NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

Update on
ASHA PROGRAMME

July 2019

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Introduction

The ASHA programme has come a long way since the first issue of the ASHA update was launched a decade ago in 2010. This issue is the twentieth in a series of updates that have been regularly produced every six months. All issues have a uniform format, starting with a brief introductory summary of the contents, an update on selection, training and status of support structures using data obtained by states and reporting on specific events that have taken place in the six months since the previous issue. Two semi-annual issues are produced, one in January, covering the period July to December and one in July, covering the period January to July.

The community processes intervention of the National Rural Health Mission, initiated in 2005, and now the National Health Mission, since 2013 subsuming the rural and urban components was designed to train and equip a female community health worker for a population of 1000 or less, depending upon geographical terrain, rooted in a community collective, the Village Health Sanitation and Nutrition Committees (VHSNC) or its urban counterpart, the Mahila Arogya Samities (MAS).

The contribution of the ASHA to the achievement of the country's targets for maternal, newborn, child health and selected infections diseases is well known and captured in several publications. In the fifteen years of the programme, several design innovations that have been scaled up country wide have emerged– from selection to training to payment to the use of technology as a job aid/training aid. The ASHA has now been integrated into the government's flagship initiative- the Ayushman Bharat- Health and Wellness Centres in which she is now an integral part of the primary health care team.

In what is likely a significant achievement, the programme, initiated in 2005 from the central level with substantial guidance has over time, enjoys state ownership. ASHA training is being undertaken in state specific issues, several states have a database of ASHA and support staff, and many states have created incentive packages for ASHA over and above that being funded by the central government. While continuing guidance from the national level, enabling sharing and cross learning across states, and funding for a substantial part of the programme of course is still part of the central budget, this sign of state ownership is encouraging.

In Section 1, programme milestones in the ten years since the first issue was launched are highlighted. Country wide, there are nearly one million ASHAs, saturating the entire population except for the state of Tamil Nadu, Goa and the Union Territory of Chandigarh. In Tamil Nadu, ASHAs are operational in tribal pockets of the state. The coverage currently in rural areas is about one ASHA per 879 population, but with wide variations between and within states. In Section 1 we also provide the customary update on selection, training and support structures. Training of ASHAs in Modules 6 and 7, initiated in 2010 in some states and as late as 2012 in some others, has finally reached 71% for the final round, i.e., Round 4, in rural areas. The analysis of training completion for all four Rounds on Module 6 and 7 masks the fact that not with standing the slow pace in several areas across the country, during this period, in several states ASHA were trained in skills and competencies needed for state specific issues. Thus for instance, states such as Jharkhand, Chhattisgarh and Odisha and some of the NE states provided intensive

training in vector borne disease, Kerala trained ASHA in palliative care and mental health, and many of the high focus states intensified training on family planning, anemia and home based young child care under POSHAN Abhiyaan.

In Section 2, we report on the changing role of the ASHA in supporting the screening, prevention, and management of non-communicable diseases. This 15 state study was nested within an assessment of the readiness of public health systems to add non-communicable diseases, in order to expand the package of services from the limited focus on maternal, new-born and child health and respond to the shifting disease burden in states. The assessment shows clearly that the motivational level of the ASHA to learn new competencies, and the confidence of the health system and the community alike in the ability of the ASHA to deliver, makes it imperative for a paradigm shift in the design of the ASHA programme. Such a redesign would need to take into consideration varying state contexts and needs, and the fit of the ASHA and other CP interventions within Ayushman Bharat.

In Section 3, we present four best practices that highlight state led innovations in the area of community processes. Country wide, the progress of the ASHA programme and the achievements of the ASHA have far outpaced the functioning of the community collectives, (Village Health, Sanitation, and Nutrition Committees (VHSNC) and Mahila Arogya Samities (MAS) intended to be public accountability fora to provide feedback to local health facilities.

However two best practices, from the state of Odisha, pertaining to the role of the ASHA and MAS and VHSNC in improving immunization coverage and responding to natural disasters respectively, fortunately seem to challenge this assumption, The MAS model highlights clearly the role of the MAS in devising creative ways of reaching migrant populations in urban slums. The role of the ASHA in serving as first responder in situations of natural disasters has been illustrated previously in several states, and this is one more reminder of the critical role of a community health worker acting in concert with an empowered community collective for prompt and effective action. The third best practice deals with the role of technology as a job aid to the ASHA. The TeCHO+ model of Gujarat illustrates the effectiveness of a custom made programme in helping frontline workers improve performance. The final best practice is reported from Assam on streamlining ASHA payments through the Public Finance Management System thereby enabling timely payment to ASHA.

Section 4 provides a list of ASHA incentives updated as of June 2019. As can be seen the list of incentives and tasks has expanded slightly and is reflective of the additional tasks being given to the ASHA. The challenge of overburdening the ASHAs whose population coverage exceeds 1000 needs to be studied.

As this update goes to print, it is clear that one of the key aspects of the update was to periodically report on progress related to selection, training and status of support structures. The updates also reported on events taking place in the six months covered by each update. Over the past two years, it has been noticed that there are very minimal changes in the progress related to selection, training, and support structures. Thus, the next issue of the update will be produced annually, while making every effort to retain the present content and ensure reporting on all aspects relevant to the ASHA.

SECTION – ONE

Programme Update: ASHA

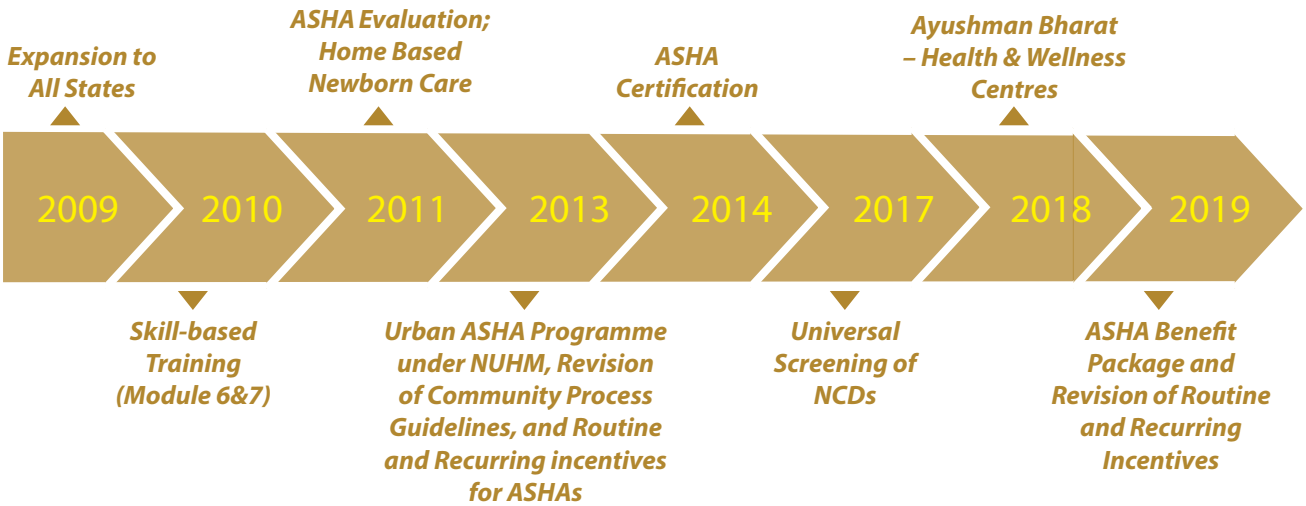
1. Programme Update Over Last Decade

ASHAs across the country, have emerged as key drivers of community-based care by bridging the gap between health services and community. The programme has evolved substantially over the years with ASHA's being widely acknowledged for their substantial contribution in improving access to care for community in areas ranging from RMNCHA to Communicable Diseases and more recently to Non communicable diseases.

The programme was launched in 18 high focus states[1] and tribal areas of other states in the year 2006 and was expanded to the entire country in 2009 on popular demand. Today the programme exists in all States/UTs except Goa and Chandigarh.

Ever since the very first update of ASHA Programme in January 2010 to the present date, there has been a steady progress in the terms of selection and capacity building of ASHAs, creating support structures, introducing monetary and non-monetary incentives. The ASHA programme as it stands today, is reflective of policy decisions taken based on evidence emerging from evaluations and field reviews as well as experiences from states implementing the programme. The ASHA has now been integrated into the government's flagship initiative – the Ayushman Bharat – Health and Wellness Centres in which she is now an integral part of the primary health care team.

The key milestones that shaped programme to its current status are as follows:



1. Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Orissa, Rajasthan, Uttar Pradesh, Uttarakhand, the eight states of the North East, and Jammu and Kashmir

1.1 Selection of ASHAs

The total ASHA target has increased by 31% (from 7,79,481 to 10,22,160) and in position by 40% (6,91,533 to 9,68,483) since the first update of January 2010 to this update in July 2019. The graph below illustrates the overall increase in number of ASHAs. (Figure 1). The increase in target is also on account of roll out of ASHA programme in urban areas under NUHM in the year 2013.

The increase in the target and in position ASHAs in rural areas has improved the population density, which has reduced from 1 ASHA per 1074 rural population to 1 ASHA per 879 rural population. This is on account of mix of tribal/hilly/difficult areas where ASHAs can be selected at lower population norms compared to 1 per 1000 in normal/plain rural areas.

1.2 Capacity Building

One of the underlying factors, that distinguishes the ASHA programme from previous efforts of implementing a community health worker programme is the mechanism built for regular training and on the job mentoring support for ASHAs. The programme focused on establishing mechanism for regular training of ASHAs through an incremental form of modular training, accompanied by active hand-holding and support. Since the launch of training of ASHAs on Module 6&7, steady progress has been made over the years to create a cadre of National, state and district trainers.

Since the launch of Module 6&7 in 2010, about 440 state trainers have been trained in Round 1 TOT, 403 in Round 2 TOT and 348 in Round 3 TOT of Module 6&7. At district level, about 11,424 ASHA trainers have been trained in Round 1 TOT, 10,581 in Round 2 TOT and 8029 in Round 3 TOT. All these efforts have translated in training of nearly 9.14 lakh ASHAs in Round 1, 8.7 L in Round 2, 8.2 L in Round 3 and 6.8 L in Round 4 of Module 6&7.

With the introduction of new tasks for ASHAs, training of ASHAs has also begun on skills related

Fig 1: The trend in ASHA Programme from 2009 to 2019 (Target & In position)

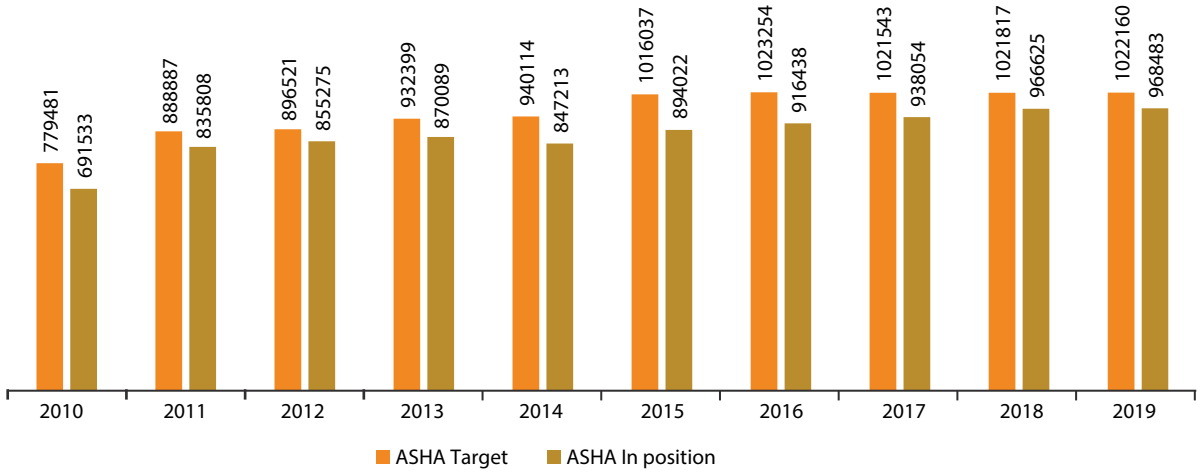
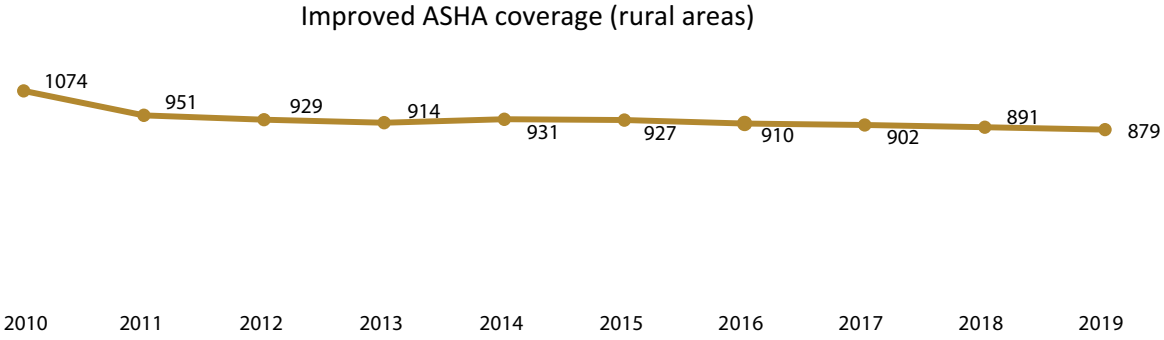
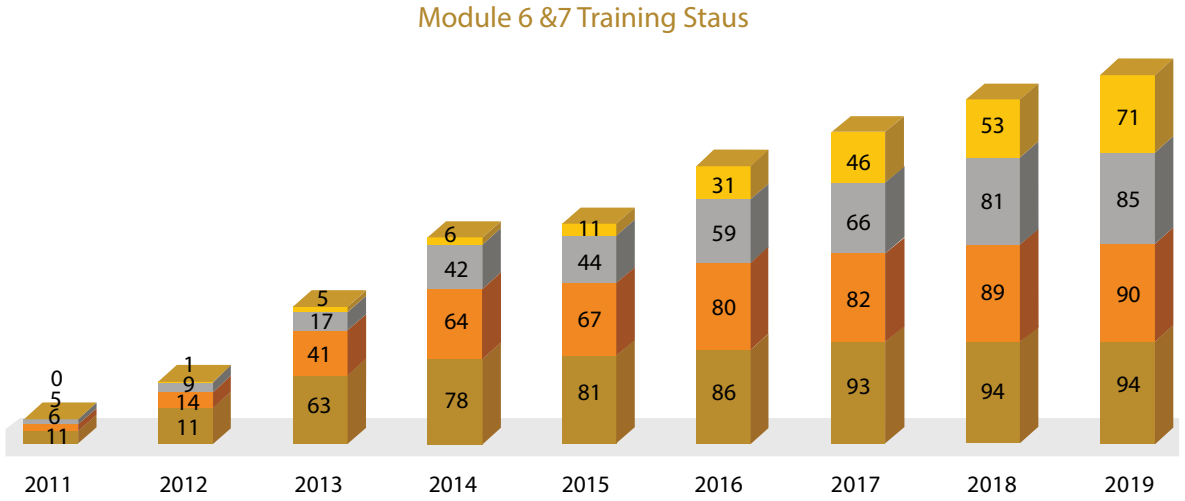


Fig 2a: Density of ASHAs as Per Rural Population





**2017 onwards training status includes % training completed for ASHAs under NUHM and NRHM against total in position*

to Non Communicable Diseases and Home Based young Child Care.

