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Update on ASHA PROGRAMME

January 2019

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Introduction

This is the nineteenth issue of the semi-annual ASHA Update, produced by the National Health Systems Resource Centre, for the National Health Mission, and covers the period between July 2018 to December 2018. This period saw two global events of significance to the ASHA programme – the first was the Astana Conference on Primary Health Care, marking the fortieth anniversary of the Alma Ata declaration and the second, the launch of WHOs Guidelines on Health Policy and System Support to optimize Community Health Worker programmes. Several of the guideline recommendations span areas such as selection, training and certification, management and supervision, and integration in and support by health system and community, and resonate powerfully with India's 14 year old ASHA programme.

When the ASHA programme launched in 2005, as a centre-piece of a India's health systems strengthening effort, the National Rural Health Mission, the focus was largely on ASHA selection and training in knowledge based content. Today the ASHAs, numbering about 9,70,676 in rural and urban areas, are seen as being critical to both components of the newly launched Ayushman Bharat- viz: the Health and Wellness Centres and the Pradhan Mantri Jan Arogya Yojana. As reported in the earlier update ASHAs are now considered to be an integral part of the Primary Health Care Team in Health and Wellness Centres. However, notwithstanding the overall positive policy and programmatic evolution of the ASHA programme, gains across the country have not been uniform, and the full potential of the ASHA is yet to be realized. However, the realization of this potential needs a redefinition and redesign of several components of the ASHA and in fact the entire community processes programme.

The opening chapter of this issue, as in the past is an update on progress on selection, training, and support for the ASHA in rural and urban areas. While there is little change in the targets and selection data, UP and Rajasthan have shown a ten percent increase in training of Round 3 of Modules 6 and 7, taking training achievement for this Round countrywide, to 86%. Training in Modules 6 and 7 is accomplished through four rounds, and encompasses key competencies related to first level care and counselling for reproductive, maternal, newborn, child health and nutrition. Delays in completion of this training has implications on ASHA functionality.

This issue also includes a section on the community based institutions – namely the Village Health, Sanitation, and Nutrition Committees in rural areas and the Mahila Arogya Samities in urban areas, which are integral to the community processes interventions and expected to serve as a key support mechanism to the ASHA. From state repots of these institutions be it related to constitution and capacity building, it is clear that this is an underutilized mechanism to enable broader community engagement and participation than is possible by the ASHA working alone.

Since the launch of primary health care programmes several decades ago, it has been a concern that

health promotion efforts at community level for action on social and environmental determinants have been largely neglected. However, there are some exceptions and, featured in this update is the experience of Gaon Kalyan Samities (GKS), as VHSNC in Odisha are called. The state has followed a systematic process of strengthening the GKS, and have been able to integrate these committees within the local government institutions, which was the vision outlined in the NRHM, at the time of its launch.

Each year, two events- the Common Review Mission and the Summit of Good, Replicable and Innovative Practices take place between August and December, and relevant information has been reported in issues of the January update since inception. This issue also summarizes the findings and recommendations of the 12th Common Review Mission that covered 18 states. All eighteen state reports acknowledge the pivotal role played by ASHAs in linking the community with the public health system and applaud the community rapport built by the ASHA. One area of concern across most states is the weakening of support and supervision to the ASHA. ASHA support structures have been critical to her functionality and need to be sustained.

This issue also includes brief narratives on the ten best practices reported in the fifth Best Practices Summit held in Kaziranga. The narratives highlight the multiple interventions in which the ASHA is playing a part and her engagement with additional sub-groups such as adolescents as evidenced in Madhya Pradesh's Rashtriya Kishore Swasthya Karyakram, and in using technology as in Gujarat's ImTeCHO effort. In the area of communicable diseases, state experiences from Odisha, Dadra & Nagar Haveli and Madhya Pradesh in Malaria, Leprosy and Tuberculosis respectively, highlight the critical role of the ASHA in meeting the country's targets in the National Health Policy, 2017, and Sustainable Development Goals. E Vittah Pravah, an innovation from Madhya Pradesh, is an effort to streamline payments via Direct Benefit Transfers holds promise for the use of digital financial transactions. The continuing role of the ASHA in addressing reproductive and child health concerns is reported from West Bengal and Bihar. From Karnataka, we have an example of how ASHA can be integrated into the Primary Health Care team in the Health and Wellness Centres, which lays the ground for future work on integration and sustainability of the ASHA programme.

In the final section, we provide an updated list of incentives. In this period the amount of routine and recurring incentive for the ASHA was doubled from the existing Rs. 1000, and the ASHA facilitator's daily honorarium for supervisory visits was raised to Rs. 350. In addition, social security benefits covering life and accident insurance and pensions were announced for the ASHA and ASHA facilitators.

One event that signifies political commitment to the ASHA programme from the highest level was the PM Samvad, organized on September 11, 2018, in which the Honourable Prime Minister interacted with ASHAs and Anganwadi workers selected from particular districts across ten states. The ASHA were selected for their exemplary performance.

2
SECTION

Programme Update: *ASHA*

Status of ASHA selection

National Overview

A total of 9,70,676 ASHAs are in position against a target of 10,22,661 ASHAs in the present update. Over the last six months, there has been an increase in the overall target number of ASHAs from 10,21,817 to 10,22,661, and in the number of ASHAs in position which increased from 9,55,625 to 9,70,676.

National Rural Health Mission

The overall selection target for rural ASHAs increased, since July 2018. The present target for rural ASHAs is 9,48,266 as compared to 9,47,972 reported in the previous edition of the update. However, during this period, the number of rural ASHAs in position also saw an increase from 8,92,052 to 9,05,047, thereby achieving 95 per cent selection target for rural areas.

Among the High Focus States, Madhya Pradesh (+428) and Uttarakhand (+565) increased the target number of ASHAs while other remaining states maintained the same target.

The number of ASHAs in position increased in all High Focus states except Jharkhand which maintained the same number of ASHAs and Madhya Pradesh (-641) where the number of ASHAs in position decreased. Uttar Pradesh, Rajasthan, and Bihar added the highest number of new ASHAs during this period.

Overall, North East states maintain 100 per cent selection of ASHAs. There has been an increase in the selection targets for ASHAs in Assam (+301) and Tripura (+376), while in rest of the States target numbers remain unchanged. Assam (+301), Tripura (+245), Arunachal Pradesh (+1) and Nagaland (+30).

Across the Non-High Focus states, though there has been an overall reduction in the target number of ASHAs, but the number of ASHAs in position has increased. Andhra Pradesh (- 785) and Tamil Nadu (-3608) significantly reduced their selection targets for ASHAs. Telangana (+2141), Jammu and Kashmir (+474), Gujarat (+24) and Maharashtra (+25) increased its selection target for ASHAs in the last six months.

In terms of the number of ASHAs in-position, Himachal Pradesh (-144), Punjab (-75), Tamil Nadu (-1255) and Telangana (-64) reported a reduction in the number of ASHAs in-position. The rest of the states increased their pool of in-position ASHAs, of which the progress in Kerala (+1851), Maharashtra (+2180) and West Bengal (+4411) is the most significant. The remaining states like Gujarat, Haryana, Jammu and Kashmir, Karnataka and West Bengal also increased the number of ASHAs in position. Majority Non-High Focus states report over 94 per cent selection of ASHAs against targets. Kerala (78%), Tamil Nadu (57%) and West Bengal (84%) remain the only states where the percentage of ASHAs in position against the target is less than 90 percent.

The Union Territories reported an overall 88 per cent ASHAs in position against their selection target. Andaman and Nicobar Islands and Lakshadweep's percentage of in position ASHAs remain unchanged at 100 per cent. Dadar and Nagar Haveli (70%) and Daman and Diu (91%) report an increase in the number of in position ASHAs. Overall, there has been a reduction in the percentage of in position ASHAs across the Union Territories due to the increase in selection targets reported by Dadar and Nagar Haveli. Puducherry does not have any rural ASHAs and Chandigarh has discontinued the use of the nomenclature of ASHAs as reported in the previous update.

Population Density

The National average for the population density per ASHAs under the NRHM is currently 881, which is a reduction from 891 as reported in July 2018. This correlates with the overall increase in the number of in position ASHAs in Non-High Focus and High Focus States. Nationally, the population density ranges from as low as 129 per ASHA in Lakshadweep to as high as 1207 per ASHA in West Bengal.

In the High Focus states, it has decreased from 864 to 815 and from 970 to 854 per ASHA in Non-High Focus states. The North East States, as well as the Union Territories, also reported a decrease in the population density of ASHAs from 671 to 639 across the NE states and from 606 to 427 across the Union Territories. This decrease in the population covered by each ASHA is attributed to the increase in the number of ASHAs selected in the last six months.

Though states such as Rajasthan, Maharashtra and West Bengal have shown a reduction in the population covered by ASHAs due to an increase in the selection of ASHAs, they still continue to report population density of more than 1000 population per ASHA.

National Urban Health Mission

Under NUHM, the country has achieved 88 per cent of the urban ASHA selection target which is an increase from the 86 per cent as reported in the previous update in July 2018.

The national target for urban ASHAs shows an increase from 73,845 to 74,395 in the last six months, which is attributed to the increase of selection targets in High Focus states, contributed primarily by Jharkhand and Uttar Pradesh. Overall, there was also an increase in the number of urban ASHAs in position which increased from 63,573 to 65,629 now.

The High Focus states in July 2018 show an increase of both target and new ASHAs selected. There is an addition of 2503 new ASHAs contributed primarily by Jharkhand (+769), Madhya Pradesh (+887) and Uttar Pradesh (+675).

However, in the last six months, the North East States and Non-High Focus states show a decline in the selection target of urban ASHAs as well as the number of ASHAs in position. Major reduction in target number of urban ASHAs have been reported from Assam. As per the state reports, this revision is on account of a systematic gap analysis across cities to identify the actual number of ASHAs required. The North East States reported an impressive 95 per cent achievement of ASHAs in position against the targets. Barring Meghalaya (81%) that shows a slight reduction in the number of urban ASHAs.

The Non-High Focus States report an overall 86 per cent selection of ASHAs. All of the Non-High Focus States barring Andhra Pradesh (77%), Jammu and Kashmir (59%) and Kerala (48%) have selected over 80% ASHAs.

Among the Union Territories, there was a slight reduction in the target for selection of urban ASHAs, the number of urban ASHAs in position largely remained consistent.

Table 1: Status of ASHA selection under NRHM and NUHM

State/UT	NRHM					NUHM		
	Rural ASHAs (Target)	Rural ASHAs (in Position)	Percentage of ASHAs in position against the target	Rural Population 2011 Census	Current Density- January 2019	Urban ASHAs (Target)	Urban ASHAs (In Position)	Percentage of ASHAs in position against the target
Bihar	93687	88331	94	92341436	1045	562	521	93
Chhattisgarh	70278	66220	98	19607961	296	3883	3771	97
Jharkhand	40964	39964	98	25055073	627	1165	1165	100
Madhya Pradesh	63867	62058	97	52557404	847	5100	4865	95
Odisha	45665	45337	99	34970562	771	1482	1450	98
Rajasthan	51180	47042	92	51500352	1095	4636	4269	92
Uttar Pradesh	159307	154776	97	155317278	1003	8036	6723	84
Uttarakhand	10470	10392	99	7036954	677	1181	1181	100
Total	**535418**	**514120**	**97**	**438387020**	**815**	**26045**	**23945**	**92**
Arunachal Pradesh	3862	3838	99	1066358	278	42	42	100
Assam	30920	30920	100	26807034	867	1212	1212	100
Manipur	3928	3928	100	1736236	442	81	81	100
Meghalaya	6519	6519	100	2371439	364	210	135	64
Mizoram	1012	1012	100	525435	519	79	79	100
Nagaland	1917	1917	100	1407536	734	75	75	100
Sikkim	641	641	100	456999	713	35	35	100
Tripura	7216	7077	98	2712464	383	551	539	98
Total	**56015**	**55852**	**100**	**37083501**	**639**	**2285**	**2198**	**96**
Andhra Pradesh	39491	39491	100	34776389	881	3810	2581	68
Delhi	0	0	0	0	0	6142	5725	93
Gujarat	38926	37585	97	34694609	923	4114	4063	99
Haryana	18000	17516	97	16509359	943	2676	2509	94
Himachal Pradesh	7930	7680	97	6176050	804	34	29	85
Jammu & Kashmir	12474	12172	98	9108060	748	85	85	100
Karnataka	39195	37853	97	37469335	990	3329	2951	89
Kerala	30927	26057	84	17471135	670	1927	1927	100
Maharashtra	61260	60794	99	61556074	1013	9845	8583	87
Punjab	17360	17137	99	17344192	1012	2600	2532	97
Tamil Nadu*	3242	2650	82	0	0	0	0	0
Telangana	26028	23756	91	21585313	909	5000	3289	66
West Bengal	61008	51511	84	62183113	1207	6072	4926	81
Total	**355586**	**334202**	**94**	**318873629**	**854**	**45634**	**39200**	**86**
Andaman & Nicobar	412	412	100	237093	575	10	0	0
Dadra & Nagar Haveli	372	262	70	183114	699	70	70	100

State/UT	NRHM					NUHM		
	Rural ASHAs (Target)	Rural ASHAs (in Position)	Percentage of ASHAs in position against the target	Rural Population 2011 Census	Current Density- January 2019	Urban ASHAs (Target)	Urban ASHAs (In Position)	Percentage of ASHAs in position against the target
Daman & Diu	98	89	91	60396	679	10	10	0
Lakshadweep	110	110	100	14141	129	0	0	0
Puducherry	0	0	0	0	0	341	206	0
Total	**992**	**873**	**88**	**494744**	**427**	**431**	**286**	**66**
Total All India	**948266**	**905047**	**95%**	**794838894**	**881**	**74395**	**65629**	**88%**

*Population density for Tamil Nadu has not been computed as the state does not have a uniform population for ASHAs.

Status of ASHA Training

With the focus on Comprehensive Primary Health Care, states have initiated multiskilling of ASHAs on Universal Screening, Prevention and Management of Non-Communicable Diseases. The previous editions of ASHA Update reported on the progress of NCD related trainings for ASHA. In April 2018, Ministry of Health and Family Welfare also launched the initiative of Home-Based Care for the Young Child as part of the Poshan Abhiyaan. The broad objectives of the HBYC programme are to-reduce child deaths and illnesses, improve nutritional status of young children and ensure proper growth and early childhood development of young children. As part of HBYC initiative, ASHAs are to undertake expanded set of five additional home visits after the 42nd day of birth in addition to the 6/7 visits specified as part of HBNC. ASHAs are to visit the child on completion of 3, 6, 9, 12 and 15 months. The quarterly home visits schedule for low birth weight babies, SNCU and NRC discharged children that ASHAs are already making will now be subsumed as part of HBYC schedule.

In view of the new training packages rolled out for ASHAs in the last two years, this section of ASHA update now provides information on trainings undertaken for State and District Trainers for ASHA. It also includes progress of ASHA trainings on Modules 6 and 7, NCDs and HBYC in both rural and urban areas.

Update on Training of Trainers for ASHA

Overall 510, 404 and 399 State ASHA Trainers have been trained across all the states in Rounds 1, 2 and 3 of Module 6 and 7. An overall increase is reported in the pool of trainers in three rounds of Module 6 and 7 in the last six months for Module 6 and 7. For example-347 state trainers were trained in Round 3 of Module 6 and 7 in July 2018, the numbers increased to 399 by December 2018. Likewise, pool of District Trainers trained for Round 3 training expanded from 6410 to 8717 in the last six months. A significant increase is visible in the training of ASHA Facilitators. The numbers of AFs trained up to Round 3 of Module 6 and 7 increased from 3168 to 27,395 by December 2018.

Trainers pool has also expanded for training of ASHAs in Non-Communicable Diseases. Majority states have trained State and District Trainers for ASHAs except Rajasthan, Dadar and Nagar Haveli, Lakshadweep and Puducherry. 214 State Trainers, 3025 District ASHA Trainers and 11,511 ASHA Facilitators have been trained so far in Training of ASHAs in NCD Module.

Despite initiation of HBYC trainings only in September 2018, states made a rapid progress on Training of Trainers in HBYC. 107 State Trainers, 617 District Trainers and 101 ASHA Facilitators have been trained so far.

ASHA Training under NRHM

Trainings of New ASHAs in Induction Module

In the last one year 25,089 new ASHAs have been inducted and training in Induction Module has been completed for 24,908 ASHAs. Chhattisgarh (1168), Madhya Pradesh (3080) Uttar Pradesh (4053) and Rajasthan (1495) trained largest number of ASHAs in Induction Module in the last one year in the High Focus states. Amongst the North Eastern states, a total of 733 ASHAs were trained in induction module of the 851 newly inducted ASHAs. A large proportion of this training has been reported from states of Arunachal Pradesh (225), Assam (301) and Manipur (138). Amongst the Non-High Focus states, Induction Module training has been completed for 13,480 ASHAs. West Bengal and Maharashtra trained over 2000 new ASHAs, over 1700 ASHAs completed Induction Training in Karnataka, Andhra Pradesh and Telangana and about 1550 ASHAs were trained in Gujarat.

