2012)

State	Proposed No. of ASHAs	No. of ASHAs Selected	% OF ASHA Selected
Andhra Pradesh	70700	70700	100
Delhi	5450	4498	83.30
Gujarat	33589	30159	89.79
Haryana	14000	13755	98.25
Jammu and Kashmir	10000	9904	99.04
Karnataka	39195	33750	86.11
Kerala	32854	31868	97.00
Maharashtra	59406	59316	99.85
Punjab	17360	16800	96.77
Tamil Nadu	6850	3905	57.01
West Bengal	61008	46818	76.74
Total	**350412**	**321473**	**91.75**

TABLE 2.1D : STATUS OF ASHA SELECTION IN UNION TERRITORIES (JUNE, 2012)

Union Territory	Proposed No. of ASHAs	No. of ASHAs Selected	% OF ASHA Selected
Andaman and Nicobar Islands	407	407	100%
Dadra & Nagar Haveli	250	208	83.20
Lakshadweep	85	83	97.65
Daman & Diu*	119	92	77.31
Total	**861**	**790**	**91.75**

*Daman and Diu has recently started ASHA program, while Union Territory Chandigarh has withdrawn its ASHA programme.

Grand Total for All States and Union Territories

Total	**896521**	**855275**	**95.4**

TABLE 2.1E : DENSITY OF ASHA IN HIGH FOCUS STATES

Name of the State	Proposed Number as per 2001 Population	ASHAs selected so far	Rural Population as per 2011 census	Proposed Density As per 2001 Population	Proposed Density As per 2011 Population
Bihar	87135	83872	9,20,75,028	1/853	1/1057
Chhattisgarh	60092	60092	19603658	1/277	1/326
Jharkhand	40964	40964	2,50,36,946	1/511	1/611
Madhya Pradesh	56941	52481	5,25,37,899	1/852	1/923
Odisha	43530	43373	3,49,51,234	1/718	1/803
Rajasthan	54915	51265	5,15,40,236	1/788	1/939
Uttar Pradesh	136174	136094	15,51,11,022	1/966	1/1139
Uttarakhand	11086	11086	70,25,583	1/569	1/634

TABLE 2.1F : DENSITY OF ASHA IN NORTH EAST STATES:

Name of the State	Proposed Number as per 2001 Population	ASHAs selected so far	Rural Population as per 2011 census	Proposed Density As per 2001 Population	Proposed Density As per 2011 Population
Assam	29693	29172	2,67,80,516	1/782	1/902
Arunachal Pradesh	3862	3757	10,69,165	1/225	1/277
Manipur	3878	3878	18,99,624	1/410	1/490
Meghalaya	6258	6258	23,68,971	1/298	1/379
Mizoram	987	987	5,29,037	1/453	1/536
Nagaland	1700	1700	14,06,861	1/969	1/828
Sikkim	666	666	4,55,962	1/722	1/685
Tripura	7367	7367	27,10,051	1/360	1/368

TABLE 2.1G : DENSITY OF ASHA IN NON HIGH FOCUS STATES

Name of the State	Proposed Number as per 2001 Population	ASHAs selected so far	Rural Population as per 2011 census	Proposed Density As per 2001 Population	Proposed Density As per 2011 Population
Andhra Pradesh	70700	70700	5,63,11,788	1/784	1/796
Delhi*	5450	4498			
Gujarat	33589	30159	3,46,70,817	1/945	1/1032
Haryana	14000	13755	1,65,31,493	1/1068	1/1181
Jammu and Kashmir	10000	9904	91,34,820	1/763	1/913
Karnataka	39195	33750	3,75,52,529	1/890	1/958
Kerala	32854	31868	1,74,55,506	1/718	1/531
Maharashtra	59406	59316	6,15,45,441	1/939	1/1036
Punjab	17360	16800	1,73,16,800	1/927	1/998
Tamil Nadu*	6850	3905			
West Bengal	61008	46818	6,22,13,676	1/947	1/1020

*Delhi has selected 1ASHA per2000 population in certain identified clusters

** ASHAs have been selected only in the tribal areas

TABLE 2.1H : DENSITY OF ASHA IN UNION TERRITORIES:

Name of the State	Proposed Number as per 2001 Population	ASHAs selected so far	Rural Population as per 2011 census	Proposed Density As per 2001 Population	Proposed Density As per 2011 Population
Andaman and Nicobar Island	407	407	244411	1/590	1/601
Dadra and Nagar Haveli	250	208	183024	1/680	1/732
Lakshadweep	85	83	14121	1/396	1/166
Daman & Diu	119	92	60331		1/507

SECTION 2.2: TRAINING OF ASHA

More than 80% of ASHAs in most high focus states and nearly all in the North East states have been trained upto Module 5. Although training of Module 5 in Madhya Pradesh started much later than rest of the High Focus states, about 80% of the ASHAs have been trained in Module 5. About 67% ASHAs have been trained in Module 5 in Rajasthan. To expedite the process of completing Module 5 training in Bihar contents of Module 5 have been merged with Module 6 and 7, and the length of the training has been increased from 20 days to 24 days, to be conducted in four rounds of six days each. Except for Karnataka where Module 5 training is complete, it is still underway in all non high focus states.

Training in Modules 6 and 7 which enables competency based training in maternal, newborn and child health and nutrition has been initiated in all states, except in Kerala and Tamil Nadu, where the states will develop state specific skill training modules for ASHA.

Training of State trainers in Round I and Round II for Modules 6 and 7 is complete in almost all states. All states have completed Round I TOT for ASHA Trainers except Uttar Pradesh. A total of 388 state trainers have been trained at the three national training sites and of this about 288 state trainers were accredited for Round 1 and 202 for Round 2. 4893 ASHA trainers, who train the ASHAs at sub district levels, have been trained across the states.

Round I ASHA Training is underway in all the high focus states, except Uttar Pradesh. Uttarakhand has completed training of ASHAs in three rounds. The state of Uttar Pradesh has opted to launch training of ASHAs in an adapted version of Module 6 and 7 to avoid duplication of the content covered in Comprehensive Child Survival Programme (CCSP) training. All North Eastern states except Assam have completed two rounds of Module 6 and 7 training for ASHAs or it is underway. Round 3 training of ASHAs has been initiated in Manipur.

The states of Jammu and Kashmir and Delhi are yet to initiate training in Modules 6 and 7. In the Non-High Focus states, Gujarat has completed two rounds of ASHA Training, with Karnataka, Maharashtra, Punjab, Haryana and West Bengal are in various stages of completing training of ASHAs in Round 1 and Round 2. Haryana is training its ASHAs in a variant called Home Based Post Partum and Newborn Care, which does not include child health and nutrition, care in pregnancy, and counselling for safe abortion and family planning.

