Update on ASHA Program

June 2010

Prepared by

Training Division,
Ministry of Health and Family Welfare and
National Health Systems Resource Centre
New Delhi

National Rural Health Mission
Ministry of Health and Family Welfare
Government of India
New Delhi - 110 001

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Introduction

Launched in April 2005, the National Rural Health Mission (NRHM) promised an architectural correction of the health system which included "communitization" as one of its key anchors. The process included several components whose collective vision was the active engagement of communities in the delivery of health care. The community process components were designed and implemented to synergize with improved access and use of services.

Key components are:

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

Five years later, the ASHA programme continues to be the centerpiece of the community processes component. In 2005, when NRHM was launched, the ASHA programme was intended for implementation in the eight high focus EAG states, the North Eastern states and in the tribal areas in the other states, enabling the creation of a cadre of community level workers. In 2008, based on popular support, and positive reports in the annual Common Review Missions (CRM) and individual state demands, the programme was scaled up to cover the entire country.[1]. The ASHA programme now has a force of 791,548 women health volunteers working with communities and serving as a bridge between people and health facilities to ensure that the key goals of the NRHM are met.

This report is the second of a series of ASHA updates[2], produced by the National Health Systems Resource Center (NHSRC) and the Training Division, Ministry of Health and Family Welfare (MOHFW). The report is divided into two parts. Sections 1 and 2 provides quantitative data on selection, training and existence of support structures in the States and Union Territories. Section 3 covers state specific issues.

[1] Himachal Pradesh does not have ASHA as they prefer to rely on the Anganwadi Worker.

[2] The first update was issued in October 2009

The October 2009 update provided a brief update on the progress of the ASHA programme in all the states, and clarifications on the guidelines of the ASHA programme. The October 2009 update had included findings of several evaluations conducted since the launch of NRHM. This current update draws on two major sources and builds on the previous report:

- The Common Review Mission, November 2009
- Evaluation of ASHA[3] (institutional component) in eight[4] states, December 2009 to March 2010.

In December 2009, the MOHFW called a meeting of the National ASHA Mentoring Group to review the ASHA programme. A significant recommendation, *inter alia*, was that the ASHA in addition to being an activist should also be skilled in providing a basic package of services. This necessitates a review of institutional mechanisms and supportive supervisory structures, including incentive, and modalities of training.

Across the board, even as the studies and reports highlight problems with implementation, there is clear and substantial evidence that the ASHA has had an impact (albeit varying in different states) on enabling the community's link with the system and increasing service utilization. ASHAs remain active and enthusiastic, despite a multitude of problems faced. The CRM teams note that the ASHA feel empowered and command respect from the community.

The challenges of poor quality of training and weak/nonexistent support structures are not insurmountable; they require sustained commitment from the programme implementers, strong and supportive civil society partnerships, and adequate financial support.

[3] The ASHA evaluation is being conducted in two phases. Phase I looks primarily the institutional mechanisms and stakeholder perspectives from state to sub block level and is largely qualitative. Phase 2 which is currently underway is primarily quantitative and will provide information to assess functionality of the ASHA in the community.

[4] Assam (Dibrugarh and Karimganj), Andhra Pradesh (East Godavari and Khammam), Bihar (Purnia and Khagaria), Jharkhand (Dhanbad and West Singhbum), Kerala (Thiruvananthapuram and Wayanad), Orissa(Angul and Nayagarh), Rajasthan (Banswara and Bundi), and West Bengal (Malda and West Singhbum).

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2 Progress of the ASHA Programme

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

1. Selection and recruitment
2. Status of training
3. Support structures

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

Section 1

Selection and Recruitment

The task of ensuring that the ASHA are in place and her capacity built to undertake the roles and responsibilities envisaged of her, was a herculean task for many states. However, this task was substantially accomplished in the poor performing, EAG states, with limited capacity, numerous competing priorities, and often poor governance environments. In terms of scaling up, the process of selection and recruitment of ASHA in and of itself constituted an intensive process, involving community engagement. In practice this played out differently in different states, but it was a process that required the health system to engage with stakeholders at the community level.

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

Table 1.A: Status of ASHA selection in EAG States (May 2010)

State Name	Proposed No. of ASHAs	Number of ASHA selected	% of ASHA selected
Bihar	87,135	72,000	82.63%
Chhattisgarh	60,092	60,092	100%
Jharkhand	40,964	40,964	100%
Madhya Pradesh	52,117	49,282	94. 56%
Orissa	34,324	34,252	99.79%
Rajasthan	48,372	43,789	90.52%
Uttar Pradesh	1,36,268	1,36,182	99.93%
Uttarakhand	9983	9983	100%

Table 1.B: Status of ASHA selection in North East States (May 2010)

State Name	Proposed No. of ASHAs	Number of ASHA selected	% of ASHA selected
Assam	29693	28798	96.98%
Arunachal Pradesh	3862	3608	93.42%
Manipur	3878	3878	100%
Meghalaya	6258	6258	100%
Mizoram	943	943	100%
Nagaland	1700	1700	100%
Sikkim	666	666	100%
Tripura	7367	7367	100%