Training of ASHAs in Module 6 and 7

There has been progress in training of ASHAs in all four rounds of Module 6 and 7. In the high focus states 95%, 91%, 86% and 48% ASHAs have been trained respectively in the four rounds of Module 6 and 7. Despite commencing the training after a long gap of three years, Bihar continues to report the slowest pace of ASHA Trainings in Module 6 and 7. Thus, in the High Focus states, other than Bihar more than 93-100% ASHAs have been trained in Round 1 and Round 2 of Module 6 and 7. In the last six months, only 3% additional ASHAs have been trained in Round 3 taking the training achievement to 4,32,432 (84%) for this round. Most progress has been observed in Rajasthan and UP that have trained 41,391 (88%) and 1,27,703 (83%) ASHAs respectively in Round 3 and is nearly a 10% increase in the last six months. There still remains a huge backlog for completion of round 4 training and only 2,45,757 (48%) ASHAs have been trained. The training backlogs are largely on account of slow training progress in Bihar, and MP. Bihar could train only 3% additional ASHAs in Round 4 in the last six months. After the discontinuation of NGO model of training, Bihar commenced training through existing systems under NHM. Thus, issues of identification of new training sites, slow tendering at district level for logistics and lack of availability of adequate trainers contribute to slow progress. Though MP shows an overall increase of 12% in Round 4 training of ASHAs, pace of ASHA trainings is relatively much slower in MP in comparison to other counterparts. Lack of adherence to training schedule by districts, delays in signing of MoUs with NGOs at district level for food and accommodation for residential training, periodic roll out of multiple large-scale campaigns for national health programmes are possible reasons for slow pace of training in MP. State of Uttar Pradesh despite being a delayed starter has remarkably maintained a steady pace of training. Rajasthan gained pace in the last six months and could train 34,668 (74%) ASHAs in round 4 that is an improvement of over 15% from last update.

Owing to small numbers in comparison to other states, the North East States show good training achievements and most states have completed training for more than 95-97% ASHAs in all four rounds of Module 6 and 7. Amongst these states only Arunachal Pradesh has the lowest training achievement as only 79% ASHAs have been trained in Round 4. The state also showed no progress in completion of these trainings in the last six months.

In the Non High Focus states, a variable progress is observed in respective rounds of Module 6 and 7. Over 96% and 90% ASHAs have been trained in Round 1 and 2, 86% in Round 3 and 61% in Round 4. If we compare it with July 2018 update, the training progress has been slow and other than 5% increase in training for Round 4, overall training achievement remain largely unchanged. States that have majorly contributed to training progress in Round 3 in last six months are Gujarat (37,126-99%) and West Bengal (50,273-99%). Karnataka did not show progress in Round 3 training despite a backlog to complete training for 16% ASHAs in this round. The state could also train only 678 ASHAs

in Round 4 in the six- month period and indicates slow progress. Other states that show good progress in Round 4 training are-Gujarat (+2084); Haryana (+17,182), Maharashtra (+3805), Punjab (+813) and West Bengal (+1120).

Progress of training in Module 6 and 7 has been slow in all UTs except Andaman and Nicobar Islands that has trained all targeted ASHAs in all four rounds of Module 6 and 7. UTs for Dadar and Nagar Haveli and Daman and Diu show progress only up to the Second round and Round 3 and 4 are yet to be commenced.

ASHA Trainings in Universal Screening, Prevention and Management of NCDs

Trainings for ASHAs to support population-based screening of NCDs need to be undertaken in Sub-Centres identified under NPCDCS to roll out PBS and for ASHAs in the service area of HWCs. Based on this requirement, each state has identified a pre-determined target to train ASHAs. As on December 2018, the target number of ASHAs to be trained in NCD is about 2.6 lakh. Against this target 1.8 lakh ASHAs have been trained in rural areas. Chhattisgarh (11,349), Odisha (15,433), Jharkhand (18,602) have trained largest number of ASHAs amongst the High Focus States against their state specific target. Of the 1.8 lakh ASHAs trained in NCDs, high focus states contribute to 37% ASHAs trained in NCDs. In North East states, all states except Arunachal Pradesh (457/1175); Manipur (1700/4063) and Meghalaya (679/750) have been able to train all ASHAs as targeted for the current financial year.

Table 2: **Status of ASHA training under NRHM**

State	ASHA Trainings under NRHM												
	Induction Module		Module 6 and 7									PBS training for NCD	
	New ASHAs selected in the last one year (Jan 2018- Dec 2018)	New ASHAs trained in induction module the last one year (Jan 2018- Dec 2018)	No. of ASHAs in position	Round 1		Round 2		Round 3		Round 4		Target (No. of ASHAs to be trained)	Total no. of ASHAs trained
				Total no. of ASHAs trained	Percentage of ASHAs trained	Total no. of ASHAs trained	Percentage of ASHAs trained	Total no. of ASHAs trained	Percentage of ASHAs trained	Total no. of ASHAs trained	Percentage of ASHAs trained		
High Focus States													
Bihar	907	0	88331	78615	89	68208	77	55994	63	9874	11	589	589
Chhattisgarh	1168	1168	66220	66169	100	66169	100	66169	100	66169	100	12000	11349
Jharkhand	382	235	39964	37045	93	37271	93	37190	93	36257	91	39964	18602
Madhya Pradesh	3080	3080	62058	62058	100	58979	95	49228	77	42953	69	21100	5680
Odisha	110	89	45337	45297	100	45297	100	45297	100	44680	99	18857	15433
Rajasthan	1495	1495	47042	45852	97	44308	94	41391	88	34668	74	6905	6398
Uttar Pradesh	5067	4053	154776	143106	92	138505	89	127703	83	1296	1	21270	9041
Uttarakhand	565	565	10392	9774	94	9460	91	9460	91	9460	91	5730	2946
Total	**12774**	**10685**	**514120**	**487916**	**95**	**468197**	**91**	**432432**	**84**	**245357**	**48**	**126415**	**70038**
North East States													
Arunachal Pradesh	241	225	3838	3669	96	3472	90	3472	90	3032	79	1175	457

State	ASHA Trainings under NRHM												
	Induction Module		Module 6 and 7									PBS training for NCD	
	New ASHAs selected in the last one year (Jan 2018- Dec 2018)	New ASHAs trained in induction module the last one year (Jan 2018- Dec 2018)	No. of ASHAs in position	Round 1		Round 2		Round 3		Round 4		Target (No. of ASHAs to be trained)	Total no. of ASHAs trained
				Total no. of ASHAs trained	Percentage of ASHAs trained	Total no. of ASHAs trained	Percentage of ASHAs trained	Total no. of ASHAs trained	Percentage of ASHAs trained	Total no. of ASHAs trained	Percentage of ASHAs trained		
Assam	301	301	30920	30920	100	30920	100	30920	100	30619	99	4063	4063
Manipur	138	138	3928	3420	87	3422	87	3416	87	3453	88	2069	1700
Meghalaya	68	0	6519	5891	90	5873	90	5914	91	5849	90	750	679
Mizoram	21	21	1012	1012	100	1012	100	1012	100	1012	100	258	258
Nagaland	30	0	1917	1576	82	1570	82	1624	85	1593	83	121	121
Sikkim	25	25	641	641	100	641	100	641	100	641	100	641	641
Tripura	27	23	7077	6800	96	6611	93	6852	97	6816	96	1820	1634
Total	**851**	**733**	**55852**	**53929**	**97**	**53521**	**96**	**53851**	**96**	**53015**	**95**	**10776**	**9553**
Non High Focus States													
Andhra Pradesh	1014	1954	39491	36868	93	34601	88	30165	76	23105	59	0	0
Gujarat	1730	1550	37585	37585	100	37585	100	37126	99	36248	96	9131	8840
Haryana	282	238	17516	17516	100	17516	100	17527	100	17182	98	18618	10353
Himachal Pradesh	0	0	7680	7539	98	7529	98	7474	97	7473	97	5199	6015
Jammu & Kashmir	369	0	12172	11800	97	11784	97	11597	95	11214	92	3204	950
Karnataka	1786	1786	37853	34047	90	33335	88	31769	84	31166	82	12663	7869
Kerala	650	600	26057										
Maharashtra	920	2893	60794	59695	98	59412	98	59124	97	58379	96	28445	27772
Punjab	132	132	17137	17137	100	17137	100	17137	100	17137	100	17137	17137
Tamil Nadu	505	505	2650	2389	90	2389	90	2389	90	2389	90	2650	2389
Telangana	1721	1721	23756	23756	100	23756	100	23756	100	0	0	31028	23756
West Bengal	2063	2101	51511	51511	100	51511	100	50273	91	44589	81	3044	2999
Total	**11172**	**13480**	**334202**	**299843**	**90**	**296555**	**89**	**288337**	**86**	**248882**	**74**	**131119**	**108080**
Union Territories													
Andaman & Nicobar	10	10	412	412	100	412	100	412	100	412	100	0	0
Dadar & Nagar Haveli	262	0	262	68	26	45	17	0	0	0	0	0	0
Daman & Diu	20	0	89	73	82	55	62	0	0	0	0	0	0
Lakshadweep	0	0	110	0	0	0	0	0	0	0	0	0	0
Total	**292**	**10**	**873**	**553**	**63**	**512**	**59**	**412**	**47**	**412**	**47**	**0**	**0**
All India Total	**25089**	**24908**	**905047**	**842241**	**93**	**818785**	**90**	**775032**	**86**	**547666**	**61**	**268310**	**187671**

ASHA Trainings under NUHM

Training of Urban ASHAs in Induction Module

Upto December 2018, states had selected 15,542 new urban ASHAs and of this induction trainings have been completed for 15,006 (97%) ASHAs highlighting a good pace.

In the High Focus states, Chhattisgarh (3682), Uttar Pradesh (1101), Jharkhand (856) Madhya Pradesh (524) and Bihar (521) trained maximum number of ASHAs in induction module. About 7172 new urban ASHAs were selected and training has been completed for 7014 ASHAs.

The North East States selected about 288 new urban ASHAs in the last one year and could complete training for 244 ASHAs, Meghalaya (185) and Arunachal Pradesh (42) added the maximum number of urban ASHAs during this time period and were successful in completing their induction training.

In the Non high focus states, West Bengal (4113), Telangana (1099), Maharashtra (602), and Delhi (589) trained the maximum number of new urban ASHAs in induction module. Gujarat, Himachal Pradesh, Haryana, Karnataka also added ASHAs within a range of 100-200 and completed trainings for the same. A key development has been initiation of Urban ASHA programme in Puducherry in the last six months. State has been able to train its newly inducted 205 ASHA in induction module.

Training of Urban ASHAs in Module 6 and 7

Training of urban ASHAs in Module 6 and 7 shows an increase in the last six months. For the entire country 42,909 ASHAs (65%) have been trained in Round 1 and 2438 ASHAs were trained in this round in the last six months. Number of ASHAs trained have also increased for other three rounds but show maximum increase in training for Round 4 where number of ASHAs trained increased from 10,895 in last update to 30,085 now. This has enabled 57% ASHAs to be trained in Round 2, 57% in Round 3 and 41% in Round 4. While 93% ASHAs have been trained in Round 1 in High Focus states, 88% and 65-67% ASHAs have been trained for North East and other Non- High Focus states and UTs.

Module 6 and 7 Training has been initiated in all High Focus states except Bihar and UP. Chhattisgarh, Odisha and Uttarakhand have moved ahead in comparison to other states. More than 93% ASHAs have been trained up to Round 4 in Chhattisgarh, Odisha has trained 94% ASHAs upto Round 3 and 75% up to Round 4. 100% Urban ASHAs have been trained in all four rounds in Uttarakhand. Jharkhand commenced urban ASHA Training in Module 6 and 7 only six months back have so far trained 66% or 769 Urban ASHAs up to round 3. MP indicates a slow pace with limited progress in training urban ASHAs.

Amongst the North East states four out of eight states have completed training for urban ASHAs Rounds 1 to Round 4. These include-Assam, Arunachal Pradesh, Manipur and Mizoram. Other states such as Nagaland, Sikkim, Tripura show comparatively lower training achievements with 55-84% ASHAs trained up to fourth round. Pace of Training is slowest in Sikkim, Assam and Meghalaya. Former two have trained not a single ASHA and only 34% ASHAs have been trained in Rounds 3 and 4 for Meghalaya.

In the Non-High Focus states good pace of urban ASHA training has been reported from Delhi, Gujarat, Haryana, Kerala, Punjab and Telangana that have trained 90-100% ASHAs in first three rounds of Module 6 and 7. Andhra Pradesh has also commenced trainings for ASHAs in this package in the last six months and has been able to complete trainings for 65% ASHAs up to Round 3 and 54% ASHAs in Round 4. Pace of training is slow in Karnataka and the state shows an achievement of 42–46% in all rounds of module six and seven. Unlike its rural counterpart training progress is slow even in urban Maharashtra. One possible reason for

this could be these two states have maximum of ASHAs working in large municipal corporation area slums. Coordination challenges related to planning, release of funds, monitoring etc between the governance structures of municipal corporations, city PMU and NHM result in training lags. Jammu and Kashmir, West Bengal and Himachal Pradesh are yet to train urban ASHAs on Module 6 and 7.

Amongst the UTs only Dadar and Nagar Haveli have trained its 100% ASHAs in Round 1.

Training of Universal Screening, Prevention and Management of NCDs

As on December 2018, the target projected by states for training urban ASHAs in NCD is about 30,085. Against this target 17,655 ASHAs have been trained in urban areas. Chhattisgarh (3530), Odisha (1403), MP (135), Uttrakhand (20) are the only states that have commenced the NCD trainings. In the North East states other than Manipur, Meghalaya and Sikkim all other states commenced training for urban ASHAs in NCD and have achieved 856 ASHAs trained against the total target of 1033 ASHAs. Delhi (1000), Gujarat (1500), Haryana (1293), Maharashtra (2028), Punjab (2414) and Telangana (3289) have trained a significant number of ASHAs in NCD. This training is yet commence in Andhra Pradesh, Himachal, Jammu and Kashmir and Karnataka; thus impacting the progress of operationalization of HWCs in urban context.

Table 3: Status of ASHA training under NUHM

State	ASHA Trainings under NUHM												
	Induction Module		Target no. of ASHAs to be trained	Module 6&7								NCD	
				Round 1		Round 2		Round 3		Round 4			
	New ASHAs selected in the last one year (Jan 2018-Dec 2018)	New ASHAs trained in induction module in the last one year (Jan 2018-Dec 2018)		Total no. of ASHAs trained	Percentage of ASHAs trained	Total no. of ASHAs trained	Percentage of ASHAs trained	Total no. of ASHAs trained	Percentage of ASHAs trained	Total no. of ASHAs trained	Percentage of ASHAs trained	Target (No. of ASHAs to be trained)	Total no. of ASHAs trained
High Focus States													
Bihar	521	521	521	0	0	0	0	0	0	0	0	0	0
Chhattisgarh	3771	3682	3771	3500	93	3594	95	3530	94	3682	98	3771	3530
Jharkhand	919	856	1165	769	66	769	66	769	66	769	66	1165	0
Madhya Pradesh	628	524	4865	3650	75	3003	62	2550	52	1820	37	1149	135
Odisha	11	11	1450	1366	94	1366	94	1366	94	1146	79	1450	1403
Rajasthan	319	319	4269	4076	95	3744	88	3558	83	3107	73	0	0
Uttar Pradesh	1003	1101	6723	0	0	0	0	0	0	0	0	0	0
Uttarakhand	0	0	1181	1181	100	1181	100	1181	100	1181	100	1181	20
Total	**7172**	**7014**	**23945**	**14542**	**93**	**13657**	**57**	**12954**	**54**	**11705**	**86**	**8716**	**5088**

State	ASHA Trainings under NUHM												
	Induction Module		Target no. of ASHAs to be trained	Module 6&7								NCD	
				Round 1		Round 2		Round 3		Round 4			
	New ASHAs selected in the last one year (Jan 2018-Dec 2018)	New ASHAs trained in induction module in the last one year (Jan 2018-Dec 2018)		Total no. of ASHAs trained	Percentage of ASHAs trained	Total no. of ASHAs trained	Percentage of ASHAs trained	Total no. of ASHAs trained	Percentage of ASHAs trained	Total no. of ASHAs trained	Percentage of ASHAs trained	Target (No. of ASHAs to be trained)	Total no. of ASHAs trained
North Eastern States													
Arunachal Pradesh	42	42	42	42	100	42	100	42	100	42	100	42	5
Assam	0	0	1212	1212	100	1212	100	0	0	0	0	568	568
Manipur	0	0	81	81	100	81	100	81	100	81	100	81	0
Meghalaya	185	185	135	1	1	128	95	46	34	46	34	210	0
Mizoram	0	0	79	79	100	79	100	79	100	79	100	79	79
Nagaland	34	0	75	41	55	41	55	41	55	41	55	18	18
Sikkim	10	10	35	25	71	25	71	0	0	0	0	35	0
Tripura	17	12	539	454	84	398	74	428	79	436	81	0	186
Total	**288**	**249**	**2198**	**1935**	**88**	**2006**	**91**	**717**	**33**	**725**	**33**	**1033**	**856**
Non-High Focus States													
Andhra Pradesh	0	0	2581	1712	66	1864	72	1668	65	1401	54	0	0
Delhi	589	589	5725	5725	100	5725	100	5168	90	0	0	1000	1000
Gujarat	289	276	4063	3878	95	3871	95	3890	96	3871	95	4066	1500
Haryana	186	186	2509	2509	100	2460	98	2460	98	2338	93	3222	1293
Himachal Pradesh	32	32	29	0	0	0	0	0	0	0	0	0	0
Jammu & Kashmir	4	0	85	0	0	0	0	0	0	0	0	0	0
Karnataka	109	109	2951	1356	46	1312	44	1272	43	1254	42	0	0
Kerala	350		1927	1927	100	1927	100	1927	100	1927	100	0	0
Maharashtra	859	602	8583	3429	40	2263	26	1685	20	1298	15	4251	2028
Punjab	522	522	2532	2530	100	2530	100	2530	100	2530	100	2532	2414
Tamil Nadu	0	0	0	0	0	0	0	0	0	0	0	0	0
Telangana	0	1099	3289	3289	100	3289	100	3289	100	0	0	5000	3289
West Bengal	4926	4113	4926	0	0	0	0	0	0	0	0	0	0
Total	**7866**	**7528**	**39200**	**26355**	**67**	**25241**	**64**	**23889**	**61**	**14619**	**37**	**20071**	**11524**

State	ASHA Trainings under NUHM												
	Induction Module		Target no. of ASHAs to be trained	Module 6&7								NCD	
				Round 1		Round 2		Round 3		Round 4			
	New ASHAs selected in the last one year (Jan 2018-Dec 2018)	New ASHAs trained in induction module in the last one year (Jan 2018-Dec 2018)		Total no. of ASHAs trained	Percentage of ASHAs trained	Total no. of ASHAs trained	Percentage of ASHAs trained	Total no. of ASHAs trained	Percentage of ASHAs trained	Total no. of ASHAs trained	Percentage of ASHAs trained	Target (No. of ASHAs to be trained)	Total no. of ASHAs trained
Union Territories													
Andaman & Nicobar	0	0	0	0	0	0	0	0	0	0	0	0	0
Dadar & Nagar Haveli	0	0	70	70	100	0	0	0	0	0	0	70	70
Daman & Diu	10	10	10	7	70	0	0	0	0	0	0	0	0
Puducherry	206	205	206	0	0	0	0	0	0	0	0	195	117
Lakshadweep	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	**216**	**215**	**286**	**77**	**26**	**0**	**0**	**0**	**0**	**0**	**0**	**265**	**187**
All India Total	**15542**	**15006**	**65629**	**42909**	**65**	**40904**	**62**	**37560**	**57**	**27049**	**41**	**30085**	**17655**

Status of Support Structures for Community Processes

State ASHA Mentoring Group (AMG)

ASHA Mentoring Groups (AMGs) have been constituted at the state level to act as technical support groups for assisting the State Governments in the implementation, monitoring, and review of the ASHA programme. State level AMGs have been constituted in a total of 24 states in the country. Chhattisgarh from the High Focus States, Manipur from the North East States, and Haryana, Himachal Pradesh, and Tamil Nadu are the six states which have not constituted State AMGs. The five Union Territories which have selected ASHAs also do not have AMGs.