TABLE 2.2A : TRAINING STATUS FOR HIGH FOCUS STATES

State Name	No. of ASHAs select-ed	Training Status			
		Number of ASHAs Trained in			
		Less than Module 4	Up to Module 4	Module 5	Module 6 and 7
Bihar	83872	52859 (63 %)	52859 (63 %)	• 23 state trainers trained in round 1 and 14 trained in Round 2 • 4 State Training sites established with NGOs • 708 District Trainers trained • Module 5 Training of 4 days merged with 4 rounds of Module 6 & 7 training, making it 4 Rounds of 6 days each, Round 1 training of 6 days completed for 18015 ASHAs (21.5%)	
Chhattisgarh	60092	60092 (100%) Mitanins trained in Module 1 to 12.		• 55630 Mitanins (92.6 %) trained on 13th module. • 53300 Mitanins (88.7 %) trained on module 14th and 15th module • 50989 Mitanins (84.8 %) trained on revision Round Module 16	
Jharkhand	40964	39214 (95.73%)	35675 (87.09%)	40964 (100%)	• 13 State trainers trained in Round 1 and 14 in Round 2 • 422 District Resource Persons trained in Six days state TOTs • 13683 ASHAs (33.4%) trained in Round 1 of Module 6 & 7
Madhya Pradesh	52481	47022 (89.6 %)	45777 (87.23 %)	42405 (80.8 %)	• 29 state trainers trained in Round 1 and 20 in Round 2 • 586 district trainers trained in Round 1 • 15535 (29.6%) ASHA Trained
Odisha	43530	43372 (99.6%)	43373 (99.6%)	41560 (95.5 %)	• 16 state trainers trained in Round 1 and 12 in Round 2 • 186 District Trainers trained • 22824 (52.43%) ASHAs trained in Round 1.
Rajasthan	51265	34776 (67.8%)	45110 (87.9 %)	34664 (67.6 %)	• 11 state trainers in Round 1 & 9 trained in Round 2 • 224 District Trainers trained in Round 1 • 3962 ASHAs (8%) trained in Round 1
Uttar Pradesh	136094	129150 (95%)	129150 (95%)	121580 (89.3 %)	• 22 State Trainers Trained in Round 1, • District TOTs and ASHA trainings being planned
Uttarakhand	11086	11086 (100%)	11086 (100%)	8978 (81%)	• 6 state trainers trained in Round 1 and 5 in Round 2 • 231 District trainers trained in Round 1 and 203 in Round 2 • 544 out of total 550 (99%) ASHA facilitators trained in Round 1 and 2 (7 Days) & 539 trained in Round 3 • 10313 ASHAs (93%) trained in Round 1, 10064 (91%) in Round 2 & 10209 (92%) in Round 3 of five days each.

TABLE 2.2B : TRAINING STATUS FOR NORTH EASTERN STATES

State Name	No. of ASHAs selected	Training Status			
		Number of ASHAs Trained in			
		Less than Module 4	Up to Module 4	Module 5	Module 6 and 7
Assam	29172	28544 (97.85%)	28497 (97.7%)	28422 (97.43%)	• 17 State trainers trained in Round 1 and 14 trained in Round 2 • 153 District trainers trained in Round 1 • 11444 ASHAs trained in Round 1 • ASHA Facilitators trained in 15 districts.
Arunachal Pradesh	3757	3559 (95%)	3606 (96%)	3635 (97%)	• 3 State trainers trained in Round 1 and 4 trained in Round 2 • 28 District trainers trained in Round 1 • 3602 ASHAs (95.87%) trained in Round 1 and 1039 (27.6%) trained in Round 2
Manipur	3878	3878 (100%)	3878 (100%)	3878 (100%)	• 3 State trainers trained in Round 1 and 2 • 62 District trainers trained in Round 1 and 2 • 3878 (100%) ASHAs trained in Round 1 & Round 2 • Round 3 training of ASHAs underway
Meghalaya	6258	6250 (99.9%)	6250 (99.9%)	6250 (99.9%)	• 3 State trainers trained in Round 1 and 2 • 66 District Trainers trained in Round 1 • 5732 (91.6%) ASHAs trained in Round 1 & Round 2280 • ASHA Facilitators trained in Round 1 & 245 in round 2
Mizoram	987	987 (100%)	987 (100%)	987 (100%)	• 3 State trainers trained in Round 1 and2 • 28 District Trainers trained in Round 1987 (100%) • ASHAs trained in Round 1 & 739 (74.9%) in Round 2
Nagaland	1700	1700 (100%)	1700 (100%)	1700 (100%)	• 3 State trainers trained in Round 1 • 60 District Trainers trained in Round 1 1576 (91.6%) • ASHAs trained in Round 1 & 1571 (92.4%) in Round 2
Sikkim	666	666 (100%)	666 (100%)	666 (100%)	• 3 State trainers trained in Round 1 and 4 trained in Round 2 • 20 District Trainers trained in Round 1 • 666 (100 %) ASHAs trained in Round 1 & 2
Tripura	7367	7367 (100%)	7367 (100%)	7367 (100%)	• 5 State trainers trained in Round 1 & 2 • 89 District Trainers trained in Round 1 • 7257 (98.5%) ASHAs trained in Round 1 & 6658 (90.4%) in round 2

TABLE 2.2C : TRAINING STATUS FOR NON HIGH FOCUS STATES

State Name	No. of ASHAs select-ed	Training Status			
		Number of ASHAs Trained in			
		Less than Module 4	Up to Module 4	Module 5	Module 6 and 7
Andhra Pradesh	70700	30 days training as the programme preceded NRHM, but covered women's and children's health.			• 12 State trainers trained in Round 1 and 11 in Round 2 • 654 District Trainers trained in Round 1 • 25969 (32.2%) ASHAs trained in Round 1
Delhi	4498	Module 1-4 clubbed as Module 1, 2, 3 – 2298 (51.1%) ASHAs trained Module 5 as Module 4 – 1926 (42.8%) ASHAs trained			State is yet to plan the roll-out of ASHA Module 6 & 7 training.
Gujarat	30159	26605 (88.2%)	26251 (87%)	25177 (83.5%)	• 4 state trainers trained in Round 1 and 2. Five trainers from Deepak Charitable Foundation trained in Round 1 and 2 • 160 district trainers trained in Round 1 • 25327 ASHAs (84%) trained in Round 1 & 2 • 14213 ASHAs (47.1%) trained in Round 3, 12347 (41%) in Round 4
Haryana	13755	13730 (99.8%)	13289 (96.6%)	11112 (80.8%)	• 12007 ASHAs trained in 2 days training of HBPNC module - Phase 1, supported by NIPI. • 9 state Trainers trained for Module 6 & 7
Jammu and Kashmir	9904	9500 (95.9%)	9000 (90.9%)	8300 (83.8%)	• 5 State Trainers trained in Round 1 and 6 in Round 2 • 225 District Trainers trained in Round 1 • 180 ASHA Facilitators trained
Karnataka	33750	Up to Module 5 - 33750 (100 %)			• 15 State Trainers trained in Round 1 and 10 trained in Round 2 • 240 District Trainers trained in Round 1 • 9500 ASHAs (28.1%) trained in a combined ten days training of Round 1 and 2
Kerala	31868	28205 (88.5%)	25673 (80.56 %)	22992 (72.1 %)	State is planning to train ASHAs in a state specific module.
Maha-rashtra	59316	56923 (96%)	53781 (90.7%)	27029 (45.6%)	• 15 state trainers trained in Round 1 and 13 trained in Round 2 • 412 District trainers trained • 66 BCMs and 910 Block Facilitators trained • 8657 ASHAs (14.6%) trained in Round 1 & 5619 (9.4%) trained in Round 2
Punjab	16800	16214 (96.5%)	16214 (96.5%)	16214 (96.5%)	• 5 State trainers trained in Round 1 • 326 District Trainers trained in Round 1 • 16533 ASHAs (98.4%) trained in Round 1
Tamil Nadu	6850	1639 (42%)	1639 (42%)	1639 (42%) Module 1-5 trainings done only in tribal districts	State will train ASHAs in specific areas based on local issues, such as blindness, malaria, newborn care, etc.
West Bengal	46818	42175 (90 %)	38294 (81.8%)	35154 (75%)	• 17 State Trainers trained in Round 1 and 13 trained in round 2 • 310 District trainers trained in Round 1 • 6432ASHAs (13.7%) trained in Round 1 & 303 (0.65%) trained in Round 2