Table 1.C: Status of ASHA selection in Non High Focus States (April 2010)

State Name	Proposed No. of ASHAs	Number of ASHA selected	% of ASHA selected
Andhra Pradesh	70700	70700	100%
Delhi	5400	3181	58.90%
Gujarat	31438	29081	92.50%
Haryana	14000	12706	90.75%
Himachal Pradesh	NA	NA	NA
Jammu and Kashmir	9764	9500	97.29%
Karnataka	39195	27000	68.88%
Kerala	32854	31868	97%
Maharashtra	60457	57897	95.76%
Punjab	17766	16494	92.84%
Tamil Nadu	9500	2650	27.89%
West Bengal	60984	30114	49.38%

Table 1.D: Status of ASHA selection in UTs (May 2010)

State Name	Proposed No. of ASHAs	Number ofASHA selected	% of ASHA selected
Andaman andNicobar Island	403	403	100%
Dadra and Nagar Haveli	250	107	42.80%
Daman andDiu	NA	NA	NA
Lakshadweep	85	85	100%
Puducherri	NA	NA	NA
Goa	NA	NA	NA

1.1 Involvement of PRI in selection: A common finding across the eight states was the perception among programme managers was that involving the PRI was a double edged sword, bringing with it a semblance of local accountability and ownership but also carrying the risk of politicization. In Kerala and Assam there was active engagement of the PRI. In Assam the finding was that where the community was not equally actively engaged in selecting ASHA, the candidates tended to be weaker. The evaluation highlights that where the ASHA selection has been through committee formation (ANM, AWW, SHG, PRI) as in Kerala, Assam, and Orissa, understanding of health and rights issues and motivation levels are higher. In West Bengal the selection of ASHA was done at the Gram Panchayat level by a committee comprising of Gram Pradhan, Up Sanchalak of the GP Swasthya Samity, Health Supervisor, ANM of the concerned Sub Centre and 1 Block level (BDO / BMOH) representative., through a process of application and a multilayered selection process, but with little community involvement or mobilization. In Andhra, the Sarpanch and ANM were involved in ASHA selection. In Jharkhand the process of selection was intended to be the responsibility of the Village Health Committee. In the early phases of the programme a substantial amount of time was allowed, since the VHC had to be first selected and then the Sahiyya, but then the urgency of filling in the positions took over, and the process was circumvented. In Rajasthan, the Sahayogini, a pre-existing worker of the ICDS programme was designated as the ASHA –Sahayogini. In Bihar, the process of selection is led by the Panchayats, with support from the ANM, but little community involvement.

1.2 Educational Criteria: Relaxation of the educational qualification in low literacy states ensures that areas populated by marginalized groups also have an ASHA. In Orissa the state relaxed the criterion where candidates with requisite educational qualification were not available. In states such as Rajasthan and West Bengal, where overall literacy levels vary substantially among caste groups, setting across the board higher educational qualification norms has meant that several blocks with higher representations of SC/ST communities which have lower literacy levels, were not able to muster candidates to apply to become ASHA. This has resulted in gaps in coverage, in precisely those areas which need the services of ASHA. This has happened even in a state like Kerala, where ASHA were brought in from outside the area, rather than relax the educational norm. In Andhra Pradesh the training for ASHA was preceded by a reading and writing test, with those not qualifying asked to return after obtaining these skills. For some ASHA the training institution itself held evening classes.

1.3 Population Density: The population coverage norm across states is not uniform, with inter and intra state variations. (Tables 1.3A to 1.3 D) The most commonly followed norm in the eight states appears to be the one per 1000 norm, although states such as Orissa and Rajasthan have one ASHA per AWC, and Chhatisgarh has one per habitation. More encouraging is the fact that selected states, based on programme learning have modified selection criteria based on local context. Thus we see that in Assam 3500 more ASHA have been recruited recently to ensure coverage among marginalized and vulnerable populations, and Orissa has reduced the population norm to one per 300. Of course this means reduced income from incentives in proportion to the quantum of work. The converse is also true, in states such as West Bengal, in selected areas, ASHA tend to cover more than the mandated 1000 population. In Andhra Pradesh's East Godavari district, the issue is that ASHA from higher caste communities tend not to serve communities from the lower castes. These sections then have to covered by other ASHA who then have to serve a higher population. In Jharkhand although the process of hamlet based selection was followed early on, (similar to that in Chhatisgarh), the norms were later on amended to the one per 1000 coverage, resulting in the marginalization of several hamlets and communities.

Section 2

Training of ASHA

The ASHA programme envisages that each ASHA is trained for at least 23 days in year one and then 12 days every year thereafter. Assuming that training was initiated in 2007, once systems were in place, at least 47 days of training ought to have taken place. In reality, only 13 states have completed 23 days of training over three years. In the EAG states establishing the training systems has been an enormous challenge. In general overall progress of training is slow in most states.

