Update on the ASHA Programme

January 2011

National Rural Health Mission
Ministry of Health and Family Welfare
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Contents

Introduction

The ASHA programme is a critical component of the National Rural Health Mission (NRHM), and includes several processes which aim to actively engage communities in improving health status.

Key elements of the community processes under NRHM are:

- The ASHA and her support network at block, district and state levels.
- The Village Health and Sanitation Committee (VHSC) and village health planning.
- Untied funds to the Sub Center and the VHSC to leverage their functions as avenues for public participation in monitoring and decision making.
- District Health Societies, the district planning process and the Rogi Kalyan Samitis as avenues for promoting public participation in facility management.
- Community Monitoring.
- NGOs and other civil society organisations to support the implementation of these components.

Of all the components of the community processes programme the ASHA programme has received substantial attention and this is reflected in the progress being made across the states in terms of recruitment and catching up on training. Although some states continue to lag behind in training, there has been progress this past year, with increasing number of states having established support structures. The challenge to the programme is now to fully use the potential of the ASHA in addressing newborn, child and maternal health issues and enabling increasing reach of the ASHA to marginalised communities.

Although originally designed for only the North Eastern and High Focus states, the programme was scaled up in 2008 across the entire country. The programme now has 8,25,525 ASHAs across the country. Two states, Himachal Pradesh and Goa and two Union Territories, Puducherry and Daman and Diu do not have an ASHA programme.

This report is the third in a series of ASHA updates[1], produced by the National Health Systems Resource Center (NHSRC) for the Training Division, Ministry of Health and Family Welfare (MOHFW). The objective of these biannual updates is to report on the progress of the ASHA and community processes programme in the states. The updates also summarise findings from evaluations and studies on the ASHA programme.

[1] The first update was issued in October 2009

Since the publication of the last update in June 2010, data from evaluations of the ASHA programme have become available. These are:

- Concurrent evaluation of National Rural Health Mission 2009 Ministry of Health and Family Welfare[2]
- Fourth Common Review Mission, Ministry of Health and Family, December 2010
- Evaluation of the ASHA Programme in eight states[3], National Health Systems Resource Center, December 2010
- Improving the performance of Accredited Social Health Activists (ASHAs) in India[4] , Prepared for the International Advisory Panel of the NRHM, January 2011.

The report is divided into four sections. Section 1 provides the findings from studies and evaluations. Sections 2 provides quantitative data on selection, population coverage and training of ASHAs. Section 3 provides information on support structures existing in the states. Section 4 reports on expenditure incurred on the ASHA programme in the States and Union Territories (all data updated as of December 2010).

[2] International Institute For Population Sciences (IIPS),2010-Concurrent Evaluation Of National Rural Health Mission, Fact Sheet: States and Union Territories, 2009: Mumbai:IIPSHealth Mission, Fact Sheet: States and Union Territories, 2009: Mumbai:IIPS

[3] Assam(Dibrugarh and Kairmganj), Andhra Pradesh(East Godavari and Khammam), Bihar(Purnia and Kha-garia), Jharkhand(Danbhad and West Singhbhoom), Kerala(Thiruvanaanthpuram and Wayanad), Orissa (Anugul and Nayagarh), Rajasthan(Banswara and Bundi) and West Bengal(Malda and Bir Bhum)

[4] The study covered the states of Bihar, Chattissgarh, Rajasthan and Uttar Pradesh

Section: 1

Key Findings from Studies and Evaluations

i. Findings from the Concurrent Evaluation

Background

The concurrent evaluation was commissioned by the Ministry of Health and Family Welfare in 197 selected districts in all states and Union Territories. The targeted sample size from each district were – 1 District hospital, 2 CHCs, 4 PHCs, 12 SHCs, 24 villages, 24 ASHAs, 12 Panchayati Raj Institution (PRI) representatives from Gram Panchayats and 1200 households with a currently married woman between the ages of 15-45 yrs. Varying samples of ASHA per district were interviewed during the period May to December 2009. (Tables 1 to 4 summarise the key findings from the ASHA section of the concurrent evaluation.)

Highlights

Though the concurrent evaluation shows a high degree of variability across the states, there are common patterns within the state groups: High focus, North East states, Non High Focus and UnionTerritories. In most of the High Focus and North East states, three of the Non High Focus states and some of the UTs, 90% of the ASHA have completed training in Module 1. However in training in Module 2 and beyond, Bihar, Arunachal Pradesh and Punjab lag behind. In terms of drug kit provision, 80% of ASHA in Chhattisgarh, Uttar Pradesh, Uttarakhand, Orissa, Manipur, Mizoram, Sikkim, Tripura and Punjab have received drug kits, the other states have yet to provide these to significant percentage of the ASHAs. Respondents from the category of currently married women who report that the ASHA provides free drug supply roughly correlates with the percentage of ASHA that have drug kits. This is true of Chattissgarh, Uttarakhand, Rajasthan, Assam, Tripura, Andhra, Karnataka, Kerala and Maharashtra. In the other states it is considerably lower, which could be due to poor replenishments or the functionality of the ASHA. The percentage of ASHA who have received pregnancy kits also varies widely across the states.

In terms of payment the average amount the ASHA receives per month ranges from Rs. 320 in Chattissgarh and to Rs. 1056 in Uttarakhand. In Rajasthan the ASHA received Rs. 840 and in Bihar the ASHA reported receiving Rs. 770. ASHAs in Sikkim, Assam and Mizoram get payments ranging form Rs. 412 to Rs. 616 with much lower amounts being reported from other North East states. One reason for this, could be the number of cases registered for JSY and escorted to institutions for deliveries. In the Non High focus states, where fertility is low, and the JSY for the mother is limited to the BPL category, the number of escorted delivery as well as payment to the ASHA are low.

Less than 50% of ASHA receive payment for family planning or for attending the Village Health and Nutrition day and this is likely due to failure of the system to pay the ASHA for these activities since the ASHA functionality is known to be good for these activities from other studies. Even those who report payments are likely getting paid irregularly when correlated with other studies.

In the area of being a DOTS (Directly Observed Treatment Short-Course) provider, the ASHAs are reasonable active especially in consideration of the overall incidence for TB and also that both the ANM (Auxiliary Nurse Midwife) and AWW (Aganwadi Workers) are eligible to become DOTS providers.

On Village Health and Sanitation Committees (VHSC), from the findings of the concurrent evaluation, they appear to be non- functional in Bihar, Jharkhand, Jammu and Kashmir, Uttarakhand and Assam, and 50% are functional in Chhattisgarh and Orissa. The percentage of GPs reporting existence of VHSC correlates with those having received un-tied funds, except in MP and UP where receipt of funds was lower. In the NE states, except for Arunachal Pradesh and Assam, VHSC presence and functionality was over 60% being highest in Mizoram. The percentage of GPs perceiving that NRHM had brought improvements was in all instances higher than those reporting active VHSCs, except in MP and Mizoram. In the non- high focus states, West Bengal with 29%, Haryana with 41% and Andhra with 60% were the lowest in reporting active VHSCs, whereas Kerala, Maharashtra and Tamil Nadu in the order performed well on these parameters. Except in Gujarat and Haryana reporting on un- tied funds correlates with the existence of the VHSC.

