NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

UPDATE ON
ASHA PROGRAMME

JANUARY 2018

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Introduction

This is the seventeenth issue of the ASHA Update and covers the period July 2017 to December 2017. The issue is structured according in its usual format, opening with the report on the status of selection, training and support structures for ASHA in rural and urban areas. The status of selection and training shows a slight increase over the previous six months, but the pace of training is unaccountably slow. The process of certification marks a milestone in the ASHA programme, to standardize the quality of training and to ensure that the ASHA is certified in a set of basic skills. An estimated 2260 ASHAs and ASHA Facilitators from 9 states- Arunachal Pradesh, Assam, Delhi, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Sikkim and Tripura are expected to appear in the first theory examination to be organized in late January, 2018 by NIOS.

Section Three is an excerpt of Community Processes chapter of the Eleventh Common Review Mission report which draws a positive picture of the ASHA programme, with an increasing number of states contributing resources from the state budget to include monetary and non-monetary incentives for the ASHA, both as a form of recognition, and as a way of motivating and sustaining her efforts. The findings, however, in equal measure highlight the limited policy and programmatic attention to the stagnation in training and quality of field support.

Section Four reports on the evaluation of the ASHA programme of Tripura state. Using a realist evaluation methodology, the evaluation highlights high functionality levels of the ASHA and a strong training and support system, but also emphasizes lacunae in the competencies of the ASHA in being able to recognize danger signs early and undertake referral. The state's ASHA Varosha Divas planned as a monthly meeting in which ASHA skills are assessed, while highlighted as a best practice, fails to live upto its potential as a measure for continued competency building of the ASHA.

Section Five describes the development and application of a systems readiness tool to assess the preparedness of the health system in undertaking universal screening for five Common Non-Communicable diseases. While the study itself traces system preparedness from community to district level services, this section focuses on the function of the ASHA in this intervention. The key role of the ASHA is in population enumeration to identify all adults thirty years and above, undertake mobilization for screening by the Multi purpose worker, undertake health promotion for behavioural change and follow-up for treatment adherence. As the findings show, ASHAs are enthusiastic in embracing this new role, but there are gaps in training, job-aids, but most importantly a lack of preparedness of higher level facilities to undertake screening and treatment of patients diagnosed and supervisory and mentoring support to the ASHA.

The role of the ASHA in contributing to improvements in maternal, new born and child health indicators has been well documented. In order for the ASHA to continue to retain community embeddedness and serve a pivotal role in comprehensive primary health care, her competencies and skills in taking on newer

roles will need strengthening. Thanks to the diversity of health system contexts, several states that have strengthened health care systems and achieved high levels of coverage with RCH interventions, have begun expanding the range of services available to communities for primary health care. In Section Six, we report on three best practices. The first one from Kerala reports on the role of the ASHA in the state's mental health programme, named, *Sampoorna Manasikarogyam*, in which the ASHA after a community awareness programme, undertakes home visits, screening using a structured case detection questionnaire, referral and mobilization for treatment. In the second, using the platform of Participatory Learning and Action, (PLA) that has proved successful in reducing newborn deaths in the state of Jharkhand, women's groups and Sahiyyas, actively facilitated by *Ekjut* and *SNEHA* were trained in addressing gender based violence. This pilot with 39 women's groups demonstrates that the PLA approach has benefits beyond maternal and newborn health. The third Best Practice is the use of a maternal clinical assessment tool by ASHAs, to strengthen their ability to identify and track high risk pregnant women and women in the post-partum period, which enabled early access to care.

All three best practices yield some valuable lessons beyond the positive health outcomes. In the Kerala experience, notwithstanding the best efforts of the ASHA, in the cases of chronic illnesses, the Medical officer at the Primary Health Centre and a strong functional district health system spanning the functions of clinical, managerial and public health is necessary. The Jharkhand intervention demonstrates the key role of NGOs in facilitating intensive community processes at the pilot stage in capacity building, concurrent documentation and evaluation and supporting the district/sub district teams to undertake implementation. The Karnataka experience demonstrates that the use of technology can be empowering for frontline workers with positive health outcomes and improving continuum of care. Here again the role of an intermediary NGO was crucial.

The final section of the report provides an updated list of incentives as of December 2017. These incentives are those approved at the national level. State specific incentives are also funded through the instrument of the Project implementation Plans and can also be provided through state budgets.

2
SECTION

Programme Update

A. STATUS OF ASHA SELECTION

A total of 9,39,978 (92%) ASHAs are in position against the target of 10,22, 265. There has been an increase in both the target and number of ASHAs in position in the last six months. The total selection target increased from 10,21,543 to 10,22, 265 and number of ASHAs in position also show a corresponding increase from earlier 9,38,054 to 9,39,978.

A.1 National Rural Health Mission

The previous edition of Update reported substantial downward revisions in target and selected number of rural ASHAs on account of state specific corrections undertaken to avoid duplications in figures of rural-urban ASHAs and the turnover rates. The overall target and selection however, shows an increase and indicates that certain states have revised the targets and selected new ASHAs to improve coverage of the left-out population.

The present target for rural ASHAs is 9,48,070 in comparison to 9,47,130 reported in July 2017. 8,83,062 ASHAs are currently in position in rural areas in comparison to 8,77,835 engaged six months before. At the national level, this has enabled achieving about 93% of selection against the target of 9,48,070 for the rural areas.

States which have increased selection targets are Chhattisgarh (+650), Madhya Pradesh (+165), Andhra Pradesh (+1012).

Overall, 5227 ASHAs have been newly inducted in the programme in the last six months. Of this, significant proportion 58% (3018) new ASHAs have been added in the high focus states. All high focus states show a significant increase in the number of ASHAs except Uttarakhand where a drop out of 73 ASHAs is observed in the last six months.

Amongst the North East states- Arunachal Pradesh and Assam have selected new ASHAs and the numbers of ASHAs in position remain largely unchanged for other states. All eight states have completed selection of nearly 99% ASHAs against the target.

Nearly 91% ASHAs are in position against the target in the Non-High Focus States. From July 2017 significant increase in the number of new ASHAs selected are observed in Karnataka (+1544), Andhra Pradesh (+1242) Gujarat (+441), West Bengal (+232), Haryana (+126) and Punjab (+125). Maharashtra is the only state amongst the Non-High focus group that shows a downward revision in the target and selected number of ASHAs mainly due to drop outs amongst ASHAs.

Some states and UTs have less than 90% ASHAs against the target. These are Rajasthan (88%), Kerala (78%), Tamil Nadu (57%), West Bengal (81%), Chandigarh (62%), Dadar and Nagar Haveli (83%), Daman and Diu (75%) are the few states and Union Territories where ASHA selection status is less than 90%.

Population Density

Average population being covered by an ASHA under NRHM at national level is 899 and is a minor reduction from 902 reported in July 2017. The range of rural population covered by ASHA varies from 189 to 1259 reported by Lakshadweep and West Bengal respectively. The population density has remained unchanged for North East states and Union Territories at 653 and 609 respectively over the last six months. However, it has reduced from 880 to 874 in High Focus states and by a single point to 979 in Non-high Focus states.

Though, few states Odisha (775 to 777), Uttarakhand (705 to 710), Arunachal Pradesh (279 to 278), Andhra Pradesh (856 to 886) and Maharashtra (1044-1065) report an increase in population density in the last six months; significant number of new ASHAs selected in other states have brought down the average population being covered by an ASHA.

Bihar, Rajasthan, Uttar Pradesh, Karnataka, Maharashtra, Punjab and West Bengal continue to have population density of over 1000 but these states also indicate reductions in the average population covered by each ASHA. Maharashtra is the only state with- above 1000 population per ASHA that shows an increase in population density over the last six months.

A.2 National Urban Health Mission

77% ASHAs are now in position against the target of 74, 915 under the National Urban Health Mission. The target for urban ASHAs shows an increase from 74,413 to 74,915 from July 2017. However, the number of ASHAs in position has reduced significantly in the last six months. 56,916 ASHAs are presently working in urban areas and there has been a drop out of 3603 ASHAs over the last six months.

Overall, the number of urban ASHAs remain unchanged for Union Territories and shows an increase in High Focus and North East States from 19402 to 19820 and from 2179 to 2296 respectively in the last six months. However, the Non-high focus states show higher reductions in number of urban ASHAs in this period of past six months.

States which have increased the pool of Urban ASHAs are Andhra Pradesh (926), Uttar Pradesh (+424), Karnataka (+395), Kerala (+233), Delhi (+230), Haryana (+146), Chhattisgarh (+70), Tripura (+67), Mizoram (+53) and Jharkhand (+19).

States which show major drop out in Urban ASHAs are: Maharashtra(-4120), Telangana (-1135) and West Bengal (-922) and Rajasthan (-109). The substantive reduction in Maharashtra is because the present numbers reflect the number of ASHAs actually on the ground, against the total number of ASHAs selected so far that was reported earlier.

More than half the states and UTs have selected more than 90% urban ASHA selection. Uttarakhand, Manipur, Mizoram, Tripura and Jammu and Kashmir are few states which have achieved 100% selection target for urban ASHAs. States which have selected more than 90% urban ASHAs against the target are: Odisha (98%) Chhattisgarh (97%), Assam (96%), Gujarat (96%), Arunachal Pradesh (95%) Jharkhand (95%), Haryana (94%), Punjab (94%), MP (93%), Nagaland (93%), Andhra Pradesh (93%) Delhi (92%), Dadar and Nagar Haveli (92%). and West Bengal (90%).

Only three states have less than 50% of ASHAs selected against the target and include: Kerala (38%), Maharashtra (34%), Daman and Diu (18%).

Table 1: State Wise ASHA Target, Selection and Density under NRHM and NUHM

State/UT	NRHM					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
High Focus States								
Bihar	93687	87210	93.1	92341436	1059	562	344	61.2
Chhattisgarh	70278	66215	94.2	19607961	296	3883	3771	97.1
Jharkhand	40964	39964	97.6	25055073	627	246	235	95.5
Madhya-Pradesh	62748	62681	99.9	52557404	838	4200	3907	93.0
Odisha	45665	44987	98.5	34970562	777	1482	1449	97.8
Rajasthan	51036	44902	88.0	51500352	1147	4674	3967	84.9
Uttar Pradesh	160175	145592	90.9	155317278	1067	6813	5109	75.0
Uttarakhand	10048	9907	98.6	7036954	710	1038	1038	100.0
Total	534601	501458	93.8	438387020	874	22898	19820	86.6
North East States								
Arunachal Pradesh	3862	3837	99.4	1066358	278	42	40	95.2
Assam	30619	30563	99.8	26807034	877	1336	1289	96.5
Manipur	3928	3928	100.0	1736236	442	81	81	100.0
Meghalaya	6519	6519	100.0	2371439	364	*210*	*169*	80.5
Mizoram	964	964	100.0	525435	545	*127*	127	100.0
Nagaland	1887	1887	100.0	1407536	746	*41*	*38*	92.7
Sikkim	641	639	99.7	456999	715	35	25	71.4
Tripura	6840	6832	99.9	2712464	397	527	527	100.0
Total	55260	55169	99.8	36017143	653	2399	2296	95.7
Non-High Focus States								
Andhra Pradesh	40021	39236	98.0	34776389	886	3698	3428	92.7
Delhi	NA	NA	NA	NA	NA	5809	5360	92.3
Gujarat	38902	36996	95.1	34694609	938	4114	3958	96.2
Haryana	18000	17349	96.4	16509359	952	2676	2506	93.7
Himachal Pradesh	7930	7829	98.7	6176050	789	34	28	82.4
Jammu & Kashmir	12000	11843	98.7	9108060	769	63	63	100.0
Karnataka	39195	36067	92.0	37469335	1039	3508	2757	78.6
Kerala	30927	24206	78.3	17471135	722	4804	1820	38.0
Maharashtra	61235	57782	94.4	61556074	1065	9877	3405	34.5
Punjab	17360	17200	99.1	17344192	1008	2600	2436	93.7
Tamil Nadu	6850	3905	57.0	NA	0	1336	0	0.0
Telangana	23887	23820	99.7	21585313	906	3843	3225	83.9
West Bengal	61008	49389	81.0	62183113	1259	6072	5481	90.3

State/UT	NRHM					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
Total	357315	325622	91.1	318873629	979	48434	34467	71.2
Union Territories								
Andaman & Nicobar	412	407	98.8	237093	583	10	0	0.0
Chandigarh	24	15	62.5	28991	0	25	18	72.0
Dadra- & Nagar Haveli	250	208	83.2	183114	880	50	46	92.0
Daman & Diu	98	73	74.5	60396	827	38	7	18.4
Lakshadweep	110	110	100.0	14141	129	0	0	0
Puducherry	0	0	0	395200	0	341	262	76.8
Total	894	813	90.9	494744	609	464	333	71.8
Total All India	**948070**	**883062**	**93.1**	**793772536**	**899**	**74195**	**56916**	**76.7**

B. STATUS OF ASHA TRAINING:

B.1. ASHA Training under NRHM

The number of ASHAs trained in Module 6 and 7 shows an increase to 97%, 91%, 73% and 53% ASHAs have been trained in four rounds of Module 6 and 7 respectively. Nationally, overall proportion of ASHAs trained in Round 1 of Module 6 and 7 remain largely the same but an average increase of 3-4%is observed in ASHA training achievements for Round 2,3 and 4 over the last six months. This builds a case that states with significant unmet training targets will need to plan more batches and expedite pace of training to enable completion of all four rounds of Module 6 and 7 by the end of Financial Year 2018.

In the High Focus States as a whole, the achievement for Module 6 and 7 training are 95%, 91%, 66%, and 43 % respectively for Rounds 1 to 4. Training figures for up to Round 3 show about cent percent achievement in Chhattisgarh, Odisha and Uttarakhand and are consistent with reports in July 2017 Update. Number of ASHAs trained up to Round 3 remain unchanged for Jharkhand in this last six months with more than 93% ASHAs been trained up to Round 3.

States which have moved forward in Module 6 and 7 training in High Focus states are the three large states of Madhya Pradesh, Rajasthan and Uttar Pradesh. These states had relatively a greater number of ASHAs to train and show an increase in ASHA training achievements for all three Rounds over the last six months. There has been a marginal increase of 2-5% for Round 1 and 3-6% for Round 2. The percent of ASHAs trained in Round 2 for MP has increased from 86-92%, in Uttar Pradesh it has gone up from 75 to 90% and in Rajasthan from 84 to 87% in the last six months. Progress in ASHA training for Round 3 has been comparatively slow for Madhya Pradesh (86 to 89%) and Rajasthan (65 to 70.3%). Uttar-Pradesh on the other hand, started Round 3 training in July 2017 and could complete training for 19% ASHAs in the last six months.

In the High focus group of states, Chhattisgarh and Odisha have trained more than 95% ASHAs in Round 4. Jharkhand and Uttarakhand are other two states which show substantial progress from July 2017 and have completed training 86% and 89% ASHAs respectively. Madhya Pradesh and Rajasthan have also moved forward and have trained about 57% and 47% ASHAs in Round 4. The only state where Round 4 training is yet to commence is Uttar Pradesh.

There are state specific reasons for slow progress in ASHA training. For example, as a move to improve training quality, Madhya Pradesh undertook a state-wide re-appraisal of the NGOs engaged in ASHA training, planned short refresher and re-evaluation of the ASHA trainers. Only those NGOs and trainers were continued to support trainings who could pass the re-appraisal criteria. Further training of ASHAs could commence only after the completion of this exercise and led to slow progress. The last six months in Rajasthan witnessed slow-downs related to contractual workforce under NHM making it difficult for the state team to schedule trainings across the districts.

The 20 days training for ASHAs in four rounds of Module 6 and 7 was initiated in Bihar with support from NGOs as State Training Agencies at the state and district level in year 2011. Use of four NGO-State Training Agencies (STAs) for implementing trainings at the state and district has been discontinued since March 2016. Challenges with respect to identification of training sites and attrition of trainers thereafter have stalled progress in ASHA trainings in Bihar.

Majority North East States have trained more than 95% ASHAs up to Round 3, except Arunachal Pradesh and Meghalaya. These states have trained about 90% ASHAs in Round 2 and 3 and would need to expedite this training for remaining 10% ASHAs.

Training of all ASHAs in Sikkim and Tripura and 95% ASHAs in Assam and Manipur has been completed in Round 4. Arunachal Pradesh, Meghalaya and Nagaland report training 79%, 83% and 84 % ASHAs respectively in Round 4.

Amongst the Non-High focus states, Haryana, Maharashtra, Telangana and West Bengal had trained 100% ASHAs in first round in July 2017 itself. Karnataka and Kerala covered substantial ground in the last six months and have completed training for all targeted ASHAs in Round 1. All other remaining states have trained 95% ASHAs up to Round 1 except Andhra Pradesh and Tamil Nadu that have trained 84% and 50% ASHAs respectively. As reported in July 2017, Round 2 training has been completed for all ASHAs in Haryana, Maharashtra and Telangana. Gujarat, Himachal-Pradesh and Punjab trained few ASHAs in Round 2 in the last six months and now have more than 96% ASHAs trained. Karnataka and West Bengal trained 1078 and 983 ASHAs in the last six months in Round 2 taking their achievement to 83% and 100% respectively. Overall progress in Round 3 training for the Non-High Focus states shows only a marginal increase of about 2% in the last six months. Jammu and Kashmir took a major leap by training maximum number of 2341 ASHAs in Round 3 and enabling the state to train 92% ASHAs in this round. Other states that trained 1000 plus ASHAs in the last six months were Maharashtra(1238), West Bengal(1172) and Telangana(1029) increasing their training achievement in Round 3 training to 97%, 98% and 73% respectively. Andhra Pradesh, Tamil Nadu and Kerala are few states with comparatively low training achievements and report slow progress for training in Round 3.