Table 2A: ASHA training status in EAG States (May 2010)

State Number	Name of ASHAs selected	Training Status Number of ASHAs Trained in Module 1	Module 2	Module 3	Module 4	Module 5
Bihar	72,000	69,402	35,000	35,000	35,000	#
Chhattisgarh	60,092	60,092	60,092	60,092	60,092	60,092
Jharkhand	40,964	40,115	39,482	39,214	35,675	20,785
Madhya Pradesh	49,282	45,908	42,153	41,237	37,969	#
Orissa	34,252	34,117	33,910	33,910	33,910	34,124
Rajasthan	43,789	40,310	33811	32652	2847	#
Uttar Pradesh	1,36,182	1,35,130	1,28,434	1,28,434	1,28,434	#
Uttarakhand	9983	9,975	9,975	9,975	9,975	8,978

 # = yet to begin

Table 1.3 D: Density of ASHA in UTs

State Name	Proposed No. of ASHAs	Sanctioned No. of Anganwadi Centre (2007)	Estimated Rural Population (2008)	Density of ASHA (ASHA: Population)
Andaman and Nicobar Island	403	672	239858	1 : 595
Dadra and Nagar Haveli	250	219	169995	1 : 680
Lakshadweep	85	87	33647	1 : 396

1.4 Tracking Drop outs: The issue of drop outs is mentioned in several reports, but states have not yet found a way of reliably tracking and reporting ASHA dropouts. Some states such as Assam, have begun developing norms for tracking dropouts, but this data is not yet being collated beyond the individual PHC or at best at block level, and is not being reported upwards. Reasons for dropouts appear to be out migration, enrollment into ANM course, or appointment as AWC, or simply lack of interest. This issue needs further exploration.

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Table 2 B: ASHA training status in North East States (May 2010)

State Number	Name of ASHAs selected	Training Status Number of ASHAs Trained in Module 1	Module 2	Module 3	Module 4	Module 5
Assam	28798	26225	26225	26225	26225	23271
Arunachal Pradesh	3608	3379	3212	3156	2533	1176
Manipur	3878	3878	3000	3000	3000	3000
Meghalaya	6258	6175	6175	6175	6175	3427
Mizoram	943	943	943	943	943	932
Nagaland	1700	1700	1700	1700	1700	1700
Sikkim	666	666	666	666	666	666
Tripura	7367	7367	7367	7367	7367	7367

Table 2 C: ASHA training status in Non High Focus states (April 2010)

State Number	Name of ASHAs selected	Training Status Number of ASHAs Trained in Module 1	Module 2	Module 3	Module 4	Module 5
Andhra Pradesh	70700	70700	70700	70700	70700	70700
Delhi	3181	2266	2266	2266	2266	2266
Gujarat	29081	27229	24142	22370	18272	2915
Haryana	12706	11597	10211	10211	10211	#
Jammu & Kashmir	9500	9500	9000	9000	9000	#
Karnataka	27000	25400	25400	25400	25400	25400
Kerala	31868	30763	30763	30763	30763	0
Maharashtra	57897	51357	8413	7905	7411	3938
Punjab	16494	15481	Going on	Going on	Going on	0
Tamil Nadu	2650	0	0	0	0	0
West Bengal	30114	22364	18482	16567	13674	11196

Table 3D: ASHA training status in Union Territories (April 2010)

State Number	Name of ASHAs selected	Number of ASHAs Trained Module 1	Module 2	Module 3	Module 4	Module 5
Dadra and Nagar Haveli	107	87	87	87	87	87
Lakshadweep	85	85	85	0	0	0

Section 3

Support Structures

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

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

Other Support mechanisms include:

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

The National Asha Mentoring Group provides input to the NHSRC and the MOHFW on key policy matters related to the ASHA programme. Their contribution in shaping the ASHA programme at the national level is substantial. In the December 09 consultation, their views and recommendation on enabling a service provider role for ASHA has resulted in a new role for the ASHA. However their recommendations may differ from the course the Ministry chooses to adopt. A case in point is the involvement of ASHA in social marketing programmes. The recent approval of a scheme to incentivize ASHA to distribute sanitary napkins is an example. Another is the recommendation that ASHA be paid a fixed slab, plus payments for performance in specific activities thereafter.

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

The supportive institutional network at state level and below (Tables 3A to 3D) has not expanded as rapidly as the ASHA programme in the states, limiting the potential effectiveness of the ASHA.

In some states ASHA have been trained in selected sites on selected topics. For instance, ASHA in Bihar have been trained in early pregnancy diagnosis with a one time supply of the kit, and in Orissa, in three districts are being trained in a post partum care programme.

Training Sites: There is general consensus that residential training makes for better learning, improves motivation and serves to strengthen bonds among ASHA and between ASHA and the trainers. While some states have made this mandatory, in practice this does not always happen, with trainers and ASHA preferring non residential training. While part of it relates to family and household constraints for the ASHA, part of the reason is that there is insufficient access to residential sites in the blocks.