Table 1: Concurrent Evaluation : High Focus States

Name of the state	Sample size of ASHAs	% of ASHAs who have received training in module 1	% of ASHAs who have received training in module 2 or more	% of trained ASHAs who received drug kits.	% of married women- 15 to 49 who reported ASHAs provided medicines free of cost.	% of ASHA received pregnancy testing kit	% of ASHA who are DOTS providers	% of ASHA received Family planning incentives	% of ASHA received VHND incentives	Average monthly JSY registered by ASHA	Average monthly JSY cases taken for Institutional delivery by ASHA	Average amount received per month by ASHA (Rs.)#	% of GPs reporting existence of VHSC in village	% of GPs reporting VHSCs received untied funds	% of GPs perceiving "NRHM brought improvement"
Bihar	209	97.6	43.5	34	14	63.3	40.2	45.5	1.9	2.9	2.1	769	4.4	0.9	69.9
Chhattisgarh	96	97.9	97.9	87.5	81.4	79.2	13.5	35.4	77.1	1.3	0.8	320	54.2	43.8	83.3
J&K	56	94.1	80.4	67.9	24	0	12.5	1.8	1.8	1	0.7	106	5.9	2.9	32.4
Jharkhand	120	98.3	73.3	54.2	45.7	23.6	15	1.7	0	1.5	0.5	36	19.4	4.2	44.4
MP	213	83.7	87.5	70	38.8	41.5	33.3	46.9	17.8	2.1	1.7	432	91.9	24.8	60.5
Orissa	216	98.6	98.1	93.1	64.1	75	35.2	44.9	61.1	2.3	1.8	588	56.5	38.9	76.9
Rajasthan	113	91.1	89.9	45.5	57.3	74.5	43.4	42.7	46.9	2.2	1.1	840	83.3	70.2	89.3
UP	383	86.9	84.6	83.1	46.1	63.2	63.4	42.6	6.2	2.2	1.7	384	76.6	48.3	83.6
Uttarakhand	50	93.9	100	94	43	78.6	48	40	30	2.3	1.9	1056	10	0	73.3

Table 2: Concurrent Evaluation: North East States

Name of the State	Sample size of ASHAs	% of ASHAs who have received training in module 1	% of ASHAs who have received training in module 2 or more	% of trained ASHAs who received drug kits.	% of married women- 15 to 49 who reported ASHAs provided medicines free of cost.	% of ASHA received pregnancy testing kit	% of ASHA who are DOTS providers	% of ASHA received Family planning incentives	% of ASHA received VHND incentives	Average monthly JSY registered by ASHA	Average monthly JSY cases taken for Institutional delivery by ASHA	Average amount received per month by ASHA (Rs.)#	% of ANMs reporting ASHA in position	% of GPs reporting existence of VHSC in village	% of GPs reporting VHSCs received untied funds	% of GPs perceiving "NRHM brought improvement"
Arunachal Pradesh	19	88.2	29.4	47.4	16.7	69.2	5.3	0	0	0.9	0.9	162	75	25	12.5	25
Assam	103	96.9	96.9	56.3	69.3	66.3	29.1	5.8	16.5	1.9	1.3	616	100	25.6	4.7	58.1
Manipur	200	91.3	94.3	81	50.5	57.3	9	5.5	10.9	1.7	1	75	99	66.7	57.8	72.5
Mizoram	115	98.2	78.8	87	42.3	86.4	6.1	0.9	1.7	1.3	0.8	412	98.8	97.8	85.4	76.4
Nagaland	128	84.6	64.1	70.6	29.2	46.5	9.6	0	0	0.6	0.2	65	97.1	73.3	54.7	58.7
Sikkim	85	91.7	98.8	87.1	54.3	84	16.5	22.6	51.8	1.4	1.2	536	95.3	78.7	51.1	89.4
Tripura	96	94.7	98.9	94.8	82.5	49.3	38.5	11.5	30.2	1.2	0.7	184	100	100	95.8	97.9

Table 3: Concurrent Evaluation: Non High Focus States

Name of the State	Sample size of ASHAs	% of ASHAs who have received training in module 1	% of ASHAs who have received training in module 2 or more	% of trained ASHAs who received drug kits.	% of married women- 15 to 49 who reported ASHAs provided medicines free of cost.	% of ASHA received pregnancy testing kit	% of ASHA who are DOTS providers	% of ASHA received Family planning incentives	% of ASHA received VHND incentives	Average monthly JSY registered by ASHA	Average monthly JSY cases taken for Institutional delivery by ASHA	Average amount received per month by ASHA (Rs.)#	% of ANMs reporting ASHA in position	% of GPs reporting existence of VHSC in village	% of GPs reporting VHSCs received untied funds	% of GPs perceiving "NRHM brought improvement"
Andhra Pradesh	142	96.4	97.1	64.1	79.6	73.7	69	62	0.7	2.5	2	405	100	59.2	50.7	81.7
Delhi	6	0	83.3	83.3	6.1	83.3	83.3	67	16.7	0.4	0.3	608	8.3	0	0	4.2
Goa	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	0	78.3	52.2	47.8
Gujarat	119	97.4	80.3	79	81	42.9	32.8	6.7	5	0.9	0.7	307	78.6	70.3	12.3	39.5
Haryana	120	84.5	73.1	10.8	62.9	39.7	35.8	21.7	6.7	1.2	0.7	258	98.3	41.4	28.3	58.3
Karnataka	58	100	100	36.2	40	45.2	27.6	50	8.6	0.5	0.2	299	80	94.1	76.5	77.9
Kerala	87	87.4	86.2	14.9	57.8	9.6	17.2	17.2	16.1	1.9	1.5	327	100	100	100	81.3
Maharashtra	34	100	100	61.8	49.6	0	29.4	4.2	5.9	1	1	398	43.2	97.9	54.3	67
Punjab	105	91	60	82.9	62	11	32.4	20	17.1	1.3	0.7	398	100	78	74.6	79.7
Tamil Nadu	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	0	91.3	76.1	91.3
West Bengal	13	92.3	100	15.4	36.9	54.5	0	0	0	4.2	1.8	185	14.8	29	6.5	74.2

Table 4: Concurrent Evaluation: Union Territories

Name of the State	Sample size of ASHAs	% of ASHAs who have received training in module 1	% of ASHAs who have received training in module 2 or more	% of trained ASHAs who received drug kits.	% of married women- 15 to 49 who reported ASHAs provided medicines free of cost.	% of ASHA received pregnancy testing kit	% of ASHA who are DOTS providers	% of ASHA received Family planning incentives	% of ASHA received VHND incentives	Average monthly JSY registered by ASHA	Average monthly JSY cases taken for Institutional delivery by ASHA	Average amount received per month by ASHA (Rs.)#	% of ANMs reporting ASHA in position	% of GPs reporting existence of VHSC in village	% of GPs reporting VHSCs received untied funds	% of GPs perceiving "NRHM brought improve-ment"
A &N Islands	14	100	85.7	71.4	75.1	0	14.3	0	0	0.8	0.7	475	41.7	38	33.3	42.9
Chandigarh	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	33.33	0	16.66
Dadra & Nagar Haveli	13	46.2	53.8	76.9	71.8	66.7	23.1	7.7	7.7	0	0	215	81.81	9.09	0	54.54
Daman & Diu	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	0	45.5	36.4	72.7
Lakshadweep	24	76.2	0	0	22.7	0	16.7	8.3	0	1.3	1	63	100	11.11	0	77.77
Puducherry	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	50	50	70.8

ii. ASHA Evaluation in Eight States

Background

This evaluation commissioned by the National ASHA Mentoring Group, and coordinated by NHSRC covered two districts each in eight states, which included five high focus states (Assam, Bihar, Orissa, Rajasthan, and Jharkhand) and three Non High Focus states (Andhra Pradesh, West Bengal, and Kerala).). The evaluation was conducted in two purposively selected districts each in eight states, with one being a well performing district and the second with a high proportion of scheduled castes/ scheduled tribes to capture the divergences in views between various stakeholders and examine data from geographically and programmatically diverse districts.

The evaluation was conducted in two phases i.e, Phase 1 –Used qualitative methodology and consisted of in depth interviews with key stakeholders at the state and district level and review of secondary data. *Phase 2*- Used a structured questionnaire for the Following(Table5) : Sample for this survey was - 200 ASHAs, 1200 beneficiaries or service users (Service user A - Mothers of children from 0-6 months – 800 & Service User B- Mothers of children 6 months – 2 years who had an episode of illness in the last month- 400), 200 Anganwadi workers, 200 Panchayati Raj elected members and 59 ANMs per state. Table 6 and 7 summarises findings from the evaluation[5].