Round 4 training progressed well in Gujarat, Himachal Pradesh, Maharashtra, Punjab and West Bengal and these states have trained its 91%, 95%, 92%, 86% ASHAs respectively.

Non-high focus states where Round 4 training is yet to begin are Haryana, Telangana, Jammu and Kashmir and Kerala. Andhra Pradesh and Karnataka will need to expedite progress in Round 4 training with 49% and 78% training achievement so far.

None of the Union Territories have gone beyond Round 2 training of ASHAs in Module 6 and 7. Except Daman and Diu that has trained 100 percent ASHAs in Round 1, the other UTs have a substantial ground to cover with respect to training their ASHAs. The UTs need to the harness the advantage of having smaller numbers and plan for continuous trainings in upcoming months to consolidate their training achievements.

B.2. ASHA Training Under NUHM

During the last six months there has been a significant increase in training of Urban ASHAs in Induction Module from 70.1% in July 2017 to 85.8% in January 2018. While the total induction training achievement

has not increased for High Focus and North East states, it has increased substantially from 59% to 82.9 % in the Non-High focus states.

In the High focus states, induction training for new urban ASHAs has been completed in-Rajasthan and Uttar Pradesh. Chhattisgarh selected new Urban ASHAs and this proportionately reduced its training achievement to 99% in this last six months. Bihar, Madhya Pradesh and Odisha are other states that show good progress with more than 90%ASHAs trained in Induction round. Jharkhand could train only 185 Urban ASHAs in the last six months and with 79% achievement of induction training, state will need to expedite further progress. Uttarakhand is the only state where Urban ASHA training has not moved forward in the last six months and remains stagnant at just 5% ASHAs trained in Induction Module.

The North East States except Meghalaya and Tripura have completed training for Urban ASHAs. While Meghalaya has trained 88% urban ASHAs, Tripura is yet to commence this training.

Amongst the Non-High Focus Delhi has the oldest Urban ASHA programme in the country and has completed training ASHAs in induction as well as Module 6 and 7.

The good news is state of West Bengal could start Induction training for urban ASHAs in the last six months and has also trained 3341 (61%) ASHAs. Maharashtra trained 1181 new urban ASHAs thus completing induction training for its target number of ASHAs. Other states which show significant progress in training are Gujarat and Haryana which have added 458 and 268 trained ASHAs in the urban pool.

With regards Module 6 and 7 training, nationally we see about 9% increase in training of ASHAs in Round 1. In the High Focus states - Bihar, Jharkhand, Uttar Pradesh and Uttarakhand are yet to start this training for urban ASHAs. Training figures remained unchanged for Chhattisgarh (99% ASHAs trained), Madhya Pradesh (64% ASHAs trained) and Rajasthan (94% ASHAs trained) and have increased for Odisha from 1222 to 1393. Training scenario for Round 1 in North East states remains unchanged in the last six months. Three states- Meghalaya, Manipur and Nagaland have completed training target number of ASHAs while other states could not commence this round in the past six months.

Amongst the Non-High Focus states, only Gujarat, Haryana, Maharashtra and Punjab commenced this training last year and show a significant increase in the training achievements. Delhi, Gujarat, Punjab and Haryana have trained more than 90% urban ASHAs in Round 1 while Maharashtra has trained 41% of urban ASHAs.

Table 2: Status of ASHA Training under NRHM

State/UT	No. of ASHA - Target	ASHA selected or 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.	%	No.	%
High Focus States										
Bihar	93687	87210	78336	89.8	67725	77.7	55818	64	7148	8
Chhattisgarh	70278	66215	66169	99.9	66169	99.9	66169	99.9	66169	100
Jharkhand	40964	39964	37045	92.7	37271	93.3	37910	94.9	34386	86
Madhya Pradesh	62748	62681	61317	97.8	60740	96.9	55776	88.9	35554	57
Odisha	45665	44987	45260	100.6	45289	100	45241	100	42731	95
Rajasthan	51036	44902	42754	95.2	38742	86.3	31559	70.3	21030	47
Uttar Pradesh	160175	145592	137531	94.5	130814	89.9	27885	19.1	0	0
Uttarakhand	10048	9907	10313	104.1	10381	104.8	10286	103.8	8821	89
Total	**534601**	**501458**	**478725**	**95.5**	**457131**	**91.2**	**330644**	**65.9**	**215839**	**43**

State/UT	No. of ASHA - Target	ASHA selected or 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.	%	No.	%
North East States										
Arunachal Pradesh	3862	3837	3669	95.6	3472	90.5	3472	90.5	3032	79.0
Assam	30619	30563	29560	96.7	29257	95.7	29215	95.6	29179	95.5
Manipur	3928	3928	3804	96.8	3804	96.8	3804	96.8	3756	95.6
Meghalaya	6519	6519	5891	90.4	5873	90.1	5941	91.1	5414	83.1
Mizoram	964	964	964	100.0	964	100.0	964	100.0	964	100.0
Nagaland	1887	1887	1887	100.0	1887	100.0	1887	100.0	1593	84.4
Sikkim	641	639	641	100.3	641	100.3	639	100.0	639	100.0
Tripura	6840	6832	7257	106.2	7009	102.6	7280	106.6	7252	106.2
Total	**55260**	**55169**	**53673**	**97.3**	**52907**	**95.9**	**53202**	**96.4**	**51829**	**94.0**
Non-High Focus States										
Andhra Pradesh	40021	39236	33367	85.0	32427	82.7	24932	63.5	19057	48.6
Delhi	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Gujarat	38902	36996	35678	96.4	34849	94.2	34223	92.5	33637	90.9
Haryana	18000	17349	18900	108.9	18399	106.1	17081	98.5		0.0
Himachal Pradesh	7930	7829	7539	96.3	7529	96.2	7474	95.5	7473	95.5
Jammu & Kashmir	12000	11843	11683	98.7	11453	96.7	10864	91.7	NA	0.0
Karnataka	39195	36067	36724	101.8	30147	83.6	26802	74.3	27984	77.6
Kerala	30927	24206	26192	108.2	4400	18.2	0	0.0	0	0.0
Maharashtra	61235	57782	57782	100.0	57512	99.5	56109	97.1	53111	91.9
Punjab	17360	17200	16263	94.5	16263	94.6	16436	95.6	16344	95.0
Tamil Nadu	6850	3905	1953	50.0	1953	50.0	1953	50.0	1953	50.0
Telangana	23887	23820	26309	110.5	24096	101.2	17564	73.7	NA	0.0
West Bengal	61008	49389	50435	102.1	49833	100.9	48451	98.1	42163	85.4
Total	**357315**	**325622**	**322825**	**99.2**	**288861**	**88.7**	**261889**	**80.4**	**201722**	**62.0**
Union Territories										
Andaman & Nicobar	412	407	272	66.8	272	66.8	0	0	0	0
Chandigarh	24	15	0	0.0	NA	0.0	0	0	0	0
Dadra & Nagar Haveli	250	208	68	32.7	45	21.6	0	0	0	0
Daman & Diu	98	73	73	100.0	55	75.3	0	0	0	0
Lakshadweep	110	110	0	0.0	0	0.0	0	0	0	0
Total	**894**	**813**	**413**	**50.8**	**372**	**45.8**	**0**	**0**	**0**	**0**
Total All India	**948070**	**883062**	**855636**	**96.9**	**799271**	**90.51**	**645735**	**73.12**	**469390**	**53.15**

Table 3: Status of ASHA Training Under NUHM

State/UT	ASHA selected	Induction Training		Module 6and 7 (Round 1)	
	No	No	%	No	%
High Focus States					
Bihar	344	313	91.0	0	0.0
Chhattisgarh	3771	3730	98.9	3730	98.9
Jharkhand	235	185	78.7	0	0.0
Madhya Pradesh	3907	3723	95.3	2650	67.8
Odisha	1449	1360	93.9	1393	96.1
Rajasthan	3967	3967	100.0	3712	93.6
Uttar Pradesh	5109	5109	100.0	0	0.0
Uttarakhand	1038	50	4.8	0	0.0
Total	**19820**	**18437**	**93.0**	**11485**	**58.0**
North East States					
Arunachal Pradesh	40	40	100.0	0	0.0
Assam	1289	1336	103.7	0	0.0
Manipur	81	81	100.0	0	0.0
Meghalaya	169	148	87.6	169	100.0
Mizoram	127	127	100.0	127	100.0
Nagaland	38	41	107.9	41	107.9
Sikkim	25	25	100.0	0	0.0
Tripura	527	0	0.0	0	0.0
Total	**2296**	**1798**	**78.3**	**337**	**14.7**
Non-High Focus States					
Andhra Pradesh	3428	0	0.0	0	0.0
Delhi	5360	6221	116.1	5764	107.5
Gujarat	3958	3790	95.7	3574	90.3
Haryana	2506	2572	102.6	2438	97.3
Himachal Pradesh	28	32	114.3	0	0.0
Jammu & Kashmir	63	63	100.0	0	0.0
Karnataka	2757	2582	93.7	0	0.0
Kerala	1820	1587	87.2	0	0.0
Maharashtra	3405	3405	100.0	1393	40.9
Punjab	2436	2362	97.0	2362	97.0
Tamil Nadu	0	0		0	
Telangana	3225	2644	82.0	0	0.0
West Bengal	5481	3341	61.0	0	0.0
Total	**34467**	**28599**	**82.9**	**15531**	**45.1**
Union Territories					
Chandigarh	18	NA	0.0	NA	0.0
Dadra & Nagar Haveli	46	NA	0.0	NA	0.0
Daman & Diu	7	NA	0.0	NA	0.0
Puducherry	262	NA	0.0	NA	0.0
Total	**333**	**NA**	**0.0**	**NA**	**0.0**
Total All India	**56916**	**48834**	**85.8**	**27353**	**48.1**

UPDATE ON ASHA CERTIFICATION

The January 2016 edition of ASHA Update reported on the process of ASHA Certification. The process began in 2014 with a tripartite arrangement between the Ministry of Health and Family Welfare (MoHFW), National Health Systems Resource Centre (NHSRC) and the National Institute of Open Schooling (NIOS) to initiate the process of accreditation of training sites and certification for trainers and ASHAs/ASHA Facilitators (AF).

A key objective of the certification was to provide a legal and administrative framework within which the ASHA would be responsible for providing community level care for a range of illnesses.

The process would also enhance the competency and professional credibility of ASHAs, allow her to use a set of drugs and point of care diagnostics appropriate to that level of care and also provide an assurance to the community on the quality of services being provided by the ASHA. It would also promote the ASHA's sense of self recognition and worth.

The year 2017 witnessed field level action with reference to the process of the ASHA Certification. Based on the readiness of the states (assessed on the levels of completion of training of ASHAs in Rounds 1-4 of Module 6 & 7), the ASHA Certification has been implemented so far in 17 states namely Arunachal Pradesh, Assam, Chhattisgarh, Delhi, Gujarat, Himachal Pradesh, Jammu and Kashmir, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Punjab, Odisha, Sikkim, Tripura, Uttarakhand and West Bengal.

This programme involves accrediting or certifying four key components:
(i) Training curriculum
(ii) Training Sites
(iii) Trainers
(iv) ASHAs and ASHA Facilitators

The supplementary book that was developed to aide ASHAs in preparation for Certification is now available in Hindi, English and a few regional languages-Assamese, Kannada, Bengali, Marathi, Punjabi, Nepali, Urdu, Odia and Gujarati.

Hitherto, 31 state training sites across the above mentioned 17 states and 33 district training sites across 7 states (Arunachal Pradesh, Assam, Delhi, Jammu and Kashmir, Jharkhand, Odisha and Punjab) have been accredited by NIOS. National Resource Team (NRT) of 27 trainers was created by NHSRC to support the programme in training of trainers and accreditation of training sites. 158 state trainers from the above-mentioned 17 states have now been trained by NRTs in a 6-days refresher training organized by NHSRC and have been certified by NIOS. 310 District trainers have been certified across 12 states - Arunachal Pradesh, Assam, Gujarat, Jammu and Kashmir, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Odisha, Punjab, Sikkim and Uttarakhand.

The final step in the programme is certification of ASHAs and ASHA Facilitators and has been initiated after certification of district/ASHA trainers, accreditation of state/district training sites and after ensuring availability of supplementary book in regional languages in the concerned states.

ASHAs and ASHA Facilitators underwent a 10- days Refresher training in certification covering the content given in the supplementary book provided to them by NIOS in the last six months. The training also included practice of essential skills (weighing the new-born, measuring temperature of the new-born, keeping the new-born warm, preparation of ORS in case of diarrhoea, use of Nishchay kit for diagnosing pregnancy and hand-washing) and random skills (including viva and demonstration for malaria tests). These skills were practiced repeatedly during the course of the training and were performed by the ASHAs as a part of the final external skill evaluation conducted by NIOS. An estimated 2260 ASHAs and ASHA Facilitators from 9 states- Arunachal Pradesh, Assam, Delhi, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Sikkim and Tripura are expected to appear in the first theory examination to be organized in late January, 2018 by NIOS.

C. STATUS OF SUPPORT STRUCTURES FOR COMMUNITY PROCESSES

The status of support structures across states largely remains unchanged from previous edition of ASHA Update.

Among the eight high focus states all except Odisha, continue to have support cadre in place at all four levels, state, district, block and sub-block, level. Odisha continues to manage the programme support through regular cadre staff at block level. However, state has an additional cadre of District Coordinators for VHSNCs in position (26/30 in place).

Bihar, which has support cadre at all four levels, continues to report persisting high ratio of vacant positions at all levels except at state level. Few additions have been made at block level, where number of BCMs has increased from 277 to 294, and the ASHA Facilitators increased from 4140 to 4153. Similarly, Rajasthan, showed high proportion of vacancies in last update but has substantially closed the gap, especially at block level, (No. of Block ASHA Coordinators increased from 166 to 216 against the target of 249, and no. of AFs increased from 990 to 1395 against the target of 1528).Uttar Pradesh has added to its block and sub-block level cadres. BCMs increased from 722 to 803, against target of 820. AFs increased from 5931 to 5971, but their target also has seen minor raise, from 6807 to 6815. Madhya Pradesh has also seen additions (No. of BCMs increased from 252 to 267 against the target of 313, and no. of AFs increased from 4978 to 4268 against the target of 5074). There is no change in support cadres in Chhattisgarh (with 100% positions filled at all levels except AF), and Jharkhand and Uttarakhand (with almost all positions filled).

The support structures in the eight north-east states remain at the same level, with no major additions seen. Sikkim, which had reported initiating recruitment of support cadre at block level, has not yet completed the process. Only noteworthy additions is in Meghalaya (AFs increased from 324 to 334 against target of 334).

Most of the Non-High focus states, continue to utilize regular cadre staff in ASHA programme support at different levels. But Himachal Pradesh has added a new cadre of BCMs at block level (70/74 in place). Consequently, it has, along-with Haryana and Maharashtra, dedicated support cadre for community processes at all four levels. But Haryana has seen a decrease in no. of AFs in position (from 575 to 554), and the state is also unable to recruit for vacant AF positions, due to an ongoing court case. It has also seen additions to DCMs (no. of DCMs in place increased from 17 to 20, but the target also increased from 21 to 22). Maharashtra and West Bengal are two other states that have seen noteworthy additions to their support cadres. States that continue to have put in place dedicated support cadres at three levels are Punjab (state, district & AF level) and Karnataka (state, block & AF level).

Table 4: Status of Community Process Support Structure

State	State Level	District Level	Block Level	Sector Level
Bihar	State AMG was constituted in June 2010, two meetings held so far and the last meeting held on June 2016. ARC set up and registered, as a separate society accountable to State Health Society. Seven members team of ARC and 9 out of 12 Divisional Coordinators currently in position. There are also 38 DDAs out of 54 sanctioned. State Trainers: Round 1 - 6 Round 2 - 2 Round 3 - 6	12/38 District Community Mobilisers in place District Trainers: Round 1 - 803 Round 2 - 532 Round 3 - 190	294/534 Block Community Mobilisers in place.	4153/4470 ASHA Facilitators in place, (1 per 20 ASHA).

State	State Level	District Level	Block Level	Sector Level
Chhattisgarh	AMG Not established. ARC is working under SHRC with a team of 6 programme coordinators led by a team leader. 2 programme associates in place for NUHM. 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: NRHM - 292 NUHM - 25	292/292 Block Mobilisers in place for NRHM and 25/25 Block Coordinators for NUHM. Mitanin Trainers – 3351	3150/3220 Mitanin trainers (AFs) in place, (1 per 20 ASHAs). Under NUHM-202/204 Mitanin trainers (AFs) in place (1 per 20 ASHAs).
Jharkhand	State AMG constituted in 2012 and reconstituted in 2013, 10 meetings held, last meeting in October 2017. Community Mobilization Cell/ARC works within SPMU with three consultants. State Trainers: Round 1 - 9 Round 2 - 9 Round 3 - 9	22/24 District Programme Coordinators in place. District Trainers: Round 1 - 44 Round 2 - 39 Round 3 - 39	656/688 Block Trainers & DRPs in place.	2200/2200 Sahiya Saathi in place (1 per 20 Sahiyas).
Madhya Pradesh	State AMG formed in Oct 2008, later merged with MGCA. 23 meetings held. Last meeting in Dec 2017. ARC team led by State Nodal officer with 2 team members. State Trainers: Round 1 – 41 Round 2 – 39 Round 3 – 25 Dec Rep - R 1, 2 & 3 - 27	46/51 District Community Mobilisers in place. District MGCAs formed. District Trainers: Round 1 - 458 Round 2 - 416 Round 3 - 367	267/313 Block Community Mobilisers in place, 313 Block MGCAs in place.	4268/5074 ASHA Facilitators in place (1 for 10 ASHAs in tribal areas, and 1 for 2 sub-centres in other areas).
Odisha	State AMG constituted in 2009, total 4 meetings held, last meeting in 2012. Community Processes Resource Centre (CPRC) in place with a team 4 Sr./ consultants & 5 training coordinators and 1 programme assistant. State Trainers: Round 1 – 16 Round 2 – 16 Round 3 – 16	30/30 District Community Mobilisers in place. District AMGs constituted. 26/30 District Coordinators for GKS are also in place. District Trainers – 267	Existing Block PMU staff manages the programme.	2210/2290 Community Facilitators (AFs) in place. (1 per 20 ASHAs).

