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Update on
ASHA PROGRAMME

July 2017

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MINISTRY OF HEALTH AND FAMILY WELFARE
GOVERNMENT OF INDIA

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INTRODUCTION

This is the sixteenth issue of the ASHA Update produced by the National Health Systems Resource Centre for the National Health Mission, Ministry of Health and Family Welfare. The biannual updates capture the key activities related to ASHA and the community processes interventions of the National Health Mission undertaken in the preceding six months of the year. These cover annual events such as the Common Review Mission, the state nodal officer's meetings, the National ASHA Mentoring Group Meetings and the Best Practices Summits. The updates also provide summaries of ASHA and Community Processes evaluations and assessments undertaken by the NHSRC as well as other organizations. This issue reports on events that occurred in the period between January 2017 and June 2017.

In Section 2 we report on ASHA selection, training progress, and the status of support structures for the ASHA. The overall percentage of ASHAs in position against the target stands at 93% under National Rural Health Mission (NRHM). While High Focus states have 93% ASHAs in position, Non-High Focus states have 91%, and North East States have a near complete coverage with 99.57% ASHAs in place. The population density of ASHAs has also remained at same level (average population being covered by an ASHA moving to 902 from 900).

The selection of ASHAs under National Urban Health Mission (NUHM) has also improved, though not substantively, and presently, 60,519 ASHAs are in place against the target of 74,413 (81%). Both target and selection figures have seen only small change in numbers in last six months, and states are presently focusing on completing the selections and starting the training. The training of ASHAs in four rounds of Module 6&7, has also progressed only marginally. Presently, overall training coverage for Rounds 1 to 4 stands at 96%, 87%, 70% and 49% respectively. Lack of substantive progress in Rounds 3 and 4 reflects that the states are moving slowly in equipping ASHAs with knowledge and skills related to infant and young child feeding as well as the violence against women, which are the major content areas of these two training modules. But most states are also reporting that they plan to cover ground in completing Round 3 and 4 trainings in the current financial year. The support structures across states reflect no major additions in this period, except some recruitments for vacant positions in a few states. The coordination of support structures for community processes under NRHM and NUHM, has improved in this period, and their integration has been effected in many states.

In Section 3, we report on the preparatory community processes interventions being undertaken by states for the Prevention, Screening and Control of Common Non-communicable diseases. This initiative has been launched recently as a part of efforts for expanding primary health care services from a 'selective' to a more 'comprehensive' package. This is also an opportunity to engage ASHAs in a new role, namely, family and community level actions for chronic conditions. The design of this intervention also envisages that the ASHA and ANM collaborate closely in order to undertake screening, prevention, referral and follow up interventions. This is also reflected in joint training and team based incentives. Both were initiated in May 2017.

In 2010, a large scale evaluation of the ASHA programme in eight states was undertaken using the Realist Evaluation methodology to assess the functionality and effectiveness of the ASHAs. Subsequently the evaluation was undertaken in a phased manner in other states as well. The updates have reported key findings from all of the evaluations. The evaluations have played an important role in getting the attention of policy makers and programme officers in these states and in providing implementation support. Section 4 presents findings of the ASHA evaluation conducted in the state of Mizoram. ASHA functionality in the state was high, as over 90% mothers in the sample interviewed, reported that the ASHA motivated them for institutional delivery and escorted them to institutions. ASHA functionality in management of the sick child was also high. However, skills of ASHAs in ORS preparation, and her ability to communicate the criticality of referral in case of maternal complications need strengthening. Payment delays were reported by all ASHAs, partly on account of low banking density. Supportive supervision and review of the ASHA programme at all levels was observed to be facing challenges. The evaluation identifies clearly that programme effectiveness in terms of some of the key parameters, such as regular incentive payments, refresher training for skills and knowledge, and effective on the job hand holding, is low, which also reduces the credibility and goodwill garnered by the ASHA.

Section 5 deals with the Village Health, Sanitation and Nutrition Committees (VHSNC) community based institutions created and supported under the National Health Mission. The performance of VHSNC across states is mixed, at best. A key distinguishing factor is the training and handholding provided to the VHSNC, an explicit articulation of their roles and responsibilities and the extent to which the ASHA and her support structures are engaged. However there is no gainsaying the fact that in terms of sheer numbers to be trained this is an onerous task and requires well established training and support systems. Recently, the MoHFW launched the VISHWAS campaign, to strengthen community level convergent action on social determinants. VISHWAS will be implemented in close synergy with the Swachh Bharat Mission (SBM). This section also includes an introduction to the VISHWAS campaign. This section also provides an update on the Mahila Arogya Samities, the urban counterpart of the VHSNC. To date nearly 66% of MAS have been formed (against the present target), with 60% having a bank account.

In the final section, we report on seven best practices that were presented at the National Summit on Good and Replicable Practices held in Indore, Madhya Pradesh. The best practices pertain to areas such as the screening of ASHA for common Non-Communicable Diseases in the state of Jammu and Kashmir, expansion of the Home Based Newborn Care to addressing childhood diarrhoea and pneumonia from Odisha, the critical role of ASHA in expanding access to malaria control, also from Odisha, and development of 'mhealth' solutions to support ASHA. They also include two best practices on community processes in the National Urban Health Mission from Chhattisgarh and Haryana, and one on 'the role of the ASHA in clearing the backlog of cataract surgeries'. All seven best practices demonstrate the changing and expanding role of the ASHA. However, the extent to which such pilot interventions are scaled up even within the state of origin depends largely on the training and support system for the ASHA.

PROGRAMME UPDATE

Over last six months the total target for ASHAs has increased from 10,18,019 to 10, 21,543 while the selection figures have reduced from 9,39,728 to 9,38,054. The over selection status remains at 92%.

ASHA Selection - National Rural Health Mission (NRHM)

The total number of ASHAs working under the programme presently is 8,77,535 as compared to the total of 8,82,947 in January 2017. This amounts to 93% selection against the total target of 9,47, 130 (compared to 949030 in Jan 2017 – which is a decrease of 1900).

Major contributors to the reduction in overall target are the states of Uttar Pradesh (-983), Odisha (-147), Meghalaya (-221), and Telangana (-2703). Uttar Pradesh has reported this decrease in target based on a re-assessment of area assigned to ASHAs, across all districts. Telangana's reported decrease of 2703 is on account of correction made by state in reported figures and removal of duplication of numbers reported for urban and rural ASHAs. An increase in the target of ASHAs is also noted from states of Rajasthan (+735), Gujarat (+714), Maharashtra (+547), Mizoram (+124), and Nagaland (+41). Rajasthan reflects an addition of 735, as state has increased the no. of Anganwadis, which forms the basis of ASHA selection in the state. It is important to note that state has reported a reduction in the target by 3979 ASHAs in the data shared in January 2017.

The overall number of ASHAs in position, has seen a decrease of 5412, on account of substantial downward revisions in a number of states: Rajasthan (-3852), Kerala (- 4013), and Telangana (- 2085). The downward correction reported by Rajasthan is based on segregation of ASHAs under NRHM and NUHM and removal of duplication of figures. Kerala has undertaken an assessment of performance of ASHAs over the period of past one year, and 4013 ASHAs have been dropped out from the programme across the districts. The revision in Telangana is based on correction made by state after separating out the urban ASHAs.

As a group, the High Focus states have seen a reduction of 395 in target and a reduction of 1787 in number of ASHAs in position. The North East states as a group have seen a reduction of 63 and 46 respectively, in the target and number of ASHAs in position. The Non-High Focus states have seen an overall decrease of 1442 and 3579 respectively in the target and number of ASHAs in position.

The states, which have reported good progress in selection of ASHAs are: Karnataka (1154) West Bengal (900), Madhya Pradesh (683), Bihar (626), Chhattisgarh (500), Uttar Pradesh (486), Gujarat (221), Maharashtra (194), and Mizoram (124).

At the national level, about 93% ASHAs are in position. However, in few states the selection status is less than 90%. These are West Bengal (at 81%), Rajasthan (87%) and Kerala (78%).

Population Density

Average population being covered by each ASHA under NRHM at the national level is 902, with no significant change from the figure of 900 reported in January, 2017.

The average population covered by ASHA has seen a small increase from 876 to 879 in High Focus states and from 976 to 986 in Non-High Focus states. The population density in North East states has however declined from 671 to 652, presently at 653, which is a decrease from 671 in Jan 2017. Arunachal Pradesh continues to report the lowest average population density per ASHA, in the country, at 279. Other six states that remain at below 500 average population coverage are; Mizoram (482), Manipur (442), Meghalaya (364), Tripura (397), and Chhattisgarh (296). Mizoram now has 1091 ASHAs in position based on approval of increased target and subsequent selection, and has reached a population density of 482.

States of Rajasthan, Bihar, Uttar Pradesh, Karnataka, Maharashtra, Punjab and West Bengal have population density of over 1000, as reported in January 2017. But among them, states, which have reported a decline, are: Bihar (1067 compared to 1075 in Jan), Uttar Pradesh (1071 compared to 1075 in Jan) among high focus states, and Karnataka (1085 compared to 1123 in Jan), Maharashtra (1044 compared to 1047 in Jan), and West Bengal (1265 compared to 1289 in Jan) among the Non-High Focus states. Rajasthan has seen a minor increase (1176 compared to 1070 in Jan), and Punjab remains at same level (at 1016).

Few other states which have reported some change in population density are – Nagaland (where density has decreased from 746 to 731), Kerala (increased from 619 to 722) and Telangana, (increases from 833 to 906).

ASHA Selection – NUHM

Under National Urban Health Mission (NUHM), the selection status is at 81%, similar to the progress reported in January 2017. However, during the last six months, the target for urban ASHAs has been increased from 68,989 to 74,413 and the number of ASHAs in position has also increased from 56,781 to 60,519.

The increase in the target by 5424, is mainly from the group of Non-High Focus States, which have reported an increase of 5506. The North Eastern states have reported a decline of 82 in the target while no change has been reported from High Focus states and UTs.

Among the states, substantial increase in target is noted in Kerala (target increased from 2298 to 4804), Telangana (increased from 3698 to 4983), West Bengal (moving from 6068 to 6403) and Tamil Nadu, which has reported a target of 1336 compared to zero in Jan, though selection of ASHAs is yet to be initiated. Small increment in target was also reported in Karnataka, Maharashtra and Sikkim.

In North East states, few states have reported small decrease in target, leading to overall decrease of 82 in the group -Meghalaya, (decreased from 255 to 210), Mizoram (decreased from 127 to 79). Nagaland (decrease from 47 to 41). Among the states where progress is noted in selection are - Gujarat (increased from 3717 to 3917), Haryana (from 2253 to 2360), Karnataka (from 1701 to 2362), Maharashtra (from 6857 to 7525), and Telanagana (from 2576 to 4360). Kerala has reported reduction in ASHAs selected (from 1927 to 1587) due to high drop-outs. Among the High Focus states the rise in numbers is contributed mainly by UP (moving from 4012 to 4685). The North East states together have reported a decrease of 138 (from 2317 to 2179) due to drop outs reported from states of Assam, Mizoram, Sikkim and Tripura.

The overall selection percentage is highest in North East states, at 93%, while it is 85%, 79% and 72% in High Focus states, Non-High Focus states and UTs, respectively.