In order to provide a legal and administrative framework within which the ASHA is equipped with skills for providing care for a range of illnesses and to ensure quality of services provided to the community, the process of ASHA certification was launched in the year 2014. As part of this process all components of ASHAs training i.e., the curriculum, trainers, sites and ASHAs are being certified.

ASHA Certification is currently being implemented in 24 States and 1 UT based on status of completion of ASHA training and readiness of states. These states are – Arunachal Pradesh, Assam, Chhattisgarh, Dadar and Nagar Haveli, Delhi, Gujarat, Haryana, Himachal Pradesh, Jammu and Kashmir, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Manipur, Meghalaya, Mizoram, Nagaland, Odisha, Punjab, Rajasthan, Sikkim, Telangana, Tripura, Uttarakhand and West Bengal.

'Supplementary book for ASHA – An aide to preparing for certification' has been developed in regional languages for the ASHAs and encompasses all essential content from available ASHA modules. Over last five years, 35 state training sites and 104 district training sites have been accredited by NIOS. With regard to the trainers, 232 state trainers and 686 district trainers have been certified by NIOS. Till date, about 16,391 ASHAs and ASHA Facilitators across 15 states have been certified (Arunachal Pradesh, Assam, Chhattisgarh, Delhi, Himachal Pradesh, Jammu and Kashmir, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Odisha, Punjab, Sikkim, Tripura and Uttarakhand).

Support Structures **–** The supportive institutional network at state level and below has expanded rapidly, especially over last five years, as states have increasingly become cognizant of the necessity of a strong support structure to enhance the community processes component. Presently most of the states have a well-established support structure for community processes. The ASHA facilitators provide on the job supervision and mentoring, and one facilitator has been selected for a cluster of 10-20 ASHAs. Over last five years, the number of positions sanctioned and filled for support structures have gradually increased as new positions positions were created in states of Uttar Pradesh, Himachal Pradesh, West Bengal, Arunachal Pradesh, Andhra Pradesh, Telangana, and Andaman & Nicobar Islands.

	2014		2019	
	Target	In-position	Target	In-position
District Community Mobilizer	497	424	675	571
Block Community Mobilizer	3215	2632	4516	3894
ASHA Facilitator	37164	29558	41276	37383

1.3 Incentives

Performance Linked Monetary Incentives

As the tasks performed by ASHAs expanded since the launch of programme, the performance linked incentives have also increased. Currently, there are about 40 nationally approved incentives for

activities in areas of maternal, newborn, child health, family planning, infectious diseases and non-communicable diseases which are common in most of the states. The performance-based incentives for ASHAs vary across states based on local context.

As most incentives provided to ASHAs depend on the population covered by ASHAs and fertility rate in their catchment area, incentives for routine and recurring activities amounting to Rs. 1000 per month was introduced in 2013. This incentive was later increased to Rs. 2000 pm in 2018 as part of ASHA benefit package.

Over last five years, about 13 new incentives were introduced for ASHAs for activities linked with – Home Based Young Child Care, National Deworming Day, Intensified Diarrhoea Control Fortnight, Promotion of Breast Feeding – MAA programme, DPT booster, Post Abortion IUCD insertion, Mission Parivar Vikas, Rashtriya Kishor Swasthya Karyakaram, PLA meetings, Kala Azar, Source Reduction for prevention of Dengue and Chikangunya, Listing and verification of beneficiaries for PMJAY and NCD screening. In addition, unit rate of nearly 11 existing incentives, under RNTCP, NLEP and NVBDCP programmes, Family planning, Child health and Immunization, have been increased to adequately compensate the efforts made by ASHAs (Details of Incentive are included in Section 4).

In addition to the above – mentioned performance-based incentives, some states have also introduced fixed monthly honorarium or top up incentives for ASHAs. These include states of Arunachal Pradesh, Sikkim, Kerala, Rajasthan, Haryana, West Bengal, Karnataka, Chhattisgarh, Tripura, Odisha, HP, AP, Telangana, Delhi, Gujarat, UP and UK.

Efforts have been made to streamline the payments of ASHAs with the introduction of DBT payments in all states barring few remote areas with poor availability of banking services in states like Arunachal Pradesh, Meghalaya, Nagaland and Andaman & Nicobar Islands.

Social Security Measures

The provision of social security to ASHAs in the form of medical and life insurance emerged as a state led mechanism to provide motivation for the ASHA. These have been started in the states of Chhattisgarh, Assam, Jharkhand, Kerala, Uttar Pradesh, Uttrakhand, Odisha and West Bengal. States of Delhi, Maharashtra, Sikkim, Gujarat and Madhya Pradesh facilitated enrollment of ASHAs in existing National Schemes.

Drawing from these experiences, the ASHA benefit package introduced in the year 2018, extended the benefits of Life insurance, accident insurance and pension to all eligible ASHAs and ASHA Facilitators across all states and UTs through:

- Pradhan Mantri Jeevan Jyoti Beema Yojana (premium of Rs. 330 contributed by GOI)
- Pradhan Mantri Suraksha Beema Yojana (premium of Rs. 12 contributed by GOI)
- Pradhan Mantri Shram Yogi Maan Dhan (50% contribution of premium by GOI and 50% by beneficiaries)

ASHAs are certainly the face of NHM and the health system at the community level.

In the current backdrop of CPHC, the ASHA programme is also in phase of transition and warrants the need to "reflect and rethink" for strengthening programme components that have worked, redesigning the mechanisms that have shown persistent challenges and exploring innovative solutions to meet the new requirements for ASHAs to take on more complex tasks.

2. Programme Update Over Last Six Months

2.1 Selection Status

Over the last six months between January to July 2019, the selection status has remained same at 95%. However, there has been slight decrease in the overall target number of ASHAs from ***10,22,661 to 10,22,160*** and number of ASHAs in position from ***9,70,676 to 9,68,483.***

Rural ASHAs

The overall percentage of ASHAs in-position against the target in rural population has increased slightly by 1% since January 2019. However, the present target for rural ASHAs has reduced to 9,46,563 as compared to 9,48,266 and

the number of in-position ASHAs has decreased to 9,04,211 from 9,05,047 reported in January 2019 Update. This is mainly on account of correction of figures reported from Chhattisgarh and shifting of ASHAs from rural to urban areas in Odisha (64) and Rajasthan (849).

In ***High Focus States*** Rajasthan (-849) and Odisha (-64) have decreased their selection target in rural areas due to conversion of some rural ASHAs to urban ASHAs on account of urbanization. Correction in rural ASHA target figures (-2001) is reported from Chhattisgarh while no change in target has been reported from remaining states. Selection of new ASHAs is reported only from states of Bihar (+506), MP (+453) and Rajasthan (+388). Drop out has been reported only from two states, Odisha and UP. Of these two, higher figure of 3563 is noted from UP which indicates about 2% attrition.

Amongst the ***North East States*** only Mizoram (+79) has increased the target and also selected 100% ASHAs against the revised target. The percentage of ASHAs in position against the target is maintained to approximately 100%.

Across ***Non-High Focus States***, Gujarat (+429), Jammu & Kashmir (+642) and AP (+61) have increased their selection target. In terms of ASHAs in-position, almost all the non-high focus states have increased their pool except Telangana (-498) and AP (-40) where drop out was reported. Among ***Union Territories (UTs)*** the selection target and in-position remained unchanged except for Lakshadweep where marginal reduction was noted for in position ASHAs.

Population Density

In terms of population density, the majority of the states have one ASHA for 1000 population or less. The National average as for population density of ASHAs under the NRHM is currently 879, which is similar to the figure reported in January 2019. The population density ranges from 1 per 136 in Lakshadweep to 1 per 1192 per ASHA in West Bengal.

In few states the density per ASHA continues to be over 1000. This is despite the increase in ASHA selection and reduction in population density in states of Bihar, Rajasthan, and West Bengal. States of Maharashtra and Punjab report no change in population density as number of ASHAs remain same as reported in last update while in state of UP population density has increased from 1003 to 1027 due to attrition of ASHAs as mentioned above.

Urban ASHAs

Under NUHM, selection status is about 85% reflecting reduction from the figure of 88% reported in the January 2019. This is due to the fact that the overall target for Urban ASHAs has increased from 74,395 to 75,597 while number of ASHAs in-position has reduced from 65,629 to 64,272.

Among the ***High Focus States***, 22,741 urban ASHAs are in position against the increased target of 27,673 i.e., 82%. Thus, reflecting a 10% reduction from last update where 23,945 ASHAs were in position out of the proposed 26,045. This is on account of major upward revision in target reported from states of Rajasthan (+849), Bihar (+415), UP(+300) and Odisha (+64) and decline in number of ASHAs in-position in states of MP (-840) and UP (-442).

In North East States, target has marginally increased from 2285 to 2300 and in-position has also increased from 2198 to 2242 over last six months. Status across all NE states has remained same, except in Nagaland, where target has increased (+15) and in Meghalaya which has reported an increase (+44) in-position.

Overall, in the ***Non-High Focus States*** the target has reduced from 45,634 to 45,193 and ASHAs in-position has decreased to 39,021 (-179) from the previous update. States of Delhi (+116) and Jammu & Kashmir (+53) has increased their selection target but downward revision of target as been reported from AP (-610). With regards to in-position only five states have shown an increase in selection. These are Delhi (+92), Karnataka (+56), Haryana (+19), HP (+4) and Jammu & Kashmir (+2). Attrition has been reported from states of Telangana (-270), Punjab (-84), Maharashtra (-21) and Gujarat(-5).

Amongst the ***Union Territories***, the target of Urban ASHAs remained the same but there was a slight reduction of in-position ASHAs (-18) in the last six months.

Table 1

State/UT	ASHAs under NRHM					ASHAs under NUHM		
	Target	In position	% ° in position	Rural Current Population Density – 2011		Target	In position	% ° in position
High Focus States								
Bihar	93687	88837	95	92341436	1039	977	527	54
Chhattisgarh	68277	66220	97	19607961	296	3883	3771	97
Jharkhand	40964	39964	98	25055073	627	1165	1165	100
Madhya Pradesh	63867	62511	98	52557404	841	5100	4025	79
Odisha	45601	45105	99	34970562	775	1546	1522	98
Rajasthan	50331	47430	94	51500352	1086	5485	4269	78
Uttar Pradesh	159307	151213	95	155317278	1027	8336	6281	75
Uttarakhand	10470	10392	99	7036954	677	1181	1181	100
Total	**532504**	**511672**	**96**	**438387020**	**857**	**27673**	**22741**	**82**
North Eastern States								
Arunachal Pradesh	3862	3838	99	1066358	278	42	42	100
Assam	30920	30920	100	26807034	867	1212	1212	100
Manipur	3928	3928	100	1736236	442	81	81	100
Meghalaya	6519	6519	100	2371439	364	210	179	85
Mizoram	1091	1091	100	525435	482	79	79	100
Nagaland	1917	1917	100	1407536	734	90	75	83
Sikkim	641	641	100	456999	713	35	35	100
Tripura	7216	7077	98	2712464	383	551	539	98
Total	**56094**	**55931**	**100**	**37083501**	**663**	**2300**	**2242**	**97**
Non High Focus States								
Andhra Pradesh	39552	39451	100	34776389	882	3200	2609	82
Delhi		0				6258	5817	93
Gujarat	39355	38102	97	34694609	911	4114	4058	99
Haryana	18000	17606	98	16509359	938	2676	2528	94
Himachal Pradesh	7930	7787	98	6176050	793	34	33	97
Jammu & Kashmir	13116	12270	94	9108060	742	138	87	63
Karnataka	39195	38427	98	37469335	975	3329	3007	90
Kerala	30927	26057	84	17471135	670	1927	1927	100
Maharashtra	61260	60816	99	61556074	1012	9845	8562	87
Punjab	17360	17144	99	17344192	1012	2600	2448	94
Tamil Nadu*	3242	2650	82	NA	NA	NA	NA	NA
Telangana	26028	23258	89	21585313	928	5000	3019	60
West Bengal	61008	52173	86	62183113	1192	6072	4926	81
Total	**356973**	**335741**	**94**	**318873629**	**950**	**45193**	**39021**	**86**
Union Territories								
Andaman & Nicobar	412	412	100	237093	575	10	0	0
Dadra & Nagar Haveli	372	262	70	183114	699	70	65	93
Daman & Diu	98	89	91	60396	679	10	10	100
Lakshadweep	110	104	95	14141	136	0	0	
Puducherry	0	0		0		341	193	57
Total	**992**	**867**	**87**	**494744**	**571**	**431**	**268**	**62**
Total All India	**946563**	**904211**	**96**	**794838894**	**879**	**75597**	**64272**	**85**

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

2.2. Status of ASHA Training

Since the launch of new initiatives such as Universal Screening of NCDs, operationalization of Health and Wellness Centres and Home-Based young Child Care, skill building for ASHAs on these areas has started across most states and is at varying stages of roll out.