State	State Level	District Level	Block Level	Sector Level
Rajasthan	State AMG constituted in June 2006, last meeting held in Sep 2010. Team of two consultants working in SPMU. State Trainers: Round 1 - 25 Round 2 - 25 Round 3 - 25	26/34 District Community Mobilisers in place. District Trainers: Round 1 - 745 Round 2 - 718 Round 3 - 631	216/249 Block ASHA Coordinators in place.	1395/1528 PHC ASHA Supervisors in place (1 per PHC).
Uttar Pradesh	State AMG constituted in Aug 2008, last meeting held in Dec 2016. Community Processes Division led by a Nodal officer works within SPMU, with a team of 10 Consultants. 10/12 Regional Coordinators also in place. State Trainers: Round 1 - 71 Round 2 - 63 Round 3 - 4	70/75 District Community Mobilisers in position. 72 Districts have District AMGs. District Trainers: Round 1 - 3135 Round 2 - 1650	803/820 Block Community Mobilisers in place.	5971/6815 ASHA Facilitators in position. (1 per 20 ASHAs).
Uttarakhand	AMG constituted in 2009, total 26 meetings held, last meeting in May 2016. State has one Nodal Officer, 1 program manager & 2 Programme Coordinators in place in SPMU. State Trainers: Round 1 - 6 Round 2 - 5 Round 3 - 5	District ARCs outsourced to NGOs. 13/13 District Community Mobilisers in place. District Trainers: Round 1 - 165 Round 2 -156 Round 3 - 75 State has reported that at presently only 13 DCMs are available as both, state and district trainers.	101/101 Block Community Mobilisers in place. NUHM – 6 Community Mobilisers in place.	604/606 AFs in place. (The target of 606 includes 550 rural & 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, 9 meetings held, last meeting held in Aug 2015. ARC – 3 member team within SPMU. State Trainers: Round 1 - 2 Round 2 - 2 Round 3 - 3	17/20 District Community Mobilisers in place District Trainers: Round 1 - 22 Round 2 - 28 Round 3 - 28	84/84 Block Community Mobilisers in place.	348/352ASHA Facilitators in place (1 per 10-15 ASHAs).

State	State Level	District Level	Block Level	Sector Level
Assam	State AMG constituted in 2010-11, 8 meetings held. Last meeting held in Jan 2016. ARC housed in SPMU, with 1 Programme Manager - ASHA, and 1 State Community Mobilizer in place. State Trainers: Round 1 - 15 Round 2 - 12 Round 3 - 7	26/27 District Community Mobilisers in place District Trainers: Round 1 - 447 Round 2 - 447 Round 3 - 447	139/149 Block Community Mobilizers in place.	2878/2878 ASHA Facilitators in place (1 per 10 ASHAs)..
Manipur	State AMG constituted in Dec 2008, 11 meetings held. 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 District Community Mobilisers in place. District Trainers: Round 1 - 62 Round 2 - 62 Round 3 - 62	Existing BPMU staff.	192/194 ASHA Facilitators (1 per 10 to 20 ASHAs) in place.
Meghalaya	AMG formed in Oct 2009. 6 meetings held. Last meeting held in Oct 2014. ARC in place, within SPMU with 2 programme managers. State trainers: Round 1 - 3 Round 2 - 3 Round 3 - 2	10/11 District Community Process Coordinators in place. District Trainers: Round 1 - 66 Round 2 - 56 Round 3 - 56	Existing BPMU staff.	334/334 ASHA Facilitators in place (1 per 20 ASHAs).
Mizoram	State AMG constituted in April 2008, 9 meetings held, last meeting held in Sep 2015. ARC team within SPMU, with a team of three consultants. State Trainers: Round 1 - 3 Round 2 - 3 Round 3 - 3	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 March 2010, 5 meetings held, last meeting in Aug 2013. ARC housed under SPMU. with team of 2. State Trainers: Round 1 - 3 Round 2 - 2 Round 3 - 2	11/11 District Community Mobilisers in place. District Trainers: Round 1 - 63 Round 2 - 63 Round 3 - 63	68/68 Block ASHA Coordinators (BACs) in place.	Block ASHA Coordinators play field level support role.

State	State Level	District Level	Block Level	Sector Level
Sikkim	State AMG constituted in 2010, reconstituted in April 2016. 2 meetings held, last meeting held in Nov 2013. One State ASHA Nodal Officer in place. State Trainers: Round 1 - 2 Round 2 - 2 Round 3 - 3	Existing DPMU staff. District Trainers: Round 1 - 18 Round 2 - 13 Round 3 - 11	Existing BPMU Staff.	71/71 ASHA Facilitators in place, (1 per 10 ASHAs).
Tripura	State AMG constituted in May 2009, 8 meetings held, last meeting held in Nov 2013. ARC constituted (1 state ASHA Programme Manager). State Trainers: Round 1 - 6 Round 2 - 6 Round 3 - 6	7/8 District ASHA Coordinators in place (3 DCMs in original 4 districts and 4 Sub Divisional Coordinators acting as DCM in newly formed district). District Trainers: Round 1 - 66 Round 2 - 89 Round 3 - 89	9/11 Sub-division level ASHA Coordinators in place.	399/400 ASHA Facilitators in place.

Status of ASHA support structure in Non High Focus States

Name of State	State Level	District Level	Block Level	Sector Level
Andhra Pradesh	AMG constituted in May 2015. Functions of ARC managed by a team based in SPMU and Directorate . State Trainers: Round 1 - 9 Round 2 - 9 Round 3 - 9	10/13 District Community Mobilisers 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 - 306 Round 2 - 317 Round 3 - 312	225/225 PHNs designated as Block Community Mobilisers.	1385/1410 Health Supervisors at PHC level play the role of ASHA Facilitator.
Delhi	State AMG formed in July 2010, 6 meetings held, last meeting held in Jan 2015. ARC in place; with one State level Nodal Officer, two State ASHA Coordinators, & two consultants. State Trainers: Round 1 - 54 Round 2 - 54 Round 3 - 54	8/11 District ASHA Coordinators in place District Mentoring Group also in place. District Trainers: Round 1 - 255 Round 2 - 261 Round 3 - 318	113 ASHA Units in place (One unit per 50,000 population). Each unit has Unit Mentoring Group composed of 4-5 members. 1005/1123 ANMs designated as ASHA mentors in place.	

Name of State	State Level	District Level	Block Level	Sector Level
Gujarat	State AMG Constituted in Aug 2011, 5 meetings held, last meeting in March 2015. ARC working under the office of Rural Health Department under Commissionerate of Health Office with 3 consultants. State Trainers: Round 1 - 7 Round 2 - 7 Round 3 - 7	Existing DPMU staff leads the programme. 33/33 Programme Assistants - ASHA, in position. District AMG formed in 24 districts. District Trainers: Round 1 - 119 Round 2 - 91 Round 3 - 51	Existing BPMU staff.	**3467**/3751 ASHA Facilitators in place (1 per 10 to 20 ASHAs/1 per PHC).
Haryana	AMG not constituted ARC in place within the SPMU with 7 members team. State Trainers: Round 1 - 10 Round 2 - 10 Round 3 - 10	20/22 DACs in place in District Trainers: Round 1- 377 Round 2 - 377 Round 3 - 377	107/113 Block ASHA Coordinators in place.	554/900 ASHA Facilitators in place.
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 Round 3 - 23	10/12 District ASHA Coordinating Assistants. District Trainers: Round 1 - 260 Round 2 - 260 Round 3 - 260	70/74 Block ASHA Coordinators in place.	Existing staff - Female health worker playing role of ASHA Facilitator - 2000/2071 in place.
Jammu & Kashmir	State AMG established in 2012-13. 1 ASHA Nodal Officer and 1 state ASHA Programme Manager, & 2 Assistant ASHA Programme Managers & 1 Project Officer ASHA, in place within SPMU. State Trainers: Round 1 - 12 Round 2 - 12 Round 3 - 12	Existing staff. Total 22/22 in number. District Trainers: Round 1 – 190 Round 2 - 190 Round 3 - 190	Existing staff - 117/117 - Community Health Officer or ANMs/LHVs support the programme .	811/816 – existing cadre of ANMs/ LHVs designated to support ASHA programme. 1 per 10 ASHAs in 44 Hard to Reach blocks and 1 per 20 ASHAs in 73 other blocks**.**
Karnataka	State AMG constituted in Oct 2012 reconstituted in Feb. 2017. Last meeting held in Feb. 2017. ASHA Nodal Officer in Health Directorate. Deputy Director for ASHA Training based within SIHFW. One ASHA Programme Manager – ASHA in SPMU. State Trainers: Round 1 - 7 Round 2 - 7 Round 3 - 7	27/30 District ASHA Mentors in place. District Trainers: Round 1 - 140 Round 2 - 121 Round 3 - 118	163/176 Block Mobilisers in place.	1671/1800 ASHA Facilitators in place.

Name of State	State Level	District Level	Block Level	Sector Level
Kerala	State AMG constituted in 2008, 7 meetings held, last meeting held in Dec 2015. State ASHA Team with one Nodal Officer and consultant based within SPMU. State Trainers - 7	13/14 District ASHA Coordinators in place. District Trainers - 40	Existing Staff. 201/214 block level staff engaged.	Existing staff – Junior Public Health Nurse.
Maharashtra	State AMG constituted in Oct 2007, 5 meetings held, last meeting held in July, 2013. Under Nodal Officer – ASHA, 1 Programme Manager – ASHA & 1 on VHSNC, work as ARC team based within SPMU. State Trainers: Round 1 - 13, Round 2 - 13, Round 3 - 13.	34/34 District Community Mobilizers in place . District AMG formed in all districts. District Trainers: Round 1 - 1412 Round 2 - 1374 Round 3 - 1329	334/355 Block Community Mobilizers in place. Block AMG formed in 70 tribal blocks and in 281 Non-tribal blocks.	3397/3562 AFs 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 District Community Mobilizers in place District Trainers: Round 1 - 347 Round 2 - 345 Round 3 - 342	Existing Staff (Block Extension Educator working as BCM in many places).	867/898 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. State Trainers - 3	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 2015, but meetings not held. ASHA Resource Centre is located within SPMU with a team of four. State Trainers: Round 1 - 3 Round 2 - 3 Round 3 - 3	31 DCM positions approved. Not yet recruited. District Trainers: Round 1 - 326 Round 2 - 326 Round 3 - 326	Existing BPMU Staff, 151/151 CHO/PHN support.	1353/1387 Multi Purpose Health Supervisors (MPHS-F), 1 per PHC designated as ASHA Facilitator.

Name of State	State Level	District Level	Block Level	Sector Level
West Bengal	State AMG formed in Sep 2010, total 4 meetings held, last meeting held in Dec 2011. ARC team of 10 members, led by State NGO Coordinator is located within SPMU. Training is managed by Child In Need Institute CINI State Trainers: Round 1 - 11 Round 2 - 11 Round 3 - 11	21/26 DCMs in place District Trainers: Round 1 - 569 Round 2 - 569 Round 3 - 569	475/666 Block Community Mobilizers in place (2 per block).	Existing staff (Health Supervisor at Gram Panchayat level) supports ASHA programme.

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	Programme managed by SPMU	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	Programme managed by SPMU	Existing staff	Existing staff	Existing staff
Puducherry	Programme managed by SPMU	Existing staff	Existing staff	Existing staff

3
SECTION

Key Findings from Eleventh Common Review Mission on Community Processes

The Eleventh Common Review Mission (CRM) was undertaken in sixteen states[1] during the time period- 3rd November 2017 to 10th November 2017. The Community Processes interventions were studied as part of the Terms of Reference (TOR) Seven. This section summarizes the key findings from CRM on- the ASHA Programme, Gender, the Village Health Sanitation and Nutrition Committees & Convergence, Mahila Arogya Samitis, Rogi Kalyan Samitis and the Community Action for Health.

NATIONAL OVERVIEW

- ASHAs have emerged as an important resource at the community level, who have been able to play an important role in linking community with the health services especially in the areas of RCH and Communicable Diseases. In the current backdrop of strengthening delivery of primary care services closer to the community, ASHAs are now being viewed as a key member of the primary health care team at the Sub centre level. This has also been articulated in the National Health Policy 2017 which suggest that ASHAs in coordination with the Multi-Purpose Workers (M/F) will play an important role in addressing issues of Non-Communicable Diseases and provision of palliative care and mental health etc. These recommendations have paved the path for the future roles of the ASHAs depending on the state context.
- Currently 9,38, 054 ASHAs are in position across all states and UTs of the country except Goa, against the target of 10,21,543 ASHAs, both in urban and rural areas. The selection figures reflect that 93% ASHAs in rural areas and 81% in urban areas have been selected.
- States are at varying stages for completion of training of ASHAs in module 6 &7. Across the country about 97% ASHAs have been trained in Round 1, 88% in Round 2, 70% in Round 3 and 49% in Round 4 in rural areas. In urban areas about 70% ASHAs have completed training in Induction module and training of Module 6&7 has begun in few states (Madhya Pradesh, Odisha, Rajasthan, Meghalaya, Mizoram, Nagaland, Gujarat, Haryana, Punjab) while Delhi has completed all rounds of Module 6 &7 training. Overall the training progress indicate a plateau in the training pace over past one year.
- Since the launch of universal screening of NCDs in the year 2017, training of ASHAs has been initiated across selected districts (160 in first phase) across all states. So far nearly 20,000 ASHAs have been trained under this initiative.

1 Sixteen States - Bihar, Chhattisgarh, Jharkhand, Odisha, Uttarakhand, Uttar Pradesh, Assam, Manipur, Meghalaya, Nagaland, Haryana, Karnataka, Maharashtra, Punjab, Telangana and West Bengal.

- Process of ASHA certification has been introduced across seventeen states (Arunachal Pradesh, Assam, Chhattisgarh, Delhi, Gujarat, Himachal Pradesh, J &K, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Odisha, Punjab, Sikkim, Tripura, Uttarakhand and West Bengal). As part of this process, all training components of the ASHA training would be certified i.e, Training curriculum, State and district trainers, state and district training sites, ASHA facilitators and ASHAs.
- Supportive institutional network at state level and below has expanded rapidly over few years, as states have increasingly become cognizant of the necessity of a strong support structure to enhance the community processes component. However, commensurate investment in building capacities of the support structures is still lacking in most states affecting the effectiveness of the supportive supervision.
- Provision of social security to ASHAs in the form of medical and life insurance has also emerged as a state led mechanism to provide motivation for the ASHA. These have been started in the states of Chhattisgarh, Assam, Jharkhand, Kerala, Uttar Pradesh, Uttarakhand, Odisha and West Bengal. States of Delhi, Maharashtra, Sikkim, Gujarat and Madhya Pradesh have facilitated enrollment of ASHAs in existing National Schemes.
- Progress is noted in creating additional support mechanisms for ASHAs such as – additional monthly honorarium to ASHAs, implementing social security mechanism and creating career opportunities for ASHAs. However, critical components like operationalizing Grievance Redressal mechanism and creating rest rooms for ASHAs have not received due attention.
- Systemic issues like absence of a systematic logistics system to ensure timely drug and equipment kit filling of ASHAs and persistent delays in payment of incentives especially for activities related to NVBDCP, NLEP and RNTCP are yet to be fully resolved.
- Nearly 5 Lakh VHSNCs and 65,000 and MAS have been constituted across states. However, despite the efforts made by states in training the VHSNC and MAS members, the progress has been limited mainly on account of the challenge of training large number of VHSNC/MAS members across states.
- VISHWAS (Village based initiative to synergize health, water and sanitation) campaign has been launched by MoHFW to strengthen the convergent action on social determinants of health, utilizing the platform of VHSNCs**.** This would facilitate capacity building and strengthening the VHSNCs.

Key Findings

- Overall, the findings from the eleventh common review mission have once again acknowledged the efforts of the ASHAs as a critical frontline worker who has enabled improved access to health care services and has facilitated behaviour change at the community level. Most reports applaud ASHA's agency and high levels of motivation, who do not hesitate to use their own resources whenever required to support the community.
- With the launch of universal screening of Non-Communicable diseases, ASHAs have also been trained in selected districts to conduct enumeration, risk assessment, mobilize community for screening and support treatment compliance. Preliminary reports from states where field level activities have been initiated, indicate towards the high potential of ASHAs and ANMs working as a team to deliver these services. However, the issues raised in the findings about slow pace and variable quality of training of ASHAs in some states would need to be addressed as a pre-requisite to achieve this potential. Though the convergence at field level has been documented across states through the individual efforts of ASHAs, ANMs and AWWs, primarily in organizing VHNDs, but none of the states (except

UP) have reported a systemic mechanism of team building among the three frontline functionaries. The monthly meeting of the ASHAs, ANMs and AWWs at SHC, envisaged to plan and improve service delivery is yet to be fully operationalized across all states.