TABLE 2.2D : TRAINING STATUS FOR UNION TERRITORIES

State Name	No. of ASHAs selected	Training Status			
		Number of ASHAs Trained in			
		Less than Module 4	Up to Module 4	Module 5	Module 6 and 7
Andaman and Nicobar Island	407	100%	100%	100%	State has not yet made plans to train ASHAs in Modules 6 and 7.
Dadra and Nager Haveli	208	85 (41 %)	85 (41 %)	85 (41 %)	45 ASHAs have been trained in Round 1 of Module 6 and 7 training
Lakshadweep	83	83	-	-	No data available
Daman and Diu					State has recently introduced the ASHA programme

SECTION 2.3: SUPPORT STRUCTURES

Box 2: Support structures as per Guidelines on Support Mechanisms for ASHAs[1]

At the state level the programme is expected to be supported by an ASHA Resource Centre with a team of Programme Manager, Deputy Project Manager, Communications and Documentation Officer, Training Officer Regional or Zonal Coordinators, Statistical Assistant, Data Assistant and Office Attendant. State ASHA Mentoring Group, consisting of NGO representatives, academicians, training institutions and research organisations will provide policy guidance and programmatic oversight.

At the district level, a unit of a District Nodal Officer supported by a District Community Mobiliser and Data Assistant is expected to manage the programme in districts.

At the block level, a Block Nodal Officer supported by ASHA facilitators (appointed at a ratio of 1:20 ASHA) are expected to provide support and supervision

The National ASHA Mentoring Group provides input to the NHSRC and the MOHFW on key policy matters related to the ASHA programme. Currently the group meets on a biannual basis to review the ASHA programme and provide policy inputs. Some members of the mentoring group have also been represented on the High Level Expert Group and the Working Group on NRHM for the XII Plan. Several members are also members of state level ASHA mentoring groups and thus bring valuable field insights from various states to the forum. NHSRC functions as the secretariat for the National ASHA Mentoring Group.

The supportive institutional network at state level and below (Tables 3 A to 3D) has expanded rapidly in the past year, as states have increasingly become cognizant of the necessity of a strong support structure to enhance the community processes component.

Most high focus states have established support and supervisory mechanisms at state, district, block and sub block levels. While some states such as UP and MP have no state ASHA Resource Centres, there is a dedicated team, which undertakes the functions

related to the ARC. Madhya Pradesh is in the process of appointing district and block community mobilizers.

In North East, state level support mechanisms are in place across all states except Mizoram and Sikkim. At the district level, barring these two states and Nagaland support structures for ASHA Programme are in place. All North East states except Nagaland are yet to establish the block level support mechanisms. However considering their small numbers of ASHAs, management by existing structures appears to suffice.

ASHA facilitators were considered an integral part of the ASHA programme and were expected to be deployed even before the selection of the ASHA. They were intended to facilitate the community led selection of the ASHA. While some states did appoint them for the selection, they tended to drop them after the ASHA were in place. Most of the High Focus and North East States have engaged ASHA facilitators.

The Non high focus states like Punjab, tribal districts of Maharashtra and Gujarat have district level support structures and have started appointing ASHA facilitators. Others have no support systems below the state and not even at the state in several cases, but are using the existing programme structures to manage and support the ASHA programme.

A challenge across the states is training of the support structures to effectively carry out their functions of ensuring outcomes of the ASHA and community processes programme. A handbook for facilitators has been developed and sent to the states.

2.4 Status of Drug Kit Distribution in the States:

Drug Kit was to be provided to all ASHAs on completion of Training in Module 1. All states have completed or are in the process of completing the distribution of drug kits. Delays have been primarily on account of the cumbersome tendering processes in the states.

Regular replenishments is not streamlined in all states. It is occurring in all North East states and amongst the High Focus States only Chattissgarh, Odisha and Uttarakhand have done this. In the Non-High Focus states annual replenishment is seen in Jammu and Kashmir, Punjab, Maharashtra and West Bengal. Mechanisms of refill are mostly need based which are done either on a quarterly or monthly basis in some states.

TABLE 2.3A : STATUS OF ASHA SUPPORT STRUCTURE IN HIGH FOCUS STATES

STATUS OF SUPPORT STRUCTURE FOR ASHA				
High Focus States	**State Level**	**District Level**	**Block Level**	**Sector Level**
Bihar	• AMG constituted and meeting held quarterly • ARC established • Eight Divisional ASHA Coordinators are placed	• 23 out of 38 DCMs and • 31 out of 38 DDAs are in place.	• 421 out of 504 BCM are in place.	• 3787 out of 4150 ASHA Facilitators (one per 20 ASHA) are in place
Chhattisgarh	• ARC is working under SHRC • AMG yet to be formalized.	• 34 District Coordinators in place	• 438 Block Coordinators in place	• 3000 Mitanin trainers in place. (1 per 20)
Jharkhand	• AMG constituted and meeting held regularly • VHSRC established under SHRC	• 24 District Programme Coordinators in place	• 850 Block Trainers in place	• 2157 Sahiyaa Saathi selected and trained. (1 per 20 Sahiyas)
Madhya Pradesh	• AMG merged with MGCA to from MGCA • MGCA members allocated districts for monitoring and handholding • State Nodal officer and team of six consultants for ASHA appointed. • ARC is under the process of notification	• DCM placed in 4 districts • District MGCA constituted and training is underway.	• 147 Block Community Mobilizers are in place in 43/50 districts; • 248 Block MGCA constituted	Existing staff
Odisha	• AMG constituted • CPRC in place	• AMG constituted and meeting held regularly • DAC in place	Existing staff	• 1152 sector in-charge to facilitate monthly meeting of ASHAs
Rajasthan	• AMG constituted • ARC moved to SHSRC	• DAC posted in 27/34 districts	• 237 BAC selected • 119 currently working	• 1321 PHC ASHA Supervisors (1 per PHC)
Uttar Pradesh	• AMG constituted and meeting held regularly • No ARC, programme management done by one Nodal officer, two regional coordinators and one facilitator supported by NHSRC.	• 60/75 DCMs are in place. • District AMG constituted	Existing staff	Existing staff
Uttrakhand	• AMG constituted • ARC is outsourced to NGO –HIHT	• District ARC outsourced to NGOs	• 47 BCs placed (one coordinator per 2 blocks)	• 550 ASHA facilitators (1 for 15-20 ASHAs)

