सत्यमेव जयते

Ministry of Health & Family Welfare
Government of India

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

ANNUAL ASHA UPDATE

2020-21

Annual ASHA Update
2020-21

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1 Introduction

The ASHA programme, a key component of community processes has continuously evolved over the last decade and a half. Serving as a facilitator, mobilizer and provider of community level care, ASHA has emerged as the cornerstone of the National Health Mission. The country currently has 9.83 Lakh ASHAs in position against the target of 10.35 Lakh across 35 States and UTs (i.e., all except Goa and Chandigarh) making it the world's largest community volunteer programme. ASHAs have been 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. ASHAs are also critical component of the Community platforms like Village Health and Sanitation Committees (VHSNC), Mahila Arogya Samiti (MAS) and Community Based Planning and Monitoring under National Health Mission. ASHAs have been playing a key role in the country's response for prevention and management of the COVID-19. In addition to performing tasks related to COVID-19, ASHAs also continued to support community members for accessing essential health services.

The programme has evolved in many significant ways since its launch in 2005, responding to local context and national priorities. Mechanisms built for regular modular training, on the job mentoring, creation of strong support structures and performance linked monetary and non-monetary incentives have contributed to the strengthening and sustainability of the programme.

With the launch of Ayushman Bharat Programme, ASHA in rural and urban areas is now an integral part of the functional team at the Ayushman Bharat - Health and Wellness Centre (AB-HWC) while retaining her social activist role. The role of ASHAs has been expanded to provide Oral care, Eye care, Emergency care, ENT care, MNS care, elderly, and palliative care at the community level. She is being strengthened to play an active role in health communication and home and community-based interventions to support the delivery of comprehensive primary health care, by appropriate training and performance linked incentives. In an interaction, ASHAs of Nayagarh district in Odisha said "We feel proud that the expansion of the package of services at the level of the AB-HWC is being done. It helps us render care for all members of the family. It will enhance our credibility. With incentive for newer packages, our income per household visit too shall increase. Of course, the competition to get selected as ASHA in the village will also get tougher".

This issue of annual ASHA update is first, since the COVID-19 pandemic and is twenty first in the series of the update. This issue of ASHA update covers status on the ASHA program, ASHA's role in prevention and control of COVID-19 pandemic, programme update on community-based institutions, best practices under community processes, and key highlights of the annual community processes state nodal officer workshop. One annual issue is being released covering the financial year April 2020 to March 2021.

ASHA's role in maternal, newborn and child health has been well documented in number of publications. More than 15 years of the programme have brought innovations that have been scaled up country wide and encompasses selection, training, payment and to the use of technology as a job aid/training aid.

Section on ASHA programme update (Chapter 2) provides an overview of trends in the ASHA program since 2010. Number of ASHAs in position have increased gradually from 6.9 L in 2010 to 9.8 L in 2020. The coverage currently in rural areas is about one ASHA per 979 population, but with

wide variations between and within states. This section also provides comprehensive overview of the training status for ASHAs across different states. Modular training of ASHAs have progressed to 96% in Round 1, 92% in Round 2, 89% in Round 3, and 83% in Round 4, in rural areas. Similarly, NCD & HBYC training completion for rural ASHAs, remained at 55% and 60% respectively. The progress of the training of ASHAs nation-wide is slow in comparison with the last update. Majority of states have involved ASHAs in COVID-19 related activities and training activities during the period. The section also provides an overview of the ASHA certification program in 24 states/UTs. Nation-wide, 36,544 ASHAs have been certified and accredited in these States/UTs.

Section 3 on ASHA's role in prevention and management of COVID-19 response, outlines the role played by ASHAs in containment of the pandemic at the grass root level. Best practices of the various States/UTs in community mobilization, support extended for both essential and non-essential services, highlight the varied and dynamic role played by ASHAs in the field. Overview of state-wise training of ASHAs in wave 1 and wave 2 of the pandemic has been provided.

Section 4 draws the current scenario of status of constitution and training of community platforms (VHSNC and MAS). Across India, approximately 5.5 Lakh VHSNCs have been constituted and 57% of them have been trained on the VHSNC guidelines as per the handbook. Similarly, 80,238 MAS have been constituted in the urban slum areas and 89% of them have been trained on MAS guidelines as per the handbook.

In Section 5, we present three best practices that highlight state led innovations in community processes. Digital Community Engagement Platforms for Improving Family Planning, Maternal Child Health and Nutrition outcomes by the state of Chhattisgarh, Strengthening Cluster Meeting as capacity building platform for ASHAs by the state of Uttar Pradesh and an Innovation Fostering Health service delivery and strengthening ASHA monitoring system by Madhya Pradesh have been highlighted.

In Section 6, we report key highlights of the annual workshop for state nodal officers for Community Processes (CP), held online on 4th, 6th, and 9th November 2020. The workshop focused on identifying trends in the CP programme and planning for collective action for advancing comprehensive primary Health care services across the country. Eventually, Section 7 talks about the ASHA incentives under various programs of NHM.

Moving forward, one of the key aspects of the update is to periodically report on progress related to selection, training, status of support structures and status of community platforms. As the role of ASHAs has expanded with the roll-out of Ayushman Bharat, in the next update we intend to capture the progress of training of ASHAs in the expanded package of services. Additionally, functioning of the community platforms is being prioritized for enhanced ownership on Ayushman Bharat – Health and Wellness Centres (AB-HWC) and assured support to people on sociocultural and environmental determinants of health. Au revoir..till we meet again in the next annual issue.

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2 ASHA Programme Update

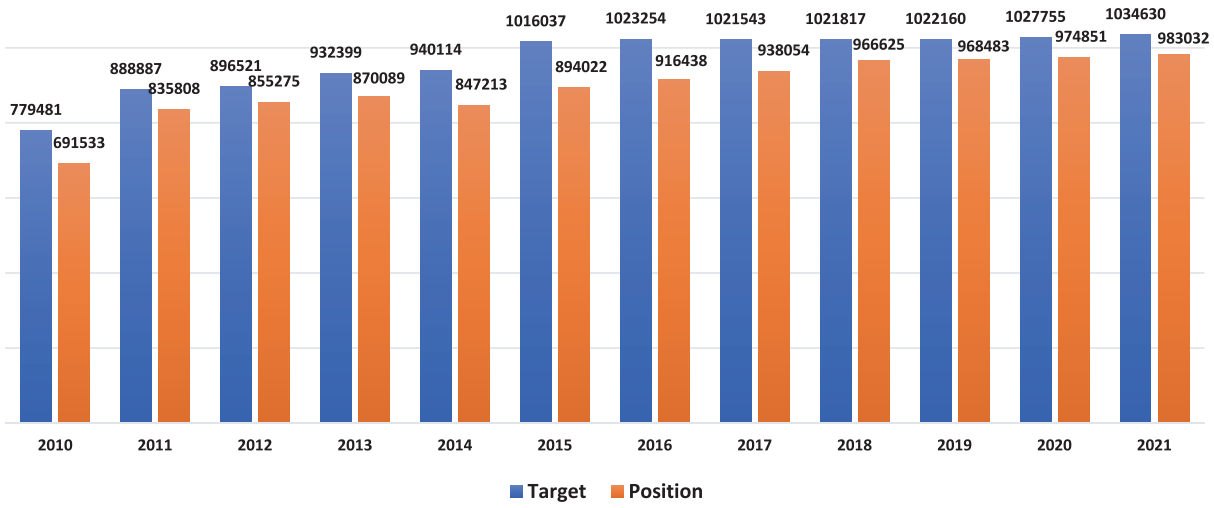
NATIONAL OVERVIEW

This section provides information on three major areas related to the ASHA programme across the country, namely the number of ASHAs in position against the targets, the status of training (in Modules 6 and 7, NCD and HBYC) and the status of support structures. The primary source of this information is state/UT reports related to the ASHA and Community Processes Programmes as of 31st March 2021

The ASHA program continues to be the centre piece of the community processes covering all States/UTs (except Goa and Chandigarh) in both urban and rural populations. Ever since the very first ASHA update in October 2009 to the present date, there has been a steady progress in terms of ASHA selection, training, and service delivery across most of the states/UT. Presently a total of 9,83,032 ASHAs are in position in the country, against the target of 10,34,630 (95% in position) under the National Health Mission (NRHM and NUHM) following the norms of one ASHA for every 1000 population in rural areas and one ASHA covering 2500 population in urban areas. From the first update of 2010 to this update for FY 2020-21, spanning eleven years, the total ASHA target has increased by approx. 33% (from 7,79,481 to 10,34,630) and in position ASHAs by 42% (6,91,533 to 9,83,032).

The graph below illustrates the overall increase in the number of ASHAs over a decade. (Figure-1). The increase in target is also on account of the rollout of the ASHA program in urban areas under NUHM in the year 2013.

FIGURE 1- THE TREND IN ASHA PROGRAM FROM YEAR 2010 TO 2020 (TARGET & IN POSITION)



SELECTION STATUS OF ASHAs AGAINST THE TARGET

STATUS OF ASHA SELECTION IN RURAL AREAS

Currently, the total number of ASHAs working under NRHM is around 9,14,101, against the target of 9,56,672 ASHAs. This reflects nearly 96% completion of the selection process across all states/UTs. Except for Bihar, Rajasthan, Kerala, Telangana, West Bengal, DD&DNH, and Lakshadweep, all other states/UTs have around 95% or more ASHAs in place against the set targets of ASHA selection.

- High focus states- Jharkhand has selected 100% ASHAs while Uttarakhand and Odisha have 98% and 99% ASHAs in place, respectively. The rest of the states in the group (Chhattisgarh, Madhya Pradesh, Uttar Pradesh), Bihar and Rajasthan have around 95% ASHAs in position against the targets.
- North-Eastern states, except Nagaland (96%) and Tripura (99%), all other states have selected 100% ASHAs against the target.
- Non-high focus states, except Kerala, Telangana, and West Bengal, the rest of the states have reported selection of above 90% ASHAs against the target. Kerala has achieved only 78% ASHA selection while West Bengal and Telangana have completed 89% and 90% selection respectively.
- Union Territories, except the UTs of Daman, Diu & Dadar Nagar-Haveli and Lakshadweep where 92% ASHAs are in position against their respective targets, the rest of the UTs reported more than 96% ASHAs in position.

POPULATION DENSITY PER ASHA

In terms of population for the selection of ASHAs, majority of the states have one ASHA for 1,000 population or less. The National average for population per ASHA under the NRHM currently is 979 based on the National Commission on Population projection for 2020-21. The population per ASHA ranges from 153 in the UT of Lakshadweep to 1,241 per ASHA in Bihar.

Presently there are only six states- Bihar, Rajasthan and Uttar Pradesh (among high focus states) and Maharashtra, Punjab and West Bengal (among the non-high focus states) that have an average population of more than 1,000 being covered by each ASHA- Average population covered by an ASHA remains highest in Bihar at 1,241, while Rajasthan, West Bengal, Uttar Pradesh, Maharashtra and Punjab states come 2nd, 3rd, 4th, 5th and 6th with an average population per ASHA of 1218, 1164, 1141, 1070 and 1041 respectively.

Since Chhattisgarh has selected ASHAs per habitation, among high focus states, Chhattisgarh has the lowest population per ASHA at 319. The states of Uttarakhand, Jharkhand, Odisha, and Madhya Pradesh, have an average of 679, 718, 779 and 945 population, respectively.

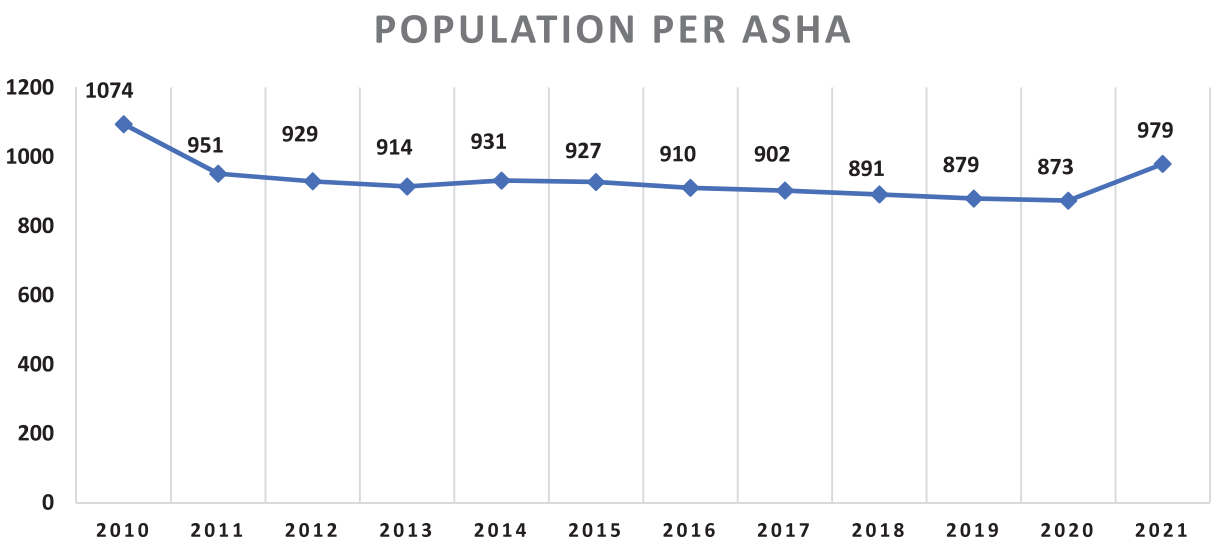
Among the non-high focus states, the lowest average population per ASHA remains at 429 in the state of Kerala, while Himachal Pradesh, Telangana, Andhra Pradesh, Gujarat, and Haryana states, have an average of 843, 864, 896, 946 and 999 population per ASHA, respectively.

In north- east states, Arunachal Pradesh has the lowest average population per ASHA at 285 and the population to high as 951 per ASHA in Assam. While the other five states in the northeast are below 600 average population (Tripura- 360, Meghalaya – 397, Mizoram-549, Manipur –551 and Sikkim-583). Nagaland has an average of 656 population per ASHA.

Among the Union Territories, except the Lakshadweep where an ASHA covers an average of 153 population, the rest of the UTs, have an average population coverage between 343 to 762 population.

While the population density for the year 2010- 2020 is based on Census 2011 population, that for the FY 2020-21 is based on the projected population of FY 2020-21. Despite the change in source, the population density over the last decade has gradually improved in states/UTs, except in a few states like Bihar, Uttar Pradesh, West Bengal, Punjab and Maharashtra.

FIGURE 2- POPULATION PER ASHA IN RURAL AREAS – THE TREND



STATUS OF ASHA SELECTION IN URBAN AREAS

Under National Urban Health Mission (NUHM), a total of 68,931 ASHAs (88%) have been selected against the target of 77,958 across the country. With the overall completion of selection currently at 88% under NUHM, states like Bihar, MP, UP, Arunachal Pradesh, Manipur, Maharashtra, and Telangana have achieved less than the national average and these states need to expedite the selection process.

In High Focus states, the total number of ASHAs in position is 87% as compared to the target. All the states except Bihar (60%), Uttar Pradesh (81%), Madhya Pradesh (85%) and Jharkhand (88%) have above 90% ASHAs in position against their respective targets.

In North-East states, 93% of ASHAs are in position against the target. All states except Arunachal Pradesh (56%) and Manipur (65%) have over 90% ASHAs in position. Assam, Mizoram, and Nagaland have achieved 100% selection of ASHAs against the target.

In the Non-High Focus states, except Telangana (72%), Maharashtra (76%), Karnataka and West Bengal (94%), all states have close to or above over 95% ASHAs in position against the target.

Amongst the Union Territories, the overall in-position ASHAs is reported to be 96% against the target. Except for DD&DNH (92%), the rest of all UTs have reported more than 95% ASHA selection against the target. The table-1 below shows the overall status of ASHA selection against the target till 31st March 2021.