Table 5: Sample Covered in Each State

States & Districts	ASHA	Service User A	Service User B	ANM	AWW	PRI
Kerala: Wayanad and Thiruvananthapuram	200	800	397	50	200	200
Orissa: Nayagarh and Angul	200	769	351	51	200	199
West Bengal: Birbhum and Malda	184	711	341	48	139	116
Assam: Karimganj and Dibrugarh	200	791	387	50	199	200
Rajasthan: Banswada and Boondi	200	726	366	71	194	186
Andhra Pradesh: Khammam and East Godavari	200	671	359	74	193	196
Bihar: Khagaria and Purnea	200	757	289	55	198	167
Jharkhand: Dhanbad and West Singhbum	197	726	345	51	198	193

Highlights

Most ASHA's in the sample of this study are educated upto class VIII and above. The density of ASHA deployment varies across and within states, with most states having over 50% of ASHA catering to a population of less than 1000. In tribal areas of Jharkhand, Khammam and Banswara, ASHA density is less than one per 500, in about 25%, 36%, and 19%, respectively, indicating that states have interpreted the norms to suit their contexts to some extent. In West Bengal, 60%, cover more than 1000 population, and this can be explained possibly because of high population density. Most ASHAs come from poor households, and the proportion of ASHAs who are SC/ST is equal to or more than the proportion of the SC/ST population on in most states. In the two districts of Bihar, in Trivandrum district and in Birbhum district it is somewhat (e.g. 10% of ASHAs are SC as compared to 14% SC in the population.) Only Andhra shows conscious affirmative action with regard to SC representation and

[5] Detailed summary of the findings of the eight state evaluation of the ASHA programme is available on National Health Systems Resource Centre website www.nhsrcindia.org

tribal districts have usually preferred ASHAs from ST background. Minorities appear under-represented.

The vast majority of ASHAs are *functional*, (i.e. carry out a defined task) irrespective of context and other constraints, although there is a wide variation in the exact set of tasks and services that an ASHA carries out, the percentage of potential users of these services who are reached *(coverage)*, and the *effectiveness*[6] with which this task is undertaken. *Effectiveness* is defined in terms of achieving desired behaviour changes (largely the preventive and promotive role), providing appropriate care for childhood illnesses such as Acute Respiratory Infections (ARI) or diarrhoea, or actual use of services in a health facility when a referral is made.

Table 6: On Pregnancy and Newborn Care

Name of the States	1	2	3	5	6	8	
	Access to ASHA services of potential Service; user A	% of service users A who were visited at least thrice by ASHA during antenatal period	% of service users A who went for institutional delivery	% of service users A who received three ANCs or more	% of User A who were visited more than two times in first month after delivery	% of service user A reporting they received advice from ASHA for early initiation of breast feeding	% of service user A reporting that they breastfed within four hours of birth
Kerala	84.7	86	97.3	89.4	43.3	91	92.4
Orissa	75.9	72.5	92.8	70.4	57.1	72.7	91.3
W.B	67.2	75.1	65	48.8	36.6	84.1	88.4
Assam	76.9	66.9	72.3	54	48.8	64.3	91.8
Rajasthan	76.4	60.8	93.5	52.2	37.9	46.1	83.1
AP	49.9	79.3	93.7	82.1	57.1	79.1	90
Bihar	72.5	58.9	81.7	20.8	31.6	69.6	82.2
Jharkhand	59.7	59.6	54.4	50.7	37.6	82.5	74.1

In terms of coverage, the access to ASHA services was highest in Kerala with 85% of the potential users reported receiving Services from ASHA and lowest in AP with 50% while Orissa, Assam, Rajasthan and Jharkhand followed with 73-76%. Of the high focus states institutional deliveries rates were highest in Orissa and Rajasthan (93%) followed by Bihar at 82%. At least three ANCs were received by the highest of 89% and 82% of service users A in Kerala and AP while among high focus states it drops to the highest of 70% in Orissa and less than 54% in all other states with the lowest of 21% in Bihar. For New born care, a high proportion of service users A reported receiving advice on early initiation of breastfeeding which was over 73% in all states except for Assam & Bihar with 64-69% and Rajasthan where it was the lowest. However over 80% of all service users A reported breastfeeding the newborn in first four hours of birth across all states except Jharkhand.

[6] *Effectiveness* is defined in terms of achieving desired behaviour changes (largely the preventive and promotive role), providing appropriate care for childhood illnesses such as Acute Respiratory Infections (ARI) or diarrhoea, or actual use of services in a health facility when a referral is made.

Table 7: On Childhood Illnesses

	1	2	3	4	5
Indicator	Of those user Bs who had diarrhea, the % in whom ASHA helped in some way	Of those User Bs with signs of ARI, the % in Whom ASHA helped in some way	User Bs who had diarrhea the % to whom ASHA gave ORS from her kit	% of User B with diarrhea and who overall got ORS	% user Bs with ARI who sought treatment
Kerala	92.1	93.1	82.5	87.7	96.6
Orissa	90.3	97	82.9	81.3	98.6
W.Bengal	82	75	51.6	75.8	97.1
Assam	70.8	64	54.2	77.6	93.4
Rajasthan	66.7	64.2	56	75.4	91.6
AP	85.2	96	71.6	64.2	92.6
Bihar	70.9	67	26.7	74.2	94.7
Jharkhand	72.9	67	36.5	64.7	88.4

In care during illness of the sick child at least 65% of ASHAs are being consulted. However despite her being "functional" on this task, her effectiveness is lower. The opportunity to provide appropriate care appears to have been lost in the majority of cases, due to lack of skills, supplies, or limited support. For example the number of cases of diarrhoea, for whom the ASHA was able to supply ORS from her kit, was 27% in Bihar, 37% in Jharkhand, 56% in Rajasthan, and 54% in Assam. Among the high focus states, Orissa alone did much better with 83% of service users reporting that the ASHA had supplied ORS. It does seem that even where the ASHA was not supplying ORS she was making referrals in the remaining cases, but even then 20% to 35% of children with diarrhoea in most states, excluding Kerala did not receive ORS. Similarly for children with symptoms suggestive of ARI, ASHAs were consulted by 67- 92% of the mothers and a majority of the service users B (over 90%) sought treatment indicative of high referrals rates made by ASHA.

The proportion of ASHA that stated making routine household (HH) visits ranged from 57% in Jharkhand to 97% in Kerala. Of the high focus states, 88% ASHAs in Orissa reported making routine HH visits. The figure was less than 70% for the rest of the high focus states. ASHA are already making home visits for promotion of antenatal care, institutional delivery, immunisation, seeing the newborn and being consulted on the sick child, and there is a considerable loss of opportunity, when the programme fails to leverage these home visits for achieving improved health practices and better child survival. Thus the potential benefits of the ASHA programme are yet to be realised and the onus is now on the programme managers at the national and state levels to rapidly scale up skilling the ASHA to provide services that will achieve positive outcomes for maternal, newborn and child survival.

There is no evidence of the ASHA charging fees, setting up private practice, becoming a *Dai* or a tout of the private sector. ASHAs reported from a 1 % to 5% range of private sector commissions across the 16 districts. Exceptions to this are 9% in East Godavari, 11% in Bundi and 17.5% in West Singhbum. There is no significant preferential referral to the private sector evident in any state. For example in referring a case of

childhood diarrhoea to a private doctor, it was less than 5% in all states. Exceptions were 22% in Bihar, and 15% in Jharkhand. For cases of ARI, referral to private sector the pattern is the same, but 39% of cases in Bihar are referred, 14.3% in Bundi in Rajasthan, and 12% each in Khamman in AP, Birbhum in West Bengal and the two districts of Jharkhand. The highest for any district was 52% in Purnea. This referral could reflect a rational decision and referral to the private sector could be due to the lack of alternatives, more than anything else. There is no evidence of any major conflict between ANMs, AWWs and ASHAs. There could be many reasons for this: One, because the ANM has shifted her work burden onto ASHA and there is no reason for conflict. Two, it is because the early conflicts are all over, and each is used to the other being there and no longer feels threatened. Three, it is because the incentive is now clearly in different silos and there is no competition for the same incentive. Thus for institutional delivery only the ASHA gets the incentive, and for family planning the ASHA almost never gets any.