TABLE 2.3B : STATUS OF ASHA SUPPORT STRUCTURE IN NORTH EAST STATES

Status of Support Structure for ASHA				
NE States	**State Level**	**District Level**	**Block Level**	**Sector Level**
Arunachal Pradesh	• AMG constituted and meeting held regularly • ARC formed	• DCM and DDA placed in all 16 districts.	• Existing staff	• 348 ASHA Facilitators
Assam	• AMG constituted and meeting held regularly • ARC	• DCM and DDA placed in all 27 districts and managed by ARC	• Existing Staff	• 2838 ASHA Facilitators placed (One for 20 ASHAs)
Manipur	• AMG constituted and meeting held regularly • Formation of ARC is under way.	• Nine DCMs in place	• Existing staff	• 194 ASHA Facilitators
Meghalaya	• AMG formed and meetings held regularly • ARC established	• DCM placed in all seven districts and managed by ARC.	• Existing staff	• 312 ASHA Facilitators (one for 15-20 ASHAs)
Mizoram	• AMG formed • ARC not established	• Existing staff	None	None
Nagaland	• AMG formed • ARC functional under Directorate of Health services.	• Existing Staff	• 52 Block ASHA Coordinators in place	• Existing staff
Sikkim	• AMG formed • ARC does not exist	• Existing staff	• Existing Staff	• 68 ASHA Facilitators
Tripura	• AMG formed and meeting held regularly • ARC constituted	• Four ASHA Programme Managers and 11 Sub divisional ASHA Programme Managers support the program	• None	• 377 ASHA Facilitators

TABLE 2.3C : STATUS OF ASHA SUPPORT STRUCTURE IN NON- HIGH FOCUS STATES

Non high Focus States	Status of Support Structure for ASHA			
	State Level	District Level	Block Level	Sector Level
Andhra Pradesh	• AMG constituted • Indian Institute of Health and Family welfare designated as ARC	• None but managed by Project Officer, District Training Team (P.O.DTT) and District Public Health Nursing Officer(DPHNO)	• None	• ASHA coordinators are placed at PHC level
Delhi	• AMG formed • ARC established	• District Nodal Officer and District Mentoring Group in place.	• 50 ASHA Unit are in place, one unit per 100,000 population. • Support to each unit through a Nodal Committee-one MOIC and 10 facilitators.	
Gujarat	• AMG Constituted • ARC exists	• DPM for ASHA program are placed in 12 Tribal Districts • In other non-tribal districts managed through existing staff	• Existing staff	• 650 out of 1147 ASHA facilitators one per PHC.
Haryana	• AMG does not exist • ARC does not exist- A team of two Medical officers and one state NGO coordinator, working under SPMU support the program	• Existing staff	• Existing staff	• Existing staff
J & K	• ARC and AMG does not exist	• None	• None	• None
Karnataka	• AMG constituted • ARC established under SHRC.	• ASHA Mentors (Staff nurses with experience of Training ASHAs) have been placed	• Existing Staff	• Existing staff
Kerala	• AMG formed but meetings are not held regularly • ARC established under SHSRC	• Existing staff	• Existing staff	• Existing staff
Maharashtra	• AMG constituted and meetings held regularly. • SHSRC functions as ARC	• DCMs appointed in all 33 districts • District AMG formed in 15 tribal and 18 Non –tribal districts	• Block AMG formed in 70 tribal blocks and 281 in Non-tribal blocks	• 928/952 facilitators one for 10 ASHAs (in tribal districts) • 1428/1496 (at PHC level) posted in non-Tribal districts.
Punjab	• AMG does not exist • ARC does not exist but two consultants work with SHSRC for ASHA Program	• DCMs in all 20 districts	• None	• 898 ASHA Facilitators

TamilNadu	• The formation of AMG is in process • Institute of Public Health, Poonamallee is working as ARC	• Existing staff	• Existing staff	• Existing staff
West Bengal	• AMG formed and meetings held regularly • ARC outsourced to CINI	• Existing staff	• Existing staff	• Existing staff

TABLE 2.3D : STATUS OF ASHA SUPPORT STRUCTURE IN UNION TERRITORIES

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

TABLE 2.4A : STATUS OF DRUG KIT DISTRIBUTION IN HIGH FOCUS STATES

State	Status of Drug Kit distribution
Bihar	Distributed to 83624 out of 83872 (99.78) ASHAs in all 38 districts
Chhattisgarh	Distributed to all 60092 Mitanins (100%) on an annual basis.
Jharkhand	Distributed to 35000 (85.44%) Sahiyas in 2008. New Drug Kit is being distributed to ASHAs in current year and47% have received till now. Drug refill being done on quarterly basis from PHC.
Madhya Pradesh	Drug Kit distributed once to all 52393 (100%) ASHAs. Drug Kit distribution for current year under process, replenishment is done from block PHC on monthly basis as per the demands of ASHAs.
Odisha	Drug kit distributed on annual basis. Kit sanctioned in FY 2010-11 distributed in June 2011 to all 40948 ASHAs (100%). Drug replenishment is done from drugs allocated for Sub-centre, refill being done on quarterly basis as per demands of ASHAs. Drug kit user manual has been given to ASHAs
Rajasthan	One round of Drug Kit distribution done to 38056 (76%) ASHAs. Replenishment not being done on regular basis but as per demand by ASHA from PHC.
Uttar Pradesh	Drug Kits distributed only once to 128434 (94.31%) ASHAs in year 2009-10. No distribution in FYs 2010-11 and current year. Refill of only some drugs is done as per requirement from PHC.
Uttarakhand	Drug kit distributed on annual basis since FY 2008-09. Drug kit distributedto 9983(90%) ASHAS. Replenishment from PHC level is on adhoc basis Distribution for current financial year is under process.

TABLE 2.4B : STATUS OF DRULG KIT DISTRIBUTION IN NORTH EAST STATES

State	Status of Drug Kit distribution
Arunachal Pradesh	Drug Kit distributed on annual basis, given to 3757 (100%) ASHAs in current FY. No replenishment system in place.
Assam	Drug Kit distributed on annual basis, given to 28422 (96%) ASHAs in current FY. Replenishment from PHC on quarterly basis as per requirement.
Manipur	Drug Kit distributed on annual basis, given to 3878 (100%) ASHAs in current FY. No replenishment system in place.
Meghalaya	Drug Kit distributed on annual basis, given to 6250 (100%) ASHAs in current FY. No replenishment system in place.
Mizoram	Drug Kit distributed on annual basis, given to 987 (100%) ASHAs in current FY. No proper replenishment system in place, some refill given from PHC.
Nagaland	Drug Kit distributed on annual basis, given to 1700 (100%) ASHAs in current FY. No replenishment system in place.
Sikkim	Drug Kit distributed on annual basis, given to 666 (100%) ASHAs in current FY. Replenishment from PHC on quarterly basis as per requirement.
Tripura	Drug Kit distributed on annual basis, given to 7367 (100%) ASHAs in current FY. Replenishment from PHC & CHC on quarterly basis as per requirement.