TABLE-1 STATUS OF ASHAs IN POSITION AGAINST THE TARGET (RURAL AND URBAN ASHAs)

NAME OF STATES/ UTs	ASHA UNDER NRHM			National Commission on Population Projected March-21	DENSITY – PER ASHA	ASHA UNDER NUHM		
	Target	Selection	Selection %			Target	Selection	Selection %
High Focus States								
Bihar	93687	87655	94	10,87,78,000	1241	977	582	60
Chhattisgarh*	70000	68277	98	2,17,97,000	319	3883	3771	97
Jharkhand	39964	39964	100	2,86,99,000	718	1677	1475	88
Madhya Pradesh	65670	64094	98	6,05,42,000	945	5335	4525	85
Odisha	46652	46134	99	3,59,28,000	779	1803	1700	94
Rajasthan	51152	48207	94	5,86,98,000	1218	4664	4269	92
Uttar Pradesh	162885	155070	95	17,68,89,000	1141	8603	6968	81
Uttarakhand	10813	10700	99	74,54,000	697	1205	1205	100
Sub-Total	**540823**	**520101**	**96**	**49,87,85,000**	**959**	**28147**	**24495**	**87**
North-Eastern States								
Assam	31334	31334	100	2,97,87,000	951	1212	1212	100
Arunachal Pradesh	4040	4040	100	11,51,000	285	75	42	56
Manipur	3928	3928	100	21,63,000	551	186	120	65
Meghalaya	6589	6589	100	26,19,000	397	215	195	91
Mizoram	1012	1012	100	5,56,000	549	79	79	100
Nagaland	2000	1917	96	12,57,000	656	90	90	100
Sikkim	641	641	100	3,74,000	583	35	32	91
Tripura	7226	7147	99	25,76,000	360	541	504	93
Sub-Total	**56770**	**56608**	**100**	**4,04,83,000**	**715**	**2433**	**2274**	**93**
Non-High Focus States								
Andhra Pradesh	39552	38216	97	3,42,31,000	896	3200	3200	100
Delhi	NA	NA	NA	NA	NA	6345	6036	95
Gujarat	40293	38853	96	3,67,60,000	946	4711	4478	95
Haryana	18000	17557	98	1,75,40,000	999	2676	2571	96
Himachal Pradesh	7964	7881	99	66,47,000	843	34	33	97
Karnataka	39195	38674	99	3,79,42,000	981	3329	3125	94
Kerala	30927	24079	78	1,03,37,000	429	2396	2396	100
Maharashtra	61215	60816	99	6,50,52,000	1070	9922	7522	76
Punjab	17720	17223	97	1,79,35,000	1041	2700	2569	95
Tamil Nadu**	2650	2555	96	NA	NA	NA	NA	NA
Telangana	26028	23443	90	2,02,57,000	864	5000	3597	72
West Bengal	61008	54109	89	6,30,05,000	1164	6097	5701	94
Sub-Total	**344552**	**323406**	**94**	**34,58,51,000**	**1069**	**46410**	**41228**	**89**
Union Territories								
A&NI	412	394	96	2,29,000	581	10	10	100
DD&DNH	370	340	92	2,59,000	762	108	98	91
J&K	13010	12539	96	94,14,000	751	138	136	99
Lakshadweep	110	101	92	15,436	153	NA	NA	NA
Ladakh	625	612	98	2,10,000	343	371	364	98
Puducherry	NA	NA	NA	NA	NA	341	326	96
Sub-Total	**14527**	**13986**	**96**	**98,98,436**	**708**	**968**	**934**	**96**
Total All India	**956672**	**914101**	**96**	**89,50,17,436**	**979**	**77958**	**68931**	**88**

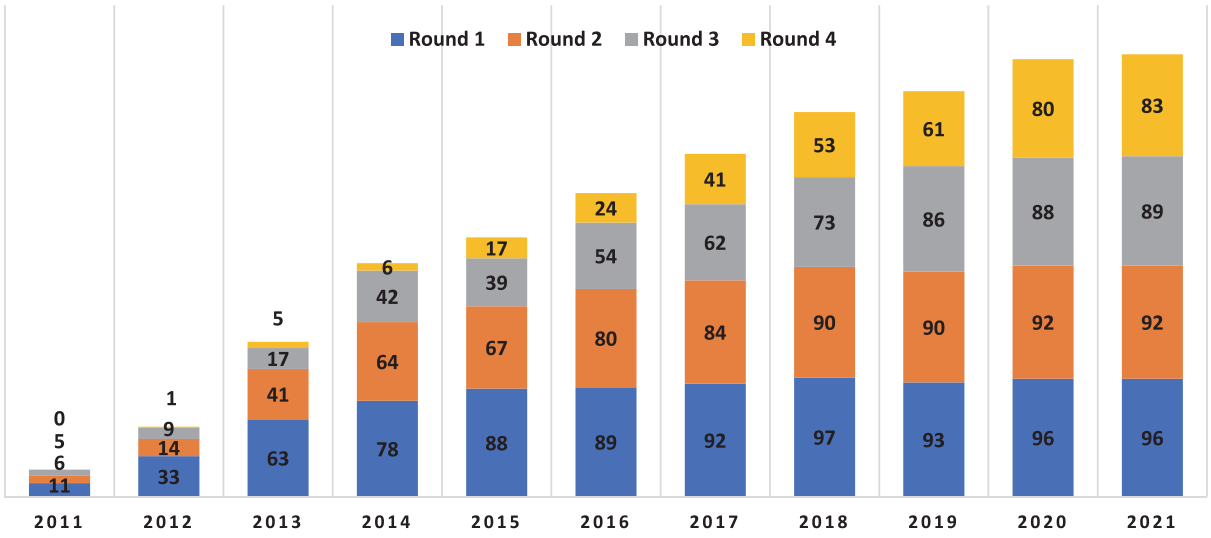
*Chhattisgarh has selected ASHAs at the habitation level.

** Tamil Nadu-ASHAs have been selected only in tribal areas

TRAINING OF ASHAs

This section provides the status of training for ASHAs on Modules 6 and 7, NCDs and HBYC in both rural and urban areas. Figure-3 presents cumulative training achievement of States and Union Territories on ASHA Module 6 & 7 up to 31st March 2021.

FIGURE-3 TRAINING OF ASHAs



TRAINING OF RURAL ASHAs IN MODULE 6 & 7

There has been progress in the training of ASHAs in all four rounds of Module 6 and 7 with an achievement of 96%, 92%, 89% and 83% in the four rounds respectively under NRHM in the country. In round 4 training, a significant increase has been reported from 80% in 2020 to 83% till March 2021.

In the High Focus states group Chhattisgarh, Jharkhand, Odisha, and Uttarakhand reported 97% or more progress in all four rounds of training. While Madhya Pradesh and Rajasthan have achieved 85%, Uttar Pradesh 84% and Bihar has achieved 47%. There remains a huge backlog for completion of round 4 training in Bihar where only 47% ASHAs have been trained.

Most of the North-Eastern states reported over 95% in all the four rounds of the ASHA training in modules 6&7. Owing to a small number in comparison to other states, these states have shown good training achievements where most of them have completed training for more than 90-100% ASHAs in all four rounds of Module 6 and 7. Amongst these states, Arunachal Pradesh has reported the lowest training achievement (75%) in round 4, followed by Nagaland (83%) and Manipur (85%) respectively.

In the Non-High Focus states, variable progress is observed in respective rounds of Module 6 and 7 training. States of Telangana (48%), Andhra Pradesh (81%), Karnataka (85%) and West Bengal (89%) have reported below 90% Round 4 training completion status as compared to the other states. There persists a huge backlog for completion of round 4 training in Telangana where only 48% ASHAs have been reportedly trained.

Progress has been noted in the training in Union Territories in Module 6&7 in Round 1,2 & 3. Andaman & Nicobar Islands and Lakshadweep have completed 100% training in all four rounds while Ladakh and Jammu & Kashmir have reported 83% and 87% training completion respectively. The UT of DD&DNH is yet to start Round 2,3 and 4 trainings.

TRAINING OF RURAL ASHAs IN UNIVERSAL SCREENING, PREVENTION AND MANAGEMENT OF NON-COMMUNICABLE DISEASES (NCDs)

With the continued and increased focus on Comprehensive Primary Health Care, states/UTs have initiated multiskilling of ASHAs in Universal Screening, Prevention and Management of Non-Communicable Diseases. The scale and quality of population-based screening (PBS) are determined by the timely training of ASHAs, however, there is tardy progress seen in the training of ASHA. Around 55% (5,02,817) ASHAs have been trained in NCDs in the country against the target of 9,14,068 in rural areas.

In the High Focus states group, 82% (4,28,258) ASHAs have been trained in PBS of NCD training against the target of 5,20,068 ASHAs. With almost 95% of the ASHAs trained, Chhattisgarh and Odisha have reported the highest percentage of ASHAs trained in the group while Jharkhand reported the second-highest 82% (32,821) number of ASHAs trained in NCDs. The states of Uttar Pradesh, Rajasthan, and Uttarakhand have reported much slower progress of NCD training with just 30% (45,797), 34% (16,590) and 53% (5,703) progress respectively. There remains a huge backlog for completion of training in Bihar and MP where only 8% (6,589) ASHAs have been trained in Bihar and 11% (6,793) in Madhya Pradesh.

In North-Eastern states, only 39% (22,337) ASHAs have been trained against the target of 56,608 ASHAs. Except for Mizoram and Sikkim, the slow pace of NCD training was reported from practically all the states. Meghalaya, Assam, Tripura, and Manipur have reported 32% (2,088), 38% (11,946), 41% (2,960) and 43% (1,700) of ASHAs trained in NCDs respectively. The state of Arunachal Pradesh has been able to train only 11% (457) ASHAs against the target till March 2021.

Among the Non-High Focus states, 77% (2,48,187) ASHAs have been trained in NCD against the target of 3,23,406. NCD training has progressed well in all non-high focus states except Gujarat and West Bengal which have reported only 23% and 61% ASHA training against the target, while Andhra Pradesh and Himachal Pradesh have both reported 76% completion. The three states of Kerala, Tamil Nadu and Telangana have reported 100% training of ASHA in NCD.

In Union Territories, the progress of NCD training of ASHAs has been trivial where only 68% (9,451) training have been completed against the target of 13986 ASHAs. UTs that have majorly contributed to training progress are Andaman & Nicobar Islands and Lakshadweep with 100% training reported. Training in other UTs is reported to be slow-paced with Jammu & Kashmir reporting only 65% training while the UTs of Ladakh and DD&DNH have reported 87% and 92% training against the target.

TRAINING OF RURAL ASHAs IN HOME BASED CARE FOR YOUNG CHILD

Despite the outbreak of COVID-19, many states progressed well in HBYC training with an overall 50% (3,29,249) ASHAs having been trained against the target of 6,60,420 ASHA till 31st March 2021. In High Focus states, against the target of 3,69,332 ASHAs, 1,53,911 (42%) have been trained in HBYC. Chhattisgarh and Odisha reported the highest progress with 94% and 99% ASHAs trained against the targets respectively. These states were followed by Uttarakhand (78%), Madhya Pradesh (61%) and Jharkhand (58%). The pace of HBYC training is reported to be slow from Rajasthan and Bihar, which reported only 11% and 20% ASHAs trained against the targets. Uttar Pradesh is the only state that has trained only 2% (2645) ASHAs against the target of 1,55,070 in HBYC.

In North-Eastern states, around 58% ASHAs have been trained on HBYC against the group target. Almost all states have completed over 85% of training targets except for Nagaland (18%), Mizoram (53%) and Assam (54%).

In Non-High Focus states, the progress has been sub-optimal. Out of the target of 2,56,010 ASHAs to be trained in HBYC, 59% (73,033) ASHAs have been trained. Tamil Nadu and Kerala have reported 100% training against the target. This is followed by the state of Karnataka (85%), Andhra Pradesh (76%), Maharashtra (75%) and Haryana (65%). The progress of training was reported to be slow in other states with West Bengal training only 45%, Gujarat 32%, Punjab 31%, Telangana 30% ASHAs. Himachal Pradesh has reported only 21% HBYC training against the target number of ASHAs.

In Union Territories, overall, 79% ASHAs have been trained against the target, out of which DD&DNH has reported 98% training of ASHAs; Jammu & Kashmir reported 80% and Ladakh reported 69% training of ASHAs in HBYC. Andaman & Nicobar Islands and Lakshadweep are yet to plan ASHAs training in HBYC. The status of training in all rounds of ASHA modules 6&7 till March 2021 can be understood from the table-2 below.

TABLE 2- STATUS OF ASHA TRAINING AGAINST THE TARGET

Name of States/ UTs	ASHA Training in Modules 6&7									PBS Training		HBYC Training		
	In Position	R-1	%	R-2	%	R-3	%	R-4	%	Training	%	Target	Training	%
High Focus States														
Bihar	87655	80531	92	75769	86	66532	76	41272	47	6589	8	25079	4926	20
Chhattisgarh	68277	66169	97	66169	97	66169	97	66169	97	64865	95	66220	62561	94
Jharkhand	39931	39931	100	39905	100	39893	100	39864	100	32821	82	39931	23320	58
MP	64094	63025	98	62479	97	55070	86	54336	85	6793	11	12466	7606	61
Odisha	46134	45377	98	45167	98	45097	98	44804	97	43684	95	46134	45607	99
Rajasthan	48207	46796	97	45650	95	44051	91	40767	85	16590	34	17758	2009	11
Uttar Pradesh	155070	144090	93	140611	91	134374	87	130410	84	45797	30	155070	2645	2
Uttarakhand	10700	10700	100	10700	100	10636	99	10636	99	5703	53	6674	5237	78
Sub-Total	**520068**	**496619**	**95**	**486450**	**94**	**461822**	**89**	**428258**	**82**	**222842**	**43**	**369332**	**153911**	**42**
North-Eastern States														
Assam	31334	31334	100	31334	100	31334	100	31334	100	11946	38	18044	9700	54
Arunachal Pradesh	4040	3669	91	3472	86	3472	86	3032	75	457	11	429	392	91
Manipur	3928	3324	85	3326	85	3320	85	3357	85	1700	43	354	332	94
Meghalaya	6589	6151	93	6181	94	5929	90	5929	90	2088	32	1153	1097	95
Mizoram	1012	1012	100	1012	100	1012	100	1012	100	1012	100	1012	532	53
Nagaland	1917	1576	82	1570	82	1624	85	1593	83	1533	80	545	100	18
Sikkim	641	630	98	630	98	630	98	629	98	641	100	205	176	86
Tripura	7147	6800	95	6611	93	6852	96	6816	95	2960	41	678	678	100
Sub-Total	**56608**	**54496**	**96**	**54136**	**96**	**54173**	**96**	**53702**	**95**	**22337**	**39**	**22420**	**13007**	**58**
Non-High Focus States														
Andhra Pradesh	38216	31555	83	31263	82	30870	81	30870	81	28912	76	38216	29060	76
Gujarat	38853	37101	95	36817	95	36071	93	35543	91	8840	23	33512	10680	32
Haryana	17557	17557	100	17557	100	17557	100	17544	100	17438	99	17557	11370	65
HP	7881	7534	96	7494	95	7387	94	7370	94	6015	76	7837	1615	21
Karnataka	38674	37045	96	35402	92	34133	88	32981	85	29589	77	1984	1684	85
Kerala	24079	23950	99							24079	100	24079	24079	100
Maharashtra	60816	60251	99	59986	99	59664	98	59469	98	56954	94	60816	45834	75
Punjab	17223	17095	99	17095	99	17095	99	17095	99	17096	99	17223	5393	31
Tamil Nadu	2555	2555	100	2555	100	2555	100	2555	100	2555	100	2555	2555	100

Telangana	23443	23443	100	23443	100	23443	100	11244	48	23443	100	23443	7119	30
West Bengal	54109	54109	100	54109	100	53309	99	48357	89	33266	61	28788	12902	45
Sub-Total	**323406**	**312195**	**97**	**285721**	**88**	**282084**	**87**	**263028**	**81**	**248187**	**77**	**256010**	**152291**	**59**
Union Territories														
A&NI	394	394	100	394	100	394	100	394	100	394	100	0	0	0
DD&DNH	340	255	75	0	0	0	0	0	0	313	92	282	277	98
J&K	12539	10987	88	10529	84	10890	87	10890	87	8109	65	11676	9354	80
Lakshadweep	101	101	100	101	100	101	100	101	100	101	100	110	0	0
Ladakh	612	506	83	506	83	506	83	506	83	534	87	590	409	69
Sub-Total	**13986**	**12243**	**88**	**11530**	**82**	**11891**	**85**	**11891**	**85**	**9451**	**68**	**12658**	**10040**	**79**
Total	**914068**	**875553**	**96**	**837837**	**92**	**809970**	**89**	**756879**	**83**	**502817**	**55**	**660420**	**329249**	**50**

TRAINING OF URBAN ASHAs UNDER NATIONAL URBAN HEALTH MISSION

TRAINING OF URBAN ASHAs IN MODULES 6 & 7

The rollout of training of ASHA in all four rounds of Module 6 & 7 needs to be expedited in urban areas. A total of 84% ASHAs have been trained in Round 1, 69% in Round 2, 64% in Round 3 and 50% in Round 4 in ASHA modules 6&7 respectively.

In High Focus states, there has been slow progress in the training of ASHAs in all four rounds of Module 6 and 7 with an achievement of 82%, 64%, 57% and 54% respectively. All states except Bihar, Jharkhand and Uttar Pradesh have close to or above 88% ASHAs being trained in Round 1 and Round 2 of Module 6 and 7. Odisha and Uttarakhand reported 100% ASHAs trained in all four modules. The state of Jharkhand and Uttar Pradesh are yet to start Round-3 and 4 training of ASHAs in modules 6&7. Bihar has not initiated the training in any of the rounds in modules 6&7 for ASHA yet.

In North-Eastern states, the achievement for Module 6 and 7 training is 97%, 96%, 96%, and 89 % respectively for Rounds 1 to 4. Against the target, Arunachal Pradesh, Manipur, Mizoram, and Nagaland have completed 100% ASHAs training in all four rounds of modules 6&7. Slow pace of ASHAs training has been reported from in Sikkim, where only 53% ASHAs have been trained in round 4 of module 6&7, while the state of Tripura, Assam and Meghalaya have shown fair progress in all four rounds of module 6&7 training.

Amongst the Non-High Focus states, training of ASHAs in modules 6&7 have been progressing with an achievement of 85%, 72%, 68% and 46% in all four rounds respectively. Against the target, five states, Delhi, Haryana, Himachal Pradesh, Kerala, and Telangana have trained 100% ASHAs in rounds 1 to 3 in modules 6&7 and the progress in Round 4 varies from 0 to 93%. Maharashtra, Karnataka, and Andhra Pradesh have reported slow progress in rounds 1 to 3, where only 42%, 56% and 69% ASHAs have been trained. West Bengal has reported decent progress in Round 1 (78%) training, but it needs to immediately scale up training from Round 2 onwards. Only Kerala has reported 100% training of ASHA in round 4. There are only two states Delhi and West Bengal where round 4 training is yet to begin.