In terms of the support the ASHAs require to perform better, about 70% to 90% articulated the need for better training as the single greatest requirement. Monetary support and timely replenishment of the drug kit were a distant second. The levels of political and administrative leadership for the programme also vary between states. Stability in senior leadership levels appears to correlate with better outcomes as seen in Assam, Orissa, and Andhra. Kerala demonstrates that while high political commitment is key to deciding to actually implement the programme, clarity in design, outcome and support which are important programmatic elements in ensuring ASHA effectiveness opting for the programme itself have not been addressed. One factor accounting for slow pace and limited effectiveness of the programme in Rajasthan, Bihar and Jharkhand could be frequent leadership changes and little drive and initiative at mid levels.

The ASHA programme has been successful in terms of promotion of institutional deliveries and in immunisation. Even here the last mile, namely reaching the marginalised, is yet to be covered, with between 15% to 50% of women in some districts have not been reached. The ASHA is not as effective in influencing critical health behaviours such as three ANC check ups, breastfeeding, adequacy in complementary feeding, with the same intensity, which undermines her effectiveness in bringing about changes in health outcomes.

The study concludes that greater support is to be given to the health rights dimension of the ASHA through a more meaningful engagement with NGOs, provision of competency based training, adequate drug supplies, and mentoring and motivation (beyond cash incentives). Research on CHW programmes worldwide show that such support does lead to saving lives of children and newborns. For India, such support will enable the ASHA to become an effective provider of community based care of newborns and sick children, improve her credibility and expand her reach into marginalised communities. Without this support NRHM will have missed the opportunity of universal coverage with community based care and likely face a poor return on the substantial investment in the ASHA programme.

iii. ASHA Study for the International Advisory Panel

A study of ASHAs[7], by the Earth Institute, Columbia University and the Indian Institute of Management, Ahmedabad, in Bihar (n = 135), Chhattisgarh (n = 120), Rajasthan (n = 124), and Uttar Pradesh (n = 123), focused on the ASHA's understanding of her roles and responsibilities, training quality, current incentives, and supervisory structures. The study reveals that there is potential for ASHAs to take on some additional roles outside those originally prescribed, such as helping develop village health plans, registration of vital events with the ANM/AWW, and community based new born care. The study demonstrated that the ASHA were unable to specify all their job responsibilities. Data analysis brought to the forefront that the ASHAs lack knowledge to perform their jobs, as most have not completed the stipulated 23 days of training as recommended by the MoHFW. The study recommends that an assessment of the information that ASHAs have retained from theoretical and practical training must be conducted before ASHAs are able to work in the field, so that valuable information is not provided in error or omitted when they are counseling pregnant women and mothers on healthy practices. Pictorial job aids and frequent refresher trainings are crucial to ensure that the ASHA retains her skills. There are several key issues regarding incentives and compensation for ASHAs, which, if mitigated, would greatly contribute to an improvement in ASHAs' motivation and performance. At least 25% of ASHAs feel that the monetary compensation they receive isn't sufficient for the effort that they put in. Increasing incentives or adding additional incentives to activities should be looked into. Monetary compensation is not the sole motivation factors for the ASHAs. The desire to serve the community, increase their knowledge, becoming a part of the formal health system and the prestige associated with the position are additional reasons for becoming an ASHA. Keeping the above in mind a career progression for the ASHA to become a part of the formal health system should be considered. The success of the ASHA initiative depends on regular and reliable supervision; however this is a weak link in the system. Clear strategies and procedure for supervision need to be defined along with a list of supervisory activities and the skills for supervision to be taught to the supervisors or personnel who will conduct these activities. The study concludes that the ASHAs play a critical and effective role in bridging the gap between NRHM and the communities therefore it is important to keep the ASHA motivated to perform her duties efficiently and address issues related to provision of quality services.

iv. Common Review Mission Findings

The fourth common review mission (December 2010) reports that:

- **ASHA's roles:** There is no other component/parameter of NRHM progress which so uniformly receives positive reports as the ASHA programme- and in most cases this is despite many key processes like training, payments and supervision being weak. The positive feel is because of the impression that the ASHAs herself makes on the visiting team- and programme management has to rise to reach her level of motivation. ASHA's main effectiveness is being seen in motivating women for institutional deliveries and immunisation. ASHAs play an active role

[7] Improving the performance of Accredited Social Health Activist (ASHAs) in India, Prepared for the Interna-tional Advisory Panel

in community mobilisation especially for institutional deliveries. They are also active in referral and follow up in disease control programmes. In Kerala, they are poised to play a major role in palliative care and.. Breastfeeding practices are reported to have improved. Home based newborn care is happening in Chhattisgarh and planned in other states. There is some concern that with one per 1000 ASHA every household, there are states like Uttarakhand which is still not receiving coverage for her services and even more ASHA would be needed here. There is also concern that show she is functional in many areas, she would need better training and better support to make use of her bond with the community for better health practices and community level care provision.

- **ASHA Training and support:** ASHA programme in most states is now in the stage of introducing module 6 and 7 and the major urgency in this context is to strengthen the full time resource support at state level and the full time training and support and supervision teams within the district. Only five of the 15 states visited had an adequate support structure in place or were clearly committed to it. Payments reported range from as low as Rs. 350 per month in Kerala and Rs. 500 in Uttarakhand to Rs. 2000 per month in Assam and Jharkhand. There is high range of payments even the ASHAs of a district. Drug kit refills remains a problem – with both the low priority given to this task, and the problems of drug logistics contributing. The good news is that from all states with one exception, there are reports of good coordination between ANM, AWW and the ASHA.
- **Emerging trends in ASHA programme:** There is a strong element of mobilisation in the Chhattisgarh and Jharkhand programme. Importance given to help desks at facility for those who come to the facilities. Introduction of lodging arrangements for ASHAs in the form of ASHA *Greh in UP, Jharkhand, Uttarakhand* and help desks in states like Uttarakhand, Orissa and Jharkhand has facilitated the work of the ASHAs and increased public facility utilisation. 457 Mitanins are admitted into ANM courses in Chhattisgarh and 31 into nursing schools. Orissa has also taken a similar initiative.

Section: 2

Progress of the ASHA Programme

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

- Selection and recruitment
- Status of training
- Support structures

The matrix also provides information on modes of payment to the ASHA, innovations in the ASHA programmes for improving motivation and supervision, and strengthening the linkages with the health system.

Selection and Recruitment

In most high focus states, the required number of ASHA are already in place. New selections that are taking place are largely to cover gaps in areas where there are drop outs. The eight state evaluation of the ASHA programme indicates that overall most ASHA have been in position for over two years, indicating that attrition was probably higher in the early years of NRHM. Anecdotal evidence from the field confirms that where ASHA have not been performing there has been a self regulatory mechanism at work, with such ASHA voluntarily dropping out from the programme.

- **Selection of ASHA:** Criteria for ASHA selection were laid out in the national guidelines and followed substantially in most states. They include: Married women, educated upto Class VIII, and resident of the village /habitation. Several states used the modality of the Panchayat system rather than the Gram Sabha as the means to enable community participation.