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Table 3 A: Status of ASHA support structure and drug kit distribution in EAG states

EAG States	Status Support Strcture for ASHA					
	State Level		Disrict Level	Block Level	Sector Level	Drug Kits
	State ASHA Mentoring Group	Resource Reource Centre				
Bihar	In process	TOR/MOA being finalized as a society	Recruitment process is on	Recruitment process is on	Not yet	Procurement process is on
Chhattisgarh	Constituted	SHSRC is taking role of the ARC30 State Field Coordinators	District resource persons 427 District Resource Persons in 18 districts	Block Coordinator in each block	Block Resource Person (1 per 20 Mitanin)	Distributed to all 60092 Mitanins (100%)
Jharkhand	Consituted, and 1 meeting held	VHSRC established	District program Coordinator joined in all district except 4 dist	4 Block trainers in each block	Recruitment for ASHA Facilitaor (1 for 15-25 ASHAs) is to start	Distributed to 35000 (86%) Sahiya
Madhya Pradesh	Constituted and 2 meetings held	Not yet established	District Program Managers in 5 District	Not Yet	Not yet	Distributed to 45971 (87%) ASHAs
Orissa	Constituted and 2 meetings held	Community process Resource Centre is in place	District ASHA Coordinator is in place	BPO is responsible for ASHA and GKS in the block	None	Distributed to 34214 ASHAs (99%)
Rajasthan	Constituted and 2 meetings held so far	State ARC is in place	District ASHA Coordinator is place in all districts	150 out of 237 Block ASHA coordinator are in place	1503 ASHA Facilitator in place (1 ASHA Facilitator per PHC)	Distributed to 32059 (78%) ASHAs
Uttar Pradesh	Constituted, and 2 AMG meetings held so far	Not yet established	District Comunity Mobilizers in place	Block Health Education and Information Officer id designated as Nodal Officer for ASHA prog	Not yet	Distributed to 128434 (94%) ASHAs
Uttarakhand	Constituted on and 3 meetings held so far	State ARC in place (State has an MOU with an NGO-HIHT)	District ARC is in place in all Districts (HIHT)	Selection of Block Coordinator is in process	Selection of ASHA Facilitator is in process	Distributed to 9975 (100%) ASHAs

Table 3 B: Status of ASHA support structure and drug kit distribution in North East states

NE States	Status Support Strcture for ASHA					
	State Level		Disrict Level	Block Level	Sector Level	Drug Kits
	State ASHA Mentoring Group	Resource Reource Centre				
Arunachal Pradesh	Constituted and 1 meeting held	Not yet	Not yet	Not yet	Not yet	Distributed to 3039 (84% ASHAs
Assam	Constituted and 4 meetings held	State ARC established (State has an MOU with an NGO- Donbosco Inst)	District ARC (Donbosco Institute)	Block Coordinator is in place in every block	1 ASHA Facilitator for every 10 ASHAs in place	Distributed to 26225 (91%) ASHAs
Manipur	Constituted and 5 meetings held	Not yet	Not yet	Not yet	Not yet	Distributed to 3878 (100%) ASHAs
Meghalaya	Constituted and 3 meetings held	ARC Established	Disrict Community Mobilizer is in place	Not yet	143 ASHA Facilitator in place (1 for 15-20 ASHAs)	Distributed to 6180 (98%) ASHAs
Mizoram	Constituted and 3 meetings held	Not yet	Not yet	None	None	Distributed to 943 (100%) ASHAs
Nagaland	Constituted and 3 meetings held	ARC Established	None	40 Block ASHA Coordinator	None	Distributed to 1700 (100%) ASHAs
Sikkim	Constituted and 2 meetings held	Not yet	None	None	Not yet	Distributed to 637 (95%) ASHAs
Tripura	Constituted and 2 meetings held	ARC Established	District Commuty Mobilizer is placed in all 4 Districts	Not yet	Not yet	Distributed to 7362 (99.90%) ASHAs

Table 3 C: Status of ASHA support structure and drug kit distribution in Non High Focus states

Non high Focus States	Status Support Strcture for ASHA					
	State Level		Disrict Level	Block Level	Sector Level	Drug Kits
	State ASHA Mentoring Group	State ASHA Reource Centre				
Andhra Pradesh	Core Group formed	Not yet	Project Officer, District Training Team (P.O.DTT) Nodal Officer is the District Public Health Nursing Officer (DPHNO)	None	Every PHC has 1 ASHA Nodal Officer	Distributed to all 707000 (100%) ASHAs
Delhi	Under process	Under process	District Nodal Offier and District Mentor Group	49 ASHA unit is in place		Distributed to 2266 ASHAs Proposed for Drug kits for 5450 ASHAs
Gujarat	Not yet	Not yet	Not yet	Not yet	Not yet	Not distributed Drug kits proposed for 30,000 ASHAs in PIP
Haryana	Not yet	Not yet	Not yet	Block Extension educator act as Nodal Officer for ASHA	Not yet	Not yet distributed Drug kits proposed for 3000 best performing ASHAs
Jammu & Kashmir	In process	In process	Not yet	Not yet	Not yet	Distributed to all 9500 (100%) ASHAs
Karnataka	Constituted	Not yet	None	Block ASHA Coodinator	None	Distributed to 23500 ASHAs Drug kit proposed for 15000 ASHAs
Kerala	Constituted	SHRC constitution under process	None	None	None	Distributed to all 30909 (100% ASHs
Maharashtra	District and Block level ASHA Mentoring Group 1 extra Block Facilitator in those PHC which has more than 20 ASHAs	Constituted	SHSRC taking role of ARC	District Community Mobilizers is in all 15 tirbal district, and 13 out of 18 non tribal district	In process	PHC level Facilitator in place (1 per PHC)