In Union Territories, the training of ASHAs in modules 6 & 7 in Round 1 and 2 is 44% and 35% respectively. Only DD&DNH and Puducherry have initiated Round 1.

TRAINING OF URBAN ASHA IN UNIVERSAL SCREENING, PREVENTION AND MANAGEMENT OF NON-COMMUNICABLE DISEASES (NCDs)

About 54% (37082) ASHAs have been trained against the target of 68,931 ASHA in NCD training to rollout population-based screening of NCDs and their subsequent community follow-up.

In High Focus states, out of 24,495 in position ASHAs, overall, 45% (11,118) ASHAs have been trained in high focus states. Odisha has reported 100% ASHAs trained, followed by Chhattisgarh, Uttarakhand and Jharkhand, reported training of 94%, 76% and 66% ASHAs respectively. The pace of NCD training in the states of Madhya Pradesh and Uttar Pradesh is slow with only 14% and 48% ASHAs trained against the target. Bihar and Rajasthan are yet to initiate the NCD training or urban ASHAs.

In the North-Eastern States, 89% (2027) ASHAs have been trained against the target. The four states of Manipur, Mizoram, Nagaland, and Sikkim have already achieved 100% of their training target while Assam, Tripura and Meghalaya progressed well and reported 86%, 93% and 95% training of ASHAs in NCDs. The NCD training of ASHA has been inadequate in Arunachal Pradesh, where only 12% ASHAs have been trained.

Among Non-High focus states, 57% (23,572) training achievement is noted against the target of 41,228. Among all of them, four states of Haryana, Himachal Pradesh, Kerala and Telangana reported 100% of ASHAs trained against the target while Andhra Pradesh, Maharashtra, Delhi, Punjab and Karnataka have been processing in NCD training and reported 46%54%, 64%, 94% and 97% achievement against the target. Meanwhile, West Bengal reported minuscule (~1%) training of ASHAs on NCDs reported in and Gujarat yet initiate the training of urban ASHAs in NCD.

In Union Territories, Andaman & Nicobar Islands and Puducherry have achieved 100% of their training against the target, while DD&DNH has reported only 30% achievement. Rest all UTs have to initiate NCD training of Urban ASHAs.

TRAINING OF URBAN ASHA IN HOME BASED CARE FOR YOUNG CHILD

Across the country, 49% (22,991) urban ASHAs have been trained in Home Based Care for Young Child (HBYC) against the target of 46,764 ASHAs.

In High Focus states, a total of 69% 11,518 (69%) ASHAs have been trained on HBYC against the target of 16,574. Progress in the HBYC training is reported from Uttarakhand (100%), Chhattisgarh (98%), and Odisha (91%), while Madhya Pradesh has trained 64% (5,651) ASHAs against the target of 8,805. The remaining states of Bihar, Jharkhand, Rajasthan, and Uttar Pradesh initiate HBYC training.

In North-Eastern states, as of now only 187 (22%) ASHAs have been trained against the target of 854 ASHAs in HBYC. Three states of Manipur, Meghalaya and Sikkim have reported 100% training of ASHAs against the target, while Mizoram has achieved 19% against the set target. Assam, Arunachal Pradesh, Nagaland, and Tripura have to initiate HBYC training.

Slow progress was also reported in non-high focus states where overall 11,152 (39%) of ASHAs were trained in HBYC against the target of 28,774. Among all the states, Andhra Pradesh, Himachal Pradesh, Karnataka, and Kerala have achieved 100% ASHAs trained in HBYC. Other states of Gujarat, Delhi, Punjab, Haryana, and Telangana reported inadequate progress in HBYC training these states. Maharashtra is the only state to which has not initiated the training of ASHAs yet.

In UTs, a total of 134 ASHAs have been trained on HBYC against the target of 562. Only, DD&DNH has made decent progress in training with around where 98% ASHAs have been trained against

the target. Jammu and Kashmir have shown slow progress with only 29% of ASHAs trained against the target. The rest of the UTs have not yet rolled out HBYC training. The status of training of Urban ASHAs has been shown in the table below-

TABLE 3: STATUS OF URBAN ASHA TRAINING AGAINST TARGET

Name of States/ UTs	ASHA Training in Modules 6&7									PBS Training		HBYC Training		
	In Position	R-1	%	R-2	%	R-3	%	R-4	%	Training	%	Target	Training	%
High Focus States														
Bihar	582	0	0	0	0	0	0	0	0	0	0	0	0	0
Chhattisgarh	3771	3682	98	3682	98	3682	98	3682	98	3530	94	3771	3694	98
Jharkhand	1475	1475	100	343	23	0	0	0	0	975	66	1677	0	0
MP	4525	4430	98	4125	91	3860	85	3600	80	650	14	8805	5651	64
Odisha	1700	1700	100	1700	100	1700	100	1700	100	1700	100	1614	1466	91
Rajasthan	4269	4076	95	3744	88	3558	83	3107	73	0	0	0	0	0
Uttar Pradesh	6968	3492	50	771	11	0	0	0	0	3342	48	0	0	0
Uttarakhand	1205	1205	100	1205	100	1205	100	1205	100	921	76	707	707	100
Sub-Total	**24495**	**20060**	**82**	**15570**	**64**	**14005**	**57**	**13294**	**54**	**11118**	**45**	**16574**	**11518**	**69**
North-East States														
Assam	1212	1212	100	1212	100	1212	100	1062	88	1045	86	0	0	0
Arunachal Pradesh	42	42	100	42	100	42	100	42	100	5	12	42	0	0
Manipur	120	120	100	120	100	120	100	120	100	120	100	120	120	100
Meghalaya	195	189	97	189	97	189	97	189	97	185	95	20	20	100
Mizoram	79	79	100	79	100	79	100	79	100	79	100	79	15	19
Nagaland	90	90	100	90	100	90	100	90	100	90	100	57	0	0
Sikkim	32	17	53	17	53	17	53	17	53	32	100	32	32	100
Tripura	504	466	92	436	87	436	87	436	87	471	93	504	0	0
Sub-Total	**2274**	**2215**	**97**	**2185**	**96**	**2185**	**96**	**2035**	**89**	**2027**	**89**	**854**	**187**	**22**
Non-High Focus States														
Andhra Pradesh	3200	2210	69	2210	69	2210	69	2210	69	1457	46	3200	3200	100
Delhi	6036	6036	100	6036	100	6036	100			3890	64	2508	867	35
Gujarat	4478	4050	90	4050	90	4050	90	4050	90	0	0	4281	450	11
Haryana	2571	2571	100	2571	100	2571	100	2393	93	2571	100	2571	1129	44
HP	33	33	100	33	100	33	100	24	73	33	100	33	33	100
Maharashtra	7522	5397	72	4092	54	3144	42	2490	33	4091	54	7522	0	0
Karnataka	3125	2052	66	1927	62	1762	56	1638	52	3028	97	97	97	100
Kerala	2396	2396	100	2396	100	2396	100	2396	100	2396	100	2396	2396	100
Telangana	3597	3597	100	3597	100	3597	100	1697	47	3597	100	3597	2080	58
Punjab	2569	2248	88	2248	88	2248	88	2248	88	2414	94	2569	900	35
West Bengal	5701	4431	78	600	11	107	2	0	0	38	1	0	0	0
Sub-Total	**41228**	**35021**	**85**	**29760**	**72**	**28154**	**68**	**19146**	**46**	**23515**	**57**	**28774**	**11152**	**39**
Union Territories														
A&NI	10	0	0	0	0	0	0	0	0	10	100	0	0	0
DD&DNH	98	88	90	0	0	0	0	0	0	29	30	98	94	96
J&K	136	0	0	0	0	0	0	0	0	0	0	138	40	29
Ladakh	364	0	0	0	0	0	0	0	0	0	0	0	0	0
Puducherry	326	326	100	326	100		0		0	326	100	326	0	0
Sub-Total	**934**	**414**	**44**	**326**	**35**	**0**	**0**	**0**	**0**	**365**	**39**	**562**	**134**	**24**
Grand Total	**68931**	**57717**	**84**	**47841**	**69**	**44344**	**64**	**34475**	**50**	**37025**	**54**	**46764**	**22991**	**49**

STATUS UPDATE OF ASHA CERTIFICATION

A proposal for certification of ASHAs to enhance competency and professional credibility of ASHAs by knowledge and skill assessment was approved in December 2013. A tripartite arrangement between the Ministry of Health and Family Welfare (MOHFW), National Health Systems Resource Centre (NHSRC) and the National Institute of Open Schooling (NIOS) to undertake the process accreditation of trainers and training sites and certification for ASHAs was undertaken. Based on the readiness of the States/UTs on the levels of completion of ASHA training in Rounds 1 to 4 of Module 6 and 7, the programme has been undergoing in 24 states/UTs namely Arunachal Pradesh, Assam, Chhattisgarh, 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.

Presently, 35 state training sites across 21 states/UTs and 132 district training sites across 14 states/UTs have been accredited by NIOS. About the trainers, the National Resource Team (NRT) of 27 trainers was created by NHSRC to support the refresher training and certification of state/district trainers, accreditation of state/ district training sites and facilitating certification of ASHAs and ASHA facilitators. A total of 232 state trainers across 23 states/UTs and 1006 district trainers in 15 States/UTs have been certified by NIOS as of March 2021. In FY 2020-21, over one year, the certification examination for ASHAs and ASHA Facilitators was conducted on 28th Feb 2021. The examination of July 2020 could not be held due to the COVID-19 situation in the country.

Till now, a total of six theory examinations have been conducted for ASHAs and ASHA Facilitators. The details of number of certified ASHAs and AFs (theory and practical) are as follows-

- 31st January 2018- 2,214 certified (theory and practical) out of 2,359 from 9 states - Arunachal Pradesh, Assam, Delhi, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Sikkim and Tripura.
- 22nd July 2018- 3,994 certified (theory and practical) out of 4,593 from 14 states namely Arunachal Pradesh, Assam, Chhattisgarh, Delhi, Himachal Pradesh, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Odisha, Punjab, Sikkim, Tripura and Uttarakhand.
- 20th January 2019- 10,179 certified (theory and practical) from 11,655 from 14 states and 1 UT namely Arunachal Pradesh, Assam, Chhattisgarh, Delhi, Himachal Pradesh, Jammu and Kashmir, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Odisha, Punjab, Sikkim, Tripura and Uttarakhand.
- 10th August 2019- 7,686 certified (theory and practical) from 9,280 from 16 states namely Arunachal Pradesh, Assam, Chhattisgarh, Delhi, Himachal Pradesh, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Manipur, Mizoram, Nagaland, Odisha, Sikkim, Tripura and Uttarakhand. ASHAs from Gujarat, a few districts of Karnataka and Maharashtra were unable to appear in the theory examination due to heavy floods in affected districts and from Jammu and Kashmir due to the political situation.
- 28th January 2020- 12,471 certified from 13,865 from 17 states and 1 UT namely Arunachal Pradesh, Assam, Delhi, Gujarat, Himachal Pradesh, J&K, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Manipur, Meghalaya, Mizoram, Odisha, Punjab, Sikkim, Tripura, and Uttarakhand.
- 25th February 2021- 8,822 certified from 10428 ASHAs appeared from 11 states and 1 UT namely Arunachal Pradesh, Assam, Chhattisgarh, Himachal Pradesh, Jammu and Kashmir, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Odisha, Sikkim, and Uttarakhand.
- Hitherto, 45,366 (70%) ASHA and ASHA Facilitators have been certified out of 65,029 who appeared in the examination from January 2018 till February 2021

TABLE 4- STATUS OF ACCREDITED VOCATIONAL INSTITUTE-AVIs (STATE & DISTRICT), ASHA TRAINERS (STATE & DISTRICT) CERTIFICATION OF ASHAs & ASHA FACILITATORS

State/UTs	ASHA and ASHA Facilitators Certified					Total Certified	State AVIs	District AVIs	State Trainer	District Trainer
	Jan 2018	July 2018	Jan-2019	Aug-2019	Jan 2020					
Arunachal Pradesh	20	80	52	77	31	260	1	2	2	12
Assam	471	220	1028	537	203	2459	1	5	5	107
Chhattisgarh	0	90	271	123	0	484	1	0	20	13
Delhi	174	757	719	578	628	2856	1	11	43	0
Gujarat	0	0	0	0	35	35	2	0	6	15
Haryana	0	0	0	0	0	0	0	0	9	0
HP	0	60	233	294	291	878	1	3	12	0
J&K	0	0	466	0	2457	2923	2	11	21	122
Jharkhand	550	177	1288	1859	1530	5404	1	20	24	122
Karnataka	301	873	4114	2566	4748	12602	4	19	3	133
MP	114	237	216	233	431	1231	3	17	13	112
Maharashtra	279	473	957	278	183	2170	8	0	12	184
Manipur	0	0	0	29	30	59	1	1	8	0
Meghalaya	0	0	0	0	41	41	1	0	6	0
Mizoram	0	0	0	22	44	66	1	0	3	14
Nagaland	0	0	0	49	0	49	1	0	6	0
Odisha	0	347	359	446	945	2097	1	14	3	55
Punjab	0	233	150	0	149	532	1	2	4	21
Rajasthan	0	0	0	0	0	0	0	0	8	0
Sikkim	25	105	43	79	56	308	1	0	2	11
Telangana	0	0	0	0	0	0	0	0	3	0
Tripura	280	45	71	338	283	1017	1	2	6	59
Uttarakhand	0	297	212	178	386	1073	1	1	6	26
West Bengal	0	0	0	0	0	0	1	24	7	0
Total	**2214**	**3994**	**10179**	**7686**	**12471**	**36544**	**35**	**132**	**232**	**1006**

STATUS OF SUPPORT STRUCTURES FOR COMMUNITY PROCESSES

STATE ASHA MENTORING GROUP (SAMG)

ASHA Mentoring Groups (AMGs) have been constituted at the state level to act as technical support groups for assisting the State Governments in the implementation, monitoring, and review of the ASHA programme. State-level AMGs have been constituted in a total of 25 states/UTs (24 states and 01 UT) in the country. In Chhattisgarh, SAMG is not constituted, State Health Resource Centre (SHRC) is concerned authority instead of SAMG. Therefore, a total of four states namely Chhattisgarh, Haryana, Himachal Pradesh, and Tamil Nadu and five UTs except Jammu and Kashmir have selected ASHAs, but they do not have State ASHA Mentoring Group (AMGs). Among all States/UTs, Gujarat and Telangana are the only states, which have reported an AMG meeting in the last year. Telangana reported the last meeting in June 2020 and Gujarat reported in August 2020.

In the High Focus States, none of the state has reported AMG meetings in the last year. The last AMG meeting was held in June 2019 for Uttar Pradesh while Rajasthan, Bihar and Odisha did not have a State AMG meeting since 2010, 2011 and 2012 respectively.

Among all 25 States & 1 UT, Uttarakhand has reported the highest number (27) of AMG meetings since the constitution of the State AMG in 2009. However, there is no recent update of the meeting of AMGs in Uttarakhand, with the last AMG meeting held in July 2018.

In the North-Eastern states, all states have constituted State ASHA Mentoring Group (AMG). However, the frequency of meetings has been irregular across all these states. None of the States has reported AMG meetings for the last five years. The last AMG meeting was held in Jan 2016 for Assam while Mizoram, Nagaland, Sikkim, and Tripura have reported their last AMG meetings in 2013.

In the Non-High Focus States, except Telangana and Gujarat, none of the states have reported AMG meetings since 2019. Kerala and Maharashtra have reported AMG meetings in 2018, while Andhra Pradesh reported last AMG meetings in March 2019. Karnataka, Punjab, and Delhi reported having their last meeting in 2017, 2016 and 2015 respectively. West Bengal did not have their AMG meeting since December 2011.

In UTs, Jammu & Kashmir reported last AMG meeting in 2018. The status of support structures across the states largely remains unchanged from the previous ASHA update published in July 2019.