Table 8: Status of ASHA Selection in High Focus States (December 2010)

State Name	Proposed No. of ASHAs	Number of ASHA selected	% of ASHA selected
Bihar	87,135	78,973	90.63%
Chhattisgarh	60,092	60,092	100%
Jharkhand	40,964	40,964	100%
Madhya Pradesh	52,117	50,113	96.1 5%
Orissa	41,102	40,932	99.58%
Rajasthan	48,372	43,787	90.52%
Uttar Pradesh	1,36,268	1,36,182	99.93%
Uttarakhand	11,086	11,086	100%
Total	4,77,136	4,62,129	96.86 %

Table 9: Status of ASHA Selection in North East States (December 2010)

State Name	Proposed No. of ASHAs	Number of ASHA selected	% of ASHA selected
Assam	29,693	28,798	96.98%
Arunachal Pradesh	3,862	3,629	93.96%
Manipur	3,878	3,878	100%
Meghalaya	6,258	6,258	100%
Mizoram	987	987	100%
Nagaland	1,700	1,700	100%
Sikkim	666	666	100%
Tripura	7,367	7,367	100%
Total	54,411	53,283	97.92 %

Table 10: Status of ASHA Selection in Non High Focus States (December 2010)

State Name	Proposed No. of ASHA	Number of ASHA selected	% of ASHA selected
Andhra Pradesh	70,700	70,700	100%
Delhi	5,400	3,200	59.26%
Gujarat	31,438	29,675	94.39%
Haryana	14,075	12,857	91.35%
Jammu and Kashmir	9,764	9,500	97.29%
Karnataka	39,195	32,939	84.03%
Kerala	32,854	31,868	97%
Maharashtra	59,383	58,954	99.27%
Punjab	17,360	17,014	98.0%
Tamil Nadu	6,850	2,650	38.68%
West Bengal	61,008	39,736	65.13%
Total	3,48,027	3,09,093	88.81%

Table 11: Status of ASHA Selection in Union Territories (December 2010)

State Name	Proposed No. of ASHAs	Number of ASHA selected	% of ASHAs selected
Andaman and Nicobar Island	407	407	100%
Dadra and Nagar Haveli	250	107	42.80%
Lakshadweep	85	83	97.64%
Chandigarh	423	423	100%
Total	1165	1020	87.55%
Grand total for All States and Union Territories	8,80,739	8,25,525	93.73%

Table 12 A: Density of ASHA in EAG States

State Name	Proposed No. of ASHAs	Sanctioned No. of Anganwadi Centre (2007)	Estimated Rural Population (2008)	Density of ASHA (ASHA: Population)
Bihar	87,135	81088	87679990	1 : 1006
Chhattisgarh	60,092	34937	18645601	1 : 310
Jharkhand	40,964	32097	24184836	1 : 590
Madhya Pradesh	52,117	69238	51611676	1 : 990
Orissa	41102	41697	34584474	1 : 1007
Rajasthan	48,372	48372	51392259	1 : 1062
Uttar Pradesh	1,36,268	150727	154144864	1 : 1131
Uttarakhand	11086	9664	7121594	1 : 713

Table 12 B: Density of ASHA in NE States

State Name	Proposed No. of ASHAs	Sanctioned No. of Anganwadi Centre (2007)	Estimated Rural Population (2008)	Density of ASHA (ASHA : Population)
Assam	29693	37082	26131889	1 : 880
Arunachal Pradesh	3862	4277	1012790	1 : 262
Manipur	3878	7621	2103218	1 : 542
Meghalaya	6258	3388	2222596	1 : 355
Mizoram	987	1682	535703	1 : 568
Nagaland	1700	3194	2311450	1: 1360
Sikkim	666	988	585152	1 : 878
Tripura	7367	7351	2929393	1 : 398

Table 12 C: Density of ASHA in Non High Focus States

State Name	Proposed No. of ASHAs	Sanctioned No. of Anganwadi Centre (2007)	Estimated Rural Population (2008)	Density of ASHA (ASHA : Population)
Andhra Pradesh	70700	73944	58622215	1 : 829
Delhi	5400	6106	963215	1 : 178
Gujarat	31438	44179	36577953	1 : 1163
Haryana	14075	17192	17756921	1 : 1262
Jammu and Kashmir	9764	25483	9030995	1 : 925
Karnataka	39195	54260	38873784	1 : 992
Kerala	32854	32115	25099136	1 : 764
Maharashtra	59383	84867	64157944	1 : 1080
Punjab	17360	20169	18185256	1 : 1048
** Tamil Nadu	6850	47265	37419785	1 : 5463
West Bengal	61008	92152	64754693	1 : 1061

**Tamil Nadu has ASHA programme only for selected tribal areas

Table 12 D: Density of ASHA in Union Territories

State Name	Proposed No. of ASHAs	Sanctioned No. of Anganwadi Centre (2007)	Estimated Rural Population (2001)	Density of ASHA (ASHA : Population)
Andaman and Nicobar Island	407	672	239858	1 : 589
Chandigarh	423	423	9,00,635	1 : 2129
Dadra and Nagar Haveli	250	219	169995	1 : 680
Lakshadweep	85	87	33647	1 : 396

Training of ASHA

ASHA training in Module 5 has been completed in most states except Bihar, Rajasthan, Uttar Pradesh and Madhya Pradesh. Between July 2010 and December 2010, states developed a training strategy for rolling out training of ASHA in Module 6 and 7. Modules 6 and 7 build on Modules 1-4 and are aimed at building competency among the ASHA on asset of life saving skills to be provided at the level of the community.

Table 13 A: Training Status for High Focus States

State Name	No. of ASHAs Selected	Training Status			
		Number of ASHAs Trained in			
		Less than Module 4	Up to Module 4	Module 5	Module 6 and 7
Bihar	78,973	52,859	52,859	#	Training of 6 State trainers completed
Chhattisgarh	60,092	60,092	60,092	60,092	47652 Mitanins trained up to Module 13 and Training of state and district trainers on Module 14 and 15 completed.
Jharkhand	40,964	39,214	35,675	40,964	Training of state trainers completed.
Madhya Pradesh	50,113	44,518	35,675	40,965	Training of state trainers completed, training of ASHA Trainers is ongoing
Orissa	40,932	33,910	33,910	34,124	Training of state trainers completed and selection of ASHA trainers is ongoing
Rajasthan	43,787	35,499	35,499	#	Training of state trainers completed
Uttar Pradesh	1,36,182	1,28,434	1,28,434	#	11530 ASHAs trained under CCSP
Uttarakhand	11086	11086	11086	8,978	For all ASHAs training is On going

= yet to begin

Table 13 B: ASHA Training Status in North East States (December 2010)

State Name	No. of ASHAs Selected	Training Status			
		Number of ASHAs Trained in			
		Less Than Module 4	Up to Module 4	Module 5	Module 6 and 7
Assam	28798	26225	26225	23271	Training of state trainers completed
Arunachal Pradesh	3629	3324	2906	2497	ASHA trainers trained and ASHA training - ongoing
Manipur	3878	3878	3878	3878	ASHA training - ongoing
Meghalaya	6258	6175	6175	3589	Training of ASHA trainers - ongoing
Mizoram	987	987	987	987	ASHA training- ongoing
Nagaland	1700	1700	1700	1700	Training of ASHA trainers completed
Sikkim	666	666	666	666	ASHA training-ongoing
Tripura	7367	7367	7367	7367	Training of ASHA trainers completed.