Among the High Focus States, Madhya Pradesh and Uttarakhand are the only states which have reported an AMG meeting in the last year, both in July 2018. While Jharkhand and Uttar Pradesh had their last AMGs in 2017, Rajasthan, Bihar and Odisha have not had a State AMG meeting since 2010, 2011 and 2012 respectively.

Among all 24 States, Uttarakhand has reported the highest number of AMG meetings since the constitution of the State AMG in 2009.

In the North East States, all States have constituted State AMGs however, despite existing AMGs, the frequency of meetings have been irregular across all these states. None of the States have reported AMG meetings in the last one year. The last AMG meeting was held in 2016 for Assam. Mizoram, Nagaland, Sikkim, and Tripura have reported their last AMG meetings in 2013.

Among the Non-High Focus States, Jammu and Kashmir and Maharashtra have reported AMG meeting in the last six months, in October and September 2018 respectively. Kerala,

Karnataka, and Telangana have reported AMG meetings held in 2017, on the other hand, Andhra Pradesh, Delhi, and Gujarat have not had AMG meetings since 2015. West Bengal has not had an AMG meeting since December 2011.

The composition of the State AMGs varies across states such as Delhi and Meghalaya reported 8 members in the AMG while Madhya Pradesh has reported a total of 46 members in the State AMG.

With the introduction of Comprehensive Primary Health Care under Ayushman Bharat, there is a definite need to strengthen this crucial platform to support the ASHA programmes at the State level and the ASHAs are expected to perform wide ranging tasks related to expanded range of services. These initiatives call for greater inputs towards systematic monitoring and implementation support for the ASHA programme. Thus, revitalising State AMGs would be crucial for all states.

ASHA Support Structure at State, District, Block and Sector Level

Since the last edition of the ASHA Update, there have not been any major change in the support structures for community processes across states during the last six months.

All High Focus states except Odisha have an ASHA support cadre at State, district, block and sector level. Odisha manages the programme at block level through their existing programme management unit staff.

In the last update, Bihar had reported a significant number of vacancies across the district, block and sector level. In the last six months, the state have made recruitments for these positions yet vacancies still exist at District and Block Level. Even at the Block Level, Block Health Manager, Block Accounts Manager, and Block Monitoring and Evaluation Manager are expected to support the programme but the state reports major vacancies. Madhya Pradesh also reported significant vacancies at the block and sector level though recruitments have taken place since the last update. Chhattisgarh, Jharkhand, and Uttarakhand have not reported any major changes in their support staff.

Status of support structures at state and district level in North East states remain largely unchanged.

No major changes in the support staff have been reported across the Non-High Focus states. All Non-High Focus states barring Gujarat and Tamil Nadu have a cadre at the District level. In Gujarat 33 District Programme Assistants support the programme at the district level. In Tamil Nadu, existing staff in the District Programme Management unit and the Deputy Director of Health Services support the Community Processes programme. In Andhra Pradesh, Gujarat, Jammu and Kashmir and Tamil Nadu have regular staff to support the ASHA programme at the block level. While, Haryana, Karnataka, and Maharashtra, has engaged dedicated staff for community processes at all four levels.

Across the Union Territories, no major changes have taken place in the support structure. The programme is managed by the existing staff.

Table 4: Status of State ASHA Mentoring Groups (AMGs)

State	Status of formation	Year of formation	Total no. of AMG members	Total no. of meetings held till Dec. 2018	Month & year of last meeting held
High Focus States					
Bihar	SAMG constituted and is a registered body	2009	10	3	Jun-11
Chhattisgarh	SAMG not constituted	NA	NA	NA	NA
Jharkhand	SAMG constituted in 2010 and later reconstituted in 2016	2012	15	10	Oct-17
Madhya Pradesh	SAMG was constituted in 2012 and later reconstituted in 2013	2008	46	4	Jul-18
Odisha	SAMG constituted	2009	NA	4	2012
Rajasthan	SAMG constituted	2006	21	4	Sep-10
Uttar Pradesh	SAMG constituted	2008	29	8	Dec-17
Uttarakhand	SAMG constituted	2009	13	27	Jul-18
North East States					
Arunachal Pradesh	SAMG constituted	2010	14	9	Aug-15
Assam	SAMG constituted	2012	12	8	Jan-16
Manipur	SAMG was constituted in 2008	2008	10	11	May-14
Meghalaya	SAMG constituted	2009	8	6	Oct-14
Mizoram	SAMG constituted	2008	30	9	Sep-15
Nagaland	SAMG constituted	2010	11	5	Aug-13
Sikkim	SAMG constituted in 2010 and later reconstituted in 2016.	2016	15	2	Nov-13
Tripura	SAMG constituted	2008	18	7	Nov-13
Non High Focus States					
Andhra Pradesh	SAMG constituted	2015	15	1	2015
Delhi	SAMG constituted	2010	8	6	Jan-15
Gujarat	SAMG constituted	2013	15	7	Mar-15
Haryana	Not constituted	NA	NA	NA	NA
Himachal Pradesh	Not constituted	NA	NA	NA	NA
Jammu & Kashmir	SAMG constituted	2012	10	1	Oct-18
Karnataka	SAMG constituted in 2012 and later reconstituted in 2017	2017	NA	1	Apr-17
Kerala	SAMG constituted	2008	NA	8	Feb-17
Maharashtra	SAMG constituted	2007	16	6	Sep-18
Punjab	SAMG constituted	2014	11	3	Aug-16
Tamil Nadu	Not constituted	NA	NA	NA	NA
Telangana	SAMG constituted	2015	9	3	Nov-17
West Bengal	SAMG constituted	2010	15	4	Dec-11

Table 5: Status of Community Processes Support Structures

State	District Coordinators		Block Coordinators			ASHA Facilitators		State ASHA Resource Center		
	Target	In position	Cadre designated to manage programme at district level in absence of DCM	Target	In position	Cadre designated to manage programme at block level in absence of BCM	Level of Facilitators (1 for 10 to 20 ASHAs/1 per PHC)	Target	in Position	Number of Members in ARC
High Focus States										
Bihar	38	12	26 In-Charge (DPC/DAM/DDA/ DM&E) is working as DCM	534	359	175 In-Charge (BHM/ BAM/B M&E) is working as BCM	1 AF per 20 ASHAs	4470	4188	6
Chhattisgarh	35	35	–	292	292	–	1 AF per 20 ASHAs	3220	3150	13
Jharkhand	72	71	District Programme Manager (DPC). There is also a cadre of State Trainer Team for each district.	608	608	Block Trainer Team and three Block Resource Persons per block	1 per 10 to 20 ASHAs	2260	2260	5
Madhya Pradesh	51	46	DPM/IEC Consultant/RBSK Co-ordinators/RKSK Coordinator	313	259	BEE/SS/BPM/MPW	1 AF per 10-15 ASHAs	5157	4330	9
Odisha	60	55	NA	NA	NA	NA	One AF is functional at sector level, approximately 1 AF to 20 ASHAs	717	717	3
Rajasthan	34	31	DPM	249	174	AF & BPM	1 AF supports 35- 40 ASHA/PHC level	1528	1248	5
Uttar Pradesh	75	71		820	768		1 AF for 20 ASHAs	8013	6405	21
Uttarakhand	13	12	DPM	101	101	AF & BPM	1 AF for 20 ASHAs	606	604	4
Non High Focus States										
Arunachal Pradesh	22	22		84	84		1 AF for 10-13 ASHAs	348	348	2
Assam	27	25	DPM	149	114	BPM	1 AF for 10 ASHAs	2877	2760	2
Manipur	9	9		1	0	Block Program Manager	1 AF for 20 ASHAs	194	179	3

State	District Coordinators		Block Coordinators			ASHA Facilitators		State ASHA Resource Center		
Meghalaya	11	10		39	40	BPMs nominated as BACs	1 AF per 30 ASHAs	334	334	2
Mizoram	9	9					1 AF per 10 ASHAs	109	109	2
Nagaland	11	11		72	66					2
Sikkim	4	4	LHV/IEC staff are supporting as District coordinators and they are ASHA trainers as well	NA	26 HEO/ HE/LHV	All from regular cadre supporting CP programme	1 AF for 10 ASHAs	71	71	1
Tripura	8	3		7	10			426	404	1
Non High Focus States										
Andhra Pradesh	13	10	0	0	0	0	1 AF for 20 ASHAs	1410	1385	4
Delhi	11	8		NA			1 ANM for 5 -7 ASHAs per one PUHC	1156	1500	5
Gujarat	NA	NA	We have 33 District Program Assistant- ARC.	NA	NA	NA	1 AF for 10 ASHAs	3751	3440	3
Haryana	22	20	NA	113	107	NA	1 AF for 20 ASHAs	618	618	5
Himachal Pradesh	12	10	BPM	73	73	HE/Supervisors	1 AF Per Sub-Centre	2281	1663	7
Jammu & Kashmir	22	22	CHO/Health Educator	117	117	Health Educators & FMPHWs	1 for 20 in Non HTR and 1 for 10 in HTR	816	816	4
Karnataka	30	29		176	166		1 AF per 20 ASHAs	1800	1671	3
Kerala	13	14	No separate ARC in Kerala	205	205	14				1
Maharashtra	34	33	NA	355	333	NA	One AF for 10 ASHAs in tribal area & One AF for 20 ASHAs for Non-Tribal area	3664	3517	4
Punjab	22	13		0	0		1 AF per 20 ASHAs	898	868	4
Tamil Nadu			Existing staff in the DPMU, Deputy Director of Health Services and District Maternal and Child Health Officers support the programme			Community Health Nurse cadre support the programme at block level				5
Telangana	31	5	PO DTT/DPHNOs	0	0	0	PHC level	1551	1386	2
West Bengal	26	19	NA	666	487	NA	NA	NA	NA	10

Status of the Community Processes Support Structures in Union Territories

Name of UT	State Level	District Level	Block & Sector Level
Andaman & Nicobar Island	Programme managed by SPMU	Existing DPMU staff supports the programme at district level.	Existing regular cadre support the programme.
Dadra and Nagar Haveli	Programme managed by SPMU	Existing DPMU staff supports the programme at district level.	Existing regular cadre support the programme.
Daman and Diu	Programme managed by SPMU	Existing DPMU staff supports the programme at district level.	Existing regular cadre support the programme.
Lakshadweep	Programme managed by SPMU	Existing DPMU staff supports the programme at district level.	Existing regular cadre support the programme.
Puducherry	Programme managed by SPMU	Existing DPMU staff supports the programme at district level.	Existing regular cadre support the programme.

3
SECTION

Programme Update on Community Based Institutions: *Village Health Sanitation and Nutrition Committees and Mahila Arogya Samities*

The July 2017 edition of ASHA Update provided an overview of the Village Health Sanitation and Nutrition Committees and Mahila Arogya Samities for all states. In this update we report on the progress of constitution, training, opening of bank accounts and role played by ASHAs in the platform of VHSNC & MAS in different states.

Formation of VHSNC

At the national level 5,36,903 (95%) VHSNCs have been constituted against total target of 5,67,320 for the country.

In the High Focus states 2,70,812 (92%) VHSNCs have been formed against the target of 2,95,962. All states except Chhattisgarh, Madhya Pradesh and Uttar Pradesh have formed 100% VHSNCs against the state specific target. The gaps in formation are largely on account of revision of target number of VHSNCs rather than slow pace of formation. While Chhattisgarh and Madhya Pradesh have only 5% and 10% VHSNCs to be constituted, UP needs to complete formation of a significant 23% VHSNCs for complete saturation. In all of these states VHSNCs have been formed at the revenue village level except in Bihar, where VHSNCs have been formed at the level of Gram Panchayats. All states report having more than 10 members per VHSNC except Bihar that is adhering to only a five members constitution followed by Jharkhand that reports on an average about 11 members/VHSNC. Other remaining states membership ranges between 15-20 participants.

In the North East states 45,140 VHSNCs (98%) have been constituted against the target of 46,003. Only Arunachal Pradesh and Meghalaya report small gaps in formation. Of these eight states, only Manipur, Sikkim and Tripura have VHSNC at the level of Gram Panchayat level while others have VHSNCs formed at the village or revenue village level. Average size of the committee is lowest for Arunachal Pradesh (two members/VHSNC) point towards a need for reconstitution as per the MoHFW guidelines that specify minimum 15 members to be selected in a committee. In rest other states membership ranges between 9-15 members.

The Non-High Focus states also show a good progress in the formation of VHSNCs and 22,016 (98%) have been formed against the total target of 2,24,575. In this group of states VHSNCs have been formed at the level of revenue village except in Andhra Pradesh (at GP level) and Kerala (at ward level) are governed largely by the Department of Rural Development. Other than Telangana where 12% VHSNCs are yet to be formed most other states have been able to form more than 96% VHSNCs against the target. All these VHSNCs that have been formed have a bank account and membership ranges between 5-20 being lowest in Gujarat.

UTs have small numbers of VHSNC and 100% formation with bank accounts has been completed for 235 VHSNCs.

Convergence of ASHA and VHSNCs

As per the Operational Guidelines for VHSNC, ASHA is expected to serve as the member secretary of the committee and be a joint account holder with the chairperson who is a representative of the panchayat. This is to promote better community level ownership, participation of marginalized, actual need-based village health planning. At the National Level ASHAs are serving as member secretary in about 3.7 lakh VHSNCs formed (70%) across the country. States where ASHA is not a member secretary of VHSNC include-Bihar (ANM), Odisha (AWW), Arunachal Pradesh (AWW), Nagaland (ANM or Pharmacist), Gujarat (ANM), Haryana (AWW), Himachal Pradesh (ANM), Kerala (ANM), Maharashtra (AWW), Telangana (ANM), West Bengal (ANM) Dadar and Nagar Haveli (ANM) and Daman and Diu (ANM). ASHAs serve as the joint account holder in the use of untied funds in about 3.5 lakh or 66% of VHSNCs formed. ASHAs have not been made joint account holders for management of untied funds in states of Bihar, Tripura, Haryana, Himachal Pradesh, Kerala, Tamil Nadu, Telangana, West Bengal and all UTs. These states have adopted alternate models different from the norms that have been specified in the MoHFW VHSNC guidelines.

Capacity Building of VHSNCs

While formation of VHSNCs has been undertaken to a large extent in all states and UTs, systematic efforts towards capacity building and hand holding of VHSNCs faced challenges in the early years of implementation of NRHM. States initiated adhoc district and block level orientations but institutional mechanisms for systematic capacity building through sustained efforts were not observed in many states. To overcome these challenges, MoHFW introduced a Handbook for Training of VHSNCs members in a two day programme. This training is expected to build knowledge and competencies of VHSNC members on roles and responsibilities, functions of public service monitoring, health promotion and village health planning.

In the last few years, despite having large numbers of VHSNC members to be trained, many states planned training in the Handbook to improve the capacity building processes. The VISHWAS Campaign launched in 2017, is expected to strengthen the institutional capacity of VHSNCs for effective and sustained community action on health, the key purpose for which they were created.

At the National level, members from 2.5 lakh VHSNCs (47%) have been trained on Handbook for VHSNC members. In High Focus states, in 1.8 lakh (69%) VHSNCs this training has been completed. Bihar and UP show limited progress in this regard and only in 9% and 12% of the total VHSNCs members have been oriented on the Handbook. Chhattisgarh, Jharkhand and Odisha show maximum progress in this regard have been able to complete this training for 90-100% VHSNCs. MP has moved forward and completed these training for 69% VHSNCs. Rajasthan though reports nill figures for training in MoHFW Handbook, the state had completed two day training for its members in a state specific module in 2011-12.