	NRHM					NUHM		
State/UT	Proposed ASHAs (Target)	ASHA selected / working	% of ASHA against target	Rural Population 2011 Census	Current Density of ASHAs	Proposed ASHAs (Target)	ASHA selected / working	% of ASHA against target
High Focus States								
Bihar	93687	86505	92.3	92341436	1067	391	344	87.9
Chhattisgarh*	70078	66213	94.5	19607961	296	3883	3701	95.3

State/UT	NRHM					NUHM		
	Proposed ASHAs (Target)	ASHA selected / working	% of ASHA against target	Rural Population 2011 Census	Current Density of ASHAs	Proposed ASHAs (Target)	ASHA selected / working	% of ASHA against target
Jharkhand	40964	39380	96.1	25055073	636	246	216	87.8
Madhya Pradesh	62583	61912	98.9	52557404	849	4200	3907	93
Odisha	45665	45138	98.8	34970562	775	1482	1435	96.8
Rajasthan	51036	44288	86.7	51500352	1163	4674	4076	87.2
Uttar Pradesh	160175	145024	90.5	155317278	1071	6813	4685	68.7
Uttarakhand	10048	9980	99.3	7036954	705	1038	1038	100
Total	**534236**	**498440**	**93.3**	**438387020**	**880**	**22727**	**19402**	**85.3**
North Eastern States								
Arunachal Pradesh	3862	3827	99.1	1066358	279	42	40	95.2
Assam	30619	30428	99.3	26807034	881	1336	1289	96.4
Manipur	3928	3928	100	1736236	442	81	81	100
Meghalaya	6519	6519	100	2371439	364	210	169	80.4
Mizoram	1091	1091	100	525435	482	79	74	93.6
Nagaland	1928	1925	99.8	1407536	731	41	41	100
Sikkim	641	639	99.6	456999	715	35	25	71.4
Tripura	6840	6832	99.8	2712464	397	527	460	87.2
Total	**55428**	**55189**	**99.5**	**36017143**	**653**	**2351**	**2179**	**92.6**
Non-High Focus States								
Andhra Pradesh	390009	37994	97.4	34776389	856	2660	2502	94.1
Delhi						5679	5130	90.3
Gujarat	38902	36555	93.9	34694609	949	4407	3917	88.8
Haryana	18000	17223	95.6	16509359	959	2676	2360	88.1
Himachal Pradesh	7930	7805	98.4	6176050	810	34	34	100
Jammu & Kashmir	12000	11843	98.6	9108060	769	63	63	100
Karnataka	39195	34523	88.1	37469335	1085	3508	2362	67.3
Kerala	30927	24206	78.2	17471135	722	4804	1587	33
Maharashtra	61504	58987	95.9	61556074	1044	9565	7525	78.6
Punjab	17360	17075	98.3	17344192	1016	2753	2362	85.8
Tamil Nadu **	6850	3905	57.01			1336	0	0
Telangana	23887	23820	99.7	21585313	906	4983	4360	87.5
West Bengal	61008	49157	80.5	62183113	1265	6403	6403	100
Total	**356572**	**323093**	**90.6**	**318873629**	**980**	**48871**	**38605**	**78.9**
Union Territories								
Andaman & Nicobar	412	407	98.7	237093	583	10	0	0
Chandigarh	24	15	62.5			25	18	72
Dadra & Nagar Haveli	250	208	83.2	183114	880	50	46	92
Daman & Diu	98	73	74.4	60396	827	38	7	18.4

State/UT	NRHM					NUHM		
	Proposed ASHAs (Target)	ASHA selected / working	% of ASHA against target	Rural Population 2011 Census	Current Density of ASHAs	Proposed ASHAs (Target)	ASHA selected / working	% of ASHA against target
Lakshadweep	110	110	100	14141	129			
Puducherry						341	262	76.
Total	**894**	**813**	**90.9**	**494744**	**609**	**464**	**333**	**71.7**
Total All India	**947130**	**877535**	**92.6**	**793772536**	**902**	**74413**	**60519**	**81.3**

*ASHAs are selected at hamlet level in Chhattisgarh.
** ASHAs are selected in few identified tribal areas in Tamil Nadu.

Status of ASHA Training

NRHM

In the last six months (1st Jan to 30 June 2017), progress in Round 1 has come mainly from the two High Focus States- Odisha (where training status has increased from 94% to 100%) and Uttar Pradesh (increased from 71% to 93%). Thus in UP 31,740 ASHAs have been trained while in Odisha 2653 ASHAs were trained in Round 1. Other states, that still have substantial ground to cover in round 1 are; Nagaland (73% ASHAs trained) and Andhra Pradesh (86% ASHAs trained). Rajasthan, has reported a drop of 3741 in no. of ASHAs trained in round 1 as state has revised the figures for ASHAs in position.

The progress in Round 2 has also been contributed mainly by the High Focus States, which have together trained 23449 ASHAs. UP has trained 21938 ASHAs (increase from 61% to 76%) and Odisha has trained 2316 ASHAs (94% to 99%). In North East States, the training status has remained at 95%. Non-High Focus States have trained 3347 ASHAs, of which 2609 ASHAs have been trained in Maharashtra. West Bengal and Andhra Pradesh have also trained 715 and 1558 ASHAs respectively.

With regards to Round 3, major progress is reflected from Non-High Focus States, which have together trained 37315 ASHAs with an increase of 12% (from 66% to 78%). Among High Focus States 10,771 ASHAs have been trained (training status increased from 59% to 61%). Uttar Pradesh has trained 4461 ASHAs, Rajasthan has trained 3437 ASHAs, Odisha has trained 1730 ASHAs, and Madhya Pradesh has trained 1143 ASHAs in round 3 in last six months. In North East States, only 27 ASHAs in this period and training status has overall remained unchanged.

Among the Non-High Focus States, Andhra Pradesh has trained 3291 ASHAs, and Gujarat has trained 737 ASHAs. Telangana has trained 2413 ASHAs, with an increase in training status from 54% to 69%. West Bengal has also trained 562 ASHAs during this period, but training status has remained unchanged as state has selected new ASHAs. Jammu and Kashmir and Haryana, the two states which had not trained any ASHA in Round 3 till January, have trained 8523 ASHAs and 16361 ASHAs (with 72% and 95% completion), respectively.

Slow pace of Round 4 training, which is at the level of 49% presently, is an area of concern in High focus and Non-High focus states. Only North-Eastern States have trained 94% ASHAs (though no ASHAs have been trained in round 4 in last six months in NE states). In High Focus states training status increased marginally from 34% to 39% while in Non-High Focus states it has increased from 43% to 56%. Uttar Pradesh remains the only state among the High Focus states, and Andhra Pradesh, Haryana, J&K, and Telangana among the Non-High Focus states, which are yet to start the Round 4 training.

Among the High Focus states, Bihar the only state that has not reported any training of ASHAs during last six months. The major contributors to the additional ASHAs trained in Round 4 during last six months are; Jharkhand (6088 ASHAs trained- 16% increase), Madhya Pradesh (2995 ASHAs trained- 4% increase),

Rajasthan (trained 2836 ASHAs- 9% increase) and Uttarakhand (trained 2028 ASHAs – 20% increase). In Non-High Focus states, Maharashtra, has shown remarkable leap and has trained 32268 ASHAs (largest number of ASHAs trained among all states), increasing the training status from 19% to 73.5%. Andhra Pradesh has trained 4937 ASHAs (13% increase), and West Bengal has trained 2946 ASHAs (5% increase). Himachal Pradesh which has started round 4 training during last six months, has trained 5014 ASHAs and has completed 66% ASHA training while Karnataka has reported a downward correction in the figures to completion of training of 27,757 ASHAs (80%) in Round 4.

The High Focus states, have an overall achievement of only 61% and 39% respectively in Round 3 and 4. For Non-High Focus states also training completion is only 78% and 57% respectively for Round 3 and 4. Telangana (yet to start round 4), and Andhra Pradesh (40.5% coverage of Round 4), also need to expedite the training roll out. Among the North Eastern States, plateau on training status has been reported since last two years. Eg- Round 4 training has been completed for 77% in Arunachal Pradesh, 83% in Nagaland and Meghalaya.

State/UT	ASHA selected or working	Round 1 of Module 6&7		Round 2 of Module 6&7		Round 3 of Module 6&7		Round 4 of Module 6&7	
	No.	No.	%	No.	%	No.	%	No.	%
High Focus States									
Bihar	86505	78336	90.6	67725	78.3	55818	64.5	7148	8.3
Chhattisgarh	66213	66169	99.9	66169	99.9	66169	99.9	66169	99.9
Jharkhand	39380	37045	94.1	37271	94.6	37910	96.2	32134	81.6
Madhya Pradesh	61912	58494	94.5	53383	86.2	53514	86.4	21980	35.5
Odisha	45138	45125	99.9	44731	99.1	44327	98.2	40668	90.1
Rajasthan	44288	41490	93.7	37435	84.5	28920	65.3	16210	36.6
Uttar Pradesh	145024	134751	92.9	110513	76.2	8623	5.9	0	0
Uttarakhand	9980	10313	103.3	10381	104	10286	103.1	8821	88.4
Total	**498440**	**471723**	**94.6**	**427608**	**85.8**	**305567**	**61.3**	**193130**	**38.7**
North Eastern States									
Arunachal Pradesh	3827	3669	95.9	3424	89.5	3424	89.5	2958	77.3
Assam	30428	29560	97.1	29257	96.2	29215	96.0	29179	95.9
Manipur	3928	3804	96.8	3804	96.8	3804	96.8	3756	95.6
Meghalaya	6519	5891	90.4	5873	90.1	5941	91.1	5414	83.0
Mizoram	1091	987	90.5	987	90.5	987	90.5	987	90.5
Nagaland	1925	1398	72.6	1397	72.6	1624	84.4	1593	82.8
Sikkim	639	665	104.1	665	104.1	665	104.1	665	104.1
Tripura	6832	7257	106.2	7009	102.6	7280	106.6	7252	106.1
Total	**55189**	**53231**	**96.5**	**52416**	**95.0**	**52940**	**95.9**	**51804**	**93.9**
Non-High Focus States									
Andhra Pradesh	37994	34824	91.7	33889	89.2	24311	64.0	16437	43.3
Gujarat	36555	35464	97.0	34774	95.1	34143	93.4	33444	91.5
Haryana	17223	18046	104.8	17564	102.0	16361	95.0	0	0.0
Himachal Pradesh	7805	7533	96.5	7523	96.4	7401	94.8	5014	64.2
Jammu & Kashmir	11843	11510	97.2	11453	96.7	8523	72.0	0	0.0
Karnataka	34523	35408	102.6	29069	84.2	26259	76.1	27757	80.4
Kerala	24206	26192	108.2	4400	18.2	0	0.0	0	0.0

State/UT	ASHA selected or working	Round 1 of Module 6&7		Round 2 of Module 6&7		Round 3 of Module 6&7		Round 4 of Module 6&7	
	No.	No.	%	No.	%	No.	%	No.	%
Maharashtra	58987	57844	98.1	57197	97.0	54871	93.0	43381	73.5
Punjab	17075	16243	95.1	16243	95.1	16416	96.1	16324	95.6
Tamil Nadu	3905	1953	50.0	1953	50.0	1953	50.0	1953	50.0
Telangana	23820	26224	110.1	25159	105.6	16535	69.4	0	0.0
West Bengal	49157	50317	102.4	48850	99.4	47279	96.2	40260	81.9
Total	**323093**	**321558**	**99.5**	**288074**	**89.2**	**254052**	**78.6**	**184570**	**57.1**
Union Territories									
Andaman & Nicobar	407	272	66.8	272	66.8	0	0.0	0	0.0
Chandigarh	15	0	0.0		0.0	0	0.0	0	0.0
Dadra & Nagar Haveli	208	68	32.7	45	21.6	0	0.0	0	0.0
Daman & Diu	73	73	100.0	55	75.3	0	0.0	0	0.0
Lakshadweep	110	0	0.0	0	0.0	0	0.0	0	0.0
Total	**813**	**413**	**50.8**	**372**	**45.8**	**0**	**0.0**	**0**	**0.0**
Total All India	**877535**	**846925**	**96.5**	**768470**	**87.6**	**612559**	**69.8**	**429504**	**48.9**

ASHA Training under NUHM

During last six months, significant progress is noted in training of urban ASHAs in induction module especially in North Eastern and Non-High Focus states. However, training is yet to be initiated in all Union Territories and states of Tripura, Andhra Pradesh, West Bengal and Puducherry.

The overall achievement of ASHA training is 70% for Induction Training and 39% for Round 1 of Module 6&7, which depicts an increase of 16% in Induction training and 7% for Round 1 training since the last update.