TABLE 2.4C : STATUS OF DRUG KIT DISTRIBUTION IN NON HIGH FOCUS STATES

State	Status of Drug Kit distribution
Andhra Pradesh	Drug Kit distributed once to all 70700 (100%) ASHAs. Procurement for current year refilling is under process, kitsisreplenished on monthly basis.
Delhi	Drug Kit distributed once to 3722 (83%) ASHAs, refill being done from health centre of the area on regular basis as and when required.
Gujarat	Drug Kit distributed once to 29731 (103%) ASHAs, (it includes the drop-out ASHAs). Drug refill is being done from health centre of the area as and when required.
Haryana	No Drug Kit distributed till now. UNOPS has been engaged to procure and supply drug kits. It is being distributed during HBPNC training undertaken in collaboration with NIPI
Jammu and Kashmir	Drug Kit being distributed annually since 2007. Distributed to 100% ASHAs
Karnataka	Drug Kit distributed to 33750 (100%) ASHAs, refill being done from PHC of the area on monthly basis as required.
Kerala	Drug Kit Distributed to 23,350 (73.27%) ASHAs, replenishment from PHC of the area on monthly basis as required
Maharashtra	Drug Kit distributed on annual basis. In FY 2010-11 given to 58394 (98.49%) ASHAs. Replenishment from PHC as and when required.
Punjab	Drug Kit distributed annually, given twice till now. Kit sanctioned in FY 2010-11 distributed to 16463 (98.27%) ASHAs in March 2011.
Tamilnadu	Distributed to 1639 (61.84%) tribal ASHAs in the last financial year. For the current financial year has been distributed to 260 ASHAs. Procurement is under process for the remaining ASHAs. Replenishment from PHC as and when required.
West Bengal	Drug Kit distributed annually. Distribution of Kits done for 13034 (30.15%) ASHAs. Procurement for remaining ASHAs is in process. Replenishment from PHC as required.

TABLE 2.4D : STATUS OF DRUG KIT DISTRIBUTION IN UNION TERRITORIES

Union Territory	Status of Drug Kit distribution
Andaman & Nicobar Island	Distributed to 407 (100%) ASHAs.
Dadra and Nagar Haveli	Distribute to 85 (79.43%) ASHAs.
Lakshadweep	Distributed to 85 (100%) ASHAs
Daman and Diu	State has recently introduced the ASHA programme

Indian Parliament on ASHA Programme- An analysis of related questions and issues raised

Overall the NRHM programme has attracted substantial political and media attention, and the ASHA has been an important focus of parliament questions. In 2010, the Parliament Committee on Empowerment of Women sought information on the ASHA, from the Ministry of Health and Family Welfare, which in turn gave rise to a sub-committee on Working Conditions of the ASHA. The committee raised a range of issues related to the programme from selection to training, to her interface with the ANM and AWW, her specific to description and incentive payments. The questions are diverse and span several aspects of the programme. Nonetheless, the very nature of the questions signal a high level of political interest in the programme and in the ASHA as an entity with the potential to affect the health of the community.

Table-3 provides a year wise summary of the questions, capturing specific issues in relation to certain broad aspects of the programme.

A close scrutiny of these questions from the period between 2010 to April 2012 highlights the following key features:

- Information on ASHA Programme was sought by Parliamentarians in both houses of the Parliament.

- The questions appear to be heterogeneous, covering diverse subjects and multiple issues, including selection, payments, roles and responsibilities, training and available supportive mechanisms for ASHAs.

- During early 2010, which coincide with scaling-up phase of the programme, the questions were primarily centred on the selection and recruitment of ASHAs. The initial areas of concern were shortfalls in specific states and lower involvement of PRIs in the process of selection.

- More recently, issues pertaining to coverage have become more evident in terms of seeking information on village wise selection of ASHAs and detailed information on drop-outs from different states. These issues have probably been raised to engage the attention of the stakeholders in addressing the need to reach the marginalized sections of the community through ASHAs.

- Around 25% of queries were based on the salary, honorarium or the remuneration being paid to ASHAs. The issue of low payments is highlighted in every session and explanations are sought on measures adopted by the Government to address these concerns. This confirms the fact that common demands of ASHAs are being voiced through parliamentarians.

- As the programme matured, the focus of questions moved from selection towards the capacity building and skill enhancement of ASHAs. Questions on the training status and technical issues appear from the year 2010.

- Some questions reflect the mis-perception of parliamentarians on the specific functions of the ASHA (such as ASHAs being trained in conducting home deliveries or giving parenteral medication), and indicate the need to invest in providing accurate and specific information to parliamentarians.

- Issues related to functionality of ASHAs also

emerged with details of specific evaluations being asked for. This signals an understanding in using evidence to better comprehend programme functioning.

- Specific queries on social protection for ASHA and coverage under insurance schemes have been raised several times.

- In the latter part of 2011, queries pertaining to programme achievement and outcomes started emerging. Details of achievement, availability and access to quality health care under ASHAs were asked. Information on impact of the programme on MMR and NMR has been probed and during the present year, the outcomes of Home Based Newborn Care (HBNC) for which guidelines were issued in August 2011, are already the subject of questions.

YEAR WISE DETAILS OF PARLIAMENT QUESTIONS ON ASHA

Serial No.	Subject	Specific issues raised	No. of questions		
			2010	2011	Till April 2012
1	**ASHA Selection/Recruitment/ Appointment**	Details of District/State wise details of selection; Shortfall in states; Role of PRIs and ASHA Group Coordinators; Unreached Villages; Linking ASHA and Ministry of Rural Development	6	6	7
2	**Remuneration/ Honorarium / Allowance/ Incentives for ASHA**	Provision of Fixed monthly honorarium; Mission Steering Group decisions on fixed payments; Demands from ASHAs on fixed payments; Specific rules through which payments are made; Existence of bank accounts as mode of payments; Steps taken by govt. to increase the honorarium	7	10	4
3	**Roles and responsibilities and Services Provided by ASHAs**	Role of ASHA in conducting deliveries, Newborn care; Incentives for service provision create a bias with respect to her role in community participation?	1	1	4
4	**Training provided to ASHAs**	State wise training status; Content of training modules; Reason for delays in training in certain states; Details and plan for specific training on home delivery; Skill development and first aid and newborn care; Inclusion of certain drugs for sick newborn in the training modules of ASHA	2	5	1
5	**ASHA Drug kits**	Pattern of Drug Kit Distribution in certain specified states	1	0	0
6	**Uplifting/Raising Standards of ASHA Workers**	Detailed questionnaire on working conditions of ASHA followed by a Post Evidence questionnaire - seeking details on economic and social uplifting of ASHA Social benefits being provided to ASHAs	1	0	3
7	**Programme achievement**	Details of achievement, availability and access to quality health care under ASHAs; Impact on MMR and NMR; Results of HBNC implementation in states	1	2	1
8	**Specific evaluations conducted and results**	Any assessment been done on functionality of ASHA	1	2	4
9	**Details of Complaints against ASHAs from specific parliamentary constituencies**	Specific questions for individual constituencies such as Sultanpur, Cuddalore, Jaisalmer, Barmer	0	1	2
10	**Selection of support structures**	Positioning of ASHA Group Coordinators in the states;	1		1

Total Number of questions=75 as on April 2012.