Table 13 C: ASHA Training Status in Non High Focus States (December 2010)

State Name	No. of ASHAs selected	Training Status			
		Number of ASHAs Trained in			
		Less Than Module 4	Upto Module 4	Module 5	Module 6 and 7
Andhra Pradesh	70700	70700	70700	70700	Training of state trainers completed
Delhi	3200	2075	2075	1276	Combined training On Module 1,2,3 and 4 for Phase 2 ASHAs is on going
Gujarat	29675	25534	20544	697	Training of state trainers -completed
Haryana	12857	12169	12169	5097	Training of state trainers scheduled in April
J & K	9500	9000	9000	5711	Training of ASHA trainers ongoing
Karnataka	32939	32939	32939	32939	ASHA training ongoing
Kerala	31868	25534	20544	697	NA
Maharashtra	58954	8464	8038	7029	Training of ASHA trainers ongoing
Punjab	17014	14026	14026		Training of state trainers scheduled in April
Tamil Nadu	2650	0	0	0	NA
West Bengal	39736	21666	8038	7029	Training of State Trainers completed. Planning to initiate training of ASHA trainers

Table 13 D: Training Status for UTs

Name of UT	No. of ASHAs Selected	No. of ASHA trained			
		Less Than Module 4	Upto Module 4	Module 5	Module 6 and 7
Andaman and Nicobar Island	407	184	#	#	NA
Chandigarh	423	30#	50	50	NA
Dadra and Nagar Haveli	107	87	87	87	NA
Lakshadweep	85	0	0	0	NA

Section: 3

Support Structures

As community health worker programmes in India, both NGO led and large scale interventions have demonstrated time and again, CHW programmes are only as successful as the strength of the support network afforded them. The ASHA programme has a set of supportive structures woven around it, to buttress the work of the ASHA. These include:

- National ASHA Mentoring Group
- State level ASHA Mentoring Group
- State ASHA Resource Center (or a team within existing state level bodies-such as the State Institute of Health and Family Welfare, and the State Health Systems Resource Center)
- District Community Mobilisers/Coordinators
- Block Community Mobilisers/ Coordinators
- ASHA Facilitators

Other Support mechanisms include:

- Performance Based Incentives
- Drug Kit
- Provision of other commodities such as: bicycles, sarees, identification badges, as enablers for the ASHA

Support Structures

The National ASHA Mentoring Group provides input to the NHSRC and the MOHFW on key policy matters related to the ASHA programme. Their contribution in shaping the ASHA programme at the national level is substantial.

In several states individual members of the National ASHA Mentoring Group through their organisations play a key role in supporting the ASHA programme, through field visits and reviews. The input of the National ASHA Mentoring Group has been invaluable in terms of reviewing and modifying several operational aspects of the programme, particularly given their insights from the state levels. NHSRC functions as the secretariat for the National ASHA Mentoring Group.

The supportive institutional network at state level and below (Tables 13A to 13D) has not expanded as rapidly as the ASHA programme in the states, limiting the potential effectiveness of the ASHA.

Table 14 A: Status of ASHA Support Structure and Drug Kit Distribution in High Focus States

	Status of Support Structure for ASHA					
EAG States	State Level		District Level	Block Level	Sector Level	Drug Kits
	State ASHA Mentoring Group	State ASHA Resource Centre				
Bihar	Constituted	Constituted, registration as a Society is under process. Team Leader, Two consultants,one DATA Assistant in position.Nine Divisional coordinators are going to join soon	29 out of 38 DCMs and 31 out of 38 DDAs are in place.	363 out of 504 Block community mobilisers in place.	Not yet	TWO districts have received drug kits. Hindustan Latex Limited (HLL) given the responsibility to Distribute Drug Kits to ASHAs .Planned in Phases.Eight districts to be taken up every quarter.
Chhattisgarh	Constituted	SHSRC is playing role the of ARC. State AMG yet to be formalised. 30 State field coordinators in place	District resource persons 427 District Resource Persons in 18 districts	Block Coordinator in each block	Block Resource Person (1 per 20 Mitanin) i.e. 2920 BRPs in 146 blocks	Distributed to all 60092 Mitanins (100%). Refill in progress and completed for 38,000 Mitanins.
Jharkhand	Constituted, and 1 meeting held	VHSRC established 1 State Programme Coordinator and 1 State Finance Officer in place.	20 District programme Coordinator joined in all district except 4 district for which interviews were done on Dec 10.State Trainers team consists of 48 trainers	4 Block trainers in each block .850 selected so far	Recruitment For ASHA Facilitator(1 for 20 ASHAs) is in progress.	Distributed to 35000 (85%) Sahiyas
Madhya Pradesh	Constituted	Not yet established. But a temporary set up with 4 personnel in place, including state ASHA Officer in place	District Community Mobilisers in place in 7 districts	Not yet managed through existing block level structure.	Not yet	Distributed to 45971 (91.73%)
Orissa	Constituted.	Community Process Resource Centre is in place	District ASHA Coordinator is in place	BPO is responsible for ASHA and GKS* in the block	Not yet.	Distributed to 34214 ASHAs (99%)
Rajasthan	Constituted	State ARC is in place. One Team Leader,One Pro-gramme coordina-tor,two Training coordinators in position	District ASHA Coordina-tor is place in all dis-tricts	At block level BPOs in charge through BPMUs	1152 ASHA Facilita-tor in place(1 ASHA Facilita-tor per PHC)	Distributed to 40932 (100%) ASHAs

	Status of Support Structure for ASHA					
EAG States	State Level		District	Block Level	Sector	Drug Kits
	State ASHA Mentoring Group	State ASHA Resource Centre	Level		Level	
Uttar Pradesh	Constituted	Not yet.	District Commu-nity Mobi-lizers in place	Block Health Educa-tion and Informa-tion Of-ficer id desig-nated as Nodal Officer for ASHA program	Field level suppor-tive supervi-sion done by ANMs/LHVs	Distributed to 128434 (94%) ASHAs
Uttarakhand	Constituted	State ARC in place (State has an MOU with an NGO - HIHT).	District ARC is in place in all Districts ( )	47 Block Coordinator in place	552 ASHA Facilitator in place	Distributed to 9975 (100%) ASHAs

*GKS =Gaon Kalyan Samiti, nomenclature for Village Health and Sanitation Committee

Table 14 B: Status of ASHA Structure and Drug Kit Distribution in North East States

	Status of Support Structure for ASHA					
NE States	State Level		District Level	Block Level	Sector Level	Drug Kits
	State ASHA Mentoring Group	State ASHA Resource Centre				
Arunachal Pradesh	Constituted	Constituted. One State Community Mobiliser & one state Data assistant in place.	District community mobilisers and District Data Assistants place in all 16 districts.	Not Yet .Managed through existing structures	87 ASHA facilitators in place	Distributed to 3322 (91.54%) ASHAs
Assam	Constituted.	State ARC established (State has an MOU with an NGO – Don Bosco Inst)	District Community Mobilisers in place.	Block Coordinator is in place in every block	1 ASHA Facilitator for every 10 ASHAs in place.	Distributed to 26225 (91%) ASHAs
Manipur	Constituted	Not yet.	Not yet managed through existing structures	NOT yet managed through existing structures	Not Yet	Distributed to 3878 (100%) ASHAs
Meghalaya	Constituted.	ARC Established with one State ASHA manager	Seven District Community Mobiliser are in place.	Not yet. Managed through existing structures.	143 ASHA Facilitator in place (one for 15-20 ASHAs)	Distributed to 6180 (98%) ASHAs
Mizoram	Constituted	Not Yet	Not Yet Managed through existing structures	Not yet. Managed through existing structures	Not yet. Managed through existing structures	Distributed to 943 (100%) ASHAs
Nagaland	Constituted	Not Yet	Not Yet ,managed through existing structures	Not yet, managed through existing structures	Not yet.	Distributed to 943 (100%) ASHAs
Sikkim	Constituted	Not Yet	Not yet. Managed from existing structures.	Not yet. Managed through existing structures	None so far but 71 facilitators have been proposed. Field support comes from ANMs & LHVs.	Distributed to 637 (95%) ASHAs
Tripura	Constituted .	ARC Established	District Community Mobiliser are in place in all 4 Districts	Block Facilitator selection is on going.	ASHA facilitator selection is on going	Distributed to 7362 (99.90%) ASHAs

Table 14 C: Status of ASHA Support Structure and Drug Kit Distribution in Non High Focus States

