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UPDATE ON ASHA PROGRAMME

January 2016

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Section 1:

Introduction

This is the thirteenth issue of the biannual ASHA update, produced by the National Health Systems Resource Centre (NHSRC) for the National Health Mission (NHM), Ministry of Health and Family Welfare. This issue spans the period between July 2015 and December 2015, and covers the following: In Section 2 we provide a status update on selection, training, and support structures. The Ninth Common Review Mission was held in November 2015 and we report on the key findings and recommendations related to Community Processes in Section 3. Section 4 summarises the highlights from the annual state nodal officer meeting. Section 5 includes two best practices and a brief on an ASHA from Odisha who was felicitated by the Prime Minister for outstanding performance. Section 6 has an updated list of incentives.

In November 2015 the Task Force on the Rollout of Comprehensive Primary Health Care finalized its report. The significance of this report for the ASHA programme is that a key recommendation of the report is to view the ASHA as part of an expanded team at the sub centre to provide primary health care. This development signifies the evolution of the programme and necessitates planning for this new role.

Section 2 covers the selection status and training progress. The updated data indicates slowing of training, which is an area of concern. Training in Module 6 & 7 was initiated in 2011 across most states. The low levels of coverage for Rounds 3 and 4 compared to early gains in Rounds 1 and 2 of these modules, indicate that there are likely to be long time-lags between successive Rounds. It was expected that the gap between two rounds of training be no more than eight to twelve weeks, giving the ASHA sufficient time to practice skills learnt in one round before learning new skills in the next round. Gaps of between 12 to 14 months are seen in several states. This is an area of concern and states need to be seized of it.

The concern about lack of orientation of support structures to their responsibilities, observed in previous updates, has begun to be addressed, with some states undertaking orientation and training for support staff, but this needs acceleration and institutionalization. There is also a lag in filling vacancies among support staff particularly at district and sub district levels. This also contributes to the delays in ASHA training.

When the programme was launched in 2005, it was expected that the ASHA would be accredited. In July 2015, the MOHFW signed a tripartite agreement with the NHSRC and the National Institute of Open schooling to create a certification programme for ASHA and accreditation for trainers and training sites. This is one potential avenue to re-focus on the criticality of training and ensure competencies thereby bringing some measure of assurance to the quality of services provided by the ASHA to her community.

Section 3 has the key findings of the Ninth Common Review Mission (CRM). A total of fifteen states were visited. The CRM, provides us, as always, with a rapid snapshot of the programme on the ground. The picture that emerges is one of increasing ownership of the ASHA by the health system and a mature programme overall across states, but limited to selected components. One area of concern raised by the state reports is that the community mooring of the ASHA remains tenuous. The other area of concern, reflective of training quality, referred to earlier is

poor skills of the ASHA in some states for areas such as nutrition, family planning and new-born care. On the progress of the ASHA and Community Processes components related to the National Urban Health Mission, while there is progress in some states, much more needs to be done. The role of the ASHA and the Mahila Arogya Samities, currently largely based on the lessons of its rural counterpart, - the National Rural Health Mission (NRHM), need an in-depth review and reconsideration.

In Section 4 we provide a synopsis of the proceedings of the state ASHA nodal officers meeting. This annual event has for several years now, served as a platform to bring all state nodal officers together to share best practices, lessons and challenges. The meetings also serve to build a sense of solidarity in this cutting edge team, that is largely responsible for implementation of the Community Processes programme. Since 2015 marked a decade of the Community processes intervention the meeting was partly designed to enable state nodal officers to reflect on a vision for the future, drawing from the workshop of the National ASHA Mentoring Group.

Section 5 discusses two Best Practices - the first is the Comprehensive Primary Health Care model implemented by the Jan Swasthya Sahayog, Bilaspur, Chhattisgarh in which the Village health worker/ Mitanin plays a key role. The second is an mHealth tool, REMIND, to improve supportive supervision by the ASHA facilitator, piloted in the state of Uttar Pradesh. Both models reported in this issue are led by NGOs but designed so as to be adapted into the existing systems and structures of NHM's existing community based health systems platforms, which is an important scalability feature. In the sub-section, Stories from the Field, we also report on Jamunabai, an ASHA from Odisha's Balasore district who won an award from the state for her tireless efforts on addressing malaria in her village of Tenda.

In Section 6 we provide an update on incentives. Two incentives were introduced last year - a) Incentive for mobilizing and ensuring every eligible child (1-19 years out-of-school and non-enrolled) is administered Albendazole on National Deworming day and b) For prophylactic distribution of ORS during Intensified Diarrhoea Control Fortnight.

Section 2:

ASHA Programme Progress

Status of Selection

The status of targets and selection of ASHA remains largely at the same level, since the last Update of July 2015, across 35 states and Union Territories. Overall the target for ASHAs in rural areas has reduced marginally from 9,52,578 to 9,47,344 and the target for ASHAs in urban areas increased from 63,459 to 65,665.

In terms of selection there is not much forward movement in the states and UTs of Himachal Pradesh, and Puducherry, where the programme was initiated recently. Presently a total of 8,57,309 ASHAs are in position in the country, against the target of 9,47, 344 in rural areas. In urban areas under the National Urban Health Mission (NUHM), 38,381 ASHAs have been selected against the target of 65,818 so far. In terms of selection of ASHAs in rural areas, at the national level, about 91% ASHAs are in position against the target while the respective figure for urban ASHAs under NUHM is 58%. In North eastern states about 99% rural ASHAs are in position, this figure is 91% in High Focus states and 88.44% in Non high focus states. Selection of urban ASHAs under NUHM is 90% complete in North Eastern states, 58% in High focus and roughly the same in Non High Focus states.

Table 2.1: Status of ASHA selection and density

High Focus States								
	Under NRHM					Under NUHM		
State	Proposed ASHAs (Target)	ASHA Selected/ Working	% Against Target	Rural Population 2011 Census	Current Density of ASHAs	Proposed ASHAs (Target)	ASHA Selected/ Working	% Against Target
Bihar	93687	85387	91.14	92341436	1/1081	391	44	11.25
Chhattisgarh*	68300	65713	96.21	19607961	1/298	3883	3701	95.31
Jharkhand	40964	39380	96.13	25055073	1/636	214	75	35.05
Madhya Pradesh	60657	58333	96.17	52557404	1/901	4200	3876	92.29
Odisha	45812	43154	94.20	34970562	1/810	1057	1057	100.00
Rajasthan	54915	44178	80.45	51500352	1/1166	4555	3042	66.78
Uttar Pradesh	160175	140171	87.51	155317278	1/1108	6813	0	0.00
Uttarakhand	10048	9702	96.56	7036954	1/725	1038	1038	100.00
Sub Total	**534558**	**486018**	**90.92**	**438387020**	**1/902**	**22151**	**12833**	**57.93**

**Chhattisgarh has selected ASHAs at habitation level.*

North East states								
	Under NRHM					Under NUHM		
State	Proposed ASHAs (Target)	ASHA selected/ working	% against target	Rural Population 2011 census	Current Density of ASHAs	Proposed ASHAs (Target)	ASHA selected/ working	% against target
Arunachal Pradesh	3904	3867	99.05	1066358	1/276	40	40	100.00
Assam	30619	30619	100.00	26807034	1/876	1181	1161	98.31
Manipur	3878	3878	100.00	1736236	1/448	81	81	100.00
Meghalaya	6519	6429	98.62	2371439	1/369	245	156	63.67
Mizoram	1091	1091	100.00	525435	1/482	74	0	0.00
Nagaland	1887	1887	100.00	1407536	1/746	41	30	73.17
Sikkim	641	641	100.00	456999	1/712	35	25	71.43
Tripura	6840	6765	98.90	2712464	1/401	527	523	99.24
Sub Total	**55379**	**55177**	**99.64**	**37083501**	**1/672**	**2224**	**2016**	**90.65**

Non High Focus states								
	Under NRHM					Under NUHM		
State	Proposed ASHAs (Target)	ASHA selected/ working	% against target	Rural Population 2011 census	Current Density of ASHAs	Proposed ASHAs (Target)	ASHA selected/ working	% against target
Andhra Pradesh	39009	37994	97.40	34776389	1/915	2660	2502	94.06
Delhi	NA	***NA***	NA	NA	NA	5019	4731	94.26
Gujarat	38188	35404	92.71	34694609	1/980	4366	3493	80.00
Haryana	18000	16956	94.20	16509359	1/974	2676	1869	69.84
Himachal Pradesh	7752	6447	83.17	6176050	1/958	0	0	
Jammu & Kashmir	12000	11721	97.68	9108060	1/777	238	193	81.09
Karnataka	39195	32678	83.37	37469335	1/1147	2912	1104	37.91
Kerala	30927	26002	84.08	17471135	1/672	4804	2411	50.19
Maharashtra	61155	54337	88.85	61556074	1/1133	5844	2313	39.51
Punjab	17360	16972	97.76	17344192	1/1022	2394	2187	91.35
Tamil Nadu *	6850	6204	90.57			1336	0	0.00
Telangana	25093	23391	93.22	21585313	1/923	2637	2637	100.00
West Bengal	61008	47204	77.37	62183113	1/1317	6106	0	0.00
Sub Total	**356537**	**315310**	**88.44**	**318873629**	**1/1011**	**40992**	**23440**	**57.18**

** ASHAs have been selected only in tribal areas.*

Union Territories								
	Under NRHM					Under NUHM		
State	Proposed ASHAs (Target)	ASHA selected/ working	% against target	Rural Population 2011 census	Current Density of ASHAs	Proposed ASHAs (Target)	ASHA selected/ working	% against target
Andaman and Nicobar Island	412	407	98.79	237093	1/583	10	0	0.00
Chandigarh	NA	NA	NA	NA	NA	50	46	92.00
Dadra and Nagar Haveli	250	208	83.20	183114	1/880	50	46	92.00
Daman & Diu	98	79	80.61	60396	1/765	NA	NA	NA
Lakshadweep	110	110	100.00	14141	1/129	NA	NA	NA
Puducherry	NA	NA	NA	NA	NA	341	0	0.00
Total	**870**	**804**	**92.14**	**494744**	**1/615**	**451**	**92**	**20.40**
Total All India	**947344**	**857309**	**90.49**	**788336550**	**1/919**	**65818**	**38381**	**58.31**

The overall picture within rural areas reflects no significant change, in either the target or in number of ASHAs in position except in the state of Bihar, where states has reduced the target by about 10,500.

Among the high focus states, the downward revision of target of ASHAs in rural areas ASHAs is seen in states of Odisha (reduction of 1270) and Bihar (reduction of 10,552). Upward revision of target is also noted in states of Madhya Pradesh (increase by 552) and Rajasthan (increase by 7830). These revisions in target are based on district level target revisions, or because of corrections related to separation of NRHM and NUHM programmes within districts. However, in case of state of Bihar, where the target has been reduced from 1,04,239 to 93,687, the reasons for reduction in target are as yet unclear since there is no upward revision in NUHM targets. In Rajasthan the target revision from 47,085 to 54,915 could be linked to increase in target of Anganwadi Centres (AWC) as the ASHA programme in the state is assimilated within the Integrated Child Development Scheme (ICDS), with the second Anganwadi worker being nominated as the ASHA, at the start of the NRHM in 2005. With regardto the selection of ASHAs against the targets, progress is noted only in Uttar Pradesh with selection of 5171 new ASHAs and Bihar with 369 new ASHA selection.

Drop out of ASHAs during this period is noted from states of Madhya Pradesh, Odisha and Rajasthan. Of the three states the highest figure for drop out i.e, 2779 is reported from Rajasthan. This can be linked to the introduction of a new ASHA payment system, the ASHA Soft, where ASHA functionality is assessed by the amount of incentives and used as a criterion to declare drop out.

In urban areas, no change in selection status or target is noted across these states except in Rajasthan where 42 new ASHAs have been selected. The State of Uttar Pradesh has not been able to select any ASHA in urban areas against the target of 6813. This number represents the highest state target for ASHAs under NUHM.

All eight northeastern states, have reported nearly 100% ASHA selection in rural areas (100% in six states and over 98% in Arunachal Pradesh and Meghalaya). Reduction in target is reported in Nagaland (from 1986 to 1887) as state did not receive approval for additional ASHAs in the State Programme Implementation Plan FY 2015-16. However unlike the status of ASHA selection in rural areas, only four states have completed 98-100% urban ASHA selection, while in Meghalaya, Nagaland and Sikkim about 63-73% of ASHA selection is complete. Mizoram is yet to begin selection of ASHAs in urban areas.

The Non High Focus states have reported a small downward revision in the overall target (total decreased from 3,58,234 to 356,537) and selection (figures revised from 316028 to 315310). This is mainly on account of reduction of target in Andhra Pradesh and Telangana where targets were reduced by 2027 and 2637 respectively. Among the Non high focus states only Maharashtra has increased the target from 59,203 to 61,155. If we compare the numbers of ASHAs in position with last update, very little progress has been made v.i.z, new selections are reported only from Andhra Pradesh (378), Gujarat (145), West Bengal (901) and Karnataka (2762). However, dropout figures have been reported from six states (Haryana, Himachal Pradesh, Jammu & Kashmir, Maharashtra, Punjab and Telangana). The attrition rate is within the range of 5% in five of these states (except Telangana which reports nearly 10% attrition). Himachal Pradesh, reports a drop-out of nearly 1119 ASHAs. Such high numbers of drop-outs within the early years of selection (Himachal Pradesh initiated the ASHA programme in 2013), indicates that the process of selection needs to be reviewed carefully. Haryana, Kerala and West Bengal have reported increase in target for urban ASHAs under NUHM, with an addition of 238, 504 and 1576 ASHAs respectively. Progress in selection of urban ASHAs has also been slow in the non-high focus states, as only Delhi, Kerala and Punjab have added new ASHAs. West Bengal is yet to resolve the issue of conversion of link workers to ASHAs which has stalled the process of ASHA selection since the launch of the NUHM.