During the last six months, status of Round 4 training of Module 6&7 has improved by 12% i.e., increased from 59% to 71% cumulative for rural and urban ASHAs, while there has not been much change in the status of first three rounds of Module 6&7 i.e., 94%, 90%, and 85% respectively.

Across states about 2,92,301 ASHAs have been trained in NCDs against the target of 4,37,613 ASHAs which reflects an increase of 86,975 ASHAs in training and 1,39,218 in target respectively from the last update.

To undertake these trainings, nearly 440 state trainers have been trained in Round 1 TOT of Module 6&7, 403 in Round 2 and 348 in Round 3 TOT so far. (At district level, about 11,424 ASHA trainers have been trained in Round 1 TOT, 10,581 in Round 2 TOT and 8029 in Round 3 TOT).

A steady increase is noted in training of trainers on new skill areas of NCDs and HBYC. Since the roll out of NCD training in 2017 and HBYC in 2018, about 141 state trainers and 3606 district trainers have been trained on NCDs and 136 state trainers and 2460 District trainers have received training on HBYC.

Training of ASHAs under NRHM

Induction Module

Since last update, a total of 9337 ASHAs have been selected across 18 states and Union Territories and 8039 ASHAs have been trained in induction module in 13 states and UTs.

In ***High Focus States***, a total of 4188 ASHAs were trained in induction module. Uttar Pradesh reported training of 3029, the maximum number of ASHAs in the group. This was followed by Rajasthan (403), Chhattisgarh (398), Madhya Pradesh (206) and Odisha (152). Bihar and Uttarakhand did not report any induction training in last 6 months.

Amongst North Eastern States, a total of 248 ASHAs were trained in induction module from two states of Arunachal (225) and Tripura (23). In ***Non-High Focus States***, a total of 3321 ASHAs were trained in induction module from four states. Maharashtra reported training of 1375, the maximum number of ASHAs in the group. It was followed by Gujarat (1027), West Bengal (814), and Punjab (105). About 282 ASHAs were trained in Induction Module from the UT of Dadra and Nagar Haveli.

Module 6 & 7

Overall, progress is noted in training of all four rounds of Module 6&7. The increase has been significant with 11% increase in Round 4 training of ASHAs but the progress has been marginal in case of Round 1-3 with only 1-3% increase since the last update. About 96% ASHAs have been trained in Round 1, 92% in Round 2, 86% in Round 3 and 72% in Round 4.

In ***High Focus States,*** progress has been made in all four rounds of module 6&7. A total of 96% ASHAs have been trained in Round 1, 92% in Round 2, 86% in Round 3 and 67% in Round 4 training across all High focus states. During last six months, additional, 2080 ASHAs were trained in Round 1 and 4563 in Round 2, 7528 in Round 3 and 97,690 in Round 4. Most progress has been reported from state of UP where 84,812 ASHAs have been trained in Round 4, with an increase from 1% to 57% in last six months. This is followed by progress made in Bihar (with +8471) and Madhya Pradesh (with + 4145) with regards to Round 4. Similarly, largest increase in training of Round 3 was also reported from states of Madhya Pradesh (+3241), UP (+2827) and Bihar (+1673).

Despite the progress made in last six months in MP and Bihar, these states need to expedite the pace of training as all states have completed over 85% training of ASHAs in Round 3 except for states of Bihar (65%) and MP (84%). Pace of Round 4 training is slow in four states v.i.z Bihar which has so far completed training of only 21% ASHAs, UP has completed 57%, and Rajasthan and MP have done 73-75% training. On the other hand, states of UK, Odisha, Jharkhand and Chhattisgarh have completed over 91% training in Round 4. With regards to Round 1 and 2 training, all states have completed training of over 90% ASHAs except Bihar where 79% ASHAs have been trained in Round 2 of Module 6&7.

In ***North East States*** maintain the status of over 96% training in all four rounds. The high group

average status, however masks the low training status of 82-88% for all four rounds in Manipur and Nagaland. This indicate slow pace of training of newly selected ASHAs in Module 6&7 in these states. State of Arunachal Pradesh also continues to have lowest round 4 training achievement of 79% with no progress reported over last one year.

In ***Non-High Focus States*** the training in module 6 & 7 in Round 1 to 4 is 97%, 90%, 86% and 77% respectively. With 4155 (18%) ASHAs trained in Round 4, Telangana has made the highest progress in training of ASHAs among non-high focus states, followed by West Bengal with 89% (+1814) ASHAs trained in Round 4 and 98% (+866) in Round 3. On the other hand, Karnataka has reported almost nil training progress compared to last update.

Progress of training in ***Union Territories*** in Module 6&7 has been slow and there has been not much change in training status, except for Round 1 with an increase from 63% to 76%. This is mainly due to training of 104 ASHAs in Lakshadweep (100%). Andaman and Nicobar Islands has trained all targeted ASHAs in all four rounds.

NCD Training

To roll out Comprehensive Primary Health Care through expanded range of services, states have expedited trainings of ASHAs in NCD. As on June 2019 the target number of ASHAs to be trained is 4,01,578 and the total number of ASHAs in rural areas trained are 2,71,359. The target as well as trainings of the ASHAs has increased in the last six months as compared to the target of 2,68,310 and total 1,87,671 trained ASHAs reported in Jan-19.

In ***High Focus States***, the target has increased from 1,26,415 to 1,79,184 and the total number of ASHAs trained in NCD has also improved from 70,038 to 1,35,154 leading to 75% completion of training. Chhattisgarh has shown significant increase in the ASHA target from 12000 to 66220 and also completion of training from 11,349 to 64,155. While state of Odisha has decreased its target from 18857 to 17406 from previous update.

In ***North East States***, there has been improvement in the training of ASHAs in NCD from 9,553 to 9,838 against the revised target of 11,945 from 10,776. Training progress for NCD training of ASHAs was reported mainly from two states of Nagaland (+237). Tripura (+114).

Among Non High Focus States, 60% training achievement is noted against the increased target of 2,09,953. States of Andhra Pradesh, Maharashtra, Telangana and West Bengal have reported an increase in their target substantially compared to last update while a downward revision of target is noted in Haryana. Maximum progress has been reported from states of West Bengal (+13,409), followed by Haryana (+4959).

In UTs, only Dadar and Nagar Haveli and Lakshadweep have planned training of ASHAs on NCDs. DNH has competed 100% training against the target of 282 while Lakshadweep is yet to start the training.

Table 2

		Module 6 & 7 Training								NCD Training		
Training of ASHAs under NRHM	ASHAs In Position	Round 1	%	Round 2	%	Round 3	%	Round 4	%	Target of ASHAs	Trained	%
High Focus States												
Bihar	88837	79572	90	70562	79	57667	65	18345	21	589	589	100
Chhattisgarh	66220	66169	100	66169	100	66169	100	66169	100	66220	64155	97
Jharkhand	39964	37045	93	37271	93	37190	93	36257	91	39964	26331	66
Madhya Pradesh	62511	62479	100	61159	98	52469	84	47098	75	21100	5680	27
Odisha	45105	45297	100	45297	100	45297	100	44942	100	17406	15433	89
Rajasthan	47430	45855	97	44308	93	41178	87	34668	73	6905	6398	93
Uttar Pradesh	151213	143228	95	138534	92	130530	86	86108	57	21270	13622	64

		Module 6 & 7 Training								NCD Training		
Training of ASHAs under NRHM	ASHAs In Position	Round 1	%	Round 2	%	Round 3	%	Round 4	%	Target of ASHAs	Trained	%
Uttarakhand	10392	10351	100	9460	91	9460	91	9460	91	5730	2946	51
Total	**511672**	**489996**	**96**	**472760**	**92**	**439960**	**86**	**343047**	**67**	**179184**	**135154**	**75**
North Eastern States												
Arunachal Pradesh	3838	3669	96	3472	90	3472	90	3032	79	1175	457	39
Assam	30920	30920	100	30920	100	30920	100	30920	100	4063	4063	100
Manipur	3928	3420	87	3422	87	3416	87	3453	88	2069	1700	82
Meghalaya	6519	5891	90	5873	90	5914	91	5849	90	1561	613	39
Mizoram	1091	1091	100	1091	100	1091	100	1091	100	258	258	100
Nagaland	1917	1576	82	1570	82	1624	85	1593	83	358	358	100
Sikkim	641	641	100	641	100	641	100	641	100	641	641	100
Tripura	7077	6800	96	6611	93	6852	97	6816	96	1820	1748	96
Total	**55931**	**54008**	**97**	**53600**	**96**	**53930**	**96**	**53395**	**95**	**11945**	**9838**	**82**
Non High Focus States												
Andhra Pradesh	39451	36868	93	34601	88	30165	76	27397	69	39009	0	0
Gujarat	38102	37585	99	37585	99	37126	97	36248	95	9131	8840	97
Haryana	17606	17516	99	18696	106	17719	101	17368	99	17368	15312	88
Himachal Pradesh	7787	7539	97	7529	97	7474	96	7473	96	5199	6015	116
Jammu & Kashmir	12270	11825	96	11805	96	11620	95	11455	93	3204	950	30
Karnataka	38427	34047	89	33335	87	31769	83	31166	81	12663	7869	62
Kerala	26057	26057	100	4400	17		0		0			
Maharashtra	60816	59548	98	59412	98	58981	97	58178	96	60816	27955	46
Punjab	17144	17137	100	17137	100	17137	100	17137	100	17144	17089	100
Tamil Nadu*	2650	2389	90	2389	90	2389	90	2389	90	2650	2389	90
Telangana	23258	23258	100	23258	100	23258	100	4155	18	26028	23258	89
West Bengal	52173	52173	100	52867	101	51139	98	46403	89	16741	16408	98
Total	**335741**	**325942**	**97**	**303014**	**90**	**288777**	**86**	**259369**	**77**	**209953**	**126085**	**60**
Union Territories												
Andaman & Nicobar	412	412	100	412	100	412	100	412	100	104	0	0
Dadra & Nagar Haveli	262	68	26	0	0	0	0	0	0	282	282	100
Daman & Diu	89	73	82	55	62	0	0	0	0	0	0	
Lakshadweep	104	104	100	0	0	0	0	0	0	110	0	0
Puducherry	0											
Total	**867**	**657**	**76**	**467**	**54**	**412**	**48**	**412**	**48**	**496**	**282**	**57**
Total All India	**904211**	**870603**	**96**	**829841**	**92**	**783079**	**87**	**656223**	**73**	**401578**	**271359**	**68**

Training of ASHAs under NUHM

Induction Module

During last six months about 17,312 urban ASHAs have been trained in induction module in 13 states and UTs.

A total of 11,108 ASHAs have been trained in ***High Focus States.*** As noted for rural areas, Uttar Pradesh reported training of highest 6435 number of ASHAs followed by Madhya Pradesh (3880), Jharkhand (769) and Rajasthan (24).

In ***North-Eastern States***, a total of 1486 ASHAs were trained in induction module in five states i.e., Assam (1212), Meghalaya (185), Arunachal (42), Nagaland (35) ASHAs, and Tripura (12).

Within the group of ***Non-High Focus States***, a total of 4718 ASHAs were trained in induction module in four states. State of West Bengal has trained 4253 honorary health workers who will be working as ASHAs after successful completion of training. In addition, training was conducted in states of Gujarat (276), Maharashtra (151) and Punjab (38).

Module 6 & 7

Progress of 4-5% has been noted in training of all four rounds of Module 6&7. A total of 69% ASHAs have been trained in Round 1, 65% in Round 2, 61% in Round 3 and 48% in Round 4.

In ***High Focus States,*** progress has been made in all four rounds of module 6& 7. A total of 65% ASHAs have been trained in Round 1, 62% in Round 2, 60% in Round 3 and 57% in Round 4 training across all High focus states. During last six months, 1% increase was noted in each round with additional, 270 ASHAs getting trained in Round 1, 444 in Round 2, 607 in Round 3 and 1179 in Round 4. States of MP, Odisha and Rajasthan have reported training progress in all four rounds. On the other hand, states of Uttar Pradesh and Bihar with significant number of urban ASHAs are yet to start training of Module 6 &7. State of Uttarakhand has reported 100% completion of training in all four rounds.

In the ***North Eastern States,*** an increase of 6-7% for the trainings of Round 1,Round 3 and Round 4 is reported. Except for Tripura, Sikkim and Nagaland, rest of the states have achieved 100% training target for Round 1 and Round 2. Meghalaya is the only state to report progress in training in all four rounds during last six months, by training 179 ASHAs in Round 1, 51 in Round 2, 132 each in Round 3 and Round 4. Lowest training pace is observed in the state of Nagaland with 55% training reported for all four rounds.