- Despite several initiatives taken in the recent years to address delay in payment of incentives, the issue is yet to be fully resolved especially for payment of incentives under NVBDCP and RNTCP. Stock out of drugs/equipment with ASHAs and limited availability of safety measures for ASHAs are also few critical components of the programme that continue to affect the performance of ASHAs.
- The review of mechanisms for ensuring gender equality within the health system show low levels of preparedness and warrant much more concerted efforts at all levels. With regards to the community based platforms of VHSNCs, CAH, MAS and convergence, slow pace of implementation is noted across states with varied status of implementation. Except for few states, which have invested in building capacities of these platforms and where ASHAs play a leadership role, the progress made is far from satisfactory and highlight the need for a comprehensive review.

ASHA

Selection and Training

- Selection of ASHAs against the set target is near completion (over 95%) in all states visited during CRM, except in states of West Bengal, Karnataka, Uttar Pradesh and Bihar where a shortfall of 10-20% was reported. Findings from states of Bihar, Meghalaya, Haryana and West Bengal, highlight inter and intra district gaps in ASHA selection. E.g.- Shortfall of 345 and 452 ASHAs was reported from District Madhepura in Bihar and Dakshin Dinajpur in West Bengal respectively. About 132 villages in Meghalaya and certain minority dominated areas in Gurguram, Haryana are yet to be covered by ASHAs. Even in other states, which report a shortfall of 5-10%, the gaps are more likely to be in areas which have are difficult due to geographic dispersion or have high proportion of marginalized population. As a stop gap measure, ASHAs of the neighbouring villages are often given the additional charge of the villages which do not have any ASHA as reported from Meghalaya. This arrangement however was not found to be effective on account of poor rapport with the community and large distances between villages in the hilly terrain of Meghalaya. The selection process was reported to be largely community based with either PRI representatives or VHSNCs leading the process except in both districts of Meghalaya. For instance, in South Garo hills, the village headmen (Nokma) selects the ASHAs without consultation with the community and even without consulting the ASHAs. This affects the level of motivation of ASHAs, who often drop out from the programme because of lack of interest. Lack of adequate representation of marginalized population in selection of ASHAs was reported in West Bengal, raising a concern about the selection process. In Odisha, despite the process being anchored by VHSNCs, it was reported that ASHAs from neighbouring villages (within 2 Kms) are selected if any suitable candidate is not available from the village. As the programme completes thirteen years of implementation, it is imperative that the left out and uncovered areas are mapped and measures are taken to cover such areas by ASHAs effectively. In urban areas, states have selected over 80% ASHAs against the set target. However, mapping of areas which need to be covered by ASHAs is yet to be completed across states which has not been reported from any state. In West Bengal, the existing 5444 Honorary Health Worker covering a population of 700-800 have been recently selected as urban ASHAs.
- Dropout rate for ASHAs has remained low in rural areas i.e, up to 4-5 % except in West Bengal and UP with drop rate of around 8% and 10% respectively. However, attrition is reported to be high in urban areas of Banglore in Karnataka and Gurugram in Haryana, on account of better employment opportunities and high level of migration.

- In urban areas, induction training of ASHAs is underway in all states and is at various levels of completion. Training of ASHAs in Module 6 &7 has also begun in some states (Assam, Chhattisgarh, Karnataka, Meghalaya, Nagaland, Odisha, Haryana, Punjab). Training of ASHAs in rural areas have progressed well in most visited states as training of round 3 and 4 is near completion in all states except states of Bihar, Haryana, Telangana and Uttar Pradesh. State of Bihar has not been able to resolve the issue of selection of district training agencies and trainer's attrition for over two years, therefore no training of ASHAs has been conducted since 2015. Even in states where ASHA training has been completed in all four rounds of Module 6&7, plateau is noted in terms of organizing training of ASHAs in newer areas or organizing refresher trainings. About ten districts across seven states (Chhattisgarh, Haryana, Karnataka, Maharashtra, Manipur, Meghalaya, Punjab and Telangana) have been selected for launch of universal screening of NCDs. However, training of ASHAs on NCDs was reported to have begun only in states of Karnataka, Haryana, Maharashtra and Telangana.
- As states move towards certification of ASHAs, it is important that pre-requisites of having a consistent team of trainers and well-equipped training sites at state and district level be met. Among the states visited, ASHA certification has been initiated in states of Assam, Chhattisgarh, Jharkhand, Karnataka, Maharashtra, Odisha, Punjab and Uttarakhand. Certification process of state trainers and training sites has been completed in these states and the subsequent step of certification of district trainers and training sites is underway. Challenge of non-availability of residential training sites in Karnataka, Meghalaya and Nagaland and shortfall of district trainers in Meghalaya, Bihar and Uttarakhand, are key issues that affect quality and pace of training. In state of Telangana where district training centres are used for training of ASHAs, identification of district training sites is yet to be completed in the newly formed 11 districts.

Support Structures

- States have invested in creating support structures for the programme, either through dedicated support structures at all levels (Assam, Bihar, Chhattisgarh, Jharkhand, Haryana, Karnataka, Maharashtra, Manipur, Meghalaya, Nagaland, Odisha, Uttar Pradesh and Uttarakhand) or through a mix of existing and dedicated staff in Punjab, Telanaga and West Bengal. Reports from Assam, Jharkhand, Maharashtra and UP document the efforts made by states to provide on the job mentoring support to ASHAs. ASHA facilitators continue to function as ASHAs in Bihar, Jharkhand and Odisha, this dual responsibility affects their performance in both the roles. Similar mechanisms of providing on the job mentoring support to ASHAs are however yet to be extended to urban ASHAs. Low amount of remuneration earned by ASHA facilitators, in comparison of ASHAs, was reported as a challenge in Assam. IT applications designed for ASHA facilitators (ASHA Sangini app in Kaushambi) and BCMs have emerged as useful tools to facilitate the mentoring support being provided to ASHAs in state of UP. Monitoring of rural ASHA's performance (based on ten indicators) is being done in states of Assam, Haryana, Maharashtra, Meghalaya, Nagaland, Telangana and West Bengal. Only in state of Assam, this was reported for both rural and urban ASHAs. Though regular monthly meeting of ASHAs at PHC or CHC level were a common finding reported across most states, only in state of Assam these meetings were reported to be used as platform for refresher training. Despite the high level of investments in creation of support structures, commensurate efforts in capacity building of support structures and building mechanisms of regular review meetings were lacking across most states. Regular review meetings of support structures at each level were reported in three states of Maharashtra, Odisha and Haryana. Limited capacities of district and block level functionaries on community processes affected the mentoring support provided to ASHAs in Assam.

Incentives

- ***Monetary -*** Average monthly incentives earned by ASHAs range from Rs. 1500/month to 4500/month. This is inclusive of the routine- recurring and other incentives approved under NHM and incentives provided from states funds in states of Chhattisgarh (50% top up), Haryana (1000/month) Karnataka (100% top up which has recently been changed to Rs. 3500pm), Meghalaya (100% top up) and West Bengal (2000/month)). The payment process has improved significantly to facilitate timely payments, yet delays of up to 7-9 months were reported in few areas of Chhattisgarh and Champawat district in Uttarakhand, 2-5 months in Madhepura, Bihar and both districts of Manipur, 2-3 months in Goalpara district of Assam, Jharkhand, Bhiwani in Haryana, East Khasi Hills in Meghalaya and Telangana. Large delays in payment of incentives for NVBDCP and RNTCP were common in states of Assam, Bihar, Jharkhand (extending up to 3-4 years), Meghalaya, Nagaland, Punjab (mentioned in few areas) and Telangana. Delays in Chhattisgarh were mainly on account of delay in linking of AADHAR IDs with bank accounts while in Uttarakhand this was due to systemic issues in PFMS and in South Garo hills of Meghalaya it was because of poor internet and telephone connectivity. States of Telangana and Uttarakhand have also recently announced monthly honorarium of ASHAs (Rs. 2000 pm in UK and Rs. 6000 pm in Telangana) through pooling of NHM funds and state funds. In order to streamline payments, Mitanins are paid Rs. 1500/month fixed from April to December and adjustments are made according to incentives in subsequent months of FY.

Non-Monetary

- States of Assam, Chhattisgarh, Jharkhand, Maharashtra, Odisha, UP, UK and West Bengal have also introduced social security measures for ASHAs. These are accidental insurance cover in Assam, Odisha and UP and a mix of life and accident insurance cover, pension benefits and scholarships etc. in Chhattisgarh. States of Karnataka and Maharashtra have enrolled ASHAs in existing state (Suvarna Arogya suraksha Trust) and National schemes (Prime Minister's Accidental Insurance Scheme) respectively. Awareness about the insurance scheme among ASHAs was reported to be low in UP.
- In addition, career opportunities for ASHAs have been created in states of Assam, Chhattisgarh, Karnataka, Maharashtra, Odisha, Telangana and Uttarakhand. So far 119 ASHAs have enrolled in these courses (of which 76 have completed their courses) in Assam, nine ASHAs has enrolled in Karnataka, 120 in Maharashtra (90 have completed their courses) while ASHAs met in Telangana were not aware about such provisions. Enrolment of ASHAs in equivalency programme is supported in state of Jharkhand (1800 enrolled), Odisha (450 enrolled and 269 cleared matriculation).

Drugs and Equipment Kit

- Availability of drugs and equipment with ASHAs has only improved marginally since last year's reports in most states. Of the 16 states visited, only eight states (Assam, Chhattisgarh, Haryana, Karnataka, Maharashtra (drugs provided to 24,000 ASHAs including Wardha and Prabhani few months before CRM visit), Odisha, Punjab and UP reported availability of drugs and equipment kits with ASHAs during the visits. In the remaining states drugs and equipment were either partially available or not available with the ASHAs met during the visit. For instance, in Bihar, except weighing scale no medicine and other equipment was available with ASHAs and no replenishment was done in Madhepura since last 4 years. In Jharkhand, ASHAs reported purchasing thermometers using their own money. In Meghalaya, ASHAs had weighing scale, digital thermometer and digital watch but no drugs in East Khasi Hills while in South Garo Hills stock out of HBNC kit and drug was reported as only 150 digital watches and 200 torches were supplied to the district to be equally divided among all blocks. In Uttrakhand, ASHAs have digital scale and warm bag but drug kits have not been

replenished since last 2 years. In Telangana, only 26846 ASHAs currently have drug kits and HBNC kits. In West Bengal, HBNC equipment like digital watch and weighing scale were found to be non - functioning in some areas. Contraceptives were not available with ASHAs in Assam and Haryana.

- Unavailability of drugs and equipment with ASHA, affect her functionality and undermine her credibility as community level care provider at the village level. As the tasks performed by ASHAs, continue to expand to include tasks related to NCDs, mental health, palliative care, it is necessary that these systemic issues are resolved to ensure undisrupted supplies.

Safety Measures for ASHAs

- In order to ensure safety of ASHAs various measures v.i.z.-creating rest rooms, help desks and establishing grievance redressal mechanisms for ASHAs are essential. Rest rooms for ASHAs were available only in five states but even in these states these were available at one or two facilities visited during CRM. E.g. Rest rooms were available in PHC in Khammam district in Telangana, CHC in Bihar, at DH/CHC in Odisha (142 restrooms at facilities with high caseloads) , DH and CHCs in Uttarakhand, Civil hospital in Goalpara in Assam and DH in West Bengal. Help desks for ASHAs were operational in CHCs and DH in Uttarakhand, DH in West Bengal and at all health facilities in one district of Meghalaya (East Khasi Hills). These findings reflect the variation in planning for positioning of help desks and rest rooms based on caseloads.
- Grievance Redressal committees have been constituted at district level only in states of Assam, Haryana, Manipur, Odisha, Uttar Pradesh, West Bengal and Telangana. In addition, grievance boxes were placed at health facilities in Assam and UP and toll-free no "104" was also used in Assam, Maharashtra, Haryana and Telangana. However, findings highlight that even these states, the committees had low levels of functionality.

Functionality of ASHAs

- Findings from field report high levels of functionality of ASHAs in improving access to health care services for Maternal and Child Health Services across all states, indicating the continued focus on these areas and facilitator role of ASHAs. Thus, across all states, ASHAs are viewed as enablers of accessing services such as immunization, ANC, institutional delivery and to some extent family planning services.
- Though ASHAs were found to be equipped with skills to perform these tasks, reports emphasize the need for refresher trainings to address the gaps in skills pertaining to identification of danger signs, nutrition counselling, family planning, safe abortion services and adolescent health. Findings from Maharashtra highlight that in many cases families shared that the newborns were weighed at the Anganwadi centre rather than by the ASHA. Access to marginalized has also improved with the continuous efforts of ASHAs. Effectiveness of ASHAs is affected by larger systemic issues such as geographical barriers and non-availability of phone and road connectivity, this was reported specifically from states of Meghalaya and Manipur. In Wardha district of Maharashtra, where training of ASHAs in NCDs has been started, findings indicate high skill levels and interest among ASHAs.
- The average daily time spent on ASHA work (as per existing work load) ranged from, 5- 7 hours per day in Assam and Uttar Pradesh to 3-4 hours in Haryana, Karnataka, Maharashtra, Odisha, and Uttarakhand and 2-3 hours in Nagaland. However, ASHAs in Assam and Uttarakhand said that the actual time spent by them in accompanying a pregnant woman for delivery and travelling difficult hilly areas is much more.

- Interest of ASHAs in NCDs and newer roles was supported by program managers of states of Assam, Odisha, Karnataka, Uttar Pradesh and West Bengal. These recommendations along with the finding of average daily time spent by ASHAs being in the range as envisaged in the guidelines, suggest that it is feasible to plan for new tasks for ASHAs (depending on local context and National Priorities) linked with skill based training and appropriate incentives.

Gender

- The eleventh CRM reviewed the status of training of health service providers on gender, availability and use of Medico-legal care protocols at public health facilities for survivors of sexual violence, functionality of gender resource centers and one stop crisis centers, implementation of VISHAKHA Guidelines at district and state level and availability of safety measures for frontline service providers.
- The findings however show no efforts made by all states in each of these areas. Out of the five objectives, only in terms of training of service providers on issues related to gender some progress has been made in two states of Chhattisgarh and Meghalaya. Protocols to provide medico-legal services to survivors of sexual assault were not available in any state at any level of health facilities. Similar findings surface for implementation of VISHAKHA guidelines and functioning of gender resource centres/one stop crisis centres. Formation of district committee for sexual abuse and harassment in 2013 was reported from Bijapur, Chhattisgarh (no comment on functionality).
- With regards to safety measures for frontline workers, few states have invested in creating rest rooms, help desks and grievance redressal committees for ASHAs (as documented earlier). However, no such efforts have been made for ANMs, who are often expected to reside in the SHCs and travel to outreach sites for immunization/ANC sessions.
- Despite the fact that nearly 90% of service users of public health system are women and children, 100% of frontline workers are women (ASHAs and ANMs) and almost 50% of the total workforce comprise of women, the gender issue has not received the due attention across all the visited states.

VHSNC

- As per the reports shared by states, among the 16 states visited in the CRM, constitution of VHSNCs is near complete (over 95%) in most states. Uttar Pradesh is the only state which reports less than 90% formation of VHSNCs (at 88%), with West Bengal and Uttarakhand being close at 91%, and Assam at 92%.
- A number of state reports show that restructuring of VHSNCs has been done as per the new guidelines released in 2013. The village panch has been made the Chairperson, replacing the other existing Chairpersons in almost all states where reconstitution has been done. In Assam, School teachers who were in position as Chairperson, have been replaced by village PRI members. Meghalaya, where the VHSNCs are headed by the village headman of the traditional village council under the provisions of Panchayat Extension in Scheduled Areas (PESA) Act, the VHSNCs have been restructured and ASHA has been made member secretary, though the village headman remains the Chairperson as earlier. States of Maharashtra and Odisha, continue to have Anganwadi Worker as the member secretary of VHSNC. States of Karnataka, Meghalaya and Uttarakhand, have reported that the restructuring of all VHSNCs of their states have been completed with ward panch as Chairperson. The process of reconstitution has not been undertaken yet in Uttar Pradesh, though a government order has been

released recently for reconstitution of the VHSNCs at revenue village level (i.e. villages of 500 and above population will have a separate VHSNC).

- With regards to training of VHSNCs, Meghalaya is the only state where training of VHSNC members has been reported in current year or within last one year in South Garo Hills. While in Uttarakhand training of 374 VHSNCs was conducted about 18 months back. In other states no efforts on training of VHSNC members have been reported. Orientation of VHSNC members was conducted in Bihar and Odisha nearly two years ago. This is despite the fact that in Odisha, VHSNCs have been reconstituted after the panchayat election. In Maharashtra, the last training of VHSNCs was done in 2008.

- Only few state reports have commented on regularity or quality of the VHSNC meetings. Regular monthly meetings of VHSNCS are conducted in Assam, Chhattisgarh, Karnataka, Odisha, Manipur, Punjab and Uttarakhand. Among these states, the meetings are being used to discuss issues related to health and sanitation in most states. Quality of deliberations in Manipur and Karnataka reflects substantive gaps, as the discussions focussed only on the expenditures incurred form VHSNC funds. States of Chhattisgarh and Odisha have put in place mechanisms for ensuring quality and effectiveness of VHSNC meetings. In Odisha the meeting is attended and supported by panchayat representatives to discuss issues like, institutional delivery, LLIN distribution, JE vaccination, support from ICD etc. while Gram Panchayat also conducts one review meeting with every VHSNC every month. State of Chhattisgarh has introduced Public Services Monitoring tool to be used by VHSNC to monitor issues like malfunctioning hand pumps, ration shop functioning, quality of mid-day meals etc. This tool has subsequently been incorporated in the revised VHSNC guidelines of VHSNCs in 2013.