The overall trend of downward revisions and corrections conveys an impression that in a number of states, adequacy of targets and population coverage are being assessed, at least at the macro levels. This, together with anecdotal evidence from the ground and observations made in various field

reviews and monitoring reports, suggests that a comprehensive assessment of adequacy of population coverage needs to be done with respect to every ASHA's village / designated coverage area, as well as for block and district level, to identify any left out hamlets or community pockets.

However, the unfinished task of ASHA selection, remains a challenge. About half of the selection gap (48540), is in the eight high focus states against the total gap in 35 states / UTs (90035). The States of UP, Rajasthan and Bihar, have the highest gaps (20,004, 10737 and 8,300 respectively). About an equal number of ASHA positions (41227) remains unfilled in Non High Focus States (spread over 13 states, with highest being in West Bengal at 13804, with Maharashtra, Karnataka, and Kerala at 6818, 6517 and 4925 respectively). Reports from field assessments indicate that these gaps are likely where there is a higher percentage of tribal or scheduled caste population or in geographically dispersed areas. In non-high focus states, part of the gap can be correlated to the insistence that candidates meet higher educational qualification, which is a deterrent in remote areas and among marginalized communities.

Population Density

Seven states report greater than 1000 average population covered by each ASHA (Bihar, Rajasthan, UP, Karnataka, Maharashtra, Punjab, West Bengal), The average population covered is highest in West Bengal, at 1317, with Karnataka being the second at 1147. Among the high focus states, the average population covered remains marginally above 1000 in the bigger states of Bihar, Rajasthan and UP i.e, 1081, 1091 and 1108 respectively. These states together, account for about 2.79 Lakh ASHAs, which is about 33% of the national total, and also have a higher load of beneficiaries for Reproductive and Child Health Services.

Among the high focus states, Chhattisgarh, with its ASHAs positioned at the habitation level, remains at a density of 298, the second lowest density nationally. States of Jharkhand, Uttarakhand and Odisha also have low density among high focus states with a density of 636, 725 and 810 respectively.

In the North East, five states have a density of below 500. Arunachal Pradesh has the lowest density nationally, at 276 while four other states have a density of below 500 (Manipur-448, Meghalaya-369, Mizoram-482 & Tripura-368). Among the non-high focus states, Kerala and J&K, are the only states with low density at 672 and 777 respectively.

Though data for population density at state level appears to be within the population norms, findings from various reviews and field visits have highlighted gaps at district and block levels, which is often missed at state level at the time of aggregation. The shortfall of ASHAs or failure to select ASHAs has consistently remained higher in districts and blocks with difficult geographies or higher proportion of marginalized population. It is now a decade since the launch of ASHA programme and gaps in selection in difficult areas, where ASHAs can play a critical role in improving access to care and enable reaching the unreached are unacceptable. States need to undertake assessments at block levels to map left out areas where ASHAs are yet to be selected or areas where ASHAs have been given charge of adjacent villages and carry out special drives to complete ASHA selection in these areas.

Status of Training

The overall national picture in ASHA training, reflects substantial achievements in training rounds in the last 6 months. However this national picture masks the minimal progress in conduct of trainings in a number of states, despite the fact that financial resources were available to conduct these trainings.

At the national level, three batches of Round Three Training of Trainers were conducted in last six months for states of Jammu and Kashmir, Rajasthan, Haryana, Andhra Pradesh and Karnataka. One batch of Round Two Training of Trainers has also been conducted for Uttar Pradesh, the state, which has the largest training load, and still has substantial ground to cover. A six day refresher training was conducted for state trainers of Himachal Pradesh who were trained in FY 2012-13 in two rounds of TOT of Module 6 & 7, to expedite the process of rolling out training of district trainers and ASHAs in the state. With this, training of state trainers, up to Round 3 have been completed for most states.

Significant progress is reflected in this update, for Round 4 training of Module 6 & 7, which has increased to 31 % from the figure of 11% over last six months.

In this update we also present the progress of Induction training for newly selected ASHA. The Induction training module for ASHA was introduced in 2013, to train newly inducted ASHAs, by clubbing and reorganizing the content of Modules 1 to 4 and Module 5. These new ASHA are additions due to expansion of the programme or replacements for drop-out ASHAs. About 18 states have reported training of ASHAs in Induction module. These include the states of Madhya Pradesh (2713), Rajasthan (4660), Uttar Pradesh (10323), Uttarakhand (1059), Assam (916), Arunachal Pradesh (233), Mizoram (104), Nagaland (1296), Sikkim (23), Telangana (2088), Gujarat (12705), J &K (2400), Karnataka (3614), Kerala (863), Maharashtra (4290), Punjab (1909), West Bengal (7491) and Himachal Pradesh (7461). One of the challenges faced by states is the small number of newly selected ASHAs, spread across the districts, which makes it difficult to create a batch at block level. Organization of district or divisional level training is also difficult due to budgetary constraints. However, over this period, training up to Module 5 has made very little progress, which has moved from 85% to 90%.

Progress in the four rounds of Module 6 & 7 training across the states shows, that the North East states, which have been the front-runners in completing the training rounds from the very beginning, have retained their lead. 95% of ASHA have completed Round 3 and 60% have completed Round 4. Some slowdown in the pace of training can be noticed nationally in comparison with the period ending in June 2015.

The eight High Focus states, together, have also covered substantial ground in the last six months, and have progressed from 72% to 84% in Round 1, and from 58% to 78% in Round 2. Round 3 training has been conducted for 53% ASHAs (moving up from 35%). Overall achievement for Round 4 in High Focus states stands at 20% against 2% reported in last update, when it had barely started. Among the High focus states, substantial progress is noted in Rajasthan where during the last six months, training in Round 2 has progressed from 66% to 85%, Round 3 training from 4% to 48%, and Round 4 training has also begun. The three states of Jharkhand, Odisha and Uttarakhand, which had already trained over 90% ASHAs in Rounds 1 to 3 training, have started training in Round 4, but have made very little progress. Of these states, only Odisha has completed 22% training in Round4 (as compared to 11% in July 2015) while Jharkhand has completed only 3%. No progress has been reported from Uttarakhand as Round 4 training figures remain static at 52%, indicating a plateau in the programme. Of the three larger states significant progress is noted in UP, where training in Round 2 increased by 22%. However, despite an accelerated pace the state of UP is yet to complete training in Rounds 1 and 2 and begin training of Round 3. Though the remaining two states of Bihar and MP, have made some progress in initiating training in Round 4, overall training progress has remained slow.

In the North Eastern states, most states have already completed training of over 90% ASHAs in Rounds 1 to 3 except Nagaland where only 74% ASHAs have been trained in Round 1 and 2 and 86% in Round 3. North Eastern states were the first states to initiate the Round 4 training of ASHAs and the training in the states of Manipur, Mizoram, Sikkim and Tripura is near completion. In the remaining states, substantial progress has been reported v.i.z, Arunachal Pradesh has completed training of 67% ASHAs in Round 4 (as compared to 31%) while Assam, Meghalaya and Nagaland which initiated Round 4 training, have achieved about 40%, 65% and 84% training respectively. However, training status in Nagaland shows that over 80% ASHAs have completed training in Round 4 and 86% in Round 3 while only 74% ASHAs have been trained in the preceding Rounds 1 and 2. This finding is validated by various reviews and field visits that newly selected ASHAs are directly trained in the ongoing rounds of training rather than following the sequence of Induction and round wise training in Module 6 & 7.

The data for Non High Focus states, reflects very little progress in training in last six months. Round 1 has increased from 92% to 94%, and Round 2 from 77% to 81%. Round 3 coverage is 47% against the figure of 52% reported earlier. This is on account of correction made by AP in Round 3 trained ASHAs (revised figures from 29851 to 4115). Round 4 coverage has improved only marginally and now stands at 25%, moving from 23%. Punjab and Karnataka are the only two states

which have reported over 90% training of ASHAs in all four rounds while Gujarat has completed over 80% of Round 4 trainings. Though the figures show nearly 90% completion in Rounds 1 -3 training, most states have made very little progress in training. These include the states of Andhra Pradesh, Gujarat, Haryana, Himachal Pradesh, Maharashtra, Tamilnadu and West Bengal which have reported only up to 5% increase in training figures. In contrast, J &K appears to be the only state which has shown some momentum in the training as Round 1 and 2 training has increased from 68% to 92%.

Not all states have opted for the four modular rounds of training for Module 6 &7. Kerala has trained its ASHAs in only one round of 4 days training. Tamilnadu is training only its tribal area ASHAs (1657) in four rounds of Module 6&7, and has achieved about 27% to 22% coverage in four rounds. Himachal Pradesh, the new entrant to the ASHA programme, has trained all ASHAs, in the induction training but training of module 6&7 is yet to begin. Training progress in the group of UTs reflects almost no change.

TRAINING STATUS – 3.1

State / UT	No. of ASHAs selected / working	Up to Module 5		Round 1 of Module 6 & 7		Round 2 of Module 6 & 7		Round 3 of Module 6 & 7		Round 4 of Module 6 & 7	
		No.	%	No.	%	No.	%	No.	%	No.	%
High Focus States											
Bihar	85387	78336	92	78336	92	67725	79	55818	65	7148	8
Chhattisgarh	65713	54985	84	54100	82	57701	88	58152	88	62155	95
Jharkhand*	39380	40964	104	37045	94	37271	95	36683	93	1203	3
Madhya Pradesh	58333	42098	72	55576	95	49619	85	33829	58	6855	12
Odisha*	43154	43370	101	42485	98	42415	98	42597	99	9382	22
Rajasthan*	44178	42133	95	44476	101	37585	85	21417	48	4068	9
Uttar Pradesh	140171	121640	87	86264	62	76997	55		0	0	0
Uttarakhand*	9702	8978	93	10313	106	10064	104	10209	105	5032	52
Sub Total	**486018**	**432504**	**89**	**408595**	**84**	**379377**	**78**	**258705**	**53**	**95843**	**20**
North Eastern States											
Arunachal Pradesh	3867	3635	94	3669	95	3424	89	3424	89	2573	67
Assam	30619	28422	93	29560	97	29257	96	28886	94	12308	40
Manipur	3878	3817	98	3804	98	3804	98	3804	98	3756	97
Meghalaya	6429	5588	87	5891	92	5873	91	5831	91	4183	65
Mizoram	1091	987	90	987	90	987	90	987	90	987	90
Nagaland	1887	1296	69	1398	74	1397	74	1624	86	1593	84
Sikkim*	641	666	103.9	666	103.9	666	103.9	666	103.9	666	103.9
Tripura*	6765	7367	108.9	7257	107.2	7009	103.6	7280	107.6	7061	104.4
Sub Total	**55177**	**51778**	**93.8**	**53232**	**96.5**	**52417**	**94.9**	**52502**	**95**	**33126**	**60**
Non high Focus States											
Andhra Pradesh	37994	31867	84	35754	94	31219	82	4115	11		0
Gujarat	35404	27587	78	33798	95	33009	93	31175	88	29046	82
Haryana	16956	11112	66	16151	95	15674	92		0		0
Himachal Pradesh *	6447	7461	115		0		0		0		0

State / UT	No. of ASHAs selected / working	Up to Module 5		Round 1 of Module 6 & 7		Round 2 of Module 6 & 7		Round 3 of Module 6 & 7		Round 4 of Module 6 & 7	
		No.	%	No.	%	No.	%	No.	%	No.	%
Jammu and Kashmir	11721	11253	96	10792	92	10792	92	54	0		0
Karnataka*	32678	29916	92	29651	91	29651	91	29543	90	29543	90
Kerala *	26002	29022	112	26684	103		0		0		0
Maharashtra *	54337	52247	96	55690	102	47907	88	23661	44		0
Punjab	16972	16403	97	16243	96	16243	96	16416	97	16324	96
Tamil Nadu	6204	5513	89	1657	27	1657	27	1571	25	1343	22
Telangana *	23391	25818	110	23877	102	21385	91		0		0
West Bengal *	47204	37577	80	47622	101	46886	99	42900	91	2152	5
Sub Total	**315310**	**278315**	**88**	**297919**	**94**	**254423**	**81**	**149435**	**47**	**78408**	**25**
Union Territories											
Andaman & Nicobar	407	407	100	272	67	272	67		0		0
Dadra and Nagar Haveli	208	87	42	68	33	45	22		0		0
Daman & Diu	79	69	87	55	70		0		0		0
Lakshadweep	110		0		0		0		0		0
Sub Total	**804**	**563**	**70**	**395**	**49**	**317**	**39**		**0**		**0**
Total All India	**857309**	**770621**	**90**	**760086**	**89**	**686534**	**80**	**460642**	**54**	**207377**	**24**

**Mismatch between number of ASHAs trained and selected in some rounds is noted on account of drop out of ASHAs being trained or shifting of selection figures under NUHM*