Amongst the North East States, members from 93% VHSNCs have been trained in the Handbook. All states have completed this training except Arunachal Pradesh and Meghalaya where 65% and 49% VHSNCs have undergone training in this module.

Compared to the High Focus and North East states, progress of training in VHSNC handbook has been slow in Non-High focus states and UTs. Only 10% VHSNCs from these group of states have undergone training in this module. States that show good progress in training of members in Handbook for VHSNCs are Punjab that has trained 100% and Himachal Pradesh that completed training for 76% VHSNC in the handbook

Reconstitution of VHSNCs as per the 2013 guidelines have been undertaken in a total of 3,90,256 (73%) VHSNCs across the country out of a total of 5,36,621 VHSNCs. Among the High Focus states, Bihar and Uttar Pradesh have not reconstituted the VHSNCs. All North East States have reconstituted VHSNCs, while among the Non-High Focus States, Andhra Pradesh, Gujarat and West Bengal have not reconstituted the VHSNCs as per the 2013 guidelines.

Table 1: Status of Village Health Sanitation and Nutrition Committees

State	Level of formation (GP/ Village or Revenue village)	Number of members per VHSNC (State norm)	No. of VHSNCs -Target	No. of VHSNCs - constituted	Percentage of VHSNC constituted against the target	No. of VHSNCs with bank account	Percentage of VHSNC with Bank Account	No. of VHSNCs re-constituted as per GOI guidelines 2013	Percentage of VHSNC reconstituted as per the 2013 GOI guidelines	No. of VHSNCs with ASHA as member secretary	Member Secretary other than ASHA	No. of VHSNCs with ASHA as joint signatory of bank account	Percentage of VHSNCs where ASHA is joint signatory	Total number of VHSNCs trained in VHSNC handbook
Bihar	Gram Panchayat	5	8406	8384	100	8384	100	83	1	0	ANM	0	0	777
Chhattisgarh	Revenue village	20	20126	19180	95	19180	100	19180	100	19180		19180	100	19180
Jharkhand	Revenue village	11	30012	30012	100	29635	99	29635	99	29635	NA	24009	81	27666
Madhya Pradesh	Revenue village	12 to 20	53532	47959	90	47959	100	47959	100	47959	NA	47959	100	38100
Odisha	Revenue village	Mini-mum 10 members including 3 office bearers	46118	46018	100	46018	100	46018	100	0	AWW	46018	100	46018
Rajasthan	Revenue Vil-lage	15	43440	43440	100	40698	94	43440	100	40698	Additional Charge to adjoining ASHA	40698	100	43440
Uttar Pradesh	Revenue village>500 population	18	79032	60523	77	60523	100	0	0	60523	NA	60523	100	8262
Uttarakhand	Revenue Vil-lage	15	15296	15296	100	15296	100	15296	100	15296	0	15296	100	3230
Total			**295962**	**270812**	**92**	**267693**	**99**	**201611**	**74**	**213291**		**207665**	**78**	**186673**
Arunachal Pradesh	Revenue Level	2	3772	3318	88	3318	100	3772	100	3318	AWW	3318	100	2152

State	Level of formation (GP/ Village or Revenue village)	Number of members per VHSNC (State norm)	No. of VHSNCs -Target	No. of VHSNCs - constituted	Percentage of VHSNC constituted against the target	No. of VHSNCs with bank account	Percentage of VHSNC with Bank Account	No. of VHSNCs re-constituted as per GOI guidelines 2013	Percentage of VHSNC reconstituted as per the 2013 GOI guidelines	No. of VHSNCs with ASHA as member secretary	Member Secretary other than ASHA	No. of VHSNCs with ASHA as joint signatory of bank account	Percentage of VHSNCs where ASHA is joint signatory	Total number of VHSNCs trained in VHSNC handbook
Assam	Village Level	15	27673	27673	100	27673	100	27673	100	27673	Nil	27673	100	27673
Manipur	Gram Panchayat	8 to 15 members	3878	3878	100	3878	100	3878	100	3878		3878	100	3878
Meghalaya	Village Level	12	6685	6276	94	6105	97	6105	91	6105	ASHAs are member secretary	6105	100	3073
Mizoram	Village level	Not less than 15 per VH-SNC	830	830	100	830	100	830	100	830	All ASHAs are Member Secretary	830	100	830
Nagaland	Revenue Vil-lage	15	1346	1346	100	1346	100	1346	100	970	ANM/ Pharma-cist	970	72	1346
Sikkim	Gram Panchayat	10	641	641	100	641	100	641	100	641	Not ap-plicable	641	100	641
Tripura	Gram Panchayat	9	1178	1178	100	1178	100	1178	100	0	ANM	0	0	2230
Total			**46003**	**45140**	**98**	**44969**	**100**	**45423**	**99**	**43415**	**0**	**43415**	**97**	**41823**
Andhra Pradesh	Gram Panchayat	10 to 15	12918	12874	100	12874	100	0	0	12874				
Delhi	Not Applicable	0	0	0	0	0	0	0	0	0	0	0	0	0
Gujarat	Revenue Vil-lage	5	17640	17636	100	17633	100	0	0		ANM	17403	99	3282

State	Level of formation (GP/ Village or Revenue village)	Number of members per VHSNC (State norm)	No. of VHSNCs -Target	No. of VHSNCs - constituted	Percentage of VHSNC constituted against the target	No. of VHSNCs with bank account	Percentage of VHSNC with Bank Account	No. of VHSNCs re-constituted as per GOI guidelines 2013	Percentage of VHSNC reconstituted as per the 2013 GOI guidelines	No. of VHSNCs with ASHA as member secretary	Member Secretary other than ASHA	No. of VHSNCs with ASHA as joint signatory of bank account	Percentage of VHSNCs where ASHA is joint signatory	Total number of VHSNCs trained in VHSNC handbook
Haryana	Revenue village	12 to 15	6049	6049	100	6049	100	6049	100	0	AWW	0	0	0
Himachal Pradesh	Revenue village	15	7930	7797	98	7797	100	7820	99	0	ANM	0	0	5934
Jammu & Kashmir	Gram Panchayat	8 to 15	6849	6774	99	6741	100	6774	99	6741		6741	100	
Karnataka	Revenue village	15	26007	26007	100	26007	100	26007	100	26007	0	26007	100	0
Kerala	Ward Level	15-20	19523	19523	100	19523	100	19523	100	0	ANM		0	
Maharashtra	Revenue village	7 to 14 members per VH-SNC	39873	39873	100	39873	100	39873	100	36445	AWW	36445	91	
Punjab	Revenue Village	15 members	12956	12956	100	12956	100	12956	100	12956		12956	100	12956
Tamil Nadu	Revenue village		15015	15015	100	15015	100	15015	100	15015	15015	0	0	0
Telangana	Revenue village	15	10761	8830	82	8830	100	8830	82	8830	ANM	0	0	0
West Bengal	Revenue Village (Gram Sabha)		49054	46862	96	42409	90	0	0		ANM is secretary and ASHA is member convener	0	0	
Total			**224575**	**220196**	**98**	**215707**	**98**	**142847**	**65**	**118868**		**99552**	**46**	**22172**
Andaman and Nicobar	Revenue Village	6	275	275	100	275	100	0	0	275	0	0	0	275

State	Level of formation (GP/ Village or Revenue village)	Number of members per VHSNC (State norm)	No. of VHSNCs -Target	No. of VHSNCs - constituted	Percentage of VHSNC constituted against the target	No. of VHSNCs with bank account	Percentage of VHSNC with Bank Account	No. of VHSNCs re-constituted as per GOI guidelines 2013	Percentage of VHSNC reconstituted as per the 2013 GOI guidelines	No. of VHSNCs with ASHA as member secretary	Member Secretary other than ASHA	No. of VHSNCs with ASHA as joint signatory of bank account	Percentage of VHSNCs where ASHA is joint signatory	Total number of VHSNCs trained in VHSNC handbook
Chandigarh	Revenue Village		22	22	100	22	100	0	0	0	0	0	0	0
Dadar and Nagar haveli	Revenue Village		70	70	100	61	87	0	0	0	ANM	0	0	0
Daman and Diu	Revenue Village		28	28	100		0	0	0				0	0
Goa	Revenue Village		285	260	91	236	83	260	100	0	ANM/ MPW	0	0	200
Lakshadweep	0	0	0		0		0	0	0				0	0
Puducherry	Village	7	100	100	100	99	99	100	100	NA	ANM	0	0	0
Total			**780**	**755**	**97**	**396**	**52**	**360**	**48**	**0**	**0**	**0**	**0**	**475**
All India Total			**567320**	**536903**	**95**	**528765**	**98**	**388687**	**72**	**375574**	**0**	**350632**	**66**	**250868**

Formation of Mahila Arogya Samitis (MAS)

All states except Haryana have MAS in place. Presently 28 out of 34 states/UTs have formed MAS. Total 77,003 (86%) MAS have been formed against the target of 89,446. The number of MAS which have bank account is 64,404 (83.6% against the target). Most of states/UT have on an average of 10-12 MAS members except Puducherry which has 30-40 members and Chhattisgarh reported that is no such norm exists in the state.

High focus states like Jharkhand, Odisha, Rajasthan and Uttarakhand has achieved 100% of their MAS formation and 86% of their MAS have bank accounts. This is followed by Chhattisgarh at 95% and remaining High Focus states constitution of MAS ranges between 74-90%. While 87% of total target of MAS for High Focus States, their share in the total MAS formation is 30%. So far, only 25% of MAS in these states bank accounts.

Nearly all North east states have constituted above 80% MAS against the target except Nagaland that has about 77% MAS functional. These states together have achieved 97% of their target of MAS formation, and 95% of MAS have a bank accounts. In UTs only Puducherry and Andaman & Nicobar has MAS in place, remaining all have (Lakshadweep, Dadar & Nagar Haveli and Daman & Diu) not proposed any target for MAS.

The Non-High Focus states together have achieved 86% of their target for formation of MAS, and 82% of MAS against the target also have a bank account. Telangana has formed 60% of its target MAS, lowest in Non-High Focus states (6588 formed against the target of 11,000 with 100% MAS with bank account). Tamil Nadu does not have Mahila Arogya Samitis and relies on wide network of Self-Help Groups (SHGs) in urban areas to perform functions similar to MAS. In addition to health promotion & prevention and community awareness, these SHGs are also used for screening of NCDs in certain pockets of greater Chennai Municipal Corporation.

Support for MAS

Only few states reported on active engagement of NGOs for the urban programme Rajasthan, Uttarakhand, Maharashtra, Punjab and Karnataka have leveraged NGO partnerships for outsourcing UPHCs. These states did not report challenges on integration with community based and health promotion activities as these tasks are also listed in service contracts. Maharashtra is supported by NGO SNEHA but only in Mumbai Municipal Corporation area and Chhattisgarh is supported by SHSRC.

Training for MAS

As an effort for systematic capacity building of MAS, MoHFW had shared the handbook for training of MAS modules. Capacity building of MAS in this handbook has been reported from all states except Andhra Pradesh, Haryana and all UTs. Total 49,681 (65%) MAS have been trained in handbook against the target of 76,479. Total 2,90,363 MAS members have been trained in handbook for MAS. In high focus (79%), Non-High Focus (33%) and North East states (95%) MAS have been trained in handbook. The duration of training ranges between 1 to 3 days in all states.

Chhattisgarh has undertaken several new interventions being piloted for MAS engagement. The Mitanin led model of MAS is active in health promotion and prevention activities and for action on social determinants of health. On a pilot basis, MAS are being engaged in use of electronic monitors to measure Air Quality, undertaking water testing by kits and sensitize local municipal representatives with the available data to undertake suitable action.

In Odisha, MAS are active in spreading awareness on availability of outreach services and specialist consultations. SMS alerts on these services are sent to MAS/ASHA members who further inform the community regarding schedule of outreach camps and specialists' consultations.

Puducherry has successfully conducted training of MAS in Reproductive, Maternal, Newborn, Child and Adolescent Health to improve the quality and coverage of RMNCH+A services.

Rajasthan has effectively leveraged Public Health Managers at UPHC to improve functionality of MAS. PHMs are, doing monthly capacity building, have prepared a calendar of MAS meetings, have organized exposure visit of MAS to healthcare facilities-SNCU, MCT Centres, 108 ambulance to improve uptake of these services. MAS in Rajasthan are active in promoting sanitation drives and are serving as a critical resource to inform community regarding the various healthcare entitlements, government schemes and programmes and mechanisms to avail these benefits.

The aforementioned new emerging initiatives with MAS offer promising potential to be replicated even in other states.

Table 2: Status of Mahila Arogya Samitis

State	Mahila Arogya Samiti (MAS)							Training for MAS		
	No. of cities where MAS is proposed	Target no. of MAS proposed	No. of MAS formed	Percentage of MAS formed	Number of members per MAS (State norm)	No. of MAS with bank account	Name of NGOs supporting state in implementation, if any	Target (No. of MAS to be trained)	Total number of MAS trained in handbook	Total no. of MAS members trained in handbook
High Focus States										
Bihar	22	843	721	86		245			357	3500
Chhattisgarh	19	3883	3706	95	No such norm	3706		3706	3224	27041
Jharkhand	22	918	918	100	11	876		918	786	1501
Madhya Pradesh	66	5100	3812	75	11 TO 19	3565		5100	3540	28320
Odisha	36	3132	3132	100	11 to 15	3074		3132	3132	3132
Rajasthan	61	4708	4708	100	10 to 15	4708	1. Bhoruka charitable trust-BCT 2. CFAR	4708	4708	52142
Uttar Pradesh	131	7036	5233	74	10-20	3373		7036	3977	3977
Uttarakhand	10	654	654	100	10	213	1. SPD 2. Samarpan 3. DGUS 4. Friends 5. Bombay Hospital	654	342	3420
Total	**367**	**26274**	**22884**	**87**		**19760**		**25254**	**20066**	**123033**
North East States										
Arunachal Pradesh	2	92	90	98	5 to 9	65		42	30	90
Assam	14	658	658	100	10	638		658	658	

State	Mahila Arogya Samiti (MAS)							Training for MAS		
	No. of cities where MAS is proposed	Target no. of MAS proposed	No. of MAS formed	Percentage of MAS formed	Number of members per MAS (State norm)	No. of MAS with bank account	Name of NGOs supporting state in implementation, if any	Target (No. of MAS to be trained)	Total number of MAS trained in handbook	Total no. of MAS members trained in handbook
Manipur	3	409	409	100	8	409		409	409	818
Meghalaya	4	104	104	100	12	89		104	104	104
Mizoram	2	50	50	100	15	50		50	50	750
Nagaland	4	98	75	77	15	75		70	70	265
Sikkim	1	35	35	100	15	15		35	0	0
Tripura	3	96	80	83	10	80		96	80	380
Total	**33**	**1542**	**1501**	**97**		**1421**	**0**	**1464**	**1401**	**2407**
Non High Focus States										
Andhra Pradesh	110	10900	10440	96	8	10440		0	0	0
Delhi	11	100	98	98	10 to 12	98		98	98	1176
Gujarat	60	7913	7847	99		7670		7913	3441	34410
Haryana	1	50	0	0	0	0		0	0	0
Himachal Pradesh	3	40	10	25	8	10		14	14	14
Jammu & Kashmir	6	220	220	100	8 to 12	172		220	211	1600
Karnataka	79	4071	3760	92	10 to 12 mem-bers	3513	CFAR	4071	2708	9364
Kerala	44	1048	1596*	152	8-12 on aver-age	114		1596	0	3000
Maharashtra	95	6904	5557	80	10	5557		5557	781	3906
Punjab	40	7475	7475	100	10-12 mem-bers	1963	Training conducted through the NGO- SEWA and RRC Mamta	7475	7193	20327
Tamil Nadu	0	0	0	0	0	0		0	0	0
Telangana	42	11000	6588	60	12-15	6588		11000	6588	6588
West Bengal	90	11791	9002	76	8 to 12	7098		11709	7180	84538
Total	**581**	**61512**	**52593**	**86**		**43223**		**49653**	**28214**	**164923**
Union Territories										
Andaman & Nicobar	1	10	0	0	0	0		0	0	0

State	Mahila Arogya Samiti (MAS)							Training for MAS		
	No. of cities where MAS is proposed	Target no. of MAS proposed	No. of MAS formed	Percentage of MAS formed	Number of members per MAS (State norm)	No. of MAS with bank account	Name of NGOs supporting state in implementation, if any	Target (No. of MAS to be trained)	Total number of MAS trained in handbook	Total no. of MAS members trained in handbook
Dadar & Nagar Haveli	0	0	0	0	0	0		0	0	0
Daman & Diu	0	0	0	0	0	0		0	0	0
Lakshadweep	0	0	0	0	0	0		0	0	0
Puducherry	1	108	25	23	30-40	0		108	0	0
Total	**2**	**118**	**25**	**21**	**0**	**0**		**108**	**0**	**0**
Grand total	**983**	**89446**	**77003**	**86**	**0**	**64404**		**76479**	**496812**	**290363**

*Kerala has selected more MAS than their proposed target.

4
SECTION

Rolling out VISHWAS Campaigns through Gaon Kalyan Samiti : *Odisha Experience*

The Village Health Sanitation and Nutrition Committee (VHSNC) are popularly known as Gaon Kalyan Samiti (GKS) in Odisha. More than 46,000 GKS are functional in the state at the revenue village level. GKS in Odisha are vibrant and have developed over time to enable community ownership for improving health status of the community, undertake community level monitoring for services related to nutrition, sanitation, education and safe drinking water etc and organize health promotion and prevention activities at the village level.