Punjab	Coordination through Block Nodal Officer at Block Coordination through LHV at PHC/sector level	Not yet	Established	District Community Mobilizers is placed in 8 Districts (recruitment of remaining 12 in process)	Not yet	Not yet
Tamil Nadu	None	None	None	None	None	None
West Bengal	Not in existence	Established (CINI) and ASHA cell with 5 staff	MNGO led District Prog Coordinator	MNGO led Block Coordinator/ Co-facilitator (1 per Block/ 13-15 Gram Panchayat)	1 facilitator per 5 Gram Panchayat (75 ASHAs) MNGO led	• Drug kits distributed to 7601 ASHAs • Proposed for drug kits for another 24164 ASHAs

Table 3 D: Status of ASHA support structure and drug kit distribution in UTs

UTs	Status Support Strcture for ASHA					
	State Level		Disrict Level	Block Level	Sector Level	Drug Kits
	State ASHA Mentoring Group	Resource Reource Centre				
Andaman & Nicobar Island	None	None	None	None	None	Distributed to 49 (12%) ASHAs. Drug kits proposed for another 354 ASHAs
Dadra and Nagar Haveli	None	Not yet	None	None	None	Distribute to 81 (32%) ASHAs
						Drug Kits proposed for another 169 ASHAs
Lakshadweep	None	None	None	None	None	Distributed to 85 (100%) ASHAs

State Level: At the state level the role and functioning of the State Mentoring Groups varies greatly. Chhatisgarh, Maharashtra and Assam have active State ASHA Mentoring Groups. In the other states, even where they exist, they do not really appear to be contributing to policy guidance programme oversight. Policy makers and programme implementers at the state level do not appear to be ready for the guidance that an active Mentoring Group at the state level has the potential to provide. One reason could be the preoccupation with rolling out the ASHA operational including fulfilling the training requirements. Much more advocacy is required to enable states to move beyond the creation of the ASHA Mentoring Group, and to provide the enabling environment to make it more effective.

ASHA Resource Center (ARC): are in place in six out of eight EAG states, and in four of the four NE states. Uttar Pradesh is not setting up an ARC, but plans to constitute a team of consultants to support the state ASHA programme. Three of the four remaining NE states have committed to establishing ARC in 2010-2011, but Sikkim will be supported through NE RRC. For the nine non high focus states, West Bengal, Kerala, and Maharashtra (for tribal areas) have ARC. Four of the remaining states and Maharashtra (for non tribal) propose to set up ARC this year.

District Level: The support structures for the ASHA at district levels and below are intended to support the implementation of the ASHA and VHSC components. States have been agile in appointing district level community mobilizers. Seven of the eight (except Madhya Pradesh) EAG states have district support systems in place. NHSRC is supporting Bihar to recruit district mobilizers who will be in place by June. In the NE states, at the district level three of the 8 states have district mobilizers. Except Sikkim and Nagaland the rest have proposed to appoint district mobilizers in 2010-2011.

Block Level: Three of the 8 EAG states have block facilitators and Bihar is in the process of recruiting such facilitators. In Uttar Pradesh the Block Health Education officer has been appointed the nodal officer in charge for ASHA. The remaining three states work through existing Block Programme Managers. Block level support systems exist in Assam, Meghalaya and Nagaland.

ASHA facilitator: are in place in Rajasthan and Chhatisgarh, and are being proposed in Orissa, Uttar Pradesh, Jharkhand and Uttarakhand. In the NE states, Assam and Meghalaya have ASHA facilitators. Except Sikkim (which has proposed ASHA facilitators (one per 10-15 ASHA) the remainder have proposed block level facilitators in 2010-2011. For the non high focus states, only Punjab and Maharashtra have appointed district and block facilitators.

The second element of the support structure is the distribution of the drug kit and the regularity of replenishment. On the first time distribution of drug kits most states appeared to have done well. Replenishment is an issue in most states. It is ad hoc and there is little evidence of stock cards being maintained.

Performance based Incentive payments: Possibly no other component of the ASHA intervention generates as much debate, discussion and assessment as that of her payment. National guidelines established in 2005, set out certain parameters for the performance based incentive but states were asked to adapt this to their context, which has taken place in large measure. Over time the incentive payment structures in all states have evolved very differently. Programmes such as the Janani Suraksha Yojana (JSY), Immunization and family planning, are still the predominant contributors to the incentive amount. States are incentivizing the ASHA for a host of other programmes that include: Vector Borne disease control, blindness control. States such as Rajasthan, Andhra Pradesh, and West Bengal have a form of fixed payment for ASHA but the rest follow a pattern of performance based incentives. In the early years delays, leakages and non payments of incentives were problematic across the states, but in states like Orissa and Assam, this problem has been resolved to a substantial degree by establishing a series of mechanisms to minimize these issues. They include: creating bank accounts for ASHA, enabling cheque payments and e- transfers of funds, making block officers accountable for payments, and use of monitoring registers. It is likely that where a support structure exists there are fewer delays in payment.