In ***Non-High Focus States*** the training in module 6 & 7 in Round 1 to 4 is 69%, 66%, 64% and 44% respectively. This reflects an increment of 2-3% for Round 3 and about 7% in Round 4 as compared to last update. State of AP has made good training progress in all four rounds, followed by Maharashtra. State of Telangana and Punjab have revised their figures because of attrition of ASHAs in urban areas.

There has been no progress of training in ***Union Territories*** in Module 6 & 7 in the last 6 months. Amongst the ***UTs*** the target of ASHAs has been slightly decreased from 286 to 268. Only two UTs i.e., Dadar & Nagar haveli and Daman & Diu have reported training of urban ASHAs while no training has been reported from remaining UTs.

Training on NCDs

As on June 2019, 29,942 urban ASHAs i.e., 58% against the target of 36,035 have been trained in NCDs.

In ***High Focus States***, the target has decreased from 8716 to 8524 and the total number of ASHAs trained in NCD has improved from 5088 to 5427 leading to 64% (+ 6%) completion of training. Among High Focus states, only Uttarakhand has made progress in NCD trainings with additional 569 ASHAs been trained while Odisha reported a decrease in training figures from 1403 to 1173. No training has been conducted in remaining states during this period.

In ***North East States***, there has been improvement in the trainings of ASHAs in NCD from 856 to 1239. States of Tripura and Nagaland have made progress in NCD training in last 6 months as they have trained 396 (+210) and 42 (+24) ASHAs in total respectively. State of Mizoram has already achieved 100% of its training target while Sikkim and Manipur are yet to initiate the training.

Among Non High Focus States, 54% training achievement is noted against the increased target of 25,830 The training target has been increased in states of Andhra Pradesh, Delhi and Maharashtra. Good progress has been reported from states of Delhi (+1657), Haryana (+793) and Maharashtra (+309).

Puducherry and DNH have competed 100% training against their targets while remaining three UTs have not reported any NCD training in last 6 months.

Table 3

		Module 6 &7 Training								NCD Training		
Training of ASHAs under NUHM	ASHAs In Position	Round 1	%	Round 2	%	Round 3	%	Round 4	%	Target	Trained	%
High Focus States												
Bihar	527	0	0	0	0	0	0	0	0	0	0	0
Chhattisgarh	3771	3500	93	3594	95	3530	94	3682	98	3771	3530	94
Jharkhand	1165	769	66	769	66	769	66	769	66	1165	0	0
Madhya Pradesh	4025	3725	93	3250	81	2890	72	2560	64	1149	135	12
Odisha	1522	1466	96	1466	96	1466	96	1146	75	1258	1173	93
Rajasthan	4269	4171	98	3841	90	3725	87	3546	83	0	0	0
Uttar Pradesh	6281	0	0	0	0	0	0	0	0	0	0	0
Uttarakhand	1181	1181	100	1181	100	1181	100	1181	100	1181	589	50
Total	**22741**	**14812**	**65**	**14101**	**62**	**13561**	**60**	**12884**	**57**	**8524**	**5427**	**64**
North Eastern States												
Arunachal Pradesh	42	42	100	42	100	42	100	42	100	42	5	12
Assam	1212	1212	100	1212	100	0	0	0	0	568	568	100
Manipur	81	81	100	81	100	81	100	81	100	81	0	0
Meghalaya	179	179	100	179	100	178	99	179	100	210	149	71
Mizoram	79	79	100	79	100	79	100	79	100	79	79	100
Nagaland	75	41	55	41	55	41	55	41	55	42	42	100
Sikkim	35	25	71	25	71	0	0	0	0	0	0	0
Tripura	539	454	84	398	74	428	79	436	81	396	396	0
Total	**2242**	**2113**	**94**	**2057**	**92**	**849**	**38**	**858**	**38**	**1418**	**1239**	**87**
Non High Focus States												
Andhra Pradesh	2609	2609	100	2609	100	2609	100	2331	89	3200	0	0
Delhi	5817	5725	98	5725	98	5471	94	0	0	4214	2657	63
Gujarat	4058	3881	96	3871	95	3890	96	3871	95	4066	1500	37
Haryana	2528	2509	99	2502	99	2528	100	2370	94	2370	2086	88
HP	33	0	0	0	0	0	0	0	0	0	0	0
J&K	87	0	0	0	0	0	0	0	0	0	0	0
Karnataka	3007	1356	45	1312	44	1272	42	1254	42	0	0	0
Kerala	1927	1927	100	1927	100	1927	100	1927	100			0
Maharashtra	8562	3594	42	2286	27	1782	21	1405	16	4448	2337	53
Punjab	2448	2448	100	2448	100	2448	100	2448	100	2532	2414	95
Tamil Nadu	0	0								0	0	0
Telangana	3019	3019	100	3019	100	3019	100	1372	45	5000	3019	60
West Bengal	4926	0	0	0	0	0	0	0	0	0	0	0
Total	**39021**	**27068**	**69**	**25699**	**66**	**24946**	**64**	**16978**	**44**	**25830**	**14013**	**54**
Union Territories												
Andaman & Nicobar	0	0		0	0	0	0	0	0	0	0	0
Dadar & Nagar Haveli	65	65	100		0	0	0	0	0	70	70	100
Daman & Diu	10	7	70	0	0	0	0	0	0	0	0	0
Lakshadweep	0	0		0	0	0	0	0	0	0	0	0
Puducherry	193	0	0	0	0	0	0	0	0	193	193	100
Total	**268**	**72**	**27**	**0**	**0**	**0**	**0**	**0**	**0**	**263**	**263**	**100**
All India Total	**64272**	**44065**	**69**	**41857**	**65**	**39356**	**61**	**30720**	**48**	**36035**	**20942**	**58**

ASHA Certification

A total of 10,966 ASHAs and ASHA Facilitators appeared in the third theory examination held by NIOS on 20th January, 2019 from 15 states i.e., Arunachal Pradesh, Assam, Chhattisgarh, Delhi, Himachal Pradesh, Jammu and Kashmir, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Odisha, Punjab, Sikkim, Tripura and Uttarakhand. Out of 10,966 about 10,179 have cleared the examination, with a passing percentage of 93%. Prior to the third round, 6261 ASHAs and ASHA Facilitators been certified in two exams held in 2018, taking the total of certified ASHAs to 17, 052 ASHAs.

2.3 Support Structures for Community Processes

The Support structures have been envisaged at four levels with State ASHA Mentoring Group (AMG) and State ASHA Resource Centre at state level, dedicated nodal officers at district and block level and a supervisory cadre of ASHA facilitators at sector/sub block level. The effectiveness of the programme rests on a robust support structure, with preferably a dedicated support cadre.

States which currently have relatively lower load of RCH services, have been able to utilize existing health system staff for ASHA support cadre roles. On the other hand, states with high fertility rates and poor RCH indicators, have largely invested in creating a dedicated support structures as per their context. All high focus States except Odisha have support structures at all four levels (State/District/ Block & Sub-block). North-Eastern states have 3-4 levels of support structures except Sikkim where support structure has been created at state and sub-block level. Amongst non-high focus states, Haryana, Karnataka and Maharashtra have set up dedicated support structures at all levels, while states like Andhra Pradesh, Gujarat, Telangana, Jammu and Kashmir, Kerala, Delhi, Himachal Pradesh, Punjab and West Bengal have created a mix of dedicated and existing support structures to support the programme.

State Level

State Level ASHA Mentoring Groups have been constituted in a total of 24 states to provide technical and policy support to the State Departments for the ASHA programme. The status of support structures across the states largely remains unchanged from previous ASHA update January 2019. Four states have conducted meetings of AMGs during last six months viz., Madhya Pradesh (May - 19), Uttar Pradesh (June -19), Andhra Pradesh (March -19) and Gujarat (June -19).The composition of the State AMGs varies across states with eight members in Delhi and Meghalaya and 46 members in Madhya Pradesh.

ASHA Resource Centres or Dedicated nodal officers are in place in all states except UTs. The composition and size of ARC teams ranges from 2-3 members in Odisha, seven NE states, Gujarat, Karnataka and Telangana to 4-10 members in Bihar, Jharkhand, MP, Rajasthan, UK, AP, Delhi, Haryana, HP, J&K, Maharashtra, Punjab and Tamil Nadu and over ten members in Chhattisgarh, Uttar Pradesh ad West Bengal. In states of Sikkim and Kerala, the programme is managed by one nodal officer.

	State ASHA Mentoring Group				State ARC	State Trainers		
	Year of Formation	Total No. of AMG Members	Total No.of Meetings Held	Date of Last Meeting	Team Members	Rd 1	Rd 2	Rd 3
High Focus States								
Bihar	2011	10	3	Jun-11	6	28	28	28
Chhattisgarh	Separate SAMG not constituted. SHRC supports overall planning, implementation and monitoring of ASHA programme in the state.				13	42	42	42
Jharkhand	Constituted in 2010 and reconstituted in 2016	15	10	Oct-17	4	13	9	9

	State ASHA Mentoring Group				State ARC	State Trainers		
	Year of Formation	Total No. of AMG Members	Total No.of Meetings Held	Date of Last Meeting	Team Members	Rd 1	Rd 2	Rd 3
Madhya Pradesh	Constituted in 2012 and reconstituted in 2013	46	4	May-19	8	13	13	13
Odisha	2009	NA	4	2012	3	5	5	5
Rajasthan	2006	21	4	Sep-10	5	26	26	26
Uttar Pradesh	2008	29	8	Jun-19	21	109	80	28
Uttarakhand	2009	13	27	Jul-18	4	4	4	4
Arunachal Pradesh	2010	14	9	Aug-15	2	4	4	4
Assam	2012	12	8	Jan-16	2	2	2	2
Manipur	2008	10	11	May-14	3	8	8	8
Meghalaya	2009	8	6	Oct-14	2	3	2	2
Mizoram	2008	30	9	Sep-15	2	3	3	3
Nagaland	2010	11	5	Aug-13	2	6	6	6
Sikkim	Constituted in 2010 and reconstituted in 2016.	15	2	Nov-13	1	2	2	2
Tripura	2008	18	7	Nov-13	2	6	6	6
Andhra Pradesh	2015	15	2	Mar-19	4	5	5	5
Delhi	2010	8	6	Jan-15	5	85	85	85
Gujarat	2013	15	8	Jun-19	3	6	6	6
Haryana	Not constituted	NA	NA	NA	5	9	9	9
Himachal Pradesh	Not constituted	NA	NA	NA	7	12	12	12
Jammu & Kashmir	2012	10	1	Oct-18	4	12	12	12
Karnataka	Constituted in 2012 and reconstituted in 2017	NA	1	Apr-17	3	3	3	3
Kerala	2008	22	8	Jan-18	1			
Maharashtra	2007	16	6	Sep-18	4	13	13	13
Punjab	2014	11	3	Feb-16	4	5	7	4
Tamil Nadu	Not constituted	NA	NA	NA	5			
Telangana	2015	9	3	Nov-17	2	3	3	3
West Bengal	2010	15	4	Dec-11	10	7	7	7
A&NI	Not constituted	NA	NA	NA	Existing Staff	2	2	2
DN&H	Not constituted	NA	NA	NA	Existing Staff	4	0	0
D&D	Not constituted	NA	NA	NA	Existing Staff	0	0	0
Lakshadweep	Not constituted	NA	NA	NA	Existing Staff	0	0	0

District Level

Dedicated district level positions have been created in 26 states while the programme is managed by existing staff in states of Sikkim, J&K, Tamil Nadu and five UTs. Against 675 positions, 571 i.e., 85% are filled. Among this group of states of Telangana with 84%, Bihar with 68%, Tripura with 62%, Punjab with 41% and Delhi with 27% have the maximum vacant positions against the sanctioned positions. Other states which have 10-15% vacant positions are MP, Assam, AP, HP and West Bengal. Despite these existing vacancies, status has remained largely the same as reported in last update as only three positions in West Bengal and one position in AP have been filled while attrition of one district level nodal officer has been reported from Assam. Only seven states of Chhattisgarh, Jharkhand, Arunachal Pradesh, Manipur, Mizoram, Nagaland and Gujarat have 100% filled positions.

Block Level

In comparison to the district, only 15 states have created Block level dedicated positions have been created. Against a total of 4516 positions, about 86% i.e., (3894) are filled. High proportion of vacancies have been reported in West Bengal (36%), Rajasthan (30%), Assam (23%), Bihar (22%) and MP (17%). This is followed by 6-8% vacant positions, reported from UP, Nagaland, Haryana, Karnataka and Maharashtra. States of Chhattisgarh, Jharkhand, UK and Arunachal Pradesh have 100% filled positions.

Sector Level

ASHA Facilitators who form the most critical link of then support structure network are in position in 20 states – Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttar Pradesh, Uttarakhand, Gujarat, Haryana, Karnataka, Maharashtra, Punjab, Arunachal Pradesh, Assam, Meghalaya, Manipur, Mizoram, Sikkim and Tripura. In remaining states, the job mentoring support to ASHAs is provided by existing MPW-Female/ANMs or LHVs.

Across these states a total of 37383 ASHA facilitators are in position against the target of 41276. Unlike the district and block level vacancy status, most states have over 90% positions filled. Unfilled positions of 16% exist in MP and 18% in UP.