In 2017-18 the Government of India launched the 'VISHWAS' (Village based Initiative to Synergise Health, Water and Sanitation) initiative to be implemented under the leadership of VHSNCs. The initiative aimed to build a collective initiative at community level, for improving Water, Sanitation and Hygiene situation and its impact on Health and quality of life. VISHWAS is expected to strengthen convergent action in integration with various initiatives under Swachh Bharat Mission (SBM), and will also build the institutional capacity of VHSNCs to fulfil their roles as visualized in the original design. The key strategy of this campaign will be to:

- Organize eleven monthly campaign days in every VHSNC village, which will be led by its VHSNC, and thereby build a systematic community action on key components related to Water, Sanitation and Hygiene. Objective of Swachhta Campaign.
- Create awareness on Water Sanitation & Hygiene and their impact on Health, and create a platform for local action on these issues.
- Empower communities to participate in planning and implementation of the program.
- Build the institutional capacity of VHSNCs to fulfil their roles as visualized in its original design, by undertaking the monthly campaigns.

Roll out of VISHWAS in Odisha

- Empower Panchayat to play their role effectively of the Governance of health and other public services and to enable communities to take collective action for the attainment of a higher health status and improved quality of life in the village.

Phase-1

Odisha started roll out of VISHWAS with training of district and block trainers during 2017-18. These trainers further completed a one- day field training for all Gram Panchayat Sarpanch, GKS President (Ward member) & Convener (AWW) at the block & sub block level to commence the VISHWAS activities at the village level. All ASHA were also trained as part of ASHA refresher training programme on GKS & VISHWAS activity implementation. VISHWAS module has been

translated in local language Odia and provided to each GKS office bearers and GP Sarpanch to develop clarity on the objective and process of implementation at the community level.

To increase community level awareness on this new initiative state launched special district level ceremony of VISHWAS under the chairpersonship of President- Zilla Parishad, Collector and District Magistrate in various parts of Odisha. All the line departments actively participated at the district level inaugural launching ceremony of VISHWAS. A special quarterly GP level meeting is also being organized under the Chairpersonship of GP Sarpanch to review implementation of GKS & VISHWAS activity. The Gram Panchayat participated actively in rolling out this initiative and mobilized GP fund to prepare GP Swasthya Kantha and other need-based IEC activities.

Phase-2

During 2018-19, state completed training for members from 50% GKS from 13 High Priority Districts. The block trainers trained GKS office bearers and other three active members at the field level as part of this training. In one year, trainings were completed for 5450 GKS and total 32700 members have been trained.

Phase-3

Two days Capacity Building Training Programme of GKS for the remaining 50% GKS of 13 HPDs will be covered in 2019-20.

IEC activities

Moving forward, most GKS conducted wall painting on the theme of the 11 monthly VISHWAS campaign days to organize campaigns in a systematic manner and also create awareness among the local community.

Other Key activities in the roll out of VISHWAS

Preparatory meeting

A detailed guideline of the VISHWAS training roll out strategy & detail 11 monthly campaign

ଆୟୋଜକ : ଗାଁ ସ୍ୱାସ୍ଥ୍ୟ ସମିତି, ଖାରିପ୍ରମ, ଉଚ୍ଚତପଲ୍ଲୀ, ଚାରାଯଶପୁର ଓ ବଡ଼ିଗାପଲ୍ଲୀ
ଗ୍ରାମ ପଞ୍ଚାୟତ : ବରଡ଼ାଗାଇଁ, ବ୍ଲକ : ଧରାକୋଟ (ଗଞ୍ଜାମ)

days have been provided to all the districts. Roll out trainings proceeded in the supervision of District Collectors in a convergence manner with active participation of Health, ICDS, RD & PR department. This also allowed active involvement of all line departments in preparation of the eleven-monthly plans. All eleven monthly plans of VISHWAS activities have been integrated with the workplan of GKS.

Field- Implementation

Once the training of GKS members was complete, every GKS implemented VISHWAS through the following activities:

1. Integration of 11 monthly campaigns in the Village Health Plan. Most of the GKS are being organized 11 monthly campaign days to achieve the following objectives on day wise campaign.
2. Annual planning day for Swachhta campaign involves all the stake holders & villagers to for preparing draft Swachhta Abhiyan Plan- with complete list of monthly campaign days.
3. Holding Village Health- Sanitation Days- Focusses on building use of sanitary toilet by every family & complete elimination of open defecation. General cleanliness of the Village area, Individual and home hygiene- personal hygiene and ensure use of safe & clean- drinking water- safe storage.
4. Plan for Open Defecation free Village- Most of the GKS prepared separate plan of action on the local specific issues to free from open defecation. Most of the GKS also integrated this activity with Swachh Bharat Mission.

5. Community level demonstrations for proper hand washing at the community level.
6. Initiatives to maintain proper sanitation & hygiene at the school & AWC with active involvement of the local community & school teachers.
7. Conducting individual, home- based mass meeting & demonstration for adopting safe sanitation and hygiene
8. Liquid and solid waste management through promotion of regular waste segregation and recycling.
9. Awareness activities for local community to maintain healthy life style through awareness and prevent use of tobacco and alcohol.
10. Developing an action plan for vector free village, observe a vector control day to create awareness among the community and promote use of mosquito net.
11. Organizing Campaign celebration days Gram Sabha days to identify success and major issues of the campaign.
12. Review of the progress, achievement of the VISHWAS activity implementation by GP President.
13. Awards as recognition to members who demonstrated excellent performance in rolling out campaign activities as means for motivation for other members.

What Contributed to the success of VISHWAS Campaign?

1. **District Administration:** An active involvement and leadership of the District administration that prepared plan of action for effective implantation of VISHWAS activity in convergence with Swachha Bharat Mission, ICDS, RD & PR system. The Collector & District Magistrate of Bargarh, Cuttack & Ganjam took major initiatives towards making special fund provision from Gram Panchayat development plan. This ensured better involvement of Gram Panchayat and effective implementation of VISHWAS activities at the village level.

2. **Initiatives from PRI:** Most GP Sarpanchs are actively involved in the whole process of VISHWAS activity implementation. They organized special Gram Sabha for discussion on the major success and gaps in the implementation process. GP Sarpanch mobilized funds from GP to GKS for effective implementation of VISHWAS activity.

3. **Inter Department Co-ordination - ICDS & RWSS:** All the JE of Rural Water, Sanitation and Scheme and GKS convenors (AWWs) are trained as part of training programme of GKS & VISHWAS. JE of RWSS is involved in the plan preparation process of Toilet construction at the community level. AWW & ICDS supervisors also actively involved in the whole process of 11 monthly VISHAWS activity to maintain proper sanitation of AWC and individual health hygiene.

4. **Effective Supportive Supervision & Monitoring of VISHWAS:** GKS & VISHWAS activities are being reviewed in various forum i.e. Village, GP. Sector, Block level. All MPHS (M/F) & ICDS supervisors are being trained at the district level on GKS & VISHWAS activity implementation for preparing a monitoring plan to strengthen supportive supervision & monitoring process of 11 monthly VISHWAS activity at the community level.

Programme output

Effective implementation of VISHWAS campaign in the State of Odisha led to positive outcomes. It created awareness among the people regarding improved health and hygienic practices. GKS played a vital role in identifying the health and sanitation issue at the village level. Action plans were developed to address the same through utilizing the GKS untied fund and mobilisation of additional resources from other sources such as GP funds to address the issues. There has been also been improvement in key behavioural practices like hand washing, waste management, sanitation, personal hygiene, tobacco use etc. A significant outcome of this campaign has been completion of construction of all household toilets in 9 Districts of the State, while other efforts at the community level are ongoing with an objective to promote healthy life for the people.

5
SECTION

Summary of Findings and Recommendation on Community Processes from the Twelfth Common Review Mission

Key Findings

The launch of Ayushman Bharat early this year has prioritized delivery of Comprehensive Primary Health Care as its key component to lead India's journey to Universal Health Coverage. It is well established that strong community level linkages and ownership is vital to the success of any Primary Care initiative. The CPHC efforts through Health and Wellness Centres will leverage last 14 years of investments made for Community Processes under the National Health Mission and further strengthen outreach, continuity of care and health promotion strategies for new service packages.

The CRM reports from all eighteen states acknowledge the pivotal role played by ASHAs in linking the comunity with the public health system. Reports from all states have established ASHA's success in building a strong community rapport. These, lay a strong foundation to evolve a robust community- based health system for the country that will be responsive to address healthcare priorities specified under the paradigm of CPHC.

However, CRM findings point towards efforts for streamlining and increasing performance of the support systems to ensure an equitable coverage, functionality and programme management needed for ASHAs, Village Health Sanitation and Nutrition Committees, Mahila Arogya Samities across all states. States have commenced training of ASHAs in new seventh package of services on NCDs but backlogs of trainings related to first five packages (RMNCH+A) will need to finish on priority in certain states. Considering reductions in duration of training for NCDs in certain states, mechanisms to monitor training quality through field- based reviews and refreshers will need to be implemented. Action is also required to streamline persistent challenges of irregular refilling of ASHA kits and resolve delays in payment of ASHA incentives for vertical programmes.

Avenues to improve performance of VHSNC as institutions for collective action on health at the community level will need to expand through capacity building of PRIs and increasing coordination and capacities of Gram Panchayats/ to support and monitor VHSNCs, support and supervise- delivery of community level health programmes such as- Village Health and Nutrition Day (VHND), and functioning of HWCs-Sub Health Centres (SHCs).

ASHA

Selection

All states covered under the Twelfth CRM (except Bihar, Uttar Pradesh and Tamil Nadu) report having more than 95% ASHAs in position in rural areas against the selection targets. Even Bihar and UP have selected about 93% ASHAs under NRHM and only Tamil Nadu has 57% rural ASHAs in position. State's decision to limit implementation of ASHA programme only in tribal areas explains the low selection for ASHAs in Tamil Nadu. Well defined mechanisms

to ensure community ownership in selection of rural ASHAs have been reported from Madhya Pradesh, Jharkhand, Chhattisgarh, Jammu and Kashmir, Tripura and Punjab. Reports from few states such as Bihar, Jammu and Kashmir and Rajasthan highlight a population coverage way above specified norms for ASHAs in rural areas and build a need to revise selection targets. For example- in Muzaffarpur and Kupwara district of Bihar and Jammu and Kashmir respectively, selection target for ASHA has been fixed taking into account population as per Census 2011 but ASHAs are covering 1500-2000 population and build a need to select additional new ASHAs. A significant number of - 654 villages in Kupwara have ASHAs serving a population of 1700-2000. Likewise, a high population coverage is reported in Rajasthan and is on account of stop gap measures to allocate villages with no ASHAs to other ASHAs from neighbouring villages. ASHA positions in districts of Rajasthan have been sanctioned based on the number of AWCs. Thus, rural areas with a mini AWC or no AWC do not have ASHAs and such areas are allocated to ASHAs from neighbouring villages. The high population coverage may adversely affect reach to the marginalized population and delivery of community- based services.

With regards to selection of ASHAs in urban areas, reports from Rajasthan, Madhya Pradesh, Andhra Pradesh, Arunachal Pradesh, Chhattisgarh highlight selection of more than 90% ASHAs. Shortfalls in selection of urban ASHAs have been specifically reported as challenge in Jammu and Kashmir and Bihar where districts have 45% and 61% urban ASHAs in position respectively. Findings from Jharkhand report on lack of clarity amongst City Programme Managers under NUHM regarding selection of urban ASHAs and ASHAs in Bokaro city are seen to be covering a population of 10,000-11,000.

On an average, the ASHA drop-out rates have been around 2-5% across the states. Some states like Assam, Tripura and Andhra Pradesh have done remarkably well in retaining ASHAs (no ASHA drop outs in past 6 months.) However, Arunachal Pradesh has reported a very high drop-out rate of around 20%. Low incentives, family pressure, migration, enrolment in ANM training courses and non-performance emerged as major issues affecting ASHA retention. A lack of clarity amongst ASHA programme staff on norms and process of identifying a non-functional ASHA is reported only from Uttarakhand.

Trainings

ASHA Training structures in terms of State and District trainers are fairly robust in all states but few states such as Bihar, Madhya Pradesh, Uttarakhand have highlighted issues with trainers' attrition. Training of ASHAs in rural areas has progressed and different states are in varying stages of completion of ASHA training in four rounds of Module 6 and 7. Majority states have trained above 90% rural ASHAs up to Round 2 of Module 6 and 7. Six states- Arunachal Pradesh, Andhra Pradesh, Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh have a significant proportion(more than 30-40%) of ASHAs remaining to be trained in Rounds 3 and 4 of Module 6 and 7 in comparison to other states.

ASHA trainings are to be planned in residential mode and require robust logistic support. A good and replicable practice related to ASHA training sites emerged from Korba in Chhattisgarh. The district mobilised funds worth Rs. 1.5 Crores from Member of Parliament grants to construct a Mitanin Training Centres. Five training centres– one in each block headquarter of the district have also been constructed.

On the other hand, Andhra Pradesh, Arunachal Pradesh, Bihar and Jammu and Kashmir highlight lack of adequate residential training facilities within health department and delays scheduling of ASHA trainings. Dedicated NGO training agencies were engaged to address such requirements in few states such as Madhya Pradesh, Bihar and Uttarakhand. While Madhya Pradesh continues with its NGO model for logistics support; trainings could not move

forward in FY 2017-18 on account of a long- drawn process of reappraisal of NGOs, issuing fresh contracts, refresher training and evaluation of ASHA trainers to improve training quality. Both Bihar and Uttarakhand discontinued use of NGO training agencies. This decision brought ASHA trainings in Bihar to a complete halt for the last three years. However, with dedicated efforts of the ASHA programme staff, trainings have been reinitiated from July 2018. Withdrawal of NGO support in Uttarakhand has adversely impacted- programme management, appropriate skilling of ASHAs as per norms and handholding of ASHA support staff. (New ASHAs are attending only 2-3 days of refresher trainings as against structured trainings of 5 days in respective rounds of Module 6 and 7).

Findings from Jharkhand highlight a need to expedite trainings for urban ASHAs. While Induction training for urban Sahiyas has been completed in Bokaro city, no action has been undertaken so far to commence training of ASHAs from Ranchi city.

Expansion of service packages under CPHC call for training of ASHAs in new service area of common Non-Communicable Diseases. While majority states have commenced work in this regard, only two states - MP and Jharkhand have undertaken this training as per the specified protocols. Himachal Pradesh, Rajasthan, Andhra Pradesh and Tripura conducted just one day training in NCDs and Rajasthan completed this training in two days as against the specified duration of five days. In Bihar, ASHAs were asked to complete the tasks of population enumeration and filling up CBAC forms without undergoing any formal training in NCDs.

Overall, one of these reasons- training delays, non-residential mode of training, inadequate duration and lack of structured monitoring mechanisms seem to be affecting quality of ASHA trainings. Therefore, barring a few states- Chhattisgarh, Punjab, Karnataka and Gujarat; all other states indicate knowledge and skill attrition and highlight a need of refresher training for ASHAs.

The process of ASHA certification in association with National Institute of Open School has been initiated in eleven of the eighteen CRM states. These include-Chhattisgarh, Jharkhand, Madhya Pradesh, Uttarakhand, Assam, Arunachal Pradesh, Tripura, Punjab, Karnataka and Maharashtra. So far, 102 State trainers, 272 District Trainers, 29 State Training Sites across these eleven states and 44 District Training sites from six/eleven states have been accredited by NIOS. 2015 ASHAs from- Arunachal Pradesh (20), Assam (471), Jharkhand (550), Karnataka (301), Madhya Pradesh (114), Maharashtra (279), Tripura (280) have also successfully passed the ASHA Certification Exam conducted by NIOS in January 2018.

Support structures

ASHA support structures are envisaged at four levels- state, district, block and cluster level. Bihar, Jharkhand, Chhattisgarh, Madhya Pradesh, Uttar Pradesh and Uttarakhand, Assam, Arunachal Pradesh, Tripura, Karnataka and Maharashtra have dedicated ASHA programme staff at all four levels. Major vacancies in the support structure for ASHA are observed in Bihar. Some states are using existing programme management cadres for ASHA related support functions. Rajasthan deploys a cadre of PHC supervisors, Himachal Pradesh and Jammu Kashmir have given additional responsibilities to ANMs and Andhra Pradesh has assigned the functions of an ASHA facilitator to Multi-purpose health supervisor (female) and has designated their PHC Public Health Nurses as BCMs. Gujarat has ASHA facilitators but programme is managed by existing DPMU and BPMU staff at the district and block levels respectively. Chhattisgarh is the only state that has also positioned additional Block level coordinator for Swasth Panchayat Yojna and VHSNC. Good functionality of ASHA facilitators in improving coverage of service users, organizing cluster meetings, mentoring for skill upgradation has been specifically reported only from MP, Jharkhand, Chhattisgarh and Uttar Pradesh. Bihar and Uttarakhand report limited functionality of ASHA facilitators due to- limited

clarity on functions of supportive supervision and their dual function as an ASHA. A similar lack of clarity in mentoring ASHAs is also observed amongst PHC Supervisors from Rajasthan and are largely limited to monitoring of formats on MCHN days. Mechanism of regular programme reviews at cluster, block, district levels have been explicitly reported only in- Andhra Pradesh, Jharkhand, Madhya Pradesh and Chhattisgarh. Jharkhand and Chhattisgarh have structured annual training on supportive supervision of ASHA programme staff and relates well with role clarity on their functions at field level. Early efforts to plan career progression opportunities for ASHA programme staff are reflected in MP where post graduate ASHA Sahyoginis are being skilled to serve as District Trainers and plans are also underway to train some of them as BCMs. While all states have made significant efforts in building the support structures for ASHAs at all levels; CRM findings emphasise that potential of the huge workforce developed at district, block and cluster level is yet to be completely realized in improving performance and functionality of ASHAs across all states. Supervision, on the job mentoring by ASHA support system has been reported to be weak in majority states for critical programmes such as Home Based New born Care, Family planning etc and has adversely impacted community level efforts by ASHAs for health prevention and promotion.