TABLE 5- STATUS OF AMGs, STATE ARC AND STATE ASHA TRAINERS

States/ UTs	State ASHA Monitoring Group					State ARC		State Trainers				
	Status of Formation	Year of Formation	Total No. of AMG Members	Total No. of Meetings Held	Date of Last Meeting	Status of ARC (Regd. body/independent /part of SHSRC/team with SPMU	List of Positions filled	RD1	RD2	RD3	NCD	HBYC
High Focus States												
Bihar	SAMG constituted and is a registered body	2011	10	3	Jun-11	SPMU	2	28	28	28		
Chhattisgarh	SHRC is concerned authority instead of SAMG	2011	17	19	Apr-20	Not Constituted SHRC is concerned authority instead of SAMG						
Jharkhand	SAMG constituted in 2010 and later reconstituted in 2016	2012	15	10	Oct-17	SPMU	8	9	9	2	6	
MP	SAMG constituted in 2012 and later reconstituted in 2013	2008	16	4	May-19	No	7	13	13	13	8	7
Odisha	SAMG constituted	2009	NA	4	2012	Team with SPMU	6	5	5	5	4	
Rajasthan	SAMG constituted	2006	21	4	Sep-10		3	26	26	26	2	6
Uttar Pradesh	SAMG constituted	2008	29	8	June-19	Team with SPMU	10	109	80	28	15	11
Uttarakhand	SAMG constituted	2009	13	27	Jul-18		2	4	4	2	6	

North-Eastern States												
Arunachal Pradesh	SAMG constituted	2010	14	9	Aug-15	SPMU	2	4	4	4	4	5
Assam	SAMG constituted	2012	12	8	Jan-16	Team with SPMU	2	2	2	2	2	4
Manipur	SAMG constituted	2008	11	5	Aug-13	Team with SPMU	3	8	8	8	2	3
Meghalaya	SAMG constituted	2009	8	6	Oct-14	SPMU	2	2	2	2	2	5
Mizoram	SAMG constituted	2008	30	9	Sep-15	ARC with 1 State	3	3	3	3	2	6
Nagaland	SAMG constituted	2010	11	5	Aug-13	SPMU	3	6	6	6	9	3
Sikkim	SAMG constituted in 2010 and later reconstituted in 2016	2016	15	2	Nov-13	SPMU	1	1	1	1	1	4
Tripura	SAMG constituted	2008	18	7	Nov-13	SARC/ DARC/ SDARC	7	6	6	6	3	6
Non-High Focus States												
Andhra Pradesh	SAMG constituted	2015	15	2	Mar-19	Formed	4	5	5	5	-	-
Delhi	SAMG constituted	2010	8	6	Jan-15	Team with in SPMU	4	85	85	85	11	6
Gujarat	SAMG constituted	2013	15	10	Aug-20	Team with in SPMU	4	29	29	29	29	29
Haryana	Not constituted	NA	NA	NA	NA	Team with in SPMU	5	8	8	8	5	6
HP	Not constituted	NA	NA	NA	NA		7	12	12	12	12	4
Goa	SAMG constituted	2012	10	1	Oct-18							
Karnataka	2012 and later	2012	NA	1	Apr-17	Team with in SPMU	3	3	3	3	7	2
Kerala	SAMG constituted	2008	22	8	Jan-18		1					
Maharashtra	SAMG constituted	2007	16	6	Sep-18	Established	4	12	12	12	5	5
Punjab	SAMG constituted	2014	11	3	Aug-16	SHSRC and SPMU	5	5	7	4	4	1
Tamil Nadu	Not constituted	NA	NA	NA	NA	Within state SPMU	6	18	18	18	50	22
Telangana	SAMG constituted	2015	9	5	June-20	Team with in SPMU	6	3	3	3	3	3
West Bengal	SAMG constituted	2010	15	4	Dec-11	Child in Need	10	6	6	6	6	5
Union Territories												
Andaman & Nicobar	Not constituted						Staff	2	2	2	3	
Dadra & Nagar Haveli	Not constituted						Staff	4	0	0	0	0
Daman & Diu	Not constituted						Staff	0	0	0	0	
Puducherry	Not constituted					Team within SPMU	Staff	10	10	10	2	Nil
Ladakh	Not constituted							1	1	1	1	1

Lakshadweep	Not constituted						Staff	0	0	0	0	0
Jammu and Kashmir	Not constituted	2012	10	1	Oct-18		1	22	22	22		7
Chandigarh	NA											

ASHA SUPPORT STRUCTURE AT STATES/UTs

The support structure at the state level and below has expanded rapidly, especially over the 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 the last six years, the number of positions sanctioned and filled for support structures indicates a gradual increase as new positions were created in states of Uttar Pradesh, Himachal Pradesh, West Bengal, Arunachal Pradesh, Andhra Pradesh, Telangana, and the UT of Andaman & Nicobar Islands. There are a total of 39,546 ASHA Facilitators across 20 states in the country.

In high focus States except Odisha other states have support structures at all four levels (State/ District/ Block & Sub-block).

The majority of North-Eastern states have 3 to 4 levels of the support structure, except Sikkim where support structure has been created at the state and sub- block level only.

Amongst Non-High Focus states, Haryana, Karnataka, and Maharashtra have set up dedicated support structures at all four levels, while states like Andhra Pradesh, Gujarat, Telangana, Kerala, Delhi, Himachal Pradesh, Punjab and West Bengal have created a mix of dedicated and existing support structures setup in SPMU to support the ASHA programme. The support structure improved in states/UTs and can be understood from the table given below:

TABLE 6- ASHA SUPPORT STRUCTURE AT STATE, DISTRICT, BLOCK AND SUB-BLOCK LEVEL

States/UTs	State Level	District Level	Block Level	Sub-Block Level
High Focus States				
Bihar	ARC formed and is a registered body	11 positions filled (against target of 38)	438 positions filled (against target of 534)	4258 positions filled (91% against target of 4685) 1 AF per 20 ASHAs.
Chhattisgarh	State ARC is not Constituted and SHRC is concerned authority instead of SAMG	100% position filled against a target of 35	100% position filled against a target of 292	3452 positions filled (100% against a target) 1 AF per 20 ASHAs.
Madhya Pradesh	State- ARC not constituted.	46 positions filled (against target of 51)	259 positions filled (against target of 313)	5497 positions filled (100% against the target) 1 AF per 10 - 15 ASHAs
Odisha	Team within SPMU manages the program	52 positions filled (against target of 60)	Existing staff BPM supports the program	717 positions filled (100% against the target) 1 AF per 20 ASHAs.
Rajasthan	S-ARC has not been constituted. Existing staff manages the program.	31 positions filled (against target of 34),	174 positions filled (against target of 249),	1528 positions filled (100% against the target) 1 PHC Supervisor at the PHC level
Uttar Pradesh	Team within SPMU manages the program	71 positions against a target of 75 have been filled.	764 positions against a target of 820 have been filled.	6928 positions filled (86% against target of 8013) 1 AF for 20 ASHAs.
Uttarakhand	The state has 1 Nodal officer, 1 PM & 2 PCs place in the SPMU	12 positions against a target of 13 have been filled.	100% positions filled (against target of 101),	602 positions filled (100% against target) 1 AF for 20 ASHAs in position

North-Eastern States				
Arunachal Pradesh	Team within SPMU manages the program	100% positions filled (against target of 22)	100% positions filled (against target of 84)	354 positions filled (100% against target) 1 AF for 10-13 ASHAs
Assam	ASHA Programme Manager and State Community Mobilizer manage the program	23 positions filled (against target of 33)	139 positions filled (against target of 153)	2661 positions filled (100% against target) 1 AF for 20 ASHAs
Manipur	Team within SPMU manages the program	100% positions filled (against target of 9)	Existing staff - BPM manage the programme	170 positions filled (88% against target of 194) I AF for 20 ASHAs
Meghalaya	SAMG constituted State ASHA Resource Centre in place Team within SPMU manages the program	100% positions filled (against target of 11)	100% positions filled (against target of 39) Existing staff - BPM manage the programme	333 positions filled (100% against target) Selection is at the PHC.
Mizoram	1 SNO (CP), 1 ASHA Programme Manager 1 Assistant Programme Manager manage the program.	The District ASHA Coordinators acts as a DCM in the state of Mizoram (a total of 9 in position, one for each district)	No support structure at the block level.	97 positions filled (100% against target) The selection level is SDH/ CHC/PHC.
Nagaland	Team within SPMU manages the program Senior Program Manager, CP manages all CP activities.	100% positions filled (against target of 11)	66 positions filled (against target of 72),	Block ASHA Coordinators who provide mentoring support to ASHAs
Sikkim	Team within SPMU manages the program ADHS (CP) looks after the programme with support from SPMU, DOMU and BPMU	Existing staff- LHV/IEC staff manage the programme in all 4 districts	Existing staff - BPM manage the programme	71 positions filled (100% against target)- existing ASHAs are playing the dual role 1 AF for 10 ASHAs.
Tripura	State ARC is in place and is registered at SARC/ DARC/SDARC	4 ASHA Programme Managers and 11 Sub-Divisional Programme Managers support the programme	100% positions filled (against target of 11),	415 positions filled (100% against target)- 1 AF for 20 to 25 ASHAs in position
Non- High Focus States				
Andhra Pradesh	Team-based in SPMU and Directorate manages the program	11 positions filled (against target of 13)	Existing staff - BPM manage the programme	1385 MPHS- F 1 per PHC in place- who provide mentoring support to ASHAs
Delhi	Team within SPMU manages the program	100% positions filled (against target of 11)	None	1600 ANMs in place.1 per 5-7 ASHAs at UPHCs - who provide mentoring support to ASHAs
Gujarat	Team within SPMU manages the program	100% positions filled (against target of 33) District Program Assistant is in place per district for monitoring of ASHA Programmes.	Existing staff - BPMU manage the programme	3553 positions filled (95% against target of 3751)- I AF for 10 ASHAs
Haryana	Team within SPMU manages the program	100% positions filled (against target of 22)	106 positions filled (against target of 113)	573 positions filled (93% against target of 618)- 1 AF per 20 ASHAs
Karnataka	Team within SPMU manages the program	28 positions filled (against target of 30)	169 positions filled (against target of 176)	1679 positions filled (94% against target of 2000)- 1 AF per 20 ASHAs- existing ASHAs are playing the dual role
Kerala	S-ARC has not been constituted. Existing staff manages the program.	Existing staff - manage the programme	Existing staff - manage the programme	MPWs at SHCs in place- who provide mentoring support to ASHAs

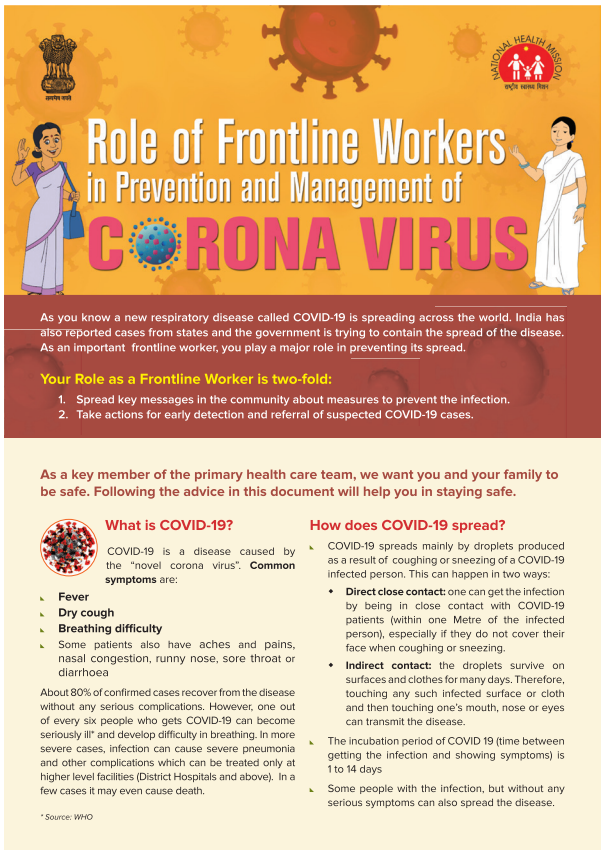
Maharashtra	State ARC has been constituted.	33 positions against a target of 34 have been filled.	336 positions against a target of 355 have been filled.	3570 positions filled (95% against target of 3664)- 1 AF per 10 ASHAs in tribal areas & 1 AF per 20 ASHAs in Non- Tribal areas
Punjab	Team within SHSRC and SPMU manage the program.	13 positions against a target of 22 have been filled.	100% positions filled (against target of 101),	869 positions filled (98% against target of 888)- 1 AF for 20 ASHAs in position.
Himachal Pradesh	None	10 positions filled as against target of 12	Existing staff - BPM manage the programme	1663 –Female Health Workers/MPW at SHCs- 1 MPW per SHC - who provide mentoring support to ASHAs
Tamil Nadu	Team within SPMU manages the program	District Maternal and Child Health Officer, DMCHO manages the program at the district level. 100% positions filled (against target of 33)	Community Health Nurse supports the program at block level. 100% positions filled (against target of 104)	195 Community Health Nurse cadre - who provide mentoring support to ASHAs
Telangana	Team within SPMU manages the program	6 positions filled (as against target of 33)	All position is vacant against a target of 81	1552 Multi-Purpose Health Supervisor (MPHS-F) at PHC level who provide mentoring support to ASHAs - 1 MPHS per 20 ASHAs
West Bengal	The program management has been outsourced to CINI- Child in Need Institute Sr. Programme Coordinator is the Nodal Officer for ASHA and is supported by CINI supported manpower	22 positions against a target of 28 have been filled. The state has one District ASHA Facilitator per district	496 positions against a target of 682 have been filled. On average, 160 ASHAs/ Block and Two (2) Block ASHA Facilitators (BAF)/ Block norm is followed. Around 80 ASHAs are supported by 1 (one) BAF.	Health Supervisor at Gram Panchayat level- who provide mentoring support to ASHAs
Union Territories				
Andaman & Nicobar Islands	State- ARC not constituted Existing staff at the state level manages the program.	Existing DPMU staff supports the programme at the district level.	Existing staff - BPM manage the programme	Existing PHC staff - who provide mentoring support to ASHAs
Lakshadweep	State- ARC not constituted Existing staff at the state level manages the program.	Existing DPMU staff supports the programme at the district level.	Existing staff - BPM manage the programme	Existing staff manages the programme
DD&DNH	UT- ARC not constituted Existing staff at the state level manages the program.	Existing DPMU staff supports the programme at the district level.	Existing staff manages the programme	Existing PHC staff - who provide mentoring support to ASHAs
Ladakh	Team within SPMU manages the program	Existing DPMU staff supports the programme at the district level. 100% positions filled against a target of 2.	Existing staff - BPM manage the programme 100% positions filled against a target of 12.	52 MPWs - who provide mentoring support to ASHAs - 1 MPW per 20 ASHAs in Non-HTR and 1 per MPW for 10 ASHAs in HTR
Jammu & Kashmir	Project Officer ASHA manages the program 100% positions filled against a target of 1	The existing CHO/Health Educator has been designated as District ASHA Coordinator (DAC) manage the programme in all 20 districts	Existing staff - block-level CHO/ Health Educators are selected as Block ASHA Coordinator (BAC) manage the programme	816 MPWs - who provide mentoring support to ASHAs 1 MPW per 20 ASHAs in Non-HTR and 1 per MPW for 10 ASHAs in HTR
Puducherry	Team within SPMU manages the program	Existing DPMU staff supports the programme at the district level.	Existing staff - BPM manage the programme	Existing ASHAs are playing a dual role

3 ASHA's Role in Prevention and Management of Covid-19

During the pandemic, ASHAs emerged as one of the key pillars of the health system's response for COVID-19 prevention and management. The engagement of ASHAs in COVID-19 related activities such as line listing and contact tracing began as soon as the first few cases were notified in some states like Kerala and Rajasthan, from February 2020 onwards as per local requirements. Subsequently, the guidelines on measures for containment of COVID-19 at the community and outreach level were issued in March 2020 to outline the broad roles and responsibilities of the ASHAs.

As has been the practice in the programme, these new tasks were accompanied by the training/skill building of ASHAs and ASHA facilitators and were linked with new incentives for ASHAs and ASHA facilitators. Brochure– "Role of Frontline Workers in Prevention and Management of Corona Virus" was developed by NHSRC in English and Hindi languages and was shared with all states/UTs for translation in regional languages. The main objective of the brochure was to – introduce COVID-19 with details of high-risk groups, key preventive measures to curtail the spread of infection and myth vs facts, roles of ASHAs and measures to be followed by ASHAs for self-care and continuation of other tasks.

BROCHURE– "ROLE OF FRONTLINE WORKERS IN PREVENTION AND MANAGEMENT OF CORONA



Nearly 7.3 lakh (80%) Rural ASHAs and 0.61 lakh (89%) Urban ASHAs were trained within two months in the first wave of COVID pandemic in April and May 2020 and 8.67 lakh (95%) rural and 0.45 lakh urban ASHAs were trained in the second wave of COVID pandemic in March 2021 against the target. Because of the travel restrictions and physical distancing norms, most states conducted the training in small batches at the PHC level. Use of digital platforms like zoom, Webex by Cisco and ECHO facilitated the fast-paced rollout of training as the live sessions by state/district teams were attended by ASHAs and AFs in small batches at PHC level or using their smart phones as per the local context of access to internet connectivity and local travel restrictions. An additional incentive of Rs. 1000 per month for ASHAs and Rs. 500 per month for ASHA facilitators were introduced for these new COVID-19 related tasks. In addition, all ASHAs and ASHA Facilitators were covered under the 'Pradhan Mantri Garib Kalyan Package', for an insurance amount of up to Rs.50 lakh as part of the health care workforce working for COVID-19.

During the pandemic, ASHAs continued to play an important role in enabling access to other essential health care services such as immunization, ANC, safe delivery, availability of medicines for chronic non-communicable and communicable diseases as per the guidelines issued for Enabling Delivery of Essential Health Services.

KEY TASKS UNDERTAKEN BY ASHAs ACROSS THE STATES/UTs

- Community-level Surveillance – Listing of all houses with a recent travel history and contact tracing for all individuals who had contact with positive/ suspected COVID-19 cases was done to facilitate early detection and timely referral of suspected cases.
- Counselling- Creating awareness on COVID-19 by sharing information about COVID-19 appropriate behaviour for prevention and about services for testing, quarantine and treatment made available by the government.
- Follow up – Home visits were undertaken for COVID-19 patients advised staying under isolation and individuals who were advised to follow home quarantine to ensure adherence to protocols and monitoring of health status.
- High-Risk Group Identification – Listing of elderly and patients with comorbidities like diabetes, hypertension, heart disease and /or respiratory illness who were more prone to develop severe complications due to COVID-19 was done for focussed counselling and regular follow-ups.
- Provision of essential services – Follow up was done with individuals requiring other essential health care services to enable access to services like ANC, institutional delivery, immunization, continued treatment for chronic illnesses like TB, Diabetes, Hypertension.
- Recording and reporting – As ASHAs are positioned at the village/ward level, ASHAs also played a key role in collecting, compiling and reporting the information that was important for the public health system to respond to the pandemic.