High Focus states with 32% of total NUHM ASHAs, have completed Induction training for 93% of ASHAs, and Round 1 of Module 6&7 training for 58% ASHAs (increase by 21%). The Non-High Focus states, which, together, have 64% of total NUHM ASHAs, have completed Induction training for 59% of ASHAs (increased by 17%), and Round 1 of Module 6&7 training for 31% ASHAs. North East states with 3.6% of total NUHM ASHAs, have completed Induction training for 78% of ASHAs (increases by 65%), and Round 1 of Module 6&7 training for 11% ASHAs.

Among the eight High Focus states, all except, Jharkhand and Uttarakhand, have completed induction training for 90% ASHAs. Jharkhand has completed for 79% ASHAs while Uttarakhand has trained only 5% ASHAs. Round 1 of Module 6&7 has been conducted in only 4 states; Chhattisgarh (101%), Madhya Pradesh (68%), Odisha (85%) & Rajasthan (91%).

Among the Non-High Focus States, seven states have completed induction training for over 94% ASHAs while round 1 training has been reported only from Delhi, Gujarat, Haryana and Punjab. Delhi has completed 100% training of ASHAs in all rounds of module 6 &7.

In North East States; five states (Arunachal, Assam and Manipur, Nagaland and Sikkim) have completed induction training for100% ASHAs, while Meghalaya and Mizoram have trained 88% and 40% respectively. Round of Module 6&7 has been conducted only in three states; Meghalaya, and Nagaland (100%), and Mizoram (39%).

State/UT	Training Status				
	ASHA selected	Induction Training		Round 1 - Mod 6 & 7	
	No	No	%	No	%
High Focus States					
Bihar	344	313	90.99	0	0.00
Chhattisgarh	3701	3730	100.8	3730	100
Jharkhand	216	170	78.7	0	0
Madhya Pradesh	3907	3723	95.3	2650	67.8
Odisha	1435	1347	93.9	1222	85.1
Rajasthan	4076	4098	100.5	3712	91.1
Uttar Pradesh	4685	4685	100	0	0
Uttarakhand	1038	50	4.8	0	0
Total	**19402**	**18116**	**93.4**	**11314**	**58.3**
North Eastern States					
Arunachal Pradesh	40	40	100	0	0.00
Assam	1289	1336	103.6	0	0.00
Manipur	81	81	100	0	0.00
Meghalaya	***169***	148	87.6	169	100
Mizoram	*74*	29	39.2	29	39.2
Nagaland	*41*	41	100	41	100
Sikkim	25	25	100	0	0.00
Tripura	460	0	0.00	0	0.00
Total	**2179**	**1700**	**78**	**239**	**10.9**
Non-High Focus States					
Andhra Pradesh	2502	0	0.00	0	0.00
Delhi*	5130	5130	100	5130	100
Gujarat	3917	3716	94.9	3476	88.7
Haryana	2360	2304	97.6	1719	72.8
Himachal Pradesh	34	28	82.3	0	0.00
Jammu & Kashmir	63	63	100	0	0.00
Karnataka	2362	2582	109.3	0	0.00
Kerala	1587	1587	100.	0	0.00
Maharashtra	7525	2224	29.5	0	0.00
Punjab	2362	2362	100	1533	64.9
Tamil Nadu	0	0		0	
Telangana	4360	2644	60.6	0	0.00
West Bengal	6403	0	0.00	0	0.00
Total	**38605**	**22640**	**58.6**	**11858**	**30.7**
Union Territories					
Chandigarh	18	0	0.00	0	0.00
Dadra & Nagar Haveli	46	0	0.00	0	0.00
Daman & Diu	7	0	0.00	0	0.00
Puducherry	341	0	0.00	0	0.00
Total	**412**	**0**	**0.00**	**0**	**0.00**
Total All India	**60519**	**42456**	**70.1**	**23411**	**38.7**

*Delhi – Round 2- 95% and Round 3 – 68%.

Support Structures

Key components of Community Processes support structures are; State ASHA Mentoring Group (AMG), State ASHA Resource Centre Team, District ASHA Support Cadre, Block ASHA Support Cadre and Sub-block level ASHA Support Cadre.

Among the High Focus States, all states except Odisha have support structures at all four levels. In Odisha the programme is managed by existing staff at block level. Despite creating support structure at all four levels, state of Bihar has reported persistent vacancies at district and block levels. High proportion of vacancies are also reported from Rajasthan at block and sub block level.

Status of support structures in North-East States is same as reported in last update except for Manipur where the process of recruitment of Block Community Mobilizers has been initiated. Thus the number of states in the north east with support structures at four levels has increased from three to four i.e, Arunachal Pradesh, Assam, Manipur and Tripura.

In Non-High focus states, Haryana, Karnataka and Maharashtra have dedicated support structure at all four levels. Of the remaining states, Andhra Pradesh, Gujarat, Telangana, Jammu & Kashmir, Kerala, Delhi, Himachal Pradesh, Punjab and West Bengal have a mix of dedicated and existing staff to manage the ASHA programme. Of these, West Bengal has selected DCMs and BCMs and have designated the GP Health Supervisors to support the ASHAs at SHC level. In Andhra Pradesh and Telangana the programme is managed by DCMs at district level, while at block level and sub block level, the programme is managed by existing staff i.e, PHNs and PHC Health Supervisors. Jammu Kashmir has designated existing staff at all levels to support the ASHA programmes. In states of Delhi, HP and Kerala dedicated support structured has been created at district level while at block and cub block level the programme is managed by designated existing staff. In Gujarat, ASHA facilitators have been selected but at block and district level the programme is managed by existing staff. Punjab has created support structures at sub block and district level but at block level the programme is managed by designated staff. The programme is managed by the existing staff at all levels in Tamil Nadu.

Over the recent years all states have made substantial progress in setting up support structures at all levels. However commensurate investment in supporting and capacity building of support structures has been low and needs strengthening.

Status of ASHA Support Structure in High Focus States

State	State Level	District Level	Block Level	Sector Level
Bihar	State AMG constituted in July 2011, only one meeting held in Feb 2011. ARC set up and registered, as a separate society accountable to State Health Society. Six members team of ARC and 5 out of 09 Divisional Coordinators currently in position. State trainers – Round 1 – 6, Round 2 – 6. Round 3 – 6.	12/38 District Community Mobilisers in place. 22/38 District Data Assistants in place. District Trainers – Round 1 -803, Round 2 – 532, Round 3 – 190.	283/534 Block Community Mobilisers in place.	4140/4470 ASHA Facilitators in place (1 per 20 ASHA).
Chhattisgarh	AMG Not established. ARC is working under SHRC with a team of 11 members. State trainers– 46 and State Trainers for NUHM - 6.	35/35 District Coordinators in place in 27 districts (2/district in some outreach districts). NUHM – 3/4 District Coordinators in place. District trainers– NRHM – 292 and NUHM -25.	292/292 Block Mobilisers in place for NRHM and 25/25 Block Coordinators in place for NUHM. Mitanin Trainers - 3351	3151/3220 Mitanin trainers (AFs) in place (1 per 20 ASHAs). Under NUHM- 202/204 Mitanin trainers (AFs) in place (1 per 20 ASHAs).

State	State Level	District Level	Block Level	Sector Level
Jharkhand	State AMG constituted in 2012 and reconstituted in 2013, 9 meetings held, last meeting in November 2016. Community Mobilization Cell/ARC works within the SPMU with a team of three members. State trainers– Round 1 – 9, Round 2 – 9. Round 3 – 9.	21/ 24 District Programme Coordinators in place. District Trainers - Round 1 -417, Round 2 – 474 and Round 3- 185.	656/688 Block Trainers and DRPs in place.	2200/2200 Sahiyaa Saathi in place (1 per 20 Sahiyas).
Madhya Pradesh	State AMG formed in Oct 2008, later merged with MGCA. 23 meetings held. Last meeting in April 2016. ARC team led by State Nodal officer with 4 team members works within the SPMU. State trainers– Round 1 – 27, Round 2 – 27, Round 3 – 27.	47/51 District Community Mobilisers in place. District MGCAs formed. District Trainers - Round 1 - 458, Round 2 – 416, Round 3 - 367.	252/313 Block Community Mobilisers in place. 313 Block MGCAs in place.	4078/5074 ASHA Facilitators in place (1 for 10 ASHAs in tribal areas, and 1 for 20 ASHAs in other areas).
Odisha	State AMG constituted in 2009, total 4 meetings held, last meeting in 2012. Community Processes Resource Centre (CPRC) in place with 4consultants, 5 training coordinators and 1 programme assistant. State trainers– Round 1 – 16, Round 2 – 16, Round 3 – 16.	30/30 District Community Mobilisers in place. District AMGs constituted. District Trainers – 267	Existing Block PMU staff manages the programme.	2018/2255 Community Facilitators (AFs) in place (1 per 20 ASHAs).
Rajasthan	State AMG constituted in June 2006, last meeting held in Sep 2010. Team of two consultants working in SPMU. State trainers– Round 1 – 25, Round 2 – 25, Round 3- 25.	25/34 District Community Mobilisers in place. District Trainers – Round 1- 720, Round 2- 570, Round 3- 612.	166/249 Block ASHA Coordinators in place.	990/ 1528 PHC ASHA Supervisors in place (1 per PHC).
Uttar Pradesh	State AMG constituted in Aug 2008, last meeting held in Dec 2016. Community Processes Division led by a Nodal officer works within SPMU, with a team of 10 Consultants. State trainers – Round 1 – 71, Round 2 – 63, Round 3 - 2.	71/75 District Community Mobilisers in position. 72 Districts have District AMGs. District Trainers, Round 1 – 3135, Round 2- 430.	722/820 Block Community Mobilisers in place.	5931/6807 ASHA Facilitators in position (1 per 20 ASHAs).
Uttarakhand	AMG constituted in June 2009, total 26 meetings held, last meeting in May 2016. State team of two programme coordinators and one data entry operator is led by one, Nodal Officer. State trainers– Round 1 – 4, Round 2 – 4 Round 3 – 4.	District ARCs outsourced to NGOs. 13/13 District Community Mobilisers in place. District Trainers Round 1- 67, Round 2-67, Round 3- 67.	100/ 101 Block Community Mobilisers in place. NUHM – 6 Community Mobilisers in place.	605/606 AFs in place (550 rural, 56 urban - 1 per 15-20 ASHAs).

Status of ASHA Support Structure in North East States

State	State Level	District Level	Block Level	Sector Level
Arunachal Pradesh	State AMG constituted in Jan 2010, 9 meetings held, last meeting held in Aug 2015. ARC – 3 member team within SPMU. State trainers– Round 1 – 4, Round 2 – 4. Round 3 - 4.	17/20 District Community Mobilisers in place. 20/20 District Data Assistants in place. District Trainers - Round 1 - 22, Round 2 – 28. Round 3 - 28.	84/84 Block Community Mobilisers in place.	348/348 ASHA Facilitators in place (1 per 10-15 ASHAs).
Assam	State AMG constituted in 2010-11. Eight8 meetings held so far, last meeting held in Jan 2016. ARC housed in SPMU, with 4 team members. State trainers - Round 1 - 4, Round 2 –4, Round 3 - 4.	25/27 District Community Mobilisers in place. District Trainers - Round 1 - 447, Round 2 – 447, Round 3 – 447.	149/ 149 Block Community Mobilizers in place.	2878/ 2878 ASHA Facilitators in place (1 per 10 ASHAs).
Manipur	State AMG constituted in Dec 2008. 11 meetings held so far, last meeting held in May 2014. ARC Team comprising of one state nodal officer, 1 ASHA Program Manager, and 1 DEO, is housed within SPMU. State trainers - Round 1 - 3, Round 2 - 3. Round 3 - 3.	9/9 District Community Mobilisers in place. District Trainers - Round 1 - 62, Round 2 - 62. Round 3 – 62.	Existing BPMU staff	194/194 ASHA Facilitators (1 per 10 to 20 ASHAs) in place.
Meghalaya	AMG formed in Oct 2009. 6 meetings held. Last meeting held in Sep 2014. ARC in place, within SPMU with 2 programme managers. State trainers – Round 1 - 2, Round 2 - 2. Round 3 - 2.	10/11 District Community Process Coordinators in place. District Trainers - Round 1 - 68, Round 2 – 56, Round 3- 56.	Existing BPMU staff	324/334 ASHA Facilitators in place (1 per 20 ASHAs).
Mizoram	State AMG constituted in 2008. 9 meetings held so far, last meeting held in Sep 2015. ARC team comprising of three consultants is housed within SPMU State trainers - Round 1 - 3, Round 2 - 3. Round 3 – 3.	9/9 District ASHA Coordinators in place. District Trainers - Round 1 - 18, Round 2 – 18, Round 3- 18.	Existing staff	109/109 ASHA Facilitators in place (1 per 10 ASHAs).
Nagaland	AMG formed in 2010, 5 meetings held, last meeting in Aug 2013. ARC comprising of two consultants is housed within SPMU. State trainers - Round 1 - 3, Round 2 – 2, Round 3 – 4	11/11 District Community Mobilisers in place. District Trainers – Round 1 - 63, Round 2 – 63, Round 3- 11.	66/77 Block ASHA Coordinators (BACs) in place.	Block ASHA Coordinators provide field level support.
Sikkim	State AMG constituted in 2010. 2 meetings held so far, last meeting held in Nov 2013. One State ASHA Nodal Officer in place. State trainers - Round 1 - 2, Round 2 - 2. Round 3 – 2	Existing DPMU staff and ASHA trainers support the ASHA programme. District Trainers – Round 1 - 11, Round 2 – 11, Round 3- 11.	Existing BPMU Staff	71/71 ASHA Facilitators in place (1 per 10 ASHAs).