3 Brief descriptions on the individual ASHA Programmes in the States

Bihar: While over 80 % of the ASHA have been recruited and are in place, the pace of the ASHA training, support and other related processes in Bihar has been slow, and over 97% ASHAs have received training on Module and 42% have received training up to Module 4 . However over the past few weeks there appears to be momentum to revitalize the training programme and the creation of support structures. Until recently the state had no mechanism for support at district levels and below. However the state has just approved the selection of 533 Block Community Mobilizers and 37 District Community Mobilizers. They are expected to be in place by July 2010. A Special Task Force for Community mobilization and ASHA programme has been set up under the State Health Society (SHS) and has been meeting to plan the ASHA trainings, and to work closely with and support Pranjal in clearing the substantial training backlog.

However the state needs to seriously consider establishing a long term training system and processes to ensure that the ASHA can play the role she is intended to. Although discussions have been initiated on the creation of an ASHA Resource Center, traction on this component is needed. ASHA's key role appears to be participation in the Muskaan programme and the JSY. Critical efforts are being made to streamline ASHA payments at the district level. Procurement contracts for the ASHA drug kit have been streamlined. All guidelines of the ASHA programme have been translated into Hindi also been made available online.

Chhattisgarh: The Mitanin of Chhatisgarh continues to be the mainstay of the Community Processes programme. The focus of the training is on building skills and competencies and the state has already completed 14 rounds of training. A high level of skills is in place, there is a high degree of motivation and comprehensive support structures are in place for Mitanin Program. Mitanin help desks are in place in all the CHCs and in district hospitals. This programme has more of an activist character, on the basis of which the ASHA gets its name. There is also a conscious planning for the future. A conceptual workshop called the future of the Mitanin programme addresses how planning over the next five years–so that there is a vision for- when the programme is 12 years old. The Mitanin programme–VHSC synergy is also excellent. Its weakness is its poor quality of facility support for the referred patient as human resources and minimum levels of functionality of facilities has been slow to improve. Payment of incentives is also weak, though this is not perceived as being a limiting factor. Mitanins could often be in competition with ANMs for Family Planning or DOTS incentives.

Jharkhand: In the early years of the programme, the state involved NGOs in the selection and training of the Sahiyya/ASHA through Village Health Committees. While NGO involvement continues it is largely limited to training. The state has now constituted a Village Sahiyya Resource Center to support the Sahiyya and Village Health Committees (VHC). Stakeholders and communities alike view the Sahiyya as being the link between the people. A team of 48 state level trainers and 896 block level trainers have been put in place. Sahiyya training in Jharkhand for Module 5 has begun in several districts. Support structures for ASHA do not go below the district level. Incentive payments for Sahiyyas are made through cheques, but only for the JSY component. Other incentives including those for immunization are paid through cash. Monthly meetings for Sahiyyas are held at the Block PHC level. In Jharkhand VHC were in place before ASHA selection. The recent evaluation shows that although stakeholders see the Sahiyya as being accountable to the VHC, the members of the VHSC need to undergo training and the committees need to be strengthened before they are able to support the Sahiyya. Orientation for VHSC office bearers was undertaken by the state early this year for all 212 blocks. As a consequence of this training, about 28, 000 of the 32, 000 VHSC have accounts and funds have been transferred to about 20000 accounts. Training modules for village health planning have been created at the state level. Training has been initiated in May 2010.

Madhya Pradesh: The state ASHA programme is confined to ASHA at the community level, with a near total absence of specific support structures at state, block and district levels. The State ASHA Mentoring Group which has been place for over two years appears to have little influence on the state's programmatic decisions. Over 75% of ASHA have received training up to Module 4. 1100 new ASHA have been selected and their training is ongoing. ASHA payments for ANC, JSY, and immunization are being made through e banking facility in selected districts. The lack of support structures affects all aspects of the programme including the effectiveness of the Village Health and Sanitation Committee and the on site mentoring, support and supervision of ASHA.

Orissa: In terms of progress on the ASHA programme, Orissa has made enormous strides. This stems from strong ownership of the programme at state level and the establishment of extensive mentoring, support and supervisory mechanisms for ASHA. The evaluation demonstrates that all stakeholders felt that the ASHA programme was of "great benefit to the community and the public health system". ASHA is owned by the community and this confidence in her has been bolstered by the state in supporting the ASHA in a variety of innovative ways beyond sound training and ongoing mentoring. The high ownership of the system is evident in several ways. These include a systematic structure of review meetings for ASHA at block, district and state levels, a system of performance awards, facilities for ASHA to stay in when she escorts patients to the health institutions, and bicycles. Payments to ASHA are streamlined and there is little backlog. The Gaon Kalyan Samitis (Village Health and Sanitation Committees) have been established and are currently undergoing training. The state government has established ASHA Gruha (rest house), for ASHA to stay in when escorting women for institutional delivery. Accountability for ASHA payment rests with the Chief District Medical Officer who is expected to report on "no pending payments to ASHA" on a monthly basis. ASHA training in Orissa was managed by the health department, but for Round 5 there has been NGO involvement with apparently positive results. One gap that remains to be addressed is the lack of sub block ASHA facilitators which in states such as Chhatisgarh and Assam make a significant difference to ASHA effectiveness. A second challenge is the continuing exclusion of vulnerable and marginalized populations. The state is planning to increase the ASHA in these areas from the one per 1000 norm to one per 300.