Table 3.1 Status of ASHA Support Structure

Table 3.1 a: High Focus States

Name of State	State Level	District Level	Block Level	Sector Level
Bihar	State AMG constituted in July 2011, only one meeting held in Feb 2011. Five members team of ARC and 9/12 Divisional ASHA Coordinators in place. State trainers – Round 1 – 28, Round 2 – 22. Round 3 – 13.	13/ 38 DCMs in place District Trainers – Round 1 -803, Round 2 – 532, Round 3- 190	280/534 BCMs in place	4091/4470 ASHA Facilitators in place (one per 20 ASHA)
Chhattisgarh	AMG not established. ARC is working under SHRC with a six member team State trainers– 46	35 District Coordinators in place in 27 districts (2/ district in some outreach districts) District trainers – 3551	292/292 Block Mobilisers in place	3154/3220 Mitanin trainers in place (One per 20 ASHAs)
Jharkhand	State AMG constituted in 2012 and reconstituted in 2013, 7 meetings held, last meeting held in April 2015. Community Mobilisation Cell set up as a separate cell within the SPMU with a team of three consultants. State trainers – Round 1 – 13, Round 2 – 13. Round 3 – 12.	21/24 District Programme Coordinators in place. District Trainers - Round 1 -417, Round 2 – 474 , Round 3-185	778 /844 Block Trainers & DRPs in place	2184/2184 Sahiyaa Saathi in place (One per 20 Sahiyas

Name of State	State Level	District Level	Block Level	Sector Level
Madhya Pradesh	State AMG formed in Oct 2008, now merged with MGCA. Last meeting in Oct 2015. ARC team led by State Nodal officer with 4 team members. State trainers– Round 1 – 41, Round 2 – 39. Round 3 – 27.	36/51 District Community Mobilizers in place MGCAs formed & involved in ASHA training monitoring. District Trainers - Round 1 - 496, Round 2 – 300, Round 3- 300	258 /313 Block Community Mobilizers in place 313 Block MGCAs in place.	3846/3991 ASHA Facilitators in place (One per 20 ASHAs and one per 10 ASHAs in tribal areas)
Odisha	State AMG constituted in 2009, total 4 meetings held, last in 2012, Community Processes Resource Centre (CPRC) in place with a team 6 consultants. State trainers– Round 1 – 26, Round 2 – 21. Round 3 – 11.	29 /30 District Community Mobilizers in place. District AMGs constituted. District Trainers - Round 1 - 287, Round 2 – 166, Round 3- 166	Existing block PMU staff manages the programme	1494/1672 Community Facilitators (AFs) in place (One per 30 ASHAs)
Rajasthan	State AMG constituted in June 2006, last meeting held in Sep 2011 Team of two consultants working in SPMU. SIHFW extending support for rolling out ASHA Training. State trainers – Round 1 – 20, Round 2 – 25, Round 3- 23	26/34 District Community Mobilizers in place. District Trainers - Round 1 - 640, Round 2- 640 , Round 3- 570	164/249 Block ASHA Coordinators in place.	966/ 1528 PHC ASHA Supervisors in place (One per PHC)
Uttar Pradesh	State AMG constituted in Aug 2008, last meeting held in Dec 2015. Community Processes Division led by a Nodal officer works within SPMU, with a team of 10 Consultants. State trainers– Round 1 – 59, Round 2 - 44	72 /75 District Community Processes Managers in place 72 Districts have District AMGs. District Trainers - Round 1 – 2622.	724 / 820 Block Community Mobilizers in place	5376/6815 ASHA Facilitators in place (One per 20 ASHAs)
Uttarakhand	AMG constituted in 2009, total 21 meetings held, last meeting in May 2015. State has one Nodal Officer in SPMU, and two regional coordinators. State trainers– Round 1 – 6, Round 2 – 5. Round 3 - 5.	District ASHA Resource Centres (DARC) outsourced to NGOs. 13/13 District Community Mobilizers in place District Trainers - Round 1 - 165, Round 2 – 156, Round 3- 75	101/100 Block Community Mobilizers (6 in urban areas) in place	600/606 ASHA Facilitators in place (550 rural, 56 urban – One per 15-20 ASHAs)

Table 3.1 b: North East States

Name of State	State Level	District Level	Block Level	Sector Level
Arunachal Pradesh	State AMG constituted in Jan 2010, total meetings held – 9, last meeting held in Aug 2014. ARC housed in SPMU with a three members team. State trainers– Round 1 – 3, Round 2 – 2. Round 3 - 3.	18 /20 District Community Mobilizers in place. District Trainers - Round 1 - 22, Round 2 – 28, Round 3- 28	84/84 Block Community Mobilizers in place	348/348 ASHA Facilitators in place. (One per 10 ASHAs)

Name of State	State Level	District Level	Block Level	Sector Level
Assam	State AMG constituted, total meetings held – 8. Next meeting planned in Jan 2016. ARC housed in SPMU with a three members team State trainers - Round 1 - 17, Round 2 - 12. Round 3 - 7.	27/27 District Community Mobilizers in place District Trainers - Round 1 - 447, Round 2 – 447, Round 3- 437	149 / 149 Block Community Mobilizers in place	2878 / 2878 ASHA Facilitators in place (One for 10 ASHAs),
Manipur	State AMG constituted in Dec 2008, total meetings held – 11, last meeting held in May 2014. ARC housed within SPMU with one ASHA Program Manager. State trainers - Round 1 - 3, Round 2 - 3. Round 3 - 3.	9/9 District Community Mobilizers in place District Trainers - Round 1 - 62, Round 2 – 60, Round 3- 58	Existing BPMU staff	194/194 ASHA Facilitators in place (One for 20 ASHAs).
Meghalaya	AMG formed in Oct 2009. Reconstituted recently, 1st meeting after reconstitution held in Sep 2014. ARC housed in SPMU with two members team. State trainers - Round 1 - 3, Round 2 - 3. Round 3 – 2.	11/11 DCPC (District Community Process Coordinator) in place District Trainers - Round 1 - 70, Round 2 – 65, Round 3- 65	Existing BPMU staff	312/334 ASHA Facilitators in place (One for 15-20 ASHAs)
Mizoram	State AMG constituted in April 2008, total meetings held – 9, last meeting held in Sep 2015. ARC team within SPMU. State trainers - Round 1 - 3, Round 2 - 2. Round 3 – 3	9/9 District ASHA Coordinators in place. District Trainers - Round 1 - 18, Round 2 -18, Round 3- 18	No system of Block unit for program management or ASHA support	109/109 ASHA Facilitators in place,
Nagaland	AMG formed in Nov 2009, 5 meetings held, last meeting Aug 2013. ARC housed under SPMU. State trainers - Round 1 - 1, Round 2 - 2. Round 2 - 2.	11/11 District Community Mobilizers in District Trainers - Round 1 - 63, Round 2 – 63, Round 3- 63	68 /77 Block ASHA Coordinators (BACs) in place,	No ASHA Facilitators. Block ASHA Coordinators provide field level support
Sikkim	State AMG constituted in 2007, total meetings held - 2, last meeting held in Nov 2014. Programme managed by one designated State ASHA Nodal Officer State trainers - Round 1 - 2, Round 2 - 3. Round 3 – 4.	Existing staff of DPMU looks after ASHA programme. District Trainers - Round 1 - 23, Round 2 -23, Round 3- 13	Existing Staff of BPMU	71/71 ASHA Facilitators in place (One per 10 ASHAs)
Tripura	State AMG constituted in May 2008, total meetings held - 8, last meeting held in Nov 2013. ARC constituted (1 state ASHA Programme Manager). State trainers - Round 1 - 2, Round 2 - 5. Round 3 - 4.	8/8 District ASHA Coordinators in place (4 DCMs in original 4 districts and 4 Sub Divisional Coordinators acting as DCM in newly formed district). District Trainers - Round 1 – 65. Round 2 -65, Round 3- 65	8 /11 Sub-division level ASHA Coordinators in place	398/400 ASHA Facilitators in place

Table 3.1 c: Non- High Focus states

Name of State	State Level	District Level	Block Level	Sector Level
Andhra Pradesh	AMG constituted in May 2015. Functions of ARC are managed by a small team based in SPMU State trainers trained and qualified- Round 1 - 9, Round 2 – 9 and Round 3-11 .	6/11 District Community Mobilizers are in place. Project Officer, District Training Team (P.O.DTT) and District Public Health Nursing Officer (DPHNO) involved. District Trainers – Round 1 – 285, Round 2 - 285	225/225 PHNs are nominated as BCMs.	ANM & Health Supervisors at PHC level involved in ASHA support. 1 per PHC, MPHS (F) & Senior ANMs are nominated as ASHA Facilitator. (one per 30 ASHAs)
Delhi	State AMG formed in July 2010, total meetings held 6, last meeting held in Jan 2015 ARC in place; with one State INodal Officer, two State ASHA Coordinators, two Data Assistants and one Account Assistant. State trainers Round 1 and Round 2 – 29, Round 3 - 59.	9 /11 District ASHA Coordinators in place District Mentoring Group constituted in all districts District Trainers – 363.	1005 /1123 ANMs acting as ASHA mentors in place 113 ASHA Units (One unit per 50,000 population.) in place. Each unit has Unit Mentoring Group composed of 04-5 members, which includes MOIC, PHN, NGO representatives and 5 ANMs as facilitators.	
Gujarat	State AMG Constituted in Aug 2011, total meetings held – 5, last meeting in March 2015 ARC established under the office of Rural Health Department under Commissionerate of Health Office. State trainers - Round 1 - 9, Round 2 - 9. Round 3 - 3.	Existing staff manages the programme with support from dedicated Data Assistants in all districts 24 Districts have constituted AMG. District Trainers – Round 1 and 2- 160.	Existing staff	3405/3751 ASHA Facilitators in place (one for 10 to 20 ASHAs)
Haryana	AMG not constituted ARC in place within the SPMU with 10 member team. State trainers - Round 1 - 20, Round 2 – 17, Round 3- 14-	21 /21 District ASHA Coordinators in place District Trainers – Round 1 – 438, Round 2 - 438	198 /115 Block ASHA Coordinators in place	Existing staff – 610/1084 ASHA Facilitators were selected for a period of six months
Himachal Pradesh	State has started ASHA programme in FY 2014-15. One ASHA Nodal Officer within SPMU. State trainers - Round 1 - 36, Round 2 - 23.	Existing staff	Existing staff	Existing staff
Jammu & Kashmir	State AMG established in 2012-13. In Feb 2015, 2 members of national AMG co-opted in SAMG in Feb 2015. 1 ASHA Nodal Officer and 1 state ASHA Coordinator in place, within SPMU. State trainers - Round 1 - 15, Round 2 – 12 and Round 3- 9	Existing staff. District Trainers – Round 1- 225 , Round 2 -190	Existing staff	808/816 ANMs play the role of ASHA Facilitators
Karnataka	State AMG constituted in Oct 2012, last meeting held in June 2013. One ASHA Nodal Officer based in the Health Directorate Deputy Director for ASHA Training based within SIHFW. State trainers - Round 1 - 15, Round 2 - 10. Round 3 – 8	30 /30 District ASHA Mentors in place. District Trainers – Round 1- 240, Round 2- 203	176/176 Block ASHA Mobilisers in place One District Trainer also called as ASHA Mentor supervises ASHAs of two blocks	1588/1960 ASHA Facilitators in place.

Name of State	State Level	District Level	Block Level	Sector Level
Kerala	State AMG constituted in 2008, total meetings held – 6, last meetings in held Dec 2014 State ASHA Team with one Nodal Officer and consultant based within SPMU. State trainers – 6.	14 /14 District ASHA Coordinators in place. District Trainers – 36.	Existing staff	Existing staff
Maharashtra	State AMG constituted in Oct 2007, total meetings held – 1, last meeting held in July, 2013 One Nodal Officer-ASHA and one consultant work as ARC team based within SPMU. State trainers - Round 1 - 15, Round 2 – 13, Round 3- 13	30/30 District Community Mobilizers in place. District AMG formed in all districts. District Trainers– Round 1-1476 Round 2- 1404	339/355 Block Community Mobilizers in place Block AMG formed in 70 tribal blocks and in 281 Non-tribal blocks	2717 /2880 ASHA Facilitators in place. (One for 10 ASHAs in tribal districts & at PHC level in non- Tribal districts).
Punjab	State AMG constituted in Oct 2014. ARC not established, team of two consultants working in SPMU. State trainers - Round 1 - 5, Round 2 - 7. Round 3 - 6.	13 /22 District Community Mobilizers in place District Trainers – Round 1-326, Round 2- 311 and Round 3- 305	Existing Staff (BEE- Block Extension Educator working as BCM in many places)	857/898 ASHA Facilitators in place.
Tamil Nadu	State AMG not formed, but NGOs are involved in ASHA support Institute of Public Health, Poonamallee is working as ARC	Existing staff (DPMU & Deputy Director of Health Services and District and Maternal and Child Health Officers (DMCHO)	Existing staff (Community Health Nurse)	Existing staff (Sector Health Nurse)
Telangana	State ASHA Resource Centre and AMG to be constituted. State trainers – Round 1-4, Round 2 -4	Recruitment Process of 10 District Community Mobilizers is underway. District Trainers - Round 1-285, Round 2- 190	Existing staff of BPMU work as BCMs	Existing MPHS-female support ASHAs
West Bengal	State AMG formed in Sep 2010, total 4 meetings held, last meeting held in Dec 2011. ASHA training managed by Child In Need Institute State trainers - Round 1 - 22, Round 2 - 18. Round 3 – 13	18/26 District Community Mobilizers in place. District Trainers – Round 1-1377, Round 2- 1016, Round 3- 82.	Existing staff supports, Recruitment for Block Community Mobilizers in process (209/666 selected - 2 per block).	Existing staff (Health Supervisor posted at Gram Panchayat level)

Table 3.1 d: Union Territories

UTs	State Level	District Level	Block Level	Sector Level
Andaman & Nicobar Island	ASHA programme is managed by SPMU team	Existing staff	Existing staff	Existing staff
Chandigarh	UT has started ASHA programme in FY 2014-15. ASHA programme managed by one designated nodal officer.	Existing staff	Existing staff	Existing staff
Dadra and Nagar Haveli	ASHA programme is managed by SPMU team	Existing staff	Existing staff	Existing staff
Lakshadweep	ASHA Programe is managed by Medical officer in-charge of Island	Existing staff	Existing staff	Existing staff
Daman and Diu	ASHA programme is managed by SPMU team	Existing staff	Existing staff	Existing staff

A Community Processes Resource Centre (CPRC) (also known as ASHA Resource Centre) is expected to lead and support the programme, at the state level, led by a team leader, with a team of Programme Managers and consultants for different components of ASHA and VHSNC Programmes. State ASHA Mentoring Group, consisting of NGO representatives, academicians, training institutions and research organizations, is to provide policy guidance and programmatic oversight.