Tripura	State AMG constituted in May 2009. 8 meetings held so far, last meeting held in Nov 2013. Programme is managed by 1 state ASHA Programme Manager. State trainers - Round 1-3. Round 2-3 and Round -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 - 87. Round 3 – 89.	8/11 Sub-division level ASHA Coordinators in place.	399/ 400 ASHA Facilitators in place.

Status of ASHA Support Structure in Non- High Focus States

Name of State	State Level	District Level	Block Level	Sector Level
Andhra Pradesh	AMG constituted in May 2015. Functions of ARC managed by a team based in SPMU and Directorate. State trainers - Round 1 - 9, Round 2 – 9 and Round 3- 9.	13/13 District Community Mobilisers in place. Project Officer District Training Team (P.O. DTT) and District Public Health Nursing Officer (DPHNO) also support the programme. District Trainers – Round 1-306, Round 2-317, Round 3- 312.	225/225 PHNs designated as Block Community Mobilisers.	1385/ 1410 Health Supervisors at PHC level play the role of ASHA Facilitator.
Delhi	State AMG formed in July 20106 meetings held so far, last meeting held in Jan 2015. ARC team comprising of a team of five consultants is led by one State level Nodal Officer. State trainers - Round 1- 54, Round 2- 54 .	10/ 11 District ASHA Coordinators in place. District ASHA Mentoring Group also in place. District Trainers - Round 1- 255, Round 2- 261, Round 3 - 318.	113 ASHA Units in place (One unit per 50,000 population). Each unit has Unit Mentoring Group composed of 4-5 members1005/ 1123 ANMs designated as ASHA mentors in place.	
Gujarat	State AMG Constituted in Aug 2011. 5 meetings held so far, last meeting in March 2015. ARC working under the office of Rural Health Department under Commissionerate of Health Office. ARC team includes four members. State trainers – Round 1- 7, Round 2- 7, Round 3 - 7.	Existing DPMU staff leads the programme. 33/33 Programme Assistants - ASHA, in position. District AMG formed in 24 districts. District Trainers – Round 1 – 85, Round 2-80, Round 3 - 19.	Existing BPMU staff	3487/3751 ASHA Facilitators in place (1 per 10 ASHAs).
Haryana	AMG not constituted. ARC in place within the SPMU with 10members team. State trainers - Round 1 - 10, Round 2 - 10, Round 3 - 10.	17/ 21 DACs in place. District Trainers – Round 1- 377, Round 2 -377 Round 3 - 377.	104/113 Block ASHA Coordinators in place.	575/900 ASHA Facilitators in place.

Name of State	State Level	District Level	Block Level	Sector Level
Himachal Pradesh	State has started ASHA programme in FY 2014-15. One ASHA Nodal Officer works within SPMU. State trainers –Round 1- 23, Round 2- 23 and Round - 23.	11/12 District ASHA Coordinating Assistants. District Trainers – Round 1 - 260, Round 2 – 260, Round 3-260.	Existing BPMU staff	Existing staff –2071/2071 Female health workers play role of ASHA Facilitator (1 per HSC).
Jammu & Kashmir	State AMG established in 2012-13. ARC team comprising of five members is housed within SPMU. State trainers –Round 1-12, Round 2-12, Round 3-12.	Existing staff. Total 22/22 in number. District Trainers – Round 1 and 2 -190, Round 3- 60.	Existing staff - 117/117 Community Health Officer or ANMs/LHVs support the ASHA programme.	811/816 – existing cadre of ANMs/LHVs designated to support ASHA programme. (1 per 10 ASHAs in Hard to Reach blocks (44) and 1 per 20 ASHAs in other blocks (73).)
Karnataka	State AMG was constituted in Oct 2012Last meeting held in Feb 2017. ASHA programme is managed by One ASHA Nodal Officer and one ASHA Programme Manager State trainers - Round 1 - 7, Round 2 - 7and Round 3 – 7.	27/30 District ASHA Mentors in place. District Trainers- Round 1 – 140, Round 2 – 121, Round 3 - 118.	163/176 Block Mobilisers in place.	1763/1800 ASHA Facilitators in place.
Kerala	State AMG constituted in 2008, 7 meetings held, last meeting held in Dec 2015. State ARC Team of two members is based within SPMU. State trainers – 7.	13/14 District ASHA Coordinators in place. District Trainers – 40.	Existing Staff. 204/214 block level staff manages the programme.	Existing staff – Junior Public Health Nurse.
Maharashtra	State AMG constituted in Oct 2007. 5 meetings held so far, last meeting held in July, 2013. ARC team including 4 members is located within SPMU. State trainers -Round 1 - 13, Round 2 - 13. Round 3 – 13.	31/34 District Community Mobilizers in place. District AMG formed in all districts. District Trainers - Round 1 - 1412, Round 2 – 1374, Round 3 – 1329.	331/355 Block Community Mobilizers in place. Block AMG formed in 70 tribal blocks and in 281 Non-tribal blocks.	3250/3562 AFs in place. 1 per 10 ASHAs in tribal and 1 per 20 in ASHAs non- Tribal districts.
Punjab	State AMG constituted in Oct 2014. One meeting held in Oct 2014. ASHA programme is managed by one consultant CP (SHSRC) and one Programme. Manager ASHA 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 - 307. Round 2 – 305, Round 3 - 302.	Existing Staff (Block Extension Educator working as BCM in many places).	864/898 ASHA Facilitators in place.

Name of State	State Level	District Level	Block Level	Sector Level
Tamilnadu	State AMG not formed, but NGOs are involved in ASHA support. Institute of Public Health, Poonamallee designated as ARC. State trainers -3	Existing staff (DPMU and Deputy Director of Health Services and District and Maternal and Child Health Officers (DMCHO). District Trainers -31	Existing staff- Community Health Nurse	Existing staff- Sector Health Nurse per PHC
Telangana	State AMG formed in May 2015 but meetings not held. ASHA Resource within SPMU has a team of four members State trainers – Round 1 - 3, Round 2 – 3, Round 3 - 3.	31 District Community Mobilizer positions approved. Recruitment yet to be initiated. District Trainers –Round 1 - 326. Round 2– 326, Round 3 – 174.	Existing BPMU staff 151/151 CHO/PHN coordinates the works.	1353/1387 Multi Purpose Health Supervisor (MPHS-F), 1 per PHC designated as ASHA Facilitator.
West Bengal	State AMG formed in Sep 2010. 4 meetings held so far last meeting held in Dec 2011. ARC team includes 9 members is located within SPMU. Training is managed by Child In Need Institute CINI. State trainers- Round 1 - 11, Round 2 – 11, Round 3 - 11.	21/26 DCMs in place. District Trainers – Round 1 - 739, Round 2 – 739, Round 3 - 739.	463/666 Block Community Mobilizers in place (2 per block).	Existing staff (Health Supervisor at Gram Panchayat level) supports ASHA programme.

Status of ASHA Support Structure in UTs

Name of UT	State Level	District Level	Block Level	Sector Level
Andaman & Nicobar Island	Programme managed by SPMU	Existing staff	Existing staff	Existing staff
Chandigarh	Programme managed by SPMU	Existing staff	Existing staff	Existing staff
Dadra and Nagar Haveli	Programme managed by SPMU	Existing staff	Existing staff	Existing staff
Daman and Diu	Programme managed by SPMU	Existing staff	Existing staff	Existing staff
Lakshadweep	Programme managed by SPMU	Existing staff	Existing staff	Existing staff
Puducherry	Programme managed by SPMU	Existing staff	Existing staff	Existing staff

Section 3

UNIVERSAL SCREENING OF COMMON NON-COMMUNICABLE DISEASES

World Health Organization (WHO) has identified four major NCDs - Cardiovascular Diseases (CVD) such as heart attacks and stroke, Diabetes, Chronic Respiratory Diseases (Chronic Obstructive Pulmonary Diseases and Asthma) and Cancer, for accounting to high proportion of mortality in India. These NCDs together account for over 60 per cent of all deaths. (WHO 2014). The National Programme for the Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS) was initiated in 100 districts in 2010 to prevent and control the major NCDs. The main focus of the programme is on health promotion, early diagnosis, management and referral of cases, besides strengthening the infrastructure and capacity building. The programme was later expanded to 468 districts in 2012 and 606 districts in 2013. The program focuses on opportunistic screening for common NCDs.

MoHFW has launched the initiative of upgrading the existing Sub centers to Health and Wellness Centres, in the year 2016. The key objectives of this initiative are to expand the range of primary healthcare services currently delivered through the public health system from selective to comprehensive Primary Health Care (CPHC), and also to bring the services closer to the community. The comprehensive services would be provided by a primary health care team comprising of MPW (M&F) and ASHAs and led by Mid-level provider. The expanded package would include services related to Non-Communicable diseases, Mental health, ENT, Opthalmology, Oral health, Geriatric and palliative health care and Trauma care, in addition to the existing services (RCH and communicable diseases). As part of this effort, population based screening of common NCDs and cancers (Hypertension, Diabetes, Oral cancer, Breast cancer and Cervical cancer) has also been rolled out in 2016, as the first step.

In June 2016, Operational Guidelines were launched in order to expand the services for primary health care in public health system. These guidelines envisage conducting risk assessment, screening, referral and follow up for selected NCDs (hypertension, diabetes, oral cancer, breast cancer and cervical cancer) amongst population aged 30 years and above. Screening for four conditions (Hypertension, Diabetes, Oral Cancer and Breast Cancer) will be provided at the level of the sub-centre. For cervical cancer, screening will be undertaken at the level of the PHC by a trained staff nurse or a lady MO.

Training

All frontline workers (ASHA and MPW/ANM), Staff Nurses and Medical officers in PHCs are being trained for a set of competencies commensurate to their roles. The training modules on universal screening of NCDs for ASHA, MPW (F)/ANM, Staff nurses and Medical Officers) were launched on 16th May 2017.

Training of Trainers workshop for state trainers of ASHA, MPW/ANM and Staff Nurses was conducted by NHSRC in collaboration with AIIIMS and NICPR while training for Medical Officers was conducted by NCD cell, MoHFW. So far state trainers for ASHAs (81), ANM (75) and staff nurses (65) have been trained.

Training modules for ASHA, ANMs, Staff nurses and MOs have been disseminated to states, and training has been initiated across all states. About 117 districts and 26 cities have been selected by states for the launch of universal screening of common NCDs. So far 3607 ASHAs and 1017 ANM/MPWs have been trained across all states/UTs. In few states, a short orientation has been done for the staff nurses and medical officers while formal trainings for Staff nurses and Medical Officers is yet to be initiated.