Details on ASHA Incentives

National guidelines for the ASHA define her as a volunteer but who needs to be compensated for her time in situations such as attending training programmes, monthly review meetings, and other meetings, which would mean the loss of a day's wage. In addition, she is eligible for incentives offered under various national and state specific programmes. In the initial phase of the programme itself, all the other health care programmes were entreated to work out performance based payments arrangements, which could be diverted to ASHAs. Over a period of time, many National Health Programmes and other national schemes under NRHM have created such performance based incentives for the ASHAs. States have the flexibility to enlarge the scope of these payments to ASHAs, in a manner that key priorities in public health of a particular region receive the attention of ASHAs, thereby ensuring better community outreach and successful programme outcomes.

Table-3 Summarizes a list of incentives to ASHAs which have been approved at the National level.

This compilation is based on minutes of the Mission Steering Group Meetings and orders and guidelines issued by the Ministry of Health and Family Welfare

TABLE 3 : ASHA INCENTIVES

Serial Num.	Heads of Compensation	Amount in Rs/case	Source of Fund	Source Document
I	**Maternal Health**			
1	**JSY financial package**			JSY Guidelines-2006
2	• Promoting institutional delivery in any government facility for both urban and rural families, and ensured ANC care for the woman	200- across all the states	Maternal Health- RCH Flexi pool	
	• Making transport arrangements and for escorting pregnant women/family members to the institution[1]	250- only for the[2] North- East and High Focus States and notified tribal areas of Non –High Focus states		
3	• As Transactional cost if ASHA escorts the pregnant women and stays with her in the hospital	150- only for the North- East and High Focus States and notified tribal areas of Non –High Focus states		

1 *In case the arrangement is done directly by the beneficiary the sum is paid to the beneficiary directly. It may also be paid directly to the transport service provider*

2 *Many states have withdrawn this incentive after the launch of JSSK. In this schemefree transport is to be provided from home to health institution, between facilities and drop-back for pregnant women and sick newborn.*

II	**Child Health**			
1	Undertaking six (in case of institutional deliveries)and seven(for home deliveries) home- visits for the care of the newborn and post- partum mother[3]	250	Child Health- RCH Flexi pool	HBNC Guidelines – August 2011
III	**Immunization**			
1	Social mobilisation of children for immunization during VHND	150/session	Routine Immunization Pool	Order on Revised Financial Norms under UIP- T.13011i01/2077-CC-May 2012
2	Complete immunization for a child under one year	100.00		
3	Full immunization per child upto two years age(all vaccination received between First and second year age after completing full immunization after one year	Rs 50	Routine Immunization Pool	Order on Revised Financial Norms under UIP- T.13011i01/2077-CC-May 2012
4	Mobilizing children for OPV immunization under Pulse polio Programme	75/day	IPPI funds	
IV	**Family Planning**			
1	Ensuring spacing of 2 years after marriage	500	Family planning Compensation Funds	Minutes Mission Steering Group meeting- April-2012
2	Ensuring spacing of 3 years after birth of First child	500		
3	Ensuring a couple to opt for permanent limiting method after 2 children	1000		
4	Counselling, motivating and follow up of the cases for Tubectomy	150	Family Planning Sterilization compensation funds	Revised Compensation package for Family Planning- September 2007-No-N 11019/2/2006-TO-Ply
5	Counselling, motivating and follow up of the cases for Vasectomy/ NSV	200		
6	Social marketing of contraceptives- as home delivery through ASHAs	1 for a pack of three condoms 1 for a cycle of OCP 2 for a pack of ECPs	Family planning Fund	Detailed Guidelines on home delivery of contraceptives by ASHAs-Aug-2011-N 11012/3/2012-FP
V	**Adolescent Health**			
1	Distributing sanitary napkins to adolescent girls	Re 1/ pack of 6 sanitary napkins	Menstrual hygiene- ARSH	Operational guidelines on Scheme for Promotion of Menstrual Hygiene Aug. 2010
2	Organizing monthly meeting with adolescent girls pertaining to Menstrual Hygiene	50/meeting	VHSNC Funds	
VI	**Nirmal Gram PanchayatProgramme**			
	Motivating households to construct and use a toilet	75/Toilet constructed	Funds for IEC activities under District Project Outlay under TSC	Minutes MSG-Meeting April 2012; DO No. W-11042/7/2007/-CSRP-Part

3 *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 newborn are safe until 42nd of delivery.*

VII	**Village Health Sanitation and Nutrition Committee**			
	Facilitating monthly meetings of VHSNC followed by meeting with women and adolescent girls	150/meeting	VHSNC Untied Fund	MOHFW Order Z-18015/12/2012-NRHM-II
VIII	**Revised National Tuberculosis Control Programme**			
	Acting as a DOTS Provider(only after completion of treatment or cure)	250	RNTCP Funds	Revised Norms and Basis of Costing under RNTCP
IX	**National Leprosy Eradication Programme**			
1	Referral and ensuring compliance for complete treatment in pauci-bacillary cases of Leprosy	300	NLEP Funds	Guidelines for involving ASHAs under NLEP
2	Referral and ensuring compliance for complete treatment in multi-bacillary cases of Leprosy	500		
X	**National Vector Borne Disease Control Programme**			
1	Preparing blood slides	5/slide	NVDCP Funds for Malaria control	NVDCP Guidelines for involvement of ASHAs in Vector Borne Diseases-2009
2	Providing complete treatment for RDT positive Pf cases	20		
3	Providing complete radical treatment to positive Pf and Pv case detected by blood slide, as per drug regimen	50		

Fund Release and Expenditure Pattern for ASHA Programme

ASHA guidelines issued by the Ministry of Health and Family Welfare in July 2006, laid out the operational guidelines, including financial flows and budgets for the ASHA programme.

The present financial norms under NRHM provide for a budget provision of up to Rs. 10,000 per ASHA per year which includes expenditures on selection processes including social mobilization, training of ASHAs and ASHA trainers, drug kit, support structure from state to sub block levels, and expenses for the supply of identity cards, bags, and badges for the ASHA. ASHA incentives are not part of this amount. They are budgeted for under various other programmes.

State-wise information on funds released and expenditures incurred by states over the period of FY 05-06 to FY2011-12 are provided in Tables given below. As expected, the expenditures reported during the initial years of 2005 to 2008 are quite low, since states were in the process of establishing the institutional and programmatic structures for NRHM overall and for the ASHA and community processes components in particular. Despite increases however, overall fund absorption still remains low. During FY 2011-12, among the eight EAG states the percentage expenditure over the funds sanctioned, was as low as 26% (for Madhya Pradesh).