Non high Focus States	Status of Support Structure for ASHA					
	State Level		District Level	Block Level	Sector Level	Drug Kits
	State ASHA Mentoring Group	State ASHA Resource Centre				
Andhra Pradesh	Core Group formed	Not Yet .Under process IIHFW is identified as State Resource Centre.	Not yet. Managed through Project Officer, District Training Team (P.O.DTT) and District Public Health Nursing Officer (DPHNO)	Not yet.	Every PHC has 1 ASHA Nodal Officer	Distributed to all 70700 (100%) ASHAs
Delhi	Constituted	Constituted. One state level Trainer, one Data assistant and account assistant in position.	District Nodal Officer and District Mentoring Group in place.	50 ASHA Unit are in place one unit per 100,000 population. Support to each unit through a Nodal Committee-one MOIC & 10 facilitators.		Distributed to 2680 ASHAs i.e 83.75%
Gujarat	Not yet	Constituted	Not Yet. Support from existing structures	No yet. Support from existing structures	Not Yet	Procurement and distribution of drug kits is going on.
Haryana	Not Yet	Not Yet. Managed through existing structures	Civil Surgeon& Deputy Civil Surgeon (NRHM) Support in capacity building & Trainings. & Designated as District Nodal Officer	SMO-CHC in charge and MO-PHC in charge designated to monitor & Support Programme at Block level	ANM of Sub Centre designated to monitor and support ASHA	Distributed Drug kits for 5000 best performing ASHAs
Jammu & Kashmir	Not yet	Not yet	Not Yet. Support from existing structures	Not Yet.Support from Existing structures	Not Yet.	Distributed to all 9500 (100%) ASHAs
Karnataka	Constituted	Not yet.One Programme officer in place.	District programme officer in place. One senior health inspector and One master trainer at district level.	Block Medical officer,1 LHV &1 trainer & 1ANM provide support.	None	Distributed to 32939 selected and trained ASHAs 100%.
Kerala	Constituted	Constituted.	Not yet. Support from existing structures	Not yet. Support from existing structures	Not yet	Distributed to 23,350 (73.27%) ASHAs

(Contd...)

Non high Focus States	Status of Support Structure for ASHA					
	State Level		District Level	Block Level	Sector Level	Drug Kits
	State ASHA Mentoring Group	State ASHA Resource Centre				
Maharashtra	State AMG constituted..	Constituted. SHSRC PUNE taking role of ARC	33/33 District Community mobilizers have been appointed. 15 Dist. AMGs,in 15 Tribal districts and 18 Dist. AMGs in 18 non tribal districts in place	70 Block AMGs in the 15 tribal districts and 281 block AMGs in the 18 non tribal districts	893/952 facilitators posted in tribal districts. 1303/1496 posted in non Tribal districts.	Distributed to 23000 ASHAs in tribal districts =39%
Punjab	Not yet	Constituted. State Level Consultant on Community Participation in SHSRC.	18/20 District Community Mobilizers in place.	Not yet. Managed through existing structures	Not yet	Distributed to 14,500 ASHAs =85.22%
Tamil Nadu	Not yet	Institute of Public Health Poonamallee is the state ARC	Not yet. Support from existing structures.	Not yet. Support from existing structures	Not yet.	Procurement & distribution ongoing.
West Bengal	Constituted .	In process	MNGO led District Prog Coordinator (only for training)	MNGO led co-facilitator (Only for training)	None	• Drug kits distributed to 21029 ASHAs • 52.92%

Table 14 D: Status of ASHA Support Structure and Drug Kit Distribution in UTs

UTs	Status of Support Structure for ASHA					
	State Level		District Level	Block Level	Sector Level	Drug Kits
	State ASHA Mentoring Group	State ASHA Resource Centre				
Andaman & Nicobar Island	Not yet	Not yet	Support form existing structures	Not yet	Not yet	Distributed to 49 (12%) ASHAs Drug kits proposed for another 354 ASHAs
Dadra and Nagar Haveli	Not yet	Not Yet	Not yet	Not yet	Not yet .Support form Sub Centre ANMs	Distribute to 85 (79.43%) ASHAs Drug Kits proposed for another 169 ASHAs
Lakshadweep	Not yet	Not yet	Not yet	Not yet support from existing structure	Not yet. Support from ANMs	Distributed to 85 (100%) ASHAs

Section: 4

Expenditures Incurred on the ASHA Programme

The financial guidelines for the ASHA programme were initially laid out in the Accredited Social Health Activist guidelines[8], issued by the Ministry of Health and Family Welfare in July 2006. This document laid out the operational guidelines for the ASHA programme, including financial flows and budgets for the ASHA programme.

At that time, the financial norms for an ASHA (which included costs incurred on selection processes including social mobilization, training, (including costs of training trainers), drug kit and un-tied funds to the village) amounted to Rs. 7415 per ASHA. The guidelines also stipulated that the incentive payments would come from the various programmes and thus were not part of this amount.

In October 2006, a revised set of financial guidelines were issued by the MOHFW to make provision for a support structure from state to sub block levels, and for the supply of identity cards, bags, and badges for the ASHA. In this revised version of financial guidelines, different norms were specified for states with less than 20,000 ASHA and for states with more than 20,000 ASHA. With this set of revised guidelines, the amount allocated per ASHA was increased to Rs. 10,000. The original amount of Rs. 7415 was left unchanged and the additional amount was budgeted for support systems.

As against these norms, information on funds released and expenditures incurred for FY 05-06 to FY 09-10 are provided in Tables 14 to 17. Although funds were released to the high focus and NE states, in the years 05-06 and 06-07, hardly any expenditures were reported. This is to be expected since states were in the process of establishing the institutional and programmatic structures for NRHM overall and for the ASHA and community processes components. In the three functional years since then, states ought to have spent about Rs. 30,000 per ASHA. This data does not include a break up of the amount into costs incurred on selection, training, drug kits, or other accessories to the ASHA.

There is a direct correlation between expenditures and performance on the ASHA programme in the high focus states. Thus Chhattisgarh with its Mitanin programme reports the highest expenditure at Rs. 13,686 (in three years). Uttarakhand which also had set up support systems and provided high quality training through NGO involvement reports about Rs. 12, 304 for the same period. Bihar has spent the least on the programme, namely Rs. 3373. Of the NE states, most report over Rs. 10,000 for the past three years. In the non high focus states, where the programme expanded statewide in FY 2008, Delhi reports high expenditures followed by Kerala. The poor absorption of funds correlates with lack of support structures and other support activities, little investment in training quality, limited internal capacity, and reluctance to engage with external technical resources, such as NGOs.

[8] Accredited Social Health Activist Guidelines, (ASHA), Ministry of Health and Family Welfare, Government of India.

Table 15 A: Funds released and Expenditure on ASHA Programme - High Focus States - reported in Rs. Crores

	2005-08			2008-09				2009-10						Total : 2005 - 2010			
Name of State	Fund released	Expen-diture	% Expenditure over fund released	Fund released	Net Cumulative Fund available	Expen-diture	% Expenditure over cumulative fund	Fund released	Net Cumulative Fund available	Expen-diture	% Expenditure over cumulative fund	No of ASHAs (as on April 10)*	Fund Spent per ASHA, (in Rs.) FY 09-10	Total Fund released	Expen-diture	% Expenditure over total fund released	Total Fund Spent per ASHA, (in Rs.)
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Bihar	31.89	4.73	14.83	17.15	44.31	5.78	13.04	56.03	94.56	13.57	14.35	71395	1901	105.07	24.08	22.92	3373
Chhattisgarh	18.11	20.12	111.10		0	5.99		17.7	11.71	12.21	104.27	28000	4361	35.81	38.32	107.01	13686
Jharkhand	28.78	6.72	23.35	9.51	31.57	17.96	56.89	8.56	22.17	5.42	24.45	40964	1323	46.85	30.1	64.25	7348
Madhya Pradesh	19.39	13.22	68.18	7.94	14.11	4.88	34.59	39.87	49.1	7.38	15.03	49282	1498	67.2	25.48	37.92	5170
Orissa	24.51	4.6	18.77	4.07	23.98	9.54	39.78	27.9	42.34	18.51	43.72	34252	5404	56.48	32.65	57.81	9532
Rajasthan	25.43	4.35	17.11	12.23	33.31	12.88	38.67	41.5	61.93	15.23	24.59	43111	3533	79.16	32.46	41.01	7529
Uttar Pradesh	45.24	12.13	26.81	116.11	149.22	65.06	43.60	135	219.16	7.96	3.63	136182	585	296.35	85.15	28.73	6253
Uttarakhand	2.58	2.47	95.74	8.87	8.98	4.18	46.55	9.85	14.65	6.99	47.71	11086	6305	21.3	13.64	64.04	12304
Total for All States	195.93	68.34	34.88	175.88	305.48	126.27	41.34	336.41	515.62	87.27	16.93	414272	2107	708.22	281.88	39.80	6804