State	District Level			Block Level			Sector level			District Trainers		
	Targets	In position	Remarks	Target	In position	Remarks	Sector Level	Target	In Position	Round-1	Round-2	Round-3
Bihar	38	12		534	414		1 AF per 20 ASHAs	4685	4194	803	535	370
Chhattisgarh	35	35		292	292		1 AF per 20 ASHAs	3220	3150	450	450	450
Jharkhand	24	24		582	582		1 for 10 to 20 ASHAs	2260	2260	44	39	39
Madhya Pradesh	51	46		313	259		1 AF per 10-15 ASHAs	5157	4330	**420**	**420**	**314**
Odisha	60	55	Additional District Coordinators for VHSNCs in position	Existing staff - BPM manages the programme			1 AF per 20 ASHAs	717	717	267	267	267
Rajasthan	34	31		249	174		1 PHC Supervisor at PHC level	1528	1248	610	568	567
Uttar Pradesh	75	71		820	764		1 AF for 20 ASHAs	8013	6405	3135	2983	1078
Uttarakhand	13	12		101	101		I AF for 20 ASHAs	606	604	45	45	45
Arunachal Pradesh	22	22		84	84		1 AF for 10-13 ASHAs	348	348	22	28	28
Assam	27	24		149	114		1 AF for 10 ASHAs	2877	2760	339	339	339

State	District Level			Block Level			Sector level			District Trainers		
	Targets	In position	Remarks	Target	In position	Remarks	Sector Level	Target	In Position	Round-1	Round-2	Round-3
Manipur	9	9		Existing BPMU staff supports the programme			I AF for 20 ASHAs	194	178	50	50	50
Meghalaya	11	10		Existing BPMU staff supports the programme			1 AF per 30 ASHAs	334	334	65	58	69
Mizoram	9	9		Existing BPMU staff supports the programme			1 AF per 10 ASHAs	109	109	18	18	18
Nagaland	11	11		72	66		Block ASHA coordinators play the role of ASHA facilitators			66	66	66
Sikkim	LHV/IEC staff manages the programme in all 4 districts			Existing BPMU staff supports the programme			1 AF for 10 ASHAs	71	71	11	11	11
Tripura	8	3		10	7		1 AF	426	404	92	88	76
Andhra Pradesh	13	11		Existing BPMU staff supports the programme			1385 MPHS- F (1 per PHC) - designated to mentor ASHAs			306	317	312
Delhi	11	8		Not applicable			1600 ANM 1 (per 5-7 ASHAs at UPHCs) - designated to mentor ASHAs			**255**	**261**	**318**
Gujarat	33	33	District programme Assistants manages the programme at district level	Existing BPMU staff supports the programme			1 AF for 10 ASHAs	3751	3468	139	139	139
Haryana	22	21		113	106		1 AF for 20 ASHAs	618	618	470	377	377
Himachal Pradesh	12	10		Existing BPMU staff supports the programme			1663 - (1 ANM per Sub-Center) - designated to mentor ASHAs			40	40	40
Jammu & Kashmir	Existing cadre of CHO/ Health Educator manages the programme in all 22 districts			Existing BPMU staff supports the programme			816 ANM (1 per 20 in North Hard to Reach area and 1 ANM for 10 in HTR - designated to mentor ASHAs			136	135	128
Karnataka	30	28		176	169		1 AF per 20 ASHAs	1800	1800	140	140	140
Kerala	14	13		Existing BPMU staff supports the programme								
Maharashtra	34	33		355	334		1 AF per 10 ASHAs in tribal areas & 1 AF per 20 ASHAs in Non-Tribal areas	3664	3517	1432	1400	1329
Punjab	22	13					1 AF per 20 ASHAs	898	868	347	345	342
Tamil Nadu	Existing staff in DPMU, Deputy Director of Health Services and District Maternal and Child Health Officers support the programme			Community Health Nurse cadre manages the programme								
Telangana	31	5		0	0	0	1386 MPHS designated to mentor ASHAs per PHC level			331	331	331

State	District Level			Block Level			Sector level			District Trainers		
	Targets	In position	Remarks	Target	In position	Remarks	Sector Level	Target	In Position	Round-1	Round-2	Round-3
West Bengal	26	22		666	428	NA	2 per block			1395	1135	790
Andaman & Nicobar Island	Existing DPMU staff supports the programme at district level.			Existing staff - BPM manages the programme			Existing PHC staff supports ASHAs			3	3	3
Dadra and Nagar Haveli	Existing DPMU staff supports the programme at district level.			Existing staff - BPM manages the programme			Existing PHC staff supports ASHAs			NA	NA	NA
Daman and Diu	Existing DPMU staff supports the programme at district level.			Existing staff - BPM manages the programme			Existing staff manages the programme			NA	NA	NA
Lakshadweep	Existing DPMU staff supports the programme at district level.			Existing staff - BPM manages the programme			Existing staff manages the programme			NA	NA	NA
Puducherry	Existing DPMU staff supports the programme at district level.			Existing staff - BPM manages the programme			Existing staff manages the programme			NA	NA	NA

SECTION – TWO

Findings from Assessment of Public Health System Readiness to Roll Out Population Based Screening and Control of Non-Communicable Diseases – Sub Study

In 2017, India made a paradigm shift in the delivery of primary healthcare. Under roll out of Comprehensive Primary Health Care (CPHC), Sub Health Centres (SHC) and Primary Health Centres (PHC) across the country are being upgraded to Health and Wellness Centres (HWC). These centres provide an expanded range of services in addition to existing services for reproductive, maternal and child health, common illnesses, communicable disease, and will include – care for non-communicable diseases (NCD), eye-ENT care, oral health, geriatric and palliative care, care for common emergencies and mental health care.

Introduction of services for NCDs at primary health care level is the first step undertaken for expanding services responding to epidemiological transition. The Universal Screening, Prevention and Management of NCDs (Hypertension, Diabetes and three cancers – Oral, Breast and Cervical Cancers) was launched in year 2017. It involves ASHA workers undertaking population enumeration, community-based risk assessment of individuals above 30 years of age and community mobilization for screening. This is followed by screening of individuals for common NCDs - hypertension, diabetes (once in a year) and oral, and breast cancer (once in five years), by service providers at SHCs. Screening for cervical cancer (once in five years) is planned at PHCs. Suspected cases are referred to appropriate higher facilities for confirmation and initiation of treatment, with follow up care for hypertension and diabetes to be undertaken at SHCs.

As is well known, the ASHA programme was initiated as part of India' flagship initiative – National Health Mission in 2005. The health system then was largely focused on providing care for maternal, child health and select communicable diseases. Therefore, ASHAs have also been selected, trained and mentored for activities related to these focus areas, over the years. With roll out of CPHC, there is expansion of range of tasks to be performed by ASHAs. Although her core roles of being a link worker, community mobilizer and service provider remain the same, the tasks have been expanded.

As part of the universal screening of NCDs, ASHAs are trained in a specific NCD module, for five days to equip them for the following tasks:

1. Enumeration of the entire population using Family Folder and creating individual health record for all above 30 years.
2. Community Based Risk Assessment (CBAC) for all individuals above 30 years.
3. Mobilize all individuals of 30 years and above for NCD screening being organized at SHC or at community level places like Anganwadi Centre, Panchayat Bhavan etc.

4. Conducting health promotion activities to create health awareness in the community, enable lifestyle modifications to address risk factors and prevent NCDs. This could be done through home visits and using community platforms like VHSNC/MAS, during VHND etc.
5. Following up patients for regular check-ups and treatment adherence.
6. Constitution of patient support groups and facilitating regular meetings.

In FY 2017-18, an assessment was undertaken across 15 states (Table 1), to understand the System Readiness for Rolling out Universal Screening, Prevention and Management of common NCDs. One key objective of this intervention was to understand community level readiness to implement this programme and involved studying various ASHA related parameters that would be crucial in enabling a continuum of care for these services.

Table 1: *List of States and Districts included in the study*

High Focus States	Non High Focus States	North East States
1. **Haryana –** Panchkula	7. **Maharashtra –** Wardha	13. **Assam –** Jorhat
2. **Jharkhand –** Bokaro	8. **Punjab –** Hoshiarpur	14. **Manipur –** Thoubal
3. **Chhattisgarh –** Durg	9. **Karnataka –** Udupi	15. **Sikkim –** East Sikkim
4. **Uttar Pradesh –** Lalitpur	10. **Gujarat –** Porbandar	
5. **Madhya Pradesh** – Khargone	11. **Andhra Pradesh –** Anantpur	
6. **Rajasthan –** Churu	12. **Jammu and Kashmir –** Baramulla	

In the January 2018 edition of the ASHA update, brief findings from visits to 14 states were reported. In the second phase of the study (January-June 2018), five states were selected for repeat visits, to understand change in readiness over a period of 6-8 months. The selection was based on readiness level observed during first visit. Two states with low level of health system readiness (Haryana, Madhya Pradesh), two states with moderate level of readiness (Gujarat, Sikkim) and one state with better readiness for implementing the initiative (Maharashtra) were selected for revisits.

In the following section, brief findings of the complete study with focus on repeat visits along with recommendations are discussed.

Key Findings:

◆ Capacity Building, Knowledge and Skills

Structured five days training with inclusion of all required topics was conducted in seven districts (Maharashtra, Karnataka, Manipur, Sikkim, Assam, Jharkhand, and Uttar Pradesh). In other districts, training duration was reduced, affecting the skills and knowledge of ASHAs, especially regarding health promotion and treatment adherence as observed during Focused Group Discussions. Other challenges namely, non-availability of module in local language (Sikkim, Manipur, Jammu and Kashmir), limited involvement of existing pool of ASHA trainers for NCD training was observed in some districts. Joint one-day training of ASHAs and ANMs was conducted in only five districts (Maharashtra, Karnataka, Manipur, Jharkhand and Sikkim). Better understanding among frontline workers, regarding each other's role and clarity on checklists was observed wherever joint training were conducted. However, district management staff reported logistic difficulty in conducting joint training.

Skills and knowledge among ASHAs varied across districts, based on quality of training, time elapsed since training and initiation of activities such as population enumeration and CBAC form filling, and mentoring of ASHAs during undertaking newer tasks. Although ASHAs in most states, were well informed about the formats – CBAC, family folder and basic information about NCDs, focus on soft skills of conducting health promotion activities, ensuring treatment adherence was limited.

◆ Involvement of Support Structure

Coordination between programme management teams – NCD division and ASHA programme division at state and district level was limited in some states, resulting in non-involvement of ASHA support structure and trainers.

ASHA facilitators were trained along with ASHAs in only four districts (Maharashtra, Karnataka, Manipur and Uttar Pradesh). Block and district community mobilizers were not actively involved in most

states. Support by ASHA facilitators was limited to population enumeration and CBAC form filling, and processes after enumeration were not clear.

This also affected incentive disbursal. Although provision has been made for additional incentives, the management and support structure at district and sub-district level were not aware. In none of the districts, ASHAs had received incentive for CBAC form filling and mobilization of an individual for screening (Rs. 10 per person) and for ensuring treatment adherence of patients with hypertension and diabetes (Rs. 50 for six months follow up).

Change Observed During Second Round Assessment

Improvement was observed in some states. E.g. In Gujarat, ASHAs were given only one-day orientation regarding their roles. Later, all ASHAs were trained in the module for five days, which was also reflected in better knowledge among ASHAs. Frontline workers were also involved in follow up of confirmed cases through home visits and patient cards/booklets were being used to aid in this purpose at all levels. However, in Madhya Pradesh, the programme implementation approach remained campaign based as against structured and planned universal screening. ASHAs training strategy was also not revised. ASHAs had received only one day orientation previously and no refresher training was conducted.

Scaling up of NCD screening, including ASHA training in the entire district was seen in Maharashtra and Sikkim. In Maharashtra, ASHAs had been trained in NCDs in the previous year and population enumeration activities were also completed. However, ASHAs had not received refresher training, and hence, attrition in skills was observed. In Sikkim, ASHAs had received structured five days training and one day joint training with ANMs and they had continued the activities of population enumeration and CBAC form assessment. In Haryana, although ASHAs had received training, ANMs, and MOs had not yet received training. This affected ASHA's role as they could only fill up the CBAC forms and there was no upward linkage. Beyond CBAC form filling undertaken by ASHAs, no other component of NCD screening was initiated.

Therefore, in some districts, there was progress in training, resulting in better knowledge and skills among ASHAs. ASHAs had also started providing follow up care. However, at the same time, limited hand holding after training and lack of refresher training was also observed in some districts. There was lack of commensurate strengthening of health facilities affecting role of ASHAs.

ASHAs Taking On New Tasks

High level of motivation was observed among ASHAs to implement this initiative. ASHAs had started community mobilization activities for NCD services using existing platforms – home visits, VHND, VHSNC meetings, gram sabhas etc. in some districts (Maharashtra, Chhattisgarh, Jharkhand, Karnataka, Manipur, and Sikkim). Health promotion activities, especially for tobacco control were initiated by ASHAs in Maharashtra and Sikkim. Screening activities were initiated in five districts (Maharashtra, Chhattisgarh, Karnataka, Sikkim and Andhra Pradesh), where ASHAs were taking active role and mobilizing the high risk individuals for screening. In Maharashtra and Gujarat (second visit), ASHAs had started maintaining list of individuals confirmed with hypertension and diabetes and mobilizing patients for treatment compliance.

ASHAs also reported some challenges in undertaking these new activities. ASHAs from states like Uttar Pradesh with high fertility rates and higher RCH workloads, and from difficult regions in northeast states, while welcoming the initiative, shared that they would find it difficult to accommodate additional activities in their work day. ASHAs from Haryana, UP and Maharashtra reported challenge of cultural barriers. ASHAs anticipated that mobilization of males and conducting risk assessment (measuring waist circumference or asking questions related to tobacco, alcohol habits) would be a challenge. In states of Assam, Manipur and Chhattisgarh where tobacco chewing is culturally more acceptable, ASHAs anticipated that the biggest challenge would be to convince people to avoid tobacco and alcohol.

ASHAs also shared during Focused Group Discussions, that systemic challenges would affect the implementation of the programme viz. weak referral linkages (Chhattisgarh), unavailability of medicines and diagnostics (Assam, Manipur) etc.