At the district level, the District Nodal Officer and District Community Mobiliser together are expected to lead and support the programme, while the Block Community Mobiliser, under the oversight of Block Medical Officer, has to support at the block level. Support and hand-holding to ASHAs on the ground is to be provided by ASHA facilitators, placed at cluster level (one ASHA Facilitator for 10 to 20 ASHAs). These support structures at all levels will support both ASHA programme, VHSNC interventions, as well as all other community processes components.

Across the states, process of completing recruitments for ASHA support structures or establishing dedicated ASHA support cadres has not seen any major additions during this period. This is partly because, states which had planned to put in place dedicated support cadre have already completed the process.. However some states have undertaken training and orientation of the support staff. There are reports from many states on conducting regular reviews of ASHA programme at the state level, and also ensuring review meetings in the districts.

It needs no repetition that effectiveness of the programme rests on a robust support structure, with preferably a dedicated support cadre. States which now have lower load of RCH services, may actually be able to use the existing health system staff for ASHA support cadre roles, and some states, particularly from among the Non High Focus states, are actually doing it successfully, (like J&K and Delhi). But states with high fertility rates and high IMR and MMR (almost all of High Focus states fall under this group), face much more complex and demanding roles for ASHA support structures.

Among the high focus states, there is no new addition to the support structures and cadres in place. **Odisha** is the only state which has a support cadre at state, district and cluster level, but not at block level. All other seven states have a dedicated support cadre at all four levels. **Chhattisgarh,** with its seasoned support structure, has 100% support cadre in position against the target, at state, district and block levels. At the district level, it has 35 District Coordinators against 27 districts (putting in place 2 coordinators in a few outreach districts). Bihar has seen further depletion of district and block level coordinators, reducing DCMs from 14 to 13 (against target of 38), and block coordinators from 283 to 280 (against target of 534). It has also revised its target of ASHA Facilitators from 4964 to 4470, (in line with the reduced target of number of ASHAs), but the number of AFs in position has increased from 4068 to 4091. Jharkhand reflects only minor change in its support cadre, with number of AFs increasing from 2175 to 2184 (against the target of 2184).

Madhya Pradesh has continued adding to its support cadre. Though it has raised only marginally, the number of DCMs from 31 to 36 (against target of 51), and BCMs from 241 to 258 (against target of 313), it has made substantive additions to AFs, raising their number from 3480 to 3846 (against target of 3991). **Rajasthan** has also added some numbers to its DCMs (raised 24 to 26 against the target of 34), and BCMs (raised from 100 to 164 against the target of 249), but there is some decrease in its ASHA supervisors (down from 1076 to 966). In **Uttar Pradesh**, selection of Block Community Mobilizers is underway and so far 724 BCMs have been selected against the target of 820. However, attrition is noted for ASHA Facilitators as the number reduced from 5412 to 5376.

Four out of eight North East States (Manipur, Meghalaya, Mizoram and Sikkim) do not have a dedicated support cadre at block level. All Northeast states except Nagaland, have ASHA Facilitators in position, and District ASHA Coordinators are in place in all states except, Sikkim. Sikkim has a dedicated support cadre, at state and cluster level, with 71 AFs in place at cluster level. Almost all NE states continue to have close to 100% positions under ASHA support structure filled up. State Trainers from all NE states have been trained up to round 3 TOT of Module 6 & 7 training.

Among the Non High Focus states, Haryana, Karnataka and Maharashtra are the only three states with a dedicated support structure at all four levels, among the Non High Focus states. Punjab has a dedicated support cadre at all three levels, except at the block level. At block level it uses regular cadre Block Extension Officers (BEEs), Gujarat, has a dedicated support cadre in place at only state and sub-block levels and has added few AFs, having now 3405 AFs against the target of 3751. At block and district levels, existing health department cadre continues to play support roles. Existing staff supports the programme, though their involvement and effective support provided by them to ASHA and VHSNC programme varies greatly across states. Jammu and Kashmir is using the existing cadre (ANMs and MPWs) for support in the field level as AFs, but it is strengthening its regular review systems to enable the cadre to play an effective support role. Delhi now has District ASHA Coordinators in place (9/11 in place), and continues to use existing ANMs in urban health centres as ASHA mentors, (1005 mentors in place against target 1123).

ASHA Certification Process Update

The ASHA certification was conceptualized with the key objectives of –

- Providing a legal and administrative framework within which the ASHA is eligible and responsible for providing care through drugs and supplies for a range of illnesses.
- Enhancing competency and professional credibility of ASHAs.
- Improving the quality of training and ensure desired programme outcomes.
- Providing assurance to the community on the quality of services being provided by the ASHA.
- Promoting a sense of self recognition and worth

The four programme components that would be certified are - (i) Training curriculum, (ii) Training Sites, (iii) Trainers and (iv) ASHAs and ASHA Facilitators.

The first step towards this was signing of tripartite Memorandum of Understanding between National School of Open Schooling (NIOS), Ministry of Health and Family Welfare and National Health System Resource System in July 2014. As part of the MOU, the MoHFW provides overall policy and funding support to the process, NHSRC is responsible for overall technical oversight and NIOS is the certificate issuing authority for Trainers, Training Sites and ASHAs.

A Project Steering Committee has been constituted as an apex advisory body for certification process, under the chairmanship of the Joint Secretary (Policy). As per committee's recommendation, two technical committees were constituted to guide the process of curriculum standardization and development of accreditation guidelines.

a. Technical Advisory Committee for curriculum standardization

b. Accreditation Guidelines Committee for developing guidelines for accreditation of trainers and sites.

The composition of both committees was approved by the Project Steering committee which includes public health professionals experienced in community health, curriculum development experts, members of the nursing fraternity, communication experts and representatives of the Skills Development Council.

Based on the recommendations of TAC, a supplementary guide has been developed to aide ASHAs in preparation for certification. The guide covers all essential competencies (i.e, content of Modules 1-5 or Induction Module, Modules 6 and 7, Reaching the Unreached and Mobilizing for Action on Violence Against Women), as approved by the Project Steering Committee. It comprises of a series of worksheets with objective questions, problem solving exercise, focusing on an analysis of field issues and ASHA's ability to identify the corrective action. The guidelines for accreditation of trainers and sites evaluation strategy for accreditation of trainers and sites developed by Accreditation Guidelines Committee, have been circulated to states.

While several states have proposed for certification of ASHAs in the State Programme Implementation Plans of Financial 2014-15 and 2015-16, based on the readiness of the states, assessed on the levels of completion of training of ASHAs in Rounds 1-4 of Module 6 & 7, about twelve states will initiate the process of ASHA certification in the first phase. These are – Arunachal Pradesh, Assam, Chhattisgarh, Delhi, Gujarat, Jharkhand, Karnataka, Punjab, Sikkim, Tripura, Uttrakhand, West Bengal. It is expected that the first batch of ASHAs would register in July 16, and appear for the examination in January, 2016. During the time of six months between registration and examination, ASHAs would receive two rounds of refresher training in the supplementary guide.

The first step in the implementation of certification was the creation of National Resource Team (NRT) to support the refresher training and certification of state / district trainers, accreditation of state/ district training sites and also facilitate certification of ASHAs and ASHA facilitators. About 27 state trainers were identified based on their performance in the earlier three rounds of Training of Trainers of Module 6 & 7 and participated in five days orientation and refresher training workshop in October, 2015.

The next steps at state level include certification of state trainers and accreditation of state training sites from the above mentioned twelve states. This will be followed by translation of supplementary guide in regional languages, certification of district trainers and sites, refresher training of ASHAs and eventually certification of ASHAs in these states. Simultaneously, the number of states and number of ASHAs covered, will increase based on progress of ASHA training across states.

Section 3:

Key Findings of Ninth Common Review Mission

This section reports on key findings from the Ninth Common Review Mission (CRM), undertaken in 18 states (Andhra Pradesh, Assam, Chhattisgarh, Delhi, Haryana, Himachal Pradesh, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Manipur, Meghalaya, Odisha, Punjab, Rajasthan, Uttar Pradesh, Uttarakhand, and West Bengal), between 30th October to 6th November, 2015. Key findings and recommendations regarding Community Processes of the CRM are as follows -

ASHA

- Of the three North Eastern states (Assam, Manipur and Meghalaya) and the eight high focus states (Chhattisgarh, Jharkhand, MP, Odisha, Punjab, Rajasthan, UP and UK), visited Chhattisgarh and Jharkhand have had the ASHA programme in place before the launch of the National Rural Health Mission (and now the National Health Mission- NHM) in 2005. Seven of the eight non-high focus states (AP, Delhi, Haryana, Karnataka, Maharashtra, Punjab and West Bengal) have had an ASHA programme since 2009, except for the state of Himachal Pradesh which has begun selection and training of ASHA only two years ago.

- The findings from across the states are mixed, which is not unexpected in a programme of this scale and given the size and diversity of the country. Overall there is an emerging picture of a mature programme with established systems for some components. All reports indicate an increasing ownership of the ASHA by the health system. The role of the ASHA as a facilitator continues to be dominant as noted in previous CRM reports. Increasing home visits by ASHAs are reported. In Punjab, the report states that the ASHA "has acquired visibility and stature". In several states increases in outpatient cases, immunization coverage and institutional deliveries are being attributed to the ASHA. The reports of the ninth CRM emphasize the increasing reach of the ASHA to vulnerable households from Uttar Pradesh, Punjab, Maharashtra, and Assam. Some state reports however, caution that the ASHAs community moorings appear to have become tenuous, indicating that the village level platforms such as the VHSNC and MAS need strengthening, that inter-sectoral convergence needs to be stronger, and that the role of the ASHA as a mobilizer needs to be better emphasized.

- **ASHA Selection:** In terms of ASHA selection, except for four states - West Bengal, Karnataka, Delhi and Uttar Pradesh, selection is over 95%. Yet there are inter district discrepancies, particularly in the high priority districts. In Koppal district of Karnataka, there is a vacancy of 34%. In the Char areas of Assam there is a shortage of 293 ASHA, apparently as a result of being disallowed in the PIP. In Manipur's Thoubal district a shortfall of 55 ASHA is reported, 11% in Nabrangpur, Odisha, and about 26% in Bikaner district in Rajasthan.

- Under the NUHM, except for Uttar Pradesh and West Bengal which have not yet begun selecting ASHAs, most other states are in the process of ASHA selection. Induction training for ASHAs has begun in seven states - Andhra Pradesh, Jharkhand,

Chhattisgarh, Madhya Pradesh, Meghalaya, Manipur and Punjab. About ten states- Andhra Pradesh, Chhattisgarh, Assam, Madhya Pradesh, Jharkhand, Rajasthan, Meghalaya, Manipur, Odisha and Punjab have constituted Mahila Arogya Samiti and of them Chhattisgarh, Odisha, MP, Jharkhand and Manipur have initiated training of Mahila Arogya Samitis.

- The key challenge is that states are yet to use and adapt the learning from NRHM to strengthen the role of the urban ASHA. A second issue is that the incentive amount for ASHA in urban areas, needs reconsideration, as there are anecdotal reports of difficulty in selecting ASHA or higher anticipated drop-outs owing to other available options. The third is the limited clarity about the role of Mahila Arogya Samiti in urban areas. Vulnerability Mapping has begun only in Odisha and Assam. In Karnataka and Maharashtra, the state is faced with the challenge of converting link workers into ASHAs as they are getting a fixed monthly remuneration.

- **Attrition Rate:** Annual attrition rate ranges from a low of 0.6 percent in Assam to nearly 11% in Punjab. Most of this attrition is on account of being elected as Panchayat representative, a testimony to her empowerment and credibility. Some reduced coverage and an increasing burden of work on existing ASHA, who is handed over charge for indefinite periods of the neighbouring village where there is an ASHA vacancy.

- **Training:** Training in Module 6 and 7 and induction modules for newly recruited ASHA are underway in the states. States are making steady progress in the training, although the pace is slow in some states- particularly UP, Haryana and Assam. In Sitapur District of Uttar Pradesh, ASHAs reported not having been trained for over three years and training has just been re-initiated. Two important causes across states appear to be - trainer attrition and lack of fund releases, although this is a problem at district and sub district level. This is an area of concern particularly since states are required to be readying for accreditation of training sites, trainer and ASHAs as part of certification by the National Institute of Open Schooling.

- In West Bengal and Odisha, the reports suggest a direct correlation between robust training systems and effective trainers to the knowledge levels among ASHAs. This has been facilitated in both states by a strong, full time support mechanism that has provided leadership and handholding support to the districts. Weak training systems and trainer attrition was reported from Meghalaya, Uttar Pradesh and Rajasthan, thus slowing down the process even further. In Delhi the report states that competing priorities of the state trainers (who are full time employees of the health department and service providers) delays the pace of training. The issue of non literate ASHA and the lack of appropriate training material as an impediment to training has been reported from Andhra Pradesh, Jharkhand, Madhya Pradesh, and is also corroborated by other field reports. Chhattisgarh appears to have overcome this issue by ensuring high quality ASHA facilitators who interact frequently with the Mitanin in the field and ensure that the requisite skills and knowledge are in place by reinforcement over a long period of time.