- Release of untied fund was reported to be regular in all states except in four states of Jharkhand, Manipur, Assam and Uttarakhand. Untied fund has not been released for nearly two years in Jharkhand and in one district of Manipur. In states of Assam and Uttarakhand, fund for FY 2017-18 are yet to be released. Assam has also reported a specific problem of funds being released in instalments of Rs. 2000, with the next instalment being released after submission of Utilization Certificate (UC) of the earlier instalment. Some irregularities were also reported in Maharashtra (funds of one VHSNC were deposited in the account of another neighbouring VHSNC). Most of states report release of funds in two instalments of Rs. 5000 each.

- Nearly 100% expenditure of untied fund is noted in Odisha and Chhattisgarh and 70% in Uttarakhand. The pattern emerging from the expenditures of united funds across the states, reflects focus on issues of hygiene, sanitation, support for vulnerable families in seeking healthcare by providing transport in emergencies, and supporting in buying medicines in some cases, and providing loans for medical expenses for very poor households. In Uttarakhand, "Doli" locally made stretcher cum Palnquin is used in hilly areas for transporting pregnant women and old patients up to road head using VHSNC funds. Purchase of equipment, furniture and other aids for the VHND, support for stationary and small expenses for refreshments for VHSNC meetings are few other areas of expenditure reported. In Maharashtra, expenditures from united funds were made without any proposals and approvals in the VHSNC meetings and all withdrawals, in large amounts, were made in cash, by the Anganawadi worker, who is the member secretary. In Bihar, influence of PRI members on the decision of using untied funds was reported to affect the utilization of funds.

- Odisha has introduced innovative mechanisms such as awards to VHSNCs - one best GKS (VHSNC) in every block, and one best GKS in every GP every year. In addition, state has provided one stretcher to every village in difficult areas of High Priority Districts (HPDs) to help in transporting pregnant mothers from remote villages to the nearest road head under Sammpurna programme. This was purchased from Rs. 1000 of GKS funds which were later reimbursed from NHM.

VISHWAS (Village based Initiative for Synergising Health, Water and Sanitation) Campaign

- VISHWAS Campaign has been recently launched for building synergistic action on social determinants of health using the platform of VHSNCs. Training of state level trainers has been completed in Manipur while in Odisha training of both state and district trainers has been completed and training of VHSNC is planned to start in November and December. In Maharashtra, the rollout of the campaign is planned from December.

Mahila Arogya Samiti (MAS)

- All states except Haryana have MAS in place. Five states (Assam, Bihar, Jharkhand, Punjab, and Telangana), have not given any update on MAS programme. Though 14 out of 15 states have achieved the target for formation of MAS, there are still major gaps in proportion of MAS which have bank accounts. States like Bihar report that almost all of the target MAS have formed but only about 50% of them have bank accounts. Meghalaya has reported problems in opening of zero balance bank accounts. West Bengal has formed less than 50% of its target MAS (4748 formed against the target of 11709, with only 3304 with bank accounts). State reports have underscored the problems being faced in formation of MAS in metropolitan cities under municipal corporation areas such as Bangalore, Kolkata and Mumbai. Maharashtra report highlights this issue despite the collaboration with NGO Sneha, which has substantial experience in such community level interventions.
- Regular monthly meetings and good functionality of MAS has been reported from states like, Chhattisgarh, Odisha, Manipur and Meghalaya. Odisha has developed an innovative system of grading of MASs on 10 measurable indicators, based on which they are marked Red, Yellow and Green, and corrective action is undertaken accordingly. Report from Chhattisgarh documents that MAS has been successful in addressing issues like alcoholism and facilitation of land donation for opening of Swasthya Suvidha Kendra.
- Capacity building of MAS has been reported from only few states like Odisha, Chhattisgarh and Meghalaya. All state reports have emphasized on the need for; strengthening support processes for formation and handholding of MAS, regular training of MAS members and also assessment of adequacy of MAS targets.

Rogi Kalyan Samiti (RKS)

- All state reports state formation of RKS being in place at all levels of facilities except in Manipur where RKS is yet to be formed in urban areas. However, low functionality in RKS of facilities at block level and below and low investment in training of RKS members emerge as major concerns.
- General Body (GB) and Executive Committee (EC) are reported as being in place in all states except Assam and Bihar, where separate mechanisms do not exist. Although there are variations across states in regularity of meetings and active role being played by these two institutional mechanisms. Across states, GB meetings are held on a biannual basis while the EC meetings are held either monthly or once in two months. Some states like Uttarakhand and Bihar, report RKS meetings being held, when required. In Chhattisgarh, GB meetings are held regularly but EC meetings are not regular.

On the other hand, GB meetings not regular but EC meets mostly on monthly basis in Manipur. In Maharashtra, and Telangana, two meetings of GB and 3 to 5 meetings of EC are reported as being held every year.

- Diverse nature of membership is noted across states, ranging from local MLAs to PRI representatives, representatives of NGOs and community members. Manipur reports inadequate representation of civil society and community. In West Bengal members are mostly facility staff, with weak PRI and community representation. In Chhattisgarh, active role is being played by members in monitoring of facilities through regular visits, and it has led to perceptible improvements in facilities. While in Maharashtra members have no regular process of conducting review of facilities, and they reportedly do it whenever they visit the facility. Low participation of RKS Members, especially PRIs representatives was reported in Jharkhand.
- States of Assam and Maharashtra have reported that untied funds received by RKS and the earnings from user charges are not being pooled, and the user charges, are being pooled into state funds. In Assam, facilities had not received untied funds for 2017-18 yet. In Chhattisgarh, RKSs funds were received in May 2017. Income sources of RKS in Bihar include, OPD and Emergency registrations, renting out premises, charges from C-sections and ambulance services. In West Bengal in addition to untied funds, RSBY funds and Swasthya Saathi reimbursements are also being pooled.
- Expenses incurred from RKS funds are mainly on gap filling in HR, mainly support staff, contracting of services like cleaning, and minor repairs. Use of RKS funds for drug purchases was reported in Maharashtra and West Bengal while in Uttarakhand, expenses were found to be mainly on improving facilities in hospitals, for service providers.
- Systems for Patient feedback or Grievance Redressal are clearly not high on agenda of the RKSs, which is reflected in absence of such systems across states.
- Need for training of RKS members and enabling them to conduct assessment of facilities and its key services, especially food, laundry, cleaning etc, and also building a roadmap for facility improvement, has been highlighted in various states reports.

Community Action for Health (CAH)

- Only eight states have reported Community Action for Health programme being implemented (Assam, Bihar, Jharkhand, Maharashtra, Meghalaya, Orissa. Uttarakhand and UP). While in Karnataka the initiative has been discontinued after the implementation of the Community based Monitoring Programme – (CBMP) in its pilot phase. Among these states, an active programme at field level is evident in Jharkhand, Maharashtra and Meghalaya, where the programme has been operational since pilot phase. In Maharashtra, the CAH programme is being implemented in collaboration with NGO Saathi, since the pilot phase and has expanded from six to 14 districts. In Meghalaya, the CAH initiative is being implemented in four districts through one state level resource organization and two district level implementing NGOs. In Jharkhand, CAH is being implemented in all 24 districts. Findings from these states show positive results of the community based accountability mechanisms. States of Uttarakhand and Assam have not received approval for CAH for FY 2017-18, though they were approved the programme and had started activities in year 2016-17. While Uttar Pradesh is implementing CAH in 12 districts, though no specific activities are reported to have been conducted since last two years. State of Chhattisgarh focusses on VHSNC as the fulcrum for CAH activities.

Convergence

- Convergence in programme implementation is reported from nine states (Assam, Chhattisgarh, Maharashtra, Meghalaya, Uttar Pradesh, Nagaland, West Bengal, Haryana).
- Evidence of convergence was seen only at the field level among the frontline workers, the panchayat representatives and VHSNC members. No mechanism of promoting convergence between different departments has been reported at state, district and block level except in states of Chhattisgarh and Maharashtra.
- Organisation of VHNDs, school health programmes, Adolescent Health programme, and water and sanitation campaigns efforts, are the main areas in which convergence was noted at community level. Active role of ASHAs and VHSNCs is reported in activities under Swachh Bharat Abhiyan and village hygiene and sanitation campaigns. Convergence between different departments at the district level, is reported to be through the regular meetings conducted by either Collector or the Minister in Charge of the district.
- State of Chhattisgarh has implemented Swasthya Panchayat Yojana (SPY), under which every Gram Panchayat is scored on a set of parameters of health and its key social determinants. A monthly process of public services monitoring on 29 key indicators in monthly VHSNC meeting, is facilitated by ASHA. The state report also mentions convergence at other levels, like, leveraging of the resources from different sources for strengthening health facilities (District Mineral Fund, Panchayat funds, Zilla Nirman Samiti and CSR funds pooled in Bijapur district). The Central Reserve Police Force (CRPF) also provide support to health department in organizing health camps, identifying malaria cases, and in helping locals in accessing the ambulance services (in Bijapur district which has poor mobile services in remote areas). Strong convergence is also reported through meetings held by Minister in Charge and active District Level Vigilance and Monitoring Committees (DLVMCs).
- In Maharashtra, close institutional convergence exists between Panchayat System and Health System, as the rural health system is placed under District Panchayat. The District Health Officer (DHO) oversees the rural health system, (including PHCs and SCs) and reports to CEO- Zila Panchayat (ZP). The Civil Surgeon (CS), who reports directly to the state's Health Department, is in charge of the DH, SDH and CHCs. The active role of ZP ensures close coordination with all other departments, like, Education, ICDS and Water and sanitation, and also integration with district level planning process under district planning committee (DPC). The NUHM programme implementation is through municipal corporations and councils, who coordinate with CS and oversees the DH, SDHs and CHCs. But challenges of coordination still remain at these two levels of convergence.

Recommendations

- As the current policy discourse positions ASHAs as a key member of the primary health care team to jointly deliver an expanded package of services, closer to the community, it is essential that the challenges of slow and varied quality of training, delays in payments, stock out of drug and equipment kits, are resolved.
- Process of regular refresher training for ASHAs needs to be institutionalized using PHC meeting platforms and periodic modular training to achieve a minimum of 15 days per year.
- With the changing role of ASHAs, the capacities of the support structures also need to be strengthened simultaneously to enable effective on the job mentoring support for ASHAs.

- In urban areas, the issue of high attrition rate due to high level of migration and better employment opportunities, highlights the need to design urban context based tasks linked with new incentives to facilitate retention of ASHAs. Extension of all existing programme components viz., training, non-monetary incentives and support measures to urban ASHAs also needs to be prioritized.
- Delays in payment of ASHA incentives across most states despite several initiatives of routing all payments through PFMS, need an urgent action. Larger delays were reported for payment of incentives for activities related to NVBDCP, RNTCP, NLEP.
- Lack of efforts at the state level in implementing measures for ensuring gender equality is a major concern that needs to be addressed on urgent basis. This was noted even in the slow progress made by states in operationalizing grievance redressal mechanisms and creating rest rooms for ASHAs.
- The untapped potential of VHSNCs, RKS and MAS in most states on account of limited capacity building initiatives, have highlighted gaps in utilizing these community based platforms to address social determinants and take collective community actions. Strategies such as proactive engagement with NGOs and building capacities of support structures to effectively supervise VHSNCs, RKS and MAS could be adopted to bridge this gap.

4
SECTION

Findings from Recent Evaluations

KEY FINDINGS FROM ASHA EVALUATION: TRIPURA

The fifth round of ASHA evaluation was conducted in Tripura in the year 2017-18. The evaluation followed the same realist methodology as used in earlier rounds of evaluation. A Mixed method approach was adopted in the evaluation i.e, during the qualitative phase in depth interviews were undertaken with all the stake holders and the quantitative phase included a cross-sectional survey with service users who received services from ASHAs (A- Women who had delivered in last six months and B -Children between 6.1 months-2 years of age who had any episode of illness during last one month), ASHAs, AWWs, ANMs and PRI representatives.
The sample of respondents in each district was:

Respondents	Tripura	Gomati	Khowai
ASHAs	200	100	100
Service-users (Beneficiary A)	735	366	369
Service-users (Beneficiary B)	399	200	199
ANMs	67	42	25
AWW	200	100	100
Representatives of the Panchayati Raj Institutions (PRI)	200	100	100

KEY FINDINGS

The ASHA programme was piloted in two high priority districts of North Tripura and Dhalai; in the year 2006 and was soon scaled across the state in the year 2007-08. ASHAs were selected at the level of Aanganwadi centres (AWC) to address the issue of scattered settlements in the state. The average population coverage of an ASHA ranges from 200 to 1,000.

State has created a network of support structures at four levels with regular review meetings being organized at the level of Health care facilities. ASHA Varosha Divas is organized on a fixed day in all Health Facilities including District Hospital, Community Health Centre, Primary Health Centre throughout the State. Resource persons for this meeting include Medical Officer-in-charge, ASHA Program Manager and AYUSH medical officers. ASHAs undergo knowledge and skill assessments in the shape of tests and a structured format.

At state level, the programme is managed by one Nodal Officer and one Programme Manager and at the district level District ASHA coordinators have been posted in all eight districts. Since state does not have the concept of Block Health Administration, one ASHA nodal officer has been designated at across all level of health facilities, i.e. Sub-divisional and District Programme Managers. State has total 400 ASHA facilitators in

place, who provide on the job mentoring and supportive supervision to ASHAs. Despite the wide network and strong review process, field level monitoring was reported to be a challenge in difficult to reach areas.

Substantial progress has been made in terms of training, as all in position ASHAs have been trained in four rounds of Module 6 &7. Based on state's readiness, Tripura was also one of the first few states where ASHA certification was initiated. At the time of the visit, six state trainers and one state training site had been certified under this process.

In absence of a formal Grievance redressal mechanism, the district officials shared that a register is maintained for ASHAs to report their issues at district and sub divisional. However, there is no mechanism to follow up and to ensure that action is taken to address the grievances reported by the ASHAs. Payment process has been streamlined across the state but in difficult areas with low bank density, ASHAs have to travel long distances to access their bank accounts.

With regard to the provision of services related to maternal health, high levels of functionality were noted during antenatal and post-partum period but functionality during post-[natal period (and neonatal period) was relatively much lower. Over 94% of service users were visited by ASHA at least five times during pregnancy but only 32% received atleast six visits from ASHAs coinciding with the new-born visits with. Atleast three ANCs were received by 88% service users and institutional Delivery was reported in 92% of the cases. Of these about 76% service users reported that ASHAs were the main motivators for institutional delivery and 88% shared that they were accompanied by ASHAs at the time of delivery. About 96% of the services users who had any maternal complication, sought ASHA's advice for seeking care. However, only 19% received any information from ASHAs about danger signs. The skill level of ASHAs were also found to be low regarding identification of maternal complications. As 74% ASHAs reported that they would refer a pregnant woman immediately to the institution in case of vaginal bleeding, 68% ASHAs said so in case of Headache/dizziness/blurred vision, 51% in case of convulsions/fits and 31% in case of loss of foetal movements. Though the findings related to functionality and effectiveness indicated little inter-district variations, high level of variations is noted for skill levels of ASHAs with lower figures being reported from Khowai district.

Table 1: Indicators

		Tripura	Gomati	Khowai
Functionality	% of service users A who were visited at least five times by ASHA during antenatal period	94.8	92.9	96.8
	% of Service Users A whom ASHA helped in making the birth plan	75.4	71.9	78.9
	% of Service Users A who reported that ASHA advised them for institutional delivery	98.7	98.4	99.6
	% of user A who had complication during pregnancy and sought ASHA's advice for treatment	78.2	80	75
	% of service users A who were visited at least six times by ASHA during post-natal period	32	30.1	33.9
Effectiveness	% of service users A who received three ANCs or more	88.8	81.7	95.9
	% of service user A who said ASHA was present during all ANC visits	53.1	57.3	49.1
	% of service users A who received ANC and reported getting 90 IFA or more	91.7	88.5	94.9
	% of service users A who went for institutional delivery	91.5	90.8	92.5
	% of Service User A who went for institutional delivery and cited ASHA as a motivator-referral by ASHA	76.4	75.2	77.6
	% of Service User As who went for institutional delivery and were accompanied by ASHAs	88.8	87.2	90.4
	% of service user A who had institutional delivery and whom ASHAs helped in arranging transport	44.5	48.9	40.1
	% of service users who were counselled on danger signs of pregnancy	18.6	22.4	14.9
	% of service users who had any maternal complication and sought treatment	96.4	97.1	95

		Tripura	Gomati	Khowai
Knowledge	% of ASHAs who said that they would refer a pregnant woman immediately to the institution in case of bleeding from vagina	73.5	81	66
	% of ASHAs who said that they would refer a pregnant woman immediately to the institution in case of loss of foetal movements	31	41	21
	% of ASHAs who said that they would refer a pregnant woman immediately to the institution in case of Headache/dizziness/blurred vision	67.5	60	75
	% of ASHAs who said that they would refer a pregnant woman immediately to the institution in case of convulsions and fits	50.5	51	50

Regarding the childhood illness, the functionality of ASHAs for childhood illness like Diarrhoea and Acute Respiratory Illness was found to be high as all users reported of ASHA helping them in both the conditions. Regarding effectiveness, 74.3% of users reported that they received ORS for their child suffering from diarrhoea, and 99.2% of children sought treatment for ARI. However, skills of ASHAs were low in terms of knowing the correct steps to make ORS, with only 11% of ASHAs able to describe the correct steps. About 16% of ASHAs said that they would advise additional fluid intake during diarrhoea. About 48% of ASHAs knew that feeding is to be continued during diarrhoea and 58% of ASHAs could specify chest wall indrawing as a danger sign for suspecting pneumonia. As noted earlier the findings indicate low levels of skill sets in most cases in Khowai district compared to Gomati district.