To summarize, ASHAs were aware about the burden of NCDs and economic hardships faced by

community members to seek care and welcomed the initiative. However, the enthusiasm among ASHAs was not always equalled by commensurate system inputs. Variable quality of training across districts affected the skills of ASHAs to conduct risk assessment and health promotion. Limited availability of diagnostics, medicines and trained human resources at health facilities further affected her credibility in the community. On the job mentoring to ASHAs for newer tasks was limited by weak supportive supervision. In areas with poor MCH indicators, ASHAs also raised concerns about their inability to manage the increasing work load. Implications of these findings and recommendations are discussed below.

Implications of Findings

Assessment of roll out of universal screening and management of NCDs is a dipstick diagnosis for implementation of Comprehensive Primary Health Care. The findings indicate readiness to deliver long term care and to deliver additional services. ASHAs' role is also expanding to provide chronic care and the findings will guide the next steps for deciding her tasks in delivery of CPHC.

- NCD services are being perceived as an additional task, especially where there is HR shortage and in states with greater RCH and communicable disease caseload (e.g. – Uttar Pradesh, Rajasthan, Madhya Pradesh, Assam). Particularly at the level of SHCs, frontline workers are engaged in immunization, ANC, HBNC, follow up of children with low-birth weight, children discharged from SNCU, NRC etc. Thus, the additional activity for population enumeration and screening of all individuals in the catchment area above 30 years, can be perceived as an additional and time consuming task. More evidence in terms of case loads and time required for tasks will be needed to further understand this issue. However, it can be noted that, the activity of population enumeration and screening is to be completed over a period of one year. Moreover, caseload of confirmed NCD cases requiring follow up care per ASHA/ per SHC would also be less. Role of FLWs also includes health promotion, which can be delivered through existing platforms – VHND, home visits, VHSNC, thereby not burdening them with extra work. These interventions would not require additional resources, but need reorientation of service providers. Community members were largely unaware about additional services and additional role of frontline workers as observed during study. Therefore, using community platforms would also help ASHAs in supporting her role as link worker. 'Patient Support Groups' is another such platform. It was observed that, knowledge regarding patient support groups was limited among service providers and ASHAs. The training module of ASHAs briefly explains about the Patient Support Groups and ASHAs' role in creating such groups. These can be created and utilized for ensuring treatment compliance which can facilitate ASHAs role. Bringing clarity about the caseload and tasks expected from service providers can therefore facilitate better planning and implementation.
- ASHAs also reported certain cultural barriers. The target population for ASHAs was mothers, children, and adolescents till now, and with NCD services, adult men have been included in her target population. Here again, role clarity among team members and allocation of NCD related work to male frontline workers – MPW-M will be effective.
- In MCH and communicable disease care (episodic care) delivered till now by health system, ASHAs were the face for majority of community based activities for health prevention and promotion. However, in NCD related services (long term care), other community platforms can lead this role, facilitated by team of frontline workers at HWC. This will require strengthening VHSNCs, forming Patient Support Groups.
- On one hand, it is observed that, being a part of community, ASHAs can take on this additional task to mobilize community and ensure compliance, provided health system challenges are also resolved and commensurate linkages are functional. However, there is also concern regarding increasing complexity of tasks and capacity of ASHAs with current educational qualification and age criteria to undertake these tasks. IT systems are proposed to be used, which may facilitate her work, but the learning curve for IT system will vary among ASHAs. Evidence is required for effectiveness of use of telementoring platforms and IT tools.
- Existing systemic challenges – Findings from most states indicate low to moderate levels

of preparedness in terms of training of HR, availability of medicines, diagnostics and service delivery across different levels of care, to support the roll out of this new intervention. Key role of ASHA is to mobilize community to avail services and weak response from heath system will affect ASHAs' credibility in the community.

- Interstate variations– States are currently at different levels of readiness and will progress at differing pace. States also differ in healthcare priorities as these are at different stages of epidemiological transition. Although the perceived burden of non-communicable diseases is lower in states like Uttar Pradesh, Bihar, Jharkhand compared to states like Punjab, Tamil Nadu and Kerala, these states still require considerable efforts for prevention of NCDs. Therefore, in states with lower burden of NCDs, role of ASHAs is primarily screening and prevention, while in states with higher burden of NCDs, follow up care and prevention both are crucial. Therefore, standards for monitoring and evaluation can be differential based on the context and phase of programme implementation. Timelines proposed for population coverage need to be different as need for resources will also vary.
- Interstate variations also have implication on current population norms for ASHAs. Although the workload on ASHAs would be less with better organization of team work and by using community based platforms, there might still be requirement of additional Community Health Worker. This is the case particularly in states where epidemiological transition has recently started and in states with current low preparedness of health system. Here, a model of an additional community health worker with different set of skills required for chronic diseases can be piloted and implementation research can be undertaken.

Key Recommendations

Program Implementation

1. Utilizing community platforms – E.g. VHNDs can also be utilized for NCD screening activities. During VHSNC meetings, health promotion and prevention activities for NCDs can also be discussed. Patient Support Groups can facilitate ASHAs' role in treatment compliance. Community mobilization and health promotion activities to be planned before and during the population enumeration, to support ASHAs and increase community engagement.
2. Role allocation among members of primary healthcare team – Health promotion and follow up care is a team work. MPW-M to be involved in community outreach activities and especially for health promotion and treatment compliance among men.
3. Using force multipliers for capacity building – In order to undertake large scale trainings for newer package of services, supplementary methods would be required. Telementoring platforms can be utilized, based on state context and readiness. Refresher trainings need to be planned regularly, using either classroom training or virtual training methods, as required, as this is a new initiative for frontline workers, in both the content and target population.
4. Involving support structure – Ensuring training of ASHA facilitators along with ASHAs and conducting one-day joint training of ANMs with ASHAs as per training strategy. Orientation of ASHA support system at block and district level in universal screening, prevention and management of NCDs.
5. Regular and timely incentive disbursal for CBAC form as well as follow up of patients. (Rs. 10 per CBAC form and Rs. 50 per individual for follow up of treatment of hypertension, diabetes and cancer and ensuing compliance for a period of 6 months).
6. Creating responsive health system to ensure effectiveness of ASHAs role in addressing chronic disease care.

Policy Level

1. Interstate variation – Considering that states are at different stages of health system readiness and at different stages of epidemiological transition, programme implementation strategies should be targeted to accommodate such differences. Although universal screening and management for common NCDs is to be implemented across states, focus on its sub components will vary between states. In states with current low NCD burden, focus is required on prevention as well as

screening. On the other hand, in states with high burden, where there are known cases, prevention for complications and treatment compliance of known cases will form a significant part of FLWs' work. State wise Disease Burden data can form a basis for having different categories of states. Indicators for programme monitoring can be different for these group of states.

2. Health promotion – Social, commercial and environmental determinants for NCDs require action at macro and micro levels. At the community level, collective action will be required for health promotion for non-communicable diseases, especially for changes in lifestyle, diet, tobacco-alcohol habits etc. Accountability for these activities should largely rest with community platforms – VHSNC, PSG with FLWs having the role of facilitators.
3. Research – Evidence is required regarding time use by ASHAs on different tasks with addition of activities. Based on evidence regarding workload, different models for work allocation can be piloted. Evidence is also required regarding effectiveness of use of IT tools among ASHAs and approaches for facilitating the IT interventions.

SECTION – THREE

Best Practices

In this section, we present few good practices pertaining to all key pillars of Community Processes i.e., ASHAs, MAS and VHSNCs.

These are:

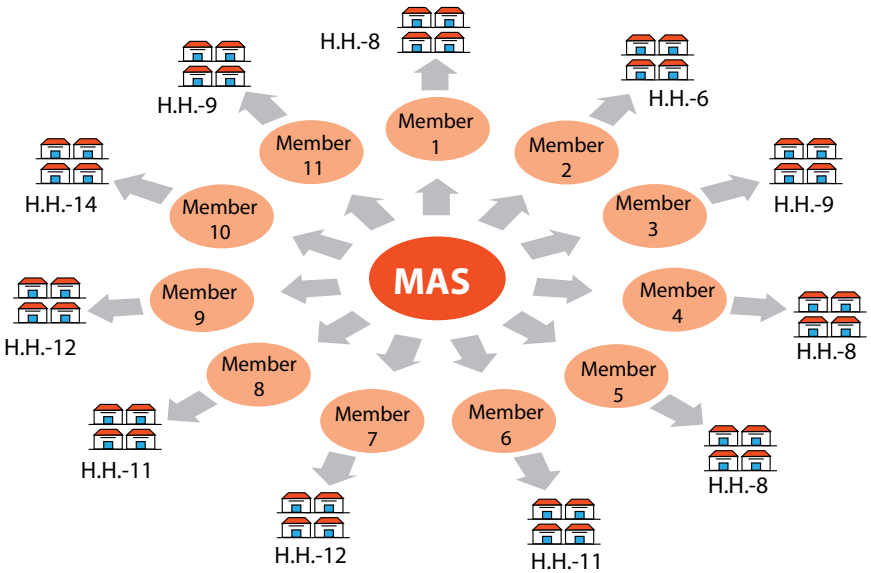
1. Contribution of Mahila Arogya Samiti (MAS) towards Measles Rubella (MR) vaccination in the Urban slums – Odisha.
2. "TeCHO+" (Technology enabled Community Health Operations) to support continuum of care – Gujarat.
3. ASHA Payment and Performance Monitoring System (APPMS) – NHM, Assam.
4. Role played by ASHAs and Gaon Kalyan Samiti to support community in Cyclone "FANI" Odisha.

The encouraging outcomes of these practices demonstrate how initiatives led by strong community structures and community health workers are capable of catalyzing solutions to address local health issues, whether it is due to poor health care seeking behavior or caused by a natural disaster. In addition, leveraging technological solutions to streamline processes has exemplified the potential to bring efficiency in the system.

1. Contribution of Mahila Arogya Samiti (MAS) towards Measles Rubella (MR) Vaccination in the Urban Slums – Odisha

Creating health awareness to improve health services seeking behaviour in urban areas is often difficult on account of constantly shifting migrant population and heterogeneous groups with different cultural and social backgrounds. Limited

Fig 1: Distribution of Households among the MAS Members during the MR Campaign



acceptance of the immunization services, difficulty in tracking children as per due list and high number of school drop outs also affected the demand of the Measles-Rubella (MR) vaccine in the urban communities of Odisha.

The Measles-Rubella (MR) campaign was implemented from January 2018 to April 2018 as part of global and nation-wide efforts to eliminate measles and control rubella. In Odisha, Mahila Arogya Samitis (MAS) were proactively engaged during the community phase of MR campaign to mobilize children who were due for immunization.

The households were assigned to a specific MAS member who then motivated and mobilized the identified children to attend the immunization sessions/ health institutions. In case of resistant families, all MAS members visited the households in groups with ANM, PHM and community leader to resolve their concerns and mobilize for vaccination.

Distribution of Households among the MAS Members during the MR Campaign

The household resource map was prepared by MAS members and ASHAs for identification of children and preparation of due list for vaccination during the campaign period. *Bindi* was used as a symbol for depicting the beneficiaries on the Map. A smaller *bindi* was used for mothers and relatively bigger *bindi* was used for children.

In addition, MAS members used the green card and red card to distinguish the houses based on their vaccination status. This, if the child from a household had received vaccination, one green card was pasted in front of the house and in case of non-receipt of the vaccine, red card was pasted. During the MAS meeting, members identified the house where there is a beneficiary and tracked the immunization progress over subsequent meetings. The MAS members also identified non-school going children, which helped in preparation of comprehensive list of non-school going children. While this may be perceived as stigmatizing, the fact that MAS members are from the same community and familiar with the population, care was taken that these households do not face any stigma.

The actual vaccination drive was planned for a period of 5 weeks in three phases – 1) In schools for 2 weeks, 2) In communities for 2 weeks, and 3) Mop-up of left-outs for 1 week. In the slums, existing routine immunization sites served as locations for administering MR vaccine.

Urban ASHAs and MAS members played a crucial role in mobilizing communities to participate in the MR vaccination drive. They organized local folk shows, mass rallies and slum meetings for spreading awareness. The MAS members also made follow-up visits to the schools where attendance was low on the day of the immunization and mobilized the parents and children for immunization.

Involvement of organized community structures (Mahila Arogya Samiti) working closely with ASHAs proved to be one of the key factors for improving the immunization coverage to 95.7%.

Fig 2: Use of Planning Tools by MAS Members

2. "TeCHO+" (Technology enabled Community Health Operations) for Frontline Workers to Support Continuum of Care – Gujarat

TeCHO+ application has been launched as a Comprehensive Public Health Management IT Solution in Gujarat. It is a mobile and web based application functioning as a job-aid at various levels from community to the state level administrators for improving coverage and quality of health services i.e., Android based application of ASHAs, MPW, CHOs; Web based portal for service providers at PHC/block/district level and for administrators at PHC/block/district/state level. At present, the android based application is being used by 10,793 Female Health Workers, 850 CHOs and 2487 ASHAs from selected districts of Narmada and Bharuch. The web portal is being used by 2219 users at health facilities and administrators.

After a successful pilot and evaluation in 3 tribal districts since 2013, the TeCHO+ Project was launched by the Hon. Prime Minister on 8th October, 2017 to scale up in entire state of Gujarat. TeCHO stands for "Technology enabled Community Health Operation". The results of the Cluster Randomised trial, conducted to assess effectiveness of the initiative in 22 PHCs of tribal area of Gujarat since Jan 2015[2], showed better outcomes in intervention areas compared to the control areas:

- 61% increase in postnatal care of new-born babies,
- 52% increase in cases of exclusive breast feeding and
- 16% reduction in infant mortality rate

Key Components of the Application Include

TeCHO+ Application

Mobile phone as job aid to health workers to increase coverage health care

- Longitudinal, health record and digital tracking of all individuals.
- Scheduling and activity planning in form of reminder.
- Use of multimedia to transmit targeted health information and improve counselling for behaviour change communication.
- Manage electronic health record.
- Notify stock levels and stock out of health commodities.
- Receive training content in form of multimedia files.
- Decision support in form of digital checklist and In-built algorithms to screen and risk stratify a case with complications.
- Referral coordination to facilitate referral to functional facility and emergency transport.