Rajasthan: Given the status of the programme, the state has instituted several mechanisms that have the potential to strengthen the effectiveness of the ASHA and Community Processes programme. The ASHA Resource Centre has just become functional. NGOs are involved in the Mentoring Group and in the training of ASHA. The ASHA is a representative of the ICDS system and working within NRHM, thus representing an effective convergence point for nutrition and health. Issues with payment persist. VHSCs have been formed in the state, but trainings have not yet been initiated. ASHA functioning appears to improve in direct proportion to the state of the health system in the district. Overall the assessment of the ASHA programme highlights the need for strong institutional structures from state to district levels and below, particularly integration with the District Health System.

Uttar Pradesh: The programme at the grassroots appears effective. However training has been slow and of limited effectiveness. Modules 2, 3 and 4 were combined and delivered. Training on Module 5 for ASHA is yet to begin, although state and district trainers are being trained. A number of new initiatives such as ASHA Sammelan, ASHA Award, ASHA Quarterly Magazine, and ASHA Identity Cards are facilitating ASHA programme in the state. Incentive payments for ASHAs are made through cheques for JSY and Immunization. State level resource centers are not in position. District coordinators are in position. Block level facilitators are not in position. Monitoring guidelines have been issued but still to be made effective. Drug kits distribution started- but not yet reached all.

Uttarakhand: 23 days of ASHA training have been completed including training on Module V. Drug kits distribution is complete for all ASHAs. Incentive payment for ASHAs is made through cheques for JSY and Immunization. VHSCs are not functional. NGOs play a major role in support at the state as the ASHA resource center and at district and block levels. Support structures are in place. District ASHA resource centers are also functional and a reasonable programme of monitoring is in place.

Assam: The ASHA programme in Assam continues at a high level of performance. Other than strong institutional support and training rigour, the state has also seen stability and commitment in political and programmatic leadership. Stakeholders perceive that the ASHA have contributed to increased awareness and demand in the community for services related to immunization, Institutional delivery and family planning. 3500 additional ASHA have been recruited recently into the programme to increase coverage in tribal hamlets. A radio programme for ASHA has been launched recently and every ASHA has been given a radio. The state has recently selected one facilitator for every ten ASHA, perhaps the only state to have such a high ratio of facilitators for ASHA. Training for ASHA has been outsourced to a state level NGO. More than 80% of ASHAs have received training up to Module-5. All ASHAs have opened their bank account, and incentive payments for ASHAs are made in cheque, and e-transfer is happening wherever facilities are available. Processes for refilling the drug kit have been streamlined, with the kits now being filled monthly. 24,000 of the 26,000 VHSC have been created. Training of VHSC is being rolled out through MNGOs and FNGOs.

Other North East States (Arunachal Pradesh, Manipur, Meghalaya, Mizoram, Nagaland, Sikkim and Tripura):

In all the 7 States, ASHA programme is doing well. There is a full time 'Community Mobilization Facilitator' at State level.

- All the ASHAs have been trained up to Module 5 in Nagaland, Mizoram, Sikkim and Tripura, while more than 75% ASHAs have been trained in Assam and Manipur, and Module 5 training is in progress in state of Arunachal Pradesh and Meghalaya.

- State ASHA Resource Centre is established in the state of Meghalaya, Nagaland and Tripura, while rest of the state shave proposed in their PIP.
- ASHA Mentoring Group is functional in all the States
- Drug kit refilling is happening well in Sikkim and Tripura, moderate in Manipur and Mizoram, poor in Nagaland. There is no refilling of drug kits in Arunachal Pradesh and Meghalaya.
- Incentives payment for ASHAs are made through cash in all the 7 States
- Monthly meetings are operational in all states except in Arunachal Pradesh (where monthly meeting are held only in those PHC run by Karuna Trust)
- Weekly radio program for ASHA has been launched in Tripura and Manipur, and radio sets have been distributed to all the ASHAs
- Bicycles have been distributed to ASHAs in the four valley districts of Manipur.