So far, Screening has been initiated in states/UT of Chhattisgarh, Gujarat, Maharashtra, Telangana and Dadar and Nagar Haveli and over one lakh population has been screened for common NCDs.

FINDINGS FROM RECENT EVALUATION

Key Findings from ASHA Evaluation: Mizoram

The fourth round of the ASHA evaluation was conducted in Mizoram in the year 2016-17. Key findings of the evaluation are resented in this section. As reported in previous updates, the evaluation followed a Realist approach and used a mix of qualitative and quantitative methods. In depth interviews with all the stake holders were conducted in Phase 1 while cross-sectional survey was conducted in phase 2. During phase 2, interviews were conducted with ASHAs, two categories of service users who received services from ASHAs (A-Women who had delivered in last six months and B-Children between 6.1 months-2years of age who had any episode of illness during last one month), AWWs, ANMs and PRI representatives. However, the sample size for the evaluation was estimated according to the state context i.e state currently has about 1091 ASHAs in place against the target of 1094.

The sample of respondents in each district was:

Respondents	Mizoram	Serchhip	Kolasib
ASHAs	80	40	40
Service-users (Beneficiary A)	320	160	156
Service-users (Beneficiary B)	160	80	80
ANMs	20	10	10
AWW	80	40	40
Representatives of PRI	80	40	40

Key Findings

The state team leading the programme is very committed and a strong ownership towards the programme was evident. All 987 ASHAs in rural areas, have been trained up to Module 7 and they have also undergone special training in malaria treatment. A new set of 104 ASHAs (approved in the current year) have been selected and their training has begun. Good rapport was noted between the ASHAs and the PHC and SHC staff, especially with the ANMs. The ASHAs shared that ASHA work has given them social recognition and improved their confidence levels.

The program component that needs strengthening is the monitoring and supervision at all three levels. The performance of ASHA mobiliser's in supporting ASHAs is affected by the limited support provided at the district level. There is no system of review and support of the District ASHA Coordinators at the state level. This is due to a lack of a systematic approach towards monitoring and supervision. The roles and responsibilities are not clearly understood at all three levels and there is no action plan made by the mobiliser or district coordinator to review progress. Review monthly meetings are not held at PHC, district or state level.

The ASHA mobilisers only meet the district coordinator once a quarter when they submit a report (not in a group). There is no documentation of field visits or review reports at either mobiliser or district level. High costs of travel, poor communications and lack of physical accessibility to the villages and health centres emerged as a challenge for both the ASHAs and the ASHA mobilisers. ASHAs find it difficult to travel to the PHC often and ASHAs mobilisers face difficulties to travel for regular field visits. This is a major concern in border districts.

Delays in payment of incentives were common across the state. ASHAs face issues in opening of bank accounts and even withdrawal of money because of poor accessibility to banking services. Aadhaar cards were provided only at the district headquarters, and ASHAs who were not able to travel the distance were not able to get the card. The recent rule of making payment to bank accounts linked with Aadhaar, has further made it difficult for ASHAs to receive timely payments.

With regards to the provision of services to beneficiaries during antenatal, intrapartum and postpartum period, high levels of functionality of ASHAs was noted. Over 99% service users A reported that ASHAs visited them atleast five times during antenatal period and 92% reported that ASHAs visited them atleast six times during the postnatal period. Access to antenatal care and institutional delivery care was 100% as reported by all service users. About 99% services users A in Serchhip and 83% in Kolasib shared that it was ASHA, who motivated them for institutional delivery. ASHAs accompanied the pregnant women to institution for delivery in 100% cases in Serchhip and in 71% in Kolasib. All women who had any form of maternal complication sought ASHA's advice for treatment. However, only 57% of service users A in Serchhip and 81% in Kolasib reported getting counselling on danger signs from ASHAs during antenatal period. When asked about the important danger signs during pregnancy that need immediate referral, almost all ASHAs were aware about loss of foetal movements, vaginal bleeding and headache/blurred vision/dizziness but only 60% ASHAs in Kolasib knew that immediate referral should be made in case of convulsions.

		Indicators	Mizoram	Serchhip	Kolasib
Functionality	2	% of service users A who were visited at least five times by ASHA during antenatal period.	99	100	98.1
	3	% of Service Users A whom ASHA helped in making the birth plan.	85.7	94.7	74.9
	4	% of Service Users A who reported that ASHA advised them for institutional delivery.	100	100	100
	5	% of user A who had complication during pregnancy and sought ASHA's advice for treatment.	100	100	100
	6	% of service users A who were visited at least six times by ASHA during post natal period.	92.2	92.2	92.2
Effectiveness	7	% of service users A who received three ANCs or more.	100	100	100
	8	% of service user A who said ASHA was present during all ANC visits.	82.8	81.6	84
	9	% of service users A who had an ANC card made.	91.9	94.7	89.1
	10	% of service users A who received ANC and reported getting 90 IFA or more.	96.1	100	92.3
	11	% of service users A who received ANC and reported getting their BP checked.	100	100	100
	12	% of service users A who went for institutional delivery.	99.35	100	98.7
	13	% of Service User A who went for institutional delivery and cited ASHA as a motivator-referral by ASHA.	91.2	99.3	83.1
	14	% of Service User As who went for institutional delivery and were accompanied by ASHAs.	85.6	100	71.4
	15	% of service user A who had institutional delivery and whom ASHAs helped in arranging transport.	35.9	40.8	31.2
	16	% of service users who were counselled on danger signs of pregnancy.	68.8	56.6	80.8
	17	% of service users who had any maternal complication and sought treatment.	100	100	100

		Indicators	Mizoram	Serchhip	Kolasib
Knowledge	18	% of ASHAs who said that they would refer a pregnant woman immediately to the institution in case of bleeding from vagina.	100	100	100
	19	% of ASHAs who said that they would refer a pregnant woman immediately to the institution in case of loss of foetal movements.	97.5	97.5	97.5
	20	% of ASHAs who said that they would refer a pregnant woman immediately to the institution in case of Headache/dizziness/blurred vision.	98.8	100	97.5
	21	% of ASHAs who said that they would refer a pregnant woman immediately to the institution in case of convulsions and fits.	72.5	85	60

In case of management of childhood illnesses, high levels of functionality and effectiveness can be observed. Table below shows that, all service users who reported that their child suffered from diarrhoea or ARI in last one month, received help from ASHAs in management of the illness and also sought treatment. However, in Kolasib only 77% service users B reported that ASHA could give them ORS from her kit. This is due to poor availability of drug kits with ASHAs (only 8 ASHAs in Kolasib and 21 ASHAs in Serchhip had ORS available in their kits on the day of interview). Skills of ASHAs were found to be low regarding steps of preparing ORS (58% ASHAs could correctly list the steps) and about counselling for increased fluid intake during diarrhoeal episode (only 33% ASHAs said they would give the advice about increases fluid intake).

Overall the findings highlight high levels of functionality and effectiveness of the ASHAs in the state. However, roles and responsibilities of support structures at all levels need to be clearly defined with provision for mobility support to undertake regular field visits. Regular refresher training in key topics at monthly review meetings which should be held at all three levels (PHC, district and state) will strengthen the programme. Mapping need to be undertaken to understand the local issues faced in some districts where transport is unavailable, or banks do not exist close enough for the ASHA. Alternate plans need to be developed for such areas to ensure timely payments and easy access. Process of replenishment of drug kits and HBNC kits needs to be streamlined.

		Mizoram	Serchhip	Kolasib
Functionality	% of user B who had diarrhoea and whom ASHA helped in some way.	100	100	100
	% of user B with signs of ARI and whom ASHA helped in some way.	100	100	100
	% of user B who had diarrhoea and whom ASHA gave ORS from her kit.	85	100	76.9
Effectiveness	% of user B with diarrhoea who overall got ORS.	95	100	92.3
	% of user B with ARI who sought treatment.	100	100	100
Knowledge	% of ASHA who had knowledge of making ORS.	57.5	60	55
	% of ASHA who had knowledge of advising increased fluid intake in case of diarrhoea.	32.5	35	30
	% of ASHA who had knowledge of advising continued feeding for the child who had diarrhoea.	86.3	80	92.5
	% of ASHA who could specify chest wall indrawing as a danger to suspect pneumonia.	95	100	90

COMMUNITY BASED INSTITUTIONS

A. Village Health Sanitation and Nutrition Committees (VHSNC) under National Rural Health Mission (NRHM)

VHSNCs are an important mechanism to ensure community participation at all levels, which include participation as beneficiaries, in supporting health activities, in implementing, and even in monitoring and action based planning for health programmes. The guidelines suggest VHSNCs to be formed at the level of revenue village. The VHSNCs are mandated to function under the ambit of the Panchayat Raj Institutions (PRI), as a sub- committee or standing committee of Gram Panchayat. The VHSNCs will be re-structured after every election of village panchayat. The guidelines for VHSNCs were revised in 2013, according to which, a local village panch (preferably woman or SC/ ST) would be its chairperson, and ASHA should be its member secretary.

Presently about 5,22,232 VHSNCs have been established against the target of 5,48,655 which is 95% of the target. Of these, about 5,08,166 VHSNCs have their bank account, which is 93% against the target.

The states of Bihar, Uttar Pradesh, Sikkim, Tripura, Andhra Pradesh, and Himachal Pradesh have established the VHSNCs at the Gram Panchayat level. All other states have formed VHSNCs at the revenue village level.

The High focus states have the biggest – 50% share of the VHSNCs, while Non-High Focus states have 42%, North East states have 8% and UTs have .09% share. The percentage of VHSNCs formed against the target is 94% in High Focus states, while it is 97% in Non-High Focus states. North East states have formed 94% of VHSNCs formed against target. UTs have 100% VHSNCs formed against the target.

The percentage of VHSNCs which have a bank account, a critical indicator of their functionality, is between 92 to 93% (against the target) in High Focus states, Non-High Focus states, and North East States.

The numbers shown above reflect that the states largely have VHSNCs in place, with most of them also having a functional bank account. If we look at the numbers, above 97% of the VHSNCs formed have a bank account. But the programme reports from the states reflect that, functionality of VHSNCs, faces variety of challenges, in terms of, participation of community, as well as the support and handholding provided. The percentage expenditure of VHSNC funds has shown declining pattern over the years, and in recent years, untied funds are being released to states on a top up basis, under which each VHSNC gets an amount, based on its expenditure to ensure that it has the assigned Rs. 10000 of united fund at the start of the year.

The systematic capacity building and hand holding of VHSNCs, especially in terms of sustained efforts, has faced large gaps over the years. Though most of the states have conducted some orientation for VHSNCs from time to time, there is no definite regularity, structure and sustainability to this process.

The task is onerous due to the overall large no of VHSNC members to be trained, and the diversities in their engagement and ability to participate in VHSNC processes as well as the orientations/trainings. After the new guidelines, were issued and subsequently Handbook for VHSNC members was also released to facilitate their capacity building, in 2013, efforts have been made to improve the capacity building processes. The VISHWAS Campaign launched recently, details of which are being given in this chapter, is expected to strengthen the institutional capacity of VHSNCs for effective and sustained community action on health, the key purpose for which they were created.