Web interface to provide timely information and tools to PHC/CHC/District hospital to facilitate supportive supervision and referral linkages

- Digital tracking of selected high-risk cases.
- Registration of birth and death events.
- Data synthesis and aggregation to provide monthly reports.
- Human resource management - list of health workforce cadres and monitor performance monitoring of ASHAs.
- Manage inventory and distribution of health commodities.
- Calculation and timely payment of incentive to ASHAs.
- Mass broadcast of motivational messages and training content to ASHAs using announcement feature.
- GVK EMRI call center contact beneficiaries for reminder of drop out services and verification of service already provided.

2. Dhiren Modi, Shrey Desai, Kapilkumar Dave, Shobha Shah, Gayatri Desai, Nishith Dholakia, Ravi Gopalan and Pankaj Shah. Cluster randomized trial of a mHealth intervention "ImTeCHO" to improve delivery of proven maternal, neonatal, and child care interventions through community-based Accredited Social Health Activists (ASHAs) by enhancing their motivation and strengthening supervision in tribal areas of Gujarat, India: study protocol for a randomized controlled trial. Trials (2017) 18:270

Fig 3: Techo+ Application

The application has been integrated with the state initiative of e-Mamta which captured details of family as a base unit. The family health survey feature allows the ANMs to validate/edit the legacy family data available under e-Mamta. The lowest level of data unit in Techo+ is the ASHA catchment area, which allows the flexibility of shifting households/ individuals on creation of new villages/urban wards.

Key Benefits of the Application for ASHAs include:

- Support in Inter Personal Communication through use of in built mobile video.
- Notification for high risk cases for improved follow up.
- Useful for timely identification, referral and management of beneficiaries.
- Reminder for due service through work plans.
- Ease of maintaining records of all beneficiaries
- Supports estimation of performance linked incentive.

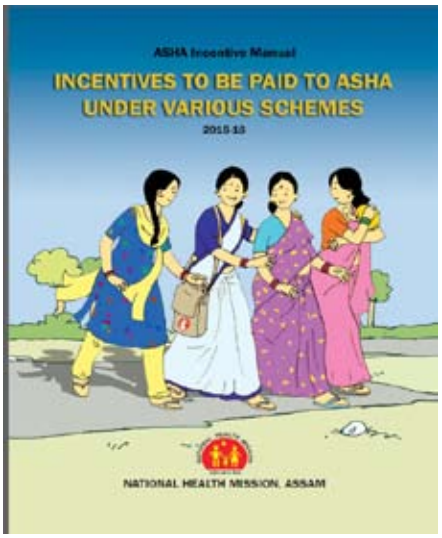
The IT platform has been expanded to include nutrition, non-communicable diseases, cerebral palsy and ophthalmology, with a plan to add RBSK, Mental Health and epidemic surveillance in a phased wise manner. This would facilitate functioning of ASHAs in new service areas as envisaged for delivery of Comprehensive Primary Health Care.

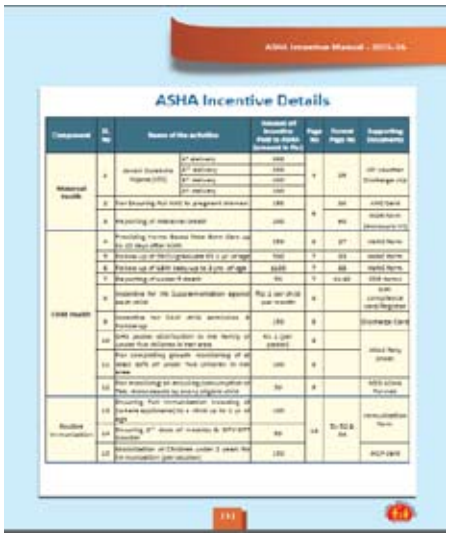
3. ASHA Payment and Performance Monitoring System (APPMS) – NHM, Assam

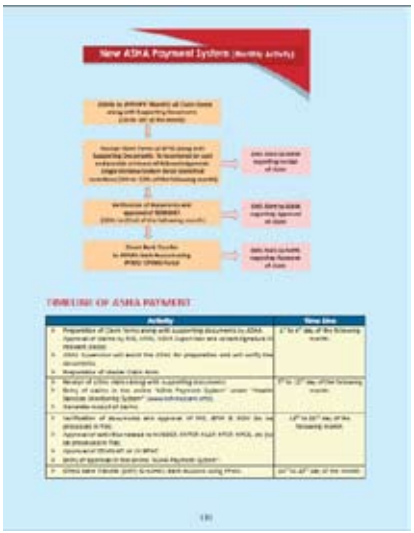
ASHA Payment and Performance Monitoring System (APPMS) initiative was implemented in the state with an objective to make some fundamental structural changes in the ASHA programme *to ensure timely payments to ASHAs and enhance the programme effectiveness through regular monitoring.*

Strategies adopted in roll out of the system included:

i. Comprehensive guidelines on payment of ASHA incentives was developed covering all programmes and all 55 activities to be performed by ASHAs. Guideline was translated in all local languages like Assamese, Bengali, Hindi, Bodo and English and its availability ensured with all ASHAs, all accounts persons and all programme officers.







ii. Simplification of Master Claim Forms to ease the process of filling by ASHAs and approval by accounts department.

ASHA Incentive Master Claim Form

To

SDM&HO or i/c Block PHC

.....

Sub: Submission of ASHA incentive claim for the period from ..... to .....

Sir/Madam,

With reference to the subject cited above, I have to the honour to submit the ASHA incentive claims for the period from ..... to .....as per statement mentioned below.

Sl No	Activity	Rate (Rs.)	Number of claims	Amount Claimed (Rs.)	Documents submitted	Amount approved (Rs.) (For office use only)	Remarks (Approving Authority)
1.	JSY incentive for ASHA for 1st Delivery (Rural) – for Antenatal Component.	300.00					
2.	JSY incentive for ASHA for 1st Delivery (Rural) – for facilitating Institutional Delivery.	300.00					
3.	JSY incentive for ASHA for 2nd Delivery (Rural) – for Antenatal Component.	300.00					
4.	JSY incentive for ASHA for 2nd Delivery (Rural) – for facilitating Institutional Delivery.	300.00					
5.	JSY incentive for ASHA for 3rd Delivery (Rural) – for Antenatal Component.	200.00					
6.	JSY incentive for ASHA for 3rd Delivery (Rural) – for facilitating Institutional Delivery.	200.00					
7.	JSY incentive for ASHA for 4th Delivery (Rural) – for Antenatal Component.	100.00					
8.	JSY incentive for ASHA for 4th Delivery (Rural) – for facilitating Institutional Delivery.	100.00					
9.	JSY incentive (Urban) – for Antenatal Component.	200.00					
10	JSY incentive (Urban) – for facilitating Institutional Delivery.	200.00					
11	For ANC registration within 1st Trimester.	50.00					
12	For ensuring full ANC.	100.00					
13	For reporting of Maternal Deaths.	200.00					
14	ASHA incentive for CAC services	150.00					
15	For providing HbNC upto 42 days after birth.	250.00					
16	For follow up of SNCU graduate till 1 year of age.	500.00					
17	For follow up of LBW baby up to 2 years of age.	1100.00					
	Sub Total Page No 1 (sl 1 to 17)						

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iii. Implementation of single window system for all claims to simplify the process for ASHAs to claim the incentive by eliminating the need not seek multiple approvals.

iv. Fixing of accountability for verification of claims with the ANMs and Accounts personnel within a specified time frame.

v. Fixing of timeframe for submission of claim and release of payment.

vi. Opening of Bank Account of all ASHAs registered with PFMS (Public Financial Management System) to facilitate 100% DBT payments.

vii. Development of online ASHA Payment and Performance Monitoring System in open source platform using the in-house capacity of National Health Mission, Assam.

Key Outcomes of the Initiative are:

1. ASHA payment system has been streamlined and monthly payment is released to ASHAs as per fixed timeframe.
2. 100% payment is made to bank account of ASHAs through Direct Benefit Transfer.
3. System has been able to establish transparency and accountability in payment process. SMS alerts are now sent to ASHAs on claim submission and payment are an important feature of the APPMS.
4. It allows programme officers to monitor the programme using the analysis reports and alerts.
5. The poor/ non performing ASHAs are identified and supported through motivation and reorientation. This is achieved through monthly follow up of poor/non-performing ASHAs based on the report generated from the system.

APPMS Module under Swasthya Sewa Dapoon

The system has been developed using in-house capacity and Open Source Technology and hosted in NHM own server. National Health Mission, Assam has won the **SKOTCH Swasth Bharat Gold Award** for implementation of ASHA Payment and Performance Monitoring System (APPMS).

4. ASHA and Gaon Kalyan Samiti work as a team to face the cyclone "FANI" in Odisha

On 3rd May, 2019, 14 districts of coastal Odisha were devastated by a massive cyclone, "FANI" which caused extensive damage to houses, trees, roads, electricity lines and health facilities and loss of many lives. The Cyclone brought led to huge healthcare needs and challenges, in addition to the crisis of food and shelter. The health administration took immediate steps to repair the health institutions and restore services, along with community level healthcare support activities.

During this period, both before and after the Cyclone, ASHAs actively played the role of Community Mobilisers with exemplary dedication. During the pre-cyclone phase, ASHAs played key role in alerting and mobilising the community for shifting to safer places and also facilitated shifting of expectant pregnant women to the nearby hospitals for delivery.

During the post-cyclone phase, the sources of drinking water were extensively damaged and poor sanitation conditions created risk of spreading health hazards and epidemic at the community level. ASHAs moved door to door in their communities on a daily basis to spread awareness on prevention and distributed ORS packets, halogen, chlorine tablets, sanitary napkins, etc. with a special focus on pregnant women, newborns and persons with disability.

With support of Gaon Kalyan Samitis (GKS/VHSNC), ASHAs conducted sanitation drives for disinfection of open wells, promoting use of impregnated bed nets, demonstration of hand washing and personal hygiene. Signages were placed near the contaminated water bodies to alert the public. ASHAs acted as depot holders of medicines for treatment of minor ailments and also facilitated linkage with the health facility for referral and treatment.

The Gaon Kalyan Samiti prepared special Village Health Plans during the post cyclonic phase, held regular meetings and spread messages through Swasthya Kantha (The Health Wall created by VHSNC for IEC messages and updated health information and notices).

Consistent and joint efforts of ASHAs and GKS/ VHSNCs, contributed in raising timely alerts, improved access to essential care and increased community level awareness about prevention of illness during and after the cyclone. ASHAs made their mark as "Community level soldiers" and along with GKS/VHSNCs proved that community process interventions have the ability to respond to the local health needs, even those created due to unplanned natural disasters.

Fig 4: Preparatory Activities in the Community

SECTION – FOUR

ASHA Incentives

Range of incentives for ASHAs is mentioned below-

	Activities	Amount in Rs/Case	Source of Fund and Fund Linkages	Documented in
	I. Maternal Health			
1	Janani Suraksha Yojana incentives			MOHFW Order No. Z 14018/1/2012/-JSY JSY-section Ministry of Health and Family Welfare-6th.February-2013
A	For ensuring antenatal care for the woman	Rs. 300 for Rural areas and Rs. 200 for Urban areas	Maternal Health-NRHM-RCHFlexi pool	
B	For facilitating institutional delivery	Rs. 300 for Rural areas and Rs. 200 for Urban areas		
	II. Child Health			
1	Undertaking Home Visit for the care of the New Born and mother[3] – Six Visits in Case of Institutional Delivery (Days 3rd, 7th, 14th, 21st, 28th & 42nd) -Seven visits in case of Home Deliveries (Days 1st, 3rd, 7th, 14th, 21st,28th & 42nd)	Rs. 250	Child Health-NHM-RCH Flexi pool	HBNC Guidelines – August-2014
2	Undertaking Home Visits of Young Child – Five Visits (as per schedule - 3rd month, 6th month, 9th month, 12th month and 15th month	Rs. 50/visit with total Rs. 250/per child for making 05 visits		D.O. No. Z-28020/177/2017-CH 3rd May-2018
3	Undertaking follow up visits to children discharged from facility or Severe Acute Malnutrition (SAM) management centre	Rs. 150 only after MUAC is equal to nor-more than 125mm		Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV
4	Ensuring quarterly follow up of low birth weight babies and newborns discharged after treatment from Specialized New born Care Units[4]	Rs. 50/Quarter-from the 3rd month until 1 year of age		Order on revised rate of ASHA incentives-D.O-Z.28020/187/2012-CH, MoHFW-