Partly this is because support structures at all levels have not been universally established, and even where they are, the full complement of staff is not in pace. A second reason is the under investment in capacity building of support staff. A third reason is the slow pace of printing and procuring of training modules and communication aids for the ASHA.

Of the eight high focus states, Uttarakhand, Chhattisgarh and Odisha still stand out as the front-runners and have spent an amount of more than Rs. 20000/- per ASHA, over the period of 2005-12. This again reinforces the direct correlation between the expenditures and the pace of programme implementation on the ground. All three states have a well grounded support system and are investing in training structures for the ASHAs.

Bihar and Jharkhand continue to remain in the category of the low expenditure states. However Bihar has moved ahead substantially in FY 11-12, and has put in place an extensive support system and a network of training sites and a cadre of trainers, which is reflected strongly in its expenditure. It has raised its overall expenditure per ASHA (for the period of 2005 to 2012) to Rs. 8494, compared to Rs. 6083/- spent during 2005-11.

Uttar Pradesh has fared poorly in the last FY 2011-12 with having spent only 6.3% of its sanctioned funds for the ASHA programme. This is likely the consequence of the other ills affecting the NRHM programme in the state. Rajasthan is also improving and has spent 67% of its sanctioned funds in this period, and stands next to only the top three states of Chhattisgarh, Odisha and Uttarakhand in this respect.

The overall pattern of expenditure in North East states reflects well grounded programme, and five out of the eight NE states, Arunachal Pradesh, Assam, Mizoram, Nagaland and Sikkim have spent above Rs. 20,000 per ASHA over the period of 2005-12.

In the non high focus states, where the programme expanded state wide in FY 2008, Delhi and Gujarat report spending over Rs. 20000 per ASHA (for the period of 2005 to 2012), followed by West Bengal (spending 19245). Poor absorption of funds correlates with lack of support structures and other support activities, little investment in training quality, limited internal capacity, and reluctance to engage with external technical resources, such as NGOs, in all these states.

TABLE 5.1 - FUNDS RELEASED AND EXPENDITURE ON ASHA PROGRAM - HIGH FOCUS STATES - REPORTED IN RS. CRORES

Sl. No.	Name of State	No of ASHAs (as on 31 March 2011)	2005-08			2008-09			2009-10			2010-11			2011-12			Total : 2005 - 2012			
			Fund released	Expenditure	% Expenditure over fund released	Fund released	Expenditure	% Expenditure over fund released	Fund released	Expenditure	% Expenditure over fund released	Fund released	Expenditure	% Expenditure over fund released	Fund released	Expenditure	% Expenditure over fund released	Total Fund released	Total Expenditure	% Expenditure over fund released	Total Fund Spent per ASHA, (in Rs.)
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
1	Bihar	79808	31.89	4.73	14.83	17.15	5.78	33.70	56.03	13.57	24.22	57.04	19.35	33.92	57.41	25.16	43.83	219.52	68.59	31.25	8594
2	Chhattisgarh	28000	18.11	20.12	111.10		5.99		17.7	12.21	68.98	25.83	19.95	77.24	23.68	25.31	106.88	85.32	83.58	97.96	29850
3	Jharkhand	40964	28.78	6.72	23.35	9.51	17.96	188.85	8.56	5.42	63.32	22.02	4.73	21.48	19.88	9.8	49.30	88.75	44.63	50.29	10895
4	Madhya Pradesh	50113	19.39	13.22	68.18	7.94	4.88	61.46	39.87	7.38	18.51	34.64	27.25	78.67	42.08	11.15	26.50	143.92	63.88	44.39	12747
5	Odisha	40942	24.51	4.6	18.77	4.07	9.54	234.40	27.9	18.51	66.34	35.78	27.04	75.57	25.2	27.05	107.34	117.46	86.74	73.85	21186
6	Rajasthan	47209	25.43	4.35	17.11	12.23	12.88	105.31	41.5	15.23	36.70	27.91	29.67	106.31	27.78	18.65	67.13	134.85	80.78	59.90	17111
7	Uttar Pradesh	136182	45.24	12.13	26.81	116.11	65.06	56.03	135	7.96	5.90	137.30	84.96	61.88	38.6	2.43	6.30	472.25	172.54	36.54	12670
8	Uttarakhand	11086	2.58	2.47	95.74	8.87	4.18	47.13	9.85	6.99	70.96	11.08	11.11	100.27	12.25	8.48	69.22	44.63	33.23	74.46	29975
	Total for All States	434304	195.93	68.34	34.88	175.88	126.27	71.79	336.41	87.27	25.94	351.60	224.06	63.73	246.88	128.03	51.86	1306.70	633.97	48.52	14597

Data source - ROPs & PIPs. Expenditure data is presented as reported by states and may need further verification.
No. of ASHAs in CG is taken as equal to no. of Anganwadi centres, which is the the basis of allocation of funds to state for ASHA program. Actual no. of ASHAs in state, with one ASHA for every habitation, is 60092,

TABLE 5.2 - FUNDS RELEASED AND EXPENDITURE ON ASHA PROGRAM : NON - HIGH FOCUS STATES - REPORTED IN RS. CRORES

Sl. No.	Name of State	No of ASHAs (as on 31 March 2011)	2005-08			2008-09			2009-10			2010-11			2011-12			Total : 2005 - 2012			
			Fund released	Expend-iture	% Ex-penditure over fund released	Fund released	Expendi-ture	% Ex-penditure over fund released	Fund released	Expendi-ture	% Ex-penditure over fund released	Fund released	Expendi-ture	% Ex-penditure over fund released	Fund released	Expendi-ture	% Ex-penditure over fund released	Total Fund released	Total Expendi-ture	% Expendi-ture over fund released	Total Fund Spent per ASHA, (in Rs.)
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
1	Andhra Pradesh	70700	0	2.23			0.18		8.5	9.74	114.59	26.90	15.25	56.69	26.44	12.28	46.42	61.84	39.68	64.15	5612
2	Delhi	3622	0	0		14.72	2.62	17.80	19.04	1.37	7.20	0.00	2.91		5.73	1.08	18.82	39.49	7.98	20.20	22028
3	Gujarat	29552	4.85	0.87	17.94	11	14.4	130.91	25.38	4.95	19.50	32.08	37.41	116.61	32.33	5.88	18.18	105.64	63.51	60.12	21491
4	Haryana	12857	0	1.36			0.22		8.89	4.82	54.22	7.32	8.78	119.95	5.96	0.68	11.35	22.17	15.86	71.52	12333
5	Jammu Kashmir	9500	1.02	1.4	137.25	2.92	2.17	74.32	4.21	1.14	27.08	6.60	1.59	24.09	3.48	3.65	105.01	18.23	9.95	54.60	10477
6	Karnataka	33105	0	0.63		7.71	6.34	82.23	34.66	16.04	46.28	9.43	13.68	145.07	55.63	13.57	24.40	107.43	50.26	46.79	15183
7	Kerala	31868	0.57	1.38	242.11		21.6		21.17	10.06	47.52	15.00	12.76	85.07	10.86	3.99	36.70	47.60	49.79	104.60	15622
8	Maha-rashtra	59151	3.36	0.28	8.33	16.34	5.33	32.62	71.77	17.69	24.65	54.86	39.43	71.87	38.03	35.31	92.87	184.36	98.04	53.18	16575
9	Punjab	16597	0	0.38			0.78		4.49	3.47	77.28	14.75	9.18	62.24	7.40	4.17	56.29	26.64	17.98	67.48	10831
10	Tamil-nadu*	2650													1.78	0.06	3.21	1.78	0.06	3.21	216
11	West Bengal	42003	0	4.96		5.17	1.7	32.88	5.72	12.86	224.83	97.49	36.19	37.12	74.24	25.12	33.84	182.62	80.83	44.26	19245
	Total for All States	311605	9.8	13.49	137.65	57.86	55.34	95.64	203.83	82.14	40.30	264.43	177.18	67.00	261.88	105.78	40.39	797.80	433.93	54.39	13926