Table 2: Indicator

		Tripura	Gomati	Khowai
Functionality	% of user B who had diarrhoea and whom ASHA helped in some way	94.3	92	100
	% of user B with signs of ARI and whom ASHA helped in some way	95.9	94	98.2
	% of user B who had diarrhoea and whom ASHA gave ORS from her kit	74.3	80	60
Effectiveness	% of user B with diarrhoea who overall got ORS	74.3	80	60
	% of user B with ARI who sought treatment	99.2	98.5	100
Knowledge	% of ASHA who had knowledge of making ORS	11	17	5
	% of ASHA who had knowledge of advising fluid intake in case of diarrhoea	15.5	15	16
	% of ASHA who had knowledge of advising continued feeding for the child who had diarrhoea	47	55	39
	% of ASHA who could specify chest wall indrawing as a danger to suspect pneumonia	58	53	63

Overall, the findings indicate high level of functionality of ASHAs but also highlight the need to focus on building skills of ASHAs in the area of identification of danger signs during pregnancy and management of childhood illness. It was observed that every ASHA *Varosha Diwas* has an assessment planned as an activity but little follow up or corrective action is being undertaken.

5
SECTION

ASHA Related Findings from the Assessment on System Readiness to Roll Out Universal Screening, Prevention and Management of Common Non-Communicable Diseases

BACKGROUND

The year 2017 witnessed a paradigm shift in enabling the public health care systems in India to move from delivering selective health care to Comprehensive Primary Health Care (CPHC). Based on the recommendations of the National Health Policy, the CPHC roll out will aim to upgrade all existing Sub Health Centres and Primary Health Centres to "Health and Wellness Centres". The HWCs would provide an expanded range of primary care services, moving beyond reproductive and child health care and communicable diseases, to include services related to Non-Communicable diseases, Mental health, ENT, Ophthalmology, Oral health, elderly care, palliative health care and Trauma care. The Universal Screening, Prevention and Management of Non-Communicable Diseases (Hypertension, Diabetes and three cancers – Oral, Breast and Cervical Cancers) was launched in the year 2017 in 109 districts as the first step in move towards the CPHC. These districts were selected by states based on the functioning status of National Program on Prevention and Control of Cancer, Diabetes, Cardiovascular diseases and Stroke (NPCDCS).

The key components of universal screening of NCDs include - Population Enumeration, Community based risk assessment, Screening of all individuals of 30 years and above, Health Promotion, followed by management, appropriate referral and follow up for common NCDs.

The roll out of CPHC would also lead to expansion of the range of tasks being performed by ASHAs at the community level, which until now mostly comprised of care for maternal, child health and communicable diseases.

As part of the universal screening of NCDs, ASHAs would be trained for five days to equip her for the following tasks that she is expected to perform:

1. Enumeration of the entire population using Family Folder and creating individual health record for all above 30 years.
2. Completion of Community Based Risk Assessment (CBAC) for all individuals above 30 years.
3. Mobilize all individuals of 30 years and above for NCD screening being organized at SC or at community level places like Anganwadi Centre, Panchayat Bhavan etc.
4. Conducting health promotion activities to create health awareness in the community, enable lifestyle modifications to address risk factors and prevent NCDs. This could be done through home visits and using community platforms like VHSNC/MAS, during VHND etc.
5. Following up patients for regular check-ups and treatment adherence.
6. Constitution of patient support groups and facilitating regular meetings.

The July 2017 edition of ASHA update also reported on the Training Strategy for ASHA and Multi-Purpose Workers, Staff Nurses and Medical Officers of the Primary Health Care to implement this programme. It also provided a brief status update on the launch of this programme in 116 districts and 26 cities.

The programme has expanded significantly in the last six months and is rolling out in 19,497 Health Sub Centres in 160 districts across the country. As on 31st December, 2017, 29,270 ASHAs and 11,635 Auxiliary Nurse Midwives/Multi-Purpose Workers (ANM/MPW) have been trained on Module on Common Non-Communicable Diseases in these districts. Screening of common NCDs has been initiated in sixteen states and two Union Territories and 62,55,915 individuals have been screened so far.

During the last six months, the National Health Systems Resource Centre also undertook an assessment to understand the System Readiness for Rolling out Universal Screening, Prevention and Management of common NCDs. One of the key objectives of this intervention was also to understand the community level readiness to implement this programme and involved studying various ASHA related parameters that would be crucial in enabling a continuum of care for these services. This section provides a brief on rationale, broad objectives, methods and also summarizes the key ASHA related findings from the study.

RATIONALE OF THE STUDY:

The successful roll out of universal NCD screening relies mainly on health system's responsiveness i.e., availability of trained human resource, diagnostics, medicines and follow up services for NCDs. Since the primary healthcare system currently provides selective primary health care services, focusing mainly on services related to Reproductive, Maternal and Child Health Care and Communicable Diseases, it is important to assess the readiness of the public health system to deliver the expanded range of services. This would provide useful insights and enable the programme managers/policy makers for better planning and effective implementation of the programme.

The broad objectives of the assessment are to-

- Assess the readiness of the public health system at facility and community levels to roll out universal screening, prevention, management and control of common NCDs.
- Understand the current status of provision of services under NPCDCS and ability to respond to the increase in need for treatment and referral services.
- Provide feedback to the programme managers for better planning.

METHODOLOGY OF THE STUDY:

The assessment is expected to be undertaken periodically, (preferably every six months) across all states. The first three rounds of the assessment would be conducted by National Health Systems Resource Centre (NHSRC). The third round would be conducted jointly by NHSRC and state teams to facilitate capacity building of the state teams in the process. For the first three rounds, the same health facilities in every state would be visited and assessed.

Selection criteria for a district and block in each state, was the completion of front line workers' training at the sub centres (1 per 3000-5000 population). Selection of districts was made by states based on the functioning of NPCDCS. Primary (SHC/PHC) and secondary level (CHC and DH) facilities were selected following the referral chain from selected SHCs. Checklist used for health facilities has been adapted from the World Health Organization (WHO) Service Availability and Readiness Assessment (SARA) tool. This tool was used to collect information on a set of tracer indicators in following domains- basic amenities, equipment, diagnostics,

medicines, human resources and training. Semi-structured interviews and focused group discussions were conducted with service providers, community health workers and community members.

The first phase of the study has been completed in 14 districts/states.

High Focus states	Non high focus States	North East states
1. Haryana- Panchkula	6. Maharashtra- Wardha	10. Assam- Jorhat
2. Jharkhand- Bokaro	7. Punjab- Hoshiarpur	11. Manipur- Thoubal
3. Chhattisgarh- Durg	8. Karnataka- Udupi	12. Sikkim- East Sikkim
4. Uttar Pradesh- Lalitpur	9. Gujarat- Porbandar	13. Arunachal Pradesh- Papam Pure
5. Madhya Pradesh- Khargone		14. Tripura- South Tripura

In this section, we present the preliminary findings related to readiness of the ASHAs to undertake these additional tasks that emerged from interviews and FGDs conducted with ASHAs and community members from these districts.

I. Training:

ASHAs were trained in universal screening, prevention and control of NCDs Maharashtra, Karnataka, Manipur, Sikkim, Assam, Jharkhand, Uttar Pradesh and Tripura. In remaining six states, the training duration for ASHAs was reduced, which affected the skills and knowledge among ASHAs. For instance, in Madhya Pradesh, universal screening was conducted in campaign mode (clubbed with a Leprosy Case Detection Campaign) without the prerequisites of- training of frontline workers on NCDs. ASHAs were trained in only one-day orientation about leprosy and NCDs. However, ASHAs and ANMs were trained prior to this at Mahila Swasthya Shibir - a women's health camp intervention. While in Gujarat, ASHA training was conducted for only one day. Modules were provided in regional languages in all states except in Sikkim and Manipur, where English module was provided. This was reported as a major issue by ASHAs in these two states.

Joint day training of ASHAs with MPW (F) intended to improve team work was conducted only in few states. (Maharashtra, Karnataka, Manipur, Jharkhand and Sikkim). It was noted that ASHAs and MPWs had better understanding of each other's role and about the filling of formats, when such joint trainings were conducted. However, the district officials reported difficulty in arranging joint training sessions. Another issue in training was lack of training for all ASHAs from the sub-centre area (Arunachal Pradesh).

Only in four visited districts i.e, from Maharashtra, Karnataka, Manipur and UP, ASHA facilitators were also trained which helped them in understanding the role of ASHAs and facilitating support to ASHAs. Block and district level support staff for ASHAs, namely BCM and DCM were also involved in trainings in Maharashtra.

A good practice observed in states of Maharashtra, Haryana, UP, Karnataka, is screening of frontline workers for hypertension and diabetes, during training. In Haryana and Maharashtra, ASHAs were also screened for oral cancer (by oral visual examination) and breast cancer (by clinical breast examination) during the training. In Assam, screening of ASHAs for NCDs was separately arranged after training. This enabled ASHAs to understand the need to screen apparently healthy individuals and be better able to motivate individuals to seek screening services.

II. Skills and Knowledge:

Skills and Knowledge among ASHAs varied across districts and states, based on duration of training, topics covered during training, quality of training and time elapsed since training and initiation of activities like population enumeration and CBAC from filling.

In districts of Maharashtra, Chhattisgarh, Sikkim and Uttar Pradesh, it was observed that, ASHAs were

knowledgeable about NCDs, risk factors and their role in population enumeration, CBAC form filling, health promotion, community mobilization, follow up of treatment and details of screening activity- target population, method, frequency of screening, and site. They also had adequate skills for waist circumference measurement, CBAC form and family folder filling. This could be attributed to a detailed training for five days including hands on training for filling the formats.

In districts of Karnataka and Arunachal Pradesh, ASHAs in visited SHCs had adequate knowledge regarding NCDs and their role, but knowledge about specific details of some topics was limited. E.g. In Karnataka, ASHAs knowledge was limited regarding cancer screening (especially cervical cancer) and they expressed need for refresher training with more details about cancers. In Assam and Jharkhand, ASHAs had good knowledge about NCDs but programmatic knowledge about frequency of screening was limited. In Tripura and Manipur, even though ASHAs knew their role very well, skill attrition was noted on account of delay in initiating the population enumeration after completion of training. In Manipur, non-availability of module in local language was reported to be a major concern. In Haryana, Gujarat and Madhya Pradesh, ASHAs had very limited knowledge regarding diseases as well as program details. ASHAs in the visited SHCs of Punjab had not undergone training for NCDs, however, ASHAs had knowledge regarding cancers and risk factors as they were oriented in state initiatives for cancer screening and were also part of cancer detection campaign. Knowledge about patient support groups was lacking in all the states.

III. Activities initiated under universal screening of NCDs:

Community mobilization activities using platforms like- home visits, VHNDs and VHSNC meetings, SHGs and gram sabhas etc. were underway in states of Maharashtra, Chhattisgarh, Jharkhand, Karnataka, Manipur, Tripura and Sikkim.

In only half of the visited states was population enumeration started after training of frontline workers. It was noted that ASHAs were not provided with health promotion material- flip charts, posters etc. in most of the states. This has also restricted community mobilization activities to be undertaken by ASHAs.

Screening at SHCs for NCDs was initiated only in five districts (in Maharashtra, Chhattisgarh, Karnataka, Sikkim and Tripura) at the time of the visit. ASHAs were taking active part in the screening process. In Maharashtra, ASHAs had also started maintaining follow up data from health cards collected during home visits and mobilizing patients for treatment compliance.

INITIATIVES BY ASHAS

Maharashtra- ASHA in the village Saheli (SHC, Malegaon) shared their efforts for tobacco control and informed that during Gram Sabha, community members were encouraged to drop tobacco pouches in a box kept by the ASHA and PRI members, to initiate cessation.

Sikkim- Health promotion and community mobilization for screening was initiated in the state with inception of CATCH programme (started a few years ago) and is an on-going process in the district. Both the ASHAs and the MPWs were actively involved in the process including the screening. Health promotion in the form of counselling is carried out by the ASHAs through home visits, using the English alphabet A to G for easy understanding among the community and the ASHAs as well. (A- No to Alcohol, B- Control Blood Pressure, C- No to Cigarette and Tobacco, D- Healthy Diet, E- Regular Exercise, F- Control Fatness, G- Control Blood Glucose)

One ASHA from Manipur shared that after training,she was successful in helping the family member to quit the habit of tobacco consumption while one ASHA from Maharashtra shared that she had quit habit of tobacco chewing herself after training.

IV. Perception about program and change in her role:

Findings from most states indicate high levels of motivation among ASHAs to implement this initiative. They were aware about the burden of NCDs in the community and expressed the need of such initiatives in the community. ASHAs from Assam, Manipur and Chhattisgarh shared that the initiative will help in promoting healthy lifestyle, and in addition reduce high out of pocket expenditure and prevent premature deaths.

ASHAs from states like UP with high fertility rates and higher RCH work load, and from difficult regions in northeast states, while welcoming initiative, shared that they would find it difficult to accommodate additional activities in their work day. E.g. in UP, all ASHAs are in position against the target set at both the visited SHCs. However, inadequacy in estimating the targets for ASHAs was noted as the average population per ASHA was around 2000. Overall district had a shortfall of 97 ASHAs in rural areas (865 in position against the target of 982). District officials informed that in many areas ASHAs cater to additional population beyond her allotted population across the district and shared challenges faced in new ASHA selection. This high population density per ASHA and high TFR of the district has led to high workload for ASHAs in terms of HBNC visits, immunization and antenatal care.

ASHAs from Haryana, UP and Maharashtra reported cultural barriers would affect their performance to carry on community mobilization and community-based risk assessments. In Haryana, ASHAs anticipated that mobilization of males and conducting risk assessment (measuring waist circumference or asking questions related to habits) would be a challenge due to cultural barriers. Both SHCs visited in Haryana had one male MPW, and ASHAs shared that they would prefer if MPW (M) could accompany them during home visits. In Maharashtra, ASHAs shared that they ask the family members or the individual himself to measure the waist circumference. In UP, it was observed during community interaction as well as reported by front line workers that, awareness about NCDs, associated risk factors was low among community members. This coupled with non-availability of health promotion/IEC materials with ASHAs, affect the community level activities of health promotion and CBAC filing. ASHAs across most states reported that they fill the alcohol habit related information in CBAC form based on the information provided by the females in the household or as per ASHAs' knowledge, if male members are reluctant to share the details or provide false information as perceived by the ASHA.

In states of Assam, Manipur and Chhattisgarh where tobacco chewing is culturally more acceptable, ASHAs mentioned that the biggest challenge would be to convince people to avoid tobacco and alcohol. In addition, ASHAs from these states also shared that the systemic challenges of health systems would affect the implementation of the program viz. weak referral linkages (Chhattisgarh), unavailability of medicines and diagnostics (Assam, Manipur) etc.

The challenges are evident from narrative of an ASHA in Manipur- She said"*..though we mobilize the community, services are usually not available because of lack of health care providers, equipment, infrastructure and drugs at the health facilities".* ASHAs in Manipur also shared that lack of free referral transport during emergencies other than child birth one of the biggest challenge faced by community in seeking care.

ASHAs in all of the 14 states visited had neither received any incentive for the tasks performed under universal screening of NCDs nor were they aware of their entitlements. This was reported as a concern by ASHAs and some of the district management team, who were also not aware about the incentive provision.

The other findings from most states indicate low to moderate levels of preparedness in terms of training of HR, availability of medicines, diagnostics and service delivery across different levels of care, to support the roll out of this new intervention. Since ASHAs are expected to mobilize the community to seek care within the public health system, a weakly responsive health system, may also affect their credibility in the community. The high level of enthusiasm observed among the ASHAs would need to be backed up with strengthening the service delivery at all levels.

With regards to improve the functionality of ASHAs and the support provided to them, the following actions would need to be prioritized:

- Regular and timely incentive disbursal for CBAC form as well as follow up of patients. (Rs. 10 per CBAC form and Rs. 50 per individual for follow up of treatment of hypertension, diabetes and cancer and ensuing compliance for a period of 6 months).
- Community mobilization and health promotion activities to be planned before and during the population enumeration, to support ASHAs and increase community engagement.
- Refresher training for ASHAs to be planned periodically using either classroom training or virtual training methods, as required.
- Ensuing training of ASHA facilitators along with ASHAs and conducting one day joint training of ANMs with ASHAs as per training strategy.
- Orientation of ASHA support system at block and district level in universal screening, prevention and management of NCDs.
- Ensuring that there is no time lag between completion of training and initiation of community level activities to prevent skill attrition.

6
SECTION

State Specific Initiatives on Building Capacities of ASHAs to Respond to New Challenges

In the past twelve years of the National Health Mission, ASHAs have demonstrated that they form a critical part of the public health care delivery system. Time and again, findings from the field across all the states, acknowledge the major role played by ASHAs in- improving community's access to reproductive, maternal and new-born health care services, motivating people to adopt healthy behaviours and also in enabling health services reach to the most marginalized and vulnerable groups. Levels of motivation for an ASHA have only increased over the years, and increasingly they use their own agency to support the communities they serve. The standards for training and support structures are better developed now and make it easy for an ASHA to assimilate new knowledge and skills. Evidence from the field suggest that with simultaneous integrated efforts for health systems strengthening states now also feel more confident to experiment and harness the potential of ASHA in addressing complex community level health and related challenges.