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

	Activities	Amount in Rs/Case	Source of Fund and Fund Linkages	Documented in
5	Mobilizing and ensuring every eligible child (1-19 years out-of-school and non-enrolled) is administered Albendazole.	Rs. 100/ASHA/ Bi-Annual		Operational Guidelines for National Deworming Day January 2016
6	***Intensified Diarrhoea Control Fortnight***			
A	Week-1 – Prophylactic distribution of ORS to families with under-five children	Rs. 1 per ORS packet for 100 under five children	Child Health-NHM-RCH Flexi pool	OGs for Intensified Diarrhoea Control Fortnight June 2015
B	Week-2 – Facilitating growth monitoring of all children in village; screening and referral of undernourished children and counselling to under-five children household	Rs. 100 per ASHA for completing at least 80% of household		
7	MAA (Mother's Absolute Affection) Programme Promotion of Breastfeeding- Quarterly mother meeting	Rs. 100/ASHA/ Quarterly meeting		Operational Guidelines for Promotion of Breastfeeding- MAA -2016
	III. Immunization			
1	Ensuring full immunization for a child under one year	Rs. 100	Routine Immunization Pool	Order on Revised Financial Norms under UIP- T.13011i01/2077-CC-May-2012
2	Ensuring complete immunization per child up-to two years age (all vaccination received between 1st and second year of age after completing full immunization after one year)	Rs. 75[5]		Order no – T.13011/01/2012/-CC& V
3	Ensuring DPT Booster at 5-6 years of age	Rs. 50		Order no– T.13011/01/2012/- CC& V
4	Mobilizing children for OPV immunization under Pulse polio Programme	Rs. 100/day[6]	IPPI funds	Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV
	IV. Family Planning			
1	Ensuring spacing of 2 years after marriage[7]	Rs. 500	Family planning-NHM RCH Flexi Pool	Order No- D.O – N-11012/11/2012 – FP, May 2012
2	Ensuring spacing of 3 years after birth of 1st child	Rs. 500		
3	Ensuring a couple to opt for permanent limiting method after 2 children[8]	Rs. 1000		

5. Revised from Rs. 50 to Rs. 75.

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

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

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

	Activities	Amount in Rs/Case	Source of Fund and Fund Linkages	Documented in
4	Counselling, motivating and follow up of the cases for Tubectomy	Rs. 200 in 11 states with high fertility rates (UP, Bihar, MP, Rajasthan, Chhattisgarh, Jharkhand, Odisha, Uttarakhand, Assam, Haryana and Gujarat) Rs. 300 in 146 MPV districts Rs. 150 in remaining states		Revised Compensation package for Family Planning- September DO-N 11026/11/2014-FP-2014
5	Counselling, motivating and follow up of the cases for Vasectomy/NSV	Rs. 300 in 11 states with high fertility rates (UP, Bihar, MP, Rajasthan, Chhattisgarh, Jharkhand, Odisha, Uttarakhand, Assam, Haryana and Gujarat) and 400 in 146 MPV districts and Rs. 200 in remaining states		
6	Counselling, motivating and follow up of the cases for Female Postpartum sterilization	Rs. 300 in 11 states with high fertility rates (UP, Bihar, MP, Rajasthan, Chhattisgarh, Jharkhand, Odisha, Uttarakhand, Assam, Haryana and Gujarat) and 400 in 146 MPV districts		
7	Social marketing of contraceptives- as home delivery through ASHAs	Rs. 1 for a pack of 03 condoms, Rs. 1 for a cycle of OCP, Rs. 2 for a pack of ECPs		Guidelines on home delivery of contraceptives by ASHAs-Aug-2011-N 11012/3/2012-FP
8	Facilitating beneficiary to the health facility for the PPIUCD insertion	Rs. 150/per case		Order on revised rate of ASHA incentives-D.O. No. P17018/14/13- NRHM-IV
9	Facilitating beneficiary to the health facility for the PAIUCD insertion	Rs. 150/case		Order on revised rate of ASHA Incentives -2016

	Activities	Amount in Rs/Case	Source of Fund and Fund Linkages	Documented in
	Mission Parivar Vikas- In selected 145 districts in seven states- (57 in UP, 38 in Bihar,25 in MP, 14 RJS, 9 in Jharkhand, 02 in Chhattisgarh and 2 in Assam)			
10	Mobilizing beneficiaries for Injectable Contraceptive MPA (Antara Program) and a non-hormonal weekly centchroman pill (Chhaya)	Rs. 100 per dose	Family planning-RCH-NHM FlexiPool	D.O.No.N. 110023/2/2016-FP
11	ProvidingNayiPahel kit - FP kit for newly weds- (In initial phase ASHA may be given 2 kits/ASHA)	Rs. 100/ASHA/ NayiPahel kit distribution		
12	Mobilizing Saas Bahu for Saas Bahu Sammelan- - (maximum four rounds)	Rs. 100/per meeting		
13	Updating of Eligible Couple survey before each MPV campaign-	Rs. 150/ASHA/ Quarterly round		
	V. Adolescent Health			
1	Distributing sanitary napkins to adolescent girls	Rs. 1/pack of 6 sanitary napkins	Menstrual hygiene Scheme–RCH – NHM Flexi pool	Operational guidelines on Scheme for Promotion of Menstrual Hygiene August 2010
2	Organizing monthly meeting with adolescent girls pertaining to Menstrual Hygiene	Rs. 50/meeting	VHSNC Funds	
3	Facilitating selection of peer educators(Given once every two years)	Rs. 100/Per PE	RKSK- NHM Flexi pool	Operational framework for Rashtriya Kishor Swasthya Karyakram – January 2014
4	Mobilizing adolescents for Adolescent Health day	Rs. 200/Per AHD		
	VI. Incentive for Routine Recurrent Activities			
1	Mobilizing and attending Village Health and Nutrition Days or Urban Health and Nutrition Days	Rs. 200 per session	NHM- Flexi Pool	Order on revised rate of ASHA incentives-D.O. No. P17018/14/13- NRHM-IV
2	Convening and guiding monthly meeting of VHSNC/MAS	Rs. 150		
3	Attending monthly meeting at Block PHC/U-PHC	Rs. 150		
4	a. Line listing of households done at beginning of the year and updated every six months b. Maintaining village health register and supporting universal registration of births and deaths to be updated on monthly basis c. Preparation of due list of children to be immunized on monthly basis d. Preparation of list of ANC beneficiaries to be updated on monthly basis	Rs. 1500[9]		Order No. F No7 (84)/2018 NHM-I. Dated-28th September 2018

9. Increased from Rs. 500 to Rs. 1500 from October 2018 as part of ASHA Benefit Package

	Activities	Amount in Rs/Case	Source of Fund and Fund Linkages	Documented in
	e. Preparation of list of eligible couples to be updated on monthly basis			
VII. Participatory Learning and Action- (In selected 10 states that have low RMNCH+A indicators – Assam, Bihar, Chhattisgarh, Jharkhand, MP, Meghalaya, Odisha, Rajasthan, Uttarakhand and UP)				
1	Conducting PLA meetings- 2 meetings per month– Note-Incentive is also applicable for AFs @Rs.100/- per meeting for 10 meetings in a month	Rs. 100/ASHA/ per meeting for 02 meetings in a month	NHM- Flexi Pool	D.O. No. Z.15015/56/2015-NHM-1 (Part)- Dated 4th January 2016
VIII. Revised National Tuberculosis Control Programme[10]				
1	Honorarium and counselling charges for being a DOTS provider		RNTCP Funds	Order on revised rate of ASHA incentives-D.O. No. P17018/14/13- NRHM-IV
A	For Category I of TB patients (New cases of Tuberculosis)	Rs. 1000 for 42 contacts over six or seven months of treatment		
B	For Category II of TB patients (previously treated TB cases)	Rs. 1500 for 57 contacts over eight to nine months of treatment including 24-36 injections in intensive phase		
3	For treatment and support to drug resistant TB patients	Rs. 5000 for completed course of treatment (Rs. 2000 should be given at the end on intensive phase and Rs. 3000 at the end of consolidation Phase		
4	For notification if suspect referred is diagnosed to be TB patient by MO/ Lab[11]	Rs. 100		Revised National Tuberculosis Control Program- Guidelines for partnership- Year 2014
IX. National Leprosy Eradication Programme[12]				
1	Referral and ensuring compliance for complete treatment in pauci-bacillary cases of Leprosy - for 33 states (except Goa, Chandigarh & Puducherry).	Rs. 250 (for facilitating diagnosis of leprosy case) + Rs. 400 (for follow up on completion of treatment)	NLEP Funds	Order on revised rate of ASHA incentives-D.O. No. Z.16025/2013/-Lep CCD dates August 21st, 2015

10. Initially ASHAs were eligible to an incentive of Rs. 250 for being DOTS provider to both new and previously treated TB cases. Incentive to ASHA for providing treatment and support Drug resistant TB patients have now been revised from Rs. 2500 to Rs. 5000 for completed course of treatment.
11. Provision for Rs. 100 notification incentive for all care providers including ASHA/Urban ASHA/AWW/unqualified practitioners etc if suspect referred is diagnosed to be TB patient by MO/Lab.
12. Incentives under NLEP for facilitating diagnosis and follow up for completion of treatment for pauci bacillary cases was Rs. 300 before and has now been revised to-Rs 250 and Rs. 400 now. For facilitating diagnosis and follow up for completion of treatment for multi- bacillary cases were Rs. 500 incentive was given to ASHA before and has now been revised to-Rs 250 and Rs. 600. New incentive added for identification of new case with visible deformity in hand, feet and eyes.

	Activities	Amount in Rs/Case	Source of Fund and Fund Linkages	Documented in
2	Referral and ensuring compliance for complete treatment in multi-bacillary cases of Leprosy- for 33 states (except Goa, Chandigarh & Puducherry).	Rs. 250 (for facilitating diagnosis of leprosy case) + Rs. 600 (for follow up on completion of treatment)		
3	Identification of new case with visible deformity in hand, feet and eyes.	Rs. 200 after confirmation of diagnosis		
X. National Vector Borne Disease Control Programme				
A. Malaria[13]				
1	Preparing blood slides or testing through RDT	Rs. 15/slide or test	NVBDCP funds for Malaria control	Order on revised rate of ASHA incentives-D.O. No. P17018/14/13- NRHM-IV
2	Providing complete treatment for RDT positive Pf cases	Rs. 75/- per positive cases		
3	Providing complete radical treatment to positive Pf and Pv case detected by blood slide, as per drug regime			
4	Referring a case and ensuring complete treatment	Rs. 300 (not in their updated list)		
B. Lymphatic Filariasis				
1	One time line listing of lymphoedema and hydrocele cases in all areas of non-endemic and endemic districts	Rs. 200	NVBDCP funds for control of Lymphatic Filariasis	Order on revised rate of ASHA incentives-D.O. No. P17018/14/13- NRHM-IV
2	Annual Mass Drug Administration for cases of Lymphatic Filariasis[14]	Rs. 200/day for maximum three days to cover 50 houses and 250 persons		
C. Acute Encephalitis Syndrome/Japanese Encephalitis				
1	Referral of AES/JE cases to the nearest CHC/DH/Medical College	Rs. 300 per case	NVBDCP Funds	Order on revised rate of ASHA incentives- D.O. No. P17018/14/13-NRHM-IV
D. Kala azar elimination				
1	Supporting the spray rounds (IRS) for sensitizing the community to accept indoor spraying[15]	Rs. 100/- per round during Indoor Residual Spray i.e. 200 in total for two rounds	NVBDCP Funds	Minutes Mission Steering Group meeting- February-2015

13. Incentive for slide preparation was Rs. 5 and has been revised to Rs. 15. Incentive for providing treatment for RDT positive Pf cases was Rs. 20 before and has been revised to Rs. 75. Incentive for providing complete radical treatment to positive Pf and Pv case detected by blood slide, as per drug regimen was Rs. 50 before. Similarly incentive for referring a case of malaria and ensuring complete treatment was Rs. 200/case and has been revised to Rs. 300 now.
14. Incentive has been revised from Rs. 100 to Rs. 200 per day for maximum three days to cover 50 houses or 250 persons.
15. ASHAs may be incentivized of total Rs.. 200/- (Rs.100 for each round) for the two rounds of insecticide spray in the affected districts of Uttar Pradesh, Bihar, Jharkhand and West Bengal.

	Activities	Amount in Rs/Case	Source of Fund and Fund Linkages	Documented in
2	Referring a suspected case and ensuring complete treatment.	Rs. 500/per notified case	NVBDCP Funds	Minutes Mission Steering Group meeting- February-2018
E. Dengue and Chikungunya				
1	Source reduction & IEC activities for prevention andcontrol of Dengue and Chikungunya in 12 High endemic States (Andhra Pradesh, Assam, Gujarat, Karnataka, Kerala, Maharashtra, Odisha, Punjab, Rajasthan, Tamil Nadu, Telangana and West Bengal)	Rs. 200/- (1 Rupee/ House for maximum 200 houses PM for 05 months- during peak transmission season). The incentive should not be exceed Rs. 1000/ASHA/Year	NVBDCP Funds	Updated list of NVBDCP incentive shared by MoHFW-NVBDCP Division – Dated-16th August-2018
F. National Iodine Deficiency Disorder Control Program				
1	Salt testing	Rs.25 a month for testing 50 salt samples	NIDDCP Funds	National Iodine Deficiency Disorders Control Programme – October-2006
XI. Incentives under Comprehensive Primary Health Care (CPHC) and Universal NCDs Screening				
1	Maintaining data validation and collection of additional information-per completed form/family for PMJAY–under Ayushman Bharat	Rs. 5/form/family	NHM funds	D.O.No.7 (30)/2018-NHM-I Dated 16th April- 2018
2	Filling up of CBAC forms of all individuals over 30 years of age and mobilizing them for screening on NCD screening.	Rs. 10/per form/per individual as one time incentive	NPCDCS Funds	D.O.No.Z-1505/39/2017- NHM-I Dated 19th July- 2017
3	Follow up of patients diagnosed with Hypertension/Diabetes and three common cancers for initiation of treatment and ensuring compliance for a period of 6 months	Rs. 50/per case/ twice a year		
XII. Drinking water and sanitation				
1	Motivating Households to construct toilet and promote the use of toilets.	Rs. 75 per household	Ministry of Drinking Water and Sanitation	Order No. Jt.D.O.No.W-11042/7/2007- CRSP-part- Ministry of Drinking Water and Sanitation - 18th May-12
2	Motivating Households to take individual tap connections	Rs. 75 per household		Order No. -11042/31/2012 -Water II Ministry of Drinking Water and Sanitation - February-2013

Note:

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Mission of Health & Family Welfare
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