Drugs and Equipment Kit

Like previous CRM findings availability of Drug and Equipment kit with ASHAs appear as a persistent challenge in certain states. Only Andhra Pradesh, Rajasthan, Madhya Pradesh, Jharkhand have regular replenishment of ASHA drug kits from PHCs (HSCs in Jharkhand). Other states such as Himachal Pradesh, J&K, Uttarakhand, UP, and Punjab reported erratic refilling of the drug kits. None of the ASHAs in East Siang district of Arunachal Pradesh were provided drug kits. While, availability of kits is not a challenge in Rajasthan, state has not included Amoxicillin syrup in ASHA kit to provide a pre-referral dose for neonatal sepsis. HBNC kits have been made available to ASHAs in all states and items such as weighing scale, thermometer and watch are available with all ASHAs. Jharkhand had even added an umbrella, water bottle and bags in the kit. However, equipment was not-functional in Rajasthan, Himachal Pradesh and Chhattisgarh.

Incentives

Monetary

The average incentives received by ASHAs is around Rs. 3000 to 4000 and includes the incentive for routine and recurrent activities for ASHA. The average monthly incentives earned by ASHAs ranges from Rs. 1500 in Tripura to Rs. 7500/month in Telangana. In addition to the incentive for routine recurrent activity; certain states are also providing fixed honorarium to ASHA from state funds. These include Chhattisgarh (75% top-up incentive from April 2018 onwards), Rajasthan (Rs. 2500/month from ICDS), Himachal Pradesh (Rs. 1200/month), Arunachal Pradesh (Rs. 1000/- from State Budget, Tripura (100% Top up incentive), Uttarakhand (Rs. 5000/- annually), Karnataka (Rs 3500/month). Gujarat and Telangana are also offering fixed monthly honorarium to ASHAs. Assam, has introduced a voucher system for verifying HBNC visits by ASHAs where a voucher booklet is given to the mother at the time of her delivery and when the ASHA visits the mother for her HBNC visit, she is given one voucher by the mother duly signed as a testimony of her visit. Aided by online bank transfers, PFMS, IT based Incentive Tracking systems such as ASHA Soft; mechanisms for payment of ASHA incentives have streamlined in many states. No or minimal delay in payment of incentives is observed in Assam, Chhattisgarh, Madhya Pradesh, Rajasthan, Himachal Pradesh, Uttar Pradesh, Punjab, Bihar, and Maharashtra. Delay in payment of incentives were majorly observed in the states of Arunachal Pradesh (3-6 months), J&K (3-4 months), UK (6 months), Tripura (5-6 months) & Jharkhand (6 months) and are usually related to incentives provided under vertical programmes. Rigid norms for ASHA

payments are observed in MP, where escort function has been made mandatory to receive JSY incentive for ASHAs.

Assam, Madhya Pradesh and Rajasthan are using ASHA payment software which was has helped them create a database of all ASHA's up to the block/village level and has facilitated auto-computation of incentives based on entry of online reports and vouchers.

Non-Monetory incentives

In the past few years several states have introduced non-monetary incentives to ensure motivation of ASHAs and include several social welfare measures, building career opportunities, supporting educational equivalence, higher education etc. The social welfare schemes for the ASHAs are most well developed in the states of Chhattisgarh, Jharkhand and Jammu and Kashmir. Chhattisgarh alone offers a range of 16 different benefits under the 'Mukhyamantri Mitanin Kalyan Kosh'. These include: Life insurance cover of Rs.50,000 to Mitanin in event of death of Mitanin's husband. For Mitanins who do not have a spouse, the Mitanin herself is insured, coverage for all Mitanins irrespective of BPL/APL status under the Rashtriya Swasthya Bima Yojana (RSBY), Educational Incentive of Rs. 2000 for clearing Class 8th, Rs. 5000 for Class 10th, Rs. 10,000 for Class 12th, and Rs. 10,000 for Graduation or Post Graduation, Scholarship of Rs. 1200 per annum for ASHA's children who are studying in 9th till 12th class, Emergency Assistance- Financial assistance to Mitanins in cases of emergency situations, Free Treatment at all Government Health facilities, Maternity Benefit extending even for Mitanin trainers, Block Coordinators and Swastha Panchayat Coordinators, Six months leave starting from 9th month of pregnancy, Financial incentive of Rs. 15,000 for up to 2 children with a gap of 3 years between two children and Financial incentive of Rs. 10,000 in case the conditionality of 2 children and gap of three years in not fulfilled. Others include Higher Education support for Mitanin's children- Financial assistance for Mitanins whose children secure over 75% marks in Class 10th or 12th - Rs. 25,000 for class 10th & Rs. 50,000 for class 12^{th,} KanyaVivah- Financial assistance of Rs. 10,000 is provided for marriage of daughters of single (widowed or separated) Mitanins, Old age assistance- Mitanins who are currently of 55 years of age and have not been covered under Swavlambhan Yojana are provided financial assistance of Rs. 20,000 after completion of 60 years, Support to families in case of death of Mitanin- Financial assistance of Rs. 20,000 to families in case of death of Mitanin who are not covered under Life insurance, Swavlambhan Pension Yojana- Mitanins are enrolled in Swavlambhan Pension Yojana, Livelihood promotion and skill development- Mitanins are supported to enrol in livelihood promotion activities. Chhattisgarh has also adopted a system of reservation of seats for ASHAs in ANM and Staff Nurse Courses. A similar reservation policy has also been adopted by MP (wherein there is a 25% reservation in ANM training institutes & 10% in GNM training institutes for ASHAs) and in Punjab. However, in Punjab the ASHAs were neither aware nor enrolling in ANM/ GNM courses. Jammu and Kashmir has recently approved an amount of Rs. 800 per ASHA per annum under the Social Security Scheme for ASHAs. Also, in case of permanent disability to an ASHA due to any natural or unnatural cause, she will be paid lump sum amount of Rs. 2.5 lakhs. Similarly, if an ASHA suffers from loss of life, the legal dependent of the deceased will be paid Rs 5 lakhs lump sum amount one time. This amount shall be paid only if the legal dependent is unemployed, however, if the legal dependent is employed, he/she shall be paid Rs. 2.5 lakhs. In addition, financial Assistance up to Rs. 2 lakhs in case of emergency or hospitalization, for diseases like Cardiac disorder, Kidney failure, hepatitis or any other life-threatening disease, will be provided to ASHA after approval from the State Health Society.

The state of Jharkhand too has introduced welfare schemes for Sahiyas and include 'Sahiya Sahayta Nidhi-Central Scheme' wherein financial assistance is provided to all Sahiya, Sahiya Saathi, STT and BTT in rural areas under various situations like death, disability, accident,

education, serious illness, etc. The state also awards best performing ASHAs and VHSNC annually. Besides these some other non-monetary incentives like Uniform, cycles, umbrella, bottle and bags are also being provided. Rajasthan has launched the 'ASHA Jyoti' programme in 2015 to improve educational level of ASHAs, and cost is borne by NHM. Himachal Pradesh has planned a medical insurance scheme for ASHAs to be rolled out shortly within few months.

In addition, states of Tripura, Jharkhand and Bihar have built 'ASHA Ghar'/'ASHA Rest rooms' in the referral/high case load facilities. However, these rooms were largely dysfunctional or of sub-quality standards in Jharkhand (except for the DH Bokaro) and Bihar.

Mechanisms for Grievance redressal

Except in Rajasthan, Tripura, Telangana and Bihar; some form of Grievance Redressal mechanism has been established in all states. In UP and Jharkhand, the state has set up grievance boxes at their health facilities. The ASHAs are aware of these but raised lack of response and appropriate action to their grievances by the system. Maharashtra, Himachal Pradesh and J&K have set up the Grievance redressal system of ASHAs through the 24*7 helpline numbers. All grievances made to 104 were marked to the concerned officials for the redressal and was monitored by the District level Officials. However, limited awareness of ASHAs and hence less numbers of complaints emerge as areas of concern. In UP, ASHAs have put forth a demand to enable a tele-mobile based grievance redressal mechanism which will enable complaints to be registered on real time basis. ASHAs in Jammu and Kashmir strongly recommend an active grievance redressal mechanism at the block level instead of at district level.

ASHA Functionality

Findings from all eighteen CRM states suggest that ASHAs are motivated and committed to their work. Overall, ASHA functionality is seen to be better where- ASHA programme staff/ASHA facilitators are proactive, are providing necessary supportive supervision, on the job mentoring and where ASHAs have received adequate training. ASHAs have a good rapport with the community that also seek her assistance for their healthcare needs. They are seen to be reaching the marginalised communities except in UP and Bihar. On an average ASHAs are spending about 3-4 hours a day on ASHA related activities. It ranged from 2-3 hours. in Tripura to 7-8 hours in Jharkhand (not including the time spent in accompanying patients to referral hospitals). In Rajasthan, ASHAs reported that they had to spend extra time for daily visit to the AWC for signing registers and supporting AWWs in their daily activities.

The community-based interactions undertaken by CRM teams for RCH related services highlight that while ASHAs have performed well on facilitation of beneficiaries to avail services such as institutional delivery, immunization, VHND etc; their role in completing follow up visits to beneficiary households, improving health education of the community and counselling to adopt healthy behaviours has been limited. Even where ASHAs have been successful to a certain extent in building community awareness on exclusive breastfeeding, IYCF etc; actual translation of this awareness to practise is a challenge. The above findings have been reported particularly from states of Madhya Pradesh, Uttarakhand, UP, Bihar Himachal Pradesh, Jharkhand, Karnataka, Assam and Gujarat. Issues related to inadequate birth preparedness have been reported from Telangana, Punjab, Chhattisgarh, and Uttar Pradesh and Assam

These findings from community interactions indicate that while ASHAs are reaching beneficiaries and are also providing mobilization support, they are challenged in bringing about the necessary behavioural change through counselling and health education efforts. This could partly be attributed to complexity of changing behaviours and lack of attention and persistent efforts by the support system to upgrade skills of ASHAs through on the job

mentoring and guidance. Provision of specific counselling tools, communication kits etc are available but greater attention is required on use of these tools during home visits to improve their beneficiary interactions and enable community to take decisions for healthy living.

Although many states have started the process of population enumeration and filling of CBAC forms, a major focus of ASHA activities continue to be on RMNCH+A activities and relates to her past trainings and proportion of beneficiaries for these services in her area. Despite this, recall of certain topics such as- 'warning/danger signs' new-borns, complementary feeding, follow up and referral of SAM children, use of ANTARA was low in states of Rajasthan, Himachal Pradesh, Assam, UK, Tripura, Telangana and indicate an urgent need of refresher trainings for the ASHAs.

In states such as Rajasthan, UP and Tripura where preliminary steps for NCD screening have been undertaken, ASHA's performance in the area of population enumeration, CBAC filling and undertaking health promotion activities was adversely affected due to inadequate duration of training in districts. The ASHAs in J&K and Tamil Nadu were not involved in population enumeration and CBAC filling and hence were unaware of the programme. In addition to the routine activities, the Sahiyas in Jharkhand are also involved in conducting regular meetings of PLA (in-coordination with the AWWs and BTTs). Jharkhand seems to be the only state that is continuing with the system for Performance monitoring included in the National Guidelines for ASHA facilitators. This has facilitated close monitoring of the non-performing Sahiyas and removal of non-performers, if scores continue to remain poor over a period of 6 months. However, state faced political pressure against replacement of non-functional Sahiyas in Bokaro.

In contrast with the findings from other states, mobilization of beneficiaries by Mitanins to private health facilities is reported from Chhattisgarh and needs a deeper exploration to validate- whether these are random instances limited only to Korba, and constraints that prompt such private sectors referrals by ASHAs.

Village Health Sanitation and Nutrition Committee (VHSNC)

One of the four core principles of Primary Health Care is to build a Community ownership to increase access, delivery and monitoring of healthcare services. VHSNC is one such platform that ensures community participation to support implementation, monitoring and action-based planning for healthcare activities. Some of the activities related to the functioning of VHSNC include – Holding regular monthly meetings, managing of Untied Village Health Fund, record maintenance, organizing local collective action for health promotion, monitoring public service delivery.

The CRM state reports suggest that there is a wide variation in the performance of VHSNCs across the country, and VHSNCs in many states are yet to emerge as institutional platforms for aforementioned functions Andhra Pradesh has demonstrated good model of VHSNCs. The committees have- been constituted as per the guidelines, achieved 100% target for establishment. regular monthly meetings (99% of the expected target) and utilized nearly 90% of the funds. Other states which have constituted about 90% VHSNCs against the target are MP and J&K. In Rajasthan, the community representation in constitution of the VHSNCs was inadequate as most of the members are ex-officio.

Very few VHSNCs are functional in Punjab, MP (about 40%), Arunachal Pradesh and Uttarakhand, A lack of clarity amongst the committee members regarding their roles and responsibilities has been reported from later too. Jharkhand and Rajasthan also demonstrated wide intra-state variation in the functionality of the VHSNC. In Jharkhand, VHSNCs in Bokaro district were non-functional whereas the ones in Kanke block of Ranchi district very extremely active. Similarly, in Rajasthan the VHSNCs in Baran were non-functional as opposed to the ones in Jodhpur. MP has 'Gram

Sabha Swasthya Gram Tadathrthya Samiti' where chairman of the committee is a female Panch ASHA is the treasurer. (and designated as Sahayak-sachiv/asst. secretary leading to limited awareness of Sarpanch about the initiative.

Although regular meetings are being held monthly in the states of AP, Telangana and Jharkhand, frequency isquarterly in Himachal Pradesh and are ineffective in generating a village level action on health and related social determinants The last training of the VHSNC members in Rajasthan, J&K and Jharkhand was carried out atleast 7-8 years back and the members themselves couldn't recollect the content of training. Himachal Pradesh, Madhya Pradesh, Uttarakhand, and Tamil Nadu have also jot conducted VHSNC trainings in the recent past. However, as a good practise, the state of UK and MP have started training their Asha Facilitators in PLA-linked activities to revise participation of VHSNC members through these meetings. On one hand fund utilization by the VHSNCs has been poor in the states of MP, Rajasthan and Tamil Nadu, whereas on the other hand, the VHSNC members in Jharkhand (Bokaro district) had to pool own money for carrying cleanliness activities in the village. Documentation related to the minutes of meetings and other activities was found only in HP and Varanasi District of UP, whereas it was not found in the states of UP (Farukhabad District), J&K, Tripura and TN.

VISHWAS (Village based Initiative to Synergise Health Water And Sanitation)

The 'VISHWAS' (Village based Initiative to Synergise Health, Water and Sanitation) campaign was launched to build a collective initiative at community level, for improving Water, Sanitation and Hygiene situation and its impact on Health and quality of life. It is envisioned that it will strengthen the convergent action in under the various initiatives of Swachh Bharat Mission (SBM), and will also build the institutional capacity of VHSNCs to fulfil their roles as visualized in the original design.

Only the states of Jharkhand and UP reported rolling out the VISHWAS campaign. In Jharkhand (District Bokaro), VISHWAS module training for 77 Sahiya Saathis was completed. Platform of VHSNC meetings was being utilised for discussing 2 topics (as given under VISHWAS campaign) every month, by the Sahiyas, with support from Sahiya Saathi in the village. In UP, although the VISHWAS campaign has been launched, the frontline workers were not aware about the same. However, their understanding about cleanliness was satisfactory and discussion also indicated that village sanitation is a major agenda in all VHSNC meetings.

Rogi Kalyan Samitis (RKS)

Rogi Kalyan Samiti (Patient Welfare Committee)/ Hospital Management Society is a registered society which acts as a group of trustees for the hospitals to manage the affairs of the hospital. It consists of members from local Panchayati Raj Institutions (PRIs), NGOs, locally elected representatives and officials from Government sector who are responsible for proper functioning and management of the healthcare facility. It is free to prescribe, generate and use the funds, as per its judgement for smooth functioning and maintaining the quality of services.

The RKS has been formed, as per the recommended guidelines, in all states except in MP (not at PHC level) and Tripura. In Arunachal Pradesh and Punjab, although the RKS has been formed, they are not functional. UP has a unique structure because, as per the State government orders, the RKS committee of every PHC is formed at CHC level and hence the PHC-RKS funds are also received at CHC. The PHC-MO (PHC Amritpur and Jahanganj) were completely unaware of RKS Fund utilization (of approximately 1.7 Lakhs/PHC in FY 2017-18).

The major source of funds for the RKS across the country is the user fees charged and the untied funds received through NHM. However, in addition to this, HP was also generating funds through renting of shops & premises, within

the facility campus, as well as through local donations. In J&K, the funds generated through the user charges (through OPD tickets and lab diagnostic tests) were being deposited into Hospital Development Fund (HDF), which was a separate account from RKS fund.