State/UT	Proposed No of VHSNC -Target	No of VHSNC Formed	No of VHSNC with Bank Account	% of VHSNC Formed against target	% VHSNC with bank account
High Focus States					
Bihar	8462	8384	7908	99.08	93.45
Chhattisgarh	20126	19180	19180	95.30	95.30
Jharkhand	30012	29635	29635	98.74	98.74
Madhya Pradesh	53532	47959	47959	89.59	89.59
Odisha	46564	45407	45407	97.52	97.52
Rajasthan	43440	43440	40698	100.00	93.69
Uttar Pradesh	59163	51914	51413	87.75	86.90
Uttarakhand	16826	15296	15296	90.91	90.91
Total	**278125**	**261215**	**257496**	**93.92**	**92.58**
North Eastern States					
Arunachal Pradesh	3862	3772	3772	97.67	97.67
Assam	30619	28207	27470	92.12	89.72
Manipur	3878	3878	3878	100.00	100.00
Meghalaya	6356	6249	6249	98.32	98.32
Mizoram	830	830	668	100.00	80.48
Nagaland	1324	1324	1324	100.00	100.00
Sikkim	641	641	641	100.00	100.00
Tripura	1178	1038	1038	88.12	88.12
Total	**44826**	**42167**	**41268**	**94.07**	**92.06**
Non-High Focus States					
Andhra Pradesh	12940	11891	11891	91.89	91.89
Gujarat	17623	17286	17286	98.09	98.09
Goa	260	260	236	100.00	90.77
Haryana	6049	6049	6049	100.00	100.00
Himachal Pradesh	8000	7579	7523	94.74	94.04
Jammu & Kashmir	6886	6741	6719	97.89	97.57
Karnataka	26007	26007	26007	100.00	100.00
Kerala	19523	19523	19523	100.00	100.00
Maharashtra	40022	40022	40022	100.00	100.00
Punjab	12956	12956	12956	100.00	100.00
Tamil Nadu	15015	15015	15015	100.00	100.00
Telangana	10859	10426	8830	96.01	81.32
West Bengal	49063	44594	36844	90.89	75.10
Total	**225203**	**218349**	**208901**	**96.96**	**92.76**

State/UT	Proposed No of VHSNC -Target	No of VHSNC Formed	No of VHSNC with Bank Account	% of VHSNC Formed against target	% VHSNC with bank account
Union Territories					
Andaman & Nicobar	280	280	280	100.00	100.00
Chandigarh	22	22	22	100.00	100.00
Dadra & Nagar Haveli	71	71	71	100.00	100.00
Daman & Diu	28	28	28	100.00	100.00
Puducherry	100	100	100	100.00	100.00
Total	**501**	**501**	**501**	**100.00**	**100.00**
Total All India	**548655**	**522232**	**508166**	**95.18**	**92.62**

VISHWAS (Village based Initiative to Synergise, Health, Water and Sanitation) Campaign

Ministry of Health and Family Welfare has launched the VISHWAS Campaign, to strengthen, community level convergent action on social determinants of health. VISHWAS is a yearlong campaign to be carried out by each VHSNC in its area, through 11 monthly campaign days.

The focus of the campaign is on building awareness and social mobilization, developing community level volunteers and champions for action on water, sanitation and health, and building a platform for integration/building synergies between various government programmes. The campaign will be carried out in close synergy with the Swachh Bharat Mission (SBM).

Each monthly campaign day will focus on a select theme and will not only build awareness and provide information about the particular theme and its linkages with Sanitation with Health, but it will also link resources, and targets within the available programmes, with the village needs and community level planning. The eleven campaign days are following:

- Annual Planning Day for Swachhata Campaign
- Village Health and Sanitation Day (Components of Village Cleanliness and linkages between Hygiene and Sanitation and Health)
- Open Defecation Free (ODF) Day
- Hand Washing Day
- School and Anganwadi Sanitation day
- Liquid and Solid Waste Management Day
- Individual and Home Hygiene Day (safe water and food handling, better upkeep of drinking water)
- Healthy Life Style Day/Health Promotion and Communicable Diseases (NCD) Day
- Communicable Diseases and Vector Control Day
- Celebration Day for Swachhata Champions
- Gram Sabha on Sanitation & Cleanliness

As is reflected in the framework of Campaign, the effort is to converge all community level aspects of water and sanitation, so that not only infrastructure of all key elements of sanitation can improve, but also the aware-ness building and community mobilization on these issues can be strengthened. A module/manual for the rollout of campaign has been released by ministry, and state trainers from all states have been trained in 3 days Training of Trainers (TOT) by the national resource pool. States are in the process of rolling out the campaign.

B. Mahila Arogya Samiti (MAS) under National Urban Health Mission (NUHM)

Mahila Arogya Samiti (MAS) under NUHM, is a key community level institution for mobilisation of community and their active engagement with the health system. MAS is expected to act as a leadership platform for women and community group in each slum area for improving awareness and access of community for health services, develop health plans specific to the local needs and serve as a mechanism to promote community action for health. MAS is formed at the level of 50 to 100 households, and would have 10 to 12 members.

Presently 29 out of 36 states/UTs have formed MAS. Total 65165 MAS have been formed against the target of 98619 (which is 66%). The no. of MAS which have bank account is 47449 (which is 48% against the target).

While 27% of total target of MAS is in the High Focus States, their share in the total MAS formed is 32%, and their share in total MAS with bank account is 34%. These states together have achieved 79% of their target of MAS formation, and 60% of their MAS (against the target) also have bank account.

The Non-High Focus states account for 72% share of the total target of MAS, and 65% of share of the total MAS formed. Their share in total MAS with bank account is 34%. These states together have achieved 61% of their target for formation of MAS, and 42% of MAS against the target also have a bank account. It is noteworthy that, all metropolitan cities are in these states, and they represent a large share of the NUHM programme challenges.

The North East states account for only 1.4% % share of the total target of MAS, and 2% share of the total MAS formed. Their share in total MAS with bank account is 2.6%. These states together have achieved 61% of their target for formation of MAS, and 42% of MAS against the target also have a bank account. Trainings of MAS have been started in a number of states, but the progress is still in initial phases.

State/UT	Proposed No of MAS - Target	No of MAS Formed	No of MAS with Bank Account	% of MAS formed against target	% of MAS with bank account against target
High Focus States					
Bihar	2449	374	261	15.27	10.66
Chhattisgarh	3883	3699	3595	95.26	92.58
Jharkhand	918	742	694	80.83	75.60
Madhya Pradesh	4200	3654	3499	87.00	83.31
Odisha	3132	3132	3089	100.00	98.63
Rajasthan	4708	4708	4429	100.00	94.07
Uttar Pradesh	6813	4428	252	64.99	3.70
Uttarakhand	500	250	250	50.00	50.00
Total	**26603**	**20987**	**16069**	**78.89**	**60.40**
North Eastern States					
Arunachal Pradesh	92	90	65	97.83	70.65
Assam	634	634	634	100.00	100.00
Manipur	409	409	409	100.00	100.00
Meghalaya	105	104	7	99.05	6.67
Mizoram	29	29	29	100.00	100.00
Nagaland	75	75	68	100.00	90.67
Sikkim	15	15	15	100.00	100.00
Tripura	96	80	80	83.33	83.33
Total	**1363**	**1346**	**1242**	**98.75**	**91.12**

State/UT	Proposed No of MAS - Target	No of MAS Formed	No of MAS with Bank Account	% of MAS formed against target	% of MAS with bank account against target
Non-High Focus States					
Andhra Pradesh	10310	10310	10310	100.00	100.00
Gujarat	8554	7738	7605	90.46	88.91
Goa	12	12	12	100.00	100.00
Himachal Pradesh	40	25	0	62.50	0.00
Jammu & Kashmir	220	214	196	97.27	89.09
Karnataka	4404	4404	4404	100.00	100.00
Kerala	938	1048	1048	111.73	111.73
Maharashtra	9393	2045	416	21.77	4.43
Puducherry	108	16	16	14.81	14.81
Punjab	7619	7473	20	98.08	0.26
Tamil Nadu	6346	1025	0	16.15	0.00
Telangana	11000	4129	3020	37.54	27.45
West Bengal	11709	4393	3091	37.52	26.40
Total	**70545**	**42816**	**30122**	**60.69**	**42.70**
Total All India	**98619**	**65165**	**47449**	**66.08**	**48.11**

GOOD PRACTICES UNDER COMMUNITY PROCESSES

In this section, the good and replicable practices pertaining to the thematic area of Community Processes presented at the recent National summit of Good and Replicable Practices held in Indore, Madhya Pradesh are presented in brief.

During the summit the following community based models were presented:

1. Screening and Orientation of ASHAs for Non-Communicable Diseases – J &K.
2. HBNC+ for reducing diarrhoea and pneumonia and improving nutrition – Odisha.
3. m-Health solution to support ASHA Facilitators for maternal health and child survival – Uttar Pradesh.
4. Inter-Sectoral Convergence with Urban Local Bodies (ULBs) for increasing service utilization at UPHCs and conducting special Outreach Camps under UPHCs – Haryana.
5. Leveraging Community Processes for Urban Slums – Chhattisgarh.
6. Improving access to malaria control services at community level through the community volunteers – Odisha.
7. Cataract backlog free district – moving towards universal eye care services – Tripura.

It is encouraging to note that out of the seven interventions, three were identified from the thematic area of Community processes while the remaining four were presented as emerging models under other thematic areas of Disease Control Programmes, National Blindness Control Programme and National Urban Health Mission. This reflects the acknowledgement of the important role that community process interventions can play in addressing local health issues.

Out of the listed interventions, the m-Health Solution for supporting ASHA facilitators and Leveraging Community Processes for Urban Slums, were documented in the January 2016 issue of Update on ASHA Programme. The remaining five interventions are presented in brief.

1. Screening and Orientation of ASHAs for Non-Communicable Diseases - J&K

Against the current back drop of implementing the comprehensive primary health care services including universal screening of common NCDs, the state of Jammu and Kashmir organized a screening camp for the ASHAs and ANMs on the occasion of International Women's day on March 8th, 2017. The camp was organized in response to the MoHFW's guidance to undertake screening of frontline workers – ASHA and ANMs, in common NCDs (Hypertension, Diabetes and three cancers – Oral, Breast and Cervical).

The main objectives of organizing screening camp were to:

1. Instil a sense of caring among the ASHAs, who ensure improved access to all health care services and also play the role of care providers at the community level.

2. Orient the ASHAs about the importance of timely identification of NCDs, treatment compliance and life style modifications.
3. Develop an understanding among the ASHAs and ANMs about their roles in roll out of Universal Screening of Common NCDs.

The screening camp was organized by NHM, J&K in coordination with Faculty of Endocrinology, AIIMS New Delhi and SKIIMS, Srinagar. All samples collected during the camp were transported to SKIIMS for testing. The faculty from AIIMS and SKIIMS alongwith the NHM state team also gave a brief orientation to ASHAs on Non-Communicable Diseases. In addition, this platform also provided space to ASHAs to share their grievances with the Mission Director, NHM J&K, District Magistrate and District Health Authorities, Pulwama. The cost of organizing local logistics of the camp was borne by District Health Administration, Pulwama while the budget for investigations was shared by SKIIMS.

The following services were provided at the camp:

- Check up for BP/ height/ weight.
- Sample collection for Blood sugar/LFT/KFT/Lipid Profile.
- Ultrasonography

Out of 500 ASHAs in the district, 399 participated in the camp. Based on the findings of the examination and laboratory test conducted, the following results were reported:

- Mean age of the ASHAs was 35.62 years (ranging 21-55 years).
- BMI (Body Mass Index): Mean BMI of the evaluated ASHA workers was 25.95±4.78 kg/m^2. About 14.28% of the ASHA workers were in the obese category with mean BMI 33.962.
- Hypertension: About 5.26% of the ASHAs were hypertensive with the mean BP of 156/100 mm of Hg.
- Diabetes: About 7.89 % of the ASHAs were diabetic with mean Glucose 157±15.66.
- Lipidemia: Dyslipidemia was noted in 16.58% with a mean value of blood serum cholesterol level as 148.14±55.17 ng/dl.
- Liver Enzyme: Amongst the various liver enzymes, Alkaline Phosphatase (15.13%) and Aspartate Serum Amino Transpherase (10.18%) showed higher levels as compared to other enzymes.
- Calcium: Hypocalcemia was reported among 44.9% ASHAs with the mean serum calcium levels of 7.77±1.78 mg/dl.