Andhra Pradesh: The ASHA form a strong supportive mechanism for the health system. At the village level, ASHA perform a variety of functions including home visits to the newborn, tracking of pregnancies, and immunization. VHSC have been formed in all the Panchayats, but they meet once in three months. No training or orientation of VHSC has been conducted so far. At the PHC level, the Lady Health Visitor is designated the nodal officer for ASHA. Problems with payments to ASHA have been highlighted. After the initial training of ASHA no refresher trainings have been conducted. T There were initially differential sets of incentives for ASHS in tribal and non tribal areas. In Mandals where the programme of the Society for Eradication of Poverty exists, ASHA are paid, a fixed sum of Rs. 320 in addition to performance based incentives. he next set of challenges for the state are to address the issue of continued training for ASHA and the creation of support structures, and the strengthening of the VHSC.

Delhi: 3181 ASHAs have been selected as against a target of 5400 and VHSC has been formed in 182 urbanized villages. 19 days training completed (Module 4) and drug kits distributed. Support structure and monitoring system said to be in place. Delhi has developed a three tier mechanisms for ASHA- A flat payment, a second tier of ASHA incentives from the programme, and then incentive payments for national programmes.

Jammu and Kashmir: 9500 ASHA have been selected, of which 100% have received training on Module 1 and 94.73% (9000) ASHAs have received training up to Module 5 (23 days). Drug kits and regular schedule of monitoring meetings are in place. Payments are made by cheques. Support structures are weak. 6788 VHSC have been constituted

Kerala: Although originally intended to address communicable and non communicable diseases, and palliative care, in practice the ASHA programme appears to be RCH centric. The ASHA training takes place at the district level and this has led to a slow pace in the training, although the quality is better with little transmission loss. The ASHA programme is well supported by the various levels of the Panchayat system. The drug kits have been supplied but issues of inventory management and procurement have yet to be streamlined. There is no NGO involvement in the programme.

Maharashtra: The state of Maharashtra initiated the programme by selecting and training ASHA in the tribal districts as a first phase. , 9,434 ASHAs have been selected in tribal areas (99.80%) out of which 3,938 ASHAs have been trained in all modules including Module 5. In non-tribal areas 48,463

ASHAs have been selected (95.13%) all of whom have been trained in Module 1. 9,000 ASHAs have received drug kits. SHSRC, Pune functions as the ASHA Resource Centre (ARC) in the state. ASHA mentoring group have been established at state, district, and block levels. District community mobilizers are in place for monitoring and supporting the programme. Block facilitators have also been appointed. ICCHN, an NGO supporting the state government in implementation of ASHA programme has prepared a training module for block facilitators in local language. ICCHN, SATHI-Cehat along with other NGOs are involved in training of ASHAs in the five tribal districts in the state. Manuals have been specially developed for these low literate ASHAs.

Punjab: 92.84% ASHAs have been selected and training on module-1 (7 days) is completed, and training for Module 2, 3 and 4 is on going. There are reported delays in translation of modules. No state specificities have been introduced and no support structures of any sort are in place. Drug kits have been distributed to those ASHAs who received training of Module 1. 13199 VHSC have been formed.

Gujarat: 92.50% ASHA have been selected and 23 days training reached though only 11% have covered upto module 5. Modules are available in Gujarati. Participation in Mamta Taruni & Mamta Diwas is a special feature. 16,860 VHSC have been formed.

Karnataka: 27000 ASHA have been selected and a 30 days training schedule combining all modules has been followed. Drug kits have been distributed to 25400 ASHAs. State AMG has been formed but no support structures at district and block levels are in place. 23,026 VHSC have formed out of 27,683 expected.

Haryana: 12,706 ASHAs have been selected and training is ongoing. Upto module IV has been achieved. ASHA Diary is put in place. No drug kits have been distributed to ASHAs. No support structures or system of monitoring is there. VHSC have been formed in 6282 Village Panchayats.

West Bengal: The ASHA programme in the state was rolled out in phases, beginning with the poorest performing blocks. ASHA selection is complete in 235 of 341 blocks. The educational qualification for ASHA is pegged at Class X. ASHA training has been outsourced through CINI, who in turn works with the MNGOs and FNGOs in the state. The training is completely outside the system, although Medical officers could be called in as resource persons. ASHA are actively involved with the functioning of the health system. They attend the sub center on the immunization day, and the monthly meeting with ICDS. The state has not yet created support structures for ASHA, although a short term arrangement for support staff, in the form of two cadres of workers (one coordinator for 150-200 ASHA, and one co-facilitator for 25 ASHA), have been appointed for the training. Payments to ASHA are performance based, and amount to a fixed amount of Rs. 800 per month. This is currently made in cash at the block level monthly meeting. Drug kit supplies have been initiated. In West Bengal, the Gram Unnayan Samiti (GUS) which has been created at the level of the Gram Panchayat for oversight of health and education activities, and are expected to function as VHSC. In selected districts, the GUS have been trained and supported to perform functions of village planning and monitoring of health and nutrition interventions, but this has yet to be called up across all the districts.

Tamil Nadu: 2650 ASHAs have been selected through a list prepared by the Village Health Nurses (VHN). Training is expected to be initiated soon. The modules are being adapted per the state requirements. NGOs will work closely with the government in conducting the training. The state proposes to add 4200 ASHA in 42 blocks. VHSC have been formed in 12,618 Village Panchayat and 2540 Town Panchayats. Funds have been released to the VHSC.

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