BEST PRACTICES REPORTED FROM STATES/UTs

- Community Mobilization – ASHAs were included as core members of committees formed at the village /ward level to take preventive measures including active surveillance in many states like – DD&DNH, Karnataka, Meghalaya, Mizoram, Nagaland and Uttar Pradesh. ASHAs also led the community level action by working closely with VHSNCs and MAS in the states of Mizoram, Chhattisgarh, Odisha and Tripura. In Chhattisgarh and Odisha, walls created by VHSNCs were used for health promotion to disseminate important preventive messages. ASHAs also worked

closely with local teams of volunteers for community-level activities in Andhra Pradesh and Kerala.

- Supporting the Marginalized –Across states, ASHAs played a critical role in supporting the individuals/families from vulnerable groups who had limited access to social and health services. This was particularly noted in the case of migrant returnees, where ASHAs performed several tasks to support them viz, line listing, counselling, facilitating home and institution-based quarantine and enabling access to other health services. Special efforts were reported in this regard from states of Jharkhand, Madhya Pradesh, Odisha and Uttar Pradesh. (One such example is tracking of 30.44 lakh migrants in UP by ASHAs in two phases). On the other hand, ASHAs in Delhi and Kerala provided local support to migrant workers during lockdown by working closely with primary health care teams and Corona control room respectively. COVID-19 related services –ASHAs supported setting up and smooth functioning of quarantine centres in Nagaland, Odisha and Uttar Pradesh. They were also actively involved in the distribution of home care kits and close monitoring of COVID-19 patients during home isolation in Bihar, Delhi, Gujarat and Telangana while in Sikkim, ASHAs were engaged in mitigating stigma associated with the patients who returned home after recovery from COVID-19. During the early phase of the pandemic, reports of ASHAs stitching and distributing cloth masks emerged from states of Mizoram, Nagaland, Odisha, Rajasthan and Uttarakhand. Some states like Uttarakhand, West Bengal and Mizoram deputed ASHAs along with other primary health care team members at state/ district borders for screening.

- Essential non-COVID-19 services - To assure continued access to medicines, door step delivery of medicines was conducted through ASHAs for patients with chronic illnesses in Bihar, Chhattisgarh, Madhya Pradesh, Odisha, Meghalaya, Punjab, Telangana (for TB patients) and in Jharkhand, Assam, J&K, Madhya Pradesh, Manipur, Meghalaya, Mizoram, Andhra Pradesh, Kerala, Telangana and Puducherry (for elderly and hypertensive and diabetes patients)

- IT system – State-specific IT applications were designed for ASHAs by a few states to address the urgent need for real-time tracking for planning and follow up by a few states. These examples include – launch of the Corona Access app in Delhi, updating of the IDSP module in the TECHO+ app in Gujarat, updating of PLA application in Jharkhand and development of an application for ASHAs surveillance in Punjab. However, the actual usage of these applications needs to be further studied.

- As the programme progresses in the current paradigm of comprehensive primary health care while simultaneously adapting to the 'new normal' imposed by the pandemic, the next phase of the programme must be designed to resolve a few systemic challenges and promote local innovations for improved sustainability.

TRAINING OF ASHAs IN PREVENTION AND MANAGEMENT OF COVID-19

The status of training for the Rural and Urban ASHAs during the first and second wave of COVID-19 pandemic is given in table 7 and 8 below.

TABLE 7- TRAINING OF ASHAs IN PREVENTION AND MANAGEMENT OF COVID-19 IN RURAL & URBAN

Training Status	Rural ASHAs				Urban ASHAs			
	First wave		Second wave		First wave		Second wave	
	No. of State/ UTs	States Names	No. of States/ UTs	States Names	No. of State/ UTs	States Names	No. of State/ UTs	States Names
100%	19	Bihar, Jharkhand, MP, Rajasthan, Arunachal Pradesh, Assam, Mizoram, Sikkim, Tripura, Gujarat HP, Kerala, Maharashtra, Punjab, Telangana, A&NI, J&K, Lakshadweep, Ladakh	15	Jharkhand, Odisha, Rajasthan, Uttarakhand, Arunachal Pradesh, Mizoram, Andhra Pradesh, Gujarat, Haryana, Karnataka, Kerala, Maharashtra, Tamil Nadu, Telangana, DD&DNH	11	Bihar, Rajasthan, Assam, Nagaland, Sikkim, HP, Delhi, Gujarat, Kerala, Maharashtra, Telangana	15	Rajasthan, Uttarakhand, Assam, Manipur, Mizoram, Andhra Pradesh, Gujarat, Haryana. Karnataka, Kerala, Maharashtra, Telangana, DD&DNH, J&K, Puducherry
90-99%	10	Chhattisgarh, Odisha, Manipur, Meghalaya, Nagaland, Andhra Pradesh, Haryana, Karnataka, Tamil Nadu, West Bengal	5	Chhattisgarh, Madhya Pradesh, Uttar Pradesh, Nagaland, Tripura	7	Chhattisgarh, Odisha, Arunachal Pradesh, Andhra Pradesh, Haryana, Karnataka, Punjab	7	Chhattisgarh, Jharkhand, MP, Arunachal Pradesh, Meghalaya, Delhi, West Bengal
75-89%	1	Uttar Pradesh	2	Assam, Ladakh	2	Tripura, Puducherry	2	UP, Tripura
< 75%	0	None	3	Bihar, Himachal Pradesh, J&K	2	Manipur, Mizoram,	1	HP
0%	2	Uttarakhand, DD&DNH	7	Manipur, Meghalaya, Sikkim, Punjab, West Bengal, A&NI, Lakshadweep	10	Jharkhand, MP, UP, Uttarakhand, Meghalaya, West Bengal, DD&DNH, A&NI, J&K, Ladakh	7	Bihar, Odisha, Nagaland, Sikkim, Punjab, A&NI, Ladakh
Total	**32***		**32***		**32***		**32***	

*Tamil Nadu has only Rural ASHAs, and Puducherry and Delhi have only urban ASHAs

TABLE-8 STATUS OF ASHA TRAINING IN PREVENTION AND MANAGEMENT OF COVID-19

Name of State/ UT	Rural ASHAs						Urban ASHAs					
	First Wave			Second Wave			First Wave			Second Wave		
	In Position	Trained	%	Target	Trained	%	In Position	Trained	%	Target	Trained	%
Bihar	87655	25000	29	85272	85272	100	582	0	0	550	550	100
Chhattisgarh	68277	67512	99	68277	67805	99	3771	3729	99	3771	3721	99
Jharkhand	39931	39807	100	39931	39964	100	1475	1475	100	1677	0	0
Madhya Pradesh	64094	62350	97	63183	62511	99	4525	4235	94	4525	0	0
Odisha	46134	45934	100	45941	45941	100	1700	0	0	1614	1522	94
Rajasthan	48207	48207	100	47924	47886	100	4269	4269	100	4298	4298	100

UP	155070	139592	90	156632	132811	85	6968	5666	81	6968	0	0
Uttarakhand	10700	10700	100	10418	0	0	1205	1205	100	1205	0	0
Sub-Total	**520068**	**439102**	**84**	**517578**	**482190**	**93**	**24495**	**20579**	**84**	**24608**	**10091**	**41**
North-Eastern States												
Assam	31334	25000	80	31334	31334	100	1212	1212	100	1212	1212	100
Arunachal Pradesh	4040	2753	68	2753	2753	100	42	40	95	42	40	95
Manipur	3928	0	0	3928	3819	97	120	120	100	120	81	68
Meghalaya	6589	0	0	6589	6426	98	195	184	94	195	0	0
Mizoram	1012	1012	100	1012	1012	100	79	79	100	79	15	19
Nagaland	1917	1845	96	1917	1845	96	90	0	0	90	90	100
Sikkim	641	0	0	641	641	100	32	0	0	35	35	100
Tripura	7147	7147	100	7158	7158	100	504	398	79	504	427	85
Sub-Total	**56608**	**37757**	**67**	**55332**	**54988**	**99**	**2274**	**2033**	**89**	**2277**	**1900**	**83**
Non-High Focus States												
Andhra Pradesh	38216	38216	100	38216	35015	92	3200	3200	100	2609	2509	96
Delhi	NA						6036	5926	98	5982	5982	100
Gujarat	38853	38853	100	38391	38391	100	4478	4478	100	4281	4281	100
Haryana	17557	17557	100	18000	17699	98	2571	2571	100	2676	2593	97
HP	7881	2116	27	7881	7881	100	33	33	100	33	33	100
Karnataka	38674	38674	100	38407	37790	98	3125	3125	100	3091	2900	94
Kerala	24079	24079	100	24079	24079	100	2396	2396	100	2396	2396	100
Maharashtra	60816	60816	100	60862	60862	100	7522	7522	100	6001	6001	100
Punjab	17223	0	0	17144	17111	100	2569	0	0	2532	2479	98
Tamil Nadu	2555	2555	100	2650	2520	95	NA					
Telangana	23443	23443	100	23111	23111	100	3597	3597	100	3929	3929	100
West Bengal	54109	0	0	53077	52252	98	5701	5337	94	5487	0	0
Sub-Total	**323406**	**246309**	**76**	**321818**	**316711**	**98**	**41228**	**38185**	**93**	**39017**	**33103**	**85**
Union Territories												
A&NI	394	0	0	412	412	100	10	0	0	10	0	0
DD&DNH	340	282	83	351	0	0	98	98	100	98	0	0
J&K	12539	4791	38	11640	11640	100	136	136	100	136	0	0
Lakshadweep	101	0	0	104	104	100	NA					
Ladakh	612	513	84	534	534	100	364	0	0	0	0	0
Puducherry	NA						326	326	100	341	304	89
Sub-Total	**13986**	**5586**	**40**	**13041**	**12690**	**97**	**934**	**560**	**60**	**585**	**304**	**52**
Grand Total	**914068**	**728754**	**80**	**907769**	**866579**	**95**	**68931**	**61357**	**89**	**66487**	**45398**	**68**

SOME FIELD LEVEL ACTIVITIES PERFORMED BY ASHA AND ASHA FACILITATORS

ASHAs provided with face mask and sanitizer

ASHAs demonstrating proper handwashing

Generated awareness messages by ASHA

ASHA writing health messages on the wall

ASHA conducting household surveys for identifying high risk individuals

ASHAs pasting slips on walls of households under supervision

4 Programme Update on Community-Based Institutions

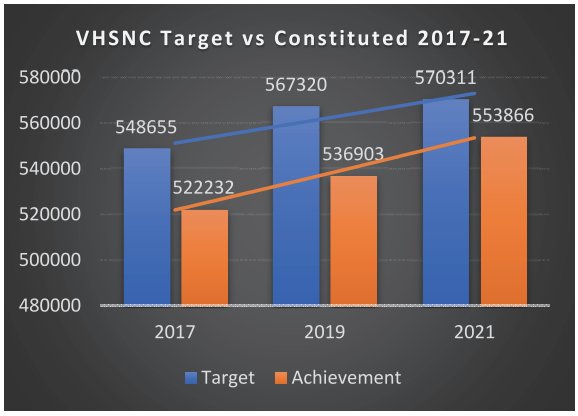
VILLAGE HEALTH SANITATION AND NUTRITION COMMITTEES AND MAHILA AROGYA SAMITIS

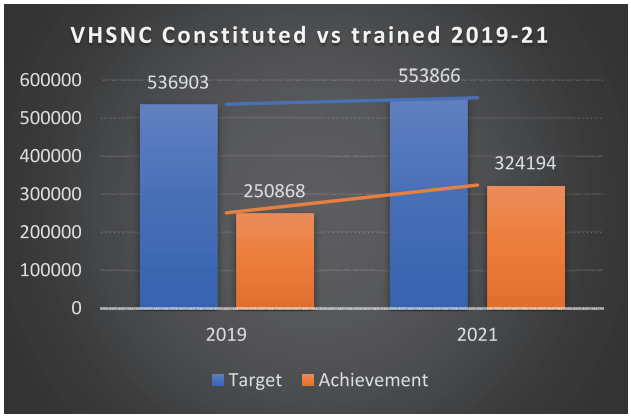
Communitization is one of the key strategies under the National Health Mission. Various community participation platforms have been created to enable active participation of the community and its representatives, especially the elected representatives of Panchayat Raj Institutions (PRIs) and the Urban Local Bodies (ULBs), in Health Promotion and Action on Social Determinants of Health. They also play a supportive and oversight role to the Health System in both delivery of services and greater utilization of the public health facilities.

Village Health Sanitation Committees (VHSNCs), at the village level, Jan Arogya Samitis at AB-HWCs and Rogi Kalyan Samiti (RKS) in a higher-level health facility (DH/SDH, CHC) are the institutional platforms created for facilitating this participation of the community. With the launch of the National Urban Health Mission (NUHM), Mahila Arogya Samiti (MAS) was created at the community level in urban areas. To strengthen the 'local level action' of the VHSNCs, a community-level campaign VISHWAS - Village-based Initiative for Synergising Health Water and Sanitation with guidance for VHSNC members and community representatives was launched in 2017.

In this update we report on the status of the constitution, training, operations of bank accounts and role played by ASHAs in the platform of VHSNC and MAS in different states including the status of VISHWAS training.

FIGURE-4 VILLAGE HEALTH SANITATION AND NUTRITION COMMITTEES TARGET VS CONSTITUTION AND TRAINING





FORMATION OF VILLAGE HEALTH SANITATION AND NUTRITION COMMITTEES

At the National level 5,53,866 (97%) VHSNCs have been constituted against total target of 5,70,311 for the country.

In the High Focus states 2,84,235 (97%) VHSNCs have been formed against the target of 2,91,852. All states except Chhattisgarh, Madhya Pradesh and Uttar Pradesh have formed 100% VHSNCs against the state-specific target. While Uttar Pradesh, Chhattisgarh and Madhya Pradesh have only 5%, 4%

and 2% VHSNCs to be constituted respectively, Bihar needs to complete the formation of a significant 16% VHSNCs for complete saturation. In all of these states, VHSNCs have been formed at the revenue village level except in Bihar, where VHSNCs have been formed at the level of Gram Panchayats. The majority of states reported 15-20 participants per VHSNC except for the state of Bihar where there are 5 members in the committee followed by Jharkhand that reported an average of 11 members.

Non-High Focus states also show good progress in the formation of VHSNCs and 2,17,053 (96%) have been formed against the total target of 2,25,007. The Non-High Focus states has reported 100% constitution from all the states except Himachal Pradesh (98%), Karnataka (97%), West Bengal (99%) and Telangana (62%). In this group of states, VHSNCs have been formed at the level of revenue village except in Andhra Pradesh, Tamil Nadu (at GP level) and West Bengal at Gram Samsad level which is the booth/ward area of Gram Panchayat. The number of committee members also ranged from 15-17 in all the states. Segregating state-wise.

In Union Territories, 6,928 (99%) VHSNCs were reported formed against a target of 6, 973. Most of the UTs reported the level of formation of VHSNCs to be at revenue village/village.

CONVERGENCE OF ASHA AND VILLAGE HEALTH SANITATION AND NUTRITION COMMITTEES

As per the Operational Guidelines for VHSNC, ASHA is expected to serve as the member secretary of the committee and be a joint account holder with the chairperson who is a representative of the panchayat. This is to promote better community-level ownership, participation of marginalized, actual need-based village health planning. Across India, ASHA is serving as member secretary in about 3.7 Lakh VHSNC formed (67%). States and UTs where ASHA is not a Member Secretary include- Bihar (ANM), Odisha (AWW), Tripura (Partially CHOs), Haryana (AWW), Kerala (ANM), Tamil Nadu (VHN), Telangana (ANM), West Bengal (ANM), DDNH & D&D (ANM), and Puducherry (ANM). Overall, 545887(99%) of constituted VHSNCs had a bank account.

CAPACITY BUILDING OF VILLAGE HEALTH SANITATION AND NUTRITION COMMITTEES

To institutionalize the capacity building of VHSNC members, MoHFW introduced a Handbook for Training of VHSNCs members in 2013 through a two-day programme. At the National level, 3.24 Lakh (59%) of total constituted VHSNCs and 19,37,978 VHSNC members have been trained on the VHSNC handbook. In High focus States, 1,42,314 (50%) of total constituted VHSNCs and 8,23,481 VHSNC members have been trained on the VHSNC handbook. Only Odisha and Chhattisgarh have completed 100% of the training, whereas other states are required to scale up the training activity. Progress of training in the North-eastern states has been 40,269(88%) with Manipur, Mizoram, Nagaland, and Sikkim completing the 100% of training. Similarly, in Non-high focus states 141336(65%) committees and 10,28,421 members have been trained on the VHSNC handbook. In UTs progress of the training is very low at 4% and an immediate scale-up is required.

In addition to the training on the VHSNC handbook, few states have initiated other training for VHSNC members. Some of those training topics include Climate change (Chhattisgarh), COVID-19 management (Jharkhand), PLA (Madhya Pradesh), Monitoring of SC-HWC (Assam), Community action for health (Karnataka), Vector-borne diseases (West Bengal) etc.

The VISHWAS campaign launched in 2017, is expected to strengthen the institutional capacity of VHSNCs for effective and sustained community action on health, and states have initiated the training on VISHWAS. Overall, 2,98,187 (54%) (36%) committee and 7,11,463 committee members have been trained on VISHWAS.