	Indicator	No. of ASHAs	Positive % against the total of 399 ASHAs
1	Diabetes	31	7.69%
2	Hypertension	21	5.26%
3	Hypothyroid	20	5.01%
4	BMI>25.8	57	14.29%
5	Dyslipidemia	66	16.6%
6	Raised Liver Enzymes	38-51	10-15%
7	Hypocalcemia	179	44.8%

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Rajouri/Ramban/Reasi/Samba/Udhampur

No.: DHS/J/1359-93 Date: 3/3/17

Subject: NCD screening of ASHAs and ANM s at Block Level on 8th of March on the occasion of International Women's Day

8th of March is **International Women's Day** .NHSRC, MoHFW, GoI has communicated to undertake NCD screening of ASHAs and ANMs at Block Level in the districts of the State. The check up shall be done for Hypertension , Diabetes, Height and weight for BMI, Ca breast and Ca Cervix which is quite feasible at Block Level as lab component is very minimal in this exercise . This screening has minimal financial implications, as it is already a part of normal facility operations at various levels in the districts. However, funds for putting up of banners and procurement of Acetic Acid for approximately 350 ASHAs and ANMs, in a Block, can easily be met out of IEC& HDF heads. The GoI guidelines for carrying out screening of Ca Oral Cavity Ca Breast and Ca Cervix are placed as **Enclosures**.

This activity will give a sense of caring amongst the cadres by the Department and will also give them hands on exposure to continuously conduct such screenings in the future .

Yours sincerely,

(Dr. Gurjeet Singh Soodan)
MS ENT
Director Health Services
Jammu

Copy for information to:

Overall response showed that ASHAs appreciated the department's initiative to organize screening for them. Orientation on NCDs followed by the screening also increased the levels of receptiveness among ASHAs about importance of timely NCD screening. This is expected to have positive impact on their functionality to mobilize community for screening. Based on the positive experience of the screening camp, state is planning to undertake similar exercise for other health workers across the state in a phased wise manner.

2. HBNC+ for reducing diarrhoea and pneumonia and improving nutrition – Odisha

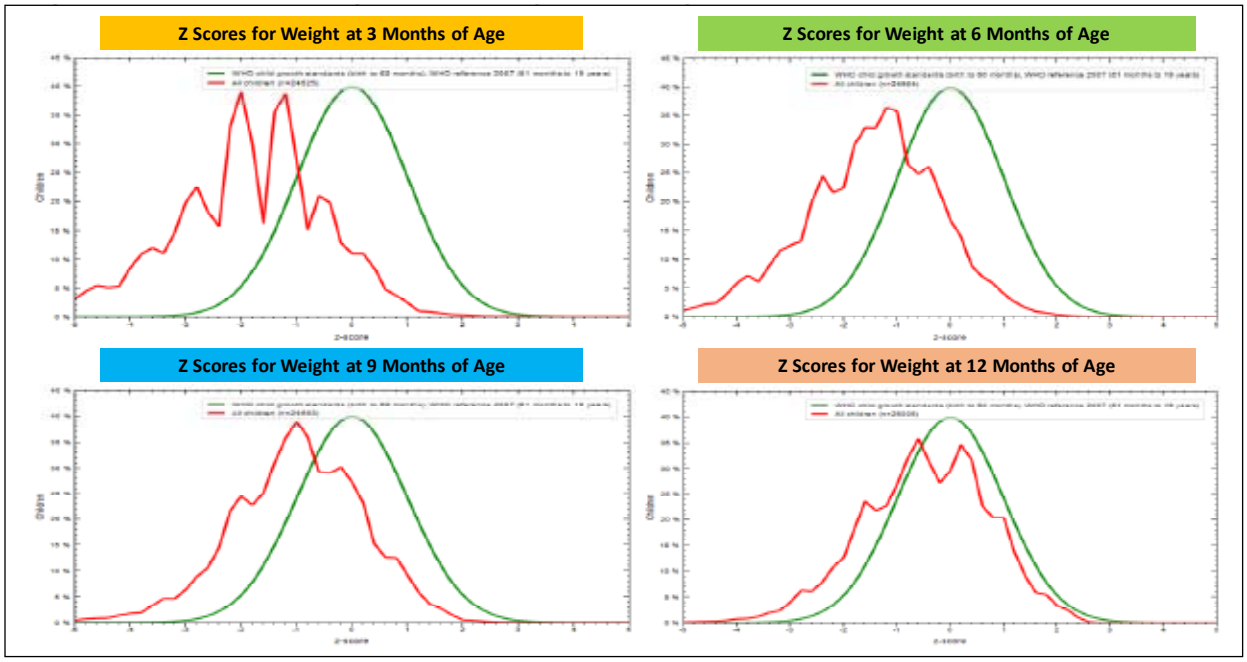
Diarrhoea and pneumonia are the two major contributory factors to infant mortality rate. In order to address these factors by preventing the onset, timely identification and management, the initiative of HBNC+ (Home Based Newborn Care Plus) was launched in the three districts of Angul, Jharsuguda and Sambalpur in the year 2014.

As part of this project, ASHAs visited infants at intervals of 3rd, 6th, 9th and 12th month, in addition to the six/ seven HBNC visits made from birth to 42 days. These additional visits provide an opportunity to ASHAs to deliver key messages on healthy child rearing practices and strengthen promotive and preventive health strategies. About 3200 ASHAs were trained to focus on immunization, early childhood development, correct use of ORS, counselling on complementary feeding, administration of IFA with the objective to reduce malnutrition, diarrhoea and pneumonia among children.

ASHAs were entitled to an incentive of Rs. 200 per child upon completion of all four visits. This incentive was provided in addition to the HBNC incentive of Rs. 250 per newborn.

Programme monitoring data from last three years shows a steady increase in coverage of home visits across three districts. About 93,325 (70%) infants received home visits, out of which 63,741 (68%) received complete 4 home visits in 3 districts. Prophylactic ORS packets were provided to 76,823 (90%) infants and pediatric IFA syrup was given to 71,136 (83%) infants.

Improvement in the nutritional status of infants was reported. About 90% of the infants who were visited had normal weight at 12 months of age. Of 12,393 infants who were severely undernourished or undernourished with weight for age Z scores less than – 2 SD at the age of 3 months, 9,818 (79%) infants showed gradual improvement and gained normal status by the time they reached the age of 12 months. Major improvement in weight for age Z score was reported between 6 months to 9 months, i.e, at the time of initiation of complementary feeding to infants.



These findings reflect that the structured visits by ASHAs at periodic intervals can lead to improvement in health status of infants. This was possible due to timely identification and management of developmental delays, childhood illness and poor nutritional status, improving home based child care practices and ensuring timely nutritional supplementation.

3. Inter-Sectoral Convergence with Urban Local Bodies(ULBs) for increasing service utilization at UPHCs and conducting special Outreach Camps under UPHCs - Haryana

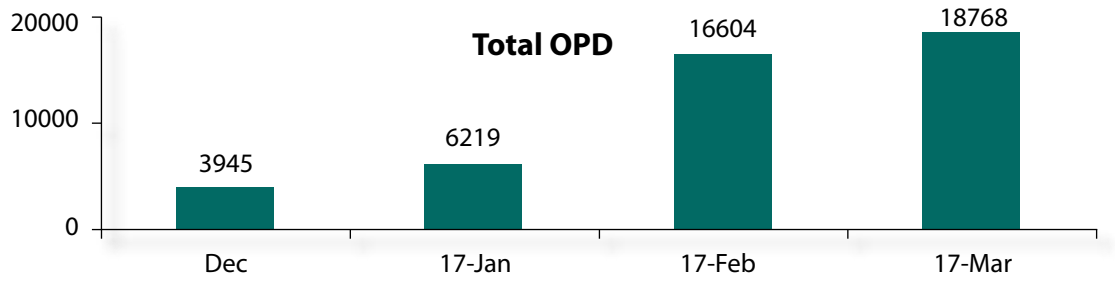
Convergence is an important component of NUHM to enable community mobilization, improve access to services and facilitate community level action. In an attempt to build strong convergence mechanisms with the urban local bodies, the state of Haryana engaged with ULBs to support organization of special outreach camps. During FY 2016-17, district level orientation meetings of ULBs under the chairmanship of Civil Surgeon and annual co-ordination meetings with legislators and other eminent persons were conducted at the district and U-PHC level, respectively. In total about 59 meetings were conducted in FY 2016-17. Ward Councilors were also included as members of the Swasthya Kalyan Samiti (SKS) in UPHCs.

The UPHC level Coordination Meeting were used as a platform to:

- Discuss the area specific issues like sanitation, Provision of potable water supply, waste management etc.
- Develop strategies to plan for better public health activities.
- Increase the utilization of services being provided by the UPHC in their catering area.

As a result of these initiatives, ULBs facilitated - a) arranging the venue for camp, b) logistics arrangement for staff, c) logistics for patients – waiting area arrangements and drinking water, and d) improved branding of NUHM through media coverage.

The number of outreach camps increased from 43 in Dec, 2016 to 136 in March, 2017 and OPD at the camps increased from the 3,945 in Dec, 2016 to 18,768 in March, 2017.



The initiative also led to increase in the OPD attendance at the UPHCs because of awareness generation by local leaders in the community and resolving of UPHC management issues pertaining to infrastructure and patient amenities by coordination with ULBs. Various examples of community ownership have been shared by states, these include, a) U-PHC on District Kurukshetra, which has now been shifted to a government building provided and maintained by Municipal Councillor of Krishna Nagar Gamri, and b) a park has also been developed and maintained by Municipal Councilor at the UPHC Krishna Nagar Gamri.

Efforts made by state to engage with ULBs have resulted in increased inter-sectoral coordination for shared outcomes results in efficient health service delivery for urban poor. Experience from the state reiterate that ULBs can play an important role in mobilization of the community and building credibility of health department in urban poor communities.

4. Improving access to malaria control services at community level through the community volunteers – Odisha

About 26% of the country's malaria cases (0.4 million) are reported from Odisha. This is mainly on account of the topographical diversity and tropical climate conditions of the state. In addition, over 90% of the malaria cases are from Plasmodium Falciparum category which can cause severe complications and even lead to mortality.

In order to address this issue, state has trained and actively engaged with ASHAs and Gaon Kalyan Samitis to enable prevention, timely identification and management of malaria at community level. The ASHAs were trained and engaged as Fever Treatment Depot (FTD) for diagnosis and treatment of malaria cases with appropriate anti-malarial drugs. In few areas where ASHAs were not available, about 3000 community volunteers were trained especially to serve hard to reach areas. These volunteers were supported by the programme (incentive based) and by CARITAS India consortium and TATA Trust.

The following strategies have been implemented in the state:

- **Early Diagnosis and Complete Treatment (EDCT):**
  - ASHAs were the first point of contact for malaria diagnosis and treatment at the village level.
  - ASHAs engaged with community platforms like Gaon Kalyan Samiti to support prevention and community mobilization activities under malaria programme.
  - ASHAs worked in coordination with AWWs and non-ASHA volunteers.

- **Addressing Malaria in VHND Sessions:**
  - Guidelines were rolled out by state to address Malaria in vulnerable population groups (pregnant mothers and under-5 children) in monthly VHND sessions.
  - Malaria screening is done by ANMs and ASHAs during the VHND sessions by bivalent RDT.
  - Malaria positive cases are treated with appropriate Antimalarials.
  - Counseling for regular use of Long Lasting Insecticide Treated Nets is provided by ASHAs.
  - ASHAs also provide counselling for follow up for treatment adherence & any complication.

- **Vector Control Interventions:**

A. LLIN Distribution in Community:

- ASHAs conduct household survey, distribute the LLIN and undertake demonstrations on the use of LLIN.
- ASHAs work with GKS to promote community mobilization, organizing IEC activities using medium of folk arts and platform of village meetings.
- ASHAs also undertake night time monitoring to promote use of LLIN.

B. Indoor Residual Spray (IRS):

- ASHAs provide counselling and advance intimation regarding date and time of spray and Do's and Don'ts regarding IRS.
- They also accompany the teams during spray.
- ASHAs also support the cases where residents who refuse to participate in the activity and provide counselling for better acceptance.