- **ASHA Functionality:** A high degree of functionality is reported on areas such as immunization, mobilizing mothers for antenatal care, and motivating them for institutional delivery. ASHAs are also active during the VHND as observed in Maharashtra and Uttar Pradesh. There is a gradual improvement in the diagnosis, referral and follow up of sick and Low Birth weight newborns, reported from Madhya Pradesh, Maharashtra and Delhi. In Maharashtra, progress has been made in the use of follow up cards for babies that are discharged from the SNCU. ASHAs also appeared to be cognizant of danger signs and make active referrals to SNCU. Knowledge levels were reported to be good in states with effective and stable training mechanism such as West Bengal and Odisha, and in the non high focus states such as Maharashtra, Andhra Pradeshand Delhi, where literacy levels of ASHA are higher. Reports from Jharkhand, Haryana, Assam, Rajasthan, Meghalaya, Manipur and Uttarakhand, point to limited skills of the ASHA that were met, especially in areas related to provision of new born care, nutrition counselling, ability to track

children with malnutrition and counselling on family planning.

- **Drug and Equipment Kit:** Another major area of concern that is evident from the reports across all 18 states is the lack of a consistent mechanism to refill the ASHAs drug kit or to replace broken components of the equipment kit. Any effort to discuss the effectiveness of the ASHA is rendered null by the lack of these two critical support mechanisms. This not only minimizes the effectiveness of the ASHA in tasks such as pregnancy diagnosis and early pregnancy registration, distribution of OCPs/Condoms, ORS, but also places the credibility of the ASHA at stake.

- **Support Structures:** The correlation between effective support structures to performance is significant. In UP, the report specifically mentions increase in pace, momentum and improved quality of training after the establishment of a state support structure. This is also the case in Odisha and Maharashtra. In Maharashtra, Odisha, and Chhattisgarh there are reports of state programme officers undertaking regular field visits. In Chhattisgarh, the presence of an effective support system at state and block and sub block levels suggest a high functionality of not just the ASHA but also VHSNC and PRI engagement. Most states have a support structure as specified in the guidelines and at most levels. The effectiveness of the support mechanism is hampered in Rajasthan, Madhya Pradesh, Meghalaya, Uttarakhand, Haryana, by one/all of the following factors: high number of vacancies, poor orientation/training, lack of mobility support, the allocation of the work of data entry to ASHA facilitators and Block Community Mobilizers for an increasing numbers of forms that the ASHAs are filling, and little handholding from the state level. The nature of support and mentoring provided to the ASHA is compromised on a poor understanding of support staff, (where they are in place) towards their tasks of ASHA and CP programme support. The consequence of lack of mentoring is visible in the field particularly related to home visits being made by the ASHA- which are not supervised for content, accuracy or completeness. In UP, the ASHA facilitator also serves as an ASHA further compromising her role of mentoring. Review meetings of district mobilizers or block mobilizers are not held regularly across most states, exceptions being Chhattisgarh, Odisha and Meghalaya.

- **Coordination at village/VHND/Sub centre level:** ASHA-ANM-AWW coordination is reported to be strong across states. The early tensions of the earlier years where there was lack of clarity on tasks, particularly incentive related tasks and claims over JSY and family planning entitlements seems to have abated. This has facilitated a platform for the coordinated action. As fertility levels decline, particularly in the non-high focus states, and as ASHA themselves have expressed, this is an opportune time to revisit the tasks of the ASHA in such contexts. The AAA platform seen in the state of Uttar Pradesh, as a form of convergence at the level of the sub centre has potential to serve as a site for coordinated service delivery, population enumeration and screening. The experience of the state of Punjab with engaging ASHA in screening for cancers and the role of the ASHA in measuring blood pressure and testing for blood glucose at the Gram Arogya Kendras in the state of Madhya Pradesh both demonstrate interest, enthusiasm and appear to address a community need, pointing to a role shift for ASHAs in these states. However skill based training is crucial for creating new tasks for ASHA.

- **Performance Monitoring:** Of the 18 states visited, thirteen states (MP, Delhi, Jharkhand, Manipur, Maharashtra, Meghalaya, Odisha, Punjab, Chhattisgarh, Assam, Karnataka, Haryana, Uttrakhand) are using the performance monitoring tool and developing mechanisms for identifying drop-out ASHAs. The tool however is also intended to support ASHA who are not able to perform on the ten key tasks that are the basis of the indicators. Reports indicate that this is not happening, and is linked to the limited awareness and time of support staff in doing so. We also have reports that non functional ASHA are removed, but the vacancies created are yet to be filled.

- **Payment:** The average payment received by ASHA ranges from Rs. 1200 in Himachal Pradesh to

Rs. 4500 in Uttar Pradesh. States such as Haryana, Karnataka, Meghalaya, Uttrakhand, West Bengal and Chhattisgarh also provide an additional honorarium from state funds. An area of concern is that despite opening of bank accounts and initiatives taken to streamline payments, delays are being reported across states. This is particularly true of programmes such as NLEP, NVBDCP and RNTCP. A notable exception is Odisha. In Rajasthan ASHAs reported that since the introduction of ASHA soft, the delays in payment have reduced considerably. Another emerging area of concern is that while approvals were obtained for a set of activities ranging from 23 in Rajasthan to 41 in Odisha, ASHA are not aware of the fact that incentives are associated with several tasks that they undertake. Engaging ASHA in campaigns with the promise of additional incentives and then not paying them needs to be flagged as a breach of trust to local implementers and policy makers alike. From Maharashtra there are reports of the ASHA being engaged by other line departments The routine and recurring monthly payments are being paid to the ASHA in only ten states - Assam, Himachal Pradesh, Jharkhand, Karnataka, Maharashtra, Odisha, Punjab, Rajasthan, Uttar Pradesh and Uttrakhand. In Himachal Pradesh, which has recently initiated the programme the state has demonstrated exemplary performance in ensuring that all ASHA payments had been made up to September 2015.

- Several states have instituted non-monetary incentives for the ASHA. These include: mobile phones, torches, bicycles, welfare measures, (social security, death compensation), but reports from Assam and Odisha, indicate that ASHA are not aware of such entitlements. They also have no avenue to complain about the fact that the equipment provided is in a state of disrepair. In Manipur ASHA have been provided with cycles, but several are not using it, and state has yet to review underlying reason and reconsider the policy. This is related to the nature of support and the level of monitoring and supportive supervision.

- **ASHA Gruha/Rest houses:** are not uniformly in place. We have reports of either complete absence or of poorly maintained rest houses, that are a barrier to the ASHA accompanying women to institutions. Reports of bad behaviour by facility staff to ASHA has surfaced in several reports.

- **Grievance redressal:** is reported as being in place from several states but no state reports indicate effectiveness.

Non approval of some of the critical components in PIP 2015-16 has affected the pace and desired outcomes of the programme at field level. Eg- mobility support for district community mobilizers in Meghalaya and additional 241 ASHAs in Char areas of Assam were not approved in FY 2015-16, affecting the quality of mentoring support and coverage of ASHAs in hard to reach areas in Meghalaya and Assam respectively.

Village Health Sanitation and Nutrition Committee

- Reports from most states reflect low priority in effectively utilising VHSNCs, and limited success in using them as the key institution for social mobilisation, as the 'platform for community action', as envisaged in the original NRHM design. New VHSNC guidelines, which envisage their reconstitution and expansion for making them more effective, have not been implemented in most states. There is also a general trend across the states of smaller amounts and irregular releases of untied funds, (attributed partly, to low expenditure patterns in past years).

- VHSNCs are in place in all states visited in 9th CRM (except Delhi) and were in adequate numbers as per their targets except in Assam, where a gap of 8% is noted at state level. This gap was higher in Dibrugarh district of Assam (20%) while reports from Sirmaur district of Himachal Pradesh also indicate 13% gap. Among the states visited, AP, HP and UP, have constituted VHSNCs at the Gram Panchayat level. West Bengal, is one state with its own variation, where VHSNCs have been formed at the level of Gram Sansad which has one or more revenue villages. Another variation is noted in Assam were VHSNCs have been formed at the level of ASHAs i.e, One VHSNC per ASHA but funds are received as per revenue villages. In all

other states VHSNCs are constituted at the level of revenue village.

- Most state reports underscore the absence of any service users and general community among VHSNC members, Ex officio members like ANM, AWW, ASHA and PRI representatives dominate the membership. Madhya Pradesh, Karnataka, Manipur, Meghalaya and Punjab, are states where restructuring of VHSNCs has been reported to have been done, as per the new GOI guidelines while it is underway in Uttrakhand. In Assam VHSCs are yet to be renamed to include Nutrition in the nomenclature and also in the core focus of its work.

- With regards to membership status of ASHAs in VHSNCs, ASHA are member secretary and joint signatory in most states except AP, Haryana, HP Maharashtra, Odisha and UP. In Haryana, Maharashtra and Odisha this role has been delegated to AWWs while in HP and UP ANMs are the joint signatories. Odisha is the only state that has diverse mix of members which is conducive for convergence v.i.z, elf Employed Mechanics, President/ secretary of the SHGs, President of the Pani Panchayat, representative of a well-functioning Yuvak Sangha or other CBOs etc. Good participation of PRI in VHSNCs were evident in Maharashtra.

- Good functionality is reported from a few states like Andhra Pradesh, Chhattisgarh, Maharashtra and Odisha. State of Maharashtra has put in place innovative systems such as allocation of untied funds as per population, i.e., Rs 5000 for up to 500 population villages, Rs. 8000 for 501 to 1500 population and Rs. 30,000 to bigger villages with more than 10000 population. In Chhattisgarh VHSNCs monitor health and social determinants in their regular monthly meetings and make action plan every month, identifying 2-3 key priority gaps.

- Low levels functionality of VHSNCs with Irregular meetings or poor quality of monthly meetings emerges as common findings in remaining states. Level of awareness among the members and their competencies in organising the affairs of VHSNC was found as one weak area across most states (except Chhattisgarh, MP and Odisha). This can be directly attributed to absence of any investment in training of VHSNC members since last 2-3 years.

- An interesting finding from Assam shows that despite no formal training of VHSNC members, they were aware of their roles and used the platform of VHND to meet beneficiaries to advise them on nutrition.

- Problems related to fund flow regarding the untied funds of VHSNCs were seen in states of HP and Assam (no fund release in 2015-16); late release of funds in Maharashtra, partial release of funds (Rs. 7500 in Punjab and Rs. 1000 in UK in 2015-16). Maharashtra has put in place a process of fund allocation to VHSNCs based on the population size, as detailed out earlier. In Uttrakhand, some ASHAs met reported spending upto Rs. 750 of their own funds to open the new VHNSC accounts as part of the reconstitution process.

- Preparation of monthly Village Health Plan by VHSNC is reported from Chhattisgarh and annual plan from Odisha, which is revised based on the need for addition of any new activity. These need based activities are often mass cleanliness drives, sensitization on prevention and management of malaria, dengue & diarrhoea, observation of various important days related to health etc.

- In other states, the pattern of expenditure shows substantial proportion of funds being spent on cleanliness and hygiene, sanitation and health related activities. Apart from these activities, provision of financial support for arranging transport and for medicines and healthcare for poor families, in some cases is reported. In some states like, Punjab, purchase of medicines is seen as a recurrent item of expenditure from VHSNC funds, across the village visited.

- In one particular example of context specific innovation, VHSNCs in Uttrakhand, have a system of Doli (a kind of Palanquin) made from the untied funds, which is made available for transporting patients upto nearest road-head in difficult areas. In Manipur, major portion of untied funds are

being spent in paying the incentives to ASHAs for organising VHNDs and in paying for refreshments for VHNDs, leaving little for other community led action.

Rogi Kalyan Samiti (RKS)

- RKS was found functional in most states, but levels of functionality vary across states on account of low levels of awareness among RKS members, about their roles and their limited involvement in functioning. Lack of orientation programmes and ad hoc support systems are the key reasons for this problem.

- Participation of PRI and NGO representations in functioning of RKS was found to be limited in all states. Across most states, meetings of RKS are not held regularly, and in some states meetings of RKS were found to held only once in the whole year (as seen in Meghalaya, West Bengal and one district of Uttarakhand – Dehradun). Regular meetings with proper records were reported only from states of Maharashtra and Manipur.

- Most state reports mentions levying of charges for certain services and diagnostics (with provision for exemptions for BPL patients in most of the cases) on behalf of the RKS. But it emerges that there is lack of a clear policy on use of RKS funds. Issues of poor fund utilization and poor record maintenance emerge as a common finding across states except in Maharashtra and AP (till the recent court case which has stalled the untied fund in AP).

- Enhanced administrative focus on RKS, after recent attention by political and administrative leadership, and RKS meetings are being done on regular basis in Delhi.

- In Haryana, as per the new rule of the Societies Registration Act, every member has to pay an annual fee of Rs. 1100 for five years, and this has created problems in renewals of the registration of RKSs (called Swasthya Kalyan Samiti in the state).

- Deviations from the guidelines were also seen regarding joint signatories of RKS account. In state of Meghalaya, PHC Accountant and ANM were joint signatories of the SC's untied funds account. In WB no member from civil society was in RKS. In a major aberration, the money collected from registration and other charges was being deposited not in RKS, but in the state treasury account of the hospital in the state of Maharashtra. In Madhya Pradesh large sum of funds has been raised for RKS from sale of shops built in the health facilities, but there was lack of clarity about use of funds and proper records were not being maintained.

Convergence

- Strong institutional convergence between VHSNCs and Gram Panchayats, is not seen on the ground in most of the states. Even in states where VHSNCs have been formed at the level of Gram Panchayat, this convergence is not reported to be any better than in other states. Eg- Himachal Pradesh, one such state, reports that despite PRI representatives being well represented in VHSNCs, RKS & District Health Society, their participation in the meetings and understanding of their roles, is not satisfactory, which is probably linked to lack of any orientation or capacity building for them.