TABLE-9 STATUS UPDATE FOR VILLAGE HEALTH AND NUTRITION COMMITTEE

States/UTs	Status update for Village Health and Nutrition Committee							Training on VHSNC Handbook			Training in VISHWAS Module		
	Level of Formation (Gram Panchayat/ Revenue Village)	Member per VHSNC	Target	Constituted as per GOI Guidelines 2013	%	Member Secretary	No. of Bank A/C	No. of VHSNCs trained	No. of VHSNC members trained	%	No. of members trained	No. of VHSNC trained	No. of DTs
High Focus States													
Bihar	Gram Pancha-yat	5	10051	8406	84	ANM	8406	1173	4559	12	0	0	0
Chhattis-garh	Revenue Village	15-17	20000	19180	96	ASHA	19180	19180	249340	96	57686	19180	40
Jharkhand	Revenue Village	11	30012	30012	100	ASHA	29635	18236	42832	61	55656	20276	42
MP	Revenue Village	12-20	50567	49567	98	Pan-chayat Secretary	49567	14930	104515	30	2346	782	87
Odisha	Revenue Village	10-12	46102	46102	100	AWW	46102	46102	135000	100	179250	32300	124
Rajasthan	Revenue Village	15	43440	43440	100	ASHA	40698	19020	114120	44	114120	19020	1565
Uttar Pradesh	Revenue Village	17	77032	72880	95	ASHA	72880	16746	139318	22	13821	3770	20
Uttara-khand	Revenue Village	15	14648	14648	100	ASHA	14648	6927	33797	47	20310	101550	0
Sub-Total			**291852**	**284235**	**97**			**142314**	**823481**	**49**	**440843**	**196878**	
North-Eastern States													
Arunachal Pradesh	Village	6-10	3772	3318	88	ASHAs	3318	2152	4304	57	39	2152	39
Assam	Village	10-15	28149	28149	100	ASHAs	28149	27673	55346	98	11370	2274	191
Manipur	Village	8-15	3878	3878	100	ASHAs	3878	3878	7756	100	0	0	50
Meghalaya	Village	7-10	6685	6310	94	ASHAs	6310	3073	4250	46	3954	1318	100
Mizoram	Village	15	830	830	100	ASHAs	830	830	1660	100	1660	830	18
Nagaland	Village	15	1346	1346	100	ASHAs	1346	1346	3444	100			
Sikkim	Village	10	641	641	100	ASHAs	641	641	6410	100	0	0	0
Tripura	Gram Pancha-yat	10-15	1178	1178	100	CHO, MPW,							
ASHA	1178	676	2356	57	120	58	49						
Sub-Total			**46479**	**45650**	**98**			**40269**	**85526**	**87**	**17143**	**6632**	
Non-High Focus states													
Andhra Pradesh	Gram Pancha-yat	15	13065	13065	100	ASHA	13065	0	0	0	130630	13065	2723
Gujarat	Revenue Villages	11	17676	17672	100	ASHA	17672	10506	52530	59			
Haryana	Revenue Villages	12-15	6049	6049	100	AWW	6049	6049	30245	100	6049	30245	370
HP	Revenue Villages	15	7930	7787	98	ASHA	7787	7295	19654	92	19654	7295	44

Goa	Gram Pancha-yat	10-12	204	201	99	MPW	202	261	1979	128	1291	119	90
Karnataka	Revenue Village	10-15	26866	26084	97	ASHA	26084	7614	7406	28	9108	4554	36
Kerala	Ward	15-20	19523	19523	100	MPW	19523	19523	234276	100			
Maharash-tra	Revenue village	15-17	39770	39770	100	ASHA Worker	39770	7954	16010	20	7954	16010	467
Punjab	Revenue Village	15	12982	12982	100	ASHA	12982	12452	73546	96	77736	12956	110
Tamil Nadu	GP	5	15015	15015	100	VHN	15015	15015	16994	100	-	-	-
Telangana	GP & RV	15-19	16876	10433	62	ANM	8830	10433	156495	62	156495	10433	124
West Bengal	Gram Samsad, which is Booth/ Ward area of GP	15	49051	48472	99	ANM	45261	44234	575781	90	-	-	-
Sub-Total			**225007**	**217053**	**96**			**141336**	**1028421**	**63**	**252422**	**94677**	
Union Territories													
A&NI	Village	6	275	275	100	ASHA	275	275	550	100	0	0	0
DD&DNH	Village	8	98	89	91	ANM	89	-	-		0	0	0
Puducherry	Revenue Village	7	99	99	100	ANM	99	Nil	Nil				
Ladakh	Revenue village	12	259	259	100		256	0	0		0	0	0
Lakshad-weep	NA												
J&K	Revenue village	8-10	6242	6206	99	ASHA	6162	0	0		0	0	0
Chandigarh	NA												
Sub-Total			**6973**	**6928**	**99**			**275**	**550**	**4**		**0**	**0**
Grand Total			**570311**	**553866**	**97**			**324194**	**1937978**	**57**		**298187**	**0**

MAHILA AROGYA SAMITIS (MAS)

FORMATION OF MAHILA AROGYA SAMITIS (MAS)

Total 80,238 (87%) MAS have been constituted against the target of 92,111 MAS in 1105 cities across India. On average there are 10-15 MAS members reported in the majority of MAS across states/UTs except for Puducherry which has an average of 50 members in each MAS.

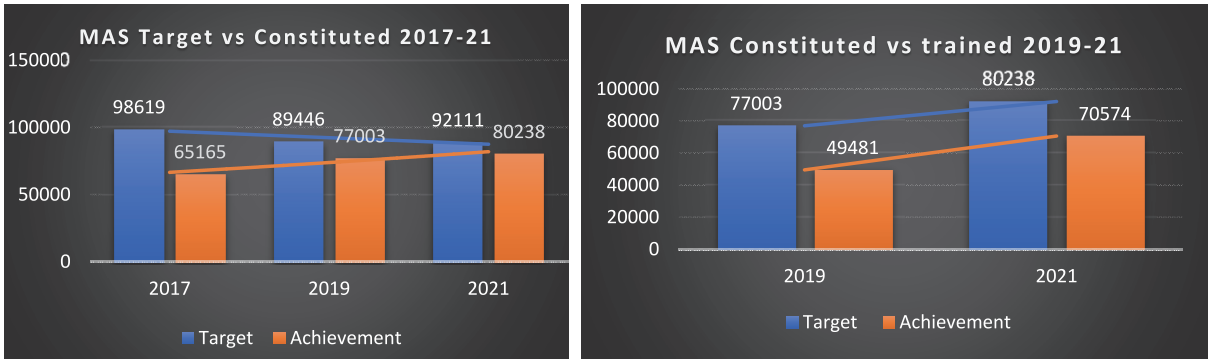
High focus states like Jharkhand, Odisha, Rajasthan have constituted 100% MAS against the state-specific targets and over 95% formed MAS have bank accounts. This is followed by Chhattisgarh which reported the constitution of 98% MAS and bank accounts of MAS. The remaining states have formation ranging between 72-88 %. The number of MAS with bank accounts is reported lowest from Uttarakhand with only 32% of constituted MAS reported having bank accounts.

In North-eastern states, around 87% MAS was constituted against the state-specific targets in 35 cities. 100% formation was reported from Assam, Meghalaya, Mizoram, Sikkim, and Tripura followed by Arunachal Pradesh (98%). Manipur and Nagaland with 68% and 66% constitution respectively.

In Non-High focus states, 54669 (86%) MAS have been constituted against the target across 604 cities. 100% constitution was reported from Andhra Pradesh, Karnataka, Maharashtra, Punjab, and Telangana. The lowest constitution was reported from Himachal Pradesh (15%) followed by Tamil Nadu (31%). 95% of MAS constituted have reported having a bank account. The average number of MAS members is raging from 8 to 12.

Similarly, in UTs 93% MAS have been constituted across 87 cities and 71% MAS have a bank account. States of Rajasthan, Uttarakhand and Himachal Pradesh also reported support from NGOs in the implementation.

FIGURE-5 MAHILA AROGYA SAMITIS (MAS) TARGET VS CONSTITUTION AND TRAINING



TRAINING OF MAHILA AROGYA SAMITIS

Nationally, 70574 (88%) against the constituted MAS and 4,13,881 MAS members have been trained on the MAS handbook. On average across all states, training was conducted for 2 days.

In High focus states, a total of 21,958 (91%) of MAS and 2,21,159 MAS members have been trained on the MAS handbook. States of Chhattisgarh, Odisha, and Rajasthan have completed 100% training, whereas other states reported training in the range of 86-92%. The lowest training against the constitution has been reported from the state of Bihar (16%) which requires massive efforts to scale up. On Average, the duration of training days were 1-2 days except for Chhattisgarh where training was done for 18 days (each round 3 days of training).

North-eastern states reported training of 1,401 (84%) of MAS and 4,787 MAS members on the MAS handbook. 100% training completion was reported from Assam, Nagaland, and Mizoram. Arunachal Pradesh, Manipur, and Meghalaya reported 71%, 67% and 94% MAS training respectively. Sikkim is yet to initiate the training of MAS. On average the duration of training for MAS was reported to be 1-2 days.

In Non-high focus states, 31,746(87%) of MAS and 3,12,235 total members have been trained on the MAS handbook. The majority of states have completed 100% of training. On average the duration of training was 1-2 days except for Tamil Nadu where training spanned over 16 days.

In UTs 45% of MAS constituted have been trained on MAS handbook and the training duration was the average of 2 days.

In addition to the training on the MAS handbook, states took initiatives depending on the local context like COVID prevention (Jharkhand, Rajasthan, Andhra Pradesh), Handwashing and RNTCP (Odisha) and RMNCHA+ (Puducherry).

TABLE-10 STATUS OF MAHILA AROGYA SAMITIES

States/UTs	Status update for Mahila Arogya Samities (MAS)						Training for MAS in Handbook				
	No. of Cities with MAS	Target	formed	%	No. of members per MAS	No. of Bank A/C	Target	Trained	%	No. of Members trained	Training duration
High Focus States											
Bihar	25	843	734	87	10 to 12	675	734	116	16	1395	1
Chhattisgarh	19	3771	3698	98	20	3622	3698	3698	100	119771	3
Jharkhand	22	918	918	100	11	876	918	793	86	1905	2
MP	66	5335	3825	72	11-19	3645	3825	3283	86	26264	1
Odisha	36	3132	3132	100	11-15	3132	3132	3132	100	12528	2
Rajasthan	61	4718	4718	100	10-12	4718	4718	4718	100	45180	1
UP	131	7036	6171	88	10-20	5127	6171	5658	92	11316	2
Uttarakhand	10	760	620	82	5-10	200	620	560	90	2800	1
Sub-Total	**370**	**26513**	**23816**	**90**		**21995**	**23816**	**21958**	**92**	**221159**	
North- Eastern States											
Arunachal Pradesh	2	92	90	98	5-10	65	90	30	33	90	2
Assam	14	658	658	100	10	658	658	658	100	3340	2
Manipur	3	604	409	68	5-8	409	409	409	100	818	1
Meghalaya	4	110	110	100	10-15	110	110	104	95	NA	3
Mizoram	3	50	50	100	10-20	50	50	50	100	50	1
Nagaland	5	113	75	66	15	75	75	70	93	265	2
Sikkim	1	35	35	100	15	15	35	0	0	0	0
Tripura	3	96	96	100	10-15	96	96	80	83	224	2
Sub-Total	**35**	**1758**	**1523**	**87**		**1478**	**1523**	**1401**	**92**	**4787**	
Non-High Focus states											
Andhra Pradesh	110	10440	10440	100	8-10	10440	10440	10440	100	92008	2
Delhi	11	110	91	83	10-15	86	91	91	100	1039	1
Gujarat	71	7171	6843	95	10-12	6829	6843	4773	70	31411	3
Haryana	1	50	48	96	5-10	48	48	48	100	270	1
HP	4	34	5	15	11-15	5	5	5	100	18	1
Goa	8	10	10	100	116	8	10	8	80	116	2
Karnataka	80	4071	4071	100	8-12	4003	4071	4071	100	19622	2
Kerala	50	2560	1596	62	8-12	683	1596	723	45	12768	3
Maharashtra	95	5557	5557	100	10	5557	5557	1493	27	14000	1
Punjab	40	7475	7475	100	12	7475	7475	7193	96	20327	2
Tamil Nadu	11	3324	1025	31	10-12	-	1025	1025	100	10250	16
Telangana	41	11000	7750	70	10	7750	7750	7750	100	7750	3
West Bengal	90	11792	9758	83	8-12	9274	9758	9483	97	102772	3
Sub-Total	**612**	**63594**	**54669**	**86**		**34750**	**54669**	**47103**	**86**	**187605**	
Union Territories											
A&NI	1	25	25	100	6	25	25	0	0	0	0
Puducherry	1	108	25	23	50	Nil	25	0	0	0	0
Ladakh	NA										
J&K	85	113	180	159	8-15	138	180	112	62	330	2
Chandigarh	NA										
Sub-Total	**87**	**246**	**230**	**93**		**163**	**230**	**112**	**49**	**330**	
Grand Total	**1105**	**92111**	**80238**	**87**		**58386**	**80238**	**70574**	**88**	**413881**	

5 Best Practices Under Community Processes

Various best practices have been piloted and upon encouraging outcomes have been scaled up across states. In this section, we summarize a few of these best practices about the thematic area of Community Processes-

- Digital Community Engagement Platforms for Improving Family Planning, Maternal Child Health and Nutrition outcomes
- Strengthening Cluster Meeting as a capacity building platform for ASHAs
- An Innovation Fostering Health service delivery and strengthening ASHA monitoring system- Madhya Pradesh

5.1 DIGITAL COMMUNITY ENGAGEMENT PLATFORMS FOR IMPROVING FAMILY PLANNING, MATERNAL CHILD HEALTH AND NUTRITION OUTCOMES

Social and behavioral change in multicultural countries like India calls for a solution that is modern yet adaptive and scalable. To bring about social and behavioral change around health, Digital Green in partnership with the Chhattisgarh government piloted a video-based approach that empowers local communities to generate and share knowledge about maternal and child health and adopt practices that improve nutrition and family planning outcomes through community videos. This peer video-based learning approach aimed to increase the knowledge of health care providers and subsequently improve the outcome of health indicators.

PROCESS OF IMPLEMENTATION

Digital green implemented the training program for frontline workers in a phased manner from 2018 as mentioned in table 11.1. As the implementation scale increased, there was a noted increase in the knowledge and perceptions of both frontline workers as well as community members. Frontline workers have been using several community platforms like VHND, AWC, VHSNC etc. to disseminate the information and skills through digital platforms. Participatory video making was enabled through the training of Mitanin (ASHA) trainers and SHRC staff. Several videos have been made in the local language with the help of local producers as mentioned in table 11.2. So far, cumulatively pico bases dissemination have been reached to 104252 men & women with tailored messages around maternal and child health, nutrition, and family planning as mentioned. Mitanin Trainers leveraged multiple community platforms like Village Health, Sanitation and Nutrition Committee (VHSNC) meetings, Village Health and Nutrition Days (VHNDs), hamlet meetings etc. to screen videos on ANC, IFA, complementary feeding, family planning etc. among the community members.

TABLE 11.1 PHASE WISE IMPLEMENTATION

District	No. of Blocks	No. of villages	No. of MTs trained on video-dissemination skills
Phase- I (March 2018)			
Rajnandgaon	5	389	50
Phase- II (August 2019)			

Rajnandgaon	9	641	70
Kabirdham	4	521	51
June 2019 Onwards			
Kabirdham	1	24	6
Total	**13**	**1575**	**177**

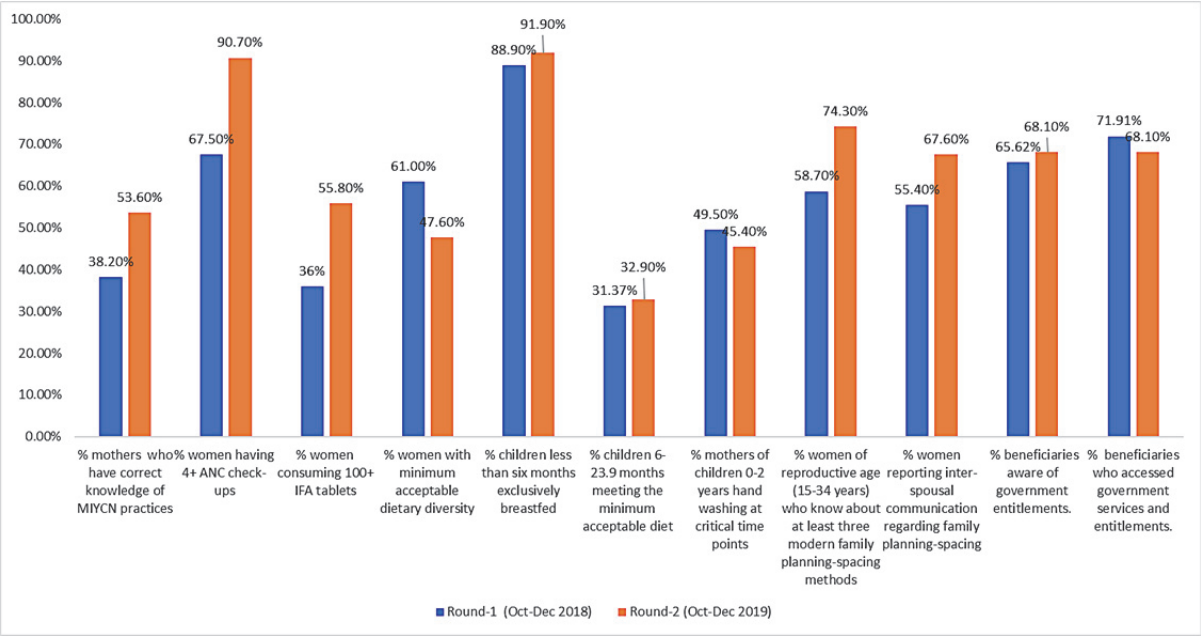
TABLE 11.2 VIDEOS PRODUCED THROUGH LOCAL PARTNERS

Sl. No.	Video Title	Language
1.	Garbhvati ke Liye Aayrangolikamahtv	Chhattisgarhi
2.	Complementary feeding	Chhattisgarhi
3.	Dast	Chhattisgarhi
4.	Kangaroo mother care	Chhattisgarhi
5.	Malaria	Chhattisgarhi
6.	Garbhvati ke parivar se charcha final	Chhattisgarhi
7.	Family Planning	Chhattisgarhi
8.	Home-based care for Common Cold and Cough	Chhattisgarhi
9.	Blood pressure	Chhattisgarhi

OUTCOME

Biannual surveys were conducted in 2018 and 2019 to address the effectiveness of the intervention and comparative outcome is outlined in the graphical presentation. Anecdotally, Government partners observed increasing attendance in Village Health and Nutrition Days (VHNDs), immunization days which were commonly used for video dissemination. Frontline workers have reported standardized messaging, ease of work, high effectiveness and increased trust and respect in them as key motivators for using this approach at the community level. Community members have shared that the videos are easy to understand, relatable and target the right messages in a locally appropriate manner. The following data is presented in figure-7 from both rounds in a comparable format.