In this section we present three case studies from field where ASHAs have been trained and supported to take on new challenges at the community level. The first case study is derived from the roll out of Comprehensive Mental Health Programme in Kerala. It describes in brief how ASHAs with systematic training are supporting community-based assessment of latent or undetected mental health issues and are enabling continuity of care for these patients. The second case study describes how training of Sahiyas in Jharkhand in PLA approach has supported them to identify concerns related to Violence against women and enabled community led action to address the same.

The third case study summarizes a field- based pilot undertaken in Koppal District of Karnataka. This pilot builds on the role of an ASHA with respect to ensuring Antenatal Care and developed her capacities to undertake systematic protocol based community level risk assessment, triaging and management of High Risk Pregnancies.

The case studies from Kerala and Karnataka demonstrate that ASHAs can play a pivotal role in strengthening community based clinical linkages required for high risk cases and chronic conditions. Training and use of standard risk assessments tools by ASHAs in both Kerala and Karnataka interventions facilitated early detection, triaging of cases and improved case management with follow up care. The effectiveness of PLA approaches is well established in improving health outcomes such as new born survival. Case study from Jharkhand highlights that use of PLA technique are also useful in addressing social concerns such as Violence against women. PLA meetings not just improved recognition of violence amongst women but empowered women to seek help for psychological violence too.

CASE STUDY 1 ▸

Expanding role of ASHA in the Delivery of Primary Health Care for Mental Illnesses as part of Kerala's "Sampoorna Manasikarogyam"

The Department of Health and Family Welfare, Government of Kerala launched the Mission AARDRAM about two years ago. The main aim of the mission is to create "People Friendly-Health Delivery System" in the state. The Mission adopted a need-based approach and aims at treating every patient with 'dignity'. As part of AARDRAM all Primary Health Centres in Kerala will be upgraded into the "Family Health Centres (FHCs)". The FHCs are strengthening community linkages through the frontline functionaries to expand the provision of primary health care services.

As per the recent evidence the current overall prevalence of any mental disorders is high in Kerala at 11.36%.[2] This includes schizophrenia and other psychotic disorders, depressive disorders, bipolar affective disorder, neurotic and stress related disorders in addition to alcohol and other substance abuse. In cognizance of high burden of mental illness, a treatment gap of 80% for the same[3] and with the overall aim to provide "need based" care under AARDRAM; Department of Health and Family Welfare Kerala implemented a focused intervention to find undetected mental health cases in the FHC area. ASHAs are a key fulcrum for this initiative and support in- case identification, integration of newly detected cases with District Mental Health Programme (DMHP) through the network of FHCs, community level management and follow up care.

The healthcare delivery system in Kerala has strong linkages with the Local Self Government and Gram Panchayats. Such a platform enabled to build community level linkages and support for ASHAs to conduct health promotion and prevention activities related to mental health concerns and overcome issues of stigma.

Implementation of "Sampoorna Manasikarogyam" involves the following steps:

a. Sensitization of elected representatives of Gram Panchayat and Frontline-Functionaries (ASHA, ANM, MPW-Male) on mental health challenges.

b. Training of ASHAs in on modalities to create awareness about mental health issues, overcoming stigma and undertaking screening of all individuals above five years of age using Standard Case detection Forms.

c. Training of PHC staff -Medical Officer, Pharmacist, Staff nurses and Health workers by DMHP to undertake management, drug dispensation and records maintenance for Mental Health cases in the FHC.

d. Roll out of Mental Health Awareness Programmes in Schools, Government Institutions, AWCs and Kudumbasree units with the support of Gram Panchayat and frontline functionaries.

e. Visits by ASHAs to all households of their coverage area.

f. Household meetings by ASHAs with individuals and families to raise mental health awareness using leaflets and flip-charts.

g. Administering Structured DMHP Case Detection Questionnaire by ASHAs to screen individuals for any mental health issues.

2 National Mental Health Survey of India; Kerala Report 2015-16, National Institute of Mental Health and Neuro-Sciences, Bengaluru and Institute of Mental Health and Neuro Sciences, Khozikode, Ministry of Health and Family Welfare, Government of India

3 Project Implementation Plan State of Kerala 2018-19

h. Evaluation of Case detection forms by DMHP team that comprises a team of psychiatrists.

i. Appointment reminders to families with cases of mental health risks and mobilization by ASHAs to attend Mental Health Camps at FHCs.

j. Diagnosis of illness, initiation of treatment by DMHP team, instructions to FHC Medical Officer on follow up care of patients who are expected to attend weekly or monthly Mental Health Clinics in the FHC.

k. Follow up of cases by ASHAs/MPWs in community level rehabilitation units with support from Local self-government representatives.

l. Review camps by DMHP once in every 6 months.

m. Evaluation of data and analysis.

The programme is currently being implemented in 170 FHCs. Implementation of the program is entrusted to the Medical Officer of the concerned FHC, DMHP support and organize awareness programmes and bi-annual medical camps and Gram Panchayats build the necessary community support and mobilize resources from Local Self Government health funds.

ASHAs are trained for half a day in the concerned FHC by the DMHP team and FHC staff. Training of ASHAs in small group with involvement of FHC staff supports in better clinical care coordination for programme and strengthens support and supervision for ASHAs by FHC Staff such as Health Inspectors/Junior Public Health Nurses (JPHNs). Training of ASHAs covers the following key areas

- Orientation on common mental health concern.
- Rationale of Sampoorna Manasikarogyam.
- Mechanisms for building community awareness, prevention and health promotion messages for mental health concerns.
- Conducting household meetings using programme leaflets and key messages.
- Use of the DMHP Case Detection Questionnaire.
- Follow up care and support for rehabilitation.

After training ASHAs undertake following activities as part of "Sampoorna Manasikarogyam":

a. Conduct Household survey and listing of individuals above five years age group.

b. Conduct household level meeting to build awareness on mental health concerns, and distributes leaflets provided by DMHP.

c. Screen and identity individuals at risk for mental illnesses and enable detection of new/unidentified cases within the community using a standard DMHP Case Detection Questionnaire.

d. Mobilize individuals at risk to attend health camps organized by DMHP at the FHCs for confirmation and generation of treatment plan.

e. Motivate newly identified cases to continue to avail care for illness management at FHCs.

f. Ensure regular follow-ups and support in reducing Treatment Drop Outs.

g. Build community awareness on prevention of Substance abuse prevention.

h. Address common adolescent mental health issues.

i. Increase community awareness on Suicide Prevention.

j. Increase awareness on mental health issues and treatment, in the community.

k. Support in rehabilitation of mentally ill in remission, within the community.

The DMHP Case Detection Questionnaire administered by ASHAs includes information on demographic and socio-economic background of the individuals. Respondent could be one of the family members or the head of the household and the questionnaire is filled for member of the family above five years age group who is demonstrating any of the listed signs/symptoms of mental illness indicated in the set of 13 questions. DMHP Case Detection Questionnaire used by ASHAs consists of the following 13 questions:

Q 1: Has any member in the family complains of depressed mood, lack of sleep, lack of interest or pleasure, reduced energy and decreased activity or has had thoughts of committing suicide in last two weeks?

Q 2: Does any member in the family exhibits extreme happiness, extreme anger, extreme devotion which disturbs others?

Q 3: Has any member in the family complaint of high heartbeat, body sweating, fatigue, fear, emotional disturbance or anxiety in the past 6 months?

Q 4: Does any member in family repeats the same activity in fear or anxiety?

Q 5: Is any member in the family using alcohol or any kind of drug or tobacco products? And whether they show more interest for continuous use of any substance and find it difficult to stop its use?

Q 6: Is any member in the family exhibiting scepticism or fear?

Q 7: Have you observed for any member in the family laughing while alone, speaking to self, murmuring?

Q 8: Does any member of the family constantly complains of feeling unwell without any obvious signs or symptoms of illness?

Q 9: Is any member in the family, especially the elderly facing problems such as-forgetfulness, behavioural problems, distrust?

Q 10: Has any member in the family threatened to commit suicide, exhibits suicidal tendency, causing self-harm for minor reasons?

Q 11: Does any member in the family has Epilepsy?

Q 12: Are any of these problems noted in children:

- Learning disability/lack of interest for studies.
- Hyperactivity/lack of concentration.
- Attitude of violence/stealing/lie/use of tobacco products.
- Age appropriate communication skill/age appropriate mental growth.

Q 13: Any other signs of mental illness observed in any individual? Specify?

It is ensured that at least one ASHA is trained from every ward and if there are more than one ASHA in a ward, the number of houses to be visited by each ASHA are divided on the day of training itself. The timeline to complete house visits in a ward is 10 days and ASHAs are provided remuneration of Rs. 150/ day for maximum 10 days.

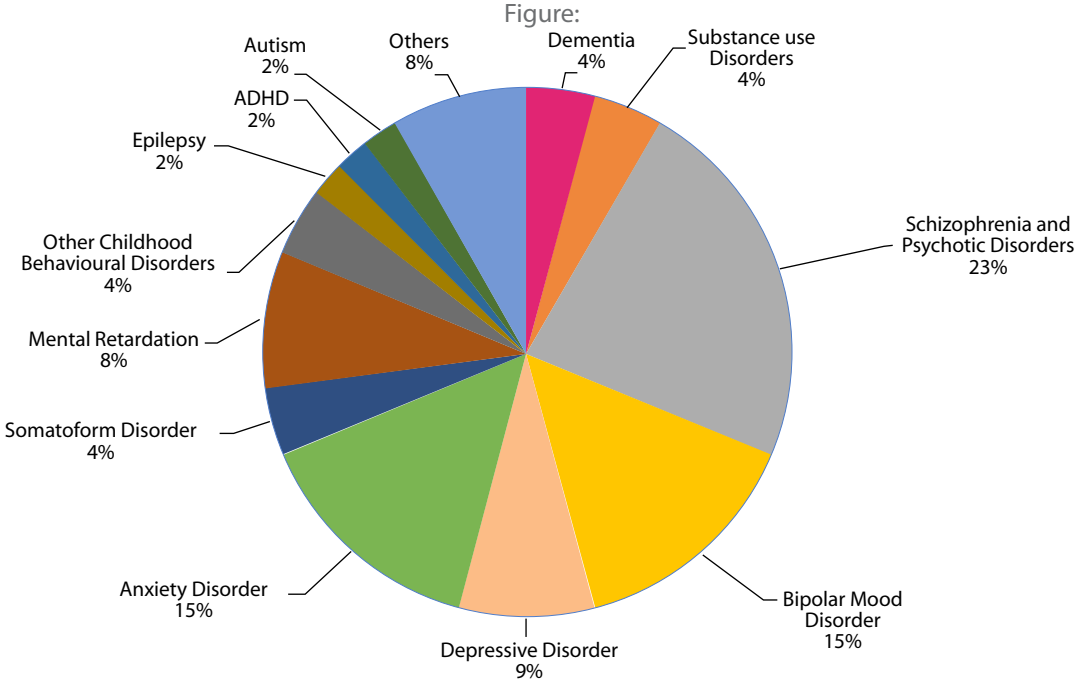
The forms filled by ASHAs after home visits are submitted to the Health Inspector (HI) of the concerned FHC for further validation and correction of errors if any. These forms are subsequently evaluated by a

team of psychiatrists from the DMHP who further classify cases as mild, moderate and severe cases of Mental illness.

Based on the confirmation of cases and inputs on scheduling of appointments from FHC staff, ASHAs follow up with the newly detected cases and encourage them to attend the medical camp conducted by DMHP at FHCs. ASHAs provide repeated intimation and follow up with the newly diagnosed cases to attend three review clinics at the FHC in the successive months which results in reduction of treatment dropouts.

Training of 2291 ASHAs under 170 FHCs has been completed and the programme is now operational in 72 FHCs across the 14 Districts of the State. As on July 2018, ASHAs have enabled detection of 5047 cases that are under treatment. Of these 3249 are newly diagnosed cases and follow up is being given by ASHAs to 1798 cases whose treatment plan has been prepared under the District Mental Health Program. Distribution of the nature of cases mobilized by ASHAs confirmed by diagnosis from Psychiatrists of DMHP is detailed in the figure below:

Figure:



The programme is now planned to be implemented in 300 more FHCs across the state in this financial year with support from NHM. The early results from this intervention have enabled an increased access to mental health care and closure of the treatment gaps with clinical coordination between ASHAs and FHCs. However, the challenges faced in the first phase of the programme will need to be systematically addressed. As per the state team, there is a need to build further clarity with respect to roles and responsibilities of Medical Officers and Health Inspectors in all aspects of the programme like screening, case detection and coordination with ASHAs for continuation of treatment and follow up care. Many cases require consultation with Medical officer even beyond minimum three review clinics that are presently mandated by DMHP. Since ASHAs are provided remuneration only to ensure attendance for three follow up check-ups at FHC; alternate measures will need to be planned for continuation of treatment beyond three follow ups. There is also a need to increase system support in view of human resource constraints in the DMHP team. The team of psychiatrists in DMHP is conducting clinics at the level of District Hospitals and CHCs. Due to staff shortages they can cover only 4-8 FHCs over a period of four months. Thus, specialists' consultation become a challenge in ensuring continuity of care.

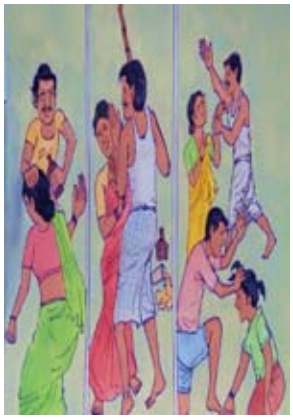
In the upcoming phases of programme implementation, state has commenced planning to use online platforms such as Tele-Health for supporting specialists' consultation to ensure continuity of care, providing clinical mentoring and decision support for Medical Officers in provision of mental healthcare. These measures would play a vital role in overcoming human resource constraints for programme implementation.

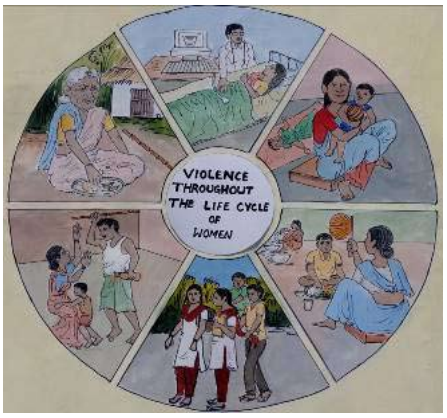
CASE STUDY 2

Exploring the Role of Sahiyas in Preventing Violence Against Women in Jharkhand

The fourth National Family Health Survey data has shown that about one in three married women in rural Jharkhand face spousal violence. The incidence of physical, sexual, emotional and economic violence among girls and women is even higher. There is currently no scalable community intervention model for the primary and secondary prevention of violence against women in rural Jharkhand. Recognizing this need, the National Health Mission-Jharkhand decided to pilot test the use of Participatory Learning and Action approach to increase women awareness on gender- based violence and plan strategic actions to address these concerns at the individual and community level.

Jharkhand is implementing the PLA intervention with Sahiyas in all districts for the last two and half years. PLA meetings are conducted with community based women collectives and state has also earmarked incentives for Sahiyas and Sahiya Sathis to facilitate these monthly meetings. The women's groups for Participatory Learning and Action (PLA) approach usually involves a group of 20-30 women, who meet monthly and work through a meeting cycle with four phases. In the first phase, groups identify and prioritise important social and health problems facing women in their community. In the second phase, they discuss and prioritise strategies to address these problems. In the third phase, groups implement their chosen strategies and in the final phase, they evaluate the process. The women's group intervention is being scaled up across the State since 2015. By 2020, an estimated 32,000 women's groups facilitated by Sahiyas and the Sahiya facilitators will be meeting monthly basis in Jharkhand.





Building on the opportunity afforded by this scale-up, Jharkhand-based civil society organization Ekjut and Mumbai-based SNEHA (Society for Nutrition, Education and Health Action) designed and piloted a module of 16 Participatory Learning and Action meetings to address violence against women. Sahiyas were also provided with related information about health, legal and police services that are available locally for survivors of violence. This intervention supported at total of 39 women's groups to conduct these 16 specified meetings over 16 months (June 2016 to September 2017).

To evaluate the preliminary benefits and outputs of this approach Ekjut team conducted a cross-sectional baseline and end-line surveys with members of the 39 groups taking part in the intervention across 22 villages of Chakradharpur and Bandhgaon blocks, in West Singhbhum District. These surveys captured information on the recognition and acceptability of violence, the prevalence rates of past year psychological and physical violence; and help-seeking pattern of violence victims.

The survey team interviewed 59% (679/1149) of women registered with the groups at baseline, and 63% (861/1371) at end-line.

The proportion of women reporting violence as unacceptable in seven scenarios proposed to them increased from 74% at baseline to 83% at end-line (adjusted $p<0.001$). In one year- psychological violence

from husbands decreased from 67% to 56% (adjusted p<0.001). Help-seeking for one-year psychological violence from husbands increased from 28% to 46% (adjusted p<0.001). One year psychological violence from family members decreased from 66% to 50% (adjusted p<0.001), as did the prevalence of past year physical violence from family members, from 27% to 12.1% (adjusted p<0.001). The proportion of women seeking help for violence from family members increased from 35% to 66% (p<0.001). A small proportion of 5% women also sought help from health, legal, or police services available for action on any form of violence.

Participatory Learning and Action meetings with women's groups facilitated by Sahiyas were found to be a feasible approach to build awareness on the issue of violence against women in rural, largely tribal communities of Jharkhand. The pilot showed promising reductions in the acceptance and incidence of psychological and physical violence in women and also showed marginal increase in help seeking by the violence victims.

However, less than 5% of women sought help from health providers, the police, or a legal aid cell. This builds a case that sensitising local governance systems through mundas (headmen), investing in public services to make them more responsive to survivors, and creating better linkages between other community-based groups and Sahiyas are required for improving help-seeking.