- Only in the states of Maharashtra and Chhattisgarh is PRI participation in VHSNCs found to be adequate.

- In most states functional convergence was seen at the community and village level, but problems exist in convergence between departments at the district and state levels.

Community Action for Health (CAH)

- Only ten states (out of the total 18 states visited) report any programme on the ground or any progress on the planned CAH interventions.

- Maharahstra has a strong programme on the ground, started in the initial phase, in 2007. It currently covers 600 villages in 13 districts, and has an elaborate set of processes on the ground,

including well attended Jan Samvads (Public Hearings) and generation of report cards with positive outcomes related to local health system issues.

- In Chhattisgarh,VHSNCs monitor 27 indicators on health, nutrition and sanitation every month. Annual *Swasth Panchayat Sammelans* are held in blocks as Public Dialogue events. This process is also linked with Swasth Gram Award Scheme, in which, Gram Panchayats are ranked on a set of health, nutriton and other social indicators.

- Odisha has introduced CAH in 13 districts. The state uses a community enquiry tool (Soochna Patrika) for community based monitoring and decentralised health planning, focussed on major health indicators. It also conducts a Gaon Kalyan Samiti mini convention at sub-block level, where a review of the progress on indicators of mother and child service delivery gaps was done by the Sector Supervisor (a designated nodal person from the block). Training of VHSNC members is also being done under CAH.

- Punjab implemented the CAH interventions in two districts in 2014-15, covering 2 blocks, 6 PHCs & 30 villages from each district) where two District level Jan Samvads were held. In 2015-16, state has planned to implement CAH in 11 districts.

- In Madhya Pradesh, CAH programme intervention was sanctioned for 5 districts in 2013-14, but the process could not take off, as implementing NGOs could not be selected. In 2015-16 it is now being implemented through MGCA members in same 5 districts (3 blocks, 15 PHCs & 45 villages in each district). Trainings at Block, PHC, and VHSNC levels are under process.

- In many other states where CAH activity is in the initial phases of planning, reconstitution of State AGCA has been done. In most of the cases a few members from the national AGCA have also been co-opted. The states of Delhi, Meghalaya Uttarakhand,Assam and Rajasthan have initiated the process for implementing CAH, but there is not much progress reported.

- The state of Uttar Pradesh appears to have made significant progress in establishing support structures on the ground and is attempting to streamline training functions. At the other end of the spectrum is the state of Haryana where past gains appear to have dissipated, with little action seen on Community Processes including RKS, and IEC. States which demonstrate good performance on the ground include Odisha, Maharashtra, West Bengal, Punjab, Chhattisgarh and Himachal. States such as Madhya Pradesh, Delhi, Assam, Uttarakhand, Manipur, Meghalaya, Karnataka, Andhra Pradesh, Rajasthan, despite adequate financial and human resources in place, need to recover lost ground and put in more intensive efforts to strengthen the programme and perform to their potential. In these states the ASHA exercises agency and performs to the best of her ability but overall systemic weaknesses undermine her efforts.

Recommendations

- The ASHA programme has been underway for nearly ten years in over half the states visited, and about seven years in the remainder. Programme evolution cannot take place unless existing support mechanisms have been strengthened. Existing vacancies must be filled and training of support staff must be instituted immediately. If necessary, the functioning and leadership provided by the state ASHA resource centres and DCMs must be assessed and appropriate modifications made.

- Consider incentives for good team performance- i.e if, in a block all training for ASHA is complete based on the existing calendar, all ASHA receive monthly payments, all new-borns are visited, and ASHA refresher training is held, then the BCM and ASHA Facilitator would get an additional incentive- either in the form of cash or a non monetary awards such as recognition at the state level, exposure visit, training at state or national level, or points towards promotion.

- Strengthening the ASHA training systems, especially as states move towards ASHA

certification is also important. While the choice of trainers (full time, on deputation) is a state issue, one recommendation would be to explore the use of Block Mobilizers, ANM and ASHA facilitators as trainers so that the roles of support, on the job mentoring and training are combined. Chhattisgarh has demonstrated that this is possible. The additional compensation for training would also serve to increase the salary package for these cadres.

- Streamlining payments is a critical priority. The ASHA is a volunteer worker, and there is no other means of tangibly compensating her effort which in many cases is hardly commensurate to the effort she is making. It appears that some gains made between 2011 and 2014 have been reversed. Particularly, payments for disease control programmes need to be expedited. Introduction of new campaigns with ASHA being promised an incentive must be monitored to assess if payments were actually made.

- The strong coordination between the team of the ASHA-ANM-AWW needs to be taken advantage of and newer tasks need to be added based on workload assessment and accompanied by training and capacity building. This needs to be a well planned exercise, and must be contextualized to local needs.

- Poor skills of the ASHA in nutrition, family planning and newborn care are reported from some states, and these have also been noted in previous CRM visits. The states must take urgent action to resolve this. The first step is to orient support structures including ANM in these skills in a two day workshop. Thereafter, over a three-month period, states must ensure that every AF/ANM spends two days with the ASHA focusing on key skills and then following up to ensure that gaps are corrected. The Role of the ASHA in MP and Punjab, in acting on non-communicable diseases needs to be studied, and a future course of action on the mechanisms to engage the ASHA as a possible member of the Primary Health Care team needs to be decided. One way of improving ASHA skills is to develop mobile based application to reinforce key messages and also to develop applications for support structures of the ASHA to enable performance tracking and supportive supervision. The REMIND model from the state of Uttar Pradesh is a good example.

- The issue of dis-allowing elements of PIP in the community processes components is partly on account of variations in interpretation of existing CP guidelines. The existing CP guidelines need to be revised to reflect current learning from the states.

- The process of restructuring of VHSNCs needs to be expedited, and key role of ASHAs in mobilising and facilitating VHSNCs should be mandated as per the new guidelines and enabling inclusions of key individuals. Training of VHSNC members needs to be undertaken on a priority basis. There is need for stronger integration of ASHA support structures to support and manage VHSNCs realigning the TORs of block and district level ASHA coordinators to given equal focus to supporting VHSNCs is important.

- More active and sustained involvement of PRI members in supporting VHSNCs and RKS needs to be promoted in all states, through advocacy with Ministry of Panchayati Raj Institutions.

- Reconstitution of RKSs as per the new guidelines needs to be undertaken on priority basis, followed by capacity building of RKS members focusing on community participation and fund management. Financial management systems of RKSs, need a review from state level and prompt corrective action to improve transparency and governance.

- Enhanced role of district and block level panchayat structures in supporting and monitoring health programmes on the ground, especially involving their standing committees, will enhance effective convergence. Implementation of Community Action for Health, should be speeded up, and integrated with the CP interventions.

- States needs to strengthen or establish State ASHA/CP Mentoring Group and engage with effective and credible NGOs to serve as resources for all components of community processes including Community Action for Health.

Section 4:

Key Highlights of the Annual State Nodal Officer Workshop, December 9th -11th, 2015

The year 2015 marked the tenth year of the Community Processes interventions under NRHM and for the ASHA programme in many states. Therefore, the annual review workshop for state nodal officers for Community Processes, held from December 9th -11th, 2015, was designed to enable collective dialogue on what the state representatives envisaged as the trend of the next ten years of the CP programme. The workshop also focused on sharing of best practices from states with regards to - Role of ASHAs in different contexts and comprehensive primary health care, programme management and support, convergence and use of ICT tools. About 68 participants from 28 states and 3 UTs attended the workshop.

In order to initiate discussions on some of the existing challenges and emerging needs from different contexts of states, the following six questions were circulated to all state nodal officers. Readers would recall that these questions were also posed to members of the National ASHA Mentoring Group during the visioning workshop that was reported on in the July 2015 issue.

1. *Given the varying contexts, what is the role of the ASHA for the future?: If we are looking at more skilled roles- should there be different categories of ASHA: Generalist ASHA and Specialist ASHA (disease control ASHA, Mental health ASHA)? If we envisage these multiple roles, how do we institutionalize systems for training and skill building on an ongoing basis?*

2. *In your view how suitable is the existing profile and design of the urban Community Processes Component? What if any modifications would you suggest?*

3. *What should the criteria be for turn-over and renewal? Upper age limit? Should low literate ASHA be replaced by more educated ASHA, especially when we are considering specialized roles and certification?*

4. *How to sustain the spirit of voluntarism? What are the dangers of advocating for a full time payment without commensurate increase in skills?*

5. *How do we strengthen the ASHA to play a pivotal role in the VHSNC and MAS, and how do we develop a serious plan to train and activate the VHSNC and MAS to enable the intensification of community action?*

6. *As the ASHA's technical skills expand what are the implications for the nature of supervisory support? What would be the implications for existing cadres - Facilitators, BCM/DCM? Their skills? What are the plans for regular review and mentoring? What should be the strategy for performance appraisal and monitoring of ASHA and support structures?*

Group discussions were organized to facilitate deliberations among state programme managers to generate ideas about future of the ASHA programme and suggest possible solutions to the emerging challenges faced by the programme. States were divided in to four groups based on their health indicators and geographic terrain. Group Discussions were ollowed by a plenary discussion where each group presented the key recommendations of the

group, which were consolidated and presented to the Secretary Health, MoHFW in the concluding session-

- The generalist ASHA should be retained but her roles can be expanded in newer areas, as per state's context, Eg- Mental Health, Diabetes, Non Communicable Disease, Communicable Disease, Palliative Care, Sickle Cell Anemia, Geriatrics and HIV etc. and she should be seen as a member of the Primary Health Care team and her skill building should follow the principle of continuum of care. However, introduction of any task should be linked with matching incentives.

- With regards to capacity building, participants suggested that the ASHA training should be undertaken through two modalities. The planned training of ASHA in new modules or refresher training of two to three day duration through existing training systems should continue, while a day long training in selected topics or for skill reinforcement should be held at the PHC level on a quarterly basis.

- The group also discussed the feasibility of adding another tier of ANM/ LHVs in the cascade and training them in a separate composite module. It was also suggested that that ASHA training in any topic by other programme divisions/departments should be routed through ASHA Resource Centre and a comprehensive annual training plan should be prepared in consultation with all programme divisions.

- To ensure effective on the job mentoring of ASHAs, ASHA facilitators should also be trained in the new specialist roles and capacities of DCMs/ BCMs should be built on supportive supervision. The group also recommended that ASHA certification should continue as per the existing guidelines and ASHAs who gets certified should be rewarded through monetary/ non-monetary incentives, as a measure of recognition.

- The group emphasized that ASHA facilitators should be selected in urban areas to support ASHA and MAS. In small towns, covered by NUHM, existing BCM and DCM would extend support Urban CP at block and district level while in larger cities and metros with Municipal Corporation, a city level Coordinator for Community Processes is necessary.

- Participants stressed the need of more clarity about process of selection of ASHAs and payment of incentives for ASHAs in newly notified Urban Areas/ geographies with <50,000 population, since neither NRHM nor NUHM norms were applicable.

- With regard to incentives, group felt that same rates (as rural areas) of incentives should be applicable in urban areas for all common activities between rural and urban ASHAs. However, the number of incentives could be expanded to include new activities as per the urban scenario, e.g.- social determinants of health such as sanitation, substance abuse, etc. Existing ASHA incentives related to referrals should also be retained in case of referrals made to Accredited/ State recognized private health facilities.

- Nodal officers from some states shared their concerns about constitution of Mahila Arogya Samiti (MAS) and were of the view that current guidelines for MAS should be re- examined. Participants suggested inclusion of male member in MAS and renaming them as MAS as Jan Aarogya Samiti (JAS) and revision of current population norms @ 50-100 households for one MAS to one MAS per ASHA. They also suggested revision in the guidelines on monitoring, training, and fund management of MAS. Group also of the view that selection and training model of Odisha should be documented and shared with other states.

- Responding to the critical question of ASHA turnover, the group recommended drafting an "Exit" policy for ASHAs with appropriate felicitation at community level and social security schemes, e.g.- AABY, pensions etc. Majority of the group members felt that ASHA in age category of 60-65 could serve as a mentor to newly selected ASHAs in the same area, with an overlap period of one year linked to a mentoring honorarium followed by a lump sum incentive.

- Group strongly suggested that ASHAs should not be replaced based on education criteria, rather such ASHAs should be supported through enrolment in equivalency programme under National Literacy Mission (NLM) and use of pictorial applications can be promoted to train such ASHAs.

- The existing guideline for non-functional ASHAs should be continued. However, with regards to continuation of ASHA after being selected as elected panchayat representatives, it was suggested that national guidelines should be issued.

- Groups suggested that National ASHA Day should be proclaimed to honour and felicitate the efforts of the ASHAs.

- Mixed incentive pattern for ASHAs should be promoted with performance based incentives and fixed honorarium linked with fixed set of activities. However, flexibility should be built in for states to decide on fixed honorarium. It was further emphasized that payment of incentives should be streamlined for timely and regular payment with a periodic increment of incentives.

- Another recommendation was that of introduction of state specific incentives in difficult geographic terrain in order to compensate for low incentive levels in North Eastern /Tribal states.

- To sustain the spirit of volunteerism, the group re-emphasized strengthening supportive supervision, which is essential for regular support and on job mentoring. Participants were of the firm view that ASHAs should not be given instructions or orders compelling them to do any task, without the approval of Mission Director or ASHA Resource Centre. They also added that District Officials should be sensitized to not dismiss ASHAs on arbitrary grounds.

- About expanding the non-monetary incentives, it was recommended suggested that all benefits available for unorganized worker should also be extended to ASHAs. Mechanisms should be built for a) Provision of social security measure for ASHAs with their inclusion in Medical Insurance schemes such as RSBY and Maternity entitlements, b) Supporting t and incentivizing ASHAs for building new skills v.i.z -primary health care etc. by linking with IGNOU or other certification opportunities and c) Supporting education of ASHA's children, awards and felicitation and organizing exposure visits.