FIGURE-7 COMPARATIVE OUTCOME OF BIANNUAL SURVEYS CONDUCTED IN 2018 AND 2019



5.2 STRENGTHENING CLUSTER MEETING AS CAPACITY BUILDING PLATFORMS FOR ASHAs

It has been a well-established fact that regular capacity building sessions are essential to encourage ASHA to perform her dedicated role. Uttar Pradesh has taken a step in strengthening capacity building activities at the monthly cluster meetings of ASHA and ASHA facilitators. This novel capacity-building intervention is aimed at improving knowledge, skills, and competencies of ASHAs around critical RMNCH+A indicators and addresses the barriers faced by ASHAs or ASHA facilitators in the achievement of the desirable outcome.

IMPLEMENTATION OF THE PROCESS

Efforts were made to identify gaps in the knowledge, attitudes and practices amongst ASHA and their facilitators were done through a Needs Assessment Consultation Meeting. This was followed by phased implementation between FY 2018-19 (61 blocks and 16 HPDs) and FY 2019-20 (127 blocks and 28 districts), and later to all the blocks. Operational guidelines were issued to CMOs and DCPMs highlighting the financial implications of the intervention. Training and facilitation modules were prepared followed by implementation of training in the cascade manner from state trainers to district and block community process officials. BCPM were provided with the responsibility of ensuring the reorientation and practice session for ASHA Sanginis in their monthly meeting on scheduled sessions for the cluster meetings. The process of the rollout of implementation and training calendar is mentioned below in figure 8 and Table 12 respectively.

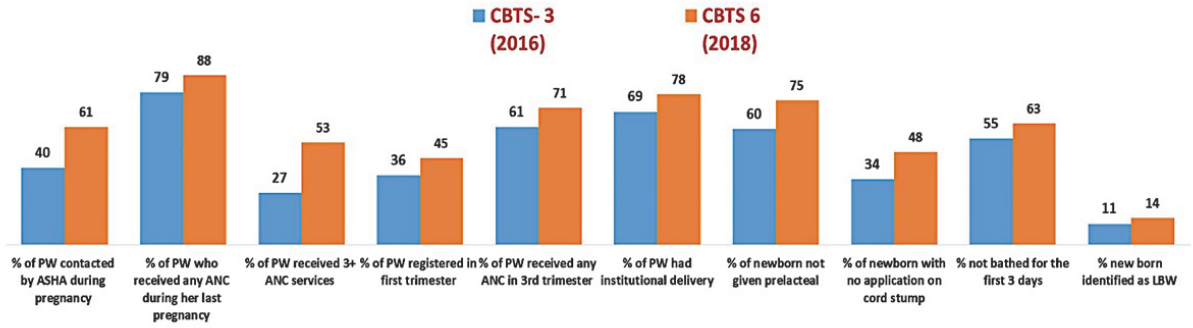
FIGURE-7 INTERVENTION ROLL-OUT PROCESS

TABLE-12 CAPACITY BUILDING CALENDAR

Month wise - Cluster Meeting Capacity Building Calendar			
April Diarrhoea Prevention & Treatment	**May** Exclusive breastfeeding, LBW, Management	**June** Birth Preparedness, ID & 48 hours' stay and FP	**July** Danger sign identification in newborn
August Early Identification & Registration of PW and VHIR updating	**September** ANC & IFA Supplementation	**October** HRP identification and referral	**November** VHND and Immunization
December Newborn care and HBNC	**January** Pneumonia prevention & treatment	**February** Non-communicable disease	**March** VHSNC

Community-Based Tracking Survey (CBTS), which is a household survey conducted by UPTSU since 2014, indicated an incremental trend in MNCH community-level indicators between Round 3 (2016) to Round 6 (2018) which depicted ASHAs' enhanced performance, skills, and competencies in providing optimum care and services to pregnant woman, mothers, and new-born mentioned below in figure 9. Improvement of knowledge and skills among ASHA and ASHA facilitators enabled them to perform well in their working area.

FIGURE-9 COMPARATIVE CBTS HIGHLIGHTING THE KEY MNCH INDICATORS PERFORMANCE IN 2016 AND 2018

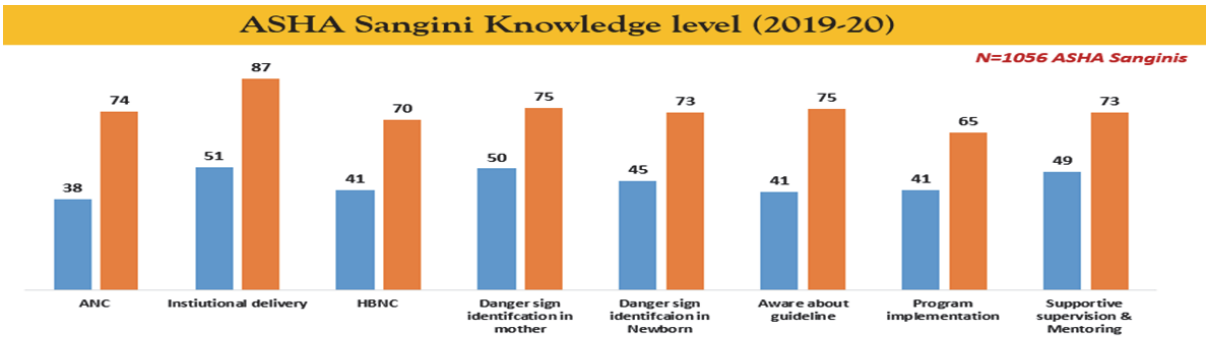


5.3 AN INNOVATION FOSTERING HEALTH SERVICE DELIVERY AND STRENGTHENING ASHA MONITORING SYSTEM- MADHYA PRADESH

ASHA SANGINI KNOWLEDGE LEVEL

Over a decade, ASHA has played a critical role in the reduction of maternal and newborn mortality. However, in difficult and remote geographies the progress of outcome indicators was slow. The data available with ASHAs can be used for effective planning and prioritization of home visits. This can also provide a benchmark for supportive supervision by ASHA Sahyogis (Facilitators) who can guide and motivate ASHAs to track the beneficiary's health progress. Therefore, to intensify the efforts of ASHAs, the state of Madhya Pradesh implemented pilot innovations fostering mapping of village health indicators by frontline workers. This innovation is intended to establish an effective service delivery and efficient review mechanism for ASHA.

FIGURE-10 ASSESSMENT OF KNOWLEDGE AMONGST ASHA FACILITATORS



STRENGTHENING ASHA MONITORING SYSTEM

Tracking of Maternal and child health indicators was done by posting an ASHA report card tracker on the walls of Aanganwadi Centre as shown in picture 11.1. Plotting of indicators with red pins enabled ASHA and ASHA facilitators in planning for focus areas for improving health outcomes. A similar tool was posted at the house of every pregnant and lactating mother and red pin plotting was done in case of missed service delivery by ASHAs. Validation of service delivery provided by ASHAs was done by ASHA facilitators and BCMs to ensure the last mile of and outcome. A sample of tracking report cards filled by ASHAs is depicted in Figure 11.2.

FIGURE 11.1 SAMPLE OF ASHA REPORT CARD BASED TRACKING

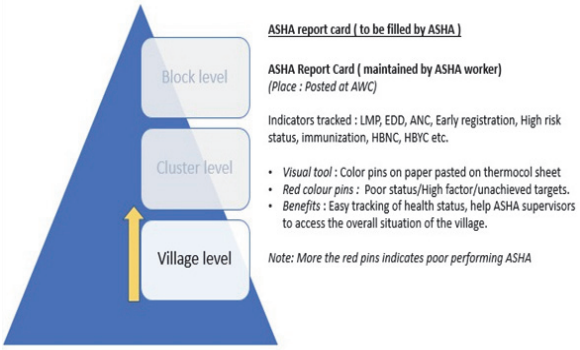


FIGURE 11.2 OVERVIEW OF ASHA REPORT CARD

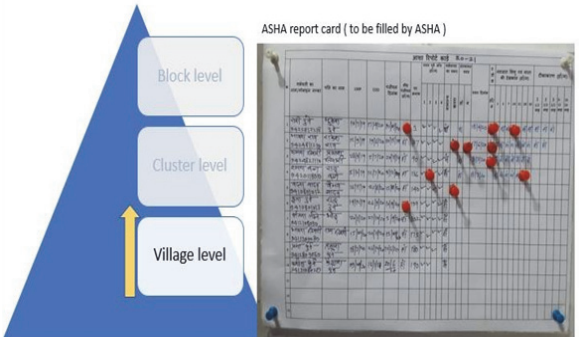
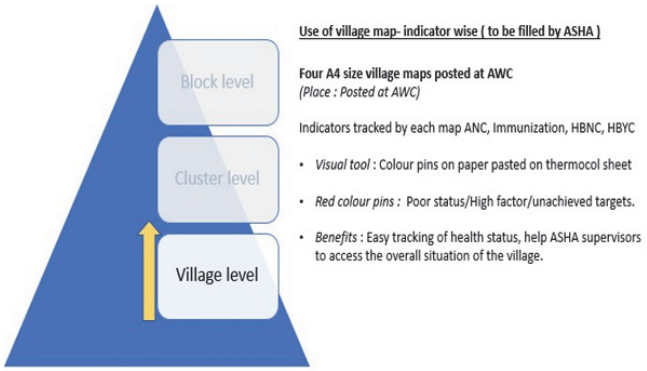


FIGURE 11.3 INDICATOR WISE VILLAGE MAP



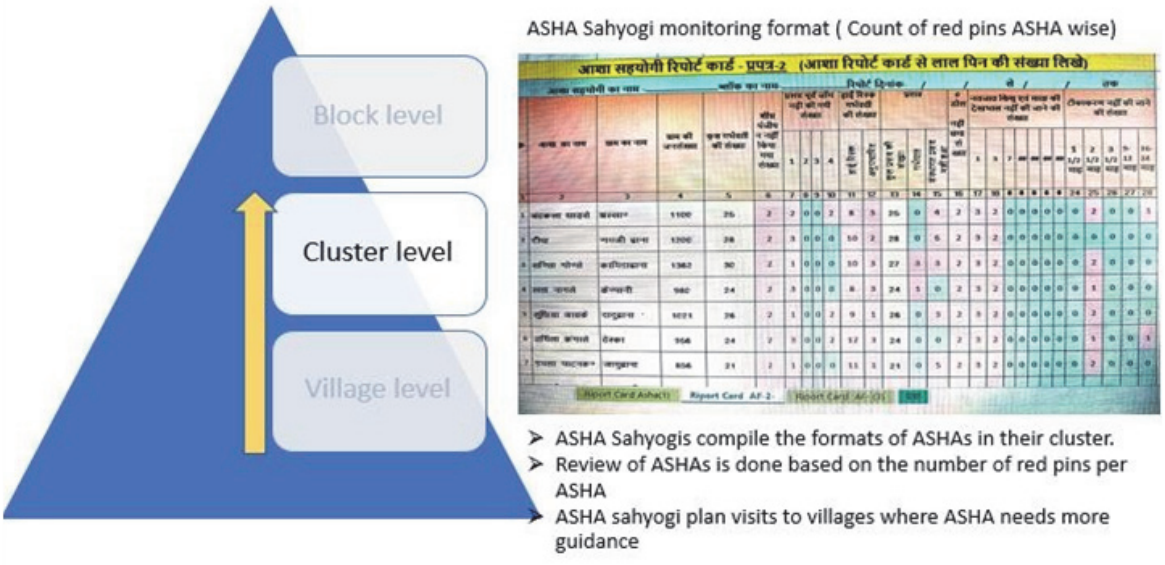
Furthermore, to understand the overall picture of the health status 'Village map' was pasted on the walls of AWCs (Figure 11.3). ANC, Immunization, HBNC and SAM/MAM were plotted on the village map through different colour-coded pins (Red, yellow, and green) (Figure 11.4). Red colour coding implies missed delivery of respective services. The column under each of the four indicators was designated for ASHA Facilitators to plot the work of ASHAs. This comprehensive tool provided firsthand information about the specific hamlets and areas which requires extra efforts for the desired improvement.

The performance-based tracking of ASHAs was done through the counting of colour-coded pins by ASHA facilitators. This also enabled planning and prioritizing of village visits by ASHA facilitators. Compilation of data at the block level by BCM helped them to identify and address loopholes in the program implementation.

Strengthening the ASHA monitoring system model of Madhya Pradesh proved useful in devising a work plan based on prioritization. This also aided supervisors to provide support to improve work

efficiency and output. Furthermore, as the data was visualized at a single place the need to refer to the register was reduced.

FIGURE 11.4 DATA COMPILATION AT CLUSTER LEVEL AND PERFORMANCE-BASED MONITORING



6 Key Highlights of the Annual Community Processes State Nodal Officer Workshop

The annual workshop for state nodal officers for Community Processes (CP), held online on 4th, 6th, and 9th November 2020, was envisaged to identify trends in the CP programme and gather plans for collective action with the advancing comprehensive primary Health care services across the country. The workshop focused on gathering suggestive recommendations on – Strengthening the support structures to mentor ASHAs, improving working conditions of ASHAs and AFs, redesigning of ASHA programme in urban and peri-urban areas, up-gradation of capacity building framework for ASHAs, engagement of ASHAs in rural areas, convergence, and community engagement. About 82 participants from 27 states and 5 UTs attended the workshop.

The initial day of the workshop focused on the trends in the evolution of the ASHA program since its inception and the subsequent achievements. Highlights outlined the critical role of ASHAs in controlling the unforeseen COVID-19 pandemic, alongside the uninterrupted delivery of the existing essential RMNCH+A services. However, the need to strengthen the ASHA program was reinforced through -Training of ASHAs, strengthening of existing support structures, streamlining payment of incentives, expediting ASHA Certification, and devising mechanisms to motivate uptake of IT applications.

Group discussions were organized to facilitate deliberations among state programme managers to generate ideas about the future of the ASHA programme and suggest possible solutions to the emerging challenges faced by the programme. States were divided into six groups based on the thematic areas- Strengthening the support structures to mentor ASHAs, improving working conditions of ASHAs and AFs, redesigning of ASHA programme in urban and peri-urban areas, up-gradation of capacity building framework for ASHAs, engagement of ASHAs in rural areas, convergence, and community engagement. Group Discussions were followed by a plenary discussion where each group presented the key recommendations of the group, which were consolidated and presented to the Additional Secretary & Mission Director, MoHFW in the concluding session.

KEY DISCUSSION POINTS FROM GROUP 1: STRENGTHENING THE SUPPORT STRUCTURES TO MENTOR ASHAs IN DELIVERING AN EXPANDED RANGE OF SERVICE AT THE COMMUNITY LEVEL

- With the implementation of the Expanded package of services under Ayushman Bharat- Health and Wellness Centres, suggestions emerged on transitioning the role of ASHAs from a volunteer/ community health worker and a community mobilizer to HWC team member for engagement in surveys and reporting.
- As ASHAs are required to work in constant coordination with the HWC team it is required that the capacities of ASHAs should also be enhanced to equip them with organizational and digital literacy skills. Recommendations also came for joint training of ASHAs and MPW-F on newer packages for better role clarity and teambuilding. Similarly, it was also insisted to organize a periodic training session for support structures of ASHAs at all levels.
- Revision of salary structures for Block and District Nodal Officers was insisted to increase motivation and reduce turnover. The group stressed on the need to redefine the role of ASHA facilitators with an increase in working days and more focus on community-level activities.

- The group also suggested the revision of the ASHA Kit in accordance with the current context of the expanded package of services. The members also presented the idea of creating a National ASHA portal with provision for state-specific modules. The need for streamlining payments linked with Public Financial Management System (PFMS) to assure regular payments was also emphasized.