The state of Andhra Pradesh reported cent percent utilization of the RKS allocated funds (including some funds which were leftover from previous year). Whereas the states of J&K and HP could only partially utilise the funds as receipt was in the last quarter of the financial year. The RKS funds were utilised for different purposes in different states. J&K utilised them for minor repairs, equipment purchasing, IEC materials and maintaining the basic amenities of the facility, whereas the funds were utilised for food & cleaning services in UK. HP was spending a part of their RKS funds for the bio-medical waste collection and management from the various healthcare facilities and for payment of salaries for additional support staff hired by the facility. A part of RKS funds were being utilised to reimburse the patients for outsourced diagnostic services to SRL in the states of HP and Jharkhand. There was misutilization of RKS funds from the CHC Kumarghat in Tripura as the RKS funds were being utilised for arranging boarding and lodging for guests, which is against the recommended guidelines.

Regular Annual meetings of the RKS committee were reported from the states of MP, HP, J&K, AP & Maharashtra. In addition to this the Executive Committee meeting in HP met quarterly. Meetings were irregularly held in Arunachal, Tripura, Rajasthan (where the RKS was named as Rajasthan Medical Relief Society) and Punjab.

The states of AP and UP have initiated some good practices for the RKS and has developed a portal for the RKS/HDS, linked to the CM Core Dashboard for monitoring and evaluation purposes. UP, has developed a structured register to record minutes of the meeting of RKS, in order to streamline accountability of RKS committee. Grievance Redressal Mechanism, Charter for Citizens Rights, creating mechanism for Patients' Feedback, which are one of the key objectives of the RKS) were not observed in the states of Rajasthan, HP, J&K and Jharkhand. Members of the RKS committees expressed a need for training for fund management in the states of J&K, UK and Jharkhand.

Mahila Arogya Samitis (MAS)

To address the peculiar challenges associated with the vulnerable populations in the Urban Slums, the Mahila Aarogya Samitis were created in the urban areas. They are expected to take collective action on issues related to Health, Nutrition, Water Sanitation and its social determinants at Slum/Ward level, in addition to improving awareness and access of community for health services, supporting the ASHAs, develop health plans specific to the local needs and serve as a mechanism to promote community action for health.

In Rajasthan, the MAS have emerged as a strong collective at community level with regular meetings while in contrast in MP, no MAS has been formed in Betul and although few MAS have been formed in the district Rajgarh, their functionality is an issue. In Rajasthan, the MAS meetings are being conducted by the District NUHM nodal officer or the Public Health Manager on a monthly basis and are used as a forum for dissemination of information based on the local health priorities. Untied funds for MAS are mostly used for purchase of identified equipment/ items for AWCs such as BP apparatus, weighing machine etc. MAS groups have been connected to National Urban Livelihoods Mission (NULM).

Another good example for MAS activities has been set by Jharkhand, wherein about 10-12 members constitute 1 MAS and each MAS covers about 50-100 households in both districts (as per the guidelines). A 2-day training workshop in 'Handbook for MAS members' has been completed. MAS members are actively engaged in helping Sahiya in conduct of her activities with regular monthly meetings being held either in anganwadi centre, community space or house of

a MAS member. The minutes are maintained by President/Secretary. The funds, received through DBT, are utilised for purchase of furniture like chairs, carpet/dari, equipment like blood pressure machine, thermometer, weighing machine, making of boards, wall paintings, etc. However, no linkage of MAS with urban local bodies was observed in both districts.

Linkages with MEPMA has led to increased functionality of MAS but ASHA or AN are not involved in the activities of MAS in Andhara Pradesh. No info from other states.

Convergence

Since health of an individual/society is governed by multiple factors, many of which fall beyond the purview of the health department, coordination of multiple agencies/department is prudent to facilitate an uptake of "Health in All Policy" across all the states. This would also synchronise their efforts for achieving the objectives of CPHC under Ayushman Bharat.

The 12th CRM effectively brought out the degree of convergence between the Ministries of Health and Women and Child Development at the field level. With issues pertaining to women and child's health being one of the core areas of work for both divisions, good degree of convergence and mutual co-operation at the field was demonstrated in the States of Himachal Pradesh and Rajasthan.

This is exemplified by 'Rajsangam' initiative of Rajasthan. Where ANMs-ASHAs-Anganwadi workers (now more popularly known as the Triple A) have created avillage level maps and are support identification of focus areas for each functionary. Mapping of Pregnant Woman (including the high risk), Children (including the malnourished and SAM) and the Immunization Status of each, including their follow-ups and continued care by these FLWs has been greatly facilitated by strengthening this platform. Another good example emerges from AP, wherein, 'convergence meetings' are held regularly at the PHCs and quarterly at the District level. Moreover, 'Health Sub-Committees' have been constituted at SHC level in order to achieve convergence between Education dept., ICDS, water and sanitation etc. Local Panchayati Raj Institutions (PRIs) are very actively engaged in the functioning of VHSNCs and RKS with the involvement of Sarpanch, DRDA, MEPMA etc.

Jharkhand too reported a fairly good level of convergence between ICDS (VHND, referral of SAM children to MTC by AWW or Sahiya, etc.) and education department (National Deworming Day Programme, Anemia Mukt Bharat including WIFS, etc.). Moreover, the Mukhiya and Jal Sahiyas of the village are responsible for construction of toilets in the village under Swach Bharat Abhiyan (SBA). However, no involvement of urban local bodies in functioning of MAS in both districts visited in the state. Lack of convergence was observed in states of MP and Punjaband was mainly related to the incentives and delegation of responsibilities.In MP, the ASHAs were not even allowed to keep their health-related material at AWC (Rajgarh district) and were forced to share their incentive with AWW/ANM for motivation for Sterilization. No info from remaining states

Gender

The health department through its large network, rooted in the community, has a huge potential of making the communities as well as the healthcare staff and facilities sensitive to the gender issues. The CRM teams gave a brief insight into the degree of gender issues sensitization across the country.

A good example of operationalizing a one stop crisis centre for the management of gender issues came from States of Rajasthan (District Baran) and Punjab (District Gurdasppur). In Rajasthan they have named the centre as a "Sakhi Centre". In Jharkhand (DH, Bokaro), 1 family counselling centre as a one- stop counselling centre (organised by YMCA Bokaro) is planned to be operationalized soon for providing free counselling on social issues. AP too has roped in

local NGOs to raise awareness against domestic violence for e.g. in Ananthpuram, ASHAs have been involved with local organizations like Yellamma Mahila Sangham. SDH and DH Bokaro have been equipped to deal with the medico-legal cases (domestic violence, sexual violence) wherein a female doctor conducts medical investigation and then a detailed injury/medical report supported by laboratory investigations is being submitted to police. A copy of the same is kept as record in DH, Bokaro.

Assam reported some gender-related issues like a strong preference for the male child in the community and minimal involvement of the males in family planning process which need to be addressed on a priority basis.

The front-line workers from the states of J&K and Jharkhand demanded training in Vishaka Guidelines and addressing gender-based violence probably indicating presence of such issues in their communities

Recommendations

1. Revision of targets and selection of ASHAs needs to be prioritized for uncovered populations and villages to ensure equitable coverage, reach to the beneficiaries, population enumeration and empanelment of beneficiaries to HWC-SHC by ASHAs.

2. States should ensure completion of ASHA trainings in Module 6 and 7, strengthen avenues for refresher trainings through PHC review meetings/cluster meeting to address the gaps in skill attrition and recall of topics.

3. Having developed the needed workforce for ASHA support system at state, district, block and sub-block level there an urgent focus is required to revitalize their performance, improve quality of supportive supervision and programme management. States may plan robust performance appraisal of DCMs, BCMs and ASHA facilitators through field validation of CP initiatives to support poor performers. Feedback mechanisms by state counterparts, annual trainings for supportive supervision as practiced in Jharkhand, and performance linked monetary/non-monetary incentive mechanisms may be introduced to improve functionality of ASHA programme staff.

4. The implementation of HWC-CPHC, Universal NCD screening would require extensive programme support for necessary change management and states with significant vacancies of DCMs/BCMs should expedite filling of these positions to support this function.

5. Reduction in duration of ASHA trainings for Module 6 and 7 or for new service packages needs to be avoided by states in any circumstance as it has direct implications on knowledge and skills of ASHAs and limit achievement of programme objectives

6. Unresolved challenges of refills for ASHA kits need to be addressed for improving outcomes related to HBNC.

7. All states would need to expedite action on implementing training of VHSNC members in VISHWAS and other necessary functions of organizing community based health promotion and monitoring and planning village level action to improve public services at the village level.

8. Avenues to improve performance of VHSNC as institutions for collective action on health at the community level will need to expand through capacity building of PRIs and increasing coordination and capacities of Gram Panchayats/to support and monitor VHSNCs, support and supervise- delivery of community level health programmes such as- Village Health and Nutrition Day (VHND), NRCs, and functioning of HWCs-Sub Health Centres (SHCs).

9. Implementation of community - based healthcare services are a key component of CPHC and would require roping in additional technical capacities/NGO partnerships that can enthuse, mentor, and handhold programme managers, primary care providers, ASHA and her support structures and VHSNCs/MAS to work in coordination. This would be useful in-activities for screening, primary prevention and management of non-communicable diseases, addressing life style issues for substance abuse, addressing gender- based violence, control of endemic/communicable diseases etc.

10. Role of RKS needs to be better realized as institutional level platforms for community participation through constitutions as per RKS guidelines, planning regular meetings and greater involvement in assessing patient satisfaction, quality of care and resolving issues with respect to delivery of services in addition to present limited function of approving local hospital based procurements.

6
SECTION

Evidence to Action Towards UHC: *Contribution of ASHAs in Successful Implementation of the Good, Replicable and Innovative Practice*

From the first summit held in 2013, the National Summit on Good and Replicable practices and Innovations in Public Healthcare Systems in India, has, in a short space of time, become an institutional mechanism for the sharing of innovations supported by the National Health Mission. The summit included 119 best practices and innovations, covering health programmes, medical devices and technologies. They span programmatic areas ranging from health systems, maternal and new-born health, family planning, tuberculosis and other communicable diseases, non-communicable diseases, mental health and e-health. They also include innovations that apply systems thinking to health problems such as the use of information technology to strengthen continuum of care and to addressing human resource shortages and challenges in capacity building, and innovations that address the needs of vulnerable slum populations in the National Urban Heath Mission.

In this section we summarize ten out of 39 key initiatives that were shortlisted for oral presentations at the fifth national summit held at Kaziranga, Assam. These initiatives are summarized in Table number 1. Additionally, three initiatives were also presented as Posters for Community Processes which included Swasthya Setu from Daman and Diu, Sahiya Sangi Portal for Tracking HBNC and Exploring the role of Sahiyas in preventing violence against women using Participatory Learning and Action approaches from Jharkhand. Although the ten identified initiatives do not exclusively pertain to ASHA programme, they highlight the important role played by ASHAs in success of these ten initiatives across different states. The ten initiatives included in this section of ASHA update also demonstrate that in the last fifteen years of the National Health Mission, ASHAs have become an integral part of wide-ranging state or district led initiatives that span across national health programmes and other inputs for health systems strengthening such as IT platform. The summary of intervention also builds evidence on important role played by ASHAs in improving health outcomes related to not just RMNCH+A but also communicable diseases and now also non-communicable diseases, certain E-governance initiatives etc. Thus, underscoring on how ASHAs will be integral in improving population coverage and expansion of services as part of India's journey towards UHC.

Table 1:

Name of the State	Name of the Initiative	Programme Description	ASHA related interventions contributing to success of the Programme
Madhya Pradesh	E-Vitta Pravah	E-Vitta Pravah is a single window payment gateway. This includes direct benefit transfer through web based application for management of NHM RoP budget and fund flow. Payments are made through single bank account at the state level and real time information system of fund availability improves fund utilization and effcient tracking of payments includes those to be made to ASHAs. The intervention was introduced by MP government to address the challenges Funds kept in large number of bank accounts at state, district and sub district levels making reconciliation difficult. Parking of funds and unused balances, lack of real time monitoring mechanism, expenditure not limited to the budget provided in RoP, a cumbersome payment through PPA and projections of artificial fund shortages.	The process flow of E-Vitta Pravah has been integrated with ASHA Payment Software, ASHA Data Base and PFMS to enable digital calculation of incentives due to each ASHA and enabling direct benefit transfer. This had led to Rs. 7.9 lakh ASHA Transaction and DBT to the tune of 55.6 crores in one quarter of implementation of the intervention.
West Bengal	Optimal Contraceptive Method Mix	West Bengal houses 8% of India's population (Census 2011) and struggles with a high growth rate despite overall reduction in total fertility rate to 1.6 (SRS-2016). This is also compounded by a high teenage fertility rate which was affecting the overall maternal health. A qualitative and quantitative approach to contraceptive use helped in reducing the pace of fertility initially. However, a concomitant reduction in maternal and infant mortality could not be achieved and the state continues to grapple with a high MMR-101(SRS-2014-16). The state reinvigorate the hitherto dormant FP programme by making available the whole range of contraceptive choices and substantially increase their contraceptive uptake. It effected a paradigm shift wherein focus was given to a well spread out basket of contraceptive method-mix. As an outcome of these initiatives, the contraceptive prevalence (mCPR) has increased by 7% from 49.9 in NFHS III to 57 in NFHS IV. With this result the state now boasts of contributing to the highest share of combined oral pill (23%), post-partum IUCDs (17%) and post abortion IUCDs (13%). The state also has the highest PPIUCD acceptance rate of 40% while it ranks third highest in male sterilization services.	The state undertook systematic trainings, counseling, inclusion of newer contraceptives strengthening of post-partum services as well as ensured the uninterrupted supply of contraceptives by the ASHA/ ANMs right down to the last mile and emphasized upon spacing methods with a focus on informed choice.

Name of the State	Name of the Initiative	Programme Description	ASHA related interventions contributing to success of the Programme
		West Bengal has a method mix which focuses equally on limiting as well as spacing methods and a balanced contraceptive mix is indicative of the improved access as well as fulfilment of reproductive rights. This is paying rich dividends as all these efforts have led to the aversion of 46 lakh unintended pregnancies, 1.53 lakh unsafe abortions and 1500 maternal deaths in a single year alone (Source: Track 20).	
Madhya Pradesh	Making of a hub: The Story of RKSK	One of the key interventions under the RKSK programme is introduction of the Peer Educators (Saathiyas) who act as a catalyst for generating demand for the adolescent health services and imparting age appropriate knowledge on key adolescent health issues to their peer groups. To effectively conduct monthly peer meetings, MP implemented innovative solutions. These involved-providing simple user friendly modules in the form comics and animations for Saathiyas, training in use of these modules and job aids, to transact relevant messages to peer groups. Topics were identified for a total 24 comics. Mix groups were formed for conducting the meetings on introductory topics, while separate discussions were organised for boys and girls on gender specific topics. Invertements were made to improve communication skills of Saathiyas to enable them serve as leaders to conduct peer meetings. The intervention led to regularity of meetings has increased from 86% to 93% in 4 months, while attendance of adolescent increased from 50% to 72%. The Saathiyas, and the brigade at large, are now more confident and understand the process of physical and mental changes that happens in this age group. There is positive peer pressure among brigade members to address harmful behaviour and adopt healthy habits.	A mentoring chain was developed to overcome last-mile challenges. ASHA Facilitators served as mentors for Sathiyas. This chain serves a dual purpose: Firstly, it works as a cascade model for mentoring, and secondly, it forms a logistic chain to distribute a new comics, every month, at the village level. ASHA and ASHA Facilitators helped in gaining confidence of parents and local influencers to enable adolescents participate in meetings to address issues related to reproductive health, substance misuse, GBV, etc. AFs also supported in better organization of the Adolescent Health Days (AHDs)
Bihar	Reducing neonatal mortality by addressing the group at the highest risk: Implementing simple	This innovation is the adaptation of Home Based Newborn Care (HBNC) guideline and ASHA Module 7 for preterm-LBW babies. These guidelines define babies at high risk as fulfilling at least one of three criteria i.e. birth-weight < 2000 gm, gestational age at birth < 37 completed weeks and not feeding well from the day of birth. For ease of communication and clear differentiation from babies who later develop sepsis,	

Name of the State	Name of the Initiative	Programme Description	ASHA related interventions contributing to success of the Programme
	interventions to identify and support the care of preterm and low birth weight babies at state-wide scale.	the name used for babies fulfilling these criteria in Bihar is 'weak newborn babies'. Those who are suspected to have sepsis are referred to as 'sick newborn babies'. Taking advantage of the relatively high institutional delivery rates in Bihar, this intervention began in 694 public health facilities, other than teaching hospitals, state-wide from September 2016 after a brief pilot in 552 facilities in June 2015. Intervention involves training of 78 master trainers from 38 districts on Guideline, Registers, Formats etc through a one day training. Orientation of RCH officers/ACMOs was done for implementation and review of Program. One day training was also conducted for 5 participants from each block i.e. Facility-in Charges, Medical Officers, Labour Room-in-Charges, Block Health Managers and Block Community Mobilisers. In addition, orientation was also provided to all Labour room nurses, HSC Nurses and all ASHAs of 534 blocks on identification, counselling for extra care, reporting and follow-up (telephonic and home visits). SHCs were utilized for continuous orientation of ANMs and ASHAs using Incremental Learning Approach (ILA)	
		ASHAs focussed on measures like (i) Frequent breast feeding in neonatal period, (ii) Extra thermal care through skin-to-skin contact or Kangaroo Mother Care (KMC) and (iii) Prevention of infection by extra skin & cord care in babies and hand hygiene of care provider during home visits. Assessments of the intervention were undertaken by Bihar TSU in in 4 rounds. (4th round in Sept-Oct 2017). Findings show increase in accurate identification of low birth weight (LBW) babies from 2% (1st Round) to 5.1% (4th Round). Increase in immediate post-partum visits by ASHAs to identified preterm & LBW babies, Increase in appropriate counselling for identified Preterm-LBW both at facility and at home. Preterm-LBW tracking intervention has led to increase in extra new born care practices in identified Weak New Born-Mother was informed about WNB increased from 19% to 30%; mothers adviced on extra care for WNBs increased from 15-26%; delayed bathing in WNB from increased from 39 to 41% and adoption of KMC for keeping newborn warm increased from 10 to 29%.	