- Participants stressed that ASHAs should continue to play a pivotal role as Member Secretary and her capacities should be built to play the leading role. Emphasis was also laid on strengthening VHSNC and MAS through capacity development of members, IEC activities and exposure visit.

- With regards skill building of VHSNCs, the group recommended two approaches i.e, a) Better Convergence with health and allied departments for institutional structures, identification of resource persons for creating a trainer pool, identification of training sites and future convergence in implementation activities and b) Involvement of NGOs in MAS, VHSNC trainings can be prioritized in states where NGO structures already exist. The National Guidelines for NGO Engagement should be adhered to but role definition and TOR for NGOs can be state specific.

- Participants also proposed that guidelines for VHSNC untied funds should be revised such that release of untied funds is proportionate to the population of the area.

- Group shared their concerns regarding orders being issued from state/district/block level on utilization of untied funds, which undermines the principle of community participation. It was recommended that untied fund should remain untied and no such order should be issued at the state level.

- The nodal officers proposed two options for Community Action for Health (CAH) -a) Training of ASHA and ASHA facilitator to strengthen VHSNC capacity for undertaking CAH with active support from block and district structures. States may consider NGO involvement in such training and b) Outsourcing the activities of CAH to NGOs but

with an understanding that it will be phased into the Community processes system over the period of next few months.

- Nodal officers reiterated the need for capacity building of support structures. They strongly recommended that all block and district level support structures should be provided induction training. Group also felt that skill upgradation of support structure should precede the training of ASHAs in new skills.

- With regards to making the programme management more effective, the group suggested that regular monthly review meetings should be organized at state, district and block levels. Job descriptions to be reviewed and synergized with activities consistent with support and monitoring of community processes interventions. Participants also felt that performance appraisal tools should be developed for support structure at all levels.

- Group raised concerns about salary disparity between staff of the same level of work. They said it is important to undertake review and rationalize salary of support structures at all levels. Nodal officers also recommended delinking of roles of ASHA facilitators and ASHAs and proposed increment of ASHA Facilitator's honorarium.

- To strengthen the performance monitoring of ASHAs, the group advised that new indicators should be introduced and analysis of reports should be shared with districts using IT based consolidation during DHS and monthly meetings.

Section 5:

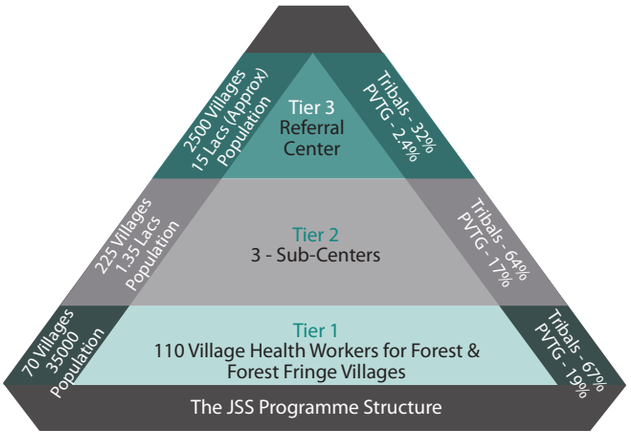
Good Practices and Stories from the Field

The two best practices presented below are the models of primary health care relying on community health workers with a decentralized service delivery framework and the use of ICT tools by ASHA support structures for providing effective mentoring support.

1. Comprehensive and Integrated Primary Health Care Model Implemented by Jan Swasthya Sahyog (JSS) in Bilaspur District of Chhattisgarh*

The primary health care model of JSS is based on the key principles of comprehensiveness, community basing, equity, responsiveness, support and quality of trainings. The primary health care services are delivered through Sub- Health Centres known as Health and Wellness Centres (HWC) with a catchment area of 54 villages with about 35,565 population (69% tribal population). All sub centres are linked with a 30 bedded referral hospital located in Ganiyari Village. Service delivery is organized such that 53% of health care is provided closer at village/hamlet level by village health workers, followed by 36% at HWCs and only 11% at the referral Centre. This enables that over half of the people needing care either for acute simple illness or for chronic illness get care at their home or within their village; about one in three patients require care at the HWC, and one in ten need to travel to the Ganiyari health care facility.

The model also focuses on social determinants by addressing inequities by caste/tribal group and reaching the most marginalized communities preferentially. In addition to efforts made to overcome social determinants like hunger and nutrition, access to drinking water and sanitation, the programme also provides supports action to agricultural extension work and veterinary services through separate dedicated staff.



The Human Resource of JSS comprises of community health workers at village level, a senior health worker (SHW) and ANM at the HWC for RCH; cluster coordinators for supportive supervision and a team of Doctor/pharmacist/lab tech/ records person support the HWC on fixed days on a weekly basis. The senior health worker (SHW) looks after chronic illnesses and acute severe illnesses, while the maternal and child health services are provided by the Auxiliary Nurse Midwife. The model harnesses potential of Community Health Workers including ASHAs, who primarily visit everyone in the village and provide the following services -

1. Management of identified acute simple illness and minor dental problems

* www.jssbilaspur.org

2. Conduct tests like slide making, RDK, urine pregnancy testing, vaginal infections, anaemia check, read tuberculins, water quality checks

3. Provides about 25 drug

4. Counsels on health care seeking

5. Birth and death registration

List of Drugs with Village Health Workers

- Paracetamol- Fever, aches, pains, inflammation
- Syrup Paracetomol- same as above but for children
- Tab. Chloroquine- for malaria
- Syrup Chloroquine- for malaria
- Tablet Co-trimaxozole- for respiratory infections- also other infections
- Syrup Co-trimoxazole- same as above for children
- Iron Tablets- anemia
- Chlorpheniramine: Anti-allergic
- Cough syrup.
- Metronidazole tablets- dysentery, some RTIs
- Albendazole- tablets- deworming
- Gentamycin eye drops- eye infections
- Calamine lotion- external application or itching
- Tab Domperidone - For Vomiting
- GV Paint.- external application: minor wounds & some RTIs
- Lindane Lotion- external application- scabies
- Betadine Lotion- external application- skin infections, minor wounds
- Mala-D- oral contraceptive
- Furazolidine- antibiotic- diarrhoea
- Amoxycillin- antibiotic- respiratory and urinary infections and other infections
- Becadexamin (mutili-vitamin/B complex)
- Vitamin A- night blindness- also to all malnourished children
- Dicyclomine- colicky pain, menstrual pain

Supervision of the VHWs is done by a cluster coordinator located in the Ganiyari Health Care Facility. All Village health workers are linked with HWCs, which is staffed with 2 ANMs and one Senior Health Worker (SHW). The SHW-is a mid level care provider with a nine month pre-service training provided by JSS followed by a structured review meetings every month.

The range of services available at HWC and the Ganyari Referral centres is comprehensive and responsive to epidemiology and demography needs of the area.

Services Available at HWC

- Acute Simple Illness - Fever, diarrhea, cough and colds, allergy, mild pain abdomen, worms, mild or moderate anemia
- Animal Bites
- Chronic Illness - Tuberculosis, Leprosy, Hypertension, Epilepsy, Sickle Cell disease, Asthma/COPD, Diabetes, Arthritis, Thyroid, Mental Illness, Rheumatic heart disease and Airborne contact dermatitis
- Nutritional - Severe Anemia and SAM
- RCH - Antenatal care, Delivery, Postpartum and neonatal care
- Eye Care - Refractive error detection and management, Cataract, decreased vision
- Public Health Administrative -Registration of Births and Deaths

Services Available at Ganyari Referral Centre

- All simple acute or chronic illness which develop complications: tuberculosis, malaria, leprosy, thin diabetes, RHD, mental health, thyroid, arthritis, soft tissue infections and animal bites
- All acute surgical illness - surgical infections, malformations, emergencies and chronic festering problems
- Cancers and follow up care
- Obstetrics and Gynaecology: Emergency obstetric care, obstructed labour, contraception, abortion services and blood transfusion
- Child health: child nutrition, early childhood infections, sickle cell disease
- Dental OPD
- Eye Care- refractive errors
- Suicide Help Line.

The VHW/Mitanin has no data reporting function but maintains a simple register which records each member of the family with their "baseline-age", sex, relationship and generates a number for every individual a number. The register also records the day of the month when they visited the family, any illness the family had, who had the illness, with whom they had sought care with and cost of care if sought outside the JSS ambit. Register has provisions for adding on new members and for recording births.

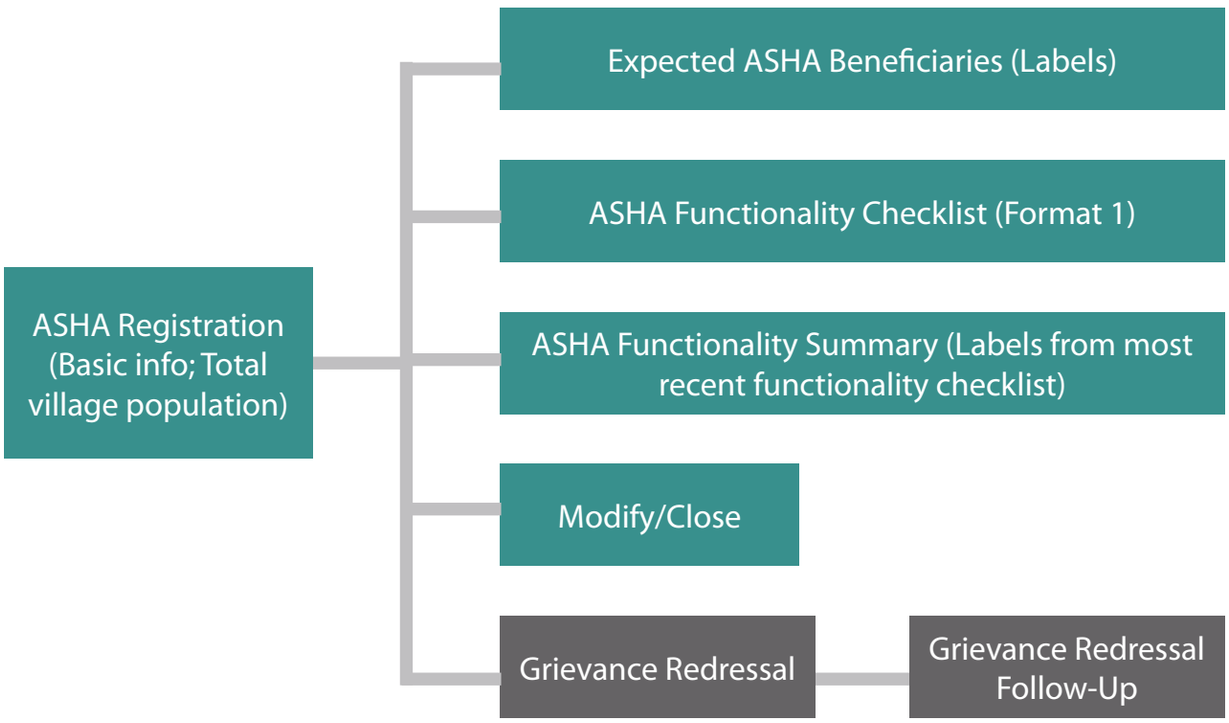
At the end of the year the data is updated at the PHC and the new sheets are printed out for each VHW. VHWs also have a pass book for the drugs that they issue.

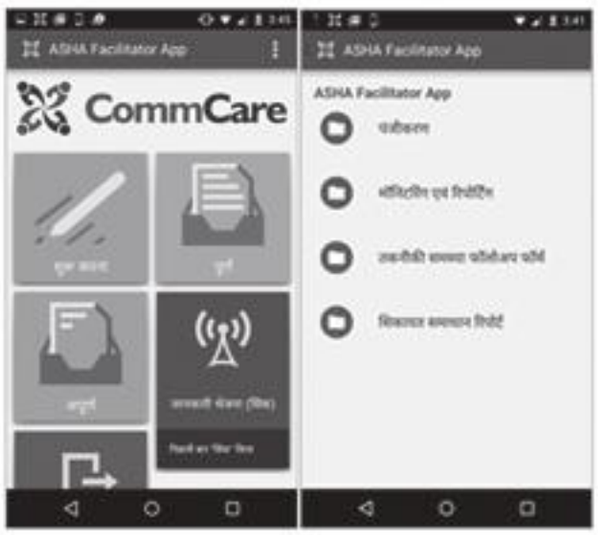
JSS model demonstrates that provision of good quality primary health care at affordable cost using the human resources, consistent with Indian Public Health Standards and implementable within existing financing strategies and package, thereby improving scalability. Incorporation of lateral supervision is an important design element, supporting administrative, clinical supervision and on the job trainings. It also shows that use of Standard Treatment Guidelines (STGs) to prepare individual patient plans are essential for service delivery. The model further illustrates that Community health workers can play the role of "Sustained Strategic change agent", accompanier or link person- to plug gaps and help navigate/ negotiate the system, in the provision of comprehensive primary healthcare. CHWs can also play a significant role in service delivery and provide support in primary healthcare addressing both the demand side and supply side barriers to access.