KEY DISCUSSION POINTS FROM GROUP 2: IMPROVING WORKING CONDITIONS OF ASHAs AND ASHA FACILITATORS

- With respect to ASHA restrooms, the need was identified for the mandatory establishment of restrooms under IPHS norms for District Hospitals under Rogi Kalyan Samities. At sub-district level or below facilities, the mandatory provision should be linked with minimum caseload under IPHS. To strengthen the upkeep and management of the restroom RKS should take necessary actions and accountability should be held by leveraging it with the NQAS certification.
- The group also suggested the provision of mobility allowances to ASHAs in the form of the monthly travel allowance.
- For safeguarding the positions of ASHAs and AFs efforts are required to organize periodic sensitization on gender-based violence and legal provisions of programme management, service delivery staff and frontline workers. National level commitment and guidance to states are required for 'zero-tolerance against the discrimination or assault of frontline workers. Removal of ASHAs should be based on performance and existing norms and not by the influence of local authorities. Group also suggested the formation of a 'State-level committee' to address gender-based violence, harassment and discrimination faced by ASHAs.
- To fortify the existing Grievance Redressal mechanisms for ASHAs, a Toll-Free helpline should be created to address the grievances faced by frontline workers and take necessary steps to address them.
- With regards to social security, the group recommended the introduction of Maternity Benefit Schemes for ASHAs and AFs. Also, alongside the existing schemes, ASHAs and AFs should be provided access to the state and central health insurance schemes regardless of their socio-economic status.
- A need was identified for providing states with the guidance on creating enabling environment for ASHAs and AFs for pursuing higher opportunities which may include continuation of existing mechanisms of enrolment in ANM/nursing courses, provision of weightage for experience as an ASHA/ AF and age relaxation for positions under health department if other criteria are met.
- With the evolving technology, it was addressed to identify solutions for providing smartphones to ASHAs and AFs. Also, the development process of the ASHA application should be undertaken for the smooth recording of data.

KEY DISCUSSION POINTS FROM GROUP 3: CAPACITY BUILDING FRAMEWORK TO ADDRESS THE NEED FOR REGULAR REFRESHER TRAINING FOR COMPLEX TASKS AND VARIED LEVELS OF LITERACY AMONG ASHAs

- Appraising the success of the cascade training model, the group suggested the creation of a district training hub with the empanelment of agencies/NGOs. The group urged for better coordination between programme divisions and ASHA resource centres for planning and

conducting training on new packages. Revision of existing training norms especially for difficult terrains was also proposed.

- 2. Suggestions were provided on the revision of ASHA certification guidelines in terms of duration, adjusting requisites for accreditation examinations and discontinuation of component of accreditation of state and district training sites were presented. The group further added that ASHA Certification through State University could add more value to ASHAs for career progression compared to the current process through NIOS.
- Given the expanded tasks of ASHAs, the group insisted on the revision of educational level requirements for selection to the 10th standard.

KEY DISCUSSION POINTS FROM GROUP 4: TERMS OF ENGAGEMENT OF ASHAs IN RURAL AREAS IN THE NEXT PHASE OF THE NHM

- With regard to incentives, the group felt that the same rates (as rural areas) of incentives should be applicable in urban areas for all common activities between rural and urban ASHAs. However, the need was felt to revise the incentive amount of the routine activity packages.
- Because of the expanded tasks of ASHAs, the group insisted on the revision of educational level requirement for selection to the 10th standard. Involvement of ASHAs in unlawful activity should be subjected to removal alongside the norms suggested in the guidelines.
- Revision of existing performance-based indicators as per the expanded package of services was desired for the identification of both non-functional and well-performing ASHAs.
- The concept of Second specialist ASHA was proposed at the AB-HWC level to cater for the demands of the expanded package of services under Comprehensive primary health care. Specialist ASHA can be skilled in mental health/palliative care/other expanded services and additional incentives on identified indicators were recommended.
- In terms of work time allocation, the group suggested new evidence on the time use of ASHAs in the context of CPHC and allocated in the follow-up for bilateral programs.
- Another key recommendation of the group was to create pool wise incentive package – RCH, NCD, CD by identification of routine activities under each service area and creating routine activities under each pool, designing incentives based on coverage indicators rather than being linked with the number of home visits made and increasing number of case-based incentives which require long- term follow- up.

KEY DISCUSSION POINTS FROM GROUP 5: CONVERGENCE AND COMMUNITY ENGAGEMENT

- To strengthen the health of the village residents, it was suggested to regularize meetings of VHSNC/MAS, the inclusion of village health review in VHSNC meetings, quarterly review by Gram Panchayat and improving ownership of PRIs & ULBs over VHSNC/ MAS.
- Strengthening the role of ASHAs in VHSNC / Village level health planning was also shared as a strategy to improve community engagement. The group opined that provision of guidelines with role clarity of different frontline workers and mechanisms of coordination, collaborative training (e.g. VISHWAS Campaign), state-specific modules (PLA Trainings), capacity building of ASHA support structures on convergence and strong IEC on inter-sectoral coordination can contribute to the strengthening of community-level engagement.

ASHA INCENTIVES UNDER NATIONAL HEALTH MISSION

PART-1 UPDATED LIST OF ASHA INCENTIVES UNDER NATIONAL HEALTH PROGRAMS

SN	ACTIVITIES	AMOUNT IN RS./CASE	SOURCE OF FUND & FUND LINK-AGES	DOCUMENTED IN
I	**Incentive for Routine Recurrent Activities**			
1	Mobilizing and attending Village Health and Nutrition Days or Urban Health and Nutrition Days	Rs.200/session	NHM- Flexi Pool	Order on revised rate of ASHA incentives- D. O. No. P17018/14/13-NRHM-1V
2	Conveying and guiding monthly meeting of VHSNC/MAS	Rs. 150		
3	Attending monthly meetings at Block PHC/UPHC	Rs. 150		
4	a. Line listing of households done at beginning of the year and updated every six months	Rs. 300		
	b. Maintaining village health register and supporting universal registration of births and deaths to be updated on the monthly basis	Rs. 300		
	c. Preparation of duelist of children to be immunized monthly	Rs. 300		Order no. F No7 (84)/2018 NHM-1- 28th Sept- 18
	d. Preparation of list of ANC beneficiaries to be updated monthly	Rs. 300		
	e. Preparation of list of eligible couple monthly	Rs. 300		
II	**Maternal Health**			
	JSY financial package			
1	a. For ensuring antenatal care for the woman	Rs.300 for Rural areas and Rs. 200 for Urban areas	Maternal Health-NRHM-RCH Flexi pool	MOHFW Order No. Z 14018/1/2012/-JSY JSY-section Ministry of Health and Family Welfare -6th. February-2013
	b. For facilitating institutional delivery	Rs. 300 for Rural areas and Rs. 200 for Urban areas		
2	Reporting Death of women (15-49 years age group) by ASHA to PHC Medical Officer[1]	Rs. 200 for reporting within 24 hours of the occurrence of death by phone	HSC/ U-PHC- Untied Fund	MoHFW-OM-120151/148/2011/MCH; Maternal Health Division, 14th Feb-2013
III	**Child Health**			
1	Home Visit for the Newborn and Post-Partum mother [2] -Six Visits in Case of Institutional Delivery (Days 3, 7, 14, 21, 28 & 42) -Seven visits in case of Home Deliveries (Days 1, 3, 7, 14, 21, 28 & 42)	Rs. 250	Child Health- NHM-RCH Flexi pool	HBNC Guidelines –August-2014

1 Under SUMAN Guidelines 2019, any person who first reports a Maternal Death in the community shall be entitled of incentive @Rs 1000/ including ASHAs, however the mode of reporting shall only be through 104 call center and no other mode of reporting except specified by the State Govt shall be included and payable after the death to be certified by the designated block team.

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

2	Home Visits of Young Child for Strengthening of Health & Nutrition of the young child through Home Visits-(recommended schedule- 3, 6, 9, 12 and 15 months) -(Rs.50X5visits)	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	For follow up visits to a child 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 Newborn Care Units [3]	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- Would be subsumed with HBYC incentive
5	Child Death Review for reporting child death of children under 5 years of age	Rs. 50		Operational Guidelines for Child Death Review- 2014
6	For mobilizing and ensuring every eligible child (1-19 years out-of-school and non-enrolled) is administered Albendazole.	Rs. 100/ ASHA/Bi-Annual		OGs for National Deworming Day January-2016
7	Week-1-ASHA incentive for prophylactic distribution of ORS to families with under-five children	Rs. 1 per ORS packet for 100 under-five children		OGs for Intensified Diarrhoea Control Fortnight – June-2015
8	Week-2- ASHA incentive for facilitating growth monitoring of all children in village; screening and referral of undernourished children to Health centre; IYCF counselling to under-five children household	Rs. 100 per ASHA for completing at least 80% of household		
9	MAA (Mother's Absolute Affection) Programme Promotion of Breastfeeding- Quarterly mother meeting	Rs. 100/ASHA/ Quarterly meeting		OGs for Promotion of Breast-feeding-MAA -2016
IV	**Immunization**			
1	Full immunization for a child under one year	Rs. 100	Routine Immunization Pool	Order on Revised Norms under UIP-T.13011i01/2077-CC-May-12
2	Complete immunization per child up to two years age (all vaccination received between 1st & IInd year of age after completing full immunization after one year	Rs. 75 [4]		Order no – T.13011/01/2012/-CC& V
3	Mobilizing children for OPV immunization under Pulse polio Programme	Rs. 100/day [5]	IPPI funds	Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV
4	DPT Booster at 5-6years of age	Rs.50		Order no-T.13011/01/2012/CCV
V	**Family Planning**			
1	Ensuring spacing of 2 years after marriage [6]	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 the birth of 1st child 5	Rs. 500		

3 This incentive will be subsumed with the HBYC incentive subsequently
4 Revised from Rs. 50 to Rs, 75
5 Revised from Rs 75/day to Rs 100/day
6 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 & DD&DNH

3	Ensuring a couple to opt for permanent limiting method after 2 children [7]	Rs. 1000		
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		
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	Female Postpartum sterilization	Rs. 300 in 11 states with high fertility rates (UP, Bihar, MP, Rajasthan, Chhattisgarh, Jharkhand, Odisha, Uttarakhand, Assam, Haryana, Gujarat) & 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	Escorting or 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	Escorting or facilitating beneficiary to the health facility for the PAIUCD insertion	Rs. 150/case		Order on revised rate of ASHA Incentives -2016
Mission Parivar Vikas- In selected 146 districts in six states- (57 in UP, 37 in Bihar, 14 RJS, 9 in Jharkhand, 02 in Chhattisgarh and 2 in Assam)				
10	Injectable Contraceptive MPA (Antara Program) and a non-hormonal weekly Centchroman pill (Chhaya) - Incentive to ASHA	Rs. 100 per dose	Family planning-RCH- NHM Flexi Pool	D.O.No.N. 110023/2/2016-FP
11	Mission Parivar Vikas Campaigns Block level activities- ASHA to be oriented on eligible couple survey for estimation of beneficiaries and will be expected to conduct eligible couple survey- maximum four rounds	Rs. 150/ ASHA/round		
12	Nayi Pahel- an FP kit for newly-weds- an FP kit would be given to the newlywed couple by ASHA (In initial phase ASHA may be given 2 kits/ ASHA)	Rs. 100/ASHA/Nayi Pahel kit distribution		
13	Saas Bahu Sammelan- mobilize Saas Bahu for the Sammelan- maximum four rounds	Rs. 100/ per meeting		

7 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

14	Updating of EC survey before each MPV campaign- Note-updating of EC survey register incentive is already part of the routine and recurring incentive			
VI	**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 meetings with adolescent girls pertaining to Menstrual Hygiene	Rs. 50/meeting	VHSNC Funds	
3	The incentive for support to Peer Educator (for facilitating selection process of peer educators)	Rs. 100/ Per PE	RKSK- NHM Flexi pool	Operational framework for Rashtriya Kishor Swasthya Karyakram – January-2014
4	The incentive for mobilizing adolescents for Adolescent Health Day	Rs. 200/ Per AHD		
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		D.O. No. Z.15015/56/2015-NHM-1 (Part)- Dated 4th January-2016
VIII	**Revised National Tuberculosis Control Programme** [8]			
	Honorarium and counselling charges for being a DOTS provider		RNTCP Funds	Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV
1	For Category I of TB patients (New cases of Tuberculosis)	Rs. 1000 for 42 contacts over six or seven months of treatment		
2	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 the intensive phase		
3	For treatment and support to drug-resistant TB patients	Rs. 5000 for a completed course of treatment (Rs. 2000 should be given at the end of the intensive phase and Rs. 3000 at the end of the consolidation phase		
4	For notification, if the suspect referred is diagnosed to be a TB patient by MO/Lab [9]	Rs.100		Revised National Tuberculosis Control Program-Guidelines for partnership- The year 2014
IX	**National Leprosy Eradication Programme** [10]			
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 upon completion of treatment)	NLEP Funds	Order on revised rate of ASHA incentives-D.O. No. P17018/14/13-NRHM-IV

8 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

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

10 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.

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 upon completion of treatment)		
X	**National Vector Borne Disease Control Programme**			
A)	**Malaria** [11]			
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	For referring a case and ensuring complete treatment	Rs. 300 (not in their updated list)		
B)	**Lymphatic Filariasis**			
1	For one timeline listing of lymph-oedema 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	For annual Mass Drug Administration for cases of Lymphatic Filariasis [12]	Rs. 200/day for a maximum of 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	Involvement of ASHAs during the spray rounds (IRS) for sensitizing the community to accept indoor spraying [13]	Rs. 100/- per round during Indoor Residual Spray i.e., Rs 200 in total for two rounds	NVBDCP funds	Minutes Mission Steering Group meeting- February-2015
2	ASHA Incentive for 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	The incentive for source reduction & IEC activities for prevention and control 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 exceeded Rs. 1000/ASHA/ Year	NVBDCP funds	The updated list of NVBDCP incentives shared by MoHFW-NVBDCP Division – Dated-16th August-2018
F)	National Iodine Deficiency Disorders Control Programme			
1	ASHA incentive for salt testing	Rs.25 a month for testing 50 salt samples	NIDDCP Funds	National Iodine Deficiency Disorders Control Program-Oct-06
XI	Incentives under Comprehensive Primary Health Care (CPHC) and Universal NCDs Screening			

11 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.

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

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

1	Maintaining data validation and collection of additional information-per completed form/family for NHPM –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 every individual –onetime activity for enumeration of all individuals, filling CBAC for all individuals 30 or > 30 years of age	Rs. 10/perform per form/ per individual as a one-time incentive		
3	Follow up of patients diagnosed with Hypertension/Diabetes and three common cancers for ignition of treatment and ensuring compliance	Rs. 50/per case/Bi-Annual		
4	Delivery of new service packages under CPHC component	Rs.1000/ASHA/PM (linked with activities)	NHM funds	D.O.No.Z-1505/11/2017-NHM-I-Dated 30th May-2018
XII	**Drinking water and sanitation**			
1	Motivating Households to construct toilets 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 – Feb-2013
XII	**Incentives to the ASHA and ASHA Facilitators during Covid-19 pandemic (applicable till September 2021)**			
1	Provision of additional incentives on account of COVID-19 related work	Rs. 1000/month/ASHA	ECRP fund	D.O No: Z-28015/58/2019-NRHM-I 4th May-2021
2	Provision of additional incentives on account of COVID-19 related work	Rs. 500/month/ASHA Facilitators		

PART-2 STATE-SPECIFIC INCENTIVES FOR ASHAS FROM STATE FUNDS

SN	Name of States	State Specific Incentives for ASHAs from State Funds
1	Andhra Pradesh	Provides balance amount to match the total incentive of Rs.10, 000/month
2	Arunachal Pradesh	Provides 100% top-up
3	Bihar	Rs.1000/PM/ASHA linked with functionality of five specified 06 activities (started in FY 2019-20)
4	Chhattisgarh	75% of matching amount of incentives over the above incentives earned by an ASHA as a top-up on an annual
5	Delhi	Rs.3000/month for functional ASHA (against the 12 core activities performed by ASHA)
6	Gujarat	Provides 50% top-up
7	Haryana	Rs. 4000/month from June-2018 and 50% top-up
8	Himachal Pradesh	Rs. 2000/month
9	Kerala	Rs.5000/month in FY 2020-21
10	Karnataka	Rs.4000/month – recently introduced replacing the top-up incentive
11	Odisha	Rs.1000 /month from state fund launched on April 1st, 2018
12	Rajasthan	Rs. 2700/month through ICDS
13	Sikkim	Rs. 6000/month
14	Tripura	Provides 100% top-up against 08 specified activities and 33% top-up based on other activities.
15	Telangana	Provides balance amount to match the total incentive of Rs. 7500/month
16	Uttarakhand	Rs.5000/year and Rs. 2000/month.
17	Uttar Pradesh	Rs.750/- per ASHA per month linked with the functionality of five specified activities (started from March 2019)
18	West Bengal	Rs.3000/month

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Special thanks to :

- Nodal Officers, ASHAs and ASHA Facilitators in all States'/Union Territories
- Senior Consultants and Consultants, Community Processes and Comprehensive Primary Health Care, in National Health Systems Resource Centre & North East Regional Resource Centre (NE-RRC).

NOTES

Namaste!

You are a valuable member of the Ayushman Bharat – Health and Wellness Centre (AB-HWC) team committed to delivering quality comprehensive primary healthcare services to the people of the country.
To reach out to community members about the services at AB- HWCs, do connect to the following social media handles-

 https://instagram.com/ayushmanhwcs

 https://twitter.com/AyushmanHWCs

 https://www.facebook.com/AyushmanHWCs

 https://www.youtube.com/c/NHSRC_MoHFW

Design & Printed at : Mittal Enterprises, Delhi

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