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

Cl. No. 6 = 5+(2-3), Cl. No. 10 = 9+(6-7), Cl. No. 14 is Cl. 11 / 13, Cl. No. 18 is Cl. 16 / 13

Table 15 B: Funds released and Expenditure on ASHA Programme: Non - High Focus States - reported in Rs. Crores

	2005-08			2008-09				2009-10						Total : 2005 - 2010			
Name of State	Fund released	Expen-diture	% Expenditure over fund released	Fund released	Net Cumulative Fund available	Expen-diture	% Expenditure over cumulative fund	Fund released	Net Cumulative Fund available	Expen-diture	% Expenditure over cumulative fund	No of ASHAs (as on April 10)*	Fund Spent per ASHA, (in Rs.) FY 09-10	Total Fund released	Expen-diture	% Expenditure over total fund released	Total Fund Spent per ASHA, (in Rs.)
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Andhra Pradesh	0	2.23				0.18		8.5	8.32	9.74	117.07	70700	138	8.5	12.15	142.94	1719
Delhi	0	0		14.72	14.72	2.62	17.80	19.04	31.14	1.37	4.40	2266	605	33.76	3.99	11.82	17608
Gujarat	4.85	0.87	17.94	11	14.98	14.4	96.13	25.38	25.96	4.95	19.07	25861	191	41.23	20.22	49.04	7819
Haryana	0	1.36				0.22		8.89	7.31	4.82	65.94	12753	378	8.89	6.4	71.99	5018
Jammu Kashmir	1.02	1.4	137.26	2.92	2.54	2.17	85.43	4.21	4.58	1.14	24.89	9500	120	8.15	4.71	57.79	4958
Karnataka	0	0.63		7.71	7.08	6.34	89.55	34.66	35.4	16.04	45.31	31876	5032	42.37	23.01	54.31	7219
Kerala	0.57	1.38	242.11			21.6		21.17	-1.24	10.06	-811.29	30909	3255	21.74	33.04	151.98	10689
Maharashtra	3.36	0.28	8.33	16.34	19.42	5.33	27.45	71.77	85.86	17.69	20.60	57897	3055	91.47	23.3	25.47	4024
Punjab	0	0.38				0.78		4.49	3.33	3.47	104.20	16494	2104	4.49	4.63	103.12	2807
West Bengal	0	4.96		5.17	0.21	1.7	809.52	5.72	4.23	12.86	304.02	23518	5468	10.89	19.52	179.25	8300
Total for All States	9.8	13.49	137.65	57.86	56.4	55.34	98.12	203.83	204.89	82.14	40.09	281774	2915	271.49	150.97	55.61	5358

Data source - ROPs & PIPs. Expenditure data is presented as reported by states and may need further verification.
Cl. No. 6 = 5+(2-3), Cl. No. 10 = 9+(6-7), Cl. No. 14 is Cl. 11 / 13, Cl. No. 18 is Cl. 16 / 13

Table 15 C: Funds Released and Expenditure on ASHA Programme - North East States - Reported in Rs. Crores

	2005-08			2008-09				2009-10						Total : 2005 - 2010			
Name of State	Fund released	Expen-diture	% Expenditure over fund released	Fund released	Net Cumulative Fund available	Expen-diture	% Expenditure over cumulative fund	Fund released	Net Cumulative Fund available	Expen-diture	% Expenditure over cumulative fund	No of ASHAs (as on April 10)*	Fund Spent per ASHA, (in Rs.) FY 09-10	Total Fund released	Expen-diture	% Expenditure over total fund released	Total Fund Spent per ASHA, (in Rs.)
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Arunachal Pradesh	1.2	1.1	91.67	3.86	3.96	1.49	37.63	3.86	6.33	2.48	39.18	3599	6891	8.92	5.07	56.84	14087
Assam	14.55	4.53	31.13	29.69	39.71	2.27	5.72	29.69	67.13	29.33	43.69	28798	10185	73.93	36.13	48.87	12546
Manipur	0	0.39		1.28	0.89	0.91	102.25	3.88	3.86	1.37	35.49	3878	3533	5.16	2.67	51.74	6885
Meghalaya	1.16	0.05	4.31	3.96	5.07	2.18	43.00	6.25	9.14	1	10.94	6258	1598	11.37	3.23	28.41	5161
Mizoram	0.02	0.05	250.00	0.94	0.91	0.92	101.10	0.94	0.93	0.76	81.72	943	8059	1.9	1.73	91.05	18346
Nagaland	0.83	0.44	53.01	0.75	1.14	0.88	77.19	1.7	1.96	1.04	53.06	1700	6118	3.28	2.36	71.95	13882
Sikkim	0.18	0.19	105.56	0.19	0.18	0.12	66.67	0.64	0.7	0.34	48.57	637	5338	1.01	0.65	64.36	10204
Tripura	3.78	0.95	25.13	4.17	7	4.49	64.14	5.26	7.77	2.44	31.40	7362	3314	13.21	7.88	59.65	10704
Total for All States	21.72	7.7	43.53	44.84	58.86	13.26	22.53	52.22	97.82	38.76	39.62	53175	7289	118.78	59.72	50.28	11231

Data source - ROPs & PIPs. Expenditure data is presented as reported by states and may need further verification.
Cl. No. 6 = 5+(2-3), Cl. No. 10 = 9+(6-7), Cl. No. 14 is Cl. 11 / 13, Cl. No. 18 is Cl. 16 / 13

Table 15 D: Funds Released and Expenditure on ASHA Programme - Union Territories - Reported in Rs. Crores

	2007-08			2008-09				2009-10						Total-2005-10			
Name of State	Fund released	Expen-diture	% Expenditure	Fund released	Net Cumulative Fund available	Expen-diture	% Expenditure over cumulative fund	Fund released	Net Cumulative Fund available	Expen-diture	% Expenditure over cumulative fund	No of ASHAs (as on April 10)*	Fund Spent per ASHA, (in Rs.)	Total Fund released	Expen-diture	% Expenditure over total fund released	Total Fund Spent per ASHA, (in Rs.)
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18
Andaman and Nikobar	0.02	0.003	15.00	0.04	0.057	0.033	57.89	0.01	0.034	0.04	400.00	369	1084	0.07	0.076	108.57	2060
Dadra & Nagar Haveli	0	0.016		0.07	0.054	0.1	185.19	0.04	-0.006	0.007	17.50	107	654	0.11	0.123	111.82	11495
Lakshdweep	0.07	0.051	72.86	0.02	0.039	0.13	333.33	0.06	-0.031	0	0.00	85	0	0.15	0.181	120.67	21294
Chandigarh	0	0		0	0	0		0.11	0.11	0	0.00	200	0	0.11	0	0.00	0
Total for All UTs	0.09	0.07	77.78	0.13	0.15	0.263	175.33	0.22	0.107	0.047	21.36	761	618	0.44	0.38	86.36	4993

Data source - ROPs & PIPs. Expenditure data is presented as reported by states and may need further verification.
Column No. 6 = Column 2+5, Cl. No. 10 = 9+(6-7), Cl. No. 14 is Cl. 11 / 13, Cl. No. 18 is Cl. 16 / 13

National Rural Health Mission
Ministry of Health and Family Welfare
Government of India
New Delhi