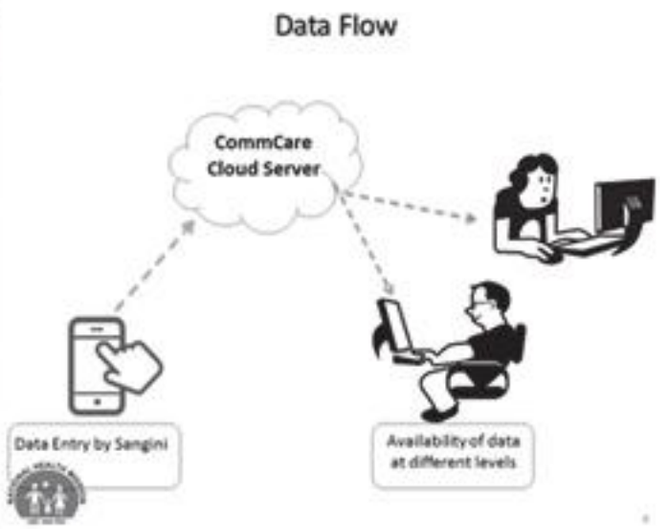
2. REMIND -m-Health Solutions to Support ASHA Sanginis (AFs) for Strengthening Supportive Supervision — Uttar Pradesh

Catholic Relief Society developed and launched a m-health solution to support ASHA facilitators in Kaushambi district of Uttar Pradesh in 2014 and later in one block of Lucknow in 2015. UP under the ReMiND project. The mobile based application for Supportive Supervision is based on National guidelines and Handbook for ASHA Facilitators and was developed in consultation with State NHM and NHSRC team. The project is currently underway in pilot district of Kaushambi with project duration from April 2014-September 2018.

As part of the project ASHA Sanginis are equipped with Android phones (MOTO E) recharged with the data pack. The application includes forms which will help AFs register the ASHAs of her sector and monitor the performance of ASHAs based on ten indicators (as per the guidelines) and support them on a regular basis.







Apart from easing data compilation by AFs, the app also allows structured supervision of the ASHAs, automates calculation of expected beneficiaries, eases follow up with ASHAs (data of previous visit available, ensures real time data availability for block and district reviews and adds transparency in data. CommCare cloud serves and ensures access of the information at different levels-block, district/state.

So far CRS team in collaboration with the state NHM has trained 79 ASHA Sanginis of Kaushambi and Bakshi ka Talab block of Lucknow on the Supervision application. CRSs also provide regular mentoring support to ASHA Sanginis through block coordinators (equivalent to Block community mobilizers who were selected only recently in the state) to assess functionality, identify areas for supporting ASHAs, meet and counsel resistant families and include marginalized communities.

In addition to the m–health solution developed for ASHA Sanginis, the project also aimed at strengthening the ASHA support structure at district and block level through – a) Facilitating block nodal officer (Block Health Education Officers) to capacitate Sanginis, b) Supporting access to online ASHA Sangini reports generated from app, c) Supporting data interpretation and use and d) Facilitating district quarterly review platform for reflecting on the progress. This has led to improved quality of mentoring support available to ASHA Sanginis and improved use of data for decision making/program management.

A key learning from this initiative is that creation of IT platforms can serve as an empowering tool for ASHA support structures and enhance the quality of mentoring support available to ASHAs which can improve the functionality and effectiveness of ASHAs.

Stories from the Field - Jamunamani Singh, ASHA, Nilgiri, Balasore, Odisha

Tenda village in Nilgiri block (mostly tribal), is located in the forest fringes inside Kuldhia sanctuary in Balasore district in a remote area. About 25% of all malaria cases detected in the district in 2014, were from this sub center. Poverty, low levels of literacy, difficult terrain, and low care seeking behavior did not deter the ASHA of Tenda village, Smt. Jamunamani Singh, from active door to door search for fever cases, early detection, treatment and promoting active use of insecticide impregnated bednets. Smt. Jamunamani Singh has been fighting against malaria and water-borne diseases like diarrhoea through spreading awareness for the last five years in the villages of Tenda and Sialghati. In one year alone she diagnosed 35 malaria cases and ensured early treatment.

Smt. Jamunamani Singh has been working as an ASHA since the year 2008. With her dedication, she has been able to bring transformation in the health behaviours of the community. In an interview to one of the newspapers, Smt. Jamunamani said "Earlier, people here did not believe that those were symptoms of diseases. They considered it ill effects of bad spirit and preferred to visit sorcerers. I interacted with them and made them understand. So far, I have got 35 malaria positive patients treated and all are out of danger."

She was felicitated by the district administration and later by State Government on Independence Day, for her contribution towards malaria control. Her resolve not to allow a single malaria-related death was appreciated by Hon'ble Prime Minister during the 14th edition of 'Mann Ki Baat' aired on Sunday dated 29th Nov, 15

"We have a network of ASHA workers in our country. Neither I nor you would have heard or talked about ASHA workers. We had conferred Padma Bhusan on Bill and Melinda Gates last year for their contribution to social work through their foundation. The duo heaps praise on ASHA karmis for their hard work and dedication. One such ASHA worker serves in a small village of Odisha's malariainfested region. Jamunamani Singh has resolved not to allow a single malaria related death in the village. I honour all Asha workers through Jamunamani," said the Prime Minister. "With her full dedication and extraordinary efforts, Jamuna made the people in her village fight malaria. She spread awareness about precautions and helped the entire village during tough times," the PM added.

Section 6:

Updated List of Incentives

S. No.	Heads of Compensation	Amount in Rs/ case	Source of Fund and Fund Linkages	Documented in
I. Maternal Health				
1.	JSY financial package			MOHFW Order No. Z 14018/1/2012/-JSY JSY -section Ministry of Health and Family Welfare -6th. Feb 2013
	For ensuring antenatal care for the woman	300 for Rural areas 200 for Urban areas	Maternal Health- NRHM-RCH Flexi pool	
	For facilitating institutional delivery	300 for Rural areas 200 for Urban areas		
	Reporting Death of women (15-49 years age group) by ASHA to U-PHC Medical Officer	200 for reporting within 24 hours of occurrence of death by phone	HSC/ U-PHC-Un-tied Fund	MOHFW- OM -120151/148/2011/MCH; Maternal Health Division; 14th Feb 2013
II. Child Health				
1.	Undertaking six (in case of institutional deliveries)and seven (for home deliveries) home- visits for the care of the new born and post- partum mother[1]	250	Child Health-NRHM-RCH Flexi pool	HBNC Guidelines –August 2011
2.	For follow up visits to a child discharged from facility or community Severe Acute Malnutrition (SAM) management centre	150 only after MUAC is equal to nor-more than 125mm		Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV
3.	Ensuring monthly follow up of low birth weight babies and newborns discharged after treatment from Specialized New born Care Units	50		Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV

1. This incentive is provided only on completion of 45days after birth of the child and should meet the following criteria-birth registration, weight-record in the MCP Card, immunization with BCG, first dose of OPV and DPT complete with due entries in the MCP card and both mother and new born are safe until 42nd of delivery.

S. No.	Heads of Compensation	Amount in Rs/ case	Source of Fund and Fund Linkages	Documented in
4.	For mobilizing and ensuring every eligible child (1-19 years out-of-school and non-enrolled) is administered Albendazole	50	Child Health-NRHM-RCH Flexi pool	Operational Guidelines for National Deworming Day - Feb, 2015
5.	ASHA incentive for prophylactic distribution of ORS	Rs. 1 per ORS packet	Child Health-NRHM-RCH Flexi pool	Operational Guidelines for Intensified Diarrhoea Control Fortnight - June 2015
III. Immunization				
1.	Complete immunization for a child under one year	100.00		Order on Revised Financial Norms under UIP-T.13011i01/2077-CC-May 2012
2.	Full immunization per child up-to two years age (all vaccination received between 1st and second year of age after completing full immunization after one year	Rs 50	Routine Immunization Pool	
3.	Mobilizing children for OPV immunization under Pulse polio Programme	100/day[2]	IPPI funds	Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV
IV. Family Planning				
1.	Ensuring spacing of 2 years after marriage	500	Family planning Compensation Funds	Minutes Mission Steering Group meeting- April- 2012
2.	Ensuring spacing of 3 years after birth of 1st child	500		
3.	Ensuring a couple to opt for permanent limiting method after 2 children	1000		
4.	Counselling, motivating and follow up of the cases for Tubectomy	150	Family Planning Sterilization compensation funds	Revised Compensation package for Family Planning- September 2007-No-N 11019/2/2006-TO-Ply
5.	Counselling, motivating and follow up of the cases for Vasectomy/ NSV	200		
6.	Social marketing of contraceptives- as home delivery through ASHAs	1 for a pack of three condoms 1 for a cycle of OCP 2 for a pack of ECPs	Family planning Fund	Detailed Guidelines on home delivery of contraceptives by ASHAs-Aug-2011-N 11012/3/2012-FP

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

S. No.	Heads of Compensation	Amount in Rs/ case	Source of Fund and Fund Linkages	Documented in
7.	Escorting or facilitating beneficiary to the health facility for the PPIUCD insertion	150/case	Family planning Fund	- Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV
V. Adolescent Health				
1.	Distributing sanitary napkins to adolescent girls	Re 1/ pack of 6 sanitary napkins	Menstrual hygiene- ARSH	Operational guidelines on Scheme for Promotion of Menstrual Hygiene Aug 2010
2.	Organizing monthly meeting with adolescent girls pertaining to Menstrual Hygiene	50/meeting	VHSNC Funds	
3.	Incentive for support to Peer Educator (for facilitating selection process of peer educators)	Per PE Rs. 100	RKSK fund	Operational framework for Rashtriya Kishor Swasthya Karyakram - Jan 2014
4.	Incentive for mobilizing adolescents for Adolescent Health day	Per AHD Rs. 150		
VI. Revised National Tuberculosis Control Programme[3]				
	Honorarium and counselling charges for being a DOTS provider		RNTCP Funds	Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV
1.	For Category I of TB patients (New cases of Tuberculosis)	1000 for 42 contacts over six or seven months of treatment		
2.	For Category II of TB patients (previously treated TB cases)	1500 for 57 contacts over eight to nine months of treatment including 24-36 injections in intensive phase		
3.	For treatment and support to drug resistant TB patients	5000 for completed course of treatment (2000 should be given at the end on intensive phase and 3000 at the end of consolidation phase		
4.	For notification if suspect referred is diagnosed to be TB patient by MO/Lab[4]	Rs.100		Revised National Tuberculosis Control Program- national Guidelines for partnership 2014

3. Initially ASHAs were eligible to an incentive of Rs 250 for being DOTS provider to both new and previously treated TB cases. Incentive to ASHA for providing treatment and support Drug resistant TB patients have now been revised from Rs 2500 to Rs 5000 for completed course of treatment.

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

S. No.	Heads of Compensation	Amount in Rs/ case	Source of Fund and Fund Linkages	Documented in
VII. National Leprosy Eradication Programme[5]				
1.	Referral and ensuring compliance for complete treatment in pauci-bacillary cases of Leprosy	250 (for facilitating diagnosis of leprosy case)+ 400(for follow up on completion of treatment)	NLEP Funds	Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV
2.	Referral and ensuring compliance for complete treatment in multi-bacillary cases of Leprosy	250 (for facilitating diagnosis of leprosy case)+ 600 (for follow up on completion of treatment)		
VIII. National Vector Borne Disease Control Programme[5]				
A) Malaria[6]				
1.	Preparing blood slides	15/slide	NVDCP Funds for Malaria control	Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV
2.	Providing complete treatment for RDT positive Pf cases	75		
3.	Providing complete radical treatment to positive Pf and Pv case detected by blood slide, as per drug regimen			
4.	For referring a case and ensuring complete treatment	300		
B) Lymphatic Filariasis				
1.	For one time line listing of lymphoedema and hydrocele cases in all areas of non-endemic and endemic districts	200	NVBDCP funds for control of Lymphatic Filariasis	Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV
2.	For annual Mass Drug Administration for cases of Lymphatic Filariasis[7]	200/day for maximum three days to cover 50 houses and 250 persons		
C) Acute Encephalitis Syndrome/Japanese Encephalitis				
1.	Referral of AES/JE cases to the nearest CHC/DH/Medical College	300 per case	NVBDCP funds	Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV

5. Incentives under NLEP for facilitating diagnosis and follow up for completion of treatment for pauci bacillary cases was Rs 300 before and has now been revised to-Rs 250 and Rs 400 now.

   For facilitating diagnosis and follow up for completion of treatment for multi-bacillary cases were Rs 500 incentive was given to ASHA before and has now been revised to-Rs 250 and Rs 600.

6. Incentive for slide preparation was Rs 5 and has been revised to Rs 15. Incentive for providing treatment for RDT positive Pf cases was Rs 20 before and has been revised to Rs 75. Incentive for providing complete radical treatment to positive Pf and Pv case detected by blood slide, as per drug regimen was Rs 50 before. Similarly-incentive for referring a case of malaria and ensuring complete treatment was Rs 200/case and has been revised to Rs 300 now.

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

S. No.	Heads of Compensation	Amount in Rs/ case	Source of Fund and Fund Linkages	Documented in
D) Kala Azar elimination				
1.	Involvement of ASHAs during the spray rounds (IRS) for sensitizing the community to accept indoor spraying[8] (New incentive)	Rs 100/- per round during Indoor Residual Spray i.e. Rs 200 in total for two rounds	NVBDCP funds	Minutes Mission Steering Group meeting- Feb- 2015
E) 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 - Oct, 2006
IX. Incentive for Routine Recurrent Activities				
	Mobilizing and attending VHND or (outreach session/ Urban Health and Nutrition Days)	200 per session	**NRHM-RCH Flexi Pool**	Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV
	Convening and guiding monthly meeting of VHSNC/ MAS	150		
	Attending monthly meeting at Block PHC/U-PHC	150		
	a) Line listing of households done at beginning of the year and updated every six months b) Maintaining village health register and supporting universal registration of birth and death. c) Preparation of due list of children to be immunized updated on monthly basis d) Preparation of due list of ANC beneficiaries to be updated on monthly basis e) Preparation of list of eligible couples updated on monthly basis	500		

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