Data source - ROPs & PIPs. Expenditure data is presented as reported by states and may need further verification.
* Financial Data for the Tamilnadu not available for period before 2011-12

TABLE 5.3 - FUNDS RELEASED AND EXPENDITURE ON ASHA PROGRAM - NORTH EAST STATES - REPORTED IN RS. CRORES

Sl. No.	Name of State	No of ASHAs (as on 31 March 2011)	2005-08			2008-09			2009-10			2010-11			2011-12			Total : 2005 - 2012			
			Fund released	Ex-pendi-ture	% Expendi-ture over fund released	Fund re-leased	Ex-pendi-ture	% Expendi-ture over fund released	Fund re-leased	Ex-pendi-ture	% Ex-penditure over fund released	Fund re-leased	Ex-pendi-ture	% Expendi-ture over fund released	Fund released	Expendi-ture	% Expendi-ture over fund released	Total Fund released	Total Expend-iture	% Ex-penditure over fund released	Total Fund Spent per ASHA, (in Rs.)
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
1	Arunachal Pradesh	3649	1.2	1.1	91.67	3.86	1.49	38.60	3.86	2.48	64.25	3.86	2.31	59.84	3.28	2.61	79.61	16.06	9.99	62.21	27382
2	Assam	29114	14.55	4.53	31.13	29.69	2.27	7.65	29.69	29.33	98.79	31.04	29.00	93.43	28.00	11.31	40.41	132.97	76.44	57.49	26257
3	Manipur	3878	0	0.39		1.28	0.91	71.09	3.88	1.37	35.31	3.88	1.78	45.88	3.50	2.09	59.70	12.54	6.54	52.15	16867
4	Meghalaya	6258	1.16	0.05	4.31	3.96	2.18	55.05	6.25	1	16.00	6.25	3.99	63.84	6.26	2.39	38.15	23.88	9.61	40.24	15352
5	Mizoram	987	0.02	0.05	250.00	0.94	0.92	97.87	0.94	0.76	80.85	0.94	0.56	59.57	0.54	0.43	80.79	3.38	2.72	80.66	27600
6	Nagaland	1700	0.83	0.44	53.01	0.75	0.88	117.33	1.7	1.04	61.18	1.70	1.39	81.76	1.70	1.42	83.52	6.68	5.17	77.39	30410
7	Sikkim	666	0.18	0.19	105.56	0.19	0.12	63.16	0.64	0.34	53.13	0.65	0.48	73.85	0.67	0.65	97.58	2.33	1.78	76.54	26762
8	Tripura	7367	3.78	0.95	25.13	4.17	4.49	107.67	5.26	2.44	46.39	7.37	1.29	17.50	5.71	4.01	70.18	26.29	13.18	50.12	17885
	Total for All States	53619	21.72	7.7	43.53	44.84	13.26	29.57	52.22	38.76	74.22	55.69	40.80	73.26	49.65	24.92	50.18	224.12	125.44	55.97	23394

Data source - ROPs & PIPs. Expenditure data is presented as reported by states and may need further verification.

TABLE 5.4 - FUNDS RELEASED AND EXPENDITURE ON ASHA PROGRAM - UNION TERRITORIES - REPORTED IN RS. CRORES

Sl. No.	Name of State	No of ASHAs (as on 31 March 2011)	2007-08			2008-09			2009-10			2010-11			2011-12			Total-2005-12			
			Fund released	Expenditure	% Expenditure	Fund released	Expenditure	% Expenditure	Fund released	Expenditure	% Expenditure	Fund released	Expenditure	% Expenditure	Fund released	Expenditure	% Expenditure	Total Fund released	Total Expenditure	% Expenditure	Total Fund Spent per ASHA, (in Rs.)
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
1	Andaman and Nikobar	407	0.02	0.003	15.00	0.04	0.033	82.50	0.01	0.04	400.00	0.10	0.07	70.00	0.10	0.08	84.61	0.27	0.23	85.41	5654
2	Dadra & Nagar Haveli	107	0	0.016		0.07	0.1	142.86	0.04	0.007	17.50	0.11	0.01	9.09	0.10	0.02	18.46	0.32	0.15	46.92	14235
3	Lakshdweep	83	0.07	0.051	72.86	0.02	0.13	650.00	0.06	0	0.00	0.09	0.03	33.33	0.10	0.00	0.00	0.34	0.21	62.13	25422
4	Chandigarh	423	0	0		0	0		0.11	0	0.00	0.01	0.01	100.00	0.02	0.00	0.00	0.14	0.01	7.35	236
	Total for All UTs	1020	0.09	0.07	77.78	0.13	0.263	202.31	0.22	0.047	21.36	0.31	0.12	38.71	0.32	0.10	32.36	1.07	0.60	56.41	5916

Data source - ROPs & PIPs. Expenditure data is presented as reported by states and may need further verification.

ABBREVIATIONS
AMG – ASHA Mentoring Group
ARC – ASHA Resource Centre
AF – ASHA Facilitators
BC – Block Coordinators
BAC – Block ASHA Coordinator
BCM – Block Community Mobiliser
BPM – Block Programme Manager
CPRC – Community Processes Resource Centre
DAC – District ASHA Coordinator
DCM – District Community Mobiliser
DDA – District Data Assistant
DPM – District Programme Manager
DRP – District Resource Person
HBNC – Home Based Newborn care
IMR – Infant Mortality Rate
IPPI – Intensive Pulse Polio Immunization
JSY – Janani Surakhsha Yojna
JSSK – Janani Shishu Surakhsha Karyakram
MGCA – Monitoring Group for Community Action
MMR – Maternal Martality Rate
NMR – Neonatal Martality Rate
Pf – Plasmodium falciparum Pv – Plasmodium vivax
SHRC – State Health Resource Centre
VHSRC – Village Health Sahiya Resource Centre

NATIONAL RURAL HEALTH MISSION

Ministry of Health and Family Welfare
Government of India, New Delhi