Name of the State	Name of the Initiative	Programme Description	ASHA related interventions contributing to success of the Programme
Madhya Pradesh	Betul Initiative for Zero TB District	In 2016, District TB Centre, Betul conducted Active Case Finding (ACF) in Key Population groups of Betul district. With this activity, district was able to reach a annualized TB case notification rate of 242 per lakh from 119 per lakh population. With sustained efforts, notification rate of the district began to decline from 4th Quarter 2016. The district commenced mapping block wise and village wise data of population at risk, suspected cases and brings them under surveillance to track emergence of new cases. Villages were classified based on total number of TB patients notified from Jan 2017 to June 2018 as notified into the RNTCP's Nikshay software as under: • Villages with zero notification during the period – depicted as Green. • Villages with 1- 2 TB Patients notified – depicted as Yellow. • Villages with more than 3 TB Patients notified – depicted as Red.	The BMO, MPWs, ANMs, ASHA Sahyoginis and ASHAs were involved in the process along with RNTCP staff under the leadership of District Collector & CMHO. The district focused its preventive activities towards these villages and on a quarterly basis ASHAs conducted house to house survey in 350 green depicted villages to find any new presumptive (symptomatic) or new case. Out of 350 villages, 102 villages were identified with either new TB Presumptive (symptomatic) or TB/Patient detected during survey. 248 Villages have been identified as Zero TB applying the definition of 18 months and where not a single presumptive or new TB case was found on repeated survey.
Dadar and Nagar Haveli	Integrated Approach to Elimination of Grade II Disability due to Leprosy	Disability Prevention, Management and Rehabilitation (DPMR) is an important component of NLEP. Dadra & Nagar Haveli, having the highest disease burden in terms of prevalence rate and annualized new case detection the country. UT has been making efforts to address Grade II disability (G2D) due to Leprosy for the last 2-3 years. All the components of DPMR were implemented by the UT and for the first time, RCS camp was organized in December 2015. In the year 2015-16, 88 cases of G2D in a population of about only 4.2 lakhs, indicating alarming situation and more hidden cases. In 2016-17 again 8 such cases were reported taking the grade II disability rate at the time of diagnosis from 1.88% in 2015-16 to 2.08% in 2016-17. It was found that pure neural cases were being missed by the heath staff including Medical Officers. Also, the working population was being missed in the active case finding campaigns (LCDCs or SAPs). A series of community level interventions were implemented to address these issues.	To handle these issues, all the Health Staff ASHAs were sensitized to screen for sensory loss in addition to hypo-pigmented patch and visible deformity. Three rounds of active case finding drives (first round of active search by General Health Staff & two rounds of LCDC) and one round of Focused Leprosy Campaign was carried out by ASHAs. To screen the working population, male MPWs, PMWs and NMS were deployed for the evening time (6pm - 8pm) to screen out the suspects. Due to these measures, there was no G2D at diagnosis (during 2017-18) in the UT till 29th March 2018. Further, UT also implemented an innovative concept of

Name of the State	Name of the Initiative	Programme Description	ASHA related interventions contributing to success of the Programme
		Although the UT marginally missed a year free from G2D at diagnosis, it has succeeded in bringing down the G2D at diagnosis from 2.08% in 2016-17 to 0.36% in the year 2017-18.	"Post-Exposure Chemoprophylaxis Project" with two pronged approach to eliminate leprosy from Dadra and Nagar Haveli. ASHAS undertook Prompt referral of symptomatic persons and enabled prophylactic drug administration to contact persons. Intensive surveys are carried out by ASHAs periodically to identify persons having symptoms of leprosy. They are promptly referred to a health facility for Multi Drug Therapy (MDT). All the contact persons of symptomatic person are identified by ASHAs. They are offered a post-exposure prophylactic drug administration, which comprises of a single dose of rifampicin. This cuts down their risk of developing leprosy by 50-60%.
Odisha	Malaria Control Programme - A Paradigm Shift	Odisha is characterized by widespread hilly, tribal, forested and conflict-affected areas which are also pockets of high malaria transmission. Odisha contributes to nearly 40 percent of malaria and nearly 50 percent of deaths in India. Following activities were undertaken in the year 2017 for intensification of antimalarial activities were taken to tackle the malaria in the area: Identification of remote and inaccessible areas which get cut off after the monsoon. • Increased surveillance of the community by means of mass surveys and identifying the malaria. • Provision of rapid diagnostics for immediate results and treatment. • Provision of 11.34 million Long Lasting Insecticides Nets (LLINs) to the identified population in high endemic areas. • Promotion of IEC/BCC for utilisation of LLINs.	All the activities listed were implemented with the support from ASHAs. 47,174 ASHAs are working as Fever Treatment Depot (FTD) holders and providing services for early diagnosis and complete treatment of malaria at community level. Special surveillance is done by ASHAs by active screening of Tribal residential School boarders & inmates. ASHAs also support mass screening in inaccessible areas for screening of individuals irrespective of fever status under State specific DAMAN programme - done by special camp approach. Passive surveillance by ASHAs increased from 61% in 2012 to 81% in 2017 78% of the total diagnosis is done by RDT.

Name of the State	Name of the Initiative	Programme Description	ASHA related interventions contributing to success of the Programme
		• Engagement of all politicians, local representatives, community groups, etc for use of LLINs and immediate reporting of fever cases. Community groups and volunteers took on themselves the task of promoting the use of LLIN by visiting the villages and requesting the community to sleep under LLIINs. Odisha is showing highest % decrease (82%) of cases in the country in 2018 Total 3 deaths due to malaria in 2018 (By September) against 24 last year State TPR is 1.26 against 6.56, last year. With current rate of reduction, Provisional API of Odisha is predicted to be 1.6; All time low in last 4 decades It is estimated to have only one district (Rayagada) with API >10 in contrast to 9, last year.	All ASHA do test by RDT at village level. By 2017, ASHAs distributed LLIN to 2 Crore high risk population of 17 high endemic districts. ASHAs sensitized community by infotainment activities and by traditional drum beating & unique bell –ringing method. Inter personal communication was done during house to house visit Three tier approach was made on LLIN use & maintenance – during pre-distribution survey, during distribution and post distribution.
Karnataka	Health and Wellness Centres the first port of call for Comprehensive Primary Health Care (CPHC) towards "Arogya Karnataka"	State of Karnataka was an early beginner in the implementation of HWCs to deliver CPHC Services in 105 SHCs of Mysore and Raichur district respectively. The state implemented all the essential inputs required for operationalizing HWCs in the two identified pilot blocks of these two districts. The early reports on service delivery are promising and six months of implementation offered lessons to scale up the initiative in the state. In six to seven months of programme delivery, about 3.5 lakh individuals availed OPD services for a comprehensive range of services at 105 HWCs in the pilot blocks. More than 50,000 individuals above 30 age group were screened in six months for Diabetes and Hypertension. About 2000 new suspected cases were referred for treatment confirmation and about 9000 new and old cases are availing follow up care and medicines refills at these HWCs.	A Team Building Training was conducted by CHOs to gain confidence of ASHAs and coordination of community level activities of HWCs. ASHAs have been multi-skilled in community level risk identificiation, health promotion and mobilization for screening of NCDs. ASHAs are being extensively used for demand generation to improve uptake of services at HWCs. ASHAs undertake community needs assessment of population and have line listed 5 lakh persons from 2 blocks
Gujarat	TeCHO+ (Technology for Community Health Operation)	TeCHO+ is a mobile & web based application which works as a job-aid for ASHAs and ANMs and administrators for improving coverage and quality of maternal, newborn and child health services. TeCHO+ application provides name based tracking of pregnant women and children using mobile phones along with Aadhar authentication.	

Name of the State	Name of the Initiative	Programme Description	ASHA related interventions contributing to success of the Programme
		Considering the limitations of the real-time data entry in e-mamta and encouraging results of the ImTeCHO project by the Health and Family Welfare Department has decided to develop and implement upgraded version of ImTeCHO covering 7/11 indicators as TeCHO+, which is launched for implementation in by Hon. Prime Minister in the entire state. Updation of Family Health Survey (database of all the person residing in the state) using TeCHO is in progress in the entire state. Additionally, all ASHAs of Bharuch, Narmada and Valsad districts will be provided with mobile phone by the end of 2018 to realize the objective of AAA. Real time data entry by service provider at point of service delivery so that real time tracking will be possible for the services of the beneficiaries. Digitalization of various Register, Records and reporting. TeCHO+ will play an important role in improving the health indicators like the MMR IMR and TFR, etc.	
Rajasthan	Mahila Arogya Samitis (MAS) Experience in Rajasthan	Mahila Arogya Samiti (MAS) is one of the key intervention under National Health Mission aimed at promoting community participation in health at all levels. MAS is expected to take collective actions on issues related to Health, Nutrition, Water, Sanitation and social determinants at the slum level. MAS Kota actively participates in the health related activities of all the departments and apart from that they are also involved in other program like ''Kishori Shakti Sanghthan'' Behaviour Change Communication- Through awareness activities using medias like"Nukkad Nataks" focussing on issues related to Social Determinants of Health and on the various schemes and programs for health. MAS members discourage selling of tobacco products in slums by raising awareness among shopkeepers as well as among the community. During UHND, MAS members visit Anganwadi Centers and mobilize cases for ANC and Immunization. Exposure visits to health care facilities and Special Amavasya Drive for immunization of children of the vulnerable groups of labours are organized as part of the special drive.	ASHA supports in constitution of MAS, training, is a member secretary, holding monthly meetings. Updating records and initiating services required for the community with MAS groups. MAS members are working in close coordination with other departments like ULB, ICDS, PHED etc with the help of ASHA & PHM. As a result of regular follow up with Ward Corporator they have constructed Roads in their Slum.

Name of the State	Name of the Initiative	Programme Description	ASHA related interventions contributing to success of the Programme
		Sanitation & Hygiene Practices During the house visits MAS members educate and generate awareness among the community on proper WASH practices. This resulted in construction of 60 household toilets. They also regularly monitor Community Toilets (SULABH) of their slum areas for hygiene and cleanliness. MAS members were trained for solid and liquid waste management with the support from the local NGO, which they spread among the community and monitor the cleanliness of the community.	

7

SECTION

An Update on ASHA Incentives

On 11th September 2018, the Honourable Prime Minister interacted with ASHAs, their beneficieries and Anganwadi Workers from 12 States. During the Direct Samvad, He announced a benefit package acknowledging the significant contribution and commitment of ASHAs. The package included the revision of incentive for Routine and Recurring Activities amount from Rs. 1000 per month to Rs. 2000 per month.

In addition to the increase in monthly incentive for routine and recurring activities for ASHAs, the PM also announced the introduction of social security benefits of life insurance, accident insurance and pension to eligible ASHAs and ASHA Facilitators by enrolling eligible ASHAs and AFs under:

- **Pradhan Mantri Jeevan Jyoti Beema Yojana:** which provides a benefit Rs. 2 lakh in case of death of the insured.
- **Pradhan Mantri Suraksha Beema Yojana:** which provides the insured with a benefit of Rs. 2 lakh for accidental death or permanent disability and Rs. 1 lakh for partial disability.
- **Pradhan Mantri Shram Yogi Maan Dhan:** which provides the beneficiary with pension benefit of Rs. 3000 pm after age of 60 years. (which is operationalised by 50% contribution of premium by GOI and 50% by the beneficiary).

The updates list of monthly ASHA incentives are as follows:

Sl. No.	Activities	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. February-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		

Sl. No.	Activities	Amount in Rs./case	Source of Fund and Fund Linkages	Documented in
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 centre	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
4	Ensuring quarterly follow up of low birth weight babies and newborns discharged after treatment from Specialized New born Care Units[2]	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	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
6	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
7	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		

1 Incentive is provided only on completion of 45 days 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 This incentive will be subsumed with the HBYC incentive subsequently.

Sl. No.	Activities	Amount in Rs./case	Source of Fund and Fund Linkages	Documented in
8	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	Full 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	Complete 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. 75[3]		Order no – T.13011/01/2012/-CC& V
3	Mobilizing children for OPV immunization under Pulse polio Programme	Rs. 100/day[4]	IPPI funds	Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV
4	DPT Booster at 5-6 years of age	Rs. 50		Order no– T.13011/01/2012/-CC& V
IV	**Family Planning**			
1	Ensuring spacing of 2 years after marriage[5]	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[5]	Rs. 500		
3	Ensuring a couple to opt for permanent limiting method after 2 children[6]	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)		Revised Compensation package for Family Planning-September DO-N 11026/11/2014-FP-2014

3 Revised from Rs. 50 to Rs. 75.

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

5 Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttar Pradesh, Uttarakhand, Arunachal Pradesh, Assam, Manipur, Meghalaya, Mizoram, Nagaland, Sikkim, Tripura, Gujarat, Haryana, Karnataka, Maharashtra, Andhra Pradesh, Telangana, West Bengal & Daman and Diu.

6 Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttar Pradesh, Uttarakhand, Arunachal Pradesh, Assam, Manipur, Meghalaya, Mizoram, Nagaland, Sikkim, Tripura, Gujarat, Haryana and Dadar & Nagar Haveli.

Sl. No.	Activities	Amount in Rs./case	Source of Fund and Fund Linkages	Documented in
		Rs. 300 in 146 MPV districts Rs. 150 in remaining states		
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) and 400 in 146 MPV districts and Rs. 200 in remaining states		
6	Female Postpartum sterilization	Rs. 300 in 11 states with high fertility rates (UP, Bihar, MP, Rajasthan, Chhattisgarh, Jharkhand, Odisha, Uttarakhand, Assam, Haryana and Gujarat) and 400 in 146 MPV districts		
7	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
8	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
9	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)			
10	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
11	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		

Sl. No.	Activities	Amount in Rs./case	Source of Fund and Fund Linkages	Documented in
12	Nayi Pahel- 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/Nayi Pahel kit distribution		
13	Saas Bahu Sammelan- mobilize Saas Bahu for the Sammelan- maximum four rounds	Rs. 100/per meeting		
14	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
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	**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	Rs. 1500[7]		Order No. F No7 (84)/2018 NHM-I. Dated-28th September 2018

7 Increased from Rs. 500 to Rs. 1500 from October 2018.

Sl. No.	Activities	Amount in Rs./case	Source of Fund and Fund Linkages	Documented in
	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			
VII	**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
VIII	**Revised National Tuberculosis Control Programme**[8]			
	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		

8 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.

Sl. No.	Activities	Amount in Rs./case	Source of Fund and Fund Linkages	Documented in
4	For notification if suspect referred is diagnosed to be TB patient by MO/ Lab[9]	Rs. 100		Revised National Tuberculosis Control Program-Guidelines for partnership- Year 2014
IX	**National Leprosy Eradication Programme**[10]			
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)		
X	**National Vector Borne Disease Control Programme**			
A)	**Malaria**[11]			
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)		
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

9 Provision for Rs. 100 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.

10 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.

11 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.

Sl. No.	Activities	Amount in Rs./case	Source of Fund and Fund Linkages	Documented in
2	For annual Mass Drug Administration for cases of Lymphatic Filariasis[12]	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[13]	Rs. 100/- per round during Indoor Residual Spray i.e. 200 in total for two rounds	NVBDCP funds	Minutes Mission Steering Group meeting- February-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- February-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 – October-2006
XI	**Incentives under Comprehensive Primary Health Care (CPHC) and Universal 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

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

13 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.

Sl. No.	Activities	Amount in Rs./case	Source of Fund and Fund Linkages	Documented in
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 new packages of 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 - February-2013

RELENTLESS EFFORTS BY AN ASHA TO SAVE A NEWBORN'S LIFE IN JHARKHAND

Mrs Gita Singh Munda (name changed) resident of Urmal Village of Saraikela District in Jharkhand felt labour pains on the night of 27th July 2018. The ASHA of the village, Manita Devi, had completed the birth planning during her ANC visits for Gita. She had also counselled the family to call emergency referral transport when Gita goes into labour. On the night when Gita experienced labour pains, the family members approached Manita who called the 108 ambulance. Despite all attempts, the referral transport could not reach the village and around 2.00 am, Gita delivered a baby boy at home. Following the protocols of her training as an ASHA, Manita continued to be with the family. It was a case of preterm delivery; the baby did not cry and was asphyxiated. Manita recalled the steps from her training to manage such babies and resuscitated the baby immediately using the Mucous extractor. Thereafter, the baby started to cry and could breathe easily. Birth-Asphyxia is common in newborns and can be prevented but if not managed, it can causes newborn mortality. Despite these attempts the baby was not out of danger. He weighed about 2.2 kg, which is less than the ideal weight of a healthy newborn. Manita called 108 ambulance and carried both mother and newborn to a PHC Manita continued to make her regular HBNC visit as per the protocols. During her 7th day visit, She also found that the baby had become hypothermic. She wrapped the baby in warm bag, called the ANM who supported mother in providing Kangroo mother care and continued to closely monitor the baby. Manitas effort ensured that the baby was exclusively breastfed, gained weight & was healthy. Manita's efforts were recognised in the PM Samvad on 11th September 2018.

Mission of Health & Family Welfare
Government of India
Nirman Bhavan, New Delhi