- **State Specific Initiatives:**

A. Malaria, Dengue and Diarrhoea (MDD) Campaign: State funded campaign to create awareness on outbreak prone monsoon influenced diseases. ASHAs played the critical role of coordinating with schools, creating awareness through interactive sessions at schools, engaging in IEC activities, e.g. Nidhi Rath Campaign, mobilizing community and increasing participation of children.

B. DAMaN: This initiative was launched in the state in 2017 to reach the inaccessible and difficult areas. Two camps are organized in difficult to reach areas and vulnerable areas biannually. The range of activities undertaken during these camps are:

- Mass malaria screening (both symptomatic and asymptomatic).
- Treating of all malaria positive cases.
- Haemoglobin estimation of Pregnant & lactating mothers.
- Growth assessment of under-5 children.

These camps were supported by ASHA, AWW, community volunteers and PRI members.

This multipronged approach adopted by state with high levels of involvement of ASHAs, has contributed to the following programme outcomes:

- Deaths due to malaria reduced by 187% in 2016 compared to 2007 in spite of increase in case detection.
- Around 40 lakh LLINs were distributed by ASHA and GKS platforms mechanism during 2010-2012.
- Reduction of malaria incidence and deaths by 73.54 % and 268.7% respectively in 2013 compared to 2010.
- Early diagnosis and complete treatment, mass screening in hard to reach areas and Tribal Residential Schools averted outbreaks.

State has recently started distribution of over 11.34 million LLINs through GFATM support in 2017. Of which 7 million have been distributed through ASHA- GKS mechanism within 2 months period and most difficult pockets have been protected before being cut off by rains.

5. Cataract backlog free district – moving towards universal eye care services - Tripura

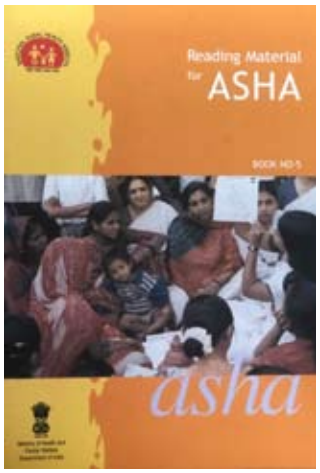
Cataract is one of the leading causes of blindness in India. Findings from a population based assessment of prevalence and causes of visual impairment conducted in Tripura in 2016, revealed that a high prevalence of blindness at 2.8%. It also reported that in 81.9% of cases, blindness was caused by cataract in Tripura. A project was launched in the district of North Tripura in 2016 to promoted timely identification of cataract and support management of cataract to prevent blindness. An MOU was signed between the District Health and Family Welfare Services with NGOs - Help Me See and P.C. Chatterjee Eye Hospital. The programme focused on community mobilization and community level screening, followed by diagnosis at PHC level and provision of cashless services to patients. Advance calendar for eye screening and cataract surgery was prepared by the District Programme for Control of Blindness Unit**.**

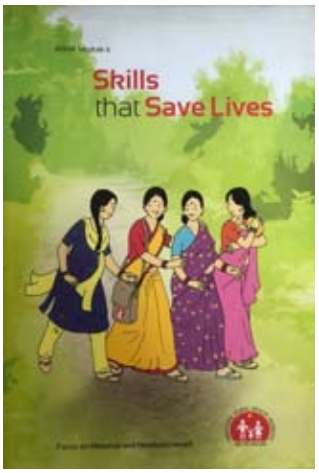
Community Mobilization: Sensitization of PRI and NGO Members was organized at district and block level, All ASHAs of the district were trained by AYUSH MOs at the ASHA Varsho Divas (PHC monthly meeting of ASHAs). Advocacy meeting was held with local MLAs, BDO and CDPOs for convergence and generating support for the project. ASHAs were trained and supported to conduct home visits to screen for cataract and mobilize patients to PHC on fixed dates. ASHAs were incentivized at the rate of Rs. 3 per household visit, in addition to the incentive available under NPCB of Rs. 175 per operated eye for facilitation of the cataract surgery.

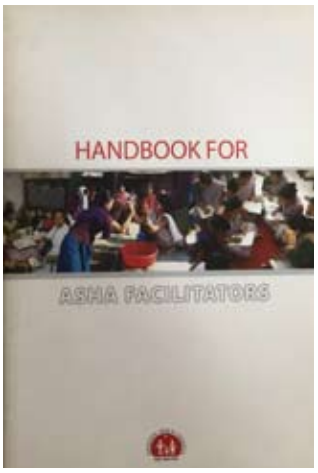
Patient Evaluation at Health Facility Level: Camps were organized at the PHC level, where District Eye Surgeon and Ophthalmic Assistant visited on fixed dates to confirm the diagnosis. Computerized data base was created for all patients at the PHC. Based on the visual impairment status of the patients, spectacles were distributed by ASHAs at their door step. Measures were taken to ensure the supply of spectacles within 10 days to the PHC/CHC.

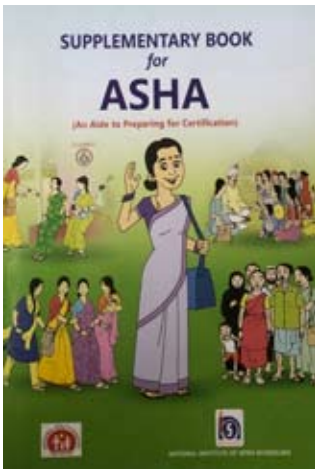
Free Services for Patients: One of the key features of the programme was the provision of free services to the patients needing surgical correction under RSBY and NPCB, including free transport services. Pre-sterilized single use kits were used by eye surgeons from Help Me See and P C Chatterjee - MSICS at the District hospital Eye OT. The necessary repair and maintenance of the Eye OT at the DH was carried out utilizing the Rogi Kalyan Samiti (RKS) fund of Rs. 5 Lakh.

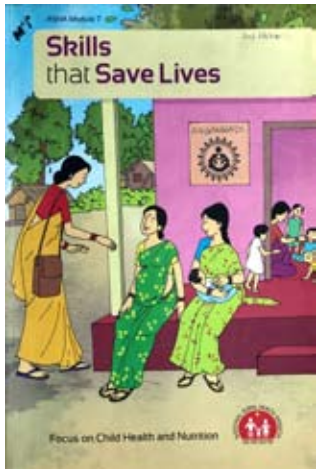
About 80,000 households were visited by 907 trained ASHAs and 2286 patients were evaluated at the PHC level. Of the 648 cataract cases identified within three months from 121 villages, 83% were operated successfully in single OT at North District Hospital between March to May 2017. About 1500 patients with refractive error received spectacles. Tele-ophthalmology services were provided to 1200 patients. The project generated demanded for eye care services and increased community ownership of the initiatives.

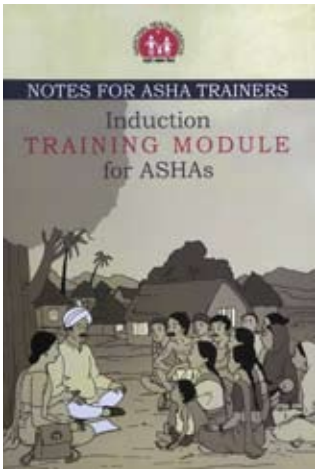

Reading Material for ASHA
asha

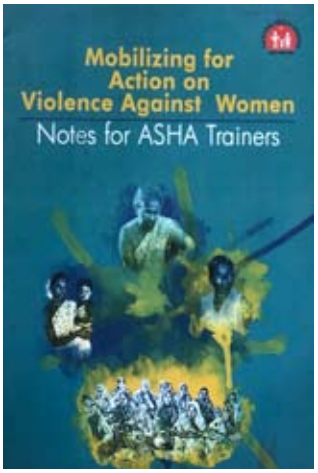

Skills that Save Lives

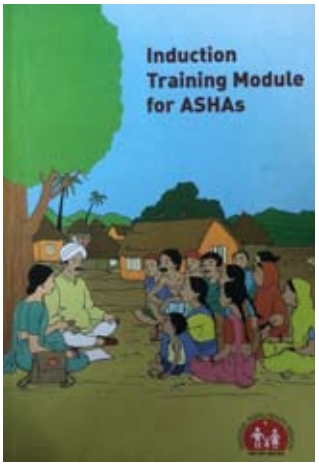

HANDBOOK FOR
ASHA FACILITATORS

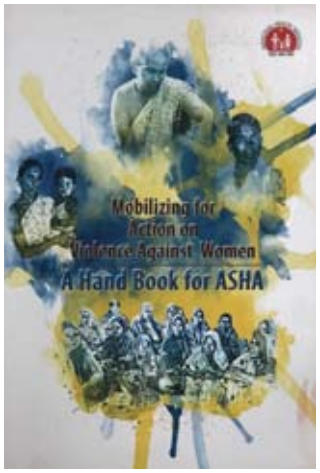

SUPPLEMENTARY BOOK for ASHA

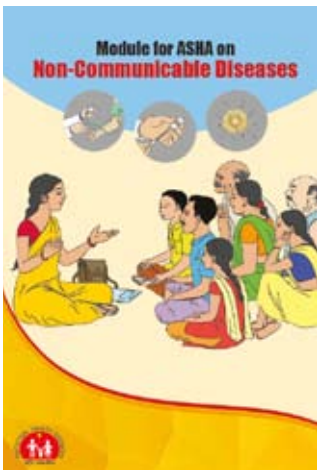

Skills that Save Lives
Focus on Child Health and Nutrition

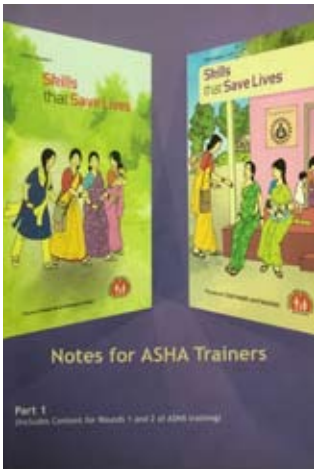

NOTES FOR ASHA TRAINERS
Induction
TRAINING MODULE
for ASHAs


Mobilizing for Action on Violence Against Women
Notes for ASHA Trainers

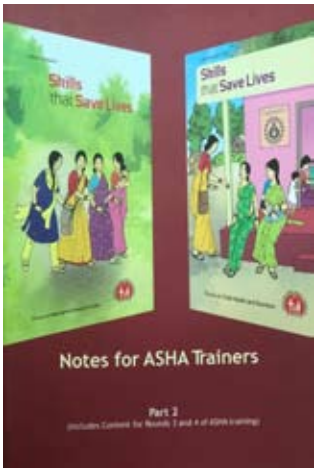

Induction Training Module for ASHAs


Mobilizing for Action on Violence Against Women
A Hand Book for ASHA

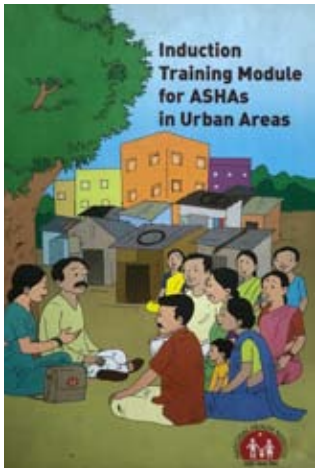

Module for ASHA on
Non-Communicable Diseases

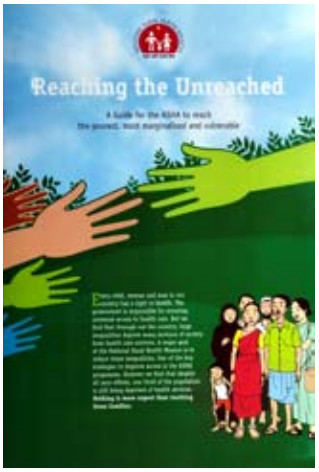

Skills that Save Lives
Notes for ASHA Trainers
Part 1


Notes for ASHA Trainers
Induction Training for ASHAs in Urban Areas


Skills that Save Lives
Notes for ASHA Trainers
Part 2


RASK


Induction Training Module for ASHAs in Urban Areas


Reaching the Unreached

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Ministry of Health and Family Welfare
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