CASE STUDY 3 ▸

Use of The Maternal Clinical Assessment Tool by ASHAs to Strengthen clinical assessments for pregnant and postpartum rural women[4]

Courtesy: Ramalingaswami Centre on Equity & Social Determinants of Health; Public Health Foundation of India, Bangalore

Between August 2016 and January 2017, the ASHAs of Sanganhal PHC (Primary Health Centre) in Koppal district (Karnataka) were involved in field testing a tool to strengthen clinical assessments for poor rural women during the antepartum and postpartum periods. The Maternal Clinical Assessment Tool (M-CAT) is designed to help Medical Officers (MOs) and frontline health workers (ANMs, ASHAs) identify and manage pregnancy and postpartum risks systematically and quickly. A team at the Ramalingaswami Centre on Equity and Social Determinants of Health ("The Centre"), Public Health Foundation of India, Bangalore developed this simple IT-enabled system, which has four components.

1. ***A set of forms to be filled by the ASHAs*** to systematically record information about the symptoms, signs and tests results indicative of risks[5], through a set of medically robust and comprehensive (yet parsimonious) questions. There are four types of forms that the ASHAs were trained to fill: pregnancy registration form, antepartum visit form, delivery registration form and postpartum visit form.
2. ***A multi-lingual software application incorporating diagnostic algorithms*** that identifies the risk conditions to be ruled out by the MO, based on the data inputted from the ASHAs' forms. The algorithms, which analyse clusters of symptoms, signs and test results, were developed by a team of doctors including senior Obstetricians/Gynaecologists.

4 A more detailed report of the M-CAT field testing titled 'Maternal Clinical Assessment Tool: A Proof of Concept Report' and a film titled 'Asha Kirana: A tool for safer pregnancy' can be found on the Centre's website https://phfi.org/the-work/centres-of-excellence/the-ramalingaswami-centre-on-equity-and-social-determinants-of-health/

5 By risks, we mean the clinical conditions that compromise a pregnant/postpartum woman's health.

3. ***Computer-generated reports*** including (a) summary risk lists for the ASHAs, ANMs and the MO, (b) medical case sheets with initial diagnoses of risk for use by the MO during the woman's visit to the PHC, and (c) data worksheets for researchers.

4. ***A systematic process of identifying and managing risks***, including a feedback loop intended to prompt the ASHA/ANM and MO to take timely actions.

The Centre's work (tool development and field testing) was supported by the National Health Mission (Karnataka) and technical inputs were also provided by National Health Systems Resource Centre.

The field testing at Sanganhal PHC in Yelburga Taluka of Koppal district assessed the *feasibility* of implementing the M-CAT in the rural public health system. A team from the PHC, including 14 ASHAs, two ANMs and an MBBS-trained MO participated in the study, along with a project-appointed Data Entry Operator and Link Worker. A total of 349 pregnant and postpartum women were covered over four successive 30-day cycles between 21 September 2016 and 20 January 2017. A team of researchers continuously monitored and evaluated implementation of the field testing.

The findings from the pilot found that use of M-CAT by ASHAs and PHC staff strengthened clinical assessments of pregnant and postpartum women in five important ways.

- Supporting ASHAs through a structured assessment checklist to build awareness of risks and of needed actions among pregnant and postpartum women, and their families;
- Adding considerable value to the ASHAs' routine antenatal/postnatal home visits;
- Improving community linkages for clinical care coordination with the PHC MO and
- Enabling good quality clinical assessments in ANC clinics by PHC MO that were often crowded;
- Integrating seamlessly into the PHC's structure, schedule of activities; being acceptable to all stakeholders in the PHC.

The fourth planned component of this intervention was the envisaged feedback loop. This could not be formally closed for two reasons:

1. ASHAs either took women to the PHC without waiting for the SMS/phone call from the ANM, or advised women to seek higher levels of care.
2. Women visited facilities other than Sanganhal for diagnostic services or treatment.

In addition to the clear benefits of implementing the M-CAT by ASHAs, the pilots demonstrated that clinical assessments for poor rural women can be further improved if:

- The ASHAs' are able to actually follow the prescribed schedule of postnatal visits;
- The ANMs' responsibilities for maternal risk management are clarified and implementation is strengthened;
- Risk conditions such as malaria and pulmonary tuberculosis are identified via blood and sputum smears at the PHC itself;
- Reliable and continuous availability of test kits for essential investigations during antenatal clinics (urine albumin and RBS) is assured; and
- Referrals become more systematic and in line with established protocols.

Before implementation of the M-CAT, the ASHAs' interactions with women during their regular home visits tended to focus on only a few issues. Typically, they would advise pregnant women on nutrition and the need for immunisation, and ask postpartum women about the baby and breastfeeding. What the M-CAT did was to add value to this. It provided more structure to the ASHAs' interactions with women, and helped them consolidate and deepen their understanding of the information they had received through their training manuals. This made their work more effective, and ultimately ended up making them feel more empowered.

SECTION 7

An Update on ASHA Incentives

UPDATED LIST OF ASHA INCENTIVES

S.N.	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. Febuary-2013
a.	For ensuring antenatal care for the woman	Rs.300 for Rural areas and Rs. 200 for Urban areas	Maternal Health-NRHM-RCH Flexi pool	
b.	For facilitating institutional delivery	Rs. 300 for Rural areas and Rs. 200 for Urban areas		
2	Reporting Death of women (15-49 years age group) by ASHA to U-PHC Medical Officer	Rs. 200 for reporting within 24 hours of occurrence of death by phone	HSC/U-PHC- Untied Fund	MOHFW-OM-120151/148/2011/MCH; Maternal Health Division; 14th Febuary-2013
II	**Child Health**			
1	Undertaking Home Visit for the care of the New Born and Post Partum mother[1] -Six Visits in Case of Institutional Delivery (Days 3rd, 7th, 14th, 21st, 28th& 42nd) -Seven visits in case of Home Deliveries (Days 1st, 3rd, 7th, 14th, 21st, 28th& 42nd)	Rs. 250	Child Health-NHM-RCH Flexi pool	HBNC Guidelines –August-2014
2	Undertaking Home Visits of Young Child for Strengthening of Health & Nutrition of young child through Home Visits- (recommended schedule- 3rd, 6th, 9th, 12th and 15th months) - (Rs.50 x 5 visits) –in 1st phase the programme is proposed to implement only in 235 POSHAN Abhiyan and Aspirational districts	Rs. 50/visit with total Rs. 250/per child for making 05 visits		D.O. No. Z-28020/177/2017-CH 3rd May-2018
3	For follow up visits to a child discharged from facility or Severe Acute Malnutrition (SAM) management center	Rs. 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

S.N.	Heads of Compensation	Amount in Rs/case	Source of Fund and Fund Link-ages	Documented in
4	Ensuring quarterly follow up of low birth weight babies and newborns discharged after treatment from Specialized New born Care Units	Rs. 50/Quarter-from the 3rd month until 1 year of age		Order on revised rate of ASHA incentives-D.O-Z.28020/187/2012-CH, MoHFW- Would be subsumed with HBYC incentive
5	Child Death Review for reporting child death of children under 5 years of age	Rs. 50		Operational Guidelines for Child Death Review- 2014
6	For mobilizing and ensuring every eligible child (1-19 years out-of-school and non-enrolled) is administered Albendazole.	Rs. 100/ASHA/Bi-Annual		Operational Guidelines for National Deworming Day January-2016
7	Week-1-ASHA incentive for prophylactic distribution of ORS to families with under-five children	Rs. 1 per ORS packet for 100 under five children		OGs for Intensified Diarrhoea Control Fortnight – June-2015
8	Week-2- ASHA incentive for facilitating growth monitoring of all children in village; screening and referral of undernourished children to Health centre; IYCF counselling to under-five children household	Rs. 100 per ASHA for completing at least 80% of household		
9	MAA (Mother's Absolute Affection) Programme Promotion of Breastfeeding-Quarterly mother meeting	Rs. 100/ASHA/ Quarterly meeting		Operational Guidelines for Promotion of Breastfeeding-MAA -2016
III	**Immunization**			
1	Complete immunization for a child under one year	Rs. 100	Routine Immunization Pool	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	Rs. 50		
3	Mobilizing children for OPV immunization under Pulse polio Programme	Rs. 100/day[2]	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	Rs. 500	Family planning – NHM RCH Flexi Pool	Order No- D.O – N-11012/11/2012 – FP, May-2012
2	Ensuring spacing of 3 years after birth of 1st child	Rs. 500		
3	Ensuring a couple to opt for permanent limiting method after 2 children	Rs. 1000		
4	Counselling, motivating and follow up of the cases for Tubectomy	Rs. 200 in 11 states with high fertility rates (UP, Bihar, MP, Rajasthan, Chhattisgarh, Jharkhand, Odisha, Uttarakhand, Assam, Haryana and Gujarat) Rs. 150 in remaining states		Revised Compensation package for Family Planning-September DO-N 11026/11/2014-FP – 2014

S.N.	Heads of Compensation	Amount in Rs/case	Source of Fund and Fund Link-ages	Documented in
5	Counselling, motivating and follow up of the cases for Vasectomy/NSV	Rs. 300 in 11 states with high fertility rates (UP, Bihar, MP, Rajasthan, Chhattisgarh, Jharkhand, Odisha, Uttarakhand, Assam, Haryana and Gujarat) Rs. 200 in remaining states		
6	Social marketing of contraceptives- as home delivery through ASHAs	Rs. 1 for a pack of 03 condoms, Rs. 1 for a cycle of OCP, Rs. 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	Rs. 150/per case		Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV
8	Escorting or facilitating beneficiary to the health facility for the PAIUCD insertion	Rs. 150/case		Order on revised rate of ASHA Incentives -2016
MISSION PARIVAR VIKAS- IN SELECTED 146 DISTRICTS IN SIX STATES- (57 in UP, 37 in Bihar, 14 RJS, 9 in Jharkhand, 02 in Chhattisgarh and 2 in Assam)				
9	Injectable Contraceptive MPA (Antara Program) and a non-hormonal weekly centchroman pill (Chhaya) - Incentive to ASHA	Rs. 100 per dose	Family planning-RCH-NHM Flexi Pool	D.O.No.N. 110023/2/2016-FP
10	Mission Parivar Vikas Campaigns Block level activities- ASHA to be oriented on eligible couple survey for estimation of beneficiaries and will be expected to conducted eligible couple survey- maximum four rounds	Rs. 150/ASHA/round		
11	NayiPahel- an FP kit for newly weds- a FP kit would be given to the newly wed couple by ASHA (In initial phase ASHA may be given 2 kits/ASHA)	Rs. 100/ASHA/NayiPahel kit distribution		
12	Saas Bahu Sammelan- mobilize Saas Bahu for the Sammelan- maximum four rounds	Rs. 100/per meeting		
13	Updating of EC survey before each MPV campaign- Note-updating of EC survey register incentive is already part of routine and recurring incentive	Rs.150/ASHA/Quarterly round		
V	**Adolescent Health**			
1	Distributing sanitary napkins to adolescent girls	Rs. 1/pack of 6 sanitary napkins	Menstrual hygiene Scheme– RCH – NHM Flexi pool	Operational guidelines on Scheme for Promotion of Menstrual Hygiene August-2010

S.N.	Heads of Compensation	Amount in Rs/case	Source of Fund and Fund Link-ages	Documented in
2	Organizing monthly meeting with adolescent girls pertaining to Menstrual Hygiene	Rs. 50/meeting	VHSNC Funds	
3	Incentive for support to Peer Educator (for facilitating selection process of peer educators)	Rs. 100/Per PE	RKSK-NHM Flexi pool	Operational framework for Rashtriya Kishor Swasthya Karyakram – January-2014
4	Incentive for mobilizing adolescents for Adolescent Health day	Rs. 200/Per AHD		
VI	**Revised National Tuberculosis Control Programme[3]**			
	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)	Rs. 1000 for 42 contacts over six or seven months of treatment		
2	For Category II of TB patients (previously treated TB cases)	Rs. 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	Rs. 5000 for completed course of treatment (Rs. 2000 should be given at the end on intensive phase and Rs. 3000 at the end of consolidation phase		
4	For notification if suspect referred is diagnosed to be TB patient by MO/Lab[4]	Rs.100		Revised National Tuberculosis Control Program-Guidelines for partnership- Year 2014
VII	**National Leprosy Eradication Programme[5]**			
1	Referral and ensuring compliance for complete treatment in pauci-bacillary cases of Leprosy - for 33 states (except Goa, Chandigarh & Puducherry).	Rs. 250 (for facilitating diagnosis of leprosy case)+ Rs. 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- for 33 states (except Goa, Chandigarh & Puducherry).	Rs. 250 (for facilitating diagnosis of leprosy case)+ Rs. 600 (for follow up on completion of treatment)		
VIII	**National Vector Borne Disease Control Programme**			
A)	**Malaria[6]**			
1	Preparing blood slides or testing through RDT	Rs. 15/slide or test	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	Rs. 75/- per positive cases		
3	Providing complete radical treatment to positive Pf and Pv case detected by blood slide, as per drug regime			
4	For referring a case and ensuring complete treatment	Rs. 300 (not in their updated list)		

S.N.	Heads of Compensation	Amount in Rs/case	Source of Fund and Fund Link-ages	Documented in
B)	**Lymphatic Filariasis**			
1	For one time line listing of lymphoedema and hydrocele cases in all areas of non-endemic and endemic districts	Rs. 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[7]	Rs. 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	Rs. 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[8]	Rs. 100/- per round during Indoor Residual Spray i.e. Rs 200 in total for two rounds	NVBDCP funds	Minutes Mission Steering Group meeting- Febuary-2015
2	ASHA Incentive for referring a suspected case and ensuring complete treatment.	Rs. 500/per notified case	NVBDCP funds	Minutes Mission Steering Group meeting- Febuary-2018
E)	**Dengue and Chikungunya**			
1	Incentive for source reduction & IEC activities for prevention and control of Dengue and Chikungunya in 12 High endemic States (Andhra Pradesh, Assam, Gujarat, Karnataka, Kerala, Maharashtra, Odisha, Punjab, Rajasthan, Tamil Nadu, Telangana and West Bengal)	Rs. 200/- (1 Rupee/House for maximum 200 houses PM for 05 months- during peak transmission season). The incentive should not be exceed Rs. 1000/ASHA/ Year	NVBDCP funds	Updated list of NVBDCP incentive shared by MoHFW-NVBDCP Division – Dated-16th August-2018
F)	**National Iodine Deficiency Disorders Control Programme**			
1	ASHA incentive for salt testing	Rs.25 a month for testing 50 salt samples	NIDDCP Funds	National Iodine Deficiency Disorders Control Programme – Octuber-2006
IX	**Incentive for Routine Recurrent Activities**			
1	Mobilizing and attending VHND or (outreach session/Urban Health and Nutrition Days)	Rs. 200 per session	NHM-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	Rs. 150		
3	Attending monthly meeting at Block PHC/5U-PHC	Rs. 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	Rs. 500		

S.N.	Heads of Compensation	Amount in Rs/case	Source of Fund and Fund Link-ages	Documented in
X	**Participatory Learning and Action- (In selected 10 states that have low RMNCH+A indicators – Assam, Bihar, Chhattisgarh, Jharkhand, MP, Meghalaya, Odisha, Rajasthan, Uttarakhand and UP)**			
1	Conducting PLA meetings- 2 meetings per month- Note-Incentive is also applicable for AFs @ Rs.100/- per meeting for 10 meetings in a month	Rs. 100/ASHA/per meeting for 02 meetings in a month		D.O. No. Z.15015/56/2015-NHM-1 (Part)- Dated 4th January-2016
XI	**Incentives under Comprehensive Primary Health Care (CPHC) and Population Based NCDs Screening**			
1	Maintaining data validation and collection of additional information- per completed form/family for NHPM –under Ayushman Bharat	Rs. 5/form/family	NHM funds	D.O.No.7 (30)/2018-NHM-I Dated 16th April-2018
2	Filling up of CBAC forms of every individual –onetime activity for enumeration of all individuals, filling CBAC for all individuals 30 or > 30 years of age	Rs. 10/per form/per individual as one time incentive	NPCDCS Funds	D.O.No.Z-1505/39/2017-NHM-I Dated 19th July-2017
3	Follow up of patients diagnosed with Hypertension/Diabetes and three common cancer for ignition of treatment and ensuring compliance	Rs. 50/per case/Bi-Annual		
4	Delivery of new service packages under CPHC component	Rs.1000/ASHA/PM (linked with activities)	NHM funds	D.O.No.Z-1505/11/2017- NHM-I-Dated 30th May-2018
XII	**Drinking water and sanitation**			
1	Motivating Households to construct toilet and promote the use of toilets.	Rs. 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-12
2	Motivating Households to take individual tap connections	Rs. 75 per household		Order No. -11042/31/2012 -Water II Ministry of Drinking Water and Sanitation – Febuary-2013
XIII	**Others**			
1	Recognize ASHAs who leave/opt to leave the programme after a minimum of 10 years in the NHM	Rs.20, 000/ASHA	NHM funds	Minutes Mission Steering Group meeting- February-2018

Footnote

1. 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.
2. Revised from Rs 75/day to Rs 100/day.
3. Initially ASHAs were eligible to an incentive of Rs 250 for being DOTS provider to both new and previously treated TB cases. Incentive to ASHA for providing treatment and support Drug resistant TB patients have now been revised from Rs 2500 to Rs 5000 for completed course of treatment.
4. 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.
5. 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.
6. 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.
7. Incentive has been revised from Rs 100 to Rs 200 per day for maximum three days to cover 50 houses or 250 persons.